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Center for Clinical Standards and Quality/Quality, Safety & Oversight Group

Ref: QSO-21-07-Psych Hospital, PRTF & ICF/IID

DATE: **December 17, 2020**

TO: State Survey Agency Directors

FROM: Director
Quality, Safety & Oversight Group

SUBJECT: COVID-19 Infection Control for Psychiatric and Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICFs/IID)

Memorandum Summary

- *CMS is committed* to taking critical steps to protect all Americans including those with intellectual and developmental disabilities to ensure America's health care facilities are prepared to respond to the Coronavirus Disease 2019 (COVID-19) Public Health Emergency (PHE).

- *CMS is providing guidance* to psychiatric hospitals, Psychiatric Residential Treatment Facilities (PRTFs) and Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICFs/IID) to improve their infection control and prevention practices, in part, to prevent or lessen the need for use of seclusion and restraint as an infection control intervention.

- *All Psychiatric hospitals, PRTFs and ICF/IIDs should monitor the CDC website* for information and resources, and contact the local health department, when necessary (CDC Resources for Health Care Facilities: https://www.cdc.gov/coronavirus/2019- ncov/healthcare-facilities/index.html).

Background

Providing care to patients and clients in Psychiatric hospitals, PRTFs and ICF/IIDs present unique care considerations and associated infection control challenges during the COVID-19 Public Health Emergency (PHE). CMS is providing additional clarification and guidance to improve infection control practices to assist in preventing the transmission of COVID-19, and to help avoid the need for use of seclusion and restraint, specifically as an infection control intervention.

Seclusion and restraint are emergency interventions that should only be used when the danger of harm to self or others clearly requires such invasive techniques, and only when staff have been trained in alternatives, as well the appropriate emergency use of these techniques. Approaches

and practices such as positive behavior management strategies have been shown to significantly reduce the use of restraint and seclusion.

<u>Discussion</u>

CMS recognizes that during the COVID-19 PHE, facilities face special challenges in supporting the needs and preferences of individuals with behavioral health needs, intellectual and developmental disabilities, dementia and other cognitive disorders, which may require a range of strategies to reduce the spread of infection while avoiding the use of restrictive interventions, including restraint and seclusion. A restraint is generally defined as a manual method that immobilizes or reduces a person's ability to move freely, or a drug used as a restriction to manage behavior or restrict freedom of movement that is not a standard treatment or dose for the person's condition. Certain devices (e.g. helmets, orthopedically prescribed devices) are excluded as restraints. Seclusion is the involuntary confinement of a person alone in a room or area from which the individual is prevented from leaving.[12]

CMS, after consulting with advocacy groups, clinicians, and other stakeholders, has developed a Frequently Asked Questions (FAQ) document to identify strategies and promising practices for Medicare or Medicaid certified facilities to help address COVID-19 prevention, treatment and mitigation strategies. This includes positive behavioral strategies to address individuals' support needs during the pandemic. These practices can be employed to assist people who refuse testing, are confirmed COVID-19 positive, or have COVID-19 symptoms, yet are unable or unwilling to isolate, cohort, or wear personal protective equipment (PPE). CMS is committed to ensuring the use of most inclusive interventions during the PHE for the protection and support of all individuals served in congregate settings.

The attached Frequently Asked Questions (FAQs) are intended to provide guidance in the following areas:
- Promising practices, measurement, and mitigation strategies for infection control during the PHE
- Use of isolation, cohorting and PPE
- Intervention, mitigation, and training strategies
- Transition and discharge during the PHE
- Engaging family, caregiver, support personnel, and community resources
- Available local, State and Federal resource guides and web links

Contact: QSOG_EmergencyPrep@cms.hhs.gov

Effective Date: Immediately. This policy should be communicated with all survey and certification staff, their managers and the State/Regional Office training coordinators within 30 days of this memorandum.

