



9/28/20

COVID-19 Infection Control Summary for Non-hospital-based Inpatient and Residential Addiction Treatment Providers

Recently, significant community transmission of COVID-19 has occurred in the United States (US) including New York State (NYS). The situation with COVID-19 infections identified in the US and NYS continues to evolve and is rapidly changing.

The purpose of this guidance is to ensure the health and safety of provider staff to provide and support patient care while limiting interruption of services as much as possible, as well as to protect the health and safety of patients and the public at large. Hospital-based OASAS programs should follow their own institution’s infection control policies and protocols. However, they should feel free to discuss any potentially useful information herein with their institution’s leadership. It has been compiled, summarized, and adapted entirely from other official sources, including guidance from the Centers for Disease Control and Prevention (CDC), the NYS Department of Health (NYS DOH), the NYS Office of Mental Health (OMH), and OASAS. It is important for all providers to keep apprised of current guidance by regularly visiting the CDC and NYS DOH websites, as well as the NYS DOH Health Commerce System (HCS).

- CDC: <https://www.cdc.gov/coronavirus/2019-ncov/index.html>
- NYS DOH: <https://health.ny.gov/diseases/communicable/coronavirus/providers.htm>
- HCS: https://commerce.health.state.ny.us/public/hcs_login.html
- OASAS: <https://oasas.ny.gov/keywords/coronavirus>

Program leadership and management must also keep their staff updated as the situation changes and educate them about the disease, its signs and symptoms, and the necessary infection control measures to protect themselves and their patients. It is important that providers who use the HCS maintain their up-to-date contact information as the NYS DOH distributes alerts and advisories through it.

If any program determines that it is necessary to take additional measures to change services delivery other than those described below and/or detailed in other guidance from NYS OASAS, due to an outbreak investigation, critical staffing shortages, local governmental unit (LGU) directive (i.e., local health department order), or for any other reason, they should immediately contact their OASAS Regional Office to inform them.

Infection Control Policy

Key definitions:

Symptoms of COVID-19 may include a temperature of 100.0 degrees Fahrenheit, subjective symptoms of a fever (e.g., malaise, fatigue, myalgias/muscle aches, chills), and/or respiratory symptoms including a sore throat, cough, and/or shortness of breath. Less common symptoms include rhinorrhea/runny nose, headache, nausea/vomiting, diarrhea, and loss of taste or smell. Atypical presentations have been described, and older adults and persons with medical comorbidities may have delayed presentation of fever and respiratory symptoms. Some people experience only mild symptoms or have vague symptoms of not feeling well. Older adults, people with underlying health conditions, and people with compromised immune systems are at high risk

of severe illness from this virus.

Close contact is defined as “being within 6 ft of a person displaying symptoms of COVID-19 or someone who has tested positive of COVID-19” without necessary personal protective equipment (PPE), within 48 hours prior to symptom onset, for 10 minutes or more. Please note that direct physical contact (i.e., touching) and being coughed or sneezed on counts as a close contact, even if exposure is less than 10 minutes.

Proximate contact is being in the same enclosed environment such as a classroom, office, or gatherings but greater than 6 ft from a person displaying symptoms of COVID-19 or someone who has tested positive for COVID-19, without necessary PPE, within 48 hours prior to symptom onset, for a duration of time greater than 1 hour. Please note that a “contact of a contact” (i.e., contact with an asymptomatic person who has had a close or proximate contact) does not qualify as a contact for infection control purposes.

Isolation is the procedure when a person is symptomatic and/or positive for COVID-19 and must be kept away from other people until they are no longer infectious, to reduce transmission risk.

Quarantine is the procedure when someone has been directly exposed to a person with potential or confirmed COVID-19 (i.e., a close or proximate contact), but has not yet developed symptoms and is being monitored for symptoms, in order to reduce transmission risk. Anyone with direct or proximate contact with a person with confirmed or suspected COVID-19 will need to be quarantined for 14 days, either within the facility, or in the community per direction of the local health department (LHD) should they leave before the 14-day period is over.

Social (i.e., physical) distancing is what everyone needs to do as much as possible to limit transmission of COVID-19, especially in the context of significant pre-symptomatic and asymptomatic transmission of COVID-19.

All providers are strongly urged to very regularly review and reinforce their policies and procedures regarding infection control for standard precautions (applicable for the care of all patients), as well as droplet and contact precautions with all staff.

