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Behavioral Health Inpatient and Residential Facilities Coronavirus Disease 2019 (COVID-19) Response Best Practices

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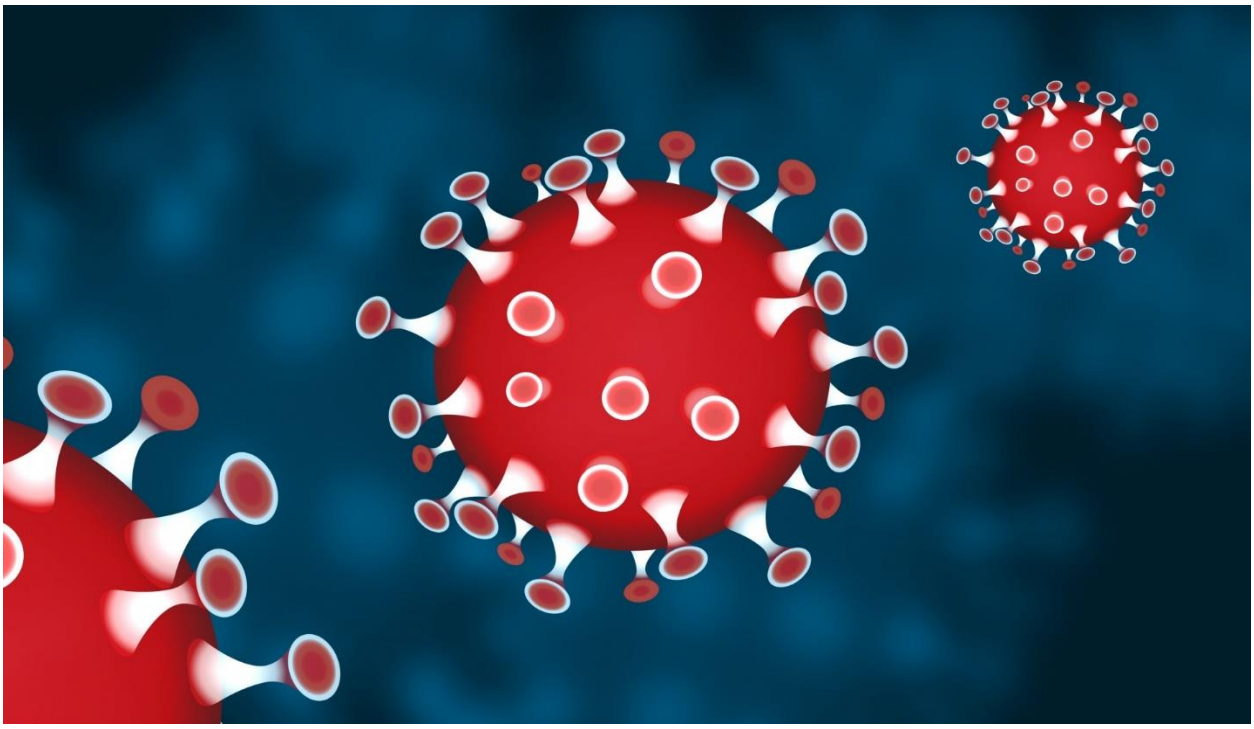

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BACKGROUND

This document outlines COVID-19 infection prevention and control best practices for behavioral health inpatient and residential care facilities to reduce the spread of COVID-19.

Patients/ Residents and staff in inpatient and residential behavioral health facilities have a higher risk of getting COVID-19 due to living and working in close-quarters and providing treatment to patients. As a result, it is important to have standardized best practices and guidelines to help staff take precautions to protect their patients/residents and themselves, while still providing high quality care. Facilities should develop and implement COVID-19 plans based on facility size, type of population and services provided. In addition to this guidance, further information may be obtained by accessing the links included in the references section.

Note: In the context of this document the use of the terms patient(s), client(s) and resident(s) is interchangeable.

SCREENING PATIENTS/RESIDENTS FOR COVID-19 AND CONSIDERATIONS WHEN ATTEMPTING TO MINIMIZE DISEASE TRANSMISSION

Screen all new patients/residents for symptoms of COVID-19 and the risk of exposure to COVID-19 at the time of admission.

