The Commonwealth of Massachusetts
Executive Office of Health and Human Services
Department of Public Health
250 Washington Street, Boston, MA 02108-4619

CHARLES D. BAKER
Governor

KARYN E. POLITO
Lieutenant Governor

MARYLOU SUDDERS
Secretary

MONICA BHAREL, MD, MPH
Commissioner

Tel: 617-624-6000
www.mass.gov/dph

To: All BSAS Licensed and Contracted Programs

From: Deirdre Calvert, LICSW, Director of the Bureau of Substance Addiction Services

Date: February 1, 2021

Re: Preventing COVID-19 Infections and Use of Personal Protective Equipment (PPE) in BSAS-licensed/contracted Programs

---

The purpose of this memo is to provide guidance to all programs licensed/contracted by the Massachusetts Department of Public Health's (DPH) Bureau of Substance Addiction Services (BSAS) regarding prevention of COVID-19 infections, procedures for reporting positive cases, and best use of Personal Protective Equipment (PPE).

This memo replaces the memos dated April 6, 2020 "Reporting/Mitigating COVID-19 Cases in BSAS-licensed/contracted Programs," April 20, 2020 "Personal Protective Equipment (PPE) in BSAS-licensed/contracted Residential Programs," April 20, 2020 "Personal Protective Equipment (PPE) in BSAS-licensed/contracted ATS, CSS, TSS, OTP, OBOT, and Outpatient Service Programs," and April 28, 2020 "Screening Patients for COVID-19 Cases in BSAS-licensed/contracted Programs."

Language from the guidance documents referenced above has been consolidated into a single guidance for ease of access by providers, to make PPE requirements/considerations consistent across different BSAS-licensed/contracted service settings, to update procedures for Required Notifications to BSAS, and to update procedures for quarantining and close contacts consistent with the most recent Centers for Disease Control and Prevention (CDC) guidance.

This guidance is intended to supplement, not supplant, provisions from regulatory agencies that oversee programs licensed/contracted by BSAS.

This guidance will be updated as needed and as additional information is available. Please regularly check mass.gov/covid19 for updated guidance.

Ongoing Prevention

BSAS-licensed/contracted programs should take precautions to prevent the spread of COVID-19, including:

- Cleaning **and** disinfecting frequently touched surfaces at least **daily**, including tables, doorknobs, light switches, countertops, handles, desks, phones, keyboards, toilets, faucets, and sinks. If surfaces are dirty, clean them (using detergent or soap and water) prior to disinfection.
- Staff/patients/residents should wash their hands with soap and water for at least 20 seconds. If available, staff/patients/residents should use alcohol-based hand rub (ABHR) to clean their hands often, especially after being in a public place, or blowing one's nose, coughing, or sneezing. Staff/patients/residents should use a hand sanitizer containing at least 60% alcohol. For further information on alcohol-based hand sanitizer, please consult BSAS' guidance on Appropriate Use of Alcohol-Based Hand Sanitizer in Substance Use Disorder Treatment.
- Staff can conduct hand hygiene rounds and offer ABHR to patients/residents if there is concern about having hand hygiene stations. If ABHR is not readily available or hands are visibly soiled then staff/patients/residents should wash their hands with soap and water for at least 20 seconds.
- Staff should work from home, whenever possible.
- Staff should not come to work if they are experiencing any symptoms of COVID-19 (even mild symptoms), have had a close contact exposure to someone with active COVID-19 infection and have not met criteria for release from quarantine or have tested positive for COVID-19 themselves and not yet been medically cleared.
- When staff are in the work setting, they should wear facemasks practice social distancing, including providing at least six feet of space between workstations. Post signage in any break rooms or other common areas to remind staff to wear masks and practice social distancing. Limit the number of individuals permitted in break rooms or other commons areas to ensure that staff can maintain distances of six feet. Staff in any clinical or care areas should also don eye protection.
- Prohibit the size of gatherings in accordance with issued executive orders.
- For further guidance on preventing COVID-19 transmission, please see the CDC's How to protect yourself.

