Maryland
DEPARTMENT OF HEALTH

Guidance for ASAM Residential SUD Treatment Providers
During the COVID-19 Outbreak

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This document is being provided by the Maryland Department of Health (MDH) Behavioral Health Administration (BHA) as a guidance tool for American Society of Addiction Medicine (ASAM) Residential Substance Use Disorder (SUD) treatment in response to the Coronavirus Disease 2019 (COVID-19). This communication is to provide guidance on what is currently known about COVID-19 based on information shared from the Centers for Disease Control and Prevention (CDC), the Substance Abuse and Mental Health Administration (SAMHSA), and the American Society of Addiction Medicine (ASAM).

Information and updates are rapidly changing, therefore, please check for updates available on the MDH, CDC, SAMHSA, and ASAM websites. If you have a behavioral health question related to COVID-19 that has not been addressed, please submit it here. For additional questions or concerns, contact your Local Behavioral Health Authority (LBHA).

Phases of COVID-19

During this pandemic, substance use disorder residential treatment providers and clinicians should consider that communities are likely to experience three phases: (1) an early phase with low prevalence; (2) a later phase with rapidly spreading virus transmission during which new cases will peak, and then begin to fall as the population prevalence of prior exposure increases; and (3) a final post-pandemic phase when either the properties of the virus, a vaccine, high levels of community immunity, or other factors bring the spread of the virus under control.

Considerations for each phase may be as follows:

1. **Early phase**: During this early phase, programs shall be implementing screening protocols, social distancing, enhanced facility cleaning and other steps to prevent transmission of the virus in their facilities. Programs should also be using this time to actively plan for the next phase of the pandemic.

2. **Peak transmission**: During this phase, it may be necessary to designate entire treatment programs as well as community housing locations to either infectious or non-infectious persons. It is imperative that programs actively work with their local behavioral health

authorities (LBHA), local health departments (LHD), and other service providers throughout their community to plan for this pandemic phase.

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

Policies and Practices for Consideration During COVID-19

Residential SUD Treatment Programs serve individuals that may not be able to meet the general recommendations around COVID-19. Suggested policies and procedures for residential programs to best protect its patients and staff are in the following areas:

POLICY I: CONTROL THE POPULATION SIZE

Utilize Telehealth

Utilization of telehealth visits are strongly recommended. BHA has provided guidance on telehealth procedures, which you can find on the BHA COVID-19 webpage. If a patient cannot safely be treated in a less intensive level of care and the program has the capacity to isolate the patient in accordance with the CDC's Transmission-Based Precautions, the program may consider treating the patient in their residential treatment program, unless referral to a hospital is needed.

Triage Admission Based Upon Patient's Need for Residential or Inpatient Care

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: (1) those with housing, but who need or could benefit from more intensive care than outpatient treatment; (2) those who are unhoused and require shelter in order to engage in any treatment; and (3) those who have urgent SUD-related medical needs.

1. **Patients with stable housing outside of residential treatment**: For patients who have safe, stable, substance free housing, and do not require urgent or immediate medical

monitoring or management, providers should evaluate individuals for amenability for a lower level of care, such as IOP or OP SUD treatment services.

2. **Patients without stable housing or who may be homeless**: When patients lack housing and require shelter in order to engage in any level of treatment, programs may need to work with local and state resources to identify housing opportunities as they change during each phase of the pandemic. Organizations which may be helpful to engage include community housing programs, local public health departments, and hospital and health care systems.

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

SAMHSA has provided guidance for patients seeking treatment or who are already in treatment in a residential treatment facility, that they should be evaluated for referral to a Level 1 or 2 program (outpatient-OP; intensive outpatient-IOP), and partial hospital programs (PHP).

Restrict Visitation

- Areas that are experiencing community spread should not allow visitors, except under limited circumstances.
- Other areas should consider limits to visitation to either no visitors or one per resident when necessary. If visitors are permitted, they should be screened prior to entry and the visit should be deferred if they screen positive (see below).

