

# **THE COVID-19 PANDEMIC EFFECT ON CAMPUS MEDICAL, COUNSELING, AND WELLNESS SERVICES**

A Survey of Campus Pandemic Response  
Successes and Lessons Learned from Fall 2020

Date of Survey: January 8–20, 2021



AMERICAN  
COLLEGE  
HEALTH  
ASSOCIATION



AMERICAN  
COLLEGE  
HEALTH  
ASSOCIATION

## **THE COVID-19 PANDEMIC EFFECT ON CAMPUS MEDICAL, COUNSELING, AND WELLNESS SERVICES**

**A Survey of Campus Pandemic Response  
Successes and Lessons Learned from Fall 2020**

**Date of Survey: January 8–20, 2021**

This report has been collaboratively created by the following members  
of the ACHA COVID-19 Task Force:

### **ACHA COVID-19 Task Force Survey Sub-Committee**

#### **Survey Sub-Committee Chairs**

Anita Barkin, DrPH, MSN, NP-C, FACHA  
Geraldine Taylor, MS, APRN-BC, FACHA

#### **Survey Sub-Committee Members**

David Anderson, PhD  
Robyn Buchsbaum, MHS  
Jean Chin, MD, MBA, FACP, FACHA  
Mary T. Hoban, PhD, MCHES  
Giang T. Nguyen, MD, MPH, MSCE, FAAFP

For additional COVID-19 information and resources for campuses,  
visit ACHA's COVID-19 Resource page:

**[www.acha.org/COVID-19](http://www.acha.org/COVID-19)**

## EXECUTIVE SUMMARY

The American College Health Association (ACHA) COVID-19 Task Force conducted its fifth COVID-19 survey between January 8 and January 20, 2021. The survey focused on qualitative data collection from campuses in response to COVID-19 during the fall semester/quarter 2020. The goal of the survey was to capture experiences from the respondents' point of view regarding key elements related to successes and lessons learned.

Of the 1,018 institutions invited to participate in an online Qualtrics survey, 325 schools responded, for a response rate of 31.9%. The sample was comprised of predominately four-year institutions, small to large sized, public and private, representing all geographic areas across the United States.

Most respondents (86.6%) felt their mitigation efforts were successful, ranking their success as a "4" or "5" on a scale of "1" to "5" (1=not successful, 5=very successful). They offered rich descriptions (2,763) of their mitigation strategies and identified the key characteristics of the successful response effort of health services including medical care, counseling and wellness/health promotion. Innovation, creativity and nimble responses to the evolving landscape of the pandemic were reflected in efforts to tailor strategies according to the unique circumstances and resources available to the institution. Responses related to "lessons" learned reflected the need for reassessment of the strategies and resources necessary to maintain and improve mitigation response based on the fall experience.

### Key Findings

- Establishment and maintenance of adequate medical mitigation such as robust testing programs, contact tracing, case management, and surveillance activities is resource intense. Addressing the mental health and well-being of students in isolation and quarantine both on and off campus required significant counseling and case management.
- Collaboration with internal and external departments and agencies and frequent, clear, transparent communication permeated all themes, highlighting the significance of these two foundational principles of organizational effectiveness.
- Leadership which was strong, responsive, adaptable, and transparent with consistent, clear decision-making and the ability to pivot in response to scientific data and new recommendations proved to be most successful.
- While strong leadership, teamwork, and effective planning were notable successes, the pandemic response exacted a toll on staff mental well-being.
- The rapid shift to virtual platforms facilitated provision of medical and counseling treatment, care, and services, staff/department meetings, and continuing education while maintaining a safe environment. Electronic health record upgrades; development of dashboards and new databases; and apps for contact tracing, surveillance, and symptom checking became part of the landscape. Ensuring timely access to IT support, interoperability of systems, and ongoing staff training and education will be essential to maximize efficiency and leverage data management going forward.
- Promoting positive health behaviors required recurrent education using multiple methods of communication. Involving students as trusted voices and providing guidance for activities which are safe and acceptable were valuable to promote student buy-in.
- The pandemic raised the profile of college health professionals as central to the public health response, integral to planning and preparedness, and indispensable in translating expert recommendations into context-specific policies and procedures for their campuses. Ensuring that college health retains "a seat at the table" and receives ongoing support to address the public health of our campuses is essential for the health and safety of the campus community.

## REPORT

### Purpose

The American College Health Association (ACHA) COVID-19 Task Force conducted its fifth COVID-19 survey between January 8 and January 20, 2021. The survey focused on qualitative data collection from campuses in response to COVID-19 during the fall semester/quarter 2020. Given the uncertainties associated with this unprecedented event, campuses reopened in varying operating capacities in the fall of 2020. The goal of this survey was to capture experiences from the respondents' point of view regarding key elements related to successes and lessons learned.

### Methods

Responses were solicited from one ACHA member at each of 1,018 institutions of higher education. The institutions were comprised of all ACHA Institutional Members, as well as Individual ACHA Members at colleges and universities that did not hold ACHA institutional memberships. Participants were asked to provide narrative answers to an online survey developed by the ACHA COVID-19 Task Force. The answers to the four questions below were to be based on their experiences from the fall semester/quarter. References to "health services" in the questions included medical, counseling and wellness/health promotion services.

1. On a scale of 1 to 5 (1=not successful, 5=very successful), how successful do you believe your health services were in responding to the overall public health needs of your campus this past fall?
2. What three words or phrases best describe your campus' health services response to the pandemic this past fall?
3. Briefly describe three things that worked well for your campus' health services this past fall (include services provided by external partners). Please limit each response to 100 words or less.
4. Briefly describe three lessons learned regarding your campus' health services response to COVID-19 this past fall. Please limit each response to 100 words or less.

Responses were collected between January 8 and January 20, 2021, using the Qualtrics platform. A total of 325 complete surveys were submitted, representing a response rate of 31.9%.

Qualitative responses were initially reviewed to identify broad themes. Eight broad themes emerged: clinical care, human resources, collaboration, leadership, management and planning, health promotion and communication, technology, behavioral mitigation, and mental health. The themes were then assigned codes. Each coded response was independently verified by all team members for accuracy and consistency. Some responses were assigned more than one code, based upon the number of themes mentioned by the respondents within each answer.