Symptomatic individuals should be moved to a quarantine area or into a separate space away from non-symptomatic or tested COVID-19 negative individuals. In some situations, such as worsening medical symptoms, or quarantine area has reached capacity, this could prompt discharge to a different setting such as a facility that can provide a higher level of care for a worsening medical condition or another group home or community setting for space capacity issues. Please refer to the following link: Centers for Medicare & Medicaid Services (CMS) Tier approach for Non-Emergent, Elective Medical Services, and Treatment Recommendations.
https://www.cms.gov/files/document/cms-non-emergent-elective-medical-recommendations.pdf

A COVID-19 testing model that will be followed must be documented in your infection prevention plan to address the following scenarios:

- Staff/patients/residents with new onset of symptoms;
- During high community positivity rate;
- Exposures within the facility;
- During an outbreak; and
- Any other scenarios based on the facility risk assessment.

Anyone with even mild symptoms of COVID-19, regardless of vaccination status, should receive a COVID-19 test as soon as possible. Please see the (CMS) testing guidelines at:
https://www.cms.gov/files/document/qso-20-38-nh-revised.pdf

Post visual alerts (signs, posters) at entrances and in strategic places providing instruction on hand hygiene, respiratory hygiene, and cough etiquette. Frequently reorient patients/residents with limited capacity.

PATIENT/RESIDENTS PLACEMENT

All new admissions and readmissions should be quarantined on admission/readmission for 14 days. People living with others in facilities and other congregate living arrangements who are unable or unwilling to isolate or cohort need to be separated from non-infected people by placement in separate living areas. For more information on nursing home infection prevention and control see: https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html

Limit the movement of COVID-19 patients/residents (e.g., have them remain in their room)

- Individuals with serious mental illnesses may have varying degrees of capacity to follow appropriate infection control procedures; therefore, it is important to establish the patient's/resident's capacity or lack of capacity when developing their COVID-19 treatment plan. Those who lack capacity may not fully appreciate the dangers of exposure. The nature of the therapeutic milieu may make minimal contact rules more challenging. Patients/residents without capacity may require more frequent reorientation to the rules, more activities one on one with staff, and an individual room. While restrictions of movement outside of their room will be implemented for some patients, the presence of mental illness does not mean an individual is incapable of practicing safe hygiene and social distancing practices. Staff should make the assessment based on the patient's capacity and behavior and carefully avoid stigmatizing those with mental illness.

Take steps to prevent known or suspected COVID-19 patients/residents from exposing other patients.

- It is advisable, when possible, to segregate the areas or individual floors as non-COVID-19 and COVID-19. This may require further restrictions in movement and accommodations should be explored. For instance, the dayroom is often the location where patients/residents congregate and receive the therapeutic benefits of the milieu. Having an alternate dayroom location, when possible, could help to reduce a patient's anxiety about exposure and maintain continuity. Also, those patients/residents with severe anxiety disorder or paranoia may feel some relief in segregation as their risk of exposure is reduced.
- Identify dedicated staff to care for COVID-19 patients/residents.
- Suspend group meetings or therapy for residents who are exhibiting signs of being sick. Decrease the size of these groups for the remaining healthy residents to ensure physical distancing. Group meetings may be held outside if possible. As an alternative to group meetings staff can bring activities and activity plans to individuals in their rooms. Some groups may also be able to interact virtually, through electronic devices.

COHORTING GUIDELINES

Develop a cohorting plan (including a map of the facility layout) to identify halls, areas or units that will house residents based on their COVID-19 status:

- **COVID-19 Free Unit/area**: Patients/Residents with no known exposure to COVID-19. Or those who have met the CDC Criteria for Discontinuation of Transmission-Based Precautions or who have completed their quarantine from the last date of known exposure and have shown no symptoms throughout the quarantine period.
- **New Admissions/Readmissions Unit/Area:** Patients/Residents that are newly admitted or readmitted and placed under observation.
- **Quarantine Unit/Area**: Patients/Residents that have had contact with confirmed COVID-19 cases.
- **COVID-19 Isolation Unit/Area**: Asymptomatic or symptomatic patients/residents with confirmed SARS-CoV-2.

