

ASAM COVID-19 TASK FORCE RECOMMENDATIONS

# CARING FOR PATIENTS DURING THE COVID-19 PANDEMIC

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Infection Control and Mitigation Strategies  
in Residential Treatment Settings



# INFECTION CONTROL AND MITIGATION STRATEGIES IN RESIDENTIAL TREATMENT SETTINGS

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A guide for addiction treatment clinicians and programs working to treat patients with substance use disorders safely and effectively during the COVID-19 pandemic<sup>1</sup>.

For additional recommendations for the Ongoing Management of the Continuum of Addiction Care during COVID-19, [please click here](#).

## CONTENT DISCLAIMER

This Clinical Guidance (“Guidance”) is provided for informational and educational purposes only. It is intended to provide practical clinical guidance to addiction medicine physicians and others caring for individuals with substance use disorders during the COVID-19 pandemic as it unfolds. Adherence to any recommendations included in this Guidance will not ensure successful treatment in every situation. Furthermore, the recommendations contained in this Guidance should not be interpreted as setting a standard of care or be deemed inclusive of all proper methods of care nor exclusive of other methods of care reasonably directed to obtaining the same results.

The ultimate judgment regarding the propriety of any specific therapy must be made by the physician and the patient in light of all the circumstances presented by the individual patient, and the known variability and biological behavior of the medical condition.

This Guidance and its conclusions and recommendations reflect the best available information at the time the Guidance was prepared. The results of future studies may require revisions to the recommendations in this Guidance to reflect new data.

ASAM does not warrant the accuracy or completeness of the Guidance and assumes no responsibility for any injury or damage to persons or property arising out of or related to any use of this Guidance or for any errors or omissions.

## INFECTION CONTROL AND MITIGATION STRATEGIES IN RESIDENTIAL TREATMENT SETTINGS

### 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 and implementation 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 congregate living programs such as sober or recovery housing.

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

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<sup>1</sup>This resource was developed by a Task Force appointed by ASAM’s Executive Council. To enable more rapid development and dissemination it was not developed through ASAM’s normal process for clinical guidance development that is overseen by the ASAM Quality Improvement Council.

## TOPICS

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### 1. Overview of Considerations for Residential Treatment during the COVID-19 Pandemic

In addition to the risks associated with COVID-19, the current crisis is increasing risks associated with substance use and substance use disorder – due to the anxiety, social isolation, and stress associated with the pandemic and its necessary 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 reduce, or ideally 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 transmission of COVID-19 across states and the situation continues to evolve 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. This document will continue to be updated as needed based on the changing situation.

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 increasing 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.

#### Policies or practices to consider

1. Staff should wear a facemask covering nose and mouth at all times while they are in the facility.
  - a. When available, facemasks are generally preferred over cloth face coverings for healthcare personnel (HCP) as facemasks offer both source control and protection for the wearer against exposure to splashes and sprays of infectious material from others (see the CDC's [Guidance on extended use and reuse of facemasks](#)). **Cloth face coverings should NOT be worn by staff instead of a respirator or facemask if personal protective equipment (PPE) is required.**
  - b. Masks with exhalation valves or vents should not be used as they do not provide adequate source control for respiratory droplets.
2. Residents should wear a cloth face covering or facemask (if tolerated) whenever they leave their room,

including for procedures outside the facility. Cloth face coverings should not be placed on anyone who has trouble breathing, or anyone who is unconscious, incapacitated, or otherwise unable to remove the mask without assistance. In addition to the categories described above, cloth face coverings should not be placed on children under 2.

3. Visitors, if permitted into the facility, should wear a cloth face covering at all times while in the facility. Serious consideration should be given to adopting a no visitor policy during ongoing community transmission of COVID-19.
4. 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. Telehealth can also be used to provide education and group services while maintaining physical distancing between patients in the same facility.
5. 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 safely quarantined if they don't have anywhere else to stay.
6. 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 transmission continues in a community, is likely to require coordination across treatment programs and state / local public health authorities.
7. Residential treatment programs should have clear policies and procedures for addressing new and current patients who have had exposure to COVID-19 but appear asymptomatic. Not every test is sufficiently sensitive to be appropriately applied to asymptomatic individuals and CDC recommendations on quarantine for COVID-19 contact apply even if testing is not pursued following exposure. Additionally, programs need to understand the difference between a positive test result and infectivity, which is considered to exist for 2 weeks after the first positive test or development of symptoms.
8. All entrants to the building (new residents, current residents, staff, visitors if permitted) should be screened with a standardized screening protocol that is routinely reviewed and revised based on updated recommendations. The screening protocol should include questions to identify anyone with symptoms of COVID-19, an initial positive test for COVID-19 within the past 14 days, recent contact with anyone who has tested positive for COVID-19 or is awaiting a COVID-19 test result, or close contact with others who have symptoms of COVID-19 but have not been tested. If possible, noncontact temperature checks should be taken for every person entering the facility (staff, patients, and any permitted visitors).
9. Patients in residential treatment should not leave the facility unless absolutely necessary (e.g. for urgent medical or psychiatric care).
10. 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](#)
11. Limit visitation
  - a. Areas of the country that are experiencing increases in COVID-19 positivity rates 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.