POLICY II: SCREEN FOR COVID-19 SYMPTOMS

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

New Patients—Phone Screening Before Arrival

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

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

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

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

If the patient reports emergency warning signs including difficulty breathing/shortness of breath, inability to walk without taking a break to catch their breath, persistent pain/pressure in the chest, new confusion/sedation, bluish lips or face, or inability to eat or drink, advise them to call 911 and inform them that COVID-19 is suspected. A protocol should be established for this process. Referral for a 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 an incoming patient screens positive for risk of COVID-19 the program could consider multiple options based on their internal and community resources and the needs of the patient. For example:

- **If the patient could safely be treated in a virtual outpatient program and has a safe place to stay**: The residential program should work to actively engage the patient in that level of care.
- **If the patient could safely be treated in a virtual outpatient program, but does not have a safe place to stay**: The program should work with their local public health authority to try to identify a place where the patient can be isolated/quarantined that will enable them to engage in virtual treatment.
- **If the patient cannot safely be treated in a less intensive level of care**: If the program has the capacity to isolate the patient in accordance with the CDC's transmission-based precautions then the CDC's transmission-based guidelines should be followed.

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

As stated above for phone screenings, a medical evaluation may be recommended for lower temperatures (<100.4F) or other symptoms (e.g., muscle aches, nausea, vomiting, diarrhea, abdominal pain, headache, runny nose, fatigue) if recommended by public health authorities. An established testing algorithm (developed in conjunction with the program's medical director and/or in consultation with a medical provider or the public health authority) should be used to guide testing of patients in such situations. While there is some overlap in symptomatology between opioid withdrawal (and, possibly withdrawal from other substances) and COVID-19, the fever and distinct new shortness of breath and cough would be the most concerning symptoms. New arrivals should also be screened for any close contacts with individuals with confirmed COVID-19 or others who have symptoms of COVID-19 but have not yet been tested. See the "Managing Individuals who Screen Positive" section for additional guidance.

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

1. Where will the screening occur?
2. What areas of the facility will the prospective patient have access to (e.g., a screening area and a designated restroom)?
3. Who will conduct the screening and how will they minimize the risk of infection (e.g., Personal Protective Equipment (PPE), maintaining six feet of distance, physical barrier, etc.)? For example, screening could be done while the 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 period immediately upon arrival to provide time to gather more data about the health of a patient. See the National Council's COVID-19 Guidance for Behavioral Health Residential Facilities.

This may be especially useful in situations when the ability to gather data prior to or at admission is compromised. For example, when the patient is sufficiently impaired that history collection is not possible or when the patient has been in an environment where data collection may be limited and community spread extremely high (e.g., recently released from jail or prison).

Screening Current Patients

Patients should be screened daily for fever (subjective or confirmed >100.4F), new or worse cough, new or worse shortness of breath, sore throat, muscle aches, and generally feeling ill. Patients should also be encouraged to report any symptoms as soon as possible, including less common symptoms such as runny nose, nausea, diarrhea, etc. Any resident with respiratory symptoms should be placed immediately in a separate room behind a closed door and isolated until staff can evaluate the situation. If there are any concerning COVID-19 symptoms (fever, shortness of breath, worsening/new cough, sore throat, muscle aches), the patient should remain in isolation and a medical provider should be contacted to determine if the patient requires a telehealth or in person visit for diagnosis and management. The local public health department should also be contacted. The patient should be given a facemask and hand sanitizer (if available). If facemasks are not available, the patient should be given tissues and instructed to cough into them and dispose of them immediately after use. If symptoms are present but do not require immediate attention, the patient should be assessed for risk based on age (>65 years) and comorbidities (diabetes, hypertension, immunosuppressive drugs). If high risk factors are present, testing should be prioritized (through emergency rooms, primary care offices or drive-thru testing services (where available).

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. This guidance applies to residential treatment facilities as well.

Consider screening all staff and residents as they enter the facility. This should include screening for fever as well as questions about new or worsened cough, shortness of breath, muscle aches, and exposure to persons known to be infected or displaying symptoms. Staff should minimize personal belongings into the facility. Everyone entering or exiting the facility should be encouraged to wash or sanitize their hands at the entry/exit. Remind patients and staff to follow social distancing and hand hygiene best practices when offsite.

Residential programs should establish relationships with medical and psychiatric providers who have this capacity to provide services virtually through telehealth. 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.

For more information on remote/virtual assessments, visit this helpful infographic.