Prescreening

Prescreen patients who are calling to schedule outpatient appointments or inpatient intake. Ask the following questions, and document the patient's answers in their care record (including any associated dates):

- Do you have or have you had any of these symptoms in the past 48 hours?
  - fever or chills
  - cough
  - shortness of breath or difficulty breathing
  - fatigue
  - muscle or body aches
  - headache
  - new loss of taste or smell
  - sore throat
  - congestion or runny nose

    - nausea or vomiting
    - diarrhea
- Have you had close contact exposure to a person with an active COVID-19 infection and have not met criteria for release from quarantine?
- Have you received a positive test result for COVID-19?
    - If so, have you been cleared from isolation?
- Are you waiting to receive results of a COVID-19 test?

If the answer to any of these questions is yes, use triage protocols to determine if the appointment is necessary or if the patient can be managed from home.

If the patient comes to the program in-person, or a chance to prescreen while making an appointment was not an option (i.e. a patient walk-in), please consult the section below regarding Admissions.

If the answer to all of the above questions is no, the patient does not require further COVID-19 screening in order to enter the program. If the patient develops symptoms consistent with COVID-19 after arriving at the program, please see section below regarding Isolation in Inpatient Settings.

Admissions

Mitigate the chance of exposing staff/patients/residents at admission by:

- Limiting points of entry to your facility.
- Designating specific staff member(s) to undertake admissions and screening activities, in order to limit staff exposure.
- Installing physical barriers (e.g. glass/plastic windows) at reception areas to limit close contact between triage staff and patients.
- Designing intake procedures and waiting spaces to reduce the amount of waiting time and contact among patients entering the facility.
- Determining if the patient has a fever (100ºF or higher) by taking their temperature using a non-contact thermometer, or asking if they've felt like they've had a fever in the past 48 hours.
- Asking the patient if they have any symptoms consistent with COVID-19 (see questions above).
- Asking patients to wear a cloth face covering or facemask once they enter your facility.

If the patient has symptoms consistent with COVID-19, ensure that the patient isolates and is tested for COVID-19. Ensure that the patient is wearing a facemask, and all staff coming in close contact are wearing appropriate PPE.

Transfer from Other Facility

Mitigate the chance of exposure from patients/residents transferring from another facility by:

- If the patient has been transferred from another facility (e.g. hospital, other SUD treatment program), determine the facility from which they were discharged, and when they were discharged.
- Review if patient discharge paperwork includes any prior COVID-19 test results, symptoms, and clearance while in the other facility's care.
- If any indication of having COVID-19 symptoms or positive testing is included in the patient's discharge paperwork, please consult the section below regarding Isolation in Inpatient Settings.
- If the patient discharge paperwork does not include any indications of COVID-19 symptoms, ask the screening questions and follow the instructions included in the section above regarding Prescreening.

Isolation in Inpatient Settings

If a patient/resident tests positive for COVID-19 or begins to exhibit signs and symptoms consistent with COVID-19:

- Direct them to an isolation room/space with the door closed if possible and with a private or separate bathroom. Such individuals require medical evaluation and guidance regarding testing for COVID-19.
- Other patients/residents should not enter the isolation room/space. Staff should not enter the isolation space without Personal Protective Equipment (PPE) appropriate to the care setting. Please see section below regarding PPE for more information on appropriate use.
- Consult BSAS' guidance regarding Waiver from Certain Regulatory Requirements, which includes the relaxation of space utilization requirements if needed for isolation.
- If your facility does not have designated isolation rooms/spaces, determine a pre-specified location/facility to which you will be sending patients/residents presenting with COVID-19 symptoms or have a COVID-19 positive test.
- Provide the patient/resident a facemask to cover their nose and mouth.
- Notify management and BSAS through the Required Notification process (see section below regarding Reporting Confirmed Cases).
- Provide the patient/resident instructions on cough etiquette and handwashing/hygiene.
- Let the patient/resident know to not leave their room (unless using the restroom), and if they do leave their room to wear a facemask.
- While in isolation, monitor for changes in symptoms. Patients/residents with progressive symptoms should receive medical evaluation by telehealth or by EMS.
- Patients may leave isolation when:
    - **If symptomatic**
        - **At least** 10 days have passed since the onset of their symptoms; **and**
        - **At least** 1 day (24 hours) have passed since fever resolved (without the use of fever reducing medications); **and**
        - Other symptoms have improved.
    - If asymptomatic
        - At least 10 days have passed since the positive COVID test was collected.

