

ACHA Guidelines

Updated COVID-19 Considerations for Institutions of Higher Education

The 2021 fall semester began with more institutions of higher education (IHEs) returning to full occupancy; in-person learning; organized programming; and cultural, educational, and athletic events with high hopes of restoring pre-pandemic campus living and learning environments. Campuses executed their fall plans as the fourth wave of the pandemic, due to the highly contagious Delta variant, took hold. Many IHEs implemented vaccine and other mitigation requirements prior to reopening, but for many IHEs, state laws and campus policies prohibiting vaccine or mask requirements impaired campus public health's ability to optimally address the pandemic. Now, almost two years into this public health crisis, campuses have implemented well-established, layered public health mitigation strategies including diagnostic testing, treatment, contact tracing, and vaccination, and built strategic partnerships. With these significant developments, campuses no longer need a full-scale update to [ACHA's existing comprehensive guidelines](#). Instead, this document serves as a brief update to assist with plans for the upcoming 2022 winter/spring terms.

Due to the rapidly evolving situation of COVID-19, this update reflects current CDC recommendations and the science on SARS CoV-2 variants, treatments, testing, vaccination, and other prevention strategies to date. Updates will be provided as necessary.

Vaccination

Access to COVID-19 vaccines have markedly expanded. Vaccine hesitancy, misinformation, and disinformation have been a central focus and have been countered with accurate, clear, tailored messaging through community engagement, peer ambassadors, and other trusted campus leaders, as well as by athletes and celebrities. Vaccine incentives offered by campuses to their students included cash, scholarships, gift cards, and campus swag.

To increase the nation's vaccination rate, the White House established COVID-19 vaccine mandates that may impact IHEs. The mandate [applies to federal employees and agencies](#). Pursuant with [Executive Order 14042](#) and COVID-19 guidance from the [Safer Federal Workforce Task Force](#), all covered employees of federal contractors

must be fully vaccinated by January 4, 2022. For IHEs, this includes full-time, part-time, and student employees who work on or in connection with a federal contract or who work in a covered contractor workplace, as those terms are broadly defined by the federal government. Covered employees who are not fully vaccinated must, with few exceptions, receive their final vaccination dose—a second dose of the Moderna or Pfizer vaccine or a single dose of Janssen/Johnson & Johnson (J&J) vaccine—by January 4, 2022.

COVID-19 vaccine schedules and dosing recommendations continue to evolve with distinctions between additional primary doses and booster doses. Additional primary doses of Pfizer/Moderna vaccine are indicated for individuals with [moderate or severe immune deficiency](#). Booster doses have been approved for all persons 18 years and older who received the J&J vaccine at least two months prior and those who received their second dose of an mRNA vaccine at least six months prior. See [CDC's guidance on Vaccine Booster Shots](#).

CDC's booster recommendation was updated on November 29, 2021, in response to the emerging Omicron variant. Those 18 and older **should** receive a booster dose of one of the mRNA vaccines (Pfizer or Moderna) six months after the primary series or the J&J vaccine at least two months after the initial single dose.

Considerations:

- Campuses without vaccine requirements should create tailored programming to improve vaccine acceptance while championing sound public health practices. ACHA's [COVID-19 Vaccination and Mitigation Initiative \(CoVAC\)](#) provides guidance and resources to increase vaccine acceptance.
- "Mix and match" or heterologous booster vaccination strategies have also been approved so that eligible persons may choose any authorized COVID-19 vaccine. Clinicians should be familiar with the vaccines and their potential side effects to assist individuals in decision-making.
- Vaccine and booster recommendations remain fluid. Clinicians should continue to monitor FDA and CDC updates.

Layered Mitigation Strategies

Optimal mitigation strategies should focus on vaccination and established public health practices with a multi-layered prevention strategy that encompasses monitoring local trends including community transmission status, COVID-19 vaccination coverage, hospital capacity, and surveillance testing of non-vaccinated individuals.

While operational guidance from CDC continues to evolve and new variants emerge, IHEs must remain flexible in modifying their mitigation strategies and devise strategies to efficiently manage resources while maintaining a response plan that addresses arising needs.

