Testing, Screening, and Outbreak Response for Institutions of Higher Education (IHEs)

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These interim considerations are based on what is currently known about the novel coronavirus (SARS-CoV-2) and the coronavirus disease (COVID-19) as of the date of posting, September 30, 2020.

These U.S. Centers for Disease Control and Prevention (CDC) considerations are meant to supplement—not replace—any federal, state, local, territorial, or tribal health and safety laws, rules, and regulations with which Institutions of Higher Education (IHE) must comply. Implementation should be guided by what is feasible, practical, and acceptable, as well as tailored to the needs of each community.

CDC will update these considerations as needed and as additional information becomes available. Please check the CDC website periodically for updated interim guidance.

The following guidance is meant to help college and university administrators protect students, faculty, and staff from COVID-19 infections and slow the spread of the virus. This document includes considerations for expanded and widespread testing; provides a tiered approach to testing in the context of an outbreak; gives examples of successful entry and periodic screening strategies; and discusses the likelihood of off-campus transmission. This guidance is an update to the "Interim Considerations for Institutions of Higher Education Administrators for SARS-CoV-2 Testing" published on June 30, 2020.

Note: This document is intended to provide considerations on the appropriate use of testing for SARS-CoV-2, the virus that causes COVID-19 (for surveillance, diagnosis, screening, or outbreak response), and does not dictate the determination of payment decisions or insurance coverage of such testing, except as may be otherwise referenced (or prescribed) by another entity or federal or state agency. CDC has no regulatory authority over testing; therefore, the information in this document is meant to assist health departments and IHEs in making decisions rather than establishing any regulatory requirements. IHEs are encouraged to work closely with their local public health authorities to develop plans and protocols appropriate for their jurisdiction.

CDC offers considerations for ways in which IHEs can help protect students, faculty, and staff and slow the spread of COVID-19. **Testing to diagnose COVID-19 is one component of a comprehensive strategy and should be used in conjunction with promoting behaviors that reduce spread, maintaining healthy environments, maintaining healthy operations, and preparing for when someone gets sick.**

IHEs vary considerably in geographic location (which differ in levels of community transmission), size, administrative structure, funding source, and organization. IHEs also vary considerably in the proportion of total student population on campus, in off-campus housing near the IHE, or commuting. As such, IHE officials should determine in collaboration with health department officials the nature of any screening or testing strategy to be implemented for purposes of surveillance, diagnosis, screening, or outbreak response, and if so, how to best do so. Testing strategies implemented should be done as part of a larger COVID-19 prevention plan. IHEs should develop a written plan that considers the implementation of testing strategies (if any) and what actions will be taken based on testing results.

CDC has released "Indicators for Dynamic School Decision Making" which specifies indicators for community COVID-19 burden and implementation of mitigation strategies to guide decision making for K-12 schools. These indicators might have relevance for IHEs that draw the majority of their students from the immediate local community and with limited or no on-campus residential facilities for students. For IHEs with residential facilities and that draw students from a much larger and diverse geographic region and from communities with different levels of current SARS-CoV-2 transmission, these indicators might have less direct applicability.

Symptom screening, diagnostic testing, and contact tracing are some of the strategies that can be taken to slow and stop the spread of COVID-19. These strategies must be carried out in a way that protects individuals' privacy and confidentiality, is consistent with applicable laws and regulations, and integrates with local public health systems. These strategies should be implemented to complement other mitigation strategies such as the use of masks, social distancing, and infection prevention and control. In addition to state and local laws, IHE administrators should follow guidance from the Equal Employment Opportunity Commission when offering testing to faculty, staff, and students who are employed by the IHE. IHEs also should follow guidance from the U.S. Department of Education on the Family Educational Rights and Privacy Act [PDF – 9 pages] and the Health Insurance Portability and Accountability Act (HIPAA) and their applicability to students and COVID-19 contact tracing and testing. See specific guidance on the application of FERPA and HIPAA to student health records.

