NATIONAL COUNCIL
FOR BEHAVIORAL HEALTH

COVID-19
GUIDANCE

FOR BEHAVIORAL HEALTH
RESIDENTIAL FACILITIES

Updated
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Note: Some URLs may have changed since the most recent publication date of this document. Please check the CDC website at **www.cdc.gov/coronavirus/2019-ncov** if you encounter broken links.

SUMMARY

Guidance for infection control and prevention of COVID-19. This additional guidance to behavioral health residential facilities will help them improve infection control and prevention practices to prevent the transmission of COVID-19, including guidance for visitation.

Coordination with the Centers for Disease Control (CDC) and state, tribal, local and territorial public health agencies/departments. We encourage all behavioral health residential facilities to monitor the CDC website at **www.cdc.gov/corona-virus/2019-ncov** for information and resources and to contact their state, tribal, local and territorial public health agencies/departments, mental health and substance use, and human services agencies and regulatory bodies for local guidance and more localized up-to-date-alerts and recommendations.[1]

Remain committed to taking critical steps to ensure America's health care facilities and clinical laboratories are prepared to respond to the threat of COVID-19. The Department of Homeland Security (DHS) has classified community mental health centers, psychiatric residential facilities, federally qualified health centers and their staff, including those who provide social services and facilitate access to behavioral health services as "Essential Critical Infrastructure Workers."[2]

BACKGROUND

COVID-19 is a new type of coronavirus. Until late 2019, this type of coronavirus was not seen in humans. The virus is thought to first infect the tissue inside the nose or the throat, then it can spread lower down into the lungs. In most cases, the illness is mild or moderate and most people recover. However, some people, particularly those over 50-years-old with medical problems, such as asthma or diabetes or who smoke tobacco or e-cigarettes, may become very ill and require emergency hospitalization.[3]
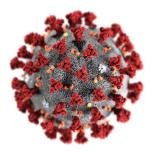
COVID-19 infection spreads between people who are in close contact with one another (within approximately 6 feet) through respiratory droplets formed when an infected person coughs or

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[1] Centers for Disease Control and Prevention. "Resources for Clinics and Healthcare Facilities," Coronavirus Disease 2019 (COVID-19). Last reviewed March 16, 2020. https://www.cdc.gov/coronavirus/2019-ncov/healthcare-facilities/index.html.
[2] Krebs, Christopher. "Guidance on the Essential Critical Infrastructure Workforce," United States Department for Homeland Security. Published March 19, 2020. https://www.cisa.gov/publication/guidance-essential-critical-infrastructure-workforce#download.
[3] Centers for Disease Control and Prevention. "About Coronavirus Disease 2019 (COVID-19)." Coronavirus Disease 2019 (COVID-19). Last reviewed February 24, 2020. https://www.cdc.gov/coronavirus/2019-ncov/about/index.html.

sneezes. The infection may also spread when individuals touch contaminated surfaces and then touch their face, but this is thought to be a less common form of infection than breathing in infected droplets in the air.[4] Covering coughs and sneezes with a sleeve or tissue, washing hands frequently with water and soap for 20 seconds or using an alcohol-based hand sanitizer and avoiding touching one's face are critical to protecting oneself and others.

The main symptoms of the infection are a fever of more than 100.4°F, a new cough within the last seven days, shortness of breath or a new sore throat within the last seven days. Behavioral health residential facilities are responsible for ensuring the health and safety of their residents and staff by implementing the standards required to help each resident attain or maintain their highest level of well-being. This guidance is provided in light of the recent spread of COVID-19 to facilities where individuals with mental illness and/or substance use disorders reside to help control and prevent the spread of the virus.

GUIDANCE

Facility staff should regularly monitor the CDC website for information and resources. Facilities should also maintain regular contact with their state regulatory bodies and health authorities, including state, tribal, local and territorial public health agencies/departments, departments of mental health and substance use, and social services departments. Regulations and guidance vary by locality, so it is important to follow the specific guidance provided by state, tribal, local and territorial public health agencies/departments.