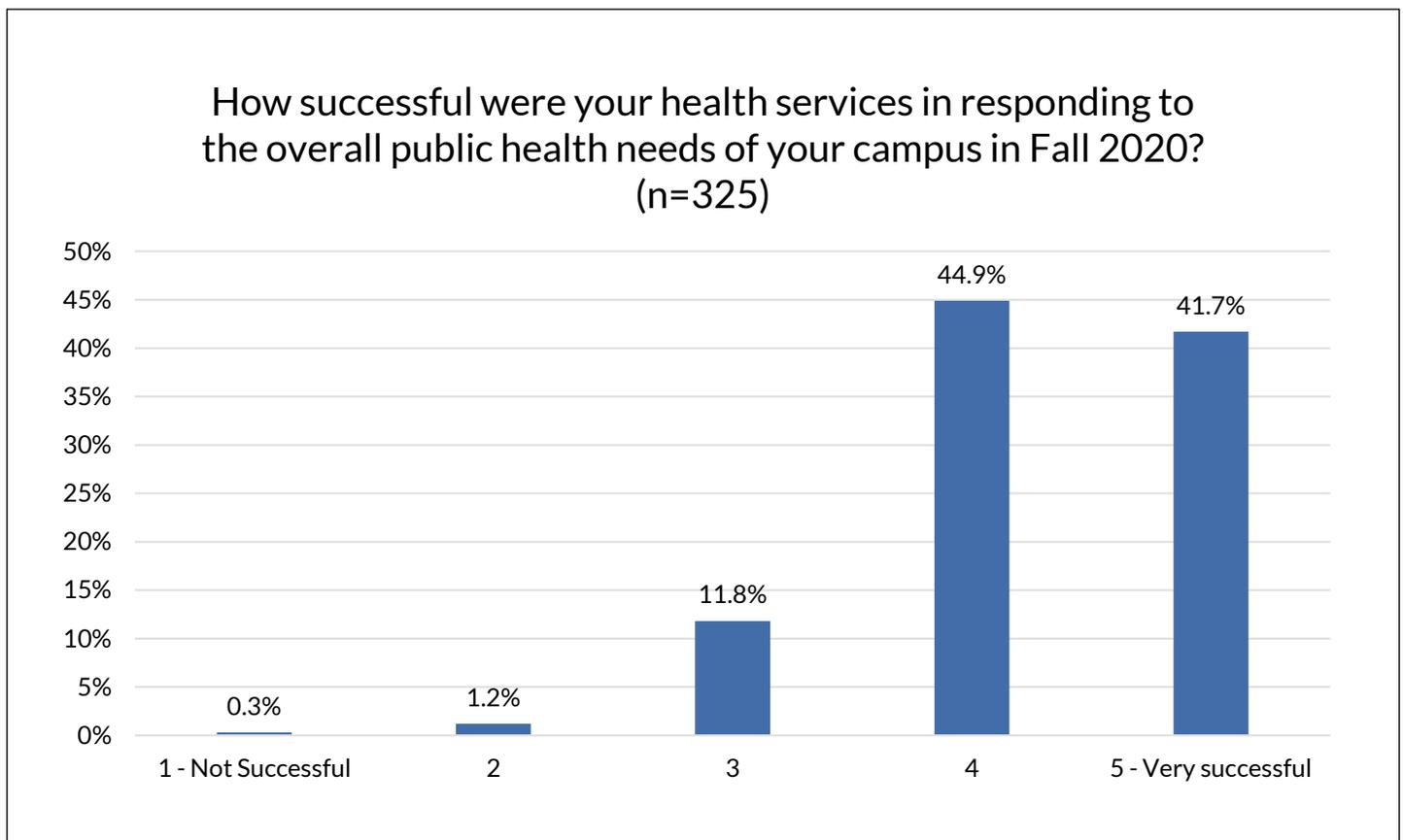
## The Sample

The demographics of the participating 325 institutions were consistent with the other four ACHA COVID-19 member surveys. The sample was predominantly comprised of four-year institutions. The breakdown of public/private schools was almost equally distributed as was that of total student enrollment with a range from small to large sized colleges. All regions of the U.S. were represented, with slightly heavier representation from the Northeast and South. Of the ten schools in the sample located outside of the U.S., one was from a U.S. territory and nine were from Canada. Of the participating schools, four were HBCUs and 93 were religiously affiliated. More than half (52.0%) of the schools were located in urban areas, 26% were in suburban areas, 20% were in towns, and 2% were in rural settings. The specifics of each campus characteristic are provided in the table below.

Institutional Characteristic	n	Valid Percent
Public	159	48.9%
Private	166	51.1%
2-year	27	8.3%
4-year	297	91.7%
Local Urban	169	52.0%
Local Suburban	84	25.8%
Local Town	64	19.7%
Local Rural	8	2.5%
Region Northeast	88	27.1%
Region Midwest	79	24.3%
Region South	92	28.3%
Region West	56	17.2%
Region U.S. Territory	1	0.3%
Region Outside the U.S. (Canada)	9	2.8%
Enrollment Less than 2,500	68	20.9%
Enrollment 2,500–4,999	69	21.2%
Enrollment 5,000–9,999	48	14.8%
Enrollment 10,000–19,999	63	19.4%
Enrollment 20,000 or more	77	23.7%