Screening Visitors

If the program is still permitting visitors, they should be screened for fever, cough, shortness of breath, sore throat, and muscle aches. They should also be screened for any close contacts with individuals with confirmed COVID-19 or others who have symptoms of COVID-19 but have not yet been tested. Visitors who screen positive based on these criteria should not be allowed to enter. The program should encourage virtual visitation as an alternative.

POLICY III: MINIMIZE CONTACT WITH POSITIVE INDIVIDUALS

Managing Patients Who Screen Positive or Are Awaiting Testing Results

The CDC has provided guidance on home care of people not requiring hospitalization.

Providers should consult with medical professionals and public health staff (local health departments) to evaluate whether a patient can be cared for at a facility. As stated above in the sections on screening, if a patient screens positive for COVID-19 symptoms, but does not have emergency warning signs his or her primary care provider should be contacted. If a patient screens positive for COVID-19 symptoms and shows emergency warning signs including difficulty breathing/shortness of breath, inability to walk without taking a break to catch their breath, persistent pain/pressure in the chest, new confusion/sedation, bluish lips or face, or inability to eat or drink, emergency medical services (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 health department should be contacted and he or she should be tested for COVID-19 (medical providers should be able to order tests); refer to state guidance for specifics on testing availability and criteria for priority testing. While waiting for test results the individual should remain isolated/quarantined. If any patient or staff member is suspected of having or tests positive for COVID-19, all other patients and staff members should be informed within two hours and provided with information on how the program is responding.

Beyond the immediate medical response, how to address new patients with symptoms consistent with COVID-19 presents a significant challenge. Programs are struggling with how to weigh the risks of COVID-19 for their patients and staff with the risks of untreated SUDs. COVID-19 represents a public health crisis, but so does addiction, and the current pandemic is likely to only increase the need for SUD treatment. As experts in the field of behavioral health, we must find ways of maintaining access to needed behavioral health treatment and resources while minimizing risks for COVID-19 transmission. This may require a combination of telehealth-based treatment, places to shelter patients during quarantine, and dedicated residential or inpatient SUD treatment programs that can treat patients who have or are suspected of having COVID-19.

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

Once a patient has been tested and diagnosed with COVID-19, the patient's room and other surfaces that the patient may have touched, should be sanitized and disinfected immediately. Staff responsible for cleaning should wear PPE (gown, gloves, mask, and eye protection if available), and they should be careful to wash their hands when they remove the PPE.

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

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

As discussed above, the patient should be tested for COVID-19 and should remain isolated while waiting for test results. Based on resources in the facility, the acuity of the patient's viral symptoms, and the patient's needs for medical monitoring and management related to the SUD or other physical health 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 a stable and safe home environment. 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 or additional planning may be needed around that discharge to ensure the safety of the patient. If a patient cannot be safely discharged, a plan should be in place for them to be quarantined to a room and bathroom. The facility should also develop a plan in the event that a sick patient requires extended quarantine.

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

- Regular monitoring of patient symptoms, including fever
- Delivery of food, medications, and other essentials while maintaining at least six feet of distance
- When PPE is required

- If an ill person must be around other people for any reason, wearing a mask and maintaining a safe distance of at least six feet from others
- Regular assessment of patient needs including mental health, emotional support, and maintaining proper hygiene

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

Ending Quarantine (self-isolation) For a Sick Patient

Quarantine (voluntary self-isolation) should be ended by a physician per current CDC guidelines, briefly:

1. If person was never tested or tested positive once and will not receive a 2nd COVID test to determine if they are infectious, quarantine can end when three criteria are fulfilled:
    - At least seven days have passed since symptoms first appeared; **AND**
    - No fever for at least 72 hours (three full days of no fever without the use of medicine that reduces fever); **AND**
    - Other symptoms have improved or preferably resolved (for example, when cough or shortness of breath have improved).

2. If person already tested positive and will not receive additional testing to determine if they are still contagious, quarantine can end when three criteria are fulfilled:
    - No fever for at least 72 hours (three full days of no fever without medicine that reduces fever); **AND**
    - Other symptoms have improved or preferably resolved.

No Capacity to Quarantine

If a program does not have the capacity to isolate or quarantine patients, the program should work with local public health authorities regarding where patients may be quarantined if they do not have anywhere else they can stay.