Types of tests to identify SARS-CoV-2

Viral tests: These tests are authorized by the Food and Drug Administration (FDA) to **diagnose current infection** with SARS-CoV-2. Results from these tests help public health officials identify and recommend isolation for people with current infection to minimize SARS-CoV-2 transmission. Viral tests identify current infection by detecting either viral genetic material (nucleic acid amplification tests (NAAT)) or viral proteins (antigen tests). A type of NAAT known as real-time reverse transcriptase polymerase chain reaction (RT-PCR) is considered by CDC to be the gold standard for SARS-CoV-2 detection. Typically, real-time RT-PCR is performed in a laboratory, and results may take one to three days.

- **Rapid antigen tests**: Several antigen tests have recently received Emergency Use Authorizations from the FDA for

diagnostic testing on symptomatic persons. These tests are authorized for use within a specified period of time (e.g., the first 5 days or 7 days [1]) after a person's symptoms have begun, when viral load is typically high. Rapid antigen tests are typically performed at or near the point of care and return results in approximately 15 minutes. The FDA has provided an FAQ for health care providers who are using diagnostic tests in screening asymptomatic individuals, and the Centers for Medicare & Medicaid Services will temporarily exercise enforcement discretion [PDF – 1 page] for the duration of the COVID-19 public health emergency under CLIA for the use of antigen tests for asymptomatic individuals. In addition, HHS has provided PREP Act coverage for any qualified practitioner testing asymptomatic persons in congregate settings.

Antibody tests: Antibody tests have been authorized by the FDA to **detect past infection** with SARS-CoV-2. CDC does not currently recommend using antibody testing to diagnose current infection. Depending on when someone was infected and the timing of the test, the test may not find antibodies in someone with a current (particularly a recent) COVID-19 infection. In addition, it is currently not known whether a positive antibody test indicates immunity against SARS-CoV-2. Therefore, antibody tests should not be used at this time to determine if an individual is immune.

Throughout this document, "testing" refers to viral testing for current infection. For more information, the FDA has provided FAQs on testing for SARS-CoV-2.

CDC recommendations for SARS-CoV-2 testing are based on what is currently known about the virus. SARS-CoV-2 is a newly identified pathogen and knowledge about the virus and the course of disease continues to emerge. Information on testing for SARS-CoV-2 will be updated as more information becomes available.

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[1] Note: the number of days varies by test; please see the manufacturer's instructions.

When testing might be performed

IHEs might test students, faculty, or staff for purposes of surveillance, diagnosis, screening, or in the context of an outbreak. Individuals should be considered for and offered testing if they:

- Show signs or symptoms consistent with COVID-19 (diagnostic)
- Have a recent known or suspected exposure to a person with laboratory-confirmed COVID-19 (diagnostic)
- Have been asked or referred to get testing by their healthcare provider or health department (diagnostic)
- Are part of a cohort for whom testing is recommended (in the context of an outbreak)
- Are attending an IHE that requires entry screening (entry testing as part of screening)
- Are in a community where public health officials are recommending expanded testing on a voluntary basis including testing of a sample of asymptomatic individuals, especially in areas of moderate to high community transmission (screening)
- Volunteer to be tested in order to monitor occurrence of cases and positivity rate (surveillance)

It is **not** recommended to retest previously positive asymptomatic individuals within 3 months of a positive test. Data currently suggest that some individuals test persistently positive due to residual virus material but are unlikely to be infectious.

Testing individuals with signs or symptoms consistent with COVID-19

Consistent with CDC's recommendations, individuals with COVID-19 signs or symptoms should talk to their healthcare provider about testing. In some locations, individuals can also visit their health department's website to look for the latest information on testing.

One approach to help identify symptomatic individuals promptly for diagnostic testing is universal symptom screening, which involves reporting of self-assessments for symptoms on a daily or regular basis. In the absence of universal symptom screening, students, faculty, and staff members can be encouraged to monitor themselves. Symptoms may range from mild symptoms to severe illness. Symptoms may appear 2–14 days after exposure to SARS-CoV-2.