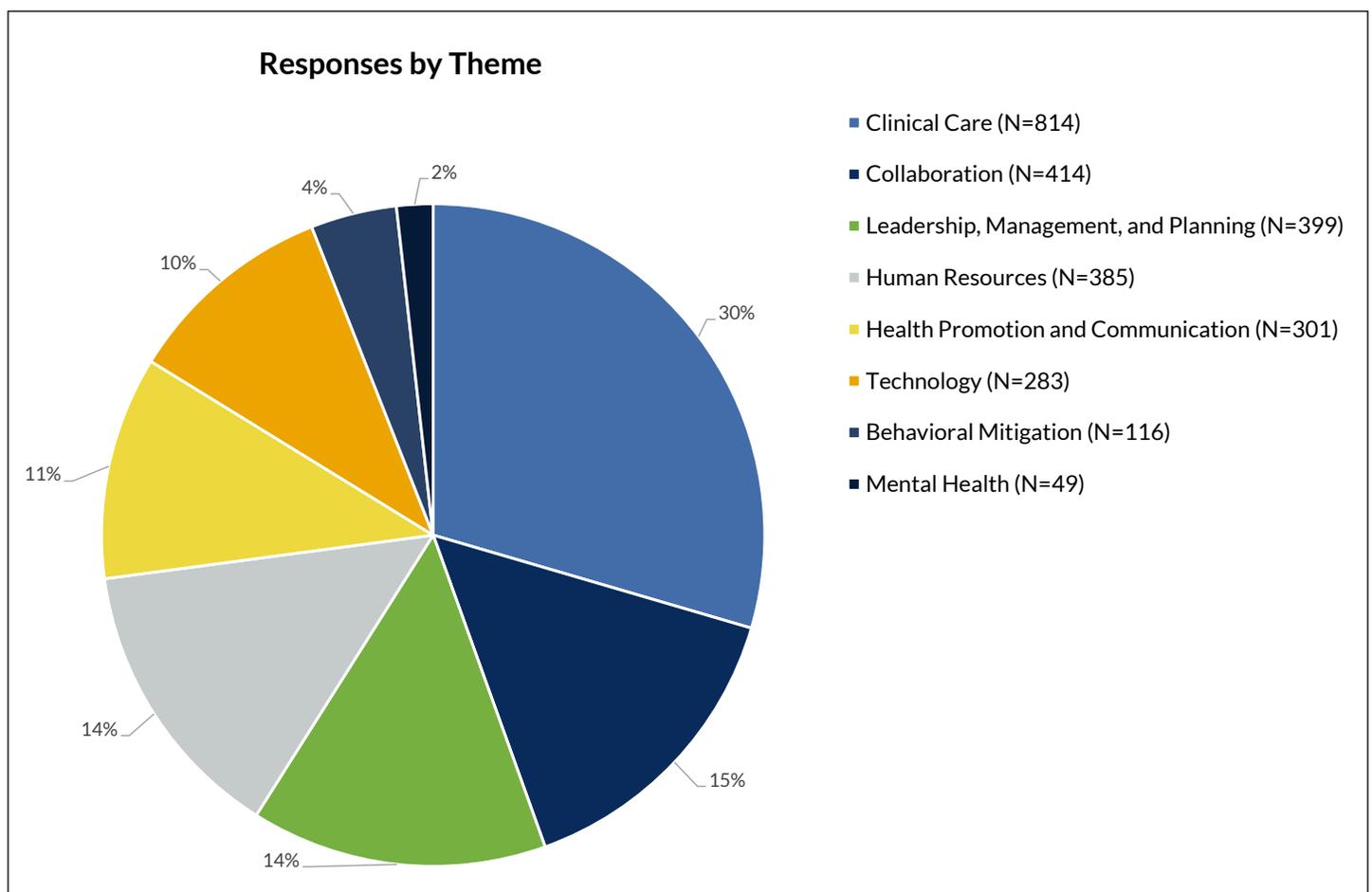
## SURVEY RESULTS

The opening question of the survey asked respondents to rate the success of their response. The vast majority of survey respondents (86.6%, N=282) felt their response to the pandemic was more successful than not. This is not entirely unexpected given that those who felt more successful may have been more likely to share that success through survey participation.





Each of the 325 participants were then asked to provide up to six different responses: three describing aspects of the response that went well and three describing lessons learned. There were a total of 2,763 responses reviewed and categorized into eight overarching themes (see chart below). Given the interconnectedness of the various themes as presented in the responses, overlap was a natural and necessary aspect of capturing the experience. Therefore, some themes have been subsumed under others; for example, human resources and comments related to the mental health of staff are included in the section “Leadership, Management and Planning” while mental health comments related to students are included under “Clinical Care.” The following narratives represent major threads within the themes with direct quotes from participants that illustrate particular aspects of the COVID-19 response. An appendix (Appendix A) accompanies this report for readers interested in exploring the responses from each theme in greater detail.



## CLINICAL CARE

Various medical service strategies were identified as contributing to the overall success of mitigation efforts. While isolation/quarantine, contact tracing, and other clinical care delivery comments were cited by participants, the number of comments on SARS-CoV-2 testing strategies far outpaced comments related to the other strategies. Strategies varied according to available resources, with some noting that “flexibility” and “creativity” were important in tailoring the mitigation response to meet campus capabilities and resources. Collaboration and support from many on- and off-campus partners were important threads throughout.

Over one-quarter of the comments related to successful testing strategies and the importance of testing to the overall mitigation effort. One respondent stated that “testing was the key to our success” while another respondent commented that carefully executed protocols and plans resulted in “a well-oiled machine.” Strategies reflected creative practices to address public health recommendations and provide easy access to testing by utilizing available resources that included on-campus testing (including wastewater surveillance), partnering with commercial laboratories, and leveraging relationships with other community providers, including public health. Testing tents, satellite locations, and drive-through clinics were employed using rapid antigen, PCR and saliva tests. Testing plans varied from testing symptomatic students only to testing students on-arrival with follow-up surveillance testing offered twice weekly; some schools also included staff and faculty in surveillance efforts. The key characteristics of successful testing programs included ease of access, no-cost, and quick turnaround of results. Testing was limited on some campuses due to financial concerns. The level of creativity and partnership that campuses exercised to deliver a robust program was captured by one respondent’s description of a testing program where “over 500,000 PCR surveillance tests were performed by our Vet school lab.”

Efficient systems for managing contact tracing and isolation/quarantine complemented testing strategies. While partnership with local public health for contact tracing was noted, on-campus management of contact tracing offered a distinct advantage in terms of efficiency. On-campus clinical providers could “act more quickly,” sometimes tracing every positive “in an hour or less per case,” and offered advantages of an overview which “afforded us a better sense of what we have to manage, consistent information, and being responsive to the entire campus.” Isolation and quarantine services were positioned to accept students quickly with monitoring and support systems in place. “Care teams” and service coordinators, utilizing staff from various departments across campus, provided support services to students. Respondents described well-orchestrated efforts to meet student needs assigned to isolation/quarantine on and off campus by delivering food or ensuring access to counseling and wellness services.

A variety of innovative strategies were employed that focused on maintaining provision of quality health services while ensuring the safety of students and staff. Some clinics eliminated walk-in services in favor of appointment-only visits, offering telemedicine and telephone triage services as well. Experienced clinicians provided expert medical oversight and advice that ensured the delivery of evidence-based care. Some schools used apps for symptom tracking, which one respondent described as “time consuming but effective.” Clinical spaces and traffic patterns were reconfigured and ventilation of indoor space was assessed and re-engineered to include the use of HEPA filters and negative pressure rooms. One respondent noted that their drive-up clinic was “popular” while another noted that they were able to provide regular in-person visits without incident due to an “adequate supply and proper use of PPE at all times for all encounters.” Combining SARS-CoV-2 testing opportunities at influenza vaccination sites was a creative way to achieve success on two fronts.

As respondents looked toward the upcoming spring semester, there was an expressed need to reassess resources and enhance efficiencies of mitigation efforts based on the experiences in the fall. Estimates for the number of isolation and quarantine rooms assigned were sometimes too low and decentralized locations for isolation/quarantine space presented challenges to providing services. The significant time and effort required for mitigation extracted a “toll on other services such as health promotion outreach and non-COVID clinical care.” Extending clinical hours, staggering provider scheduling, and expanding the use of telephone triage were identified as considerations to meet medical care needs. The call for additional staffing and supplies, including testing supplies and PPE, was noted in every aspect of medical mitigation. The importance of robust testing was noted, with some schools indicating an intent to initiate or expand surveillance efforts. The resources to do so would require more staff and supplies than some had on hand in the fall 2020 semester. Contact tracing was described as “extremely time consuming,” requiring either additional resources or outsourcing of the process.

The increased mental health needs of students were noted by many respondents, especially in regard to the challenges faced when on-campus and off-campus students are in isolation or quarantine. This concern was punctuated by a call for enhanced resources to meet the demand. Although many schools implemented phone and email check-ins on students in isolation and quarantine, the need for additional support was suggested, including enhanced consistent communication to students regarding self monitoring, clear expectations related to isolation and quarantine, and increasing wellness strategies to support mental well-being.

## COLLABORATION

Respondents attributed numerous successes to organizations that created, developed, nurtured, and leveraged their strategic partnerships to enhance and advance their plans. The more complex, widespread, immediate, and health-threatening issues demanded the broadest and deepest collaborative efforts.

Collaboration with local and state public health agencies took numerous forms and was the most frequently noted critical relationship. Partnerships with public health assisted respondents with expertise, data gathering and analysis, contact tracing and testing programs, policy and procedure development, and acquisition of testing supplies and personal protective equipment (PPE). However, other partnerships were also credited with contributing to success and included entities inside and outside the college/university. Internal partnerships included student affairs, information technology, senior administration, residence life, food services, athletics, communications, facilities, campus police/security, students, faculty, and staff. Frequently mentioned external partners, in addition to public health, included scientific and medical experts, testing resources, vendors, community providers, pharmacies, hospitals, and other college health centers.