CDC: [Interim Infection Prevention and Control Recommendations for Patients with Suspected or Confirmed Coronavirus Disease 2019 \(COVID-19\) in Healthcare Settings](#)

Also CDC: [Healthcare Infection Prevention and Control FAQs for COVID-19](#)

NYS DOH: <https://www.health.ny.gov/professionals/diseases/reporting/communicable/infection/>

Additionally:

- Providers should have the recommended Personal Protective Equipment, and should report inability to obtain PPE to their local Office of Emergency Management as well as their NYS OASAS Regional Office;
- More information from the CDC about infection control strategies and appropriate PPE can be found [here](#);
- ***Programs are encouraged to perform diagnostic testing for COVID-19. However, any COVID-19 test sample collection or any other test sample collection involving potential exposure to droplets or aerosols (e.g., influenza testing) should be done with full PPE including fit-tested N-95 respirator masks. The NYS OMH and OASAS released an [informational document about COVID-19 testing](#). Programs should carefully review this document and update program policies and protocols accordingly before proceeding with COVID-19 testing. For more information about COVID-19 testing, please see the NYS DOH guidance, “[Revised Interim Guidance](#):***

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[Protocol for COVID-19 Testing Applicable to All Health Care Providers and Local Health Departments.](#)

- ***In addition, no procedures that have the potential to generate aerosols (e.g., nebulizer treatments, CPAP) should be performed, without first discussing a specific plan to protect staff and other patients with the LHD and/or NYS OASAS Regional Office.***
- Providers should post NYS DOH Protect Yourself from COVID-19 [signage](#) throughout their facilities;
- Providers should have supplies for handwashing and hand sanitizing throughout their facilities available for patients and staff as appropriate, and should widely post handwashing signs;
- COVID-19 materials including posters can be requested from the NYS DOH by using the [request form](#);
- Providers should maintain enough supplies for appropriate environmental cleaning and disinfection. All frequently touched surfaces in the facility must be thoroughly cleaned on a regular basis per [NYS cleaning guidance](#);
- Providers should have, update, and frequently communicate a method to screen for, identify, and manage patients on admission and/or currently in the program who are or become ill;
- Limit group gatherings as much as possible. This includes but is not limited to temporarily limiting and even eliminating the size and time duration of group treatment sessions and doing them remotely as much as is possible, staggering larger groups of patients congregating such as during mealtimes, and avoiding in-person staff meetings/trainings.

Screening Provider Staff

Provider staff are exposed to the general community each day and are at risk of infection with an acute respiratory illness including influenza, respiratory syncytial virus, or COVID-19. Staff must be screened on at least a daily basis for respiratory and fever symptoms. It is recommended that staff self-screen prior to coming to work or returning from any leave for:

1. Any travel out of state*, including international travel, in the last 14 days.
2. Known contact with any Person Under Investigation (PUIs) for COVID-19 (and/or someone with symptoms suggestive of COVID-19) OR anyone with confirmed (positive test) COVID-19 within the last 14 days, within 48 hours prior to symptom onset.
3. New signs and symptoms of respiratory illness (fever (subjective or objective, i.e., $T \geq 100.0$ F), sore throat, cough, shortness of breath; *please see list of all potential symptoms above and incorporate into screening*). Programs should consider actively taking staff temperatures at the beginning of every shift, and documenting lack of an elevated temperature as well as lack of new respiratory symptoms before allowing staff to begin work.

*Anyone who has traveled to a state identified as having significant community transmission of COVID-19 must quarantine for 14 days. This only applies to those traveling to such a state for a significant period of time (i.e., not passing through). The list of states is continually updated [here](#). The NYS DOH has issued [guidance](#) about this travel advisory. However, essential health care workers who have traveled to a state with significant community transmission and are asymptomatic may be able to continue working, per NYS DOH guidance, described below.

Staff who answer yes to any of these questions, should not report to work, should self-quarantine/isolate at home, and should contact the [local health department](#) (LHD) for further guidance prior to returning to work. If they are experiencing symptoms, they should also contact their primary care provider (by phone, not visit) immediately for instructions. If they are experiencing severe symptoms (e.g., shortness of breath), they should call 911, and notify emergency responders that they are experiencing symptoms consistent with possible COVID-19. Staff who develop symptoms while at work should immediately go home and should take the transportation method that will expose the least number of people possible (e.g., avoid public transportation if possible).