- c. Programs should explore use of technology to allow for virtual visits via synchronous audiovisual communication to supplement in-person visitation.
12. Programs should implement comprehensive hygiene and disinfection cleaning protocols. This includes ready access to soap and water for hand washing or non-methanol containing hand sanitizer for patients and staff.
13. Programs should implement physical distancing (i.e., 6 feet apart) within the facility, using clear markers as to what counts as appropriate distance. Physical barriers, including clear plastic shields, can be used to protect staff at facility entrances, in nursing stations, or other common areas where appropriate.
  - 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. Ultimately, the size of a room that can safely accommodate individuals while maintaining the recommended physical distance between any two people will be the rate determining factor for the size of a group.
  - b. All group members, including staff, should wear facemasks at all times during group activities.
  - c. Routine and regular sanitization of group rooms and high-touch surfaces should be done using EPA-registered disinfectants.
14. Encourage all staff and residents to speak up if they see ways to minimize the risk of infection and to stay up to date on CDC guidelines.
15. Develop clear protocols for if a patient or staff member tests positive for COVID-19.
16. 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>)

## 2. Triage 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 can provide; 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 care can provide**

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)). If a patient cannot safely be treated in a less intensive level of care and the program has the capacity to quarantine or isolate the patient, if needed, 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 required.

Utilization of telehealth visits in all settings is strongly recommended. Some telehealth platforms may have limited capacity to provide what patients need, especially in those outpatient levels of care that incorporate groups. Telehealth can be an effective tool but some patients may not respond as expected or may have limited ability to utilize telehealth platforms in outpatient settings. This has meant that outpatient care may not be sufficient to effectively meet the needs of some patients.

## 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 the pandemic. Organizations which may be helpful to engage include community housing programs, local public health departments and behavioral health authorities, 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 these settings and populations. 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.

## 3. 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 current [symptoms identified by the Centers for Disease Control and Prevention \(CDC\)](#) as associated with COVID-19 including, fever (subjective or confirmed >100.4F) or chills, new or worse cough, new or worse shortness of breath, sore throat, muscle or body aches, headache, new loss of taste or smell, congestion or runny nose, nausea or vomiting, and diarrhea.

Screening should inquire as to whether the patient has had an initial positive test for COVID-19 within the past 10-14 days,

Ask about any close contacts with individuals with confirmed COVID-19 or others who have symptoms of COVID-19 but have not been tested or who may be awaiting their test results. [Close contact](#) is defined as being within 6 feet of a person with confirmed or suspected COVID-19 for about 15 minutes (starting from 2 days before illness onset (or, for asymptomatic people, 2 days prior to specimen collection).

If the patient screens positive for any COVID-19 symptoms but no [emergency warning signs](#) exist, 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 care. 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

If resources allow, consider viral testing (ie RT-PCR) all patients/new admissions for COVID-19. It may be helpful to establish point-of-care testing arrangements with local health centers<sup>1</sup>. Note that antibody testing should NOT be used to diagnose someone with active infection.

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 or test 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 or isolate can safely stay, and make arrangements for safe transportation.

Prior to entry into the facility, patients should be screened for fever (subjective or confirmed >100.4F) or chills, new or worse cough, new or worse shortness of breath, sore throat, muscle or body aches, headache, new loss of taste or smell, congestion or runny nose, nausea or vomiting, and diarrhea. 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, ibuprofen).

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 an external 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.