Managing Staff with COVID-19 Symptoms

Personnel who develop respiratory symptoms (e.g., cough, shortness of breath) should be instructed not to report to work. If they screen positive or develop symptoms while at work, they should be sent home or to seek medical services. Staff with symptoms of COVID-19 should be encouraged to see their primary care physician (PCP) to get tested/cleared to work. 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 two hours of receipt of a positive screening result.

Residential treatment programs should review the CDC's guidance and implement sick leave policies for health care providers and other staff that are non-punitive, flexible, and consistent with public health guidance. Movement and monitoring decisions for health care providers (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.

Staff members with any symptoms should stay home and consult their health care provider about self-quarantine and safe return to work. Program should encourage staff to follow the same CDC guidance recommended for ending a quarantine of a patient. As mentioned above, programs should implement protocols for staff members quarantined at home to 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 health care providers.

POLICY IV: EXERCISE GOOD HYGIENE

Social Distancing

Patients and staff should avoid all non-essential physical contact and try to maintain at least a six 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 a 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.

Social Distancing and Treatment Groups

Residential programs should take steps to decrease the rate of new cases and minimize contact with others. It is prudent that non-essential gatherings and support group meetings are canceled. It is recommended that support groups are provided on-line. Treatment groups that are continued should be limited and smaller. Programs should take the following policies or practices into consideration when providing treatment groups within the facility:

- Limit meetings to 10 or fewer participants;
- Individuals at high risk for complications of COVID-19 infection, who are feeling sick or have been exposed to a suspected or confirmed case of COVID-19 should self-isolate and not attend group meetings of any size;

- Participants (including staff or volunteers) should be screened for symptoms of COVID-19 prior to group attendance;
- Make arrangements such that participants are outside of close contact and can maintain a distance or 6 feet from other participants in a well-ventilated space for the duration of the meeting;
- Educate and practice respiratory hygiene (cover coughs, wash hands, dispose tissues);
- Do not share food or drinks;
- Infection control practices including hand hygiene and environmental sanitation should be implemented.

Proper Use of Personal Protective Equipment (PPE)

Staff not providing physical care to patients should maintain distance according to the CDC.

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

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.

The PPE recommended when providing physical care for a patient with known or suspected COVID-19 includes:

- Respirator or facemask
- Eye protection (e.g., goggles or a disposable face shield that covers the front and sides of the face)
- Gloves
- Isolation gowns

Facility Cleaning

The CDC has provided interim infection prevention and control recommendations in community health care settings.

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.

The cleaning of all surfaces and knobs several times each day with an Environmental Protection Agency (EPA-approved) sanitizer and washing hands for at least 20 seconds with warm soapy

water as often as possible is also recommended. Anyone with a respiratory illness (e.g., fever, cough, runny nose) should do the following:

- Be given a mask (that covers the mouth and nose) before entering the space.
- Be provided with hand sanitizer at the front desk if they are entering the office facility, and at the point of entry when they are entering a residential facility. If the individual is receiving medication, hand sanitizer should be provided and used prior to dosing.

Clean high-touch surfaces in the facility multiple times per day, especially after any resident interactions or after staff, patients or visitors have been off the premises. Shared resident-care equipment should be cleaned after each use.

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

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

Respiratory Hygiene and Cough Etiquette

Facilities should provide patients and staff with instructions on hygiene and cough etiquette. Instructions should include how to use facemasks (when needed), how to use tissues to cover nose and mouth when coughing or sneezing, how to dispose of tissues and contaminated items in waste receptacles, and how and when to perform hand hygiene. Patients should be taught that, if no tissues are available, they should cough into the bend in their elbow and wash their hands with soap and water immediately afterwards. Patients should also be encouraged to avoid touching their eyes, nose, mouth with unwashed hands.

The CDC has several handouts and posters designed to educate patients about COVID-19 and good hygiene practices.

Hand Hygiene

Staff and residents should focus on universal hygiene precautions, and hand washing often for at least 20 seconds using warm soap and water or hand sanitizer with at least 60% alcohol. Both should be easily accessible in every residential treatment facility and in every patient's room. While alcohol-based hand sanitizer is a necessity in the current environment, facilities should remain aware that patients with an Alcohol Use Disorder have been known to ingest these products. Precautions should be taken to monitor patients' behavior. Additionally, alcohol exposure on the skin, particularly with the frequency of use demanded by this emergency, has been shown to create positive testing with some tests of alcohol metabolites (particularly EtG1). This should be taken into account in drug testing policies for both patients and staff. 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.