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For critical, direct health care staff, to prevent critical staff shortages (it is the organization's responsibility to determine which staff are essential and when it is necessary to follow this guidance to avoid critical staffing shortages), the NYS DOH has issued guidance [here](#) and [here](#) for health care staff who have had a direct COVID-19 exposure that: (1) Directs them to carefully self-monitor for symptoms including checking their temperature twice daily, and still remain under quarantine when not at work; (2) Directs them to immediately leave work and not return to work if they develop symptoms and to contact their health care provider about whether COVID-19 testing would be indicated; (3) Directs them to wear a facemask while at work for at least 14 days from the exposure and be assigned as possible to work with patients at lower risk of severe illness from COVID-19; (4) Those workers who have recently traveled to a state with significant COVID-19 community transmission must obtain a COVID-19 diagnostic test within 24 hours of arrival within NYS; and (5) those workers who experience symptoms should be directed to remain under isolation until they have been afebrile ($T < 100.0\text{ F}$) without the use of anti-pyretic agents for at least 72 hours with resolving respiratory symptoms (e.g., cough), AND for at least 10 days (note increase from 7 days) from first symptom onset. They can then return to work and continue to self-monitor while wearing a facemask for at least 14 days from symptom onset. This is only a summary; please visit the NYS DOH COVID-19 page to read the full guidance [here](#) and [here](#), including description of test-based criteria for returning to work.

Screening Patients

The NYS DOH requires that agencies screen for symptoms and possible exposure, as described below, prior to accepting any new admissions or making referrals for care. Providers should also continuously monitor patients in their care for emerging symptoms, at least on a daily basis for all patients. Please continue to check [CDC criteria for evaluation for COVID-19](#), as they are subject to change. Please also see the NYS DOH guidance, "[Revised Interim Guidance: Protocol for COVID-19 Testing Applicable to All Health Care Providers and Local Health Departments](#)."

Currently, the following individuals should be evaluated by a program medical provider as possibly needing COVID-19 testing:

1. Individuals with new signs or symptoms of respiratory infection, such as fever (subjective or objective, i.e., $T \geq 100.0\text{ F}$), cough, shortness of breath, or sore throat. *Please see list of all potential symptoms above and incorporate into screening.*
2. Individuals who have, in the last 14 days, had contact with someone with a confirmed diagnosis (positive test) of COVID-19, or someone suspected as having the illness and under investigation for COVID-19, such as someone ill with respiratory illness, within 48 hours prior to symptom onset.
3. Individuals who have travelled out of state*, including internationally, within the last 14 days.

*Anyone who has traveled to a state identified as having significant community transmission of COVID-19 must quarantine for 14 days. Residential treatment providers must facilitate this quarantine. This only applies to those traveling to such a state for a significant period of time (i.e., not passing through). The list of states is continually updated [here](#). The NYS DOH has issued [guidance](#) about this travel advisory.

Patients who cannot be screened prior to presenting to the provider for admission should be screened as above upon presentation. Any patients who answer yes to any question or presents with/develops symptoms concerning for COVID-19, should be isolated in a private room and placed in a face covering or surgical face mask, if one can be medically tolerated. The program medical provider should use appropriate PPE and evaluate the patient, and the program should consult with their LHD for instructions and guidance. The NYS OMH and OASAS issued guidance for behavioral health programs about working with LHDs around testing and contact tracing efforts is [here](#). For patients who develop serious symptoms (eg., high fever, rapid breathing, chest pain) that require immediate transfer to a medical facility, the program should alert the medical facility in advance that the person being transported has symptoms consistent with possible COVID-19.

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Programs will need to have at least one room identified and available at all times for temporary isolation of patients as soon as symptoms begin pending medical evaluation, in addition to any rooms currently being used for isolation or quarantine of other individuals. For patients who will be isolated or quarantined for an extended period of time, rooms should preferably have a private bathroom. In situations where a private bathroom is not available, a shared bathroom can be used if cleaning occurs after the individual uses it.

Providers should screen all patients at least daily for symptoms of potential COVID-19. Patients who become ill during their treatment stay should be evaluated by a medical provider and treated and/or isolated based on their presentation and history. Medical providers should consult with their LHD for appropriate guidance on isolation and quarantine (including any need for the issuance of a quarantine or isolation order) and potential referral for COVID-19 testing. Again, guidance about working with LHDs can be found [here](#).

Persons who are confirmed COVID-19-positive can be isolated together when necessary. It is not preferred that symptomatic persons without a confirmed positive test be isolated together, but it is possible when absolutely necessary. It is also not preferred that asymptomatic persons who have had a contact be quarantined together, but it is possible when absolutely necessary. Persons in isolation should never be in contact with persons being quarantined.