In addition to screening for current COVID-19 related symptoms, new arrivals should also be screened for history of an initial positive test for coronavirus within the past 10- 14 days. 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 been tested or who are awaiting their test results. Close contact is defined as:

- Being within 6 feet of a person with confirmed or suspected COVID-19 for about 15 minutes (starting from 2 days before illness onset or, for asymptomatic people, 2 days prior to specimen collection)

If any COVID-19 symptoms are noted on screening 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 or Test Positive for COVID-19 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/seda-

<sup>1</sup><https://www.cdc.gov/coronavirus/2019-ncov/hcp/nursing-homes-facility-wide-testing.html>

tion, 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 is extremely high (i.e., coming straight from jail or prison).

## Screening Current Patients

Patients should be screened daily for fever (subjective and confirmed >100.4F) or chills, 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 nasal congestion or runny nose, nausea, diarrhea, headache, loss of taste or smell, 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 daily screening of all staff as they enter the facility. This should include screening for fever (subjective or confirmed >100.4F) or chills, as well as onset of any of the following symptoms within the previous 48 – 72 hours: new or worse cough, new or worse shortness of breath, sore throat, muscle or body aches, headache, new loss of taste or smell, congestion or runny nose, nausea or vomiting, and diarrhea. Staff should minimize bringing personal belongings into the facility.

Everyone entering or exiting the facility should be encouraged to wash or sanitize their hands at entry/exit. Remind patients and staff to follow physical distancing and hand hygiene best practices when off site. CDC recommends that people wear masks in all public settings and when around people who don't live in your household<sup>2</sup>.

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<sup>2</sup><https://www.cdc.gov/coronavirus/2019-ncov/prevent-getting-sick/cloth-face-cover-guidance.html#:~:text=CDC%20recommends%20all%20people%20,measures%20are%20difficult%20to%20maintain.>



## Screening Visitors

If the program is still permitting visitors, they should be screened for fever, cough, shortness of breath, sore throat, muscle aches, headache, new loss of taste or smell, congestion or runny nose, nausea or vomiting, and diarrhea. In addition to screening for current COVID-19 related symptoms, visitors should also be screened for history of an initial positive test for coronavirus within the past 10 - 14 days and they should also be screened for any close contact with individuals with confirmed COVID-19 or others who have symptoms of COVID-19 but have not been tested or are waiting for their test results. Close contact is defined as:

- Being within 6 feet of a person with confirmed or suspected COVID-19 for about 15 minutes (starting from 2 days before illness onset or, for asymptomatic people, 2 days prior to specimen collection)

Visitors who screen positive based on these criteria should not be allowed to enter. The program should encourage virtual visitation as an alternative to in-person visits as much as possible.

## Resources

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

### 4. Managing Patients who Screen Negative, but COVID-19 is Suspected

It is possible for RT-PCR testing to give a negative result that is incorrect (i.e. false negative) in some people with COVID-19. This means that patients could possibly still have COVID-19 even though the test result is negative.

The possibility of a false negative result should especially be considered if the patient's recent exposures or clinical presentation indicate that COVID-19 is likely, and diagnostic tests for other causes of illness (e.g., other respiratory illness) are negative. If COVID-19 is still suspected based on exposure history together with other clinical findings, keep the patient in isolation unless an alternative diagnosis is determined. Re-testing should be considered by healthcare providers in consultation with public health authorities.

### 5. Managing Patients who Screen or Test Positive for COVID-19

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 the patient or staff member 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 testing.

While waiting for any COVID-19 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. This should be done in a manner that balances patients and staff need to know information with respect for the privacy of the affected patient(s) or staff member(s). Alert local public health authorities as they should be able to provide recommendations or assistance with any necessary testing, contact tracing, or other actions to limit spread of the COVID-19 virus within and outside of the facility.

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 only increasing 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/isolation, and dedicated residential or inpatient addiction treatment programs or units within these programs that can treat patients for SUD 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 to 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 continues, requires coordination across treatment programs and state and local 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's SUD 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's SUD 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 addiction treatment.
- If the patient's SUD 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

All patients should wear a facemask or cloth face covering at all times while in the facility unless they are alone in a closed room. Masks with exhalation valves or vents are not recommended as they do not provide adequate source control of respiratory droplets. Patients should also have access to non-methanol-based hand sanitizer across the facility.

Any resident with respiratory symptoms should be immediately placed 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, nausea, vomiting, diarrhea, loss of smell or taste, headache, nasal congestion or runny nose), 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 assessment and management. The local public health department should also be contacted. Patients in this situation should be provided a medical-grade facemask, at a minimum a surgical mask, rather than a cloth face covering, to wear at all times even if in a closed room.

