

ACHA Guidelines

COVID-19 Considerations for Institutions of Higher Education, Fall 2022

Institutions of higher education (IHEs) are entering fall 2022 with more than two years of hard-won experience with SARS-CoV-2. Safe and effective vaccines, antivirals, monoclonal antibodies, and prophylactic medications have significantly improved the management of COVID-19. However, pandemic fatigue has engulfed the country, while the highly transmissible Omicron subvariants burn their way through the U.S. The acute phase of the pandemic crisis has ended, but neither the World Health Organization (WHO) nor the U.S. Centers for Disease Control (CDC) have declared a transition to the endemic phase of COVID-19.

College health's role and responsibility to monitor and protect the public health of its campus communities will become even more critical where collective community decisions about masking, testing, vaccination, and other public health mitigation strategies have been abandoned or are increasingly being shifted to individuals. The impact of long COVID on student health and well-being presents an additional challenge for college health and student support services. College health professionals remain essential to ongoing planning, education, and response as SARS-CoV-2 is projected to persist, mutate, and test our processes and our resolve.

These guidelines build upon the foundational principles of previous guidelines and serve as a resource for campuses as they prepare for the next phase of the pandemic. Like previous ACHA COVID-19 guidelines, this document applies to the broad spectrum of college health and can be modified depending on available staff, finances, facilities, technology, and community resources, with full recognition that today's current information and considerations could quickly become obsolete.

COVID-19 Vaccinations

Immunization remains a critical component of the campus response to COVID-19 even during the circulation of milder subvariants. Vaccination decreases the risk of severe illness, hospitalization, and death from SARS-CoV-2 infection. At this point in the pandemic, the primary COVID-19 vaccine series should be routinely recommended and made available on campus, if possible. Boosters should also be made available on campus for all eligible students, faculty, and staff. Because boosters are

necessary to maintain sufficient immunity, healthcare providers (HCPs) must be well versed in the booster eligibility categories to make appropriate vaccine recommendations to include timing, dosage, contraindications, and risks. Ideally, campus community members should be [up to date](#) on COVID-19 vaccines and boosters. If the campus does not have the resources to provide immunizations and boosters, arrangements should be made with local health resources to ensure easy access for the campus community.

Boosters

Waning antibody levels have been observed over time, so boosters are valuable in ensuring continued protection. The science is constantly evolving, so campus leaders should closely monitor the guidance from the Centers for Disease Control and Prevention (CDC) and the CDC's Advisory Committee on Immunization Practices (ACIP). For people who are at increased risk due to age, chronic medical conditions, or drug-induced immune suppression, additional boosters may be warranted above what is recommended for the general population.

Vaccine Recommendations and Requirements

At minimum, campuses should strongly recommend that all students and employees be "up to date" on COVID-19 vaccination, knowing that the definition of what it means to be up to date may change over time. Campuses that are in a position to require COVID-19 vaccinations should strongly consider doing so, because campus-level vaccine requirements are effective in ensuring a highly immunized community, and immunizations have been shown to be effective in lowering the likelihood of hospitalizations and deaths due to COVID-19. Campus leaders should have a process to grant exemptions that aligns with exemption policies for other campus requirements. Providers should be familiar with the indications, contraindications, timing, and dosing for the four authorized vaccines in the U.S. to counsel patients appropriately.

Communication and Access

With or without vaccine requirements, campuses should ensure clear communication and accurate information about vaccine safety and effectiveness and identify and

address barriers to vaccination. Trusted voices from within the community can help to maximize trust in the message. When feasible, campuses should arrange for on-site access to vaccination, knowing that students may not have the ability to travel to off-campus vaccination sites and that international students might be coming from parts of the world that don't have easy or consistent access to vaccines or boosters. To the extent possible, assess and remove any financial barriers to vaccination for all community members.

Immunizations Received Outside the U.S.

Persons who completed their COVID-19 vaccinations with brands approved or listed for emergency use by the World Health Organization (WHO) are considered to be fully vaccinated, even if those brands are not authorized for use in the U.S. While mixing of brands is not recommended by CDC for the primary vaccine series, it is allowed, and persons who are due for a booster should receive a booster dose using an authorized or approved mRNA vaccine.

Vaccine Documentation

Persons who have been vaccinated against COVID-19 should retain paper and electronic records of their vaccination status. Anyone who received the vaccine in the U.S. can obtain a replacement copy of their vaccine card by contacting their state's Immunization Information System (IIS).

Natural Infection

Immunization through natural infection can offer immunity on some level, but the degree and duration of immunity that comes with natural infection may be hard to predict. Additionally, evidence points to lower levels of immunity against the Omicron variants currently

circulating. CDC recommends vaccination even if a person has already experienced COVID-19 infection. Additional guidance on getting vaccinated post-infection can be found [here](#).

Future Options

Vaccine scientists continue to work on additional types of vaccine, such as multivalent vaccines that cover different variants of SARS-CoV-2 as well as the ancestral lineage. New modes of vaccine delivery are also being explored, including nasal sprays. Campus health professionals should monitor this constantly changing landscape and adjust guidance and communication accordingly.