The NYS DOH has issued guidance about isolation and discontinuation thereof for people in congregate care settings with confirmed or suspected COVID-19, "[Health Advisory: Discontinuation of Isolation for Patients with COVID-19 Who Are Hospitalized or in Nursing Homes, Adult Care Homes, or Other Congregate Settings with Vulnerable Residents](#)." The following is a brief summary of the full guidance:

1. *Isolate the patient from other patients in a room by themselves with the door closed.*
2. *Use Personal Protective Equipment (PPE) for staff, as appropriate to the specific situation/interaction.*
3. *Ensure frequent appropriate environmental cleaning (see guidance from OASAS and the NYS DOH on the [OASAS Coronavirus page](#)).*
4. *Create a method to track staff who enter patient room.*
5. *Care for patients who are ill symptomatically/supportively and send to a medical facility if they develop worsening/serious symptoms.*
6. *Monitor patients who are ill and keep them under isolation until they have been afebrile ($T < 100.0 F$) without the use of anti-pyretic agents for at least 72 hours with resolving respiratory symptoms (e.g., cough), AND for at least 14 days from first symptom onset. Please see full guidance from the NYS DOH on release of patients from isolation in congregate settings [here](#).*
7. *From NYS DOH: "This approach will prevent most, but may not prevent all, instances of secondary spread. The risk of transmission after recovery is likely substantially less than that during illness. To further reduce the risk, individuals returning from isolation should continue to practice proper hygiene protocols (e.g., hand washing, covering coughs) and avoid prolonged, close contact with vulnerable persons (e.g. compromised immune system, underlying illness, 70 years of age or older)."*
8. *From NYS DOH: "[Release of immunocompromised persons with COVID-19](#) from isolation (e.g., medical treatment with immunosuppressive drugs, bone marrow or solid organ transplant recipients, inherited immunodeficiency, poorly controlled HIV) should be discussed in advance with NYS DOH."*
9. *From NYS DOH: "Asymptomatic individuals who were confirmed as having COVID-19 may discontinue home isolation under the following conditions: At least 14 days have passed since the date of their first positive COVID-19 diagnostic test; AND the individual has had no subsequent illness."*
10. *Any other patients who come into direct contact within 48 hours prior to symptom onset of another patient who becomes ill with symptoms of possible COVID-19 will need to be treated as a presumed direct/close contact and quarantined for 14 days.*

Screening and Limiting Visitors

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All providers should post visiting signs outside their programs alerting people to visitor limitations and risk factors during the COVID-19 crisis. *Visitor limitations are described in guidance from [OASAS about NY Forward here](#). The program should allow for liberal on-line options for face to face interaction with family members and other visitors.*

Essential visitors are allowed and are defined as visitors who have been determined by the clinical team as required to visit for the health and wellbeing of the patient. For all visitors, providers should attempt to pre-screen/schedule visits. All visitors should be screened on the phone for:

1. Any travel out of state*, including international travel, in the last 14 days.
2. Known contact with any Person Under Investigation (PUIs) for COVID-19 (and/or someone with symptoms suggestive of COVID-19) OR anyone with confirmed (positive test) COVID-19 within the last 14 days, within 48 hours prior to symptom onset.
3. Any signs and symptoms of illness in the past 14 days: fever (subjective or objective, i.e., $T \geq 100.0$ F), cough, shortness of breath, or sore throat. *Please see list of all potential symptoms above and incorporate into screening.* Programs should consider actively taking temperatures of anyone who needs to visit the program, and documenting lack of an elevated temperature as well as lack of new respiratory symptoms before allowing entry to the facility.

*Anyone who has traveled to a state identified as having significant community transmission of COVID-19 must quarantine for 14 days and should not be allowed to visit the program. This only applies to those traveling to such a state for a significant period of time (i.e., not passing through). The list of states is continually updated [here](#). The NYS DOH has issued [guidance](#) about this travel advisory.