In certain circumstances, guidance may not specifically be available for behavioral health residential facilities. Early federal guidelines in response to COVID-19 were developed specifically for residential nursing facilities. In jurisdictions where specific guidance is not available, guidance pertaining to residential nursing facilities could be adapted to meet the unique circumstances and resources available in behavioral health residential facilities. Behavioral health residential facilities should strive to meet the intent of these standards with the resources they have available and consistent with the unique clinical needs of the population they serve.

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[4] Centers for Disease Control and Prevention. "How COVID-19 Spreads." Coronavirus Disease 2019 (COVID-2019). Last reviewed March 4, 2020. https://www.cdc.gov/coronavirus/2019-ncov/prepare/transmission.html.

ENGAGE STATE, TRIBAL, LOCAL AND TERRITORIAL PUBLIC HEALTH AGENCIES/DEPARTMENTS

- Behavioral health residential facilities should contact their state, tribal, local and territorial public health agencies/departments and emergency operations centers/incident command structures to make them aware of their residential facilities, size, population served and any other unique characteristics that might increase risk of contraction and/or transmission of COVID-19, such as resource and supply shortages. Currently, there is a strong focus on nursing homes, clinics and hospital care settings; therefore, making state, tribal, local and territorial public health agencies/ departments aware of additional care facilities is critical for emergency planning purposes and future support around supplies and resources. This may be challenging due to high call volumes to public health departments, but is critical to planning and support. To search for local health departments in your area, or find up-to-date contact information please visit the National Association of County and City Health Officials (NACCHO) **Directory of Local Health Departments**.

- If behavioral health residential facilities have questions or suspect a resident of a behavioral health residential facility has COVID-19, they should immediately contact their local and/or state health department. Per the Centers for Medicare and Medicaid Services (CMS) guidance,[5] prompt detection, triage and isolation of potentially infectious residents are essential to prevent unnecessary exposures among residents, health care personnel and visitors at the facility. Therefore, facilities should continue to be vigilant in identifying any possible infected individuals. Be aware that criteria for COVID-19 testing will vary locally depending on the prevalence of people diagnosed with COVID-19 and availability of testing kits.

- Behavioral health residential facilities should consider frequent monitoring for potential symptoms of respiratory infection, as needed throughout the day. Facilities experiencing an increased number of respiratory illnesses, regardless of suspected etiology, among patients/ residents or health care personnel should immediately contact their state, tribal, local and territorial public health agencies/departments for further guidance. Depending on the type and layout of each residential facility, an isolation room or area should be designated for any individuals believed to be infected, this can include an individual's private room.

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[5] Centers for Medicare and Medicaid Services. "Guidance for Infection Control and Prevention of Coronavirus Disease 2019 (COVID-19) in Nursing Homes." Center for Clinical Standards and Quality/Quality, Safety & Oversight Group. Published on March 12, 2020. https://www.cms.gov/files/document/qso-20-14-nh-revised.pdf.

- We encourage facilities to take advantage of resources made available by CDC and CMS to train and prepare staff to improve infection control and prevention practices.

- Facilities should maintain a person-centered approach to care. This includes communicating effectively with residents and staff, resident representatives and/or their family members and understanding residents' needs and goals of care.

GUIDANCE FOR LIMITING THE TRANSMISSION OF COVID-19 FOR BEHAVIORAL HEALTH RESIDENTIAL FACILITIES

Guidance for Infection Control and Prevention of Coronavirus Disease 2019 (COVID-19) in Nursing Homes (REVISED), **CMS** (March 13, 2020)

Guidance for NYS Behavioral Health Programs, New York State Office of Mental Health (March 11, 2020)
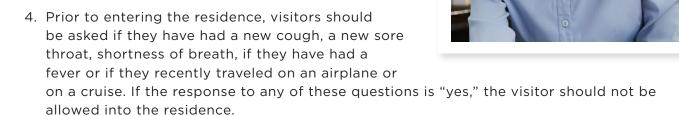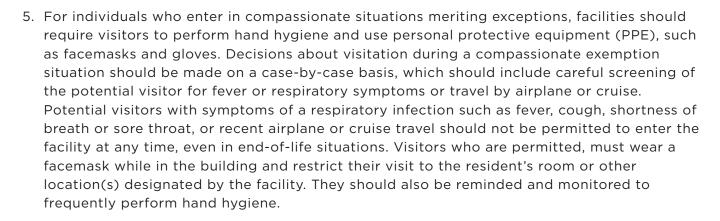
GENERAL GUIDANCE
FOR RESIDENTIAL PROGRAMS

Behavioral residential facilities should consider the following additional efforts to protect clients and staff in these programs:

1. Facilities should post educational information from trusted health sources throughout the building, including signage on how to properly wash your hands, signs and symptoms of early detection and outdoor signage to halt visitors or inform health care workers of access restrictions. Tools can be found on the **CDC website**.