Masking

Consistent and correct masking is an effective tool to combat the spread of COVID-19.^{1 2 3 4}

Well-fitted masks, worn properly, can help prevent an infected individual from spreading the infection to others and help an uninfected person from acquiring a new infection with SARS-CoV-2.⁵

Masking remains a critical tool to limit the spread of COVID-19 where case counts are high or increasing and in high-risk situations.^{6 7} Situations considered higher risk for SARS-CoV-2 exposure include crowded indoor settings, public transportation, a jobsite where someone interacts with large numbers of the public, and situations when individuals care for sick people, including those known to be infected with SARS-CoV-2. Higher risk situations also include those in which [vulnerable individuals](#) with increased risk of developing severe disease, hospitalization, and death may be exposed to the virus.

¹Islam H, Islam A, Brook A, Rudrappa M. Evaluating the effectiveness of countywide mask mandates at reducing SARS-CoV-2 infection in the United States. *J Osteopath Med.* 2022 Jan 27;122(4):211-215. doi: 10.1515/jom-2021-0214. PMID: 35086185.

²Motallebi S, Cheung RY, Mohit B, Shahabi S, Alishahi Tabriz A, Moattari S. Modeling COVID-19 Mortality Across 44 Countries: Face Covering May Reduce Deaths. *Am J Prev Med.* 2022 Apr;62(4):483-491. doi: 10.1016/j.amepre.2021.09.019. Epub 2021 Nov 11. PMID: 35305777; PMCID: PMC8580811.

³Liu J, Hao M, Chen S, Yang Y, Li J, Mei Q, Bian X, Liu K. Numerical evaluation of face masks for prevention of COVID-19 airborne transmission. *Environ Sci Pollut Res Int.* 2022 Feb 9. doi: 10.1007/s11356-022-18587-3. Epub ahead of print. PMID: 35141824.

⁴Coyle JP, Derk RC, Lindsley WG, Boots T, Blachere FM, Reynolds JS, McKinney WG, Sinsal EW, Lemons AR, Beezhold DH, Noti JD. Reduction of exposure to simulated respiratory aerosols using ventilation, physical distancing, and universal masking. *Indoor Air.* 2022 Feb;32(2):e12987. doi: 10.1111/ina.12987. PMID: 35225389; PMCID: PMC8988470.

⁵Riley J, Huntley JM, Miller JA, Slauchert ALB, Brown GD. Mask Effectiveness for Preventing Secondary Cases of COVID-19, Johnson County, Iowa, USA. *Emerg Infect Dis.* 2022 Jan;28(1):69-75. doi: 10.3201/eid2801.211591. Epub 2021 Oct 12. PMID: 34637377; PMCID: PMC8714203.

⁶Chang CN, Chien HY, Malagon-Palacios L. College reopening and community spread of COVID-19 in the United States. *Public Health.* 2022 Mar;204:70-75. doi: 10.1016/j.puhe.2022.01.001. Epub 2022 Jan 11. PMID: 35176623; PMCID: PMC8747949.

⁷Donovan CV, Rose C, Lewis KN, Vang K, Stanley N, Motley M, Brown CC, Gray FJ Jr, Thompson JW, Amick BC 3rd, Williams ML, Thomas E, Neatherlin J, Zohoori N, Porter A, Cima M. SARS-CoV-2 Incidence in K-12 School Districts with Mask-Required Versus Mask-Optional Policies - Arkansas, August-October 2021. *MMWR Morb Mortal Wkly Rep.* 2022 Mar 11;71(10):384-389. doi: 10.15585/mmwr.mm7110e1. PMID: 35271560; PMCID: PMC8912000.

NIOSH-approved respirators (N95s) offer the highest level of protection, followed by KN95s and well-fitting ASTM-rated surgical masks.⁸ Cloth masks offer a lower level of protection, but protection can be enhanced with double masking.⁹ Mask fit is very important; masks should be sealed tightly to the nose and face without gaps at mask edges. Masks should completely cover the nose and mouth and be comfortable enough for the wearer to use consistently, except when eating or drinking. Single use masks and masks that are soiled or wet should be discarded after use. Some masks may lose effectiveness with excessive reuse. Current standards for masks can be found on the CDC [NIOSH Personal Protective Equipment Information \(PPE-Info\) webpage](#).

Considerations:

- IHEs should make masks readily available if local levels of COVID-19 infections warrant mask use and at any campus locations requiring mask use. Students at high risk of SARS CoV-2 exposure or at high risk of COVID complications should be advised to use KN95 or N95 masks for personal protection and IHEs should consider providing such masks to this subset of students.
- Recognize that some people may choose to continue to mask even though the campus or community may not require it. It is important that students, faculty, and staff respect and support these personal health decisions.
- Campus health services staff should use appropriate PPE, including masks. Health services should consider universal masking for staff and patients.¹⁰
- Minimally, all persons with symptoms and those unable to be assessed for symptoms should be required to wear masks while in the campus health service building.
- Establish parameters in advance that will dictate a shift to on-campus masking and proactively communicate them before they are needed. Use CDC's [Community Risk Tool](#) for real-time masking recommendations.

Indoor Air Quality

Improving indoor air quality continues to be a critical component of decreasing transmission of COVID-19 and can have the added benefit of reducing the public health impact of other respiratory illnesses, including influenza. The SARS-CoV-2 virus is primarily transmitted through airborne particles and droplets released when infected individuals exhale. These infectious particles and droplets accumulate in indoor spaces, increasing with activities such as speaking loudly, singing, or exercising. As in prior guidance, outdoor options for classes, exercise, dining, performance, and other events should be considered and/or continued.