Please refer to the Division of Public and Behavioral Health's (DPBH) documents titled:

Separate Units to Prevent and Contain Transmission of COVID-19:
https://nvhealthresponse.nv.gov/wp-content/uploads/2020/07/Cohort-Memo-Final-6-29-2020_ADA.pdf; and

Quarantine new admits and readmissions regardless of vaccination status in nursing homes and residential facilities:
TB-Quarantine-Fully-Vaccinated-Admissions-09-13-2021.pdf (nv.gov)

Please refer to the table on the next two pages, extracted from the Centers for Disease Control and Prevention's Morbidity and Mortality Weekly Report, 2020:69:825-829, for information on challenges to effective COVID-19 infection prevention and control in a psychiatric hospital setting with possible solutions.

Group/Process	Challenges to effective COVID-19 prevention and control	Possible solutions
Patients		
Admissions	Admissions from facilities at higher risk for SARS-CoV-2 transmission (e.g., homeless shelters, group homes, and correctional facilities)	Test newly admitted patients to identify any persons with asymptomatic infection and defer integration to regular wards until results are received. If result is positive, keep patient isolated; if result is negative, conduct routine symptom screening on regular ward
Screening	Uncooperative/violent behavior when patients are being screened for symptoms or tested for SARS-CoV-2 infection	Educate patients to raise awareness of the need for screening and testing, and to avoid misinformation and fear
Cohorting	Logistical challenge to segregate according to age, gender, treatment needs, and potential for violence in addition to cohorting based on COVID-19 case status	Implement rigorous measures to prevent transmission into and within the facility to avoid the need for patient cohorting in addition to the normal necessary segregation of patients. If transmission occurs, isolate patients in single rooms, or in rooms with other COVID-19 patients as segregation of patients allows, within quarantined areas to limit interaction
Social distancing	Psychiatric treatment often requires close interaction and cannot be canceled or delayed	Conduct smaller group sessions or one-on-one therapy, with 6-foot distancing, universal use of face coverings, and more frequent decontamination of surfaces
Use of face coverings for source control	Face coverings unsuitable for patient use or patient noncompliant with use	Consider modified face coverings, modified methods of securing face coverings, or the use of facility-approved items as face coverings when possible and accepted by the patient
Exposure to cleaning products and disinfectants	Risks associated with patient behaviors (e.g., licking surfaces, attempts to ingest products if accessible)	Have staff members follow instructions on product labels for safe use, including securing products from unauthorized persons such as patients; have staff members dispense individual portions of hand sanitizer directly to patients as needed
Close connections with other high-risk facilities	Regular transfers from facilities at higher risk for SARS-CoV-2 transmission (e.g., homeless shelters, group homes, and correctional facilities)	Develop county and state level plans that support the needs of all higher-risk facilities and address issues such as integrated testing strategies, expanded screening approaches, and community surveillance

Staff members		
Physical strain	Time-consuming, frequent wellbeing checks; need for physical restraint of violent/uncooperative patients	Plan for additional or surge workforce capacity; consider flexible leave policies to account for added strain; make provisions for any staff member at higher risk of severe outcomes from COVID-19
Emotional strain	Possible high HCP turnover; potential stigma of working in a psychiatric facility with active SARS-CoV-2 transmission	Plan for additional or surge workforce capacity; develop a communications plan to address stigma
Risk of exposure for clinical care staff members	Patient behavior might increase risk of SARS-CoV-2 exposure (e.g., spitting, licking, thrashing, or intentionally dislodging PPE)	Use modified PPE to allow unrestricted movement and reduce risk of exposure for clinical care staff members working with violent and nonviolent patients (e.g., goggles instead of glasses or face shields, respirators instead of surgical masks, or Tyvek suits instead of gowns)
Risk of exposure for nonclinical care staff members	Security staff members, constantly present on some wards, might be first to respond to a patient issue/ violent situation, increasing potential for high-risk exposure; similar risks for transportation staff members who interact with patients during transfer	Use modified PPE to allow unrestricted movement and provide access to utility belts when needed for all nonclinical care staff members (e.g., goggles instead of glasses or face shields, respirators instead of surgical masks, or Tyvek suits instead of gowns)
Buildings/Wards		
Social distancing	Open patient wards and rooms to facilitate patient observation; many spaces (including bathrooms) are communal	Control and monitor access to communal areas by symptomatic patients; implement enhanced disinfection practices
Cohorting	Converting single rooms to double occupancy or moving patients to different wards for disease cohorting purposes might be impossible given patients' different psychiatric needs	Utilize other available structures or facilities when possible
Clinical case management	Units and patient rooms often not set up to provide multifaceted clinical care; for safety reasons, rooms often do not include electric outlets to run medical equipment	Plan for transfer of patients to acute care hospitals as needed