Symptoms may include:

- fever or chills
- cough
- shortness of breath or difficulty breathing
- muscle or body aches
- headache
- new loss of taste or smell
- sore throat
- congestion or runny nose
- nausea or vomiting or diarrhea

IHE administrators and healthcare providers should immediately provide options to separate students with COVID-19 symptoms or suspected or confirmed COVID-19 diagnoses by providing distance learning options, self-isolation rooms in residence halls or other housing facilities with appropriate level of support to help students manage any physical symptoms associated with the infection and the emotional issues related to isolation for adolescents and young adults (if isolation is not possible in current residence), and alternative food service arrangements for those who live on campus. IHE administrators should also provide alternative teaching and work-from-home options for faculty, instructors, and staff with COVID-19 symptoms, provided that they are well enough to continue working remotely. IHEs should be prepared to refer symptomatic individuals to an appropriate healthcare provider who will determine if viral testing for SARS-CoV-2 is appropriate. If well enough for self-care, the individuals should follow CDC guidance for caring for themselves. IHEs can also encourage individuals to watch for emergency warning signs and seek emergency medical care if these symptoms occur.

IHEs should make a communication plan for individuals with a confirmed COVID-19 diagnosis and those suspected of having COVID-19, as well as a plan to communicate known cases to students, faculty, and staff. If privacy can be ensured, the IHE may also want to be aware of SARS-CoV-2 test results and symptoms through voluntary reporting by their students, faculty, and staff. In the event of an outbreak, the IHE should develop a plan for students to stay at their current place of residence or arrange for accommodations outside the campus for isolating and to attend virtual classes. This plan should also address needed wraparound services, including for COVID-19-positive students during an outbreak, as well as quarantine plans for close contacts. The plan should ensure communications are accessible for all students, faculty and staff, including those with disabilities and limited English proficiency (*e.g.*, through interpreters and translated materials).

Testing asymptomatic individuals with recent known or suspected exposure to a person with COVID-19

Because of the potential for asymptomatic or pre-symptomatic transmission, IHEs should consider if/how they will contact-trace known and potential contacts of individuals diagnosed with COVID-19 who have been present on campus. To protect student, faculty, and staff confidentiality, a best practice for IHEs would be to consider keeping a record of students diagnosed with COVID-19 in a confidential database, so they can work with local public health departments to contact-trace and test as quickly as possible. The feasibility of identifying and testing close contacts may vary by IHE and local health department.

Additionally, in accordance with state, territorial, tribal, and local laws and regulations, a best practice is for IHEs to work with their local health departments to inform known close contacts (i.e., those who have been in close contact with a person diagnosed with COVID-19) to quarantine in their living quarters or a designated housing location, get tested as advised by their healthcare provider, practice mitigation strategies, and self-monitor for symptoms for 14 days even if they initially test negative.

Areas of campus where students might be crowded together (e.g., residence halls or other congregate living spaces, dining halls, locker rooms, laboratory facilities, libraries, student centers, and lecture rooms) may be settings with the potential for rapid and broad spread of SARS-CoV-2. Diagnostic tests may be appropriate in areas of high community spread, at the discretion of the ordering provider. If necessary, broader testing beyond close contacts may be done simultaneously with other strategies to control transmission of SARS-CoV-2 on campus. This can include expanded or widespread testing described below:

- **Expanded testing:** This includes testing of all people who were in proximity of an individual confirmed to have COVID-19 (e.g., those who shared communal spaces or bathrooms) or testing all individuals within a shared setting (e.g., testing all residents on a floor or an entire residence hall). Testing in these situations can be helpful because in high density settings it can be particularly challenging to accurately identify everyone who had close contact with an individual confirmed to have COVID-19. For example, students who do not know each other could potentially be close contacts if they are in a shared communal space. Expanded testing could be prompted by other surveillance efforts, such as wastewater (sewage) surveillance.
- **Widespread testing:** This includes testing of individuals who have been potentially exposed at some point. This might also include testing across campus building(s). Widespread testing may also be considered based on the preliminary results from initial, targeted, or expanded testing or repeat periodic campus testing such as testing across residence halls. The implementation of widespread testing may also take into consideration local institutional factors like capacity and availability of testing locally, mitigation strategies, current academic instruction plan (percentage of classes meeting in person), status of residence halls (open or closed, students per room), access to dining halls and recreation areas, access to laboratory facilities, status of sports facilities like weight rooms (are they open or closed), status of other extracurricular activities related to campus including those with large gatherings or congregate living spaces (e.g., communities of faith, sororities, fraternities) and occurrence of athletic events with spectators and other mass gatherings.

