COVID-19 GUIDANCE FOR BEHAVIORAL HEALTH RESIDENTIAL FACILITIES

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*Note:* Some URLs may have changed since the most recent publication date of this document. Please check the CDC website at [www.cdc.gov/coronavirus/2019-ncov](http://www.cdc.gov/coronavirus/2019-ncov) if you encounter broken links.
Behavioral health residential facilities are critical during the COVID-19 response. Behavioral health residential facilities should remain committed to taking critical steps to ensure America’s health care facilities are prepared to respond to the threat of COVID-19. The Department of Homeland Security has classified community mental health centers, psychiatric residential facilities, federally qualified health centers and their staff, including those who provide social services and facilitate access to behavioral health services as “Essential Critical Infrastructure Workers.” These facilities provide critical services to the community around the clock — services that remain essential during times of crises when individuals may experience increased anxiety and stress, and those with pre-existing mental health and substance use conditions may experience new or worsening symptoms.

Guidance for infection control and prevention of COVID-19. This guidance is intended to help leaders and administrators at behavioral health residential facilities improve infection control and prevention practices in response to the COVID-19 pandemic. It includes recommendations for the management of staff, patients and visitors. We understand that during an emergency response, facilities may not have the resources or supplies necessary to implement all protocols as intended. This guidance supplements COVID-19 infection control and prevention protocols from the Centers for Disease Control and Prevention (CDC) with alternative strategies to consider in the event the primary protocols are inaccessible. We recognize the immense pressure and responsibility behavioral health facilities are facing in order to be responsive to the health and safety concerns of their patients and staff, while juggling the realities of this emergency response. Limitations in resources and the community need for continuing services will sometimes result in a behavioral health facility not being able to implement the optimal strategy recommended in this guidance. We encourage all facilities to exercise judgement in determining the best approach based on the most up-to-date information and guidance.

Alternative strategies are labeled throughout this document with:

Coordination with the CDC and local and state public health departments. We encourage all behavioral health residential facilities to monitor the CDC website for information and resources and to contact their local and state health, mental health and substance use, and human services agencies and regulatory bodies for local and up-to-date alerts, guidance and recommendations.

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COVID-19 Guidance for Behavioral Health Residential Facilities

BACKGROUND

COVID-19 is a new type of coronavirus that was not seen in humans until late 2019. The virus is thought to first infect the tissue inside the nose or the throat and can then spread lower into the lungs. The main symptoms of the infection are a fever of over 100.4°F, a new cough within the last seven days, shortness of breath or a new sore throat within the last seven days. In most cases, the illness is mild or moderate and most people recover. However, some people, particularly those over 50 years old; those with medical problems, such as asthma or diabetes; or those who smoke tobacco or e-cigarettes, may become very ill and require emergency hospitalization.

COVID-19 infection spreads between people who are in close contact with one another (within approximately six feet) through respiratory droplets formed when an infected person coughs or sneezes. The infection may also spread when individuals touch contaminated surfaces, then touch their face, but this is thought to be a less common form of infection than breathing in infected droplets in the air. Covering coughs and sneezes with a sleeve or tissue, washing hands frequently with water and soap for 20 seconds or using an alcohol-based hand sanitizer and avoiding touching one’s face are critical to protecting oneself and others.

Behavioral health residential facilities are responsible for ensuring the health and safety of their patients and staff by implementing the standards required to help each resident attain or maintain their highest level of well-being. This guidance is provided in light of the recent spread of COVID-19 to facilities where individuals with mental illness and/or substance use disorders reside to help control and prevent the spread of the virus.

Note: This guidance was updated April 28, 2020, to reflect the latest information available as the COVID-19 response evolves. Updates include CDC-confirmed symptoms of COVID-19.

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Facility staff should regularly monitor the CDC website for information and resources. Facilities should also maintain regular contact with their state regulatory bodies and health authorities, including departments of health, departments of mental health and substance use and social services departments. Regulations and guidance vary by locality, so it is important to follow the specific guidance provided by state agencies. In certain circumstances, guidance may not specifically be available for behavioral health residential facilities. Early federal guidelines released by the Centers for Medicare and Medicaid Services (CMS) in response to COVID-19 were developed specifically for residential nursing facilities. To the extent possible, behavioral health residential treatment facilities should implement personal protective equipment (PPE) and physical distancing to the same standard as nursing facilities.

