



ASAM American Society of
Addiction Medicine

Caring for Patients During the COVID-19 Pandemic

ASAM COVID-19 Task Force Recommendations

Infection Control and Mitigation Strategies in Residential Treatment Facilities

Purpose of the document

This document provides guidance to residential addiction treatment programs (ASAM Levels 3.1, 3.3, 3.5 and 3.7), supporting the development of infection control and mitigation procedures to address the COVID-19 pandemic. Although focused on ASAM Level 3 treatment programs with 24-hour clinical staffing, portions of the document may be useful for community living programs such as sober housing.

As community housing programs respond to the epidemic, it is recommended that they consider the overall considerations for residential treatment programs throughout this document. As always, when a person living in the community becomes ill, they should seek medical care.

Topics

1. [Overview of Considerations for Residential Treatment during the COVID-19 Pandemic](#)
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Overview of Considerations for Residential Treatment during the COVID-19 Pandemic

In addition to the risks associated with COVID-19, the current crisis is likely to increase risks associated with substance use and substance use disorder – due to the anxiety, social isolation, and stress associated with the pandemic response. It is critical that addiction treatment services remain accessible throughout this crisis. The goal is to protect the health of residents and staff in residential treatment facilities and prevent the spread of COVID-19 in the community while maintaining treatment services in a therapeutic environment.

There is significant variability in the rate of community spread of COVID-19 across states and the situation is evolving rapidly. These recommendations should be considered in light of prevailing local, state and federal mandates and recommendations regarding disease mitigation, infection control and medical care.

Anticipated Phases of the COVID-19 Pandemic

Beyond the immediate medical response, programs are struggling with how to weigh the risks of COVID-19 for their patients and staff with the risks of untreated addiction. COVID-19 represents a public health crisis, but so does addiction and the current pandemic is likely to only increase the need for addiction treatment. As a field, we must find ways of maintaining access to needed addiction treatment while minimizing risks for COVID-19 transmission. This may require a combination of telehealth-based treatment and places to shelter patients during quarantine.

During this pandemic, addiction treatment clinicians and programs should consider that communities in the U.S. are likely to experience three phases: an early phase with low prevalence; a later phase with rapidly spreading virus transmission during which new cases will peak and then begin to fall as the population prevalence of prior exposure increases; and a final post-pandemic phase when either the properties of the virus, a vaccine, high levels of community immunity, or other factors bring the spread of the virus under control. Considerations for each phase may be as follows:

Early phase: During this early phase, most residential treatment programs have yet to have a patient or staff member test positive for COVID-19. Programs are largely working to implement screening protocols, social distancing, enhanced facility cleaning and other steps to prevent transmission of the virus in their facilities. Many facilities are also working to implement some level of telehealth capabilities, and to develop protocols for keeping symptomatic patients in isolation or quarantine. However, as the coronavirus spreads in communities across the country, programs should be using this time to actively plan for the next phase of the pandemic.

Peak transmission: While this document is primarily focused on the early pandemic response, addiction treatment providers should be aware of and planning for the next phase of the pandemic. Rapidly increasing community transmission and new cases are anticipated, with the rates of new cases peaking and then falling, as the population at large becomes exposed to the virus.

At this time, information is still being updated regard the expectations of what percentage of the U.S. population will become significantly ill when contracting the virus, how long the infectious period is prior to and after clinically obvious infection, and the level and duration of future immunity that will be associated with prior infection. Further, it is anticipated that testing and PPE supplies will remain in short supply for the foreseeable future. These issues will impact residential program protocols, and it is necessary for each clinician and program to remain up to date on changing recommendations and requirements from state and federal officials.

During this phase, it may be necessary to designated entire treatment programs as well as community housing locations as available to either infectious or non-infectious persons. It is imperative that programs actively work with public health authorities and other service providers throughout their community to plan for this pandemic phase.

Post-pandemic: When COVID-19 moves from pandemic to endemic status, separate treatment and housing programs may no longer be required. The guidance for this phase will be developed over time, but is anticipated to revert to best practices for infection control present before the pandemic, with updated best practices based upon lessons learned during the pandemic.

This document is primarily focused on providing guidance to residential addiction treatment programs (ASAM Levels 3.1, 3.3, 3.5 and 3.7) during the initial, early phase of the pandemic. ASAM will continue to update its guidance as this crisis evolves.