Air quality can be improved through three primary mechanisms:

Ventilation brings in clean outdoor air to disperse viral particles. Ventilation can be improved by opening windows and doors. Adding fans directed to the outside further improves air circulation. Newer buildings are often sealed, but the heating, ventilation, and air conditioning (HVAC) system brings in outdoor air. CO2 monitors can be used to determine CO2 levels, a surrogate measure to determine whether enough outdoor air is being brought into a classroom or office from natural or mechanical ventilation. CO2 levels above 800 parts per million (ppm) can indicate more outdoor air is needed.

Air filtration removes virus particles from indoor air. Air filtration is often a part of an HVAC system, and the highest possible filtration level of at least MERV-13 is recommended. In facilities where this is not possible, portable HEPA filters are widely available and very effective in reducing viral particles in the air. Multiple portable units may be necessary depending on the size of the room.

Air disinfection kills airborne viruses through methods like ultraviolet germicidal irradiation (UVGI). UVGI has been used in high-risk situations and/or in combination with air filtration. Currently available technologies are complex to effectively implement and should be considered only with expert guidance.

⁸ Mello VM, Eller CM, Salvio AL, Nascimento FF, Figueiredo CM, Silva ESRF, Sousa PSF, Costa PF, Paiva AAP, Mares-Guias MAMM, Lemos ERS, Horta MAP. Effectiveness of face masks in blocking the transmission of SARS-CoV-2: A preliminary evaluation of masks used by SARS-CoV-2-infected individuals. *PLoS One*. 2022 Feb 23;17(2):e0264389. doi: 10.1371/journal.pone.0264389. PMID: 35196363; PMCID: PMC8865648.

⁹ https://www.acha.org/documents/resources/guidelines/ACHA_Considerations_for_Reopening_IHEs_for_Fall_2021_5.25.21.pdf

¹⁰ Thompson ER, Williams FS, Giacini PA, Drummond S, Brown E, Nalick M, Wang Q, McDonald JR, Carlson AL. Universal masking to control healthcare-associated transmission of severe acute respiratory coronavirus virus 2 (SARS-CoV-2). *Infect Control Hosp Epidemiol*. 2022 Mar;43(3):344-350. doi: 10.1017/ice.2021.127. Epub 2021 Mar 29. PMID: 33775264; PMCID: PMC8111184.

IHE and SHS leadership should work closely with environmental health professionals to improve campus indoor air quality. Specific attention should be given to areas where indoor masking is not always feasible, such as dining venues, recreation facilities, and performing arts classrooms or similar venues. Resources are available from the [Environmental Protection Agency](#) (EPA).

Testing and Surveillance

Approaches to testing for SARS-CoV-2 are dependent on many factors including, but not limited to, local community case numbers and hospitalizations, campus levels of vaccination, testing resources, and local and state guidance or mandates. Testing remains a crucial tool to identify SARS-CoV-2 infection so that treatment, isolation, and contact notification may begin as soon as possible.

Diagnostic Testing

All individuals—those who are unvaccinated as well those who are fully vaccinated and those who are up to date on vaccination—should be tested if experiencing symptoms. Close contacts of infected individuals should be tested on or after day five (day five = five days post-exposure) or if symptoms develop. The increased availability of home antigen tests (rapid tests) makes testing less burdensome for IHEs with limited resources. Free antigen tests for personal use can be obtained from the federal government at <http://covidtests.gov>. Insurance companies and many health plans are required to cover eight home antigen tests per covered individual per month. Students should notify direct contacts and their primary care provider or student health service as soon as possible after a positive home antigen test.

Surveillance Testing

Each campus and community is unique and there are many different approaches to surveillance testing. It is important to be aware of local, community, or state guidance with respect to SARS-CoV-2 testing and to work closely with local or district health departments. Campuses will need to determine the importance of and/or need for surveillance testing by considering transmission and infection level of COVID-19 in the surrounding community as well as the campus vaccination rate.

Considerations for surveillance testing:

- Conduct pre-arrival testing for all individuals moving into campus housing, such as residence halls or Greek housing.
- Conduct pre-arrival testing for all individuals attending in person or overnight orientation.

- At-home rapid antigen tests are an option that may be used to fulfill pre-arrival testing requirements.
- Perform testing on arrival for all individuals who are not up to date with COVID-19 vaccinations.
- Consider serial surveillance testing for those who remain unvaccinated.
- The need for and/or frequency of surveillance testing will vary depending on community and campus levels of infection.
- Consider using the [CDC Community Risk Assessment Tool](#) to determine the need for and/or frequency of testing and other surveillance and mitigation strategies.

Wastewater Surveillance

Wastewater surveillance for SARS-CoV-2 is a helpful tool that can evaluate trends in community infection, complement other surveillance strategies, and assist health districts in identifying risk levels in a community. It may be useful for IHEs as an early indicator of the presence of, or trends in, COVID-19 cases on campuses.

Wastewater surveillance capabilities:

- It can identify whether infection levels in a community or on a college campus are rising or falling.
- It can detect evidence of the SARS-CoV-2 virus one to two weeks earlier than it takes to begin to receive results from clinical laboratory tests.
- It can provide surveillance in areas where testing is limited.
- It can detect and identify different variants of COVID-19.
- It is most effective when used in conjunction with other surveillance methods.

Wastewater surveillance limitations:

- Although helpful in determining community risk levels, wastewater testing cannot accurately identify discrete individuals or the number of people infected in a community.
- It may not be accurate when there are low levels of SARS-CoV-2 in a community.
- Interpretation of results is limited in communities with highly transient populations such as industrial or tourist regions.
- It is not helpful in areas that do not have access to municipal sewer systems or in areas with septic tanks.