The guidance that follows in this document offers recommendations on how to do that within the unique patient and program circumstances of behavioral health residential treatment.

Behavioral health residential facilities should proactively contact their local health departments and emergency operations centers or other incident command structures to make them aware of their residential facilities’ location, size, population served and any other unique characteristics that might increase risk of contraction or transmission of COVID-19, such as resource and supply shortages. Currently, there is a strong focus on nursing homes, clinics and hospital care settings; therefore, making local and state health departments aware of additional care facilities is critical for emergency planning purposes and future support around supplies and resources. This may be challenging due to high call volumes to state and local health departments but is critical to planning and support.

**REFERENCES**
- Coronavirus Disease 2019 (COVID-19) For Healthcare Professionals, CDC.

**LOCAL AND STATE HEALTH DEPARTMENT DIRECTORIES**
- Directory of Local Health Departments, National Association of County and City Health Officials (NACCHO)
- State & Territorial Health Department Websites, CDC
Behavioral health residential facilities should **immediately contact their local and/or state health department if they have questions or suspect a resident has COVID-19.** Per CMS guidance, prompt detection, triage and isolation of potentially infectious patients are essential to prevent unnecessary exposures among patients, health care personnel and visitors at the facility. Therefore, facilities should continue to be vigilant in identifying any possible infected individuals. Be aware that criteria for COVID-19 testing will vary locally depending on the prevalence of people diagnosed with COVID-19 and availability of testing kits.

Behavioral health residential facilities should **frequently monitor for potential symptoms of respiratory infection as needed throughout the day.** Facilities experiencing an increased number of respiratory illnesses among patients or staff, regardless of suspected etiology, should immediately contact their local and/or state health department for further guidance. Depending on the type and layout of each residential facility, an isolation room or area should be designated for any individuals believed to be infected, this can include an individual’s private room.

### GENERAL GUIDANCE FOR BEHAVIORAL HEALTH RESIDENTIAL PROGRAMS

This section includes recommendations that behavioral health residential facilities should consider implementing to protect patients and staff in these programs. Best practice protocols are presented along with alternate strategies, which facilities should only consider implementing in the event of a shortage of resources or supplies which prevents them from implementing the primary recommendation.

### COMMUNICATION AND ENGAGEMENT

The COVID-19 pandemic and public health crisis has brought about rapid change — professionally, personally and collectively – and a heightened sense of uncertainty. It is crucial that behavioral health providers and leaders communicate effectively to facilitate engagement with staff and patients during this challenging situation.

**General Education.** Immediately alert staff and patients of new protocols as they are implemented. The COVID-19 response is evolving daily. It is critical to have an efficient system in place for facility communications so the latest guidance can be quickly implemented. Make training

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opportunities and resources available to staff to support protocol implementation and workforce wellness.

Post educational information from trusted health sources throughout the building, including signage on how to properly wash your hands, signs and symptoms of early detection and outdoor signage to inform visitors and staff of access restrictions prior to entry. Communication tools can be found on the CDC website. The CDC also offers several print resources for communication, including a poster for hand washing.

**Patient Care.** Maintain a person-centered approach to care. This includes communicating effectively with staff, patients, patient representatives and patient family members about the patients’ evolving needs during this crisis, treatment goals and how new protocols may change the way care is delivered and what daily life is like at the facility. It is important that patients remain engaged in their care plan during this time of large-scale uncertainty. Empower patients to be a part of the solution so they understand their role in limiting the spread.

**Workforce Wellness.** Leaders should be prepared for staff to react strongly to having a person under investigation (PUI) or a patient who tests positive for COVID-19 in the facility. Front-line staff may feel that the higher-paid leaders, physicians and supervisors are able to work safely from a remote location while they are being exposed. Leaders should check in with staff regularly to listen and ensure they have the PPE they need, if at all possible. Not only are there inequalities in the workforce in terms of who is at higher risk for exposure; there are also racial disparities. These inequalities should be acknowledged and addressed to the extent possible.

Administrators and leaders should foster an environment of safety, trust and transparency, collaboration and input and peer support. The National Council has created guidance on organizational resilience. Consider if there are ways to incentivize safe field work. For example, a health care system may designate one facility as a location that treats patients who are symptomatic or positive for COVID-19 and offer hazard pay to staff who work at that location or staggering staff so that there are rotating groups coming on and off at regular intervals. It is important to remain flexible, creative, and responsive to staff needs to identify solutions that work within the resources and structures available to each residential facility.
PROGRAM MODIFICATIONS

Residential facilities are encouraged to take additional infection control and prevention measures even if no one within the facility has been confirmed to have COVID-19. This will require some modifications to program offerings.