Abbreviations: COVID-19 = coronavirus disease 2019; HCP = health care personnel; PPE = personal protective equipment.

Reprinted from: https://www.cdc.gov/mmwr/volumes/69/wr/mm6926a4.htm

VISITATION AND FAMILY MEMBER SUPPORT

Often family members and community support are vital components of the patients'/residents' recovery. These individuals are heavily involved in the patient's lives and have traditionally participated in family meetings and therapy. When safely implemented, this important part of treatment should continue. Continuing these meetings by scheduled appointments in a designated area, following all recommended infection control practices based on facility specific visitation plans, including a protocol for safe interaction with social distancing and cleaning/sanitizing after each use. Alternative steps depending on resources could include virtual visits. Frequent video and/or telephone contact with family and friends (staff may be helpful in facilitating) to include shared visits, walks, movies, games, television watching, drawing, and other activities.

GUIDANCE FOR BEHAVIORAL HEALTH TREATMENT

Infection control guidelines can vary between different types of treatment such as individual therapy, group therapy, and milieu therapy.

Creatively manage the use of shared common space (e.g., group mealtimes, outside times, recreation, exercise, meditation, wellness activities, game times that are staggered). Suspend group meetings or therapy for residents who are exhibiting signs and symptoms of COVID-19 or have been exposed or

tested positive for COVID-19. Ensure physical distancing for participating COVID-19 free unexposed residents. Group activities may be held outside if possible. It is also recommended to have individual activities in residents' rooms. Some groups may also be able to interact virtually, through electronic devices.
Encourage social distancing through posters, signage, television scrolls, and other posted reminders.

Offering therapy remotely, such as teletherapy by videoconference, can effectively meet patient needs and prevent infection of both patient and provider. Staff and patients/residents may be hesitant to accept changes in treatment approach. With support, most patients/residents and staff can adapt to these changes.

GUIDANCE FOR GROUP THERAPY

A. For group therapy sessions held in person, take the following actions to reduce the risk of COVID-19 in your facility:

- Create smaller patient groups (cohorts) in common locations like wings, wards, units, floors, recreation rooms, communal dining halls, workstations, breakrooms, and sleeping quarters.
    - Avoid switching patients/residents between groups.
    - Minimize movement of providers between patient/resident groups. If possible, assign provider teams to a single group.
- Stagger group sessions and consider shorter sessions. For example, you can hold two smaller group sessions for 30 minutes, instead of a larger group session for 60 minutes.
- Place chairs at least six feet apart. All participants should wear cloth face coverings.
- Bring together participants in a space free of distractions. Close the day room to group participants only.
- Make sure participants wash or sanitize their hands when they enter the session and before they leave.
- Disinfect all high-touch surfaces after the session according to CDC guidelines using an EPA approved disinfectant. Facility should follow manufacturer's recommendation for cleaning, disinfection and contact time.

B. For group therapy sessions done via teletherapy:

- Based on facility plan, and facility resources, for remote group therapy sessions, staff can lead the group activity virtually.
- If needed, a provider can have video sessions running in several rooms for psychoeducational groups, recreational therapy groups, or question and answer groups.

GUIDANCE FOR INDIVIDUAL THERAPY

- Stagger the time providers schedule therapy sessions to avoid close contact between patients/residents while in waiting areas.