/s/

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[1] https://www.cms.gov/Regulations-and-Guidance/Legislation/CFCsAndCoPs/Downloads/finalpatientrightsrule.pdf

[2] https://www.congress.gov/106/plaws/publ310/PLAW-106publ310.pdf

Attachment- CMS Guidance for Infection Control in Communities Serving Individuals with Mental Health, Psychiatric and Cognitive Impairment- Frequently Asked Questions (FAQs)

cc: Survey and Operations Group Management

CMS Guidance for Infection Control in Communities Serving Individuals with Behavioral Health, Psychiatric and Cognitive Impairment Issues

Frequently Asked Questions (FAQ)

During the COVID-19 Public Health Emergency (PHE), facilities and other community providers face a myriad of challenges supporting the needs and preferences of people with behavioral health conditions, intellectual and developmental disabilities, dementia, and other cognitive disorders as they seek to reduce and prevent the spread of infection. The purpose of this document is to provide guidance that can be used across Medicare or Medicaid certified facility types and other congregate settings to help maximize acceptance of COVID-19-related modifications, enhance quality of life during the PHE, and minimize incidents of seclusion and restraint, including those related to COVID-19 status and protective strategies.

Addressing Refusal or Reluctance to COVID-19 Modifications

1. **What promising practices can be employed to assist people with behavioral health conditions, intellectual and developmental disabilities (IDD), dementia, and other cognitive disorders who refuse testing, are confirmed COVID-19 positive, or have COVID-19 symptoms but are unable or unwilling to isolate, cohort, or wear (Personal Protective Equipment) PPE?**

   - Facilities should adhere to infection control plans and best practices involving support, individualized engagement strategies and close monitoring of any use of seclusion and restraint related to COVID-19 status, as well as adherence to PPE policies.

   - All new admissions should be quarantined on admission 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

   - Consistently remind the person of the broader community-oriented goals for using PPE (e.g. using PPE can help to protect them, and their friends, family, caregivers, and others including residents/clients/staff from infection) Help the person use distraction, relaxation, and mindfulness techniques while wearing PPE. All individuals in care should have at least one space where they can spend time safely while <u>not</u> wearing PPE

   - Try to understand the reasons for not wanting or not consenting to a test (e.g., stigma, loss of freedom, not having an area to shelter in place, fear of testing procedure), and respond to the person's expressed concerns

   - Provide education about COVID-19 including risks of transmission to others, benefits of early identification, and treatment where needed (check the Centers for Disease Control and Prevention website for the most current information on these topics). Offer several selections for face masks such as a change in texture [e.g. material, style (elastic straps behind the ears, clear mask or mask with clear portion), fashion (color, characters, sayings,

sports team logos, etc.) and type (disposable, washable)]. Although there is currently not enough evidence to support the effectiveness of face shields as a substitute for a mask, some face shields, like those that wrap around the sides of the face and extend below the chin, and hooded face shields, may have more "source control" benefits for people who cannot wear masks. For more information on masks see: https://www.cdc.gov/coronavirus/2019-ncov/prevent-getting-sick/cloth-face-cover-guidance.html

- Treat anyone who is experiencing symptoms consistent with COVID-19 (fever, chills, cough, nausea, new loss of taste or smell, sore throat, etc.) as possibly infected. For more information see: https://www.cdc.gov/coronavirus/2019-ncov/downloads/COVID19-symptoms-24x36-en.pdf and https://www.cdc.gov/coronavirus/2019-ncov/symptoms-testing/symptoms.html. Be aware of the similarities and differences between COVID-19 and influenza (flu): https://www.cdc.gov/flu/symptoms/flu-vs-covid19.htm

- Symptomatic individuals should be moved to a quarantine area or into a separate space away from non-symptomatic or tested COVID-negative individuals. In some situations such as when an individual is increasingly non-compliant with quarantine, worsening medical symptoms, or quarantine area has reached capacity, this could prompt discharge to a different setting such as a hospital, another group home or community setting, or, if appropriate, return to family or original personal home/residence.

- Encourage wearing residents to wear masks. For example, try to transition from wearing masks while sitting in more isolated settings for a few minutes to wearing it in public settings for longer periods of time. Some individuals may use a regular hand-washing schedule, followed by moisturizer. Celebrate success and say "thank you" often with PPE compliance. For information on PPE see: https://www.cdc.gov/coronavirus/2019-ncov/hcp/using-ppe.html

- Establish dedicated space for symptomatic or exposed individuals to quarantine. These arrangements will vary depending on available space (e.g. hospital with several units versus a smaller residential facility with limitations). Special considerations should be used for shared areas, like bathrooms. Key environments (e.g. dining space), rooms, and other areas should be properly cleaned and disinfected. The use of additional space should not comprise compliance with conditions of participation or other service requirements. For more information see: https://www.cdc.gov/coronavirus/2019-ncov/community/shared-congregate-house/guidance-shared-congregate-housing.html and https://www.cdc.gov/coronavirus/2019-ncov/community/organizations/cleaning-disinfection.html