For all these strategies, it is recommended that persons quarantined remain in quarantine until they complete 14 days, irrespective of a negative test result. If the SARS-CoV-2 test is positive, the individual should be under isolation. For most persons with COVID-19 illness, isolation and precautions can generally be discontinued 10 days after symptom onset and resolution of fever for at least 24 hours, without the use of fever-reducing medications, and with improvement of other symptoms. For persons who never develop symptoms, isolation and other precautions can be discontinued 10 days after the date of their first positive viral test for SARS-CoV-2 RNA.

Considerations for use of a testing strategy for SARS- CoV-2 among students, faculty, and staff in the setting of an IHE outbreak

outbreak

In the context of an outbreak at an IHE, testing might be an important addition to rapid case investigation and contact tracing. A testing strategy should only be implemented if results will lead to specific actions such as isolation of those with a positive test, contact tracing once a case is identified, quarantining close contacts, and reviewing and altering infection prevention and control practices and implemented mitigation strategies. The decision to start testing for SARS-CoV-2 among students, faculty, and staff and/or initiate an investigation in the institution should be made in consultation with the health department, taking into consideration the burden of infections. **CDC recommends considering initiation of an outbreak testing strategy with detection of a higher risk of transmission (≥ 50 per 100,000 within the last 14 days), see indicators for dynamic school decision making, among the IHE population (students and staff). This can be implemented by tiers (see below).**

- When a confirmed case of COVID-19 is identified on campus, contact tracing and quarantine of potentially exposed contacts should occur as soon as possible to reduce the risk of further transmission on campus. After potential contacts have been quarantined, close contacts should be tested in consultation with their healthcare providers and local health department.
- A comprehensive approach to reducing transmission is recommended. For those identified for potential testing, emphasize the need to wear a mask whenever they may be in close contact with others, isolate in their place of residence (in a separate room, if possible), or make an alternate arrangement for housing if needed. If unable to isolate in a separate room, all other individuals living in the shared room should also quarantine if possible. Provision of quarantine and isolation on campus might prevent further spread to communities and potentially to those at higher risk of severe illness and death, but require planning for healthcare as well as support services (e.g., meal delivery).
    - For symptomatic students, isolation should start the day symptoms are first identified—individuals should not wait for test results to begin isolation. **Known close contacts (at least 15 minutes exposure without being 6 feet or more apart at all times),** such as roommates, suitemates, those sharing an apartment, and instructors should be quarantined. If a positive test result is obtained for the initial person tested, those identified during contact tracing will be required to quarantine for 14 days.
    - Decisions about whether students, faculty, or staff with COVID-19 or their household/roommates should be directed to quarantine should be made in coordination with the local health department of the IHE . For most persons with COVID-19, isolation and precautions can generally be discontinued 10 days after symptom onset and when they have remained fever-free for at least 24 hours, without the use of fever-reducing medications, and with improvement of other symptoms. For persons who never develop symptoms, isolation and other precautions can be discontinued 10 days after the date of their first positive SARS-CoV-2 viral test.