Items Brought into the Facility

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

- Deliveries
    - Have a single point of entry for supplies (e.g., a loading dock or other less trafficked entrance)
    - Maintain physical distance between staff and delivery persons as much as possible
    - Wear gloves when receiving and opening packages
    - Wash hands once supplies have been stored or put away

- Patient belongings
    - Minimizing what belongings new patients can bring into the facility
    - If staff handle new patient belongings, ensure they wear gloves or avoid directly touching them and wash their hands immediately after handling (after removing gloves)
    - Once the patient has been admitted,
        - Consider sanitizing any belongings before they enter the patient space (e.g., launder clothes, wipe down electronics with sanitizing wipes)
        - 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

BHA encourages all providers to spend additional time to review their organizational and community emergency plans, and to stay connected to the jurisdiction's Local Behavioral Health Authority (LBHA), Local Addiction Authority (LAA), Core Service Agency (CSA), and Local Health Department (LHD). This will ensure that programs remain connected to pertinent COVID-19 information and strategies to support the Maryland constituents.

For inpatient/residential programs that plan to remain open during the current COVID-19 related emergency, care should be taken to consider CDC guidance on precautions in admitting new patients, management of current residents who may have been exposed to or who are infected with COVID-19, Medication Assisted Treatment (MAT) and take-home procedures, and visitor policies.

POLICY V: PROMOTE AWARENESS

Educate Staff and Patients

Whenever possible, SUD providers should disseminate educational pamphlets, send out email blasts, or send text message alerts to staff and patients on how to respond to a COVID-19 outbreak within your agency.

Create a COVID-19 Response Plan

Consider your own business' Continuity of Operations Plans (COOP). Ensure you have up-to-date emergency contacts for your employees and your patients. It is recommended that providers update the cell phone number, carrier, and collateral contacts for their patients often, because this population's contact information can change frequently. Ensure program leadership has contact information of the jurisdictions Local Designated Authority, State Opioid Treatment Authority, Maryland Department of Health and the Behavioral Health Administration.

Develop a communications strategy and protocol to notify patients who are diagnosed with or exposed to COVID-19, and/or patients who are experiencing respiratory illness symptoms such as fever, coughing, and runny nose that whenever possible the patient should call ahead to notify staff of their condition.

Develop a plan for possible alternative staffing scheduling in case you experience staffing shortages due to staff illness. Develop a plan for criteria for staff members who may need to stay home when ill and/or return to the workforce when well. Consider limiting critical staff

access to patients when possible. For example, some staff may meet with a patient through a glass window or through tele-communications devices within that same facility.

Current CDC and SAMHSA guidelines recommend maintaining a six-foot distance between patients onsite in any primary care setting, as best as possible. We realize in a SUD Residential Treatment setting that this guidance may be difficult to achieve, but it should be attempted to the best of everyone's ability in an aspirational sense, while considering the space and patient flow within your physical location.

If your program is not currently conducting all appointments, admissions, therapeutic sessions, etc. remotely, SUD Residential Treatment providers should consider reserving special treatment times for high-risk populations like those who have medical comorbidities. While the effects of COVID-19 for pregnant women and the fetus are unknown, providers should consider using these special times for this population as well.

FREQUENTLY ASKED QUESTIONS

How can SUD residential programs be kept abreast of COVID-19 developments that are relevant to residential treatment within the residential treatment setting?

In the event you need access to COVID-19 information, health care services, recovery support, and resources, SUD Residential Treatment providers should be contacting their Local Addiction Authority (LAA), Local Behavioral Health Authority (LBHA), or Core Service Agency (CSA) in their jurisdiction. Providers should also continue to check the CDC, MDH, and SAMHSA websites for the most up-to-date information and BHA's FAQs. Knowledge of public health guidance related to COVID-19 is 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.

Additionally, BHA is disseminating twice weekly FAQs for behavioral health partners, which are posted on the BHA COVID-19 webpage. If there is a behavioral health question related to COVID-19 that has not been addressed, please submit it here.

Up-to-date FAQs for a variety of audiences are also on Maryland's COVID-19 website.

BHA is facilitating as needed conference calls. Organizations are also encouraged to participate in webinars and calls by MDH, BHA, CDC and SAMHSA to stay abreast of updates.