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, immunosuppression). If high risk factors are present, testing should be prioritized (through emergency rooms, primary care offices or drive-thru testing services where available).

When one or more patients or staff in a facility are suspected of or confirmed to have COVID-19 infection, ensure that all persons within the facility are masked.. The [personal protective equipment](#) (PPE) needed varies with the proximity of the people involved and the length of time the interaction is sustained. The PPE needed to safely be in proximity of a person under investigation or who has tested positive is considerably greater than in other circumstances.

The infected patient's room should be sanitized and any surfaces that the person may have touched should be disinfected immediately with an EPA-registered disinfectant. If the patient had a roommate, enhanced infection control procedures should be followed for the next 14 days. For example:

- Have the roommate wear a medical-grade facemask rather than a cloth face covering;
- Designate specific patient rooms and other facilities (e.g. bathrooms) to separately, and individually, quarantine the roommate and other contacts;
- Remove all personal effects from the bathroom that the patient with suspected or confirmed COVID-19 used and store separately or move to a bathroom only to be used by the patient during isolation/quarantine.
- Avoid having any patient personal hygiene products stored in shared bathrooms. Instead, designate separate areas for patients to store personal effects.
- Sanitize all bathrooms on a regular and potentially increased schedule for the period of quarantine/isolation of any patient.
- Minimize new patient interactions with other patients and staff
- Strictly enforce physical distancing and hygiene protocols.

Any patient with symptoms concerning for COVID infection should be tested for COVID-19 and should remain quarantined /isolation 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 co-morbidities, 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 any 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/isolated to a sepa-

rate room and bathroom. The facility should also develop a plan in the event that a sick patient requires extended isolation.

Depending on the local prevalence of COVID-19, 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 situation.

For patients or staff members quarantined or isolated 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.
- The type of PPE required by quarantining/isolating patients, other patients, and staff.
- 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 Isolation for a Sick Patient

Isolation should be ended by a physician per current [CDC guidelines on discontinuation of transmission based precautions](#).

In people with [mild to moderate illness](#) who are not severely immunocompromised, isolation can end when:

- At least 10 days have passed *since symptoms first appeared* **and**
- At least 24 hours have passed *since last fever* without the use of fever-reducing medications **and**
- Symptoms (e.g., cough, shortness of breath) have improved

Patients with a positive COVID-19 test result who never developed symptoms may discontinue isolation 10 days after the date of their first positive RT-PCR test for SARS-CoV-2 RNA.

Only patients with severe COVID-19 illness may need isolation for up to 20 days after symptom onset due to the longer duration of infectiousness.

Per CDC guidelines, in general, a test-based strategy is no longer recommended to determining the end of isolation. However, in some instances, a test-based strategy could be considered for discontinuing isolation earlier than if the symptom-based strategy were used. However, many individuals will have prolonged viral shedding, limiting the utility of this approach. A test-based strategy could also be considered for some patients (e.g., those who are severely immunocompromised) in consultation with local infectious diseases experts if concerns exist for the patient being infectious for more than 20 days.

The criteria for the test-based strategy are:

Patients who are symptomatic:

- Resolution of fever without the use of fever-reducing medications **and**
- Symptoms (e.g., cough, shortness of breath) have improved, **and**
- Results are negative from at least two consecutive respiratory specimens collected  $\geq 24$  hours apart (total of two negative specimens) tested using an FDA-authorized molecular viral assay to detect SARS-CoV-2 RNA.

Patients who are not symptomatic:

- Results are negative from at least two consecutive respiratory specimens collected  $\geq 24$  hours apart (total

of two negative specimens) tested using an FDA-authorized molecular viral assay to detect SARS-CoV-2 RNA.

If in doubt, contact your local Department of Public Health.

## Staff Use of PPE

Residential treatment programs should establish protocols about proper use of personal protective equipment (PPE). In situations in which PPE is limited, plans for use should be created with the help of knowledgeable medical professionals.

Staff should wear a facemask at all times while they are in the facility.

- a. When available, facemasks are generally preferred over cloth face coverings for staff as facemasks offer both source control and protection for the wearer against exposure to splashes and sprays of infectious material from others.
- b. [Guidance on extended use and reuse of facemasks](#) is available. **Cloth face coverings should NOT be worn by staff instead of a respirator or facemask if PPE is required.**
- c. Masks with exhalation valves or vents should not be used as they do not provide adequate source control for respiratory droplets.