- A risk-based approach to testing students, faculty, or staff in an IHE with confirmed COVID-19 cases may be pursued. Such an approach should take into consideration the likelihood of exposure, which is affected by the characteristics of the IHE, application of COVID-19 infection mitigation strategies, and the results of contact investigations. Examining the IHE layout and operations, conducting walk-throughs, and interviews may aid in categorizing students, faculty, and staff into one of three tiers of testing priority, noted in tiered approach below. Prioritization should be done quickly so that testing is not delayed. Additionally, if ongoing screening for symptomatic students, faculty, and staff or contact tracing identifies additional cases, the tiered approach to testing should be applied to their contacts.
- Testing is one avenue to reduce transmission. If IHEs offer widespread testing, multiple individuals with mild symptoms, those who have symptoms but thought it was not COVID-19, and asymptomatic infections may be identified. IHEs and health departments should have an action plan to use the results of testing.
- For students, faculty, and staff, ensure that absence and sick leave policies are flexible and consistent with public health guidance and that they are aware of and understand these policies. For example, allowing students to make up assignments and exams due to illness, permitting employees to stay home to care for a sick family member, and

taking care of children due to school and childcare closures. Additional flexibilities might include giving advances on future sick leave and allowing employees to donate sick leave to each other. IHEs that do not currently offer sick leave to some or all their employees should consider drafting non-punitive "emergency sick leave" policies that include maximum accommodations for faculty in high risk groups and following OSHA guidelines.

- Some IHEs and/or health departments may have the capacity to conduct SARS-CoV-2 genome sequencing (to detect different strains of the virus) for enhanced surveillance and to provide a more in-depth understanding of the transmission dynamics.

Hierarchy for selection of persons for IHE-based testing can be as follows:

1. Persons with symptoms of COVID-19
2. Persons who have had close contact with someone with COVID-19
3. All students, faculty, and staff with possible exposure in the context of outbreak settings
4. Random sample of asymptomatic students, faculty, and staff to more rapidly detect increasing SARS-CoV-2 incidence, with consideration for incentivizing voluntary testing
5. All students, faculty, staff and members of their place of residence as part of a community-based testing strategy by health departments outside of outbreak settings [2]

Tiered approach for SARS-CoV-2 testing of persons with possible exposure in the context of an outbreak in an IHE setting

Screening for symptoms and testing of symptomatic persons should continue in addition to the testing outlined below.

- **Students, faculty, and staff in Tier 1:** who have a known close contact (**at least 15 minutes exposure** without being 6 feet or more apart at all times) with or exposure to a person with confirmed COVID-19 should be tested and quarantined as soon as possible to reduce the risk of further transmission. All quarantined individuals should follow existing guidance and stay in their current place of residence, and monitor their health for 14 days after last contact with a person who has COVID-19. If possible, stay away from others, especially people who are at higher risk for getting very sick from COVID-19.
- **Students, faculty, and staff in Tier 2 and Tier 3:** Baseline testing may be considered for these individuals based on the recommendations from their healthcare provider and assessment of exposure risk or a positive symptom screen from a reputable COVID-19 screener, such as CDC's Coronavirus Self-Checker. Students and staff in Tier 2 and Tier 3 should also be considered for testing if during contact tracing an individual is considered as a potential contact or if an individual has symptoms.

Tiered approach and inclusion criteria for SARS-CoV-2 testing of persons with possible exposure in IHE setting in the context of an outbreak

Tier 1 (highest priority for testing) [2]

- Students, faculty, and staff in the same classroom as the individual with COVID-19 (without being 6 feet or more apart at all times in the classroom) for at least 15 minutes or more beginning 2 days before the individual with COVID-19 became symptomatic (or, for asymptomatic individuals, 2 days prior to specimen collection) until the time of isolation. [3]
- Students sharing a room or bathroom in a residence hall, living in fraternity/sorority, house, or living together in off-campus housing with an individual who is COVID-19-positive.
- Students, faculty, and staff who have used the same dining hall at roughly the same time(s) as an individual with COVID-19.
- Students, faculty, and staff who are on/involved with the same athletic team as an individual with COVID-19.
- Students, faculty, and staff who have attended campus events or unsanctioned social gatherings (such as off-campus parties) where social distancing was not strictly adhered to with one or more individuals with COVID-19.
- Students, faculty, and staff identified as a close contact through case investigation and contact tracing. This includes evaluating proximity and length of contact with the individual with COVID-19.