Policies or practices to consider

1. Residential treatment programs should work quickly to either develop [telehealth-based treatment capacity](#) or partner with other treatment programs that can provide these services. Telehealth can be used to provide services to patients at a distance as well as to patients under quarantine within the same facility.
2. If a program does not have the capacity to isolate or quarantine patients, they should work with local public health authorities regarding where patients may be quarantined if they don't have anywhere else they can stay.
3. Residential treatment programs should have clear policies and procedures for addressing both new and current patients who exhibit symptoms consistent with or test positive for COVID-19. Adequately addressing these populations, especially as COVID-19 spreads, is likely to require coordination across treatment programs and state public health authorities.
4. All entrants to the building (new residents, visitors, staff) should be screened for symptoms of COVID-19, recent contact with anyone who has tested positive for COVID-19, or close contact with others who have symptoms of COVID-19 but have not yet been tested.
5. In areas with community spread, patients in residential treatment should not leave the facility unless absolutely necessary (e.g. for urgent medical or psychiatric care).
6. Staff members with any symptoms should stay home and consult their health care provider on safe return to work. See the [CDC guidance on return to work for healthcare personnel with confirmed or suspected COVID-19](#)
7. Limit visitation
 - a. Areas of the country that are experiencing community spread should not allow visitors, except under limited circumstances.
 - b. Other areas should consider limits to visitation to either no visitors or one (1) per resident when necessary. If visitors are permitted, they should be screened prior to entry and the visit should be deferred if they screen positive (see below).
8. Program should implement comprehensive hygiene and disinfection cleaning protocols.
9. Program should implement physical distancing (i.e., 6 feet apart) within the facility.
 - a. Limit group activities, meals and therapy sessions to less than 10 people, ideally 1 on 1 whenever possible. Strive to encourage residents and staff to maintain 6 feet of physical distance at all times and structure facility seating in a way that makes this intuitive for residents.
10. Encourage all staff and residents to speak up if they see a way to minimize the risk of infection and to stay up to date on CDC guidelines.
11. Develop clear protocols for if a patient or staff member tests positive for COVID-19.
12. Knowledge of and public health guidance related to COVID-19 are rapidly evolving. Stay up to date on all new CDC guidelines. Consider assigning a specific staff member to follow changes in federal and state guidance. (<https://www.cdc.gov/coronavirus/2019-ncov/index.html>)

Triaging Patients Based on Need for Residential or Inpatient Care

Residential treatment programs (ASAM Level 3) provide 24-hour on site clinical staffing, but the range of services vary widely across the continuum of care from Level 3.1 to Level 3.7. As programs consider their response to the COVID-19 pandemic, it may be useful to consider the needs of three different cohorts of current and potential patients: those with housing but who need or could benefit from more intensive care than outpatient treatment, those who are unhoused and require shelter in order to engage in any treatment, and those who have urgent addiction-related medical needs.

Patients with housing who need more intensive treatment than outpatient

SAMHSA has provided [guidance](#) that patients seeking treatment, or in treatment, in a residential treatment facility should be evaluated for referral to a Level 1 or 2 program (outpatient, intensive outpatient programs (IOP) and partial hospital programs (PHP)). Utilization of telehealth visits are strongly recommended.

If a patient cannot safely be treated in a less intensive level of care and the program has the capacity to isolate the patient in accordance with the CDC's [Transmission-Based Precautions](#), the program may consider treating the patient in their residential treatment program, unless referral to a hospital is needed.

Patients otherwise unhoused

When patients lack housing and require shelter in order to engage in any level of treatment, programs may need to work with local and state resources to identify housing opportunities as they change during each phase of the pandemic. Organizations which may be helpful to engage include community housing programs, local public health departments, and hospital and health care systems.

Patients with urgent need of daily medical monitoring or management

For patients who have physical, mental health, or addiction treatment needs of such severity that they need medically monitored or medically managed care at ASAM level 3.7 or 4, treatment facilities with this capacity should be identified and patients referred to them as needed. Infection control protocols are particularly important in this population. It is particularly important to rapidly triage patients who are medically unstable due to alcohol or benzodiazepine withdrawal, hepatitis or other infection due to drug use, toward medical evaluation.

Screening for COVID-19 Symptoms and Risk

New Patients: Phone Screening Before Arrival

COVID-19 symptoms can range from mild symptoms to severe illness. Patients should be screened for fever (subjective or confirmed >100.4F), new or worse cough, new or worse shortness of breath, sore throat, and muscle aches.

Ask about any close contacts with individuals with confirmed COVID-19 or others who have symptoms of COVID-19 but have not yet been tested. Close contacts are defined as:

- Living with or caring for a person with confirmed or suspected COVID-19
- Being within 6 feet of a person with confirmed or suspected COVID-19 for about 10 minutes, or

- Having someone with confirmed or suspected COVID-19 cough on you, kiss you, share utensils with you, or that you had direct contact with their body secretions.