Collaboration enhanced sharing of knowledge, expertise, technical skills, staff, experience, best practices, policies, guidelines, and procedures and enabled resource consolidation, including funding, staffing, and time. Collaboration spawned innovations that included videos to promote non-pharmaceutical interventions of wearing masks, observing physical distancing, and hand hygiene. Others collaborated to create outdoor spaces for testing, education, and intakes and implement telehealth and rapid response teams. Innovative utilization of students in health professions and athletic departments assisted both local public health and the campus with contact tracing for swift transitions to isolation/quarantine.

Communication was frequently mentioned in conjunction with the collaboration response. Intentional, timely, and clear communication was key in developing and sustaining successful partnerships, highlighting the necessity of active communication in these critical relationships. Expanded communications, inclusion in meetings, and information sharing strengthened relationships and led to a sense of teamwork captured by the phrases “aligned leadership,” “group effort,” “a village,” “broad, coordinated response,” and the “importance of supporting each other.”

A critical lesson learned described the need to better integrate the health and well-being of the faculty and staff. Many student health centers were unable to provide an all-encompassing response to that segment of the university community and in particular, implementing SARS-CoV-2 testing for employees was described as “complicated.” The need to delegate responsibilities, share information, communicate effectively, and utilize expertise from content specialists to break down barriers and provide an effective, coordinated, and sustained response were essential for success. Simply stated, the take home message from collaboration is accurately summed up with “silos have come down between student health and other departments across the campus. They need to stay down.”

## LEADERSHIP, MANAGEMENT, AND PLANNING

Responsive leadership, strong teamwork, planning, and wise management of resources contributed to the successful execution of emergency response. The role of leadership was critical to instill trust, ensure a coordinated response, plan effectively, inspire teamwork, and ensure adequate resources. While strong leadership, teamwork, and effective planning were notable successes, the pandemic response exacted a toll on staff mental well-being.

Respondents emphasized that the support of the campus senior leadership for the health services staff was critical to an effective pandemic response. Those presidents, vice-presidents, vice-chancellors, and directors who were cited as being strong advocates were those who clearly prioritized the health and safety of their students, faculty, and staff. Strong, consistent, and responsive leadership was most valuable when leaders listened to campus health specialists and experts and provided them a “seat at the decision-making table.” Regular meetings, sometimes as often as daily, facilitated coordinated, timely, and efficient response to a rapidly changing situation. The value of consistent leadership was reinforced by those few respondents who noted that changes in leadership and staff created some confusion and led to lack of consistency in decision making.

Respondents particularly valued those campus health leaders who advocated for the needs of their staff, expressed appreciation, and gave emotional support. Support for staff was demonstrated from supervisors and colleagues through morning debriefing meetings, tubs of snacks, and end of the week team meals, as well as through employee assistance support programs. Back-up plans were created to ensure adequate coverage in case of staff absence due to COVID-19 infection, exposure to COVID-19, or other personal or family needs. Flexible scheduling and other employee accommodations were implemented to ensure that the health center remained de-densified, with staff alternating working on-site and working at home. One college provided staff with the assurance of immunity from furloughs and salary cuts or compensation for weekend work hours.

COVID-19 and emergency response teams brought together representatives from key areas throughout the campus to assist with a coordinated approach. Many established teams had developed strong working

relationships with a firm foundation in emergency management during prior crises on campus. Some reported use of solid plans in place from prior communicable disease concerns on their campuses, including Ebola, H1N1, and H5N1. The director of the health center often played a key role, and on some teams was the incident commander. Effective emergency plans were flexible, adaptable, and updated frequently. The process was described variously as “...building a plane while flying it,” as well as “...you have to be prepared to change your model every month, every week, every day, every hour.” A few respondents noted that having too many decision makers during the crisis decreased the effectiveness of the response and recommended specific “point persons” as final decision makers. Colleges without emergency response teams or plans reported intentions to create them.

Despite the high demands on staff, strong work ethics prevailed and team members were willing to “pitch in and learn new things.” Many people volunteered to assist in nontraditional roles. “No one said ‘that’s not my job.’” Descriptors for effective teams included being flexible, strong, caring, adaptable, and nimble. One respondent mentioned that this is “... a marathon not a sprint” and everyone needed a “we can do this attitude.” Finally, one person summed it up by saying “...we have a strong team that can work together in a crisis and we have a division (student affairs) that also is supportive of each other. I think this is the most important thing regarding our COVID response.”

Emergency response to the pandemic is a resource-intensive undertaking. Since many college health centers do not bill for services and many do not have reserve funds, budget support for additional resources was a concern. Budgetary stressors centered on costs related to the need for increased staffing followed by the need for additional medical supplies and updates to electronic health record systems. Increased allocations for hiring additional nurses, contact tracers, administrative staff, testing coordinators, and case managers were helpful. The CARES Act and grant monies provided some needed budget support.

Despite contingency planning and a strong sense of commitment to the team, staffing levels were “never enough.” Hiring temporary staff often took much longer than expected and turn-over and attrition resulted in lack of continuity and loss of valuable clinical experience. Staff members often reported being “overwhelmed,” with “burn-out” cited as a common concern. Despite the resilience of the staff, frustrations resulted from “pandemic fatigue” and coping with uncertainty. Personal and family health, job security, and financial issues contributed to stresses imposed by the pandemic. Unrealistic expectations from some staff, administrators, and families made it difficult to satisfy everyone. Staff learned that they cannot be “all things to all people.” One respondent stated “... it is very hard to quickly respond to changing environment when some departments are happy with status quo. Sometimes people step up in a crisis and some do not.”

## HEALTH PROMOTION AND COMMUNICATION

The comments regarding education in the survey addressed collaboration, health promotion and outreach, and the importance of effective communication.

Close collaboration with various groups including health services, residence life, athletics, academic departments, and public health resulted in regular planning meetings to determine strategies and messaging. Effective communication as described by survey respondents was reflected as honest, transparent, and consistent and accomplished by approaches such as a centralized dashboard, a hotline, or a single access point to provide education. Strategies also emphasized frequent and regular education and communication through regular town

hall meetings, public health campaigns, and use of social media. As one respondent said: “Over communication and education are powerful tools.” Also important was flexibility to change messaging and approaches based on newly emerging information. Attention to health promotion with virtual programming and outreach was helpful; one campus reported that “our students responded amazingly well, and really exceeded our expectations in terms of creating and maintaining a culture of safety.”

Effective communication was central to the lessons learned. As one respondent reported, “There is a lot of anxiety regarding COVID: rules, testing, symptoms. Students and employees need clear and frequent messaging. There’s a lot of info and new policies to be communicated, and no one was absorbing it.” Guidance from public health authorities, CDC, ACHA, AAFP, and local health departments were mentioned as key sources for accurate information.