- Both the patient/residents and provider should wear a mask and remain at least six feet apart during in-person sessions.
    - Teletherapy is a good option for patients/ residents who struggle with wearing masks or are uncomfortable speaking with someone wearing a mask.
- After each visit and before the next patient/resident arrives, clean and disinfect all surfaces touched by both the patient and provider according to CDC guidelines using an EPA approved disinfectant. Facility should follow manufacturer's recommendation for cleaning, disinfection and contact time.
- Educate patients/residents on safety measures that reduce their risk of infection.
- If patients/residents have difficulties focusing during teletherapy, consider offering multiple shorter sessions as an alternative.

INFECTION PREVENTION AND CONTROL

Generical Personal Protective Equipment PPE considerations:

- Universal Masking Source Control Measures:
    - Healthcare Personnel (HCP) should wear a well-fitting* facemask at all times while they are in the facility.
      Well-fitting facemasks are generally preferred for HCP as facemasks offer both source control and protection for the wearer against exposure to splashes and sprays of infectious material from others. Facility should follow their internal policy on extended use and reuse of facemasks. Cloth face coverings should NOT be worn by HCP instead of a respirator or facemask and they are not considered personal protective equipment (PPE) appropriate for use by healthcare personnel.
    - Residents/Patients should wear a well-fitting* cloth face covering or facemask (if tolerated) whenever they leave their room, or when HCP are in their room to provide care, including for procedures outside the facility.
        - Cloth face coverings should not be placed on anyone who has trouble breathing, or anyone who is unconscious, incapacitated, or otherwise unable to remove the mask without assistance.
        - In addition to the categories described above cloth face coverings should not be placed on children under 2.
    - Visitors, if permitted into the facility, should wear a well-fitting* cloth face covering while in the facility. Visitors who are not able to wear source control should be encouraged to use alternatives to on-site visits with patients/residents (e.g., telephone or internet communication), particularly if the patient is at increased risk for severe illness from SARS-CoV-2 infection.

*** Note:**

A well-fitting facemask should have no air flow from the area near the eyes or from the sides of the mask; proper efficacy could be achieved with below optional methods:

- Selection of a facemask with a nose wire to help the facemask conform to the face.
- Selection of a facemask with ties rather than ear loops.
- Use of a mask fitter or brace may also help to improve fit.
- Tying the facemask's ear loops and tucking in the side pleats.

For further information, please refer to the following CDC link:
https://www.cdc.gov/coronavirus/2019-ncov/prevent-getting-sick/mask-fit-and-filtration.html

SPECIFIC PPE CONSIDERATIONS

HCP who enter the room of a patient/resident with suspected or confirmed SARS-CoV-2 infection should adhere to standard precautions and transmission based precautions, and use a NIOSH-approved N95 or equivalent or higher-level respirator, gown, gloves, and eye protection (i.e., goggles or a face shield that covers the front and sides of the face).

CLEANING AND DISINFECTANT

Ensure cleaning and disinfectant supplies are available as well as tissues, waste receptacles, and alcohol-based hand sanitizer. Ensure housekeeping and assigned staff frequently sanitize and disinfect all high touch areas.

Facilities should use an EPA approved disinfectant, following manufacturer recommendations for cleaning, disinfection and contact time.

HEALTHCARE PERSONNEL

- Train staff on standard and transmission-based precautions: airborne, contact, and droplet precautions.
- Provide staff with appropriate personal protective equipment (PPE) and training on proper usage, including putting on (donning) and taking off (doffing) PPE.
    - If PPE supplies are running low or absent, refer to the CDC Strategies to Optimize the Supply of PPE and Equipment Guidance. https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/general-optimization-strategies.html
- Communicate with staff regularly about COVID-19 and provide any relevant updates.
    - Inform staff on policies for flexible medical leave. Instruct them on who to tell if they believe they are sick with COVID-19. Sick staff should stay home.
- For staff that were in contact with someone that may be ill with COVID-19, follow CDC's guidance on how to assess risk and determine work restrictions for healthcare workers that were potentially exposed to COVID-19. https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-risk-assesment-hcp.html

https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-after-vaccination.html