If any COVID-19 symptoms exist but the patient does not report emergency warning signs, refer the patient to their primary care provider for evaluation and potential COVID-19 testing. A protocol should be established to define the conditions under which the patient can be cleared for treatment. These policies should be developed in coordination with a medical provider and updated regularly. In addition, every effort should be made to engage the patient in virtual addiction treatment services while they wait to be cleared to enter residential treatment. Residential treatment programs should work quickly to either develop telehealth-based treatment capacity or partner with other treatment programs that can provide these services.

If the patient reports emergency warning signs including difficulty breathing/shortness of breath, inability to walk without taking a break to catch their breath, persistent pain/pressure in the chest, new confusion/sedation, bluish lips or face, or inability to eat or drink, advise them to call 911 and inform them that COVID-19 is suspected. A protocol should be established for this process. Medical evaluation may be recommended for lower temperatures (<100.4 degrees F) or less common symptoms (e.g., muscle aches, nausea, vomiting, diarrhea, abdominal pain headache, runny nose, fatigue) if recommended by public health authorities.

New Patients: Screening upon arrival:

Prior to arrival, staff should ensure that prospective patients have the means to return home within a short period of time should that patient develop symptoms and/or screen positive for COVID-19 symptoms. For facilities that regularly receive patients from significant distances, if it is possible this may include either interrupting those admissions or establishing a relationship with a local facility where people who must quarantine can safely stay, and make arrangements for safe transportation.

Patients should be screened for fever (subjective or confirmed >100.4F), new or worse cough, new or worse shortness of breath, sore throat, and muscle aches. Note that fever may be intermittent or may not be present in some patients, such as those who are elderly, immunosuppressed, or taking certain medications (e.g., acetaminophen). Less common symptoms include headache, runny nose, gastrointestinal symptoms (nausea and diarrhea). Some patients have reported loss of smell; however, the significance of this symptom is not entirely certain yet.

Medical evaluation may be recommended for lower temperatures (<100.4F) or other symptoms (e.g., muscle aches, nausea, vomiting, diarrhea, abdominal pain headache, runny nose, fatigue) if recommended by public health authorities. An established testing algorithm (developed in conjunction with the program's medical director and/or in consultation with a medical provider or the public health authority) should be used to guide testing of patients in such situations. While there is some overlap in symptomatology between opioid withdrawal (and, possibly withdrawal from other substances) and COVID, the fever and distinct new shortness of breath and cough would be the most concerning symptoms.

New arrivals should also be screened for any close contacts with individuals with confirmed COVID-19 or others who have symptoms of COVID-19 but have not yet been tested. Close contacts are defined as:

- Living with or caring for a person with confirmed or suspected COVID-19;

- Being within 6 feet of a person with confirmed or suspected COVID-19 for about 10 minutes; or
- Having someone with confirmed or suspected COVID-19 cough on you, kiss you, share utensils with you, or that you had direct contact with their body secretions.

If any COVID-19 symptoms exist but the patient does not report emergency warning signs, refer the patient to call their primary care provider for evaluation and potential COVID-19 testing. See the *Managing Individuals who Screen Positive* section for additional guidance.

If the patient shows emergency warning signs including difficulty breathing/shortness of breath, inability to walk without taking a break to catch their breath, persistent pain/pressure in the chest, new confusion/sedation, bluish lips or face, or inability to eat or drink, call 911 and alert them that COVID-19 is suspected. Isolate the patient until EMS arrive. A protocol should be established for this process.

Programs should consider how they will isolate new arrivals from current residents and staff during the screening process. Where will the screening occur? What areas of the facility will the prospective patient have access to (e.g. a screening area and a designated restroom)? Who will conduct the screening and how will they minimize the risk of infection (e.g. PPE, maintaining 6 feet of distance, physical barrier, etc.)? For one example, screening could be done while patient is still in their car, if applicable. In these instances, consider also screening anyone who is in the car with the patient.

Another option is to consider instituting a 24-hour isolation immediately upon arrival to provide time to gather more data about the health of a patient. (See the [National Council's COVID-19 Guidance for Behavioral Health Residential Facilities](#)). This may be especially useful in situations when the ability to gather data prior to or at admission is compromised. For example, when the patient is sufficiently impaired that history collection is not possible or when the patient has been in an environment where data collection may be limited and community spread extremely high (i.e., coming straight from jail or prison).

Screening Current Patients

Patients should be screened daily for fever (subjective or confirmed >100.4F), new or worse cough, new or worse shortness of breath, sore throat, muscle aches, and generally feeling ill. Patients should also be encouraged to report any symptoms as soon as possible, including less common symptoms such as runny nose, nausea, diarrhea, etc.