- Pretreatment of wastewater can affect results.
- It requires cooperation and coordination with public health agencies in the community and resources to do the testing.
- Wastewater surveillance is expensive and requires specific expertise. It may not be a realistic option for many campuses.

Isolation and Quarantine Accommodations

Decisions regarding isolation and quarantine housing may be vexing and controversial for IHEs this fall as maximizing housing inventory and maintaining separate isolation accommodations are competing goals. Immunity through vaccination and natural infection has blunted the morbidity and mortality of COVID-19, and the majority of healthy, immunocompetent, traditional college-aged students will experience mild or no symptoms if infected with SARS-CoV-2. The availability of vaccines in combination with CDC's decreased timeframe of isolation have led IHEs to reevaluate the best approach to optimizing health and safety, communicating transparently, and managing the needs of those who are infected or exposed to SARS-CoV-2 while living in campus-provided housing.

Isolation and quarantine recommendations detailed in the [COVID-19 Task Force Key Considerations Update](#) from January 2022 remain relevant and current. Universities should consult with student health services (SHS) and local public health authorities and develop protocols identifying the appropriate length of isolation for infected individuals, including the timing of test-out procedures (i.e., day 5, day 7, or serial testing) acknowledging unique community characteristics (isolation/testing capacity), local trends, and established best practices. CDC's [Isolation and Quarantine Calculator](#) is a useful tool to help patients understand the length of time to isolate or quarantine.

Residential Housing Considerations:

- Separate isolation accommodations for infected students carry the lowest risk of additional exposures. Examples of such living situations include a single occupant with a private bathroom, one or more roommates each with a private bedroom and a bathroom, and single occupant bedroom and shared bathroom with other students in isolation.

- Acceptable alternatives in other congregate housing configurations:
 - Isolate/quarantine at home if able to travel by private vehicle.
 - Isolate in place while offering the roommate alternative housing accommodations.
 - Infected and exposed roommate(s) remain together with the caveat that the uninfected roommate is informed of the risks of sharing living space with an infected individual. Ideally, signed informed consent is obtained by residential life staff and all clinical questions referred to student health.
- Students at higher risk of medical complications should be encouraged to apply for housing accommodations at the start of the term, so that they might be assigned to a private room and avoid the risk of having an infected roommate later in the term.
- Establish contingency plans with local hotels and apartments.
- Optimize air quality in shared living spaces as noted in the section "Indoor Air Quality."
- Ensure students have access to meals and academic and support services for the duration of the student's confinement as defined by CDC.

Treatment and Prophylaxis

Ambulatory care providers now have multiple therapeutic options for outpatient treatment of COVID-19 with antiviral drugs, monoclonal antibodies, and prophylactic agents to augment the analgesics, antipyretics, expectorants, and antitussives used for symptomatic treatment. The National Institutes of Health (NIH) provides updated recommendations for using outpatient therapeutic interventions for adults with mild to moderate COVID-19 who are at high risk of progression to severe illness, death, or hospitalization. None of these drugs are a substitute for vaccination.

Antiviral and Monoclonal Antibody Treatments

Three antiviral agents—nirmatrelvir with ritonavir (Paxlovid), molnupiravir (Lagevrio), and remdesivir (Veklury)—are currently authorized for treatment of COVID-19. Both Paxlovid and Lagevrio are oral medications prescribed for a five-day course, while Veklury is an IV infusion administered for a three-day course. With the dominance of the Omicron subvariants, only one monoclonal antibody, bebtelovimab, is

recommended for use in treating non hospitalized individuals aged 12 and up who carry an [increased risk of severe illness](#) if infected with SARS-CoV-2. It is administered as a single IV dose. The NIH guidelines list Paxlovid or Veklury as first line treatment with Lagevrio and bebtelovimab as alternate therapies. The CDC does

not identify first line treatment in their recommendations. Both the antiviral medications and monoclonal antibodies should be initiated early in the course of the illness, with antivirals ideally initiated within five days of diagnosis and monoclonal antibodies within seven days.

Treatment	Who	When	How
Nirmatrelvir with Ritonavi (Paxlovid) ☑ <i>Antiviral</i>	Adults; children ages 12 years and older	Start as soon as possible; must begin within 5 days of when symptoms start	Taken at home by mouth (orally)
Remdesivir (Veklury) ☑ <i>Antiviral</i>	Adults and children	Start as soon as possible; must begin within 7 days of when symptoms start	Intravenous (IV) infusions at a healthcare facility for 3 consecutive days
Bebtelovimab ☑ <i>Monoclonal antibody</i>	Adults; children ages 12 years and older	Start as soon as possible; must begin within 7 days of when symptoms start	Single IV injection
Molnupiravir (Lagevrio) ☑ <i>Antiviral</i>	Adults	Start as soon as possible; must begin within 5 days of when symptoms start	Taken at home by mouth (orally)

Source: [COVID-19 Treatments and Medications](#). CDC

The phenomenon of COVID-19 rebound after the five-day course of Paxlovid treatment has been reported enough times to warrant [an advisory](#) from the Health Alert Network (HAN). Clinicians should be aware of this phenomenon which manifests as recurrent COVID-19 symptoms or a newly positive viral test after testing negative between two and eight days after initial recovery. Should this occur, patients should resume isolation for at least five days and may be released on day six if symptoms improve and if afebrile for 24 hours (without the use of fever reducing medications). The patient should wear a well-fitting mask for 10 days beginning on the day of recurrent symptoms. If the patient is unable to comply with wearing a mask for 10 days, isolation should be continued for the full 10-day period. No additional antiviral treatment is warranted.