IHEs should be prepared to adjust mitigation strategies based on new information on variants, infection rates, hospitalizations, deaths, and campus capacity to manage the situation. The campus capacity includes staffing levels, testing availability, isolation/quarantine spaces, contact tracing, and vaccination availability. When COVID-19 cases decline on campuses and locally, and vaccination rates increase, it may be reasonable to scale back communicable disease protocols. However, with the persistence of high vaccine hesitancy, low vaccination rates, and concern about variants, campuses should plan to institutionalize infection control measures such as masking, distancing, and vaccinations into campus operations.

While some schools have prepared pandemic responses, others have not adopted a formalized plan, instead utilizing a framework for a pandemic response that remains to be memorialized. A formalized pandemic response plan should have clearly defined measures to trigger the need to expand or contract resources dedicated to COVID-19. Because of the diversity in campus communities, each campus must identify its own measures and thresholds. Common triggers to consider include campus case rates among students, faculty, and staff; the availability of pandemic response resources (i.e., staffing, isolation spaces, additional monitoring capacities), and local factors such as transmission rates and hospital capacity. Basic communicable disease protocols include infection control measures such as masking, hand hygiene, physical distancing, isolation/quarantine, contact tracing, and appropriate personal protective equipment (PPE). Expanded pandemic response actions may include travel restrictions, campus shutdowns, remote learning, and limited face-to-face services.

Testing

Diagnostic Testing

The need for diagnostic testing of symptomatic individuals and close contacts of infected individuals will continue into spring semester. Both unvaccinated and fully vaccinated people require diagnostic testing if symptomatic. CDC has updated its [testing recommendations](#) for close contacts of infected individuals.

Surveillance Testing

Surveillance testing of asymptomatic individuals, particularly those who are unvaccinated, should be extended through the spring 2022 semester. Faculty, staff, students, and community members move freely between the campus and the local community. Thus, the importance of surveillance testing as part of the IHE's layered mitigation plan must consider the vaccination rate and transmission rate of the surrounding community. Prior convention used the upper level of 90% vaccination rate as the threshold to decrease the frequency of surveillance testing. Even those IHEs with COVID-19 vaccination requirements and/or a 90% or greater campus vaccination rate should continue surveillance testing to some extent if the surrounding community has low vaccination rates, high COVID-19 case rates, substantial-to-high transmission rates, and a high frequency of community interactions. Because every campus and community are different, no single universal surveillance testing strategy would apply to all. General considerations include:

- Pre-arrival testing 1–3 days prior to move-in or orientation
- Entry testing at time of move-in or orientation
- Targeted testing of populations or facilities, such as those who are unvaccinated, athletes, or those living in residence halls or Greek housing, at a frequency ranging from once weekly to twice weekly.

Rapid Self/Home Tests

Rapid home tests are available over the counter or by prescription and have increased consumer access to testing. Rapid self-testing could augment an IHE's layered mitigation strategy and decrease risky interactions by providing real time information (generally within 15 to 30 minutes) about an individual's infection status prior to attending an event, a class, or the workplace. At-home rapid tests could be used by students to fulfill a pre-arrival campus testing requirement, but it is important that clear instructions and protocols regarding the testing requirement be provided by the IHE, with oversight by campus health or another campus entity.

Self-tests are now acceptable to fulfill [the requirement for proof of a negative COVID-19 test for international travel](#) to the United States with several caveats, which are listed [here](#). Clinicians should understand the utility of rapid tests, their cost, availability, and how home testing may fit into their patient's overall plan or the overall campus strategic plan.

Contact Tracing

With more social interactions and higher density, campuses should prepare for more close contacts per infected case. Even in highly vaccinated campuses, cases are possible. Breakthrough cases are less likely to be severe in those without underlying medical conditions, but public health authorities still expect a thorough contact tracing response once an infection is identified.

Campus contact tracing (CT) teams should maintain close connection with their local health department so both can be well-informed should public health protocols or campus conditions change. Campuses should be prepared to respond efficiently to positive tests in accordance with local public health rules. If the campus' isolation and quarantine space reach capacity, the local public health department should be notified.

With fewer cases, many CT teams have been reduced. Campuses should have contingency plans in case of surges. When CT teams are overwhelmed, response times lengthen, increasing the potential of exposure and community spread. Options include maintaining on-call per diem contact tracers and preemptively training clinic staff as contact tracers (note that clinic staff may be stretched thin, and this should be accounted for when planning whether to train them as contact tracers). Electronic messaging (rather than phone) can speed up the process. Regardless of communication method, privacy must be maintained.