Screening Patients and Staff Returning to the Facility

The CDC recommends that residents of long-term care facilities do not go off site except for important medical appointments or medical or psychiatric emergencies. Consider applying this guidance to residential treatment facilities.

As behavioral health services across the country are rapidly deploying virtual assessment and treatment, relationships should be established with medical and psychiatric providers who have this capacity. Not all psychiatric emergencies can be adequately responded to through virtual means. Protocols defining the appropriate use of virtual versus in person evaluation and treatment should be established with the help of the psychiatric providers currently working with the facility, or with psychiatric providers knowledgeable of local resources.

Consider screening of all staff as they enter the facility. This should include screening for fever as well as questions about new or worsened cough, shortness of breath, muscle aches, and exposure to persons known to be infected or displaying symptoms. Staff should minimize personal belongings into the facility.

Everyone entering or exiting the facility should be encouraged to wash or sanitize their hands at the entry/exit. Remind patients and staff to follow social distancing and hand hygiene best practices when off site.

Screening Visitors

If the program is still permitting visitors, they should be screened for fever, cough, shortness of breath, sore throat, and muscle aches. They should also be screened for any close contacts with individuals with confirmed COVID-19 or others who have symptoms of COVID-19 but have not yet been tested. Close contacts are defined as:

- Living with or caring for a person with confirmed or suspected COVID-19;
- Being within 6 feet of a person with confirmed or suspected COVID-19 for about 10 minutes; or
- Having someone with confirmed or suspected COVID-19 cough on you, kiss you, share utensils with you, or that you had direct contact with their body secretions.

Visitors who screen positive based on these criteria should not be allowed to enter. The program should encourage virtual visitation as an alternative.

Resources

Helpful infographic: <https://www.bmj.com/content/368/bmj.m1182/infographic>

Managing Patients who Screen Positive

As stated above in the sections on screening, if a patient screens positive for COVID-19 symptoms but does not have emergency warning signs his or her primary care provider should be contacted. If a patient screens positive for COVID-19 symptoms and shows emergency warning signs including difficulty breathing/shortness of breath, inability to walk without taking a break to catch their breath, persistent pain/pressure in the chest, new confusion/sedation, bluish lips or face, or inability to eat or drink, EMS should be called immediately. Alert EMS that COVID-19 is suspected.

When a patient or staff member has acute respiratory symptoms consistent with COVID-19 the local public health authority should be contacted and he or she should be tested for COVID-19 (medical providers should be able to order tests); refer to state guidance for specifics on testing availability and criteria for priority testing. While waiting for test results the individual should remain isolated/quarantined. If any patient or staff member is suspected of having or tests positive for COVID-19, all other patients and staff members should be informed within 2 hours and provided with information on how the program is responding.

Beyond the immediate medical response, how to address new patients with symptoms consistent with COVID-19 presents a significant challenge. Programs are struggling with how to weigh the risks of COVID-19 for their patients and staff with the risks of untreated addiction. COVID-19 represents a public health crisis, but so does addiction and the current pandemic is likely to only increase the need for

addiction treatment. As a field, we must find ways of maintaining access to needed addiction treatment while minimizing risks for COVID-19 transmission. This may require a combination of telehealth-based treatment, places to shelter patients during quarantine, and dedicated residential or inpatient addiction treatment programs or units within these programs that can treat patients who have or are suspected of having COVID-19.

Residential treatment programs should work quickly to either develop telehealth-based treatment capacity or partner with other treatment programs that can provide these services. In addition, if the program does not have the capacity to isolate or quarantine patients, they should work with local public health authorities regarding where patients may be quarantined if they don't have anywhere else they can stay.

It may be helpful to think through treatment needs of specific populations. For example:

- 1) Patients who have housing and could be well served by telehealth-based addiction treatment.
- 2) Patients who lack housing but could be well served by telehealth-based addiction treatment if shelter could be provided.
- 3) Patients who have physical, mental health, or addiction treatment needs of such severity that they need medically monitored or medically managed care.

Residential treatment programs should have clear policies and procedures for addressing both new and current patients who exhibit symptoms consistent with or test positive for COVID-19. Adequately addressing these populations, especially as COVID-19 spreads, is likely to require coordination across treatment programs and state public health authorities.