- Any visitors meeting any of the above criteria should not be allowed a scheduled visit. Prescreened visitors should be informed they will be screened again upon arriving to the program. Screening upon arrival will include actively taking their temperature and inquiring about signs and symptoms. Any visitors arriving without pre-screening/scheduling should be told to leave or screened outside the program if they must visit the program. Any visitor who is permitted to enter the facility should wear a face covering during the entire time that they are in the facility. Visitors should be informed of the need to wear a face covering the entire time they are in the residential facility or on its premises and of the need to maintain social distancing (keep at least six feet from the patient whenever possible). When guests arrive, minimize gestures that promote close contact. For example, do not shake hands, do not bump elbows, or do not give hugs. Instead wave and verbally greet them.
- One-on-one visits and visits outdoors should be encouraged where appropriate space is available, weather permitting, and at the discretion of the staff (with patient agreement).
- Indoor visits of limited size (five or fewer people in a room if 6 foot social distance can be maintained) and duration (less than an hour) can occur and should take place in a location near to the entrance when possible.
- Visitors should be discouraged from bringing personal belongings to the visit. Visitors should not exchange food or personal items with patients except in rare circumstances as determined by the residential facility.
- Patients in isolation or quarantine are not permitted visitors. If visitors attempt to visit such individuals, the residential facility should ask them to leave, and contact their administrator.
- Visitors who fail to wear a face covering and maintain social distancing will be asked to leave the facility. Residential facilities may provide visitors with a face covering if needed.

Universal infection control precautions and [PPE conservation strategies](#)

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Because of the possibility of significant pre-and-asymptomatic transmission, possible on-going limits in access to full PPE for staff, and the possibility that an increasing number of patients may be isolated/quarantined within programs, the following measures should be incorporated into policies and protocols to minimize exposure risk to staff and other patients, which will not only reduce COVID-19 transmission risk but will limit the numbers of staff needing to go out on leave:

1. All staff should wear, at a minimum, surgical masks (not cloth face coverings) at all times when interacting with anyone.
 - a. Staff should maintain proper procedure to put on and remove face coverings.
 - b. Face coverings should fit snugly, covering both the mouth and nose at all times.
 - c. Face coverings should be stored in a clean, labeled, breathable container when not in use (i.e. when eating.)
 - d. Staff must always perform hand hygiene immediately before removing and after touching the face covering.
 - e. For surgical masks, ensure removal is not from the front of the mask, but by ear elastic or back of head ties.
 - f. Surgical masks should be replaced if wet, visibly soiled or damaged, and cloth face coverings should be washed frequently, at least once daily before using again.
2. Staff should wear gloves and a surgical mask during any direct physical contact (i.e., physical touching) with any patients. This includes blood pressures, pulse, necessary physical examinations, etc. Full PPE as appropriate to the specific circumstance should be utilized when having direct or close contact with any patient, including those in isolation or quarantine.
 - a. Staff must practice hand hygiene before putting on gloves and after.
3. Limit movement into and out of the facility by limiting participation in outside groups and social activities, etc. Patients who work and whose workplaces are open should still be allowed to work, and patients who need to visit the community for medical appointments and discharge planning purposes (e.g., housing interviews, job interviews) should also be allowed to engage in these activities and should be advised to wear mask or other face covering when in public settings, where social distancing measures are difficult to maintain. Anyone visiting the community, should be re-screened for COVID-19 symptoms and risk upon return.
4. Patients who are required to isolate or quarantine, who are medically and psychiatrically stable, are not at acutely elevated risk of overdose, and who have a safe living situation should be considered for discharge to complete their isolation/quarantine. Providers should use clinical judgment, balance risks of discharge vs risks to staff and other patients of COVID-19 exposure, and work with the LHD of the patient's home residence, which may be able to assist with the issuance of a quarantine order if needed and possibly a safe isolation/quarantine facility for the duration of the isolation/quarantine period when necessary. Providers should also consider the risk of potentially exposing other vulnerable individuals in a patient's home to COVID-19. Providers should ensure a safe and appropriate aftercare plan, including ensuring an adequate medication supply and engaging the patients while at home through telehealth. Patients who could benefit from additional residential care could be re-admitted to the program after their isolation/quarantine period has ended and/or after the COVID-19 crisis has abated.
5. Social (i.e., physical) distancing is recommended for both patients and staff at all times, whenever possible.
 - a. Consider temporarily canceling groups and/or running them remotely, delivering meals to rooms, and administering medications in rooms for all patients when there is a COVID-19 outbreak (two or more cases) in the facility.
 - b. Re-arrange furniture/beds in shared rooms.
 - c. Whenever and wherever possible, in-person groups should be small enough to allow for ideally 6 feet distance between individuals and should be limited in duration to no more than one hour.
 - d. Increase ventilation in rooms where residents congregate by opening windows.
 - e. Consider stagger mealtimes.
 - f. Consider stagger medication administration times.