With fully populated classrooms, contact tracing can be difficult. Students in large lecture halls may not remember or know the names of people who sat nearby. Class rosters or seating assignments may help. While imperfect, proximity detection applications (some are integrated into iOS and Android phones) may be preferred over the possibility of placing an entire class on a higher testing cadence (adaptive testing). CDC's guidance for contact tracing in higher education is available [here](#). CDC also has resources for [contact tracing in general](#), including easy-to-read [sample text](#).

Isolation and Quarantine

Although campus COVID-19 vaccination rates are increasing, maintaining updated plans for isolation and quarantine should continue next semester. Vaccination status matters. Highly vaccinated campuses will likely face fewer challenges with isolation/quarantine capacity; however, preparation and planning must consider the possibility of increased case numbers. The number of quarantine and isolation rooms needed will depend on factors such as campus size, the level of community spread of COVID-19, and campus vaccination rates. Policies and procedures should be coordinated and widely communicated so all members of the campus community have a clear understanding of the plans and their role. Whether campuses designate residence halls or floors or contract with local hotels or apartments for isolation and quarantine, plans should include provision of academic and support services for ill or exposed students including:

- Dining/food services
- Remote classes/note takers
- Daily check-ins with plans for further clinical evaluation as needed for worsening or progressing symptoms
- Access to counseling services, as separation from friends, classes, and activities can be difficult. Mental health should be prioritized, and counseling services should be made available remotely for students.

A team of designated student affairs/residential housing staff with the ability to expand and contract contingent on volume or need should be trained and readily available to assist students with personal needs. The length of time for isolation and quarantine should follow current CDC guidance which can be found [here](#).

Clinical Evaluation of Upper Respiratory Infections

All health care providers will be challenged over the coming months to distinguish COVID-19 from other circulating upper respiratory viruses, since clinical presentation may overlap. In preparation, student health services (SHS) could consider:

- Increasing campus influenza vaccination rates through education, access, and, when possible, an influenza vaccine requirement.
- Monitoring influenza cases on campus and in the local community to detect emerging outbreaks.

- Advising patients to call before coming to the SHS for any type of visit. Screen all patients for respiratory/COVID-19 symptoms, including but not limited to fever, cough, shortness of breath, chills, muscle pain, headache, sore throat, congestion, nausea, vomiting, diarrhea, and loss of sense of smell and taste.
- Establishing protocols for managing patients with acute respiratory symptoms, including utilizing telemedicine visits, 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.
- Providing, when possible, immediate, preferably same-day testing, for both COVID-19 and influenza. Patients can be infected with more than one virus at the same time. Coinfections with other respiratory viruses in people with COVID-19 have been reported. Therefore, identifying infection with one respiratory virus does not exclude SARS-CoV-2 virus infection.
 - COVID-19 nucleic acid amplification tests (NAATs) are available as both point-of-care and laboratory-based tests. The sensitivity of antigen tests varies but is generally lower than most laboratory based NAATs. If the prevalence of infection in the community is high and the person being tested is symptomatic, then a positive Ag test is more reliable (high pretest probability).
 - Influenza is often a clinical diagnosis; however, testing may be of value when community prevalence of COVID is also high. NAATs are the most sensitive and specific test for influenza viruses and are the preferred test if the results are available quickly. Rapid antigen testing or direct or indirect immunofluorescent antibody staining tests have limited sensitivity. A negative result should be interpreted with caution given the potential for a false-negative result, particularly during periods of high influenza activity.
 - Multiplex PCR assays are available that can detect COVID-19 and influenza as well as the other common causes of acute respiratory tract infections.

Treatment of COVID-19

Outpatient treatment of COVID-19 has been primarily supportive using analgesics, antipyretics, and antitussives as needed for symptom management, and all outpatients should be counseled that worsening symptoms require follow up with their health care provider or to emergency services if needed.

Several [monoclonal antibodies have received EUA by FDA](#) for both treatment and post-exposure prophylaxis of COVID-19 in individuals who are at high risk of severe illness, hospitalization, or death if infected with SARS-CoV-2. Early identification of individuals with robust contact tracing and rapid testing and results are critical to optimize these treatment options. Student health providers should ensure that all newly diagnosed or exposed patients are routinely assessed as soon as possible to see if they are appropriate for monoclonal antibody treatment and facilitate referral. Monoclonal antibodies require intravenous (IV) infusion or subcutaneous (SQ) injection. Identifying local resources for these services is necessary when SHS does not have the capability to provide infusion therapy. Circulating viral variants of concern may be associated with resistance to some of these monoclonal antibodies, so it is critical to monitor local conditions.