Reporting Confirmed Cases

If a staff/patient/resident tests positive for COVID-19, programs should report as follows:

- Notify the Local Board of Health and call DPH's Epidemiology Line at **617-983-6800** and follow any instructions provided.
  - Reporting of cases in staff should include complete demographic information including personal identifiers.
  - Reporting of cases in patients/residents should be reported in a de-identified way BUT the patient or resident should be encouraged to speak with the Local Board of Health or the Community Tracing Collaborative when contacts to provide information.
- Notify BSAS through the Required Notification system pursuant to BSAS' guidances:
  - Required Reporting of COVID-19 Positive Cases by BSAS Licensees and Contractors
  - COVID-19 Required Notification Form
- If the individual requires immediate medical care, call 911 for an ambulance and inform EMS of the individual's symptoms and concern for COVID-19.

Use of Personal Protective Equipment

Programs are encouraged to re-educate personnel on proper use of personal protective equipment (PPE) and when to use different types of PPE.

- BSAS is adopting a universal facemask policy for personnel and patients/residents in BSAS-licensed/contracted facilities. **All staff and patients/residents** should be provided with a facemask each day.
- Facemasks are defined as surgical or procedure masks worn to protect the mouth/nose against infectious materials.
- All staff should also be provided eye protection such as goggles or a face shield that should be worn in patient/resident areas.
- DPH is supportive of The Joint Commission's public statement; it emphasizes that none of the standards prohibit staff from bringing in their own PPE or wearing PPE throughout the day.[1]
- Cloth face coverings **do reduce the transmission of COVID-19 infection**, though they are not as effective as facemasks in preventing transmission of illness. Facilities should require patients/residents to utilize facemasks, if available, or cloth face coverings. Patients/residents symptomatic for COVID-19 and/or test positive for COVID-19 should wear medical masks.
- Providers should determine PPE needs in accordance with CDC guidelines and DPH guidelines and priorities for PPE use, depending on the setting and the type of care being administered.
- In settings where isolation protocol and physical distance can be maintained, providers should follow guidance for the care of individuals at homes and community facilities, including CDC guidance for caring for someone at home.
- In programs where facemasks are not available, staff and residents should use non-medical disposable masks or cloth face coverings. The CDC has provided guidance on the use of non-medical masks and cloth face coverings:
  - Recommended:

[1] https://www.jointcommission.org/en/resources/news-and-multimedia/news/2020/03/statement-supporting-use-of-personal-face-masks-provided-from-home-amid-covid-19-pandemic/

        - Non-medical disposable masks
            - Disposable face masks are single-use masks. They are sold online and through large retail stores. These are not the same as surgical or other medical masks.
        - Masks that fit properly (snugly around the nose and chin with no large gaps around the sides of the face)
        - Masks made with breathable fabric (such as cotton)
        - Masks made with tightly woven fabric (i.e., fabrics that do not let light pass through when held up to a light source)
        - Masks with two or three layers
        - Masks with inner filter pockets
        - Use in conjunction with eye protection such as goggles or a face shield
    - Not Recommended
        - Masks that do not fit properly (large gaps, too loose or too tight)
        - Masks made from materials that are hard to breathe through (such as plastic or leather)
        - Masks made from loosely woven fabric or that are knitted, i.e., fabrics that let light pass through
        - Masks with one layer
        - Masks with exhalation valves or vents
        - Wearing a scarf/ski mask as a mask
        - Not wearing eye protection such as goggles or a face shield

- Cloth face coverings should not be placed on young children under age 2, anyone who has trouble breathing, or is unconscious, incapacitated, or otherwise unable to remove the mask without assistance.
- With the PPE that is appropriate for and available to providers, providers should follow the CDC's guidance for optimizing the supply of PPE. Programs should continue to educate personnel on proper use of personal protective equipment (PPE) and when to use different types of PPE.

Obtaining PPE Supplies

The Commonwealth of Massachusetts is acutely aware of rapidly expanding needs for personal protective equipment (PPE) for numerous organizations across the state – including masks, gowns, gloves, and eye protection. PPE resources are limited in the Commonwealth and we must conserve the use of PPE.