The majority of traditional healthy 18–24-year-old college students are unlikely to meet the need or the criteria for these medications. Nevertheless, some students will qualify for treatment, so clinicians should be aware of the indications, dosing, route of administration, drug interactions, and availability of these drugs in the community and be prepared to either initiate treatment or refer students as needed. Campus health services should maintain a current list of local healthcare resources providing these antiviral treatments and, to the extent

possible, understand the documentation and other requirements needed to facilitate timely referral. Processes should be in place to revise protocols and treatment guidelines as new therapeutics become approved or variants render treatments ineffective. Since early treatment is dependent upon early diagnosis, college health programs must have in-house capability or partner with labs that have adequate testing capability and rapid turnaround times to avoid treatment delays.

Prophylaxis

Tixagevimab and cilgavimab (Evusheld) received EUA by FDA for pre-exposure prophylaxis for prevention of COVID-19. These two long-acting monoclonal antibodies together block the spike protein of SARS-CoV-2 to impede the virus' ability to attach and enter human cells. Evusheld has a narrow indication and is authorized for use only in individuals 12 and older weighing at least 88 pounds (40 kg) who:

- are moderately or severely immunosuppressed
- may have an inadequate immune response to vaccination
- have a history of severe adverse reactions to a COVID-19 vaccine and/or its components and can't be fully vaccinated.

The [NIH recommends](#) 300 mg tixagevimab plus 300 mg of cilgavimab administered as two consecutive 3 ml intramuscular injections. Those who received an initial dose of 150 mg tixagevimab plus 150 mg cilgavimab should receive a second dose. The second dose of Evusheld for those individuals is dependent on the timing of that initial dose.

- If the initial dose was administered ≤ 3 months prior, the second dose should be tixagevimab 150 mg plus cilgavimab 150 mg.
- If the initial dose was administered >3 months prior, the second dose should be tixagevimab 300 mg plus cilgavimab 300 mg.

Mental Health

Though the acute crisis of the pandemic is behind us, the pandemic's toll on mental health continues to reverberate and grow, causing IHEs to reinvest or reallocate resources to bolster behavioral health services for both students and the workforce. The collateral damage—from fatigue, mental exhaustion, burnout, stress, depression, and anxiety—on the campus community members' mental health has been called the second pandemic.

According to the [Spring 2021 ACHA-National College Health Assessment](#), students reported the following had negatively impacted their academic performance in the last 12 months:

Anxiety	31%
Depression	22%
Sleep difficulties	22%
Stress	29%

ACHA's previous guidelines document, [Considerations for Reopening Institutions of Higher Education for the Fall Semester 2021](#), remains relevant and provides extensive information, recommendations, and resources to address the pandemic's continued impact on the mental well-being of the campus community. Notably, counseling centers alone will not have the capacity to treat the numbers of students who seek care and services. If the institution has not yet taken steps to implement a campus-wide approach to support the mental health needs of students, it is time to engage a multidisciplinary group at all levels of the academy and begin.

Long COVID

Long COVID, now labeled more formally as post-acute sequelae of SARS-CoV-2 (PASC), is defined by the WHO as a condition that occurs in individuals with a history of probable or confirmed SARS CoV-2 infection, usually

three months from the onset of the acute COVID-19 infection with symptoms and which last for at least two months and cannot be explained by an alternative diagnosis. Symptoms can be new, an extension of those that were prominent during the acute infection, or exacerbation of a pre-existing condition. [Common symptoms](#) include fatigue, difficulty breathing or shortness of breath, chest pain or discomfort, change in smell or taste, headache, insomnia, memory impairment, anxiety, impaired concentration, but dozens more have also been attributed to long COVID. Symptoms [often occur as syndromes](#), such as cognitive pattern, pulmonary pattern, cardiac pattern, and others.

It is believed that most symptoms of long COVID will resolve within six months, but the trajectory toward resolution can be fraught and variable. Long COVID can impact mental health directly such as with "brain fog" or unexplained anxiety or as a result of the trauma of experiencing unexpected significant impairment as well as indirectly impacting support persons and caregivers of the patient.

Importantly, long COVID is a diagnosis of exclusion, as no specific diagnostic testing has been identified. In most cases, clinical intervention should target symptomatic relief, but multidisciplinary rehabilitation services will benefit patients who are experiencing significant impairment.

Long COVID is considered a disability under the Americans with Disabilities Act (ADA). If the student health service is involved in writing accommodation letters for students who are significantly impacted by long COVID, there should be close collaboration between the SHS and the institution's accommodations processes. Recommendations should be symptom(s)-specific (e.g., profound fatigue requiring assistance with mobility around campus) and time-limited (e.g., three months). Written guidelines are available [here](#).

Among the many unknowns of long COVID are the effect of vaccinations, effect of antiviral medications used during acute COVID infection, effect of various COVID variants, and disease prevalence and profiles in young adults.

Travel

As most IHEs in the U.S. resume and often encourage outbound and incoming international travel for students and faculty, the challenges of IHE-associated international travel during the ongoing pandemic remain considerable, multi-faceted, and resource intense. Variability in vaccination, testing, and documentation requirements will require ongoing monitoring, interpretation, and revision of policies and information.