Tier 2 (next highest priority for testing)

- Students, faculty, and staff in the same classroom as the individual with COVID-19 with at least 6 feet distance between individuals at all times.
- Students, faculty, or staff in the same residence hall or campus housing, but not sharing a room or bathroom.
- Students, faculty, staff, and visitors who take public transit/shuttle buses with at least 6 feet distance at the same time as an individual with COVID-19.

Tier 3 (next highest priority for testing, after tier 2) [4]

- Students, faculty, and staff who have spent time in a common space (e.g., common rooms, libraries) but not at the same time as the COVID-19-positive individual, but where short duration exposure to those with confirmed COVID-19 cannot be definitively ruled out.
- Students, faculty, and staff who are generally in-person at the institution on a different schedule and in different rooms than the individual with confirmed COVID-19, but exposure cannot be definitively ruled out.
- Students attending a class taught by a faculty member or instructor who was exposed to a COVID-19-positive student in a different classroom (Tier 1 or Tier 2), and where exposure to the students in additional classes cannot be definitively ruled out.

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[2] Note: If the decision is made to test all students, faculty, and staff in a specific classroom, cohort, grade level, or wing of the institution, then contact tracing can just focus on other potential close contacts; for example those who are part of the same cohort, eat meals together, or who otherwise spend time together.

[3] This is irrespective of whether the person with COVID-19 or the contact was wearing a mask or whether the contact was wearing respiratory personal protective equipment (PPE). For more information, visit Public Health Guidance for Community-Related Exposure.

[4] Note that if test results from Tier 1 or Tier 2 testing indicate infection among students, faculty, and staff in multiple areas of the institution, including some cases among those who were present on different days, then testing may need to be scaled-up accordingly.

Testing asymptomatic individuals without known exposure to a person with COVID-19 via entry testing and periodic repeat testing

Some IHEs have implemented policies requiring testing of all students, faculty, and staff for COVID-19 before allowing campus entry (entry testing or universal one-time testing or two-phase entry testing) or testing repeatedly throughout the semester or at specific intervals as decided by the IHE and the health department. Testing a random sample of asymptomatic students, faculty, and staff could increase the timeliness of outbreak detection and response by rapidly identifying and isolating COVID-19 cases that would have otherwise gone undetected without testing; the number of students tested should take into consideration the population size of students, faculty, and staff. In an IHE setting, with frequent movement of faculty, staff and students between the IHE and the community, a strategy of entry screening combined with regular serial testing might prevent or reduce SARS-CoV-2 transmission. Implementation of mitigation strategies (e.g., social distancing, masks, hand hygiene, enhanced cleaning and disinfection) should go along with any of the various testing strategies.

IHEs planning to implement one or more of these testing strategies will need to prepare to take further actions to support their testing efforts, such as isolating confirmed cases, quarantining those awaiting test results and close contacts, contact tracing once a case is identified, and reviewing infection prevention and control practices and implemented mitigation strategies. IHE officials should work with health department staff if the IHE plans to do entry testing and/or repeat testing.

Considerations before implementing any testing strategy include:

- Availability of dedicated resources and the logistics needed to conduct broad testing among students, faculty, and staff in IHE settings. Examples of resources include trained staff to collect specimens and conduct tests, personal protective equipment, physical space for conducting testing safely and ensuring privacy, and capacity to consistently report results in a timely manner to health departments as required.
- Capacity within the IHE or health department for follow-up and conduct contact tracing with those who test positive.
- Availability of facilities to isolate those who test positive and quarantine their close contacts.
- Levels of local community transmission.
- Risk of importation of virus into a community by incoming students.
- Likelihood of future exposures. Transmission risk is two-way; students can be exposed to the virus in the surrounding community and bring it to campus, but students can also bring the virus to the surrounding community from campus.
- Cost
- Number of viral tests (PCRor rapid antigen tests) needed and testing capacity in a CLIA-certified laboratory [PDF – 1 page] or facilities operating under a CLIA Certificate of Waiver.
- Acceptability of this testing approach among students, their families, faculty and staff.