2. Clients should be educated to stay in the residence as much as possible. If they do go out, they should keep a distance of at least 6 feet away from anyone else, including relatives who do not live in the residence, and avoid touching their faces. Programs should cancel all planned social or recreational outings. Upon returning home, they should immediately wash their hands with soap and water for at least 20 seconds or use an alcohol-based hand sanitizer. Cell phones and other frequently handled items should be sanitized daily.

3. Facilities should restrict visitation of all nonresidents (visitors and non-essential health care personnel) unless it is deemed necessary to directly support a resident's health and wellness

or for certain compassionate care situations, such as young children in residential treatment or end-of-life care. In those cases, visitors should be limited to only a specific room. Facilities are expected to notify potential visitors to defer visitation until further notice through the facilities' websites, door signage, calls to family members, letters, etc. Note: If a state implements actions that exceed CMS requirements, such as a ban on all visitation through a governor's executive order, a facility would not be out of compliance with CMS' requirements.

4. Prior to entering the residence, visitors should be asked if they have had a new cough, a new sore throat, shortness of breath, if they have had a fever or if they recently traveled on an airplane or on a cruise. If the response to any of these questions is "yes," the visitor should not be allowed into the residence.

5. For individuals who enter in compassionate situations meriting exceptions, facilities should require visitors to perform hand hygiene and use personal protective equipment (PPE), such as facemasks and gloves. Decisions about visitation during a compassionate exemption situation should be made on a case-by-case basis, which should include careful screening of the potential visitor for fever or respiratory symptoms or travel by airplane or cruise. Potential visitors with symptoms of a respiratory infection such as fever, cough, shortness of breath or sore throat, or recent airplane or cruise travel should not be permitted to enter the facility at any time, even in end-of-life situations. Visitors who are permitted, must wear a facemask while in the building and restrict their visit to the resident's room or other location(s) designated by the facility. They should also be reminded and monitored to frequently perform hand hygiene.

▶ EXCEPTIONS TO RESTRICTIONS

- **Health care workers**: Facilities should follow CDC guidelines for restricting access to health care workers. This also applies to other behavioral health care workers, such as psychiatrists, therapists, peer workers, techs, recreational therapists, etc., who provide care to residents. They should be permitted to enter a facility as long as they meet the CDC guidelines for health care workers. Facilities should contact their local health department with questions and frequently review the CDC website dedicated to COVID-19 for health care professionals.[6] Behavioral health residential facilities should review CDC

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[6] Centers for Disease Control and Prevention. "Information for Healthcare Professionals." Coronavirus Disease 2019 (COVID-19). Last reviewed March 20, 2020. https://www.cdc.gov/coronavirus/2019-nCoV/hcp/index.html.

guidance for general health care workers and adapt them as necessary to be consistent with the resources and needs of their behavioral health residential care treatment staff and patients.

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

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

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

- Creating/increasing listserv communication to update families, such as advising that they not visit.

- Assigning staff as primary contact for families for inbound calls and conduct regular out bound calls to keep families up-to-date.

- Offering a phone line with a voice recording updated at set times (for example, daily) with the facility's general operating status, such as when it is safe to resume visits.

7. When visitation is necessary or allowable, facilities should make efforts to allow safe visitation for residents and loved ones. For example:

- Suggest refraining from physical contact with residents and others while in the facility and practice social distances with no handshaking or hugging, while remaining 6 feet apart.

- If possible (for example, pending design of building), create dedicated visiting areas, like "clean rooms," near the entrance to the facility where residents can meet with visitors in a sanitized environment. Facilities should disinfect rooms after each resident-visitor meeting. According to the CDC, routine cleaning and disinfection procedures are appropriate for COVID-19 in health care settings, including those patient-care areas in which aerosol-generating procedures are performed.[7] Products with Environmental Protection Agency (EPA)-approved emerging viral pathogens claims are recommended for use against COVID-19. Management of laundry, food service utensils and medical waste should also be performed in accordance with routine procedures.