1. To the extent possible, programs should work with patients’ health care providers to institute telemedicine appointments. Most payers are removing barriers to this allowing billing if medically necessary and documenting as if they were in the office. Blood draws and monthly injections will still need to be done in-person. For behavioral health patients, treatment teams should consider increased frequency of engagement, including therapy, using alternatives to in-person meetings. Patients and staff should be reminded of the importance of hand hygiene and of not touching their faces if visiting their providers is necessary.

2. CDC guidance currently recommends suspending all groups and activities with more than 10 people. Communal dining and all group activities with more than 10 people, such as internal and external group activities, should be canceled. Facilities should utilize non-face-to-face meeting options, such as phone, video communications, etc., to the extent possible.

3. For shared bedrooms, for individuals who have not developed symptoms, ensure when possible that beds are at least six feet apart and require that patients sleep head-to-toe.

PERSONAL PROTECTIVE EQUIPMENT AND CLEANING

The shortage of PPE during the COVID-19 pandemic has raised critical concerns about how to implement effective infection control and prevention measures that are feasible given these challenging circumstances. The reality is that residential behavioral health facilities often do not have access to the appropriate PPE to implement the most effective measures and protocols. Therefore, this guidance also includes recommendations for approaches to consider in the event the preferred protocols cannot be followed.

1. Require all patients, staff and visitors to wear surgical masks while awake. If surgical masks are unavailable due to a shortage of PPE, require all patients, staff and visitors to wear cloth face coverings.

2. Some patients may not be able to comply with requests to wear facemasks or cloth face coverings at all times due to symptoms or other impairments. In these situations,
ensure all other individuals nearby wear facemasks or cloth face coverings to reduce the likelihood of transmission. Questions to ask during these situations include:

a. What is the goal? For example, for an agitated patient, the goal is for the patient to become calm, cooperative, wearing a mask in an area where they can’t infect other people.
b. What needs to be done to achieve the goal?
c. How can we involve the fewest number of staff?
d. Where does the person need to be?
e. How can we get them there?
f. Who needs to be in contact with the patient to do these things?
g. Can other people leave the room?
h. What people need what PPE to do these things?

3. Reusing masks: It is always best to use a new N95 mask, though this may not be possible given shortages. The CDC has guidance on extended use and limited reuse of N95 masks. Cloth face coverings should be washed routinely (based on the frequency of use) in a washing machine. If you are considering disinfecting N95 masks, Stanford University investigated three promising practices, including hot air, UV light and steam. There are no known methods for disinfecting surgical masks. Individuals should not share masks under any circumstances.

4. Ensure all staff and residents are trained on how to wear PPE, including masks. The CDC has several training resources, including an instructional poster and videos for donning and doffing.

5. Increase the availability and accessibility of alcohol-based hand rubs (ABHR), reinforce strong hand-hygiene practices, tissues, no-touch receptacles for disposal and facemasks at health care facility entrances, waiting rooms, resident check-ins, etc.

6. Ensure ABHR is accessible in all resident-care areas including inside and outside resident rooms.

7. According to the CDC, routine cleaning and disinfection procedures are appropriate for COVID-19 in health care settings, including those patient-care areas in which aerosol-generating procedures are performed. Products with Environmental Protection Agency (EPA)-approved emerging viral pathogens claims are recommended for use against COVID-19. Management of laundry, food service utensils and medical waste should also be performed in accordance with routine procedures.

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Will behavioral health residential facilities be cited for not having the appropriate supplies?

CMS is aware that there is a scarcity of some supplies in certain areas of the country. State and federal surveyors are unlikely to cite facilities for not having certain supplies (e.g., PPE such as gowns, N95 respirators, surgical masks and ABHR) if they are having difficulty obtaining these supplies for reasons outside of their control. However, facilities should take actions to mitigate any resource shortages and show they are taking all appropriate steps to obtain the necessary supplies as soon as possible. For example, if there is a shortage of ABHR, staff should practice effective hand washing with soap and water. Similarly, if there is a shortage of PPE (e.g., due to supplier(s) shortage which may be a regional or national issue) the facility should contact the local and state public health agency to notify them of the shortage, follow national guidelines for optimizing their current supply or identify the next best option to care for patients. If a surveyor believes a facility should be cited for not having or providing the necessary supplies, the state agency should contact their CMS Branch Office.