- To determine when staff can return to work safely, CDC also provides return to work criteria for healthcare personnel with suspected or confirmed COVID-19. https://www.cdc.gov/coronavirus/2019-ncov/hcp/return-to-work.html

- Preserve healthcare system functioning:
  Staffing shortages may become more common as healthcare workers also become infected and are quarantined. Based on facility emergency operational plans, facilities should make a plan for staff absences and shortages. Refer to CDC strategies to mitigate healthcare personnel staffing shortages at:
  https://www.cdc.gov/coronavirus/2019-ncov/hcp/mitigating-staff-shortages.html

SUPPORTS FOR SUCCESSFUL DISCHARGE AND TRANSFER

Discharge during the Public Health Emergency (PHE) is more complicated and requires additional planning. For individuals who are COVID-19 positive or have COVID-19 symptoms and are being transitioned to another setting for isolation or treatment, such as discharge to home or temporary transfer to another facility or alternate care site, below are some steps which may be taken to help ensure successful placement**.**

- Staffing and support for discharge planning and follow-up must be individualized.
- Any transition should include a person-centered plan that factors in services and support needs.
- Provide information about the move to everyone involved and be prepared to repeat it, as needed. For patients/residents with confirmed or suspected COVID-19 infection, coordinate to ensure proper quarantine is available. Personnel on the receiving end should understand the habits and schedule of the individual, with daily routines as intact as possible. The plan should address:
  - Support to move personal items.
  - Safe and adequate housing.
  - Access to clothing, personal items, meals, personal hygiene supplies, mail, phone, computer, and other technology.
  - Medication management.
  - Support from decision makers or other responsible individuals, as appropriate.
  - Access to peer supports, as appropriate.
  - Other social supports (e.g., faith-based supports, linkages to family, friends, other community and family-based support systems).
  - Access to personal protective equipment for staff and masks for residents.
  - Access to medical and non-medical transportation with drivers who have access to PPE.
  - Consideration of the cost of care at another setting, including any insurance coverage and private resources (Medicare, Medicaid, long-term care insurance, etc.)
  - Notification to decision makers, family, caregiver(s), friends, and others, as indicated, in person centered plan or at the person's direction.

- Assurance that the receiving facility or care site can meet ongoing services and support needs, including the ability to support required infection control interventions to prevent transmission of communicable diseases.
- Access to medical care/physician(s), including behavioral health providers.
- Information about the potential to return to the original setting if desired or future plans to transition to the community (if the receiving facility is not a community setting).
- If restrictions are in place for outside service providers, facilities can utilize telehealth strategies to engage outside providers to assess and otherwise engage with individuals in order to develop or refine person-centered plans of care, develop rapport, and facilitate various aspects of transition including virtual meetings with housing providers, apartment walkthroughs, pest control, provision of furnishings and supplies, and other necessary interactions.
- Facilities must ensure that all information needed to develop a community-based person-centered plan of care, services and supports, benefits, secure housing, and other information to facilitate transition is provided expediently to provider staff, family and caregiver(s), and others who may be involved in transition activities.

DISCHARGES/TRANSITIONS TO A COMMUNITY PROVIDER

- Home and community-based services providers should have direct access to service recipients prior to discharge. A person-centered plan needs to be developed, to include the individual's understanding their known or suspected diagnosis of COVID-19 and how to manage COVID-19 to prevent transmission, which may be different for each individual. If visiting restrictions are in place for outside service providers, facilities should utilize telehealth strategies to engage outside providers to assess individuals in order to develop community-based plans of care, develop rapport, and facilitate all aspects of transition. Facilities should ensure that all information needed to develop or update a person-centered service plan, provide sufficient medications, schedule critical appointments, obtain benefits, ensure medically necessary support services, secure housing and otherwise facilitate a smooth transition is provided expediently to provider staff, clinical staff, the person, his/her family or representatives, and others.
- Facility staff should be able to accommodate these functions and provide information on a flexible schedule. This means that discharge planning meetings and actual discharges may need to occur during non-traditional business hours such as evenings and weekends.
- Facility staff should ensure that community-based provider staff have the capacity to meet service recipient needs in the community, and that they have adequate caregivers and PPE to see and interact with the individual in the current residence for planning purposes.
- Institutional settings and community-based providers should work together to ensure that individuals who are no longer in need of or no longer want facility-based services can transition to the community through robust strategies to ensure that person-centered transition planning occurs, and incorporate policies and procedures that ensure sound infection control practices

for the residence, residents, clients, caregivers, and community providers. This may include the use of telehealth for team meetings, consumer/client engagement, service planning, or a virtual walk.