- If your program is CMS certified, residents still have the right to access the ombudsman program. Ombudsman access should be restricted per the guidance previously provided, except in compassionate care situations; however, facilities may review this on a case-by-

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[7] Centers for Disease Control and Prevention. "Interim Infection Prevention and Control Recommendations for Patients with Suspected or Confirmed Coronavirus Disease 2019 (COVID-19) in Healthcare Settings." Coronavirus Disease 2019 (COVID-19). Last reviewed March 19, 2020. https://www.cdc.gov/coronavirus/2019-ncov/infection-control/control-recommendations.html.

case basis. If in-person access is not available due to infection control concerns, facilities need to facilitate resident communication by phone or other format with the ombudsman program or any other entity listed in Resident Rights 42 CFR § 483.10(f)(4)(i).[8]

8. Implement active screening and monitoring of residents and staff for fever and respiratory symptoms. Advise employees to check for any signs of illness before reporting to work each day and notify their supervisor if they become ill. Facilities may consider screening staff for fever or respiratory symptoms before entering the facility; when doing so, actively take their temperature and document absence of shortness of breath, new or change in cough and sore throat. If they are ill, have them put on a facemask and self-isolate at home. Staff members should stay home if they are sick. Staff members who have had direct contact with individuals who tested positive for COVID-19 or who are designated a person under investigation (PUI) should self-quarantine for 14 days and not come to the residential program. If, after 14 days following the last contact, they have not developed symptoms, they may return to work. It is not necessary for contacts of contacts to self-quarantine.

   Note: The CDC and state health departments have issued **guidelines for health care workers** who have tested positive or who have been in contact with a COVID-19 positive person, which include less stringent quarantine and return to work criteria for workers in times of shortage. These guidelines should be considered if the program experiences significant staff shortages.

9. Clients and staff should be instructed to report symptoms as soon as possible.

10. Facilities should identify staff that work at multiple facilities, including agency staff, regional or corporate staff, etc., and actively screen and restrict them appropriately to ensure they do not place individuals in the facility at risk for COVID-19.

11. Facilities should review and revise how they interact with vendors and receive supplies, agency staff, emergency medical services (EMS) personnel and equipment, transportation providers taking residents to offsite appointments, etc. and other non-health care providers, including food delivery, etc., and take necessary actions to prevent any potential transmission. For example, do not have supply vendors transport supplies inside the facility; supplies should be dropped off at a dedicated location, like a loading dock. Facilities should ensure, to the

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[8] Centers for Medicare and Medicaid Services. "438.10 Resident rights." Published January 2, 2012. https://www.govinfo.gov/content/pkg/CFR-2011-title42-vol5/pdf/CFR-2011-title42-vol5-sec483-10.pdf.

extent possible, proper food supply, maintaining two to three weeks of food and storing additional non-perishable foods appropriately. Facilities can allow entry of these delivery visitors if needed, as long as they follow appropriate CDC guidelines for transmission-based precautions. All nonessential vendors such as salespeople and drug representatives should be prohibited.

12. Behavioral health residential facilities are advised to increase maintenance standards at all public access points throughout the facility as well as all other programs under your agency.

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

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

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

15. In shared bedrooms for individuals who have not developed symptoms, ensure that beds are at least 6 feet apart when possible and require that clients sleep head-to-toe.
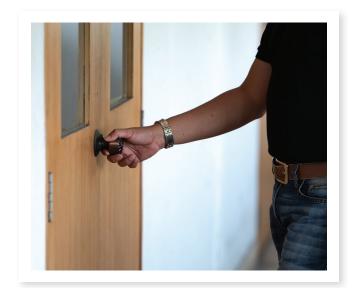
GUIDANCE
ON ACCEPTING NEW CLIENTS

1. Residential programs should continue accepting new client referrals. It is important for clients with behavioral health and substance use conditions to find homes even during this crisis.