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

- **Respirator or Facemask covering nose and mouth**
- **Eye Protection** (i.e., a disposable face shield that covers the front and sides of the face; goggles are no longer recommended by the CDC)
- **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.

For more information:

- 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.
- See the CDC's [guidance on optimizing supplies of PPE](#)

## Managing Staff with COVID-19 Symptoms

Personnel who develop symptoms (e.g., fever > 100.0 F, cough, shortness of breath, runny nose or nasal congestion (different from usual allergies), new loss of smell or taste, headache, nausea, vomiting, or diarrhea) 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 symptoms consistent with COVID-19, the local public health authority should be

contacted and the staff member should be tested for COVID-19 (medical providers should be able to order tests); refer to state guidance for specifics on testing availability. 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 (HCPs) 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/isolation for staff members suspected or confirmed of having COVID-19 should be ended by a physician per current [CDC guidelines](#). Briefly,

- HCP who are **not severely immunocompromised** and were **asymptomatic** throughout their infection may return to work when at least 10 days have passed since the date of their first positive viral diagnostic test.
- Staff members with mild to moderate illness, or who were never tested, and who are not severely immunocompromised, may return to work when:
  - At least 10 days have passed *since symptoms first appeared* **and**
  - At least 24 hours have passed *since last fever* without the use of fever-reducing medications **and**
  - Symptoms (e.g., cough, shortness of breath) have improved
- Staff members with [severe to critical illness](#) or who are severely immunocompromised, may return to work if:
  - At least 20 days have passed *since symptoms first appeared*
  - At least 24 hours have passed *since last fever* without the use of fever-reducing medications **and**
  - Symptoms (e.g., cough, shortness of breath) have improved
  - Staff who are **severely immunocompromised** but who were **asymptomatic** throughout their infection may return to work when at least 20 days have passed since the date of their first positive viral diagnostic test.

In some instances, a test-based strategy could be considered to allow staff members to return to work earlier than if the symptom-based strategy were used. However, many individuals will have prolonged viral shedding, limiting the utility of this approach. A test-based strategy could also be considered for some staff members (e.g., those who are severely immunocompromised) in consultation with local infectious diseases experts if concerns exist for the staff member being infectious for more than 20 days.

After returning to work, HCP should:

- Continue wearing a medical-grade facemask at all times while in the facility
- Self-monitor for symptoms, and seek re-evaluation from occupational health or their primary care provider if symptoms recur or worsen

For staff members quarantined/isolated 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>

## 6. 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 testing
- 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:

- 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, masking, 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 symptoms (see [New Patients: Screening upon arrival](#) section) upon entry to the facility. If any symptoms are present, visitor should not be allowed entry into the facility.

- All visitors should wear a cloth face covering at all times while in 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 visitors to restricting all visitors to the facility.

## Facility Cleaning and Precautions

Clean high-touch surfaces 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, chair arm rests, 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).
- Avoid the use of methanol-containing hand sanitizers due to [warnings](#) about poisoning and harm if ingested.
- 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 that does not contain methanol, 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 wear facemasks (make sure to cover nose and mouth), 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.

For more information, see the [CDC's Clinical Preparedness Recommendations](#) and additional information for [good hygiene practices](#).

## 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. Methanol-containing hand sanitizers should be avoided as these products can be life-threatening if ingested.
2. Additionally, exposure on the skin from alcohol-based hand-sanitizers, particularly with the frequency demanded by this emergency, has been shown to create positive testing with some tests of alcohol metabolites (particularly EtG). 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% ethyl alcohol, is a less preferable alternative. Avoid methanol-containing hand sanitizers. (see FDA: <https://www.fda.gov/drugs/drug-safety-and-availability/fda-updates-hand-sanitizers-consumers-should-not-use#products>)

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.

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 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
  - Minimize 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
  - Minimize 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.

## 7. General Resources

- Updated definition of "close contact" by the CDC: <https://www.cdc.gov/coronavirus/2019-ncov/php/contact-tracing/contact-tracing-plan/appendix.html#contact>
- 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>
- Discontinuation of Transmission-Based Precautions and Disposition of Patients with COVID-19 in Healthcare Settings <http://www.cdc.gov/coronavirus/2019-ncov/hcp/disposition-hospitalized-patients.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>
- CDC testing fact sheet for Health care providers: <https://www.fda.gov/media/134920/download>
- 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>
  - a. 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>