- 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 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

- In larger facilities, re-introduce recreational activities, for residents who are not symptomatic, like walks and exercise in a manner that allows for physical distancing, including using outdoor settings when appropriate

- Establishment of support groups for people struggling with pandemic-related constraints

- Consider establishing peer support groups for residents/clients struggling with pandemic-related constraints, where individuals can share stories to help build resilience, or establish peer "buddies" who can interact virtually. Some electronic devices may use "one chat" functions to help facilitate participation

- Consideration of health disparities and the use of culturally and linguistically tailored materials, and tailored staff assignments

- Frequent video and/or telephone contact with family and friends (staff may be helpful in facilitating) to include virtual shared visits, walks, movies, games, television watching, drawing, singing, and other activities

- Consider the discharge or transfer of individuals who want to live in a personal home or other community-based setting, which may be able to provide a safer or more preferred environment. Ensure the accepting facility is prepared and able to provide the required treatment or quarantine if the resident is positive for COVID-19. Some states have special programs in Medicaid under the "Money Follows the Person" program that can assist in transitioning eligible individuals from certain institutional to community settings: https://www.medicaid.gov/medicaid/long-term-services-supports/money-follows-person/list-of-money-follows-person-grantees/index.html

- Implement targeted educational strategies including games, planning, and counseling to help individuals better understand why testing and screening is critical to everyone's safety

- Encourage social distancing through posters, signage, television scrolls, and other posted reminders

Supports for Successful Discharge and Transfer

2. **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, what steps can be taken to help ensure successful placement?**

- Discharge during the PHE is more complicated and requires additional planning. Staffing and support for discharge planning and follow-up must be individualized. Survey activities during COVID should focus on quality and the appropriateness of discharge planning and discharge planning services.

- Any transition should include a person-centered plan that factors in services and supports needs. Provide information about the move to everyone involved and be prepared to repeat it, as needed. For 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 supports needs, including the ability to support required infection control interventions to prevent transmission
  - Access to medical care/physician(s), including behavioral health providers
  - Consideration of notification to the Protection & Advocacy about any transfers of individuals from the original setting, as needed or requested by the individual or his/her representative
  - 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 walk-throughs, 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 transmissions, 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, virtual walk through for apartments, and other strategies

Challenging Behaviors, and Seclusion and Restraint

3. What are promising practices to best address challenging behaviors (e.g. agitation, aggression, loud vocalizations, wandering), enhance quality of life, and help ensure that the use of seclusion and restraint across various care settings can be avoided?

It is important to distinguish behavioral symptoms of conditions like dementia and IDD from other mental and physical conditions, including delirium. These could include pain, infection, electrolyte disturbances, constipation, sleep disturbance, sensory impairment, untreated illness, and polypharmacy. If no clear medical cause is identified, mental conditions like depression, anxiety and psychosis – even loneliness - are possible. Some individuals may have a previous history of a mental disorder such as depression, substance use disorder(s), anxiety, and bipolar disorder. Others may have experienced trauma (e.g. Veterans, abuse, disaster survivors). Environmental stressors like change in routine, cultural issues, noise, and caregiver issues should be identified and addressed using mechanisms such as positive behavioral strategies, environmental modifications, and carefully planned transition from or to various settings.

Seclusion and restraint are emergency interventions that should only be used when the danger of harm to self or others clearly requires such invasive techniques, and only when staff have been trained in alternatives, as well the appropriate emergency use of these techniques.

- Some prescribers may use sedating medications such as antipsychotics, anti-depressants, and benzodiazepines as a way to manage challenging behaviors. These practices can expose individuals to significant risk, and should be used only when clinically indicated.

- Approaches and practices such as positive behavior management strategies have been shown to reduce the use of seclusion and restraint, and challenging behaviors.

- Maximize the use of routine schedules, avoidance of demanding tasks, creating a positive environment, and providing opportunities to engage in activities that are meaningful to the person.

- Avoidance of experiences that may trigger challenging behaviors.