- Consideration of notification to Nevada's Protection & Advocacy system about any transfers of individuals from the original setting, as needed or requested by the individual or his/her representative. The Nevada Disability Advocacy & Law Center (NDALC) serves as Nevada's federally mandated protection and advocacy system. More information on Nevada's Protection & Advocacy system can be found at: https://www.ndalc.org/

DEFINITIONS

Cloth face covering: Textile (cloth) covers that are intended to keep the person wearing one from spreading respiratory secretions when talking, sneezing, or coughing. They are not PPE and it is uncertain whether cloth face coverings protect the wearer**.** Guidance on design, use, and maintenance of cloth face coverings is included in the list of references.
Facemask: Facemasks are PPE and are often referred to as surgical masks or procedure masks. Use facemasks according to product labeling and local, state, and federal requirements. FDA-cleared surgical masks are designed to protect against splashes and sprays and are prioritized for use when such exposures are anticipated, including surgical procedures. Facemasks that are not regulated by FDA, such as some procedure masks, which are typically used for isolation purposes, may not provide protection against splashes and sprays.
Respirator: A respirator is a personal protective device that is worn on the face, covers at least the nose and mouth, and is used to reduce the wearer's risk of inhaling hazardous airborne particles (including dust particles and infectious agents), gases, or vapors. Respirators are certified by the CDC/NIOSH, including those intended for use in healthcare. Refer to the references below for a summary of different types of respirators.

REFERENCES

- CMS regulation for COVID-19 Infection Control for Psychiatric and Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICFs/IID): https://www.cms.gov/files/document/qso-21-07-psych-hospital-prtf-icf-iid.pdf
- Interim Considerations for State Psychiatric Hospitals https://www.samhsa.gov/sites/default/files/covid19-interim-considerations-for-state-psychiatric-hospitals.pdf
- Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic: https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html
- Comprehensive Hospital Preparedness Checklist for Coronavirus Disease 2019 (COVID-19): https://www.cdc.gov/coronavirus/2019-ncov/hcp/hcp-hospital-checklist.html

- Healthcare Professional Preparedness Checklist for Transport and Arrival of Patients/ Residents with Confirmed or Possible COVID-19: https://www.cdc.gov/coronavirus/2019-ncov/hcp/hcp-personnel-checklist.html
- Infection Prevention and Control Assessment Tool for Acute Care Hospitals: https://www.cdc.gov/infectioncontrol/pdf/icar/hospital.pdf
- Considerations for Preventing Spread of COVID-19 in Assisted Living Facilities: https://www.cdc.gov/coronavirus/2019-ncov/hcp/assisted-living.html
- Coronavirus Disease 2019 (COVID-19) Preparedness Checklist for Nursing Homes and other Long-Term Care Settings: https://www.cdc.gov/coronavirus/2019-ncov/downloads/novel-coronavirus-2019-Nursing-Homes-Preparedness-Checklist_3_13.pdf
- Screening for SARS-CoV-2 Infection Within a Psychiatric Hospital and Considerations for Limiting Transmission Within Residential Psychiatric Facilities — Wyoming, 2020 Screening for SARS-CoV-2 Infection Within a Psychiatric Hospital and Considerations for Limiting Transmission Within Residential Psychiatric Facilities — Wyoming, 2020 | MMWR (cdc.gov)
- Your Guide to Masks: https://www.cdc.gov/coronavirus/2019-ncov/prevent-getting-sick/about-face-coverings.html
- Types of Masks and Respirators: https://www.cdc.gov/coronavirus/2019-ncov/prevent-getting-sick/types-of-masks.html