New Arrivals

If an incoming patient screens positive for risk of COVID-19 the program could consider multiple options based on their internal and community resources and the needs of the patient. For example:

- *If the patient could safely be treated in a virtual outpatient program and has a safe place to stay*, the residential program should work to actively engage the patient in that level of care.
- *If the patient could safely be treated in a virtual outpatient program but does not have a safe place to stay*. The program should work with their local public health authority to try to identify a place where the patient can be isolated/quarantined that will enable them to engage in virtual treatment.
- *If the patient cannot safely be treated in a less intensive level of care:*
 - If the program has the capacity to isolate the patient in accordance with the CDC's [Transmission-Based Precautions](#), the program may admit the patient for treatment.
 - If the program **does not** have the capacity to isolate the patient in accordance with the CDC's [Transmission-Based Precautions](#), the program should try to identify another facility of the same or greater intensity of care which can provide care with such precautions.

Current Patients

Any resident with respiratory symptoms should be placed immediately in a separate room behind a closed door and isolated until staff can evaluate the situation. If there are any concerning COVID-19 symptoms (fever, shortness of breath, worsening/new cough, sore throat, muscle aches), the patient

should remain in isolation and a medical provider should be contacted to determine if the patient requires a telehealth or in person visit for diagnosis and management. The local public health department should also be contacted. The patient should be given a facemask and hand sanitizer (if available). If facemasks are not available, the patient should be given tissues and instructed to cough into them and dispose of them immediately after use.

If symptoms are present but do not require immediate attention, the patient should be assessed for risk based on age (>65 years) and comorbidities (diabetes, hypertension, immunosuppressive drugs). If high risk factors are present, testing should be prioritized (through emergency rooms, primary care offices or drive-thru testing services (where available)).

All staff, including medical providers, should not assess an ill patient suspected to have COVID-19 from distance closer than 6 feet unless they have been trained on and donned PPE. If PPE is not available and the patient needs to be assessed, alert EMS of risk for COVID-19 and await their arrival. Ensure that all staff know what symptoms trigger the use of a mask. Reserve masking for those situations that meet the protocol. While this is not intuitive to the compassionate group of workers at residential living facilities, ***remind staff that they cannot care for others if they cannot care for themselves safely and that other residents and patients depend on the health of their care providers as well.***

The patient's room should be sanitized and any surfaces that the person may have touched should be disinfected immediately. Staff responsible for cleaning should wear PPE (gown, gloves, mask, and eye protection if available) and they should be careful to wash their hands when they remove the PPE.

If the patient had a roommate, enhanced infection control procedures should be followed for the next 14 days. For example:

- Having the patient wear a facemask;
- Designating specific patient rooms and other facilities (e.g. bathrooms);
- Minimizing new patient interactions with other patients and staff; and
- Strictly enforcing physical distancing and hygiene protocols.

As discussed above, the patient should be tested for COVID-19 and should remain isolated while waiting for test results. Based on resources in the facility, the acuity of the patient's viral symptoms, and the patient's needs for medical monitoring and management related to the SUD or other physical health comorbidities, the program will need to determine where the patient can safely wait in isolation. This decision should be made in consultation with a physician knowledgeable in the treatment of SUD. In some cases, it may be safe and effective to quickly discharge the patient to home. However, when a patient has significant medical symptoms related to the SUD (withdrawal, soft tissue infection related to injection, etc.) it may not be safe to discharge the patient to home, or additional planning may be needed around that discharge to ensure the safety of the patient.

If a patient cannot be safely discharged, a plan should be in place for them to be quarantined to a room and bathroom. The facility should also develop a plan in the event that a sick patient requires extended quarantine.

During later community stages of the pandemic with high prevalence rates of COVID-19 and before the spread of the virus is controlled, it may be necessary to designate entire treatment programs as well as community housing locations as available to either infectious or non-infectious persons. It is imperative

that programs actively work with public health authorities and other service providers in their community to plan for this pandemic stage.

For patient or staff members quarantined either in the facility or at home, program protocols should address:

- Regular monitoring of patient symptoms, including fever.
- Delivery of food, medications, and other essentials while maintaining at least 6 feet of distance.
- When PPE is required.
- If an ill person must be around other people for any reason, they should wear a safe mask and maintain at least 6 feet of distance from others.
- Regular assessment of patient needs including mental health, emotional support, food, hygiene, medications, etc.

For patients and staff members quarantined at home, the program should organize a system for home doorstep drop-offs of groceries, medications, and other essentials. This can be as simple as a volunteer support pool or more formalized by the facility.

Ending Quarantine for a sick patient

Quarantine should be ended by a physician per current CDC guidelines, briefly:

- If person was never tested or tested positive once and will not receive a 2nd COVID test to determine if they are infectious, quarantine can end when 3 criteria are fulfilled:
 - No fever for at least 72 hours (that is three full days of no fever without the use of medicine that reduces fevers), AND
 - other symptoms have improved or preferably resolved (for example, when cough or shortness of breath have improved), AND
 - at least 7 days have passed since symptoms first appeared.
- If person already tested positive and will receive testing to determine if they are contagious, quarantine can end when 3 criteria are fulfilled:
 - No fever (without medications to reduce fever), AND
 - Other symptoms have improved or preferably resolved, AND
 - Person has had 2 negative tests in a row, 24 hours apart.