- Use of positive phrasing, praising desired behaviors, relaxation techniques, tangible preferred reinforcers, photographs, and favorite foods as rewards or incentives.

- Music therapy, aroma therapy, massage therapy, light therapy, pet therapy, and multisensory stimulation may be helpful for some individuals.

- Use of quiet areas or sensory zones that include environmental accommodations like rocking chairs or beanbag chairs.

- Supporting spiritual needs and concerns such as CMS Spiritual Support Guidance, as appropriate.

- Exercise and activity can also be effective.

- Develop consistent, strong, and trusting relationships between caregivers and individuals with challenging behaviors to more effectively engage them in interactions that will reduce anxiety and agitation.

- Provide information to residents and staff on self-care, stress, and coping, and acknowledge their sadness, tiredness, or frustration.

- Monitor eating and drinking habits for changes. This could include reminders; assistance with verbal, visual, or tactile cues; and talking with the person during mealtime.

- Watch for changes in sleep, eating, and mood as indications that individuals may need additional assistance adapting to changes, processing emotions, and implementing wellness strategies.

- Develop an array of ways for residents to maintain social connections with friends, family, and significant others. Ideas include taking picture of visits to remind the person he/she has had visitors, hosting electronic town halls, and asking family/friends to send batches of pictures and letters so the person can enjoy new daily messages.
- Incorporate wellness activities such as stretching and breathing exercises, yoga, meditation, etc. to help offset restrictions on activities outside the facility or community setting.

- Prevent and address caregiver burnout and stress – talk and listen to paid caregivers, who may be concerned about their own health status. Monitor, support, and address caregiver physical and mental health and well-being and make appropriate resources available.

- Communicate clearly and often with families and other unpaid caregivers, residents/clients, staff, and community through e-mail, social media, paper, mail, website, press releases, local media, public announcements as appropriate.

- If wellness activities are group-based:
  - Use social distancing
  - Avoid touching the same equipment (such as balls or other recreational equipment) unless the equipment is disinfected between one user and the next.
  - Advise people to wear face masks, when necessary

Seclusion and Restraint Resources:

- [Roadmap to Seclusion and Restrain Free Mental Health Services](#)
- [National Resource Center on Psychiatric Advance Directives](#)
- [SAMHSA Guidance on Inappropriate Use of Antipsychotics for Older Adults and IID](#)

Medicaid and Other Federal Resources

4. **What Medicaid or HHS funded supports and resources are available to assist individuals with cognitive, behavioral and behavioral health conditions seeking discharge or diversion from institutional care settings during the COVID-19 PHE? What resources are available to assist the individual in understanding those options?**

- A variety of community-based services and living options may be available to an individual seeking discharge from an institutional setting, depending on the state, and the person's Medicaid eligibility status. Services for certain individuals may be covered under various Medicaid statutory authorities, including state plan services, waivers, and demonstration programs. States make decisions about which residents are eligible for home and community-based services programs and other services within their Medicaid programs.

- Housing assistance may be available through U.S. Department of Housing and Urban Development programs. To understand the specific array of community based supports and services, contact the state's Medicaid agency, https://www.medicaid.gov/about-us/contact-us/contact-your-state-questions/index.html, State agency for Individuals with Intellectual/Developmental Disabilities https://nasddds.org/state-agencies/, and/or the State

Mental Health Agency http://nasmhpd.org/content/nasmhpd-rosters. The Eldercare Locator can also connect individuals, families, and caregivers to local resources such as Area Agencies on Aging, Adult Protective Services, Centers for Independent Living, Legal Aid, and Long-Term Care Ombudsman: https://eldercare.acl.gov/Public/Index.aspx

● While transitions from institutional settings to community settings require additional strategies to minimize virus transmission, transitions should not cease during these times. Individuals have the right to choose where they live, and where they receive care, and their preferences should be honored whenever possible.

Common Medicaid home and community-based services that might be available in a particular program include:

● Personal care
● Chore services
● Home-delivered meals
● Extended home health services
● Physical therapy
● Medication management
● Environmental modifications
● Respite care
● Adult day health

States have various service delivery options, such as choosing to authorize family members as paid caregivers. States may also offer care delivered through self-direction, where the person may have flexible hiring and other authority over staff and a budget; care can also be delivered through a managed care delivery system: https://www.medicaid.gov/medicaid/managed-care/managed-long-term-services-and-supports/index.html and https://acl.gov/sites/default/files/programs/2017-03/2402-a-Guidance.pdf.