The continuous marketing of support and services, including communication using multiple formats, was deemed essential. The challenges of reaching students, in particular, was highlighted with a need for continuous message reinforcement and clear, repetitive explanations of instructions. With the continuous change of information, ongoing, frequent, and honest communication was essential. One respondent cited the following representative comment: “As clearly as you think that you are communicating, it’s never enough!” One campus offered the following illustrative example: “Regular and timely announcements and communications to students, staff, faculty, and parents/families about the impact of the pandemic on learning, housing, testing, active cases, restrictions, and changes to pre-COVID campus activities. We developed a COVID webpage with all these communications, additional resources, an Ask A Question email address, and a dashboard to indicate campus COVID activity compared to our county COVID activity.”

## TECHNOLOGY

Technology was critical to the pandemic response at colleges and universities. College health professionals reflected on the importance of technology in four broad categories: telemedicine, technological systems and platforms, remote learning, and remote work. In many cases, survey participants spoke to the successful deployment of technology, but they also observed that challenges were not insignificant, and the technological solution was not always the ideal approach.

Telemedicine refers to virtual visits for both physical and mental health. Thanks to a “rapid pivot” to remote care, college health professionals “continued to deliver uninterrupted services to our student and community patients throughout the pandemic.” Many services could be offered entirely through telemedicine, and remote triage protocols were developed to allow clinical staff to limit in-person care to those patients and clients who absolutely needed that level of engagement. This opened up possibilities for the post-pandemic world: “Telehealth was a great and hopefully long-term option.” Meanwhile, it was noted that telemedicine was not always the ideal or preferred approach for all patients and clients. Insurance coverage, compliance issues (HIPAA), and legal challenges were also a concern (e.g., “legal advice on clinical care across state lines was critical”). Overall, college health professionals frequently expressed that things went well despite initial skepticism and reluctance. “We can do a lot via telehealth and still do it well; and some things definitely should NOT be addressed via telehealth.”

Aside from telemedicine, web conferencing software and other video platforms were ubiquitous during the pandemic. These platforms were also used for group-level services: “Health promotion was able to [make] workshops virtual and actually saw more engagement in workshops than when they were in person.” Aside from implementing video platforms, electronic health records (EHRs) also needed to be modified and additional modules needed to be created or purchased to suit the evolving needs. Information Technology departments were critical partners in developing new databases, symptom attestation apps, and data tracking methods for testing, contact tracing, isolation/quarantine, and vaccine management in order for college health professionals to gain a full understanding of the situation on campus, to accomplish necessary reporting duties, and to leverage data to maximize efficiency. To that point, a respondent stated, “Our campus developed an emergency management tracking system... through which all campus partners could track students placed in isolation or quarantine. It was maintained in real time and facilitated communication and support services.” Another added, “We leveraged data from our EHR to manage our internal operations. For example, within 4 hours, we could flex providers and nurses to our COVID specific area from non-COVID functions as the need presented itself.” Several participants mentioned that in order for off-site services to be reliably offered, remote electronic access and virtual private networks (VPN) were also critical.

College health professionals learned that while the presence of these systems was valuable, health services needed adequate staff support to ensure that the systems were used optimally (“It would have helped to have had a data entry person”), and systems needed to be simpler and to integrate with each other. All in all, technology made things possible, but it was not always easy. “Getting staff to transition was actually harder [than] getting students to adjust to new realities.”

Remote learning and remote work allowed campuses to create a safer environment and to ensure reduced in-person density on campus. The reduced in-person presence also allowed some health services staff to be re-deployed in new ways: “[With] less students on campus ... [we were] able to assign staff to other tasks (mass testing, flu clinic, weekend hours, etc.)” Staff working from home “focused on contact tracing and case management.” Students who needed in-person care were able to get it quickly: “[We were] able to offer quick and efficient services to those who were local.” As with other technology, transitions to different work and study platforms can create challenges. For example, when workers were off-site, it was not always easy to communicate, highlighting the importance that campus employees “indicate that change on their phone messages and offer alternative methods of communication.” While it was often harder for staff and faculty to switch to remote teaching, learners also faced challenges and “some students struggled with remote learning.”

## BEHAVIORAL MITIGATION

The responses classified within Behavioral Mitigation emphasized specific approaches used by campuses to identify COVID-19 cases early as well as to promote adoption of health- and safety-oriented behaviors.

The primary responses regarding behavioral mitigation approaches dovetail with the education and communication themes: attention was focused on clear messaging on mitigation strategies such as mask wearing, social distancing, and handwashing. Highlighted was early prevention interventions, such as staying home when sick and participating in contact tracing. The constant reinforcement of, communication about, and enforcement regarding these were essential for reported success. Specific approaches included signed student contracts, permission to leave campus, faculty/staff testing with onboarding, decreased places where people congregated

(e.g., dining facilities, athletics events), clear direction to academic departments, and the creation of safe activities on campus. Involving students in the process was cited as important for buy-in; one respondent reported “We have to learn how to promote health behaviors rather than just stress safety precautions,” and another noted “giving them conflict resolution tools helped a great deal.”

Several lessons were learned regarding these mitigation approaches. Mixed reviews were found with regard to student compliance. Several respondents stated that students followed the rules and guidelines implemented as exemplified by this respondent’s statement, “The students were cooperative. I was surprised that they rose to the occasion and followed all the rules!!! They are [more] mature than we thought!” Other respondents noted concerns such as students not being able to be relied upon to follow up; one respondent stated “Students are tired of the restrictions. We need more creative options for marketing and enforcement.” Also noted was that “it is not what they do on campus that matters but more what they do off campus.” A specific recommendation that couples the need for reinforcement with education is highlighted by this respondent’s view: “We need to keep educating the community regarding off-campus activities and gatherings which seem to be the biggest threat to spreading this virus.”

## Concluding Thoughts

The reflections of college health respondents in this survey provided rich and valuable insights regarding the experiences of colleges and universities in their response to COVID-19 during fall 2020. Respondents appeared very forthcoming with their thoughts about campus efforts, with attention paid to what worked and lessons learned. The richness of the data gathered through this primarily qualitative approach is remarkable and will serve to be most beneficial to college and university leaders now and in the future.

A challenge with this report’s compilation was to fully represent the wide variety and detail of comments made by hundreds of respondents. A limitation of this report is that, while a respectable number of institutions were represented in the responses, it is likely that many schools did not have the time to respond due to the increased responsibilities on their campuses related to COVID-19. An additional limitation is that responses were based on one respondent per school; professionals in different campus departments or disciplines may have other perspectives. Finally, this study did not ask for problems or concerns faced by campus leaders; while these may be embedded in the “lessons learned” question, a different set of responses may emerge if that query had been made directly.

From the perspective of campus respondents, the pandemic raised the profile of college medical, counseling, and wellness services. Each of these three elements of campus student health services was identified as critical to the safe organization and implementation of overall campus operations and activities during the fall. The need for health, counseling, and wellness services to be collaborative was crucial for success. Contributions made by college health professionals were integral to planning and preparedness and indispensable in translating expert recommendations into context-specific policies and procedures for their campuses. Moving forward, it is essential that college medical, counseling, and wellness services remain actively engaged with campus leadership throughout the duration of this pandemic, as their “seats at the table” help maintain their professional expertise as central to campus leaders’ decision-making and effective implementation.