Protecting and Monitoring Staff

Staff Use of PPE

Residential treatment programs should establish protocols about proper use of personal protective equipment (PPE). Given limited resources, PPE needs to be conserved. It should not be used when there is little evidence of effectiveness (i.e., masking when interacting with asymptomatic individuals). Protect supplies.

While staff not providing physical care to patients should maintain distance, according to the CDC, the PPE recommended when providing physical care for a patient with known or suspected COVID-19 includes:

- **Respirator or Facemask**

- **Eye Protection** (i.e., goggles or a disposable face shield that covers the front and sides of the face)
- **Gloves**
- **Isolation Gowns**

Staff should be trained and have practiced the appropriate use of PPE prior to caring for a patient, including attention to correct use of PPE and prevention of contamination of clothing, skin, and environment during the process of removing such equipment. Necessary PPE should be made available in areas where resident care is provided. A trash can should be placed near the exit inside the resident room to make it easy for staff to discard PPE prior to exiting the room, or before providing care for another resident in the same room.

See CDC's Interim Infection Prevention and Control Recommendations for Patients with Suspected or Confirmed Coronavirus Disease 2019 (COVID-19) in Healthcare Settings for more details:

<https://www.cdc.gov/coronavirus/2019-ncov/infection-control/control-recommendations.html>

See the CDC's guidance on optimizing supplies of PPE: <https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/index.html>

Managing Staff with COVID-19 Symptoms

Personnel who develop respiratory symptoms (e.g., cough, shortness of breath) should be instructed not to report to work. If they screen positive or develop symptoms while at work, they should be sent home or to seek medical services. Staff with symptoms of COVID-19 should be encouraged to see their PCP to get tested/cleared to work. They should wait for the test results at home.

When a staff member has acute respiratory symptoms consistent with COVID-19 the local public health authority should be contacted and he or she should be tested for COVID-19 (medical providers should be able to order tests); refer to state guidance for specifics on testing availability and criteria for priority testing. While waiting for test results the individual should remain isolated/quarantined at home. The program should have standardized processes to contact and inform any contacts of a staff member who is suspected to have COVID-19 within 2 hours of receipt of a positive screening result.

Residential treatment programs should implement [sick leave policies](#) for healthcare providers and other staff that are non-punitive, flexible, and consistent with public health guidance. Movement and monitoring decisions for HCP with exposure to COVID-19 should be made in consultation with public health authorities. Refer to the [Interim U.S. Guidance for Risk Assessment and Public Health Management of Healthcare Personnel with Potential Exposure in a Healthcare Setting to Patients with Coronavirus Disease 2019 \(COVID-19\)](#) for additional information.

Quarantine for staff member suspected or confirmed of having COVID-19 should be ended by a physician per current CDC guidelines. Briefly,

- If person was never tested or tested positive once and will not receive a 2nd COVID test to determine if they are infectious, quarantine can end when 3 criteria are fulfilled:

- No fever for at least 72 hours (that is three full days of no fever without the use of medicine that reduces fevers), AND
- other symptoms have improved or preferably resolved (for example, when cough or shortness of breath have improved), AND
- at least 7 days have passed since symptoms first appeared.
- If person already tested positive and will receive testing to determine if they are contagious, quarantine can end when 3 criteria are fulfilled:
 - No fever (without medications to reduce fever), AND
 - Other symptoms have improved or preferably resolved, AND
 - Person has had 2 negative tests in a row, 24 hours apart.

For patients and staff members quarantined at home, the program should organize a system for home doorstep drop-offs of groceries, medications, and other essentials. This can be as simple as a volunteer support pool or more formalized by the facility.

See the CDC's return to work criteria for healthcare providers: <https://www.cdc.gov/coronavirus/2019-ncov/healthcare-facilities/hcp-return-work.html>

Facility Policies and Procedures

Screening and Follow Up

Every residential facility should develop screening and follow up procedures in coordination with a physician or the public health authority. The policy should describe:

- 1) what symptoms should raise concern
- 2) under what circumstances the patient will be evaluated for potential testing
- 3) how the patient will be isolated from other patient and staff while awaiting evaluation and potential staffing
- 4) plans for isolating/quarantining patients and staff who were either
 - a. exposed to individuals with symptoms or
 - b. have tested positive for the coronavirus (SARS-CoV-2)
- 5) protocols for immediately contacting the individual's primary care doctor or the facility medical director for further guidance
- 6) processes for contacting and informing any contacts of a resident or staff member who tests positive or is suspected to have COVID-19 within 2 hours of screening or testing positive.