Select examples of testing strategies some IHEs are implementing [5] in addition to other mitigation practices to reduce transmission of COVID-19

Testing Strategy	Relevant Considerations
Entry testing (universal screening, one-time testing) (i.e., testing a campus population at one point in time, such as at the beginning of the semester)	• How will we keep track of the number of tests done? • How many tests are available? • What is the cost? • Is there sufficient capacity to do the tests? • How will we track individuals self-monitoring? • What is the likelihood of exposure following testing? • What is the level of interaction with those outside the IHE? • How will we capture future cases after one-time testing? • How will we continue to implement COVID-19 mitigation strategies?

Testing Strategy	Relevant Considerations
Two-phase entry testing (e.g., universal testing, and repeat universal testing one week later as a requirement for some situations such as moving into on-campus residential halls)	• Same considerations as above for one-time entry testing • Necessitates planning for results, including all combinations of discordant results from the two tests, with a consideration for the possibility of false positive and false negative results

Testing Strategy	Relevant Considerations
Repeat testing and/or expanded testing of a random sample (e.g., testing a random sub-sample of a campus population multiple times during a semester at specific intervals)	• How will we keep track of the number of tests done? • How many tests are available? • What is the cost? • Is there sufficient capacity to do the tests? • How will we continue to implement COVID-19 mitigation strategies? • What sample size of asymptomatic individuals should be tested, given the population of students, faculty, and staff?

Testing Strategy	Relevant Considerations
Testing in an outbreak situation (e.g., expanded testing, widespread testing)	• How will we plan when to scale up the testing from expanded to widespread testing? ◦ Testing of individuals may be done as recommended by the local health department or healthcare provider • How will we continue to implement COVID-19 mitigation strategies?

Testing Strategy	Relevant Considerations
No screening test	• How will we continue to implement COVID-19 mitigation strategies?

[5] This is an emerging area, and there is currently limited scientific evidence to guide decisions to use or not use one of these strategies, but public health research is currently being conducted to examine the effectiveness of these strategies in the IHE setting.

Considerations for the likelihood of transmission in off-campus settings

Many IHEs are adopting approaches to reduce the risk of SARS-CoV-2 transmission on campus through increased social distancing in classrooms and dining halls, requirements for face masks, reducing density of on-campus housing, and various testing strategies. However, off-campus community settings including apartments, bars and restaurants, and community spaces related to campus (e.g., spaces for athletic events, mass gatherings of communities of faith, sorority and fraternity organizations, or other groups) might pose a higher risk of SARS-CoV-2 transmission than classroom settings if social distancing policies and mitigation procedures are not being followed. Strategies to mitigate the spread of SARS-CoV-2 are not only to limit transmission on IHE campuses, but to also prevent transmission to the surrounding community. IHEs should communicate frequently to students, faculty, and staff about the risks in these settings and the potential impact on the IHE's ability to function. The communication methods should be accessible for all, including those with disabilities and limited English proficiency (e.g., through interpreters and translated materials).

More resources for institutions of higher education

- For more information on facility-wide testing for asymptomatic individuals, please see the Standardized procedure for broad-based testing for SARS-CoV-2.
- For additional considerations for reducing COVID-19 spread in IHEs, see the Considerations for Institutions of Higher Education.
- For information about daily life and coping during COVID-19 for students, faculty, and staff:
  - Encourage employees and students to take breaks from watching, reading, or listening to news stories, including social media, if they are feeling overwhelmed or distressed.
  - Promote employees and students eating healthy, exercising, getting sleep and finding time to unwind.
  - Encourage employees and students to talk with people they trust about their concerns and how they are feeling.
  - Consider posting signage for the national distress hotline: 1-800-985-5990, or text TalkWithUs to 66746
- Additional resources are available on the CDC web page for Communities, Schools, Workplaces, and Events: Information for Where You Live, Work, Learn, and Play

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