# APPENDIX A

The following quotes are a sampling of the 2,763 comments received from the survey respondents about specific strategies that contributed to the success of the COVID-19 and lessons learned. The responses included are quoted verbatim except where references to specific schools, organizations or vendors have been removed. They are organized into the themes discussed in the analysis of the survey and provide additional detail in the description of specific strategies.

## CLINICAL CARE

“...used xxxxx for testing and did so twice a week for students, faculty and staff all semester long. Since results were received within 24-36 hours.....and had ability to isolate and quarantine quickly using our homegrown contact tracing database; Clinical provider designated to reach out to + cases and contacts twice daily. Had efficient team to respond to + results, move students to a hotel using Public Safety and provided food delivery through dining services. Residential life assisted with relocation.”

“Establishing drive-by testing and now drive-by vaccination...screenings at door to control foot traffic; Very quickly established an internal task force to coordinate clinical operations and had reps on external task forces to coordinate.... program.”

“Setting up a separate COVID Response Unit that dealt with COVID testing, quarantine and isolation and daily mental health checks. Staff was recruited from departments not as busy as the health and wellness units which helped the units to not be overwhelmed especially during upticks in cases...”

“Implemented free testing on campus - our Covid team collaborated with our state health department and set up a testing site for students, employees and family members...”

“We need stronger counseling support to students in quarantine and isolation.”

“Employees and students (were) directed to contact an infectious disease coordinator when exposed or infected. We then determine need for quarantine, contact co-workers/fellow students, who may have been exposed, and offer medical advice, and refer to on and off campus resources. Great cooperation from managers, students, and faculty....”

“Students had one access point for all COVID related concerns (symptoms, exposures, questions) which was our patient portal. The students sent a message in... to a COVID Provider. We had 4 Isolation and Quarantine Coordinators (1 director and 1 project manager) to check students in and out of IQ and support them during their stay for on campus students (and) off campus students. We had designated APPs following students in isolation which were tiered by risk level...”

“We planned extremely well for the situation.... We leveraged data from our EHR to manage our internal operations. For example, within 4 hours, we could flex providers and nurses to our COVID specific area from non-COVID functions as the need presented itself. By the end of the Spring semester, we developed a functional high-volume PCR test site on our campus (xxxx Veterinary Diagnostic Laboratory) that could turn around reliable results within 48-72 hours. This included development of interfaces between (us) and the lab's IT systems. This allowed us to get residential living students into on-campus isolation accommodations quickly.”

“Pre-entry testing was set up as a drive thru during the fall. We had 2 drive thru lines, one person testing and one person registering/printing the label on the computer. The surveillance roster was split into 5 groups and assigned a weekday and a window of time to come that they found most convenient. For example, Group 3 was assigned to come between 9:30-12:30 on Wednesday. A sense of urgency and immediate response with positive cases. Teamwork throughout the Health Center and across the campus for the larger cases in navigating the complexity in a short amount of time.”

“...separate wings for respiratory complaints (that included a neg pressure room for nebulizing) and routine care; outside partnership with teaching hospital’s urgent care to see our patients after hours and on weekends with excellent communications allowed us to know of any positive cases on campus that occurred while we were closed; Ability to have our students’ PCR tested with a quick 24-48 hour turnaround.”

“We were able to expand our clinic space allowing us to have a separate entrance for the respiratory clinic. We were able to use outdoor space for COVID testing while the weather allowed.”

“We are a small State school but were able to have rapid testing in-house and several different options available for PCR via reference labs. We initiated an employee clinic to serve staff and faculty which is something we’ve wanted to do for a long time; it took Covid to make it happen. Having bags of groceries from our campus food pantry available in our Health Center to give to students we were sending home to be in isolation or quarantine who would not be able to get out to obtain groceries, or because of missing work couldn’t afford them.”

“Using an array of graduate nursing students to remotely conduct phone check-ins with our students in isolation did not work well. It was too fragmented and too difficult to document and track. Using contact tracers who were not nurses, did not work well. They were not prepared to answer all the questions that came up during the contact tracing calls. Housing density hurt us. Many, many roommates contracted COVID-19 from close “household” exposure.”

“Pre-arrival testing, testing upon arrival and 8 days later, then random testing of faculty, staff and students throughout the semester (15% per week). Universal 2-week quarantine upon arrival - taking classes remotely for those two weeks....Excellent outside lab did our random PCR testing PLUS we had Point-of-care Quick Antigen testing (xxxx) AND Point-of-care PCR testing (xxxx) for symptomatic cases.”

“If able, a larger number of rooms available for quarantine or isolation. Most of transmission of virus among college students seemed to occur outside of the classroom, such as a result of extended time at meals with others or other social engagements with larger numbers of students within a dorm room such as movie parties or gaming devices with attachment to TV or internet.”

“Mandatory testing of all students living on-campus and select academic cohorts; Contracting COVID 19 testing which allowed the health services to continue to offer/maintain overall care for our students. We opened a separate respiratory Center for students presenting with Covid symptoms. We hired....nurses to support the staff making daily check in calls to students in isolation. Director removed from in person SHC support, instead, part of mgt. team overseeing testing site, SHC and liaison with DOH.”

“Our internal contact tracing process, which was set up by our Health Promotion & Wellness office and our Chief of Police (who is our emergency manager/COVID task-force leader). Our testing for residents and athletes in

the fall worked well, because of our relationship between our school of nursing and the local medical center. Our tracking .....program (both interdisciplinary faculty/staff members are part of these teams) helped greatly with all of the various cases and scenarios within our campus community.”

“Managing quarantine was much more of a challenge than isolation! We had an initial quarantine plan that changed rapidly the first few weeks of classes. Initially we were delivering meals to students in quarantine, but with the large numbers it was overwhelming, so we worked with Public Health to find a way to allow students in quarantine to come to a designated area to pick up their meals (hot lunch, hot dinner along with a cold breakfast) daily. This has worked very well and we will continue the process in Spring.”

“Our isolation plan also needed some changes....., luckily our plans were flexible and allowed changes in processes very easily. Initially students in isolation were responsible for cleaning their own bathroom area (communal bathroom with designated sink, shower, toilet), we quickly realized that we needed daily custodial services on the floor for garbage removal, etc. A Custodian was trained to clean the isolation area with proper PPE. There was way too much work to be done with one part time RN in our Health Services office! My position was upped to full time, we hired another part time RN and we added a COVID-19 On campus Isolation and Quarantine Coordinator for spring semester to assist Health Services and Residence Life with the day to day details.”

“Transportation services for on campus students to move to isolation or quarantine housing remains a challenge as there is no entity on campus already set up for it. As a result, our health center had to borrow vans and dedicate staff to provide transportation during operating hours. Students in isolation/quarantine on campus need emotional and psychological support services as much as dining, laundry, etc. They also need sanitary products, chargers, prescriptions, weighted blankets, mail, book deliveries, etc. and we had to figure out how to procure and deliver it all. Communication, communication, communication! As much as we communicated in every venue possible, students still needed more.”