Patients. Encourage patients to wear a face mask or cloth face covering at all times based on CDC guidance and to cancel all planned social or recreational outings and stay at the facility as much as possible. If they do go out, they should keep a distance of at least six feet away from anyone else, including relatives who do not live in the program and avoid touching their faces. Upon returning to the facility, they should be screened using the procedures outlined in the Screening section. They should immediately wash their hands with soap and water for at least 20 seconds or use an alcohol-based hand sanitizer. Patients should also wash their hands before and after changing or removing a face mask. Cell phones and other frequently handled items should be sanitized daily.

Due to the unique conditions present at behavioral health residential facilities, not all patients will be able to comply with these recommendations at all times. In these cases, take a harm reduction approach that acknowledges that patients often have a difficult time social distancing, hand washing and using face coverings. As with most other interventions, continued engagement and encouragement will be needed. Any attempt at harm reduction strategies will help to reduce the chances of transmission. Leadership should support staff by coming onsite (meet outside in the lawn or driveway to socially distance) to hear concerns to reassure staff that it is okay if some patients will not follow protocols and to encourage them to continue trying to implement protocols and harm reduction strategies.

Staff. Follow CDC guidelines for restricting access to health care workers. This also applies to other behavioral health care workers, such as psychiatrists, therapists, peer workers, technicians,
recreational therapists and others who provide care to patients. They should be permitted to enter a facility as long as they meet the CDC guidelines for health care workers. Facilities should contact their local health department for questions and frequently review the CDC website dedicated to COVID-19 for health care professionals. Behavioral health residential facilities should review CDC guidance for general health care workers and adapt them as necessary to be consistent with the resources and needs of their behavioral health residential care treatment staff and patients.

All staff should be screened using the procedures in the Screening section before they enter the facility.

**Visitors.** Restrict access for all visitors unless it is deemed necessary to directly support a resident’s health and wellness or for certain compassionate care situations, such as young children in residential treatment or end of life care. Facilities are expected to notify potential visitors to defer visits until further notice (through the facilities’ websites, door signage, calls to family members, letters, etc.).

**Note:** If a state implements actions that exceed CMS requirements, such as a ban on all visits through a governor’s executive order, a facility would not be out of compliance with CMS’ requirements, including 1915(i) plan home and community based services (HCBS) rights to visitation.

In lieu of in-person visits, facilities should consider:

1. Offering alternate means of communication for people who would otherwise visit, such as virtual communications (phone, video communication, etc.).

2. Creating/increasing listserv communication to update families, such as advising not to visit.

3. Assigning staff as primary contact to families for inbound calls and conduct regular outbound calls to keep families up to date.

4. Offering a phone line with a voice recording updated at set times (e.g., daily) with the facility’s general operating status, such as when it is safe to resume visits.

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Consider exceptions on a case-by-case basis for visitors who request entry in compassionate situations. Screen all potential visitors for symptoms of COVID-19 using the procedures in the Screening section. If entry is granted, require visitors to:

1. Wear a facemask (or cloth face covering) while in the building. They should also be reminded and monitored to frequently perform hand hygiene.

2. Observe social distancing practices (i.e., remain six feet apart and refrain from physical contact).

3. Restrict their visit to the patient’s room or other location designated by the facility. If possible based on the design of the building, create dedicated visiting areas (e.g., “clean rooms”) near the entrance to the facility where patients can meet with visitors in a sanitized environment. Facilities should disinfect rooms after each patient-visitor meeting.

Note: If your program is CMS certified, patients still have the right to access the ombudsman program. Ombudsman access should be restricted per the same guidance as is required of visitors (except in compassionate care situations); however, facilities may review this on a case-by-case basis. If in-person access is not available due to infection control concerns, facilities need to facilitate resident communication (by phone or other format) with the ombudsman program or any other entity listed in Resident Rights 42 CFR § 483.10(f)(4)(i).

Vendors and Partners. Facilities should review and revise how they interact with vendors, emergency medical services (EMS) personnel and equipment, transportation providers (e.g., when taking patients to offsite appointments), and other non-health care providers who deliver supplies (e.g., food delivery) and take necessary actions to prevent any potential transmission. For example, do not have supply vendors transport supplies inside the facility; supplies should be dropped off at a dedicated location (e.g., loading dock). Facilities should ensure, to the extent possible, proper food supply, maintaining two to three weeks of food and storing additional non-perishable foods appropriately. Facilities can allow entry of these delivery visitors if needed, as long as they are following the appropriate CDC guidelines for transmission-based precautions. All nonessential vendors such as salespeople and drug representatives should be prohibited.