2. People with potential exposure to COVID-19 who are asymptomatic and have not tested positive for the virus should be accepted for admission consistent with your facility's pre-existing admission criteria and protocols. No additional precautions beyond those discussed above are indicated or necessary.

3. Programs should request referring facilities to attest that the client has not had any new symptoms consistent with COVID-19 infections.

4. Given the limitations in testing, it is not possible for programs to require a negative COVID-19 test as a condition of admission.

5. For the first 14 days after an individual arrives at the program, they should wear a mask, if masks are available. If possible, they should have their own room.

6. When masks are not available, new clients should remain in their room as much as possible during the first 14 days and maintain 6 feet distance from all other clients and staff.

7. A behavioral health residential facility can accept a resident diagnosed with COVID-19 under transmission-based precautions for COVID-19 as long as the facility can follow CDC guidance for transmission-based precautions. If a behavioral health residential facility cannot follow CDC guidance for transmission-based precautions,[9] it must wait until these precaution requirements are discontinued. CDC has released Discontinuation of Transmission-Based Precautions and Disposition of Patients with COVID-19 in Healthcare Settings (Interim Guidance).[10] Information on the duration of infectivity is limited and the interim guidance has been developed with available information from similar coronaviruses. CDC states that

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[9] Centers for Disease Control and Prevention. "Transmission-Based Precautions." Infection Control. Last reviewed January 7, 2016. https://www.cdc.gov/infectioncontrol/basics/transmission-based-precautions.html.
[10] Centers for Disease Control and Prevention. "Discontinuation of Transmission-Based Precautions and Disposition of Patients with COVID-19 in Healthcare Settings (Interim Guidance)." Coronavirus Disease 2019 (COVID-19). Last reviewed March 23, 2020. https://www.cdc.gov/coronavirus/2019-ncov/hcp/disposition-hospitalized-patients.html.

decisions to discontinue transmission-based precautions in hospitals will be made on a case-by-case basis in consultation with clinicians, infection prevention and control specialists, and public health officials. Discontinuation will be based on multiple factors.

▶ **OTHER CONSIDERATIONS FOR FACILITIES:**

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

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

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

- Increase signage for vigilant infection prevention, such as hand hygiene and cough etiquette.

GUIDANCE
ON HOW TO RESPOND IF CLIENT DEVELOPS SYMPTOMS

1. If a client in the residential program develops symptoms that could indicate a COVID-19 infection, the client should be asked to stay in their single room or in the designated isolation room/area if a single room is not available. Exposed roommates should, if possible, also have their own rooms for 14 days and if they remain symptom-free, can then share a room with others. The client should be asked to wear a mask. Meals and medication should be taken in the room.

2. The program administrator (or provider) should immediately contact their local health department for information on how to proceed with testing. Refer to the NACCHO directory to find your local health department. If the client is critically ill and is having difficulty breathing, it may be necessary to transport the client by ambulance to the hospital, if this is necessary alert the responding EMS to the client's condition. Local health departments may have made provisions for alternate housing arrangements for positive individuals, although this will depend on each jurisdiction.

3. Residents infected with COVID-19 may vary in severity from lack of symptoms to mild or severe symptoms. Most individuals who test positive for COVID-19 will never need to be

hospitalized. Hospitalization is only necessary if the individual has difficulty breathing or otherwise appears critically ill. If the client is not critically ill, they should stay in their room. It is important to reduce unnecessary visits to hospital emergency departments to help reduce the spread of COVID-19. Initially, symptoms may be mild and not require transfer to a hospital as long as the facility can follow the infection prevention and control practices recommended by CDC. Facilities without an airborne infection isolation room (AIIR) are not required to transfer the resident assuming: 1) the resident does not require a higher level of care and 2) the facility can adhere to the rest of the infection prevention and control practices recommended for caring for a resident with COVID-19. Please check the CDC infection control guidelines regularly for critical updates, such as updates to guidance for using PPE.

4. The resident may develop more severe symptoms and require transfer to a hospital for a higher level of care. Prior to transfer, EMS and the receiving facility should be alerted to the resident's diagnosis and condition and transmission-based precautions that should be followed, including placing a facemask on the resident during transfer. If the resident does not require hospitalization, they can be discharged to home (in consultation with state, tribal, local and territorial public health agencies/departments) if deemed medically and socially appropriate. For behavioral health residential facilities, the resident's care team (case manage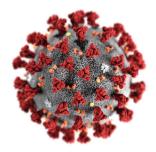r, psychiatrist, therapist) should be consulted. Pending transfer or discharge, place a facemask on the resident and isolate them in a room with the door closed.