## COLLABORATION

“Collaboration with all Student affairs to bring testing to our residential students. We had about 700 students living on campus and we tested the once a week using the saliva test. This was a group effort between SHS, residential student services and VP of student affairs office. COVID reporting tool for students living off campus. This was a reporting form on our website that allowed students, faculty or staff to report a known or suspected COVID positive student. This allowed our office to follow up with the students to see if they had any health concerns we could address, along with getting them connected to other resources on campus such as counseling or academic or financial assistance.”

“Working as teams, the entire campus worked in two teams A and B. A team worked on site Monday and Tuesday (and Wednesday for SHS), and B team worked on site Thursday and Friday. Most other offices were remote on Wednesdays. When not on campus the teams worked remotely. If someone tested positive, the entire office was not shut down for quarantine. This was very effective as we had two positive cases in our office, and we were able to continue serving our students.”

“We have an excellent working relation with our local Public Health Unit, we worked as a team to provide testing, they helped develop policies and assisted us with contact tracing; Health Services worked closely with Residence

Life, Food Services and Facility Services to coordinate Isolation and Quarantine procedures for our on-campus students. As a team we were able to successfully monitor and provide care, meals and custodial services for these students effectively. Health Services worked closely with Student Academic Services to ensure that students who were quarantine and isolation were able to continue to attend classes synchronously so minimal disruption to learning occurred.....Health Services also worked closely with Counseling Services to meet the mental health needs of our students in quarantine and isolation - resources were sent to every student to help relieve the stress and anxiety of quarantine and isolation.”

“Good, consistent internal communications. In March started having multidisciplinary “Daily huddles” on zoom. Helped to keep everyone up to date and on the same page.” Rapid adoption of public health measures such as mask wearing, distancing, handwashing and available PPE so that staff feel safe when at work.

“Quickly responded to the closure of our campus and moved all services online within 2 wks. Support of all campus dept. to work together to get the information and supplies we needed to make this happen. Identified as the public health and medical resource for.... information for the campus...part of the Covid-19 response team to make sure that evidence based reliable information was used to support our decisions and response as a campus. Adaptability and support between all HC staff for a common goal- to support our students and staff, made this possible....”

“We worked well with our local health department to meet state requirements while also meeting the needs of the campus and community. We worked with local businesses to mitigate many of the social interactions that normally take place. Worked well with student groups and group advisors to create safe activities on campus to try and create an environment that as closely as possible resembles a normal semester. Our goal was to get students engaged while yet safe and socially distanced. Provided testing, quarantine/isolation space, and guidance for all students, faculty, and staff. It was an inclusive venture that had stakeholders from the entire university.”

“Silos have come down between student health and other departments across the campus. They need to stay down. People want to help and contribute, so asking has resulted in great collaborations; Using redeployed staff from other departments to staff test centers, handle data, etc. has worked very well.”

“Health services across campus are not unified; health promotion, health center, and counseling center were not working in unison and we realized the importance of this. Learned that our health promotion efforts need to focus on fostering and building connection and focus on what students CAN do rather than constantly reminding them what not to do....”

“You cannot have enough collaboration with other departments. Communication is the key! There are some decisions that need to be made with minimal input from others and other departments. Waiting on opinions, suggestions and better ideas often delays any action taken. Within the scope of the department, decide, act, evaluate early then modify as necessary. The perception of “doing something” raises confidence of students, faculty and staff.”

“Continue to leverage resources for greatest impact.; When we stay focused and collaborative, we can get the job done, even in the midst of a public health emergency (global pandemic). Our team is truly vested in student success and willing to do whatever we can to ensure students are properly supported.”

## LEADERSHIP, MANAGEMENT, AND PLANNING

“We could not have done this without a strong leader and help from Campus Health. Having one point person that coordinated our efforts. Having all departments across campus work together.”

“We need more staff. COVID-19 response is a full-time job. We are fortunate to have a small Campus with a lot of support from our Board of Trustees and Campus administration.”

“Always being at the table. The amount of information and misinformation that is out there proved to be the most challenging. Always being available to present the scientific and public health response is critical.... There are too many voices that can easily change the narrative - politics, social media, public opinion. Consistent and regular communication is key. Importance of maintaining a reserve fund for communicable disease outbreaks. Because this was a pandemic federal funding in the way of CARES was available but in individual campus outbreaks funding won't be available and campuses must have a reserve fund to manage and respond to any campus outbreak.”

“...response included individuals from across the campus and had leadership support; regular contact with all areas involved in implementation was integral to the success; frequent, appropriate, communications from campus leadership and key partners, acknowledging frequent pivots due to changing information and landscape related to COVID.”

“.....Initially we established unrealistic timelines and found ourselves starting over when we lacked the equipment or personnel needed to meet a goal or discovered that changes to state or local guidelines set us back. It is important to have as many cross trained individuals as you can to carry on the functions of all areas. With reduced staff and increasing numbers of ill or quarantined individuals, we found out there was a definite lack of support staff in some instances.”

“Policy planning. Campus-wide Emergency Operations Planning team has met weekly. Student Health has a seat on that group, and expertise is recognized. This group brings together facilities, Human Resources, financial aid, faculty, student services, etc. It facilitates inter-disciplinary communication (and) we are able to hash out policies together.”

“... we learned the importance of having an emergency operations infrastructure in which members have had enough ongoing interaction to actually know each other, roles and expectations. Mental health services have been siloed and uncoordinated across the institution for many years, which we had already started to systematically break down with help from leadership. The response to the pandemic has accelerated this dramatically - resulting in much more access for all groups without an increase in resources. Being able to clearly track and articulate the financial impact of the pandemic, and requests for additional and new services, in order to make a case for the institution to shore up funding as both institutional and self-generated sources have been diminished.”

“The prior planning in emergency response has always included our health center....which makes them truly feel like decision makers and important parts of the university; Chief Health Officer for the university that engages with the health center on a regular basis; Flexibility and enthusiasm for helping is the best part of our clinicians. Without their attitude and partnership, we would not be successful.”

“...pre-planning which allowed us to establish protocols and have at least two table-top exercises on COVID responses. We evaluated our supply of PPE and were able to procure sufficient amounts before the semester started; community partnerships with the local health department; frequent townhalls for faculty /staff, students, and parents/family.”

“We needed more staff for wellness calls. We need weekend coverage.”

“Having someone contracted to keep up with the online information and filtering through what is based on science would help support the entire campus. This may include guidelines for staff who are licensed by different organizations and have to follow their professional guidelines. Have clear policies and contacts regarding accommodating staff based on protected grounds for medical accommodations, family status, and what can/should be less formalized. Quick change and flexibility is possible when needed.”

“Listening is a key component to communication. So, verifying that what is being heard, is understood by all. Constant evaluation of the process is necessary. What is working, what is not, where are we weak? It really is a team response.”

“I am the only nurse in our small health office. I was very grateful to all the departments on campus and administration for all banding together thus forming a great plan that worked very well for college. Thinking outside the box! Not a day went by when I did not learn something new.”