Note on Surveyors: CMS and state survey agencies have suspended survey activities not directly related to infection control and coronavirus.

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Screening by RT-PCR (real-time reverse transcription polymerase chain reaction) testing is ideal and is recommended as soon as it becomes available at your location. Antibody testing is useful in determining prior infection for COVID-19, not active ongoing infection. Practices may have limited internal laboratory capacity to complete coronavirus screenings within eight to 24 hours and may need to send samples to a large national laboratory. There are a number of national laboratories that have the capacity to process a large volume of screenings, but sample transportation and processing timeframes often mean results are not available for up to a week. Alternatively, a rapid COVID-19 test approved by the Food and Drug Administration (FDA) is capable of showing positive results in five minutes and negative results in 13 minutes. This test was made available in limited quantities during the first week of April, though it is not yet widely available.

In the absence of access to laboratory and rapid COVID-19 testing, residential treatment facilities will need to rely on symptomology screening until testing is promptly available at higher volumes.

All individuals should be screened for COVID-19 symptoms upon arrival at the facility, including staff, potential visitors and patients who have left the grounds for any period of time. Although patient-to-patient spread is a major concern for facilities, staff are the likeliest source of introducing COVID-19 to a facility and can also be the greatest allies in controlling its spread. Have a clear process for what to do with staff who become PUIs, including how to mitigate staff-to-staff and staff-to-patient exposure, and quarantine procedures while awaiting test results. Leaders and supervisors should plan to spend time with staff at the facility regularly to ensure everyone is trained and proficient in the new procedures. Residential facilities should implement an active screening and monitoring plan by executing the following:

1. Communicate to all employees about who should and should not report to the facility for work.
   a. Advise employees to check for any signs of illness before reporting to work each day and notify their supervisor if they become ill. Staff who are ill should stay home.
   b. Upon arrival at the facility, ask staff if they have had a cough, a sore throat, shortness of breath, sore throat, chills, repeated shaking with chills, muscle pain, headache, new loss of taste or smell, if they have had a fever or if they recently traveled on an airplane or on a cruise. Although not yet identified by the CDC as symptoms associated with COVID-19, you may wish to add questions about smell and taste your screening questions.

2. Ask individuals the following screening questions regarding symptoms and potential exposure.
a. Are you experiencing any of the following symptoms? Fever, cough, shortness of breath, sore throat, chills, repeated shaking with chills, muscle pain, headache, or new loss of taste or smell.
b. Have you recently traveled by airplane or cruise ship? Note: The CDC maintains information on travel locations that are high risk.
c. Have you been in contact with someone known to have COVID-19?

3. Actively measure individuals’ temperatures. A fever is 100°F (99.6 if age 65+).

4. Determine an individual’s risk levels:

a. Low Risk: You are at low risk for contracting COVID-19 if you have had only incidental or indirect contact with individuals with COVID-19, such as:
   i. Have been near someone who may have been exposed, but that person is not having symptoms of COVID-19 (fever/cough/shortness of breath/sore throat/chills/repeated shaking with chills/muscle pain/headache/new loss of taste or smell)?
   ii. Visited a facility where COVID-19 cases have been found, but didn’t have prolonged close contact with anyone with COVID-19?
   iii. Cared for a COVID-19 patient while using standard, droplet and contact precautions
b. Medium/High Risk: You are at higher risk if you’ve had prolonged close contact with individuals with COVID-19, such as:
   i. Being within six feet of the person for a prolonged period of time. According to the CDC, a prolonged period of time is “more than a few minutes.” Hong Kong says 15 minutes without the use of a surgical mask. Singapore says 30 minutes.
   ii. Unprotected direct contact with infectious secretions from someone with COVID-19.
   iii. Being coughed on without a mask and/or eye protection, touching used tissues with bare hands.
c. Other factors that affect risk:
   i. Duration of exposure. Longer exposure time likely increases risk.
   ii. Clinical symptoms of the infected person. Coughing likely increases risk (although transmission from people without symptoms is thought to account for 12% of cases).
   iii. Whether the infected person was wearing a facemask. Facemasks block droplets, preventing them from contaminating others and the environment.
   iv. Whether you were using PPE and following precautions. Risk is low when infection prevention protocols are followed when caring for COVID-19 patients.
5. If staff was exposed, they should:
   a. Continue to work as long as they do not have symptoms (fever/cough/shortness of breath/sore throat/chills/repeated shaking with chills/muscle pain/headache/new loss of taste or smell).
   b. Wear a mask while at work for 14 days after the exposure.
   c. Monitor themselves for symptoms, including checking temperature twice a day using a thermometer at work or at home.