New oral therapeutics (Paxlovid, Lagevrio) are currently being evaluated by FDA and will significantly expand outpatient treatment options when/if they are approved but must be taken early in the course of disease for maximum efficacy. **None of these drugs are substitutes for vaccination.**

Long COVID

Symptoms of SARS-CoV-2 infection that persist or evolve for weeks or months beyond the acute phase of COVID-19 are referred to as “long COVID.” Other names include convalescent coronavirus disease and post-COVID syndrome.

Dozens of physical and psychological symptoms have been associated with long COVID, but a case definition has not been established. Common [signs and symptoms](#) include weakness, general malaise, fatigue, concentration impairment (sometimes characterized as “brain fog”), and breathlessness; symptoms are not explained by an alternative diagnosis and are not related to active viral infection and infectivity. No specific diagnostic test is available.

In [a study of more than 270,000 survivors of COVID-19](#), risk of long COVID features was higher in patients who had more severe initial COVID-19 illness and slightly higher among females and young adults. White and non-

white patients were equally affected. Symptoms can occur unexpectedly and unpredictably. For 2 in 5 of the patients with features of long COVID in the 3- to 6-month convalescent period, there had been no record of any such feature in the previous three months.

Long COVID is classified as a disability by the Americans with Disabilities Act if it substantially limits, either physically or mentally, one or more major life activities. As such, the IHE's disability services office will likely be the primary responder to assist students with academic adjustments or reasonable modifications. Since long COVID is a relatively new entity with multiple symptoms and no existing confirmatory test, clinicians, disability service providers, and affected students must collaborate to optimize care plans and services.

International Travel

As the world reopens, international students have returned to U.S. campuses and some IHES are resuming education abroad programs for spring 2022. Due to the continuing evolution of the pandemic and widely divergent approaches to both outbound and incoming IHE-related international travel, it remains critically important to be well-informed of relevant recommendations, rules, and regulations as previously discussed in ACHA's Fall 2021 Guidelines, which includes links to relevant resources. Campus, local, state, tribal, national, and international realms must all be included in these considerations for all outbound and incoming IHE international travel. Relevant resources are supplied in the ACHA Fall 2021 Reopening Guidelines as well as below; it is crucial to remain current and reference these diligently in all IHE-related international travel matters, which are subject to frequent change.

An example of a recent change with potential significant impact on IHEs is this November 8, 2021, U.S. State Department vaccine requirement: non-immigrant, non-citizen air travelers to the U.S. are required to be fully vaccinated, with some narrow exceptions to this rule. The new guidelines can be found [here](#).

As of this writing, [WHO has listed the following COVID-19 vaccines for emergency use](#). This list is subject to change.

- Pfizer-BioNTech COVID-19 Vaccines (e.g., BNT162b2, COMIRNATY, Tozinameran)
- AstraZeneca-Oxford COVID-19 Vaccines (e.g., [ChAdOx1-S (recombinant)], AZD1222, Covishield, Vaxzevria)
- Janssen (Johnson & Johnson) COVID-19 Vaccine (e.g., Ad26.COV2.S)

- Moderna COVID-19 Vaccine (e.g., mRNA 1273, Takeda, Spikevax)
- Sinopharm-BIBP COVID-19 Vaccine
- Sinovac-CoronaVac COVID-19 Vaccine
- Bharat Biotech International COVID-19 Vaccines (e.g., BBV152, COVAXIN)

Conclusion

Vaccination remains the most effective way to reduce the risk of infection, transmission, severe disease, hospitalization, and death from SARS-CoV-2, and fully vaccinating the eligible unvaccinated population remains the priority to end this pandemic. As of November 29, a new variant of concern, Omicron, has arisen, and approximately [70.1% of the U.S. population have received at least one dose of COVID-19 vaccine](#).

Another cycle of winter and colder weather will drive people indoors, renewing concerns of higher case counts and a potential fifth wave. With the availability of three safe and effective vaccines, improving vaccine confidence and the vaccination rate should become the primary foci for IHEs, while continuing layered prevention strategies.