“Very active team communication (daily at times and at least weekly); Honesty. As the team leader, I had to be honest with me time about evolving situations. I shared what I knew and asked the team to help me identify gaps and/or ideas. Boundaries. Setting very clear boundaries for my team of when we need to outsource student support. Setting boundaries for college administrators to help them clearly understand when something was beyond our Center’s scope of practice.”

“Must remain flexible each day in a fluid environment. Constantly communicate and engage staff as changes to operations are being made. HS is seen as vital service on our campus.”

“Weekly staff meetings were important. With working in teams, there was the loss of the face-to-face contact with the full staff. Our presence on campus, prior to covid, was not well known or recognized by some higher administration. Our expertise was called upon and we responded with knowledge, skill and calmness in the midst of chaos. We are now talking about a new Wellness center. COVID helped give us a voice. We have a strong team that can work together in a crisis and we have a division (student affairs) that also is supportive of each other. I think this is the most important thing regarding our COVID response.”

“...we needed a case manager early in the semester and brought employee back from furlough to fulfill this role. Learned we needed to expand our response team to deal with surge in cases.

“The workload is not sustainable. Campus communication (or lack of) regarding testing, student responsibility, etc. greatly affected our workload. Setting up a COVID hotline for non-medical questions greatly reduced the amount of calls that were coming through Health Services.”

“We learned that health and wellbeing need to be more integrated into our entire university community and wellbeing of faculty and staff should not be overlooked.”

“Staff morale - not only worrying about the stress of COVID but also financial concerns, staff worried for their jobs. While we did have to let some staff go, communication and support can always be better in these instances; In the very beginning, we “bit off a bit more than we could chew” for lack of a better phrase. Just regroup and determine what we could do with limited resources and collaboration; With new leadership in place, there was a learning curve on admin styles and using teams to their fullest potential across all job duties as opposed to ‘bucketing.’”

“The incredible amount of pure exhaustion both physical and mental was something I have never experienced in my career. Taking time away even when your needed at work is key in keeping yourself healthy. Don’t take on more than you can do. Learn to put you and your team’s wellbeing first.”

“Positive collaboration among all units on campus is absolutely essential. Internal communications are included in this....Having the expectation (top-down) of a positive attitude and active caring for our patients and each other has been a “life-saver.”

“We can’t be “all things to all people”. In a public health crisis, some difficult choices have to be made and not everyone will be happy. Keeping the common good as the focus helps not to stress about what you’re giving up. There is nothing like a global pandemic to make everyone aware you exist! Caring for self and each other is what kept us going..... We agreed to give each other grace when times were tough and tempers were short. We started each morning with a brief meeting to talk through any conflict or situations that needed attention from the day before. We had a tub of snacks; some healthy-some not, for days we couldn’t get a lunch break. We celebrated the end of each week with a meal together. We laughed together, cried together, cursed together. We became closer than we’ve ever been, and we made it!”

“Ongoing need to address COVID fatigue/burnout in clinicians; Need for redundancy in staffing for clinical duties/responsibilities in setting of illness and quarantine...”

“Colleges are failing at health equity and it needs to be integrated into all campus policies.”

## **HEALTH PROMOTION AND COMMUNICATION**

“...support and outreach was at times hit or miss based on administrators and wellness professionals involved; Students are less willing to join a Zoom invitation, even though the health and wellness benefits are known and familiar, if they do not know “who else will be on the call”; we had to create a special waiting room 15 minutes in advance of the session during which time students would log on in advance of the program or event and be welcomed and introduced to peer health educators who would join the call together with them; The greatest student wellness leadership group on our campus was equally taxed by the pandemic environment as we all were. Relying on them to carry out duties, however hybrid/remote in style, was far-reaching given their own stress, anxiety, and feelings of being overwhelmed by all the changes they were undergoing. Goals and expectations did not shift enough to consider the decreased helping capacity of key student leaders, which is understandable and completely normative.”

“Regular and timely announcements and communications to students, staff, faculty and parents/families about the impact of the pandemic on learning, housing, testing, active cases, restrictions and changes to pre-COVID campus activities. We developed a COVID webpage with all these communications, additional resources, an Ask A Question email address, and a dashboard to indicate campus COVID activity compared to our county COVID activity.”

“As clearly as you think that you are communicating, it’s never enough! Our phones rang non-stop for most of the semester. We are making changes to our phone system, campus wide communication and website as a result; Campus wide communication is really important and should be on-going.”

“Health services staff constructed educational materials about cover protocols, self-protection and so forth which were made available to all of the campus community”

“Lines of communication need to be established so that messaging is correct and consistent. Be clear who should deliver the message and provide more than one platform to deliver the message.”

“Health promotion was able to remove workshops virtual and actually saw more engagement in workshops than when they were in person.”

“Lack of health promotion and health education department inhibited our ability to more effectively communicate and educate our student and staff community.”

“Stay on top of CDC and local health department guidelines; Maintain open communication with all departments. Ask questions as this is a new and evolving situation.”

## TECHNOLOGY

“Ability to pivot to telehealth services quickly to support students who were suddenly off campus and in some cases out of state. Also able to allow many staff to work remotely to varying degrees. We worked with leadership to develop an effective symptom monitoring, testing, tracking and localized contact tracing program that has been within reach of the resources of the state and the institution.”

“Learned our Covid dashboard needed to be updated regularly with plans to provide additional information on spring dashboard.”

“Our IT team set health services as a priority to work on projects around documenting and information sharing.”

“Need a data interface between our EMR and our on-campus research lab which became CLIA approved to do our campus COVID testing”

“I would change how we report information to the public on our dashboard. Our process is cumbersome, and it is time consuming. I would make improvements to our internal spreadsheet that tracked students (symptomatic, positive, close contact). There is data that we didn’t collect that I wish we would have. I would ensure our team had “two of every person”, so one person didn’t feel such burden to always be present and available.”

## BEHAVIORAL MITIGATION

“Work closely with all constituents – educate and educate again. Be willing to reward and highlight student successes; be willing to hold accountable students who knowingly behave in a way that puts others at higher risk; Develop a process that permits quick identification and quick quarantine/isolation and expanded precautions to slow spread.”

“Transmission was not an issue in the classroom setting. Instead, we saw areas of transmission in study groups and riding together in cars to places like clinical. Most individuals were scared and needed education more than anything to calm them down and recenter their focus on wellness. The students appreciated the individual calls and emails to check on their status each day. They felt as though someone cared and was looking out for them.”

“Congregate living units were a challenge. The plans for return to campus for each of the fraternity and sorority organizations were reviewed, but they may not have been as adequate as needed. Improved communication and guidance to the organizations was begun during the semester as cases increased in some of the facilities. Isolation and quarantine need to occur in a central and controlled location. Some students were allowed to isolate in apartments or Greek living units and those situations were more likely to result in infection spread. That changed in spring.”

“We need to keep educating the community regarding off campus activities and gatherings which seem to be the biggest threat to spreading this virus. Testing is key to getting this under control.”



AMERICAN  
COLLEGE  
HEALTH  
ASSOCIATION

8455 Colesville Road, Suite 740 | Silver Spring, MD 20190 | [www.acha.org](http://www.acha.org)