6. If staff develops symptoms (fever/cough/shortness of breath/sore throat/chills/repeated shaking with chills/muscle pain/headache/new loss of taste or smell), they should notify their manager and stay/go home.

7. If a patient answers “yes” to any of the above screening questions or if a thermometer reading registers a fever, see section, How to Respond if Patient Develops Symptoms.

8. Conduct twice-daily temperature checks and evaluation for development of any new symptoms for all patients and staff.

9. Advise patients and staff to report symptoms as soon as possible.

**HOW TO RESPOND IF PATIENT DEVELOPS COVID-19 SYMPTOMS**

In the event a patient develops symptoms that could indicate a COVID-19 infection, the response depends on the patient’s condition and involves either transfer to a hospital or the patient’s home or management within the residential facility. COVID-19 symptoms may vary in severity from lack of symptoms to mild or severe symptoms. Most individuals who test positive for COVID-19 will experience mild to moderate symptoms that will not require hospitalization. Hospitalization is only necessary if the individual has difficulty breathing or otherwise appears critically ill. If the patient develops more severe symptoms that require transfer to a hospital, alert the responding EMS and the receiving facility to the patient’s symptoms (or diagnosis in the event of a positive screen) and condition and follow transmission-based precautions, including placing a facemask (or cloth face covering) on the patient during transfer.

If the patient does not require hospitalization, the facility administrator or patient provider should immediately contact the local health department for information on how to proceed with testing. Local health departments may have provisions for alternate housing arrangements for positive individuals, although this will depend on each jurisdiction. Home discharge may also be an option if deemed medically and socially appropriate. This decision should be made in consultation with state or local public health authorities and the resident’s care team (case
manager, psychiatrist, therapist). Pending transfer or discharge, place a facemask (or cloth face covering) on the resident and isolate them in a room with the door closed.

In all likelihood, a patient exhibiting COVID-19 symptoms may best be managed by remaining in the residential care setting. Staff will be afraid that they will get infected but pointing out to them that they are the best persons to care for the patient is important. They know the patient and can leverage that relationship. It is important to reduce unnecessary visits to hospital emergency departments to help reduce the spread of COVID-19. Initially, symptoms may be mild and not require transfer to a hospital as long as the facility can follow the infection prevention and control practices recommended by CDC. Facilities without an airborne infection isolation room (AIIR) are not required to transfer the resident assuming: 1) the resident does not require a higher level of care and 2) the facility can adhere to the rest of the infection prevention and control practices recommended for caring for a resident with COVID-19. Please check CDC guidance regularly for critical updates, such as updates to guidance for using PPE.

If a patient meets criteria for remaining at the residential facility:

1. The patient and staff should wear facemasks (or cloth face covering).

2. The patient should maintain at least six feet distance from other patients and staff. In the event that patient care necessitates staff being closer than six feet, they should wear PPE as a harm reduction measure.

3. The patient and staff should increase the frequency of hand hygiene practices.

4. The patient should stay in their single room or in a designated isolation room/area if a single room is unavailable. Meals and medication should be taken in the room, and they should stay in their room as much as possible, to the extent it is feasible.

5. Exposed roommates should, if possible, also have their own rooms for 14 days and if they remain symptom-free, can then share a room with others.

Room sharing might be necessary if there are multiple patients with known or suspected COVID-19 in the facility. As roommates of symptomatic patients might already be exposed, it is generally not recommended to separate them in this scenario. Public health authorities can assist with decisions about resident placement.
6. When applicable, program staff should work with the patient’s mental health or primary care provider to secure enough nicotine replacement therapy (NRT) to help eliminate nicotine withdrawal and the desire to leave their room to smoke.

7. The patient should refrain from using common areas such as kitchens and lounges. Arrangements will need to be made to change existing house routines that require patients to use common spaces.