The International Travel section in ACHA's [Fall](#) and [December](#) 2021 guidelines remain relevant at the time of this writing and provide foundational information. The following expands on that guidance:

General considerations:

- Undertaking international travel during an ongoing pandemic must be thoroughly evaluated, including but not limited to the unpredictability of the pandemic in coming months, the effects of the pandemic on healthcare system viability and all-cause healthcare access in all countries, potential traveler role in creating additional healthcare demand at the destination country, the potential effect of COVID-19 on personal health (especially important for those who are medically vulnerable to serious disease), and the significant potential for international travel complications.
- Prior to travel, international travelers should research and remain current on relevant [COVID-19 rules and regulations which might impact travel](#).
- **Active involvement of an international travel decision-making body at every IHE** remains crucial for vetting and endorsing IHE-associated international travel (see previous ACHA guidelines).
- **The importance of considering and planning contingencies** for unexpected COVID-related delays and needs cannot be overstated. This may include isolation or quarantine at any point in travel, including outbound or incoming transit, and could involve unanticipated needs for lodging, additional funds, adequate essential medications, reticketing, insurance arrangements, etc. This is especially important to consider for IHE-associated group travel which could be significantly impacted by such situations.
- All IHE-associated international travelers should be required to possess **appropriate international travel health insurance including evacuation insurance** without pandemic exclusions. Requiring international travelers to register with a campus-wide travel registry prior to campus-sponsored travel can help ensure that travelers have access to resources if medical problems arise during travel.
- Travelers should remember that **increased transmission of newer COVID-19 variants** has been well-documented and that asymptomatic infections and transmission, including among fully vaccinated individuals, is presumptively common. COVID-related risks may be greater when participating in international travel and in transportation hubs.

- Bringing an **adequate supply of PPE** for transit (particularly effective face coverings) and destination—and using PPE appropriately—remains crucial. CDC continues to [strongly recommend masking](#) when in transportation hubs, including in the U.S. where the masking requirement has been lifted.
- Travelers should consider bringing an appropriate supply of self-tests (rapid antigen) for personal use in the event of exposure or illness. In addition, consideration of bringing telehealth-observed COVID-19 tests in case of requirement for validated results may be warranted.
- **Travelers should not travel when ill**; see [CDC guidelines](#).
- **Travelers should practice appropriate COVID-related public health behaviors when traveling**, both to protect their own health as well that of others, including the populations en route, at destinations, and upon their return home.

Outbound International Travel

COVID-19 Vaccination Considerations

CDC [recommends](#) that all adults undertaking international travel be vaccinated and boosted against COVID-19.

Vaccination requirements at the destination may be significantly different from those in the traveler's home state or country or the IHE's location. Travelers must research and make appropriate arrangements well in advance of travel with consideration for the following:

- Requirements for transit travel, including the requirements of air carriers and countries en route
- Entry requirements for destination countries
- Regulations within destination country (e.g., restricted entry to facilities or events if not fully vaccinated)

Specifically, travelers should understand the destination country's:

- Acceptable vaccines. A list of WHO EUL-issued vaccines may be found [here](#).
- Definition of "fully vaccinated" and "up-to-date."
- Number of doses required/booster requirements.
- The time frame of vaccine administration relative to travel (e.g., at least 14 days but no more than 270 days after last dose of primary series).

- Documentation requirements:
 - CDC COVID-19 vaccination card is usually—but not always—acceptable
 - QR code may be required
 - COVID vaccination information is not recommended on Yellow Card; may not be acceptable

COVID-19 Testing Considerations During Travel

Testing requirements at international destinations are extremely variable and subject to abrupt changes. When preparing to travel, frequent checks for policy changes should be conducted.

General COVID-19 considerations in destination countries:

- Be prepared for random testing, which may take place upon arrival.
- The [website of the U.S. embassy in the destination country](#) is an excellent resource for updated information.
- Develop contingency plans for those who test positive upon return to U.S. and consider options for travelers who need to isolate or quarantine unexpectedly (lodging, funds, reticketing, insurance, COVID regulations; consider any special issues for IHE group travel)
- Travelers with documented COVID-19 infection within 90 days of travel should carry a “Document of Recovery” which includes clinic/lab documentation of a positive COVID-19 test as well as a healthcare provider’s statement that the individual is cleared to end isolation.
- Details from CDC may be found [here](#).

Incoming International Travel

Effective June 12, 2022, CDC rescinded its requirement for passengers traveling via air into the U.S. from a foreign country to provide a negative COVID-19 test or documentation of recovery from COVID-19 prior to boarding a flight. This ruling will be reconsidered 90 days after the current rule was issued.

Considerations:

- The IHE should provide clear COVID-related communication to incoming IHE-associated travelers, including resources regarding current regulations

which are appropriate to each traveler, availability of and access to healthcare in the area (including at the IHE), potential availability of quarantine/isolation accommodations, post-travel testing sites, and health monitoring.

- Since requirements for COVID-19 vaccinations and testing differ significantly among IHEs, local, tribal, state, and federal jurisdictions, incoming travelers should be supplied with appropriate information to navigate these specifics, including resources for obtaining COVID-19 vaccinations.

Misinformation and Disinformation

Traditional public health mitigation strategies to slow the spread of infectious diseases were underutilized during the COVID-19 pandemic, partially due to the proliferation of messages discouraging compliance with public health guidance and recommendations at the same time messages containing misinformation and disinformation were amplified.