Staff Training and Environmental Modifications

5. **In addressing the needs of special populations (e.g. individuals with dementia, children/youth) during the COVID-19 PHE what training (i.e. person-centered approaches, skills or competencies), environmental modifications, or other resources may be used to assist staff?**

● The CDC has created a central repository of guidelines, tools, and resources for states, tribes, localities, and territories. See the following CDC links: CDC resources for States, tribes, localities and territories to reopen and CDC COVID-19 Health Department Resources for State, Territorial, Local and Tribal Communities

● For guidance on protection of essential workers see the following CDC links: https://www.cdc.gov/coronavirus/2019-ncov/hcp/index.html and https://www.cdc.gov/coronavirus/2019-ncov/community/critical-workers/implementing-safety-practices.html

● Training and re-training staff in engagement strategies including responsive customer trauma-

informed practices, role modeling the use of PPE, and motivational interviewing.

- Facility staff should incorporate unpaid caregivers, friends, peers and others into telehealth sessions to provide support when possible and appropriate

Specific interventions could include:

- For individuals who may need assistance in understanding situations or who may have difficulty with proposed approaches (due to aged-related cognitive disorders or other conditions) person-centered, behavioral approaches such as Staff Training in Assisted-living Residency (STAR) or positive behavior support approaches can be useful for giving staff a framework for team-based problem-solving. The goal is to understand what might underlie challenging behaviors and how to respond effectively. General points to consider include the need for the environment to be neither over- nor under-stimulating, the importance of person-centered preferences for temperature (e.g., extra blankets), light/darkness, music, etc. Information on person-centered planning and facilitation is available at: http://www.qualityforum.org/Publications/2020/07/Person_Centered_Planning_and_Practice_Final_Report.aspx, and also from the Administration for Community Living and CMS's National Center for Advancing Person-Centered Planning Practices and Systems: https://ncapps.acl.gov/

- For individuals who are unable to rely on speech alone to communicate: ensuring access to a robust array of communication tools, supports and accommodations can enhance outcomes. Examples include communication boards with symbols (e.g., objects, pictures, photographs, line drawings, visual-graphic symbols, printed words, traditional orthography) or computers, handheld devices, or tablet devices with symbols that generate speech through synthetically produced or recorded natural (digitized) means

- Increased availability of therapeutic quiet spaces and outdoor environments may improve individuals' ability to minimize stress and to increase opportunities for appealing social distancing options, including those that are not "one size fits all"

- If the facility is experiencing an unusual surge in positive COVID-19 individuals being served which is negatively affecting the quality and/or continuity of care, then the facility should consider implementing its emergency preparedness program to provide maximum ability to provide quality care while maintaining infection control

Behavioral Health Resources

6. **What promising practices exist to engage individuals with behavioral health conditions participate in COVID-19 prevention, treatment, and mitigation strategies?**

- **Motivational Interviewing** (MI) is a strengths-based, client-centered engagement intervention that enhances motivation to change and resolves ambivalence. Motivational Interviewing (MI) is "a client centered, directive method for enhancing intrinsic motivation to change by exploring and resolving ambivalence" (Miller and Rollnick, 2002). It is a way that can help people encourage themselves to change. The MI approach elicits and respects

consumers' values, wisdom, and motivation to change, rather than attempting to convince consumers to follow a particular prescribed course of action. For more information see: https://www.samhsa.gov/sites/default/files/programs_campaigns/homelessness_programs _resources/path-spotlight-motivational-interviewing.pdf.

- **Trauma-informed Care** is a strengths-based service delivery approach "that is grounded in an understanding of and responsiveness to the impact of trauma, that emphasizes physical, psychological, and emotional safety for both providers and survivors, and that creates opportunities for survivors to rebuild a sense of control and empowerment" (Hopper, Bassuk, & Olivet, 2010, p. 82). It also involves vigilance in anticipating and avoiding institutional processes and individual practices that are likely to re-traumatize individuals who already have histories of trauma, and it upholds the importance of consumer participation in the development, delivery, and evaluation of services. For more information   see: https://www.samhsa.gov/sites/default/files/programs_campaigns/childrens_mental_health /atc-whitepaper-040616.pdf