What procedure should SUD Residential Treatment Providers follow for abiding by 42 CFR Part 2 regulations?

SAMHSA has provided guidance on complying with 42 CFR Part 2. Under 42 U.S.C. §290dd-2(b)(2)(A) and 42 C.F.R. §2.51, patient identifying information may be disclosed by a part 2 program or other lawful holder to medical personnel, without patient consent, to the extent necessary to meet a bona fide medical emergency in which the patient's prior informed consent cannot be obtained. MDH would like to reiterate that under the medical emergency exception, providers make their own determinations as to whether a bona fide medical emergency exists for purposes of providing needed treatment to patients.

What warrants a complete "shut-down" of an SUD Residential Treatment Provider?

Behavioral Health Treatment providers, more specifically Substance Use Disorder Residential Treatment providers are considered essential public facilities under Maryland's Health General Article (HGA) annotated codes and COMAR. A COOP should be established for emergency scenarios, such as the current health emergency crisis and be able to admit new patients into treatment if they are not presenting in a crisis. Community SUD programs should consult with their jurisdictions Local Designated Authority before making decisions regarding the closing of a facility as a result of an emergency situation. A plan should be developed to connect patients to alternative services in the community. BHA's licensing office should also be notified of any closure or reduction in services.

Patients and staff may begin to experience emotional distress such as anxiety about COVID-19. If a program has to close temporarily, what information and guidance could we share to help support them?

Hearing the frequent news about COVID-19 can certainly cause people to feel anxious and show signs of stress, even if they are at low risk or don't know anyone affected.

The SAMHSA document entitled Coping with Stress during Infectious Disease Outbreaks includes useful information and suggestions.

Programs could adapt messaging from this document for the population that your program serves or print this document to have readily available.

Should we be worried about any somatic medication shortages and/or disruption of a medication supply for MAT medications, such as Buprenorphine/Suboxone?

At this time, there has been no reported concern from any state or federal partner about a potential for disruption in the medication supply for any MAT relevant medications (Buprenorphine/Suboxone or Methadone). Please contact the State Opioid Treatment Authority if your program has any specific concerns: frank.dyson@maryland.gov

Does the emergency health crisis (COVID-19) affect the use of the American Society of Addiction Medicine (ASAM) criteria and utilizing the Medical Necessity Criteria (MNC)?

The ASAM Criteria should continue to be used to assess the appropriate level of care for each individual; however based on guidance from SAMHSA, intensive outpatient services should be considered whenever possible in order to provide the safest environment for patients and staff ASAM has provided the resources to assist behavioral health providers.

ADDITIONAL RESOURCES

The Centers for Disease Control and Prevention

Interim Infection Prevention and Control Recommendations: https://www.cdc.gov/coronavirus/2019-ncov/infection-control/control-recommendations.html

Get Your Home Ready: https://www.cdc.gov/coronavirus/2019-ncov/prepare/get-your-household-ready-for-COVID-19.html

Household Checklist: https://www.cdc.gov/coronavirus/2019-ncov/community/home/checklist-household-ready.html

General Recommendations for Cleaning and Disinfection in Housing with People Isolated in Home Care: https://www.cdc.gov/coronavirus/2019-ncov/community/home/cleaning-disinfection.html

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

Health Care Supply of PPE: https://www.cdc.gov/coronavirus/2019-ncov/hcp/healthcare-supply-ppe-index.html

Interim Guidance for Risk Assessment: https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-risk-assesment-hcp.html

Substance Abuse and Mental Health Services Administration

TAP 34 Disaster Planning Handbook for Behavioral Health Providers: https://store.samhsa.gov/product/TAP-34-Disaster-Planning-Handbook-for-Behavioral-Health-Treatment-Programs/SMA13-4779

Tips For Social Distancing, Quarantine, And Isolation During An Infectious Disease Outbreak: https://www.samhsa.gov/sites/default/files/tips-social-distancing-quarantine-isolation-031620.pdf

Maryland Department of Health

Recommendations for Infection Control and COVID-19 Prevention in Facilities Serving Older Adults: https://phpa.health.maryland.gov/Documents/Recommendations%20for%20COVID-19%20Infection%20Control%20and%20Prevention%20-%20March%2010%202020.pdf