8. Surfaces, knobs, handles and other items that come into frequent hand contact should be sanitized frequently throughout the day.

9. In programs with several bathroom facilities:
   a. One bathroom should be set aside for the resident(s) who has been designated as a PUI or have tested positive for COVID-19.
   b. Surfaces, shower knobs, curtains, handles and other high-contact surfaces should be sanitized after each time these patients use the facilities. If possible, leave the bathroom window open to help reduce aerosolized droplets.

10. In programs with one bathroom:
   a. All patients and staff should use facemasks (or cloth face coverings) while in the bathroom.
   b. If possible, stagger shower times, ensuring that bathroom ventilation fans run for at least 20 minutes between all showers and leave window open to facilitate clearing of droplets.
   c. It is even more critical to attempt to clean surfaces after patients who are PUI or tested positive use the facility. If possible, after a PUI or person who tested positive takes a shower, other patients should avoid using that bathroom for three hours. Ventilation fans should remain on and windows should remain open during that time.
   d. If it is not feasible to have three hours between showers, try to stagger them as much as possible.

11. If programs have the capacity and the patient is cooperative, implementing in-room commodes and/or sponge baths is recommended.

12. Dishes and linens do not need to be cleaned differently if used by individuals who test positive. However, they should be washed thoroughly after use. When washing clothes,
staff (or family care providers) should be instructed to not “hug” dirty laundry while transporting it to maintain distance from their own clothes and face. Use of a hamper is recommended. After handling linens or clothing of someone who tested positive for COVID-19, staff should wash their hands with soap and water.

13. Behavioral health residential facilities are advised to increase maintenance standards throughout all public access points throughout the facility as well as all other programs under your agency. New disinfection frequency protocols are needed. Staff who manage maintenance in the facility should ensure more thorough cleansing of tables, counters and all other surfaces. Frequently touched surfaces (e.g., tables, doorknobs, light switches, handles, desks, toilets, faucets, sinks, etc.) should be disinfected daily with cleaning products labeled to be effective against rhinoviruses or human coronaviruses. This includes ensuring that clean water is used when mopping floors based on typical maintenance standards and that supplies, including soap, water and towels/proper drying equipment, are available in all staff and patient bathrooms. In addition to posted handwashing protocols, there should be adequate availability of hand sanitizer throughout the facility. Federal, state and local advisories should also be conspicuously displayed for residents, staff and visitors. Be certain to have sufficient cleaning supplies in your inventory. See CDC Guidance for Home and Community Locations for further details.

Review CDC guidance for Infection Prevention and Control Recommendations for Patients with Confirmed Coronavirus Disease 2019.

Residential programs should continue accepting new patient referrals to the extent possible. It is important for patients with behavioral health and substance use conditions to find homes even during this crisis. Rather than completely stopping admissions, residential treatment facility should consider instead slowing admissions to achieve a lower census to allow for more space and ability to implement social distancing.

Facilities should also reassess patients to identify those who could be considered for safe early discharge to reduce the number of people in the facility. The Center for Health Security (CHS) has hospital criteria for expedited discharge. CHS recommends that facilities be able to make 30 percent of their licensed bed capacity available for COVID-19 patients on one week’s notice. About 10 to 20 percent of this capacity may be mobilized within a few hours by initiating discharges. Residential treatment facilities will need to develop their own criteria for safe early discharge in consultation with the programs their patients will be receiving services from following discharge.
Whenever possible, facilities should also consider social distancing practices when determining capacity for accepting new patients. In other words, how many patients does the facility have capacity for if all patients and staff remain at least six feet apart at all times?

When accepting new patients, residential facilities should:

1. Employ the same screening procedures outlined in the Screening section. A negative screen is not necessarily needed for admittance; rather, the screening provides valuable information for how to manage the patient based on the presence or absence of symptoms or a COVID-19 diagnosis.

2. If the patient presents as asymptomatic, request referring facilities to attest that the patient has not had any new symptoms consistent with COVID-19 infections.

3. Admit individuals with potential exposure to COVID-19 who are asymptomatic and have not tested positive for the virus, as long as this is consistent with the facility’s pre-existing admission criteria and protocols. No additional precautions beyond those previously discussed are indicated or necessary.

4. A behavioral health residential facility can accept a resident diagnosed with COVID-19 under transmission-based precautions for COVID-19 as long as the facility can follow CDC guidance for transmission-based precautions. If a behavioral health residential facility cannot follow CDC guidance for transmission-based precautions, it must wait until these precaution requirements are discontinued. CDC has released Interim Guidance for Discontinuing Transmission-Based Precautions or In-Home Isolation for Persons with Laboratory-confirmed COVID-19.