Misinformation can be defined as “false and inaccurate information that is accidentally disseminated through various platforms.” In contrast, disinformation is “false information that is deliberately disseminated.”¹¹ Because misinformation and disinformation encourage individuals to reject and refuse traditional public health practices and mitigation strategies, COVID-19 continues to have a potentially dangerous presence on campuses.

While misinformation and disinformation are not new to public health (as was the case during the HIV/AIDS epidemic), both have intensified and been weaponized during the COVID pandemic. COVID messaging has been inconsistent and sometimes inflammatory. Unlike the TV, radio, or health promotion campaigns of the past, the internet and especially social media have provided unfettered access to misinformation/disinformation via many sources, which are easily shared without verification or evidence to support the claims being made within the content. This has made it very easy for misinformation and disinformation regarding COVID and public health practices to confuse and discourage college students.

Reestablishing trust in public health and health advice will be another challenge for college health. To do so will require engaging with students, listening actively, and demonstrating their voices matter. It is vital for college health professionals to acknowledge the distrust and skepticism towards the healthcare community, government, and institutions and the political climate

¹¹ M. Angeline, Y. Safitri and A. Luthfia, "Can the Damage be Undone? Analyzing Misinformation during COVID-19 Outbreak in Indonesia," 2020 *International Conference on Information Management and Technology (ICIMTech)*, 2020, pp. 360-364, doi:10.1109/ICIMTech50083.2020.9211124.

surrounding COVID when approaching an assessment or a health promotion campaign. Recognizing that not all people share misinformation in an attempt to cause harm,¹² any strategies used to moderate, counter, and debunk false information disseminated by students should be sensitive, inclusive, non-partisan, and nonjudgmental. The AAMC's Center for Health Justice offers a [Trustworthiness Toolkit](#) to aid organizations in combating mis/disinformation.

Considerations:

- Assess students regarding their beliefs and perceptions of COVID, including anxieties and fears surrounding COVID, the perceived benefits of their engagement in campus/public health mitigation strategies, and the preferred mediums for and sources of reliable information on campus. The information gathered should be widely disseminated using students' preferred campus sources of reliable information.
- Use infotainment strategies to share evidence-based information. Messaging should be presented in easily digestible segments (memes, reels, sound bites, etc.) including the use of parody, comedy, and videos instead of print.
- Utilize student volunteers, student advisory boards, student health advisory committees, or student peer educators to assist in vetting, creating, and disseminating messaging.
- Identify and create partnerships with social media influencers to craft and disseminate information on campus. College campuses have always had students who were identified as campus leaders or major influences on campus. Social media has created a new generation of influencers who can impact millions in a matter of seconds via social media.
- Utilize recognized and trusted leaders (student government, campus leaders, student athletes, sorority and fraternity members, and other influential campus student organizations) to help disseminate campus messaging.
- Create online communities that allow individuals to ask questions that seek both solutions and emotional reinforcements.¹³ This option could benefit less-resourced IHEs that may not have dedicated staffing to support a strategic social media campaign. This online community could utilize student volunteers

and peer educators and include campus faculty and researchers as community experts and moderators. Those with marketing and advertising skills may be particularly beneficial. This strategy, however, will require significant oversight, which could stress available staff.

- Tailor information to the campus, ensuring the messaging demonstrates not only the direct health impact on individuals and society but also that student engagement with health initiatives matter. It is vital that college health shows students how their individual and collective actions have a positive impact.
- [ACHA's Campus COVID-19 Vaccination and Mitigation Initiative \(CoVAC\)](#) offers free resources to correct misinformation among students, staff, and faculty. The program's toolkits will be updated in August.

Public Health Partnerships

Over the course of the pandemic, IHEs and student health service (SHS) leadership have established robust relationships with local, state, territorial, or tribal public health jurisdictions to address both ongoing impacts of COVID-19 as well as current and emerging public health concerns. Beyond this, local public health and IHE partnerships have played critical roles in addressing health equity issues in student, employee, and community populations.

These partnerships have been invaluable and should continue through the fall semester to facilitate strategies for layered prevention and management concerns. These strategies might include isolation/quarantine, contact tracing, testing, and other activities that require an understanding of campus resources, demographics, vaccination rates, case rates, and prevailing variants, as well as community conditions and local health considerations.

As pandemic conditions improve, many requirements for mitigation and surveillance may also end. IHEs should maintain and build upon their public health partnerships to optimize the campus public health presence once the immediate crises are over.

¹² Apuke, O. D., & Omar, B. (2021). Fake news and COVID-19: modeling the predictors of fake news sharing among social media users. *Telematics and Informatics*, 56, 101475.

¹³ Akbar, S. Z., Panda, A., Kukreti, D., Meena, A., & Pal, J. (2021). Misinformation as a Window into Prejudice: COVID-19 and the Information Environment in India. *Proceedings of the ACM on Human-Computer Interaction*, 4(CSCW3), 1-28.

Ongoing public health collaboration examples include:

- Joint after-action review of campus COVID-19 response in conjunction with local public health authorities.
- Regular partnership meetings to discuss COVID-19 related issues of mutual importance as previously detailed and to develop planning documents for future concerns, particularly those involving communicable diseases.
- Development of shared campus-community public health metrics.
- Assessment of other public health issues affecting the campus.
- Periodic joint table-top exercises to reinforce partnerships and prepare for future public health emergencies that may affect campus communities.