5. Room sharing might be necessary if there are multiple residents with known or suspected COVID-19 in the facility. As roommates of symptomatic residents might already be exposed, it is generally not recommended to separate them in this way. Public health authorities can assist with decisions about resident placement.

6. Program staff should work with the resident's mental health or primary care provider to secure enough nicotine replacement therapy (NRT) to help eliminate nicotine withdrawal and the desire to leave their room to smoke.

7. Other residents who are over 50 years old, have significant respiratory comorbidity or who smoke should wear masks, increase frequency of hand hygiene practices and refrain from using common areas such as kitchens and lounges. All residents should maintain at least 6 feet distance from other clients and staff.

8. Staff members and family care providers should wear masks and increase frequency of hand hygiene practices. If masks are not available, staff should, whenever possible, remain 6 feet away from positive or potentially positive individuals.

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

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

11. In programs with one bathroom, it is even more critical to attempt to clean surfaces after residents who are PUI or tested positive use the facility. If possible, after a PUI or person who tested positive takes a shower, other residents should avoid using that bathroom for three hours. Ventilation fans should remain on and windows should remain open during that time.

12. In programs with only one bathroom, all clients and staff should use masks while in the bathroom. If possible, stagger shower times, ensuring that bathroom ventilation fans run for at least 20 minutes between all showers and leave window open to facilitate clearing of droplets.

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

14. Residents who test positive or who are PUI should not use shared spaces such as kitchens, common areas and so forth. Arrangements will need to be made to change existing house routines that require clients to use common spaces.

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

GUIDANCE

FOR HANDLING CLIENTS RETURNING FROM THE HOSPITAL

1. Residential program or family care clients are admitted to psychiatric or medical hospitals for a variety of reasons. During the COVID-19 crisis, it is possible that these clients are exposed to the virus while in the hospital.

2. Most individuals who become very ill with COVID-19 and require hospitalization will recover and must be discharged once they are no longer ill enough to warrant an ongoing medical admission, though they may still have mild COVID-19 symptoms.

3. Clients in these categories will need to come home to their residential program or family care home after being discharged from the hospital. It is important that staff help manage not only the individual resident's fears, but also the anxieties of all the other housemates.

4. Behavioral health residential facilities should admit any individuals they would normally admit to their facility, including individuals from hospitals where a case of COVID-19 was or is present, following CDC transmission-based precautions guidance. Also, if possible, use the most isolated room possible for residents coming from or returning from the hospital. This room/area should have easy access to a sink for handwashing. This can serve as a step-down unit where the resident remains for 14 days with no symptoms.

GUIDANCE

FOR HEALTH CARE PERSONNEL RETURN TO WORK

For behavioral health residential facility staff with confirmed COVID-19 or who have suspected COVID-19 and demonstrate symptoms of a respiratory infection like cough, sore throat, shortness of breath or fever, but did not get tested for COVID-19, decisions about return to work for staff with confirmed or suspected COVID-19 should be made in the context of local circumstances. Options include a test-based strategy or a non-test-based strategy like time-since-illness-onset and time-since-recovery strategy. The CDC provides **Criteria for Return to Work for Healthcare Personnel** for these decisions. Behavioral health residential facilities should use these strategies to determine when staff may return to work in health care settings.

1. Test-based strategy: Facilities should exclude staff from work if they've tested positive for COVID-19, until resolution of fever without the use of fever reducing medications and improvement in respiratory symptoms, including cough, shortness of breath and negative results of an FDA Emergency Use Authorized molecular assay for COVID-19 from at least two consecutive nasopharyngeal swab specimens collected ≥24 hours apart (total of two negative specimens).

2. Non-test-based strategy. Facilities should exclude staff from work until at least 3 days (72 hours) have passed since recovery defined as resolution of fever without the use of fever-reducing medications and improvement in respiratory symptoms like cough and shortness of breath and at least 7 days have passed since symptoms first appeared.