As the pandemic continues into another year, IHEs must also address and relieve the weary workforce. College health professionals and other frontline student-facing employees have experienced long hours, increased workloads, stress, and burnout. They have been continuously exposed to infection and have endured disrespect, misbehavior, and other forms of backlash as they perform their job responsibilities, administer vaccines, or enforce campus prevention strategies and policies. Long-term investment in workplace health and wellness will be essential to revive and maintain a vibrant workforce.

Finally, the pandemic has left an indelible reminder of the critical public health role that college health plays on college campuses. The medical, mental health, and health promotion transdisciplinary model has proven essential to address the complex systems and processes needed to provide care and services to the campus. IHEs should continue to evaluate their pandemic response. All those who played a role in the response should participate and discuss strengths, weaknesses, and opportunities for improvement to develop actionable recommendations. Whether these recommendations are couched as lessons learned or formalized in an after-actions report, these exercises are necessary for ongoing and future planning, training, resource allocation, and continuous performance improvement.

Additional Resources

Campus COVID-19 Vaccination and Mitigation Initiative (Cova)

The [Campus COVID-19 Vaccination and Mitigation \(CoVAC\)](#) Initiative is a project of the American College Health Association, funded by a cooperative agreement with the Centers for Disease Control and Prevention. The goal of the CoVAC Initiative is to support healthy and thriving campus communities. This requires:

- Federal, state, and local public health policies that empower institutions of higher education (IHEs) to use every available public health tool to protect campuses and neighboring communities from COVID-19.
- Implementation of effective, equitable, inclusive, and layered prevention strategies by IHEs to reduce COVID-19 transmission on college campuses and in their surrounding communities.
- Active engagement of students, staff, faculty, and members of the surrounding community in an evidence-based combination of strategies to prevent and respond to COVID-19.

To that end, the CoVAC Initiative will:

- Equip campus professionals to lead interventions that build vaccine-preventable disease preparedness at the community level and confidence at the individual level.
- Expand the [Higher Education COVID-19 Community of Practice \(HECCOP\)](#) to engage multidisciplinary campus personnel and students in behavioral risk mitigation, including high rates of COVID-19 vaccine uptake.
- Increase COVID-19 vaccination awareness and visibility.
- Combat COVID-19 vaccine misinformation.
- Leverage campus and community assets to promote masking, physical distancing, handwashing, and vaccination.

Further Reading

Daily Testing for Contacts of Individuals with SARS-CoV-2 Infection and Attendance and SARS CoV-2 Transmission in English Secondary Schools and Colleges: An Open Label Cluster-Randomised Trial:

[https://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(21\)01908-5/fulltext](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(21)01908-5/fulltext)

Medpage Today: COVID Testing on Campus Is About More Than the Students:

https://www.medpagetoday.com/opinion/second-opinions/95243?xid=nl_secondopinion_2021-10-26&eun=g1999099d0r

Assessing COVID 19 Prevention Strategies to Permit the Safe Opening of Residential Colleges in Fall 2021:

<https://www.acpjournals.org/doi/full/10.7326/M21-2965?journalCode=aim>

Treatment Resources

Bamlanivimab and etesivimab (Eli Lilly)

- [EUA Letter of Authorization](#)
- [Fact sheet for health care providers](#)

REGEN-COV® (casirivimab and imdevimab) (Regeneron)

- [EUA Letter of Authorization](#)
- [Fact sheet for health care providers](#)

Sotrovimab (GlaxoSmithKline)

- [EUA Letter of Authorization](#)
- [Fact sheet for health care providers](#)

COVID-19 Task Force: Reopening Guidelines Committee

These guidelines were developed by the Reopening Guidelines Committee, part of ACHA's COVID-19 Task Force. A special thanks to the committee members: Jean Chin, MD, MBA, FACP, FACHA (Committee Chair); Anita Barkin, DrPH, MSN, NP-C, FACHA, and Geraldine Taylor, MS, APRN-BC, FACHA (Task Force Chairs); Michael Deichen, MD, MPH, FACHA; Catherine Ebelke, PA-C, CTH, FACHA; James Jacobs, MD, PhD; Cheryl Hug-English, MD, MPH; Rachel Mack, BA; Tondra Moore, PhD, JD, MPH; Giang Nguyen, MD, MPH, MSCE, FAAFP; and Sarah Van Orman, MD, MMM, FACHA.



AMERICAN
COLLEGE
HEALTH
ASSOCIATION