Information on the duration of infectivity is limited, and the interim guidance has been developed with available information from similar coronaviruses. CDC states that decisions to discontinue transmission-based precautions in hospitals will be made on a case-by-case basis in consultation with clinicians, infection prevention and control specialists, and public health officials. Discontinuation will be based on multiple factors. Review CDC guidance for Infection Prevention and Control Recommendations for Patients with Confirmed Coronavirus Disease 2019.

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5. Quarantine all new patients, regardless of screening results, within the facility for the first 14 days upon arrival and have them wear a facemask (or cloth face covering).

If full quarantine is unavailable, the patient should have a room of their own. Individuals who cannot comply with requests to wear a facemask (or cloth face covering) should be at higher priority for receiving their own room. When facemasks are unavailable, new patients should remain in their room as much as possible during the first 14 days and maintain six feet distance from all other patients and staff.

PATIENTS RETURNING FROM THE HOSPITAL

Residential program patients are admitted to psychiatric or medical hospitals for a variety of reasons. During the COVID-19 crisis, it is possible that these patients have either been admitted to the hospital for COVID-19-related symptoms. Most individuals who become very ill with COVID-19 and require hospitalization will recover and must be discharged once they are no longer ill enough to warrant an ongoing medical admission, though they may still have mild COVID-19 symptoms. It is also possible that residential program patients are admitted to the hospital for non-COVID-19 reasons but are exposed to the virus while in the hospital.

Patients in these categories will need to return to their residential program after being discharged from the hospital. It is important that staff help manage not only the individual resident’s fears, but also the anxieties of all the other housemates. Behavioral health residential facilities should admit any individuals that they would normally admit to their facility, including individuals from hospitals where a case of COVID-19 was or is present, following CDC transmission-based precautions guidance. Also, if possible, use the most isolated room for patients coming from or returning from the hospital. This room or area should have easy access to a sink for handwashing. This can serve as a step-down unit where the resident remains for 14 days with no symptoms.
**WHAT OTHER RESOURCES ARE AVAILABLE FOR FACILITIES TO HELP IMPROVE INFECTION CONTROL AND PREVENTION?**

**Note:** The situation regarding COVID-19 is still evolving worldwide and can change rapidly. Stakeholders should be prepared for guidance from CMS and other agencies (e.g., CDC and state health authorities) to change. Please monitor the relevant sources regularly for updates.

### CDC Resources
- Cases in U.S.
- CDC Updates: What’s New
- Communication Resources
- Donning and Doffing PPE Training
- Extended Use and Limited Reuse of N95 Filtering Facepiece Respirators
- Frequently Asked Questions
- Guidance for Healthcare Professionals
- Guidance for Home and Community Locations
- Hand Washing Poster
- Healthcare Facilities: Steps to Prepare
- Infection Prevention in Long-term Care Facilities
- Interim Infection Prevention and Control Recommendations for Patients with Suspected or Confirmed COVID-19
- Preparing for COVID-19: Long-term Care Facilities, Nursing Homes (Including policies for restricting staff and visitor access)
- Print Resources
- Protecting Healthcare Personnel (PPE Training)
- State & Territorial Health Department Websites
- Travel Precautions
- Use of Cloth Face Coverings

### CMS Resources
- Guidance for Infection Control and Prevention of COVID-19 in Nursing Homes
- Guidance for Use of Certain Industrial Respirators by Health Care Personnel
- Infection Control Toolkit for Bedside Licensed Nurses and Nurse Aides (“Head to Toe Infection Prevention (H2T) Toolkit”)
- Long Term Care Infection Control Self-Assessment Worksheet
- Regional Offices Directory
- State Operations Manual: Infection Control and Prevention Regulations and Guidance (See 42 CFR 483.80, Appendix PP, F-tag 880)

### Other
- Building Organizational Resilience in the Face of COVID-19 (National Council for Behavioral Health)
- Can N95 facial masks be used after disinfection? (Stanford Medicine)
- COVID-19 – Infection Mitigation in Residential Treatment Facilities (American Society of Addiction Medicine)
- Directory of Local Health Departments (National Association of County and City Health Officials)
- Hospital Criteria for Expedited Discharge (Center for Health Security)