3. If staff were never tested for COVID-19 but have an alternate diagnosis, for example tested positive for influenza, criteria for return to work should be based on that diagnosis.

   ▶ **RETURN TO WORK PRACTICE AND WORK RESTRICTIONS**

   After returning to work, staff should:

   1. Wear a facemask at all times while in the behavioral health facility until all symptoms completely resolve or until 14 days after illness onset, whichever is longer.

   2. Be restricted from contact with severely immunocompromised patients until 14 days after illness onset.

   3. Adhere to hand hygiene, respiratory hygiene and cough etiquette in **CDC's interim infection control guidance**, including covering nose and mouth when coughing or sneezing, disposing of tissues in waste receptacles, etc.

   4. Self-monitor for symptoms and seek re-evaluation from occupational health or primary health care provider if respiratory symptoms recur or worsen.[11]

   ▶ **CRISIS STRATEGIES TO MITIGATE STAFFING SHORTAGES**

   Behavioral health residential facilities might determine that the recommended approaches cannot be followed due to the need to mitigate staffing shortages. In such scenarios:

   1. Evaluate staff by occupational health, to the extent possible, to determine appropriateness of earlier return to work than recommended. If occupational health is not available, the staff should be evaluated by their primary health care provider.

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[11] Centers for Disease Control and Prevention. "Criteria for Return to Work for Healthcare Personnel with Confirmed or Suspected COVID-19 (Interim Guidance)." Coronavirus Disease 2019 (COVID-19). Last reviewed March 16, 2020. https://www.cdc.gov/coronavirus/2019-ncov/healthcare-facilities/hcp-return-work.html.

2. If staff return to work earlier than recommended, they should still adhere to the Return to Work Practices and Work Restrictions recommendations. For more information, see **CDC's Interim U.S. Guidance for Risk Assessment and Public Health Management of Healthcare Personnel with Potential Exposure in a Healthcare Setting to Patients with COVID-19**.

3. Behavioral health residential facilities should create contingency plans for potential staffing shortage given that these facilities cannot rely on telework. Absenteeism should be monitored daily to make quick decisions to ensure appropriate staffing levels, which might include extending hours, cross-training current employees or hiring temporary workers.[12]

FREQUENTLY ASKED QUESTIONS

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

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

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[12] Glasser, Nathaniel, et al. "Health Care Employers: How to Prepare for the Impact of COVID-19 on Your Workforce." The National Law Review. Published March 17, 2020. https://www.natlawreview.com/article/health-care-employers-how-to-prepare-impact-covid-19-your-workforce

What other resources are available for facilities to help improve infection control and prevention?

CMS urges providers to take advantage of several resources that are available:

CDC RESOURCES

Infection preventionist training: https://www.cdc.gov/longtermcare/index.html

CDC resources for health care facilities: https://www.cdc.gov/coronavirus/2019-ncov/healthcare-facilities/index.html

CDC updates: https://www.cdc.gov/coronavirus/2019-ncov/whats-new-all.html

CDC FAQ for COVID-19: https://www.cdc.gov/coronavirus/2019-ncov/infection-control/infection-prevention-control-faq.html

Information on affected U.S. locations: https://www.cdc.gov/coronavirus/2019-ncov/cases-updates/cases-in-us.html

CMS RESOURCES

Guidance for use of Certain Industrial Respirators by Health Care Personnel: https://www.cms.gov/files/document/qso-20-17-all.pdf

Long-term care facility — infection control self-assessment worksheet: https://qsep.cms.gov/data/252/A._NursingHome_InfectionControl_Worksheet11-8-19508.pdf

Infection control toolkit for bedside licensed nurses and nurse aides (Head to Toe Infection Prevention (H2T) Toolkit): https://www.cms.gov/Medicare/ProviderEnrollment-and-Certification/SurveyCertificationGenInfo/LTC-CMP-Reinvestment

Infection Control and Prevention regulations and guidance: 42 CFR 483.80, Appendix PP of the State Operations Manual. See F-tag 880: https://www.ecfr.gov/cgi-bin/retrieveECFR?gp=&SID=9d33bb66d-f5053836681241e73a3136e&mc=true&r=PART&n=pt42.5.483#se42.5.483_180

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

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