- **Culturally responsive services** promote the ability of staff to build the trust, rapport, and continuous engagement required to fully engage individuals. This work takes a large and long-term commitment by administrative leaders and should occur through multiple activities including a formal position statement; policy and procedures; new employee orientation and annual training with measurable outcomes; additions to job descriptions and competency skill checklists; adequate access to services and materials in an individual's preferred language; hiring practices; signage; as well as admission assessments and treatment   planning.   For   more   information   see: https://minorityhealth.hhs.gov/omh/browse.aspx?lvl=1&lvlid=6

- **Peer support staff** involves utilizing individuals who have lived experience with behavioral health issues. Peers can draw from similar or analogous experiences to help a person understand the ramifications of their choices, and are often the individual's most trusted resource. For more information see: https://www.samhsa.gov/brss-tacs/recovery-support-tools/peers

- **Each individual**, regardless of age or diagnosis, has differing support needs, both to understand issues linked to the COVID-19 pandemic, and to help adhere to practices effective in minimizing the spread of the virus. Taking a person-centered approach must be done through a thoughtful, process to both understand where there may be alternatives to customary guidelines (for example, for someone with sensory sensitivities who cannot tolerate a mask, individuals who may have difficulties washing hands for the recommended time, people who cannot avoid face touching), and to identify the best approaches to meet the person's particular needs. According to the National Quality Forum, "person-centered planning is a facilitated, individual-directed, positive approach to the planning and coordination of a person's services and supports based on individual aspirations, needs, preferences, and values." [1]The National Center on Advancing Person- Centered Practices

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[1] http://www.qualityforum.org/Publications/2020/07/Person_Centered_Planning_and_Practice_Final_Report.aspx

and Systems is an initiative from the Administration for Community Living and CMS that includes many resources on person-centered care, including those specific to assisting individuals during the PHE, such as the Health Care Person-Centered Profile. For more information see: https://ncapps.acl.gov/home.html

- **Supporting individuals** to feel empowered as a part of a solution is also a strong strategy. Some health settings have engaged individuals to help educate and inform their peers about prevention strategies. Some examples include providers that have enlisted the help of individuals in the creation of masks for residents, staff, or the broader community, as well as sending supportive letters and cards to front line healthcare workers

<u>Additional Resources:</u>

- Institutional Settings, including congregate residential programs: CDC Guidelines: https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control- recommendations.html

- SAMHSA Covid19: Interim Considerations for State Psychiatric Hospitals: https://www.samhsa.gov/sites/default/files/covid19-interim-considerations-for-state-psychiatric-hospitals.pdf

- CMS/ACL Person-Centered Planning and COVID-19 Resources: National Center on Advancing Person-Centered Practices and Systems

- CMS Nursing Home Resource Center: https://www.cms.gov/nursing-homes

- Health Resources and Services Administration, Alzheimer's and Related Dementia Caregiver Training Curriculum (for professionals, and unpaid caregivers): https://bhw.hrsa.gov/grants/geriatrics/alzheimers-curriculum

- The CDC has published guidance for Group Homes for Individuals with Disabilities: https://www.cdc.gov/coronavirus/2019-ncov/community/group-homes.html

- Free peer support services are available in most communities through organizations like NAMI, Mental Health America, Anxiety and Depression Association of America, SAMHSA Help Line.

- SAMHSA provides a toll free helpline to assist in referrals to community resources as does NAMI

- Centers for Independent Living are a nationwide network funded by the Administration for Community Living and are mandated to provide nursing home transition services.

- The No Wrong Door system is a statewide approach to creating a seamless interface between people needing long term services and the complex service and support system in states and communities

- [SAMHAs disaster distress helpline](#) is a national helpline for staff and residents

- [CMS Advance Care Planning and CMS Preventative Services](#) before an injury or illness allows the person to make determinations about future care, explain how others can be informed about care preferences, and facilitate caregiver identification. An advance directive is a document that appoints an agent and/or records the person's wishes about medical treatment based on personal values and preferences, to be used at a future time if the individual is unable to speak for themselves. "Advance directive" is a general term that refers to various documents such as a living will, instruction directive, health care proxy or health care power of attorney. State attorney Generals' websites typically post forms. Medicare pays for this services as an optional element of the Annual Wellness Visit, or as a Part B Service (with a co-pay/deductible)