Quarantine of New Patients

Since the coronavirus can be transmitted by asymptomatic individuals the program should also consider enhanced infection control procedures for the first 14 days after a new patient (that screens negative for COVID-19 symptoms) is admitted. For example:

- Having the patient wear a mask
- Designating specific patient rooms and other facilities (e.g. bathrooms) for new patients
- Minimizing new patient interactions with other patients and staff
- Strictly enforcing physical distancing and hygiene protocols.

Visitors:

- Limit points of entry to the facility (i.e. front door only for patients, visitors and staff; and a separate entrance for deliveries).
- Facilities should consider decreasing traffic from outside sources, including family visitation.
 - Areas of the country that are experiencing active community spread should not allow visitors, except under limited circumstances.
 - Other areas should consider limits to visitation to either no visitors or 1 per resident when necessary, maintaining physical distancing and utilizing an identified location which can be cleaned between visits. (NOTE: At this time, the CDC is recommending that [long term care facilities](#) restrict all visitation except for certain compassionate care situations, such as end of life situations).
- As restriction of all visitors is implemented, facilities can consider exceptions based on end-of-life situations or when a visitor is essential for the patient's psychiatric well-being and care.
- Encourage use of alternative mechanisms for patient and visitor interactions such as video-call applications on cell phones or tablets.
- If visitors are permitted, they should be screened prior to entry and the visit should be deferred if they screen positive.
 - All visitors should have their temperature taken and assessed for respiratory symptoms (seen "Screening upon arrival" section) upon entry to the facility. If fever or respiratory symptoms are present, visitor should not be allowed entry into the facility.
- All visitors should perform hand hygiene before and after entering the facility and common areas.
- If visitation must occur, visits should be scheduled and controlled, i.e. visiting patient room only.
- Programs should determine the threshold at which point it will move from screening of visitor to restricting all visitors to the facility.

Facility Cleaning and Precautions

Clean high-touch surfaces and in the facility multiple times per day, especially after any resident interactions. Shared resident-care equipment should be cleaned after each use.

- High touch surfaces include tables, doorknobs, light switches, countertops, handles, desks, phones, keyboards, toilets, faucets, and sinks.
- Make sure that EPA-registered, hospital-grade disinfectants are available to allow for frequent cleaning of high-touch surfaces and shared resident care equipment. Refer to [List N](#) on the EPA website for EPA-registered disinfectants that have qualified under EPA's emerging viral pathogens program for use against SARS-CoV-2. Avoid disinfectants that can cause an asthma attack ([Green Seal GS-37 certified products](#) do not contain ingredients that are known to cause asthma).
- Any surfaces touched by a resident with symptoms of COVID-19 should be disinfected immediately.
- Ensure you have adequate supplies to dispose of potentially contaminated material

Facilities should be appropriately supplied with tissues, no-touch trash receptacles, alcohol-based hand sanitizer, and patients and staff should have access to sinks with soap. Consider designating staff to manage these supplies and encourage appropriate use by patients, visitors, and staff. Fomites such as toys, reading materials, and other communal objects should be removed or regularly cleaned in accordance with [CDC disinfection guidelines](#).

Respiratory hygiene and cough etiquette

Facilities should provide patients and staff with instructions on hygiene and cough etiquette. Instructions should include how to use facemasks (when needed), how to use tissues to cover nose and mouth when coughing or sneezing, how to dispose of tissues and contaminated items in waste receptacles, and how and when to perform hand hygiene. Patients should be taught that, if no tissues are available, they should cough into the bend in their elbow and wash their hands with soap and water afterwards. Patients should also be encouraged to avoid touching their eyes, nose, mouth with unwashed hands. <https://www.cdc.gov/coronavirus/2019-ncov/hcp/clinic-preparedness.html>

The CDC has several handouts and posters designed to educate patients about COVID-19 and good hygiene practices. <https://www.cdc.gov/coronavirus/2019-ncov/communication/factsheets.html>

Hand hygiene

Soap and water or hand sanitizer should be easily accessible in every room.

1. While alcohol based hand- sanitizer is a necessity in the current environment, facilities should remain aware that patients with Alcohol Use Disorder have been known to ingest these products.
2. Additionally, exposure on the skin, particularly with the frequency demanded by this emergency, has been shown to create positive testing with some tests of alcohol metabolites (particularly EtG¹). This should be taken into account in drug testing policies for both patients and staff.