- State operated programs and facilities should coordinate with their funding agency to report current inventories of PPE, burn rates (how quickly supplies are exhausted), and quantities of PPE needed.
- Providers should make every available effort, in partnership with their respective organizations and associations, to obtain PPE through their supply chains.
- If PPE supplies are not adequate or limited, please reach out to your BSAS Regional Manager or Licensing Inspector.

Please consult the following list of resources regarding information on PPE supplies:

- Personal Protective Equipment FAQ
- Guidance For Prioritization of Personal Protective Equipment (PPE) in Massachusetts
- MA COVID-19 PPE Guidelines and Priorities

As a reminder, CDC resources can be found here:
- Infection Control Basics
- Handwashing: Clean Hands Save Lives
- How to protect yourself
- Strategies for Optimizing the Supply of Facemasks
- How to Create Your Own Face Covering
- Considerations for Wearing Masks

Exposure to a Confirmed Case

Exposure to a confirmed case is defined as a staff/patient/resident who may have had close contact with an individual who has tested positive for COVID-19, but who has not tested positive themselves.

"Close contact" is defined as living in the same household as a person who has tested positive for COVID-19, caring for a person who has tested positive for COVID-19, being within 6 feet of a person who has tested positive for COVID-19 for 15 minutes total during a period of 24 hours, or has been in direct contact with secretions (e.g. sharing utensils, being coughed on) from a person who has tested positive for COVID-19, while that person was symptomatic or in the two days before symptom onset OR in the 2 days before and 10 days after a positive test was taken in people who are asymptomatic. Decisions about who had close contact and implementation of quarantine should be made in collaboration with the DPH Epidemiology Line or the Local Board of Health.

In the event that a staff/patient/resident is a close contact of someone who has tested positive for COVID-19, it's best if to quarantine for 14 days. However, if 10 days after exposure the individual has no symptoms and the individual is able to self-monitor for any symptoms for the rest of the time period, quarantine may be ended. A staff/patient/resident can end their quarantine after 7 days if the individual has a negative test that is performed no sooner than 5 days after the exposure. The individual may end quarantine after 7 days if they can self-monitor for any signs or symptoms of COVID-19 for the remainder of the quarantine period (See DPH Quarantine Guidance).
- Note that staff members who are healthcare personnel wearing the appropriate PPE and maintaining the appropriate infection controls procedures during this contact, do not need to quarantine and may continue working (Please see DPH's Exposure and Return to Work Guidance.)
- Those in self-quarantine who have not developed symptoms and are not considered a high risk for transmission of the virus may return to work once the 14-day quarantine period has ended or sooner as outlined above.
- The work location does not need to be closed.
- The work location does not need to be cleaned and disinfected at this time.

- Staff should communicate their quarantine status to their manager via e-mail. If the exposed staff member subsequently develops symptoms and tests positive for COVID-19, follow the Reporting Confirmed Cases section of this document. If the exposed staff member completes self-quarantine without developing symptoms, they may return to work after informing their manager.
- Please also see DPH's Exposure and Return to Work Guidance.

Cleaning

Recommendations for cleaning in programs include:

- Increase the frequency of cleaning for shared spaces and high-touch surfaces, such as elevator buttons, railings, door handles, faucets, and shared items used for admissions (e.g. shared clipboards/pens/tablets used for checking in, if applicable).
- Clean all rooms with a focus on hard surfaces (e.g. desks, tables, countertops, sinks), using a disinfectant on the list of EPA Registered Antimicrobial Products for Use Against Novel Coronavirus SARS-CoV-2 (the Cause of COVD-19).
- Use alcohol wipes to clean keyboards, touchscreens, tablets, and phones.
- For further information regarding deep cleaning of a location where a staff/patient/resident was confirmed to have COVID-19 and was present in the facility while they were symptomatic, please consult EOHHS' guidance Residential and Congregate Care Guidance (see section titled "Deep Cleaning"), and CDC's guidance on Cleaning and Disinfecting Your Facility.

For the latest information, visit the DPH 2019 Novel Coronavirus website which is updated frequently: www.mass.gov/2019coronavirus.

DPH prevention guidance: printable fact sheets
CDC website: https://www.cdc.gov/coronavirus/2019-ncov/index.html

Call BSAS' Helpline at 1-800-327-5050 (8am-10pm Mon-Fri, 8am-6pm on weekends) to get information on programs and services that are best for you in your area. Go to www.helplinema.org/help for more details.