CDC Community Risk Tool

CDC has developed a [Risk Assessment Tool](#), mentioned several times previously in these guidelines, to help

communities make decisions about prevention and mitigation strategies. By typing in a specific county and state, a risk profile is generated. CDC uses a combination of several factors, including COVID-19 hospital admissions, inpatient beds occupied by COVID-19 patients, and total new COVID-19 cases in the past seven days to determine the COVID-19 community level of infection. Using this data, the COVID-19 community level is classified as low, medium, or high and specific recommendations for surveillance and mitigation strategies are provided. This tool can be a helpful adjunct to assist IHEs in making decisions about testing, masking, and other campus mitigation strategies.

For example, the guidelines suggest wearing a well-fitting mask indoors in public, regardless of vaccination status or individual risk, when the community level of COVID infections is high. If the community level of COVID infections is moderate, a well-fitting mask is recommended if someone is at increased risk of severe illness or has frequent contact with someone who is at increased risk. If low community levels of COVID infections exist, masks should be considered based on [personal risk](#).



COVID-19 County Check

Find community levels and prevention steps by county. Data updated weekly.

Select a Location (all fields required)

State County

The CDC Community Risk Tool can be accessed at www.cdc.gov/coronavirus/2019-ncov/science/community-levels.html.

Conclusion

The federal and state government funds supporting pandemic response are dissipating, public health mitigation strategies are lifting, and Americans are yearning for “post COVID living” at a time when the highly transmissible Omicron subvariants continue to dominate. Vaccination remains central to moving forward, and IHEs should continue to take every opportunity to increase vaccine uptake and vaccine confidence in the campus community.

To improve future response efforts, capitalize on the hard-fought lessons learned, build on the campus’ pandemic response capabilities, and remain proactive, IHEs should

conduct an after-action review with broad participation from key leaders and critical stakeholders. An example of a tool to facilitate this process is available [from Mathematica.org](#).

The course of the pandemic remains unpredictable; however, campuses are more knowledgeable and better equipped to deploy the layered mitigation strategies necessary to prevent a rise in case counts as cooler fall and winter temperatures drive people indoors and students arrive on campus with the expectations of a “pre-COVID” college experience. Newer vaccines and drugs should decrease morbidity and mortality, but long COVID remains a significant challenge for campus. The best weapons for college campuses continue to be the layered

prevention strategies of hand hygiene, cough etiquette, masking when appropriate, and maximizing indoor air quality in conjunction with improving vaccine uptake, including boosters. Accessibility to rapid testing and treatment, protecting our most vulnerable populations, and maintaining ongoing surveillance systems with the ability to quickly pivot as cases rise and fall will likely require ongoing local public health and community partnerships. College health professionals must recognize how

misinformation and disinformation have been used to discourage public health mitigation strategies during the pandemic. College health's long tradition of educating students on health literacy and lower risk choices will be critical to countering vaccine skepticism, misinformation, and disinformation, enhancing knowledge to improve individual risk management, and promoting the health of the entire campus community.

Resources

CDC Vaccine Information

Vaccines for COVID-19

<https://www.cdc.gov/coronavirus/2019-ncov/vaccines/index.html>

COVID-19 ACIP Vaccine Recommendations

<https://www.cdc.gov/vaccines/hcp/acip-recs/vacc-specific/covid-19.html>

COVID-19 Vaccines for People Vaccinated Outside the United States

<https://www.cdc.gov/coronavirus/2019-ncov/vaccines/people-vaccinated-abroad.html>

Finding Your Immunization Record Through Your State's IIS

<https://www.cdc.gov/vaccines/programs/iis/contacts-locate-records.html#state>

Treatment and Prophylaxis

NIH Coronavirus Disease 2019 (COVID-19) Treatment Guidelines

<https://files.covid19treatmentguidelines.nih.gov/guidelines/covid19treatmentguidelines.pdf>

NIH Guidelines: Therapeutic Management of Nonhospitalized Adults With COVID-19:

<https://www.covid19treatmentguidelines.nih.gov/management/clinical-management/nonhospitalized-adults--therapeutic-management/>

NIH Guidelines: Prevention of SARS-CoV-2 Infection

<https://www.covid19treatmentguidelines.nih.gov/overview/prevention-of-sars-cov-2/>

Wastewater Surveillance

Public Health Interpretation and Use of Wastewater Surveillance Data

<https://www.cdc.gov/healthywater/surveillance/wastewater-surveillance/public-health-interpretation.html>

Using Wastewater Surveillance Data to Support the COVID-19 Response — United States, 2020–2021

<https://www.cdc.gov/mmwr/volumes/70/wr/mm7036a2.htm>

ACHA CoVAC Resources

Credible Social Media Sources

https://www.acha.org/CoVAC/Resources/Credible_Sources_of_Information/CoVAC/Resources/Credible_Social_Media_Sources.aspx

Addressing Misinformation

https://www.acha.org/VaxForward/Talking_About_Vaccines/Addressing_Misinformation/VaxForward/Addressing_Misinformation.aspx

Using TikTok to Combat COVID-19

https://www.acha.org/documents/CoVAC/Using_TikTok_to_Combat_COVID-19_Dec2021.pdf

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); Catherine Ebelke, PA-C, CTH, FACHA; Joy Himmel, PsyD, PMHCNS-BC, LPC, NCC; Cheryl Hug-English, MD, MPH; James Jacobs, MD, PhD; Beverly Kloeppe, MBA, MD; Rachel Mack, BA; Tondra Moore, PhD, JD, MPH; Giang Nguyen, MD, MPH, MSCE, FAAFP; and Sarah Van Orman, MD, MMM, FACHA.



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