Urge staff and residents to focus on hand washing, hygiene and universal precautions. Wash hands often with soap and water (for at least 20 seconds). Using an alcohol-based hand sanitizer, with at least 60% alcohol, is a less preferable alternative.

Staff should wash hands in between any patient contact and encourage patients to do the same. Consider posting visual reminders at the entrance and in strategic places.

Physical distancing

Patients and staff should avoid all medically unnecessary physical contact and should try to maintain at least a 6 feet distance from others. Consider assigning staff to monitor both patient and staff interactions to reinforce the need for physical distancing. Common areas should be re-arranged such that there is room for residents to remain at proper distance from one another to minimize disease spread.

¹ <https://www.sciencedirect.com/science/article/pii/S0379073814000681>

Scheduling and programming should be adjusted such that groups will be no larger than 10 people, including staff. [Telehealth](#) and [virtual support groups](#) can be used to supplement these small groups as needed.

Patients should avoid sharing dishes, cups, utensils, towels, bedding, clothing, and other objects with other people in the facility. All of these items should be thoroughly sanitized after use.

Items Brought in From Outside

Residential facilities should also have policies and procedures for infection control related to bringing items into the facility. Policies to consider include:

- Deliveries
 - Have a single point of entry for supplies (e.g. a loading dock or other less trafficked entrance).
 - Maintain physical distance between staff and delivery persons as much as possible.
 - Wear gloves when receiving and opening packages.
 - Wash hands once supplies have been stored or put away.
- Patient belongings
 - Minimizing what belongings new patients can bring into the facility.
 - If staff handle new patient belongings, ensure they wear gloves or avoid directly touching them and wash their hands immediately after handling (after removing gloves).
 - Once the patient has been admitted,
 - Consider sanitizing any belongings before they enter the patient space (e.g. launder clothes, wipe down electronics with sanitizing wipes, etc.)
 - Take any belongings that have not been sanitized directly to the patient's personal space and restrict where the patient can bring these items.
- Staff belongings
 - Minimizing what belongings staff can bring into the facility.
 - Require staff to bring their belongings directly to the place where they will be stored during their shift.
 - Require staff to wash their hands immediately after storing their belongings.
 - Require staff to sanitize any belongings they keep with them during their shift (e.g. phones) prior to starting their shift.
 - Encourage staff to minimize access to their belongings during their shift and to wash their hands any time they do access them.

Resources

CDC Preparing for COVID-19: Long-term Care Facilities, Nursing Homes:

<https://www.cdc.gov/coronavirus/2019-ncov/healthcare-facilities/prevent-spread-in-long-term-care-facilities.html>

CDC Steps Healthcare Facilities Can Take Now to Prepare for Coronavirus Disease 2019 (COVID-19):

<https://www.cdc.gov/coronavirus/2019-ncov/healthcare-facilities/steps-to-prepare.html>

CDC Interim Infection Prevention and Control Recommendations for Patients with Suspected or Confirmed Coronavirus Disease 2019 (COVID-19) in Healthcare Settings:

<https://www.cdc.gov/coronavirus/2019-ncov/infection-control/control-recommendations.html>

CDC Strategies to Optimize the Supply of PPE and Equipment: <https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/index.html>

CDC Interim U.S. Guidance for Risk Assessment and Public Health Management of Healthcare Personnel with Potential Exposure in a Healthcare Setting to Patients with Coronavirus Disease (COVID-19):

<https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-risk-assesment-hcp.html>

CDC's Interim Guidance for Healthcare Facilities: Preparing for Community Transmission of COVID-19 in the United States: <https://www.cdc.gov/coronavirus/2019-ncov/healthcare-facilities/guidance-hcf.html>

AATOD Guidance for OTPs in Response to the Coronavirus (COVID-19):

<http://www.aatod.org/advocacy/policy-statements/covid-19-aatods-guidance-for-otps/>

NAATP COVID Resources: <https://www.naatp.org/covid-19-resources>

Including set of intake questions for consideration for new patients:

<https://www.naatp.org/sites/naatp.org/files/COVID19AdditionalIntakeQuestions.pdf>

Joint Commission resource: <https://www.jointcommission.org/en/resources/news-and-multimedia/blogs/on-infection-prevention-control/2020/02/19/managing-the-threat-of-the-new-coronavirus-strain/>

SAMHSA's Disaster App: <https://store.samhsa.gov/product/samhsa-disaster>

Helpful Infographic on remote consultations related to COVID-19

<https://www.bmj.com/content/368/bmj.m1182/infographic>

COVID-19 resource is from University of Washington: <https://covid-19.uwmedicine.org/Pages/default.aspx>