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- g. Administer medications to patients one at a time and avoid all direct contact, maintaining a 6-foot distance as much as is possible. For instance, place medication in a cup on a disinfected surface, step back, instruct patient to self-administer medication(s) and observe/oversee self-administration per program policy and protocols.
 - h. Minimize room changes.
 - i. Single patient rooms where possible and minimizing shared bathrooms as much as possible.
 - j. Staff providing care for patients with incomplete PPE should attempt to maintain at least 6 feet of distance whenever possible and should avoid patient interactions in small, enclosed spaces as much as possible.
 - k. Limit procedures that require direct contact (e.g., physical examination, blood draws) to only those that are medically necessary for the immediate health and safety of patients.
 - l. Adapt program to allow for more individually directed learning, reflection, coping skill development through on-line resources.
6. Activities that require outside vendors or outside personnel to come on site should be limited to essential and medically critical operations such as facility cleaning, critical supply deliveries, etc. This includes vendor and pharmacy deliveries. Deliveries should be limited to specific areas to minimize patient and staff contact.
 7. The CDC has updated necessary PPE to include surgical face masks rather than n95 respirators, for all patient care that does not generate aerosols. Staff caring for multiple individuals with suspected or confirmed COVID-19, or on quarantine after a direct exposure, can use a single face mask until it becomes soiled, damaged, or damp. Gowns and gloves should be replaced between patient each interaction and hand hygiene should be performed.
 8. Adjust staffing patterns and duties to conserve PPE. For instance, programs could assign one staff person per shift to have the most direct interaction with patients, with all other staff supporting in more remote ways, even if still on-site. These shifts could be lengthened to further conserve PPE.
 9. Source prevention (i.e., putting a mask or other face covering on the person with symptoms) should be considered an effective protective strategy in addition to staff PPE.
 10. Telehealth services should be utilized when appropriate, even within the same facilities (eg., calling patient's rooms or even personal cell phones).
 11. [For patients with respiratory illness, suspected COVID-19](#), or known COVID-19:
 - a. To the extent possible when enough private rooms with private bathrooms for isolation purposes are not available, patients with known or suspected COVID-19 should be housed in the same room for the duration of their stay in the facility. Also, to the extent possible, rooms used for isolation should be clustered together in the same area of the facility, as should rooms used for quarantine.
 - b. Personnel entering rooms where individuals are isolated or quarantined without adequate PPE recommended should maintain social distancing where possible when interacting with the patient.
 - c. Whenever possible, medicate and perform procedures/tests in the patients' rooms rather than in common areas, or even leave medications outside room/in doorway when safe and appropriate and give patient instructions to self-administer medications.
 - d. Leave meal trays outside patient doors, knock to alert them that their food is ready, and step away from the room while ensuring they get their food. Instruct patients to leave food trays when finished outside room and alert staff remotely that they are ready for pickup. Staff should use gloves to handle trays and should perform hand hygiene immediately when the gloves are removed.
 - e. Once a patient under isolation or quarantine has been discharged or transferred, the door to the patient's room should be closed and marked with a "do not enter" sign and staff, including environmental services personnel, should refrain from entering the vacated room until sufficient time has elapsed for enough air changes to remove potentially infectious particles (more information on [clearance rates under differing ventilation conditions](#) is available). After this time has elapsed, the room should undergo appropriate cleaning and surface disinfection before it is returned to routine use.

General Personal Protective Precautions for Patients:

On admission patients should be informed of the patient face covering wearing and social distancing policy.

- Patients are required to wear a [face mask or face covering](#) at all times when in the residential facility, except in cases where they are alone in their room (a single room).
- Patients are required to follow physical distancing guidelines (maintaining a distance of 6 feet and not congregating) and wearing a face covering at all times.
- On a routine basis and during hourly rounds at the residential facility, staff should monitor patients for social distancing and wearing of face masks or face coverings.
- When patients are nonadherent with these guidelines, it must be addressed with a patient-centered approach emphasizing public health and safety.
- Patient should be informed that staff should not be meeting with patients or allow patients to participate in groups or other group activities like meals in common areas (all physically distanced obviously) who are not wearing face coverings.

Guidance on Non-emergent Transportation

The following guidance has been released by the NYS Office of Mental Health, and is applicable to addiction treatment programs:

It is important to consider the risks of close contact posed by transportation in cars and vans. However, there are times when individuals living in congregate settings need to be transported non-emergently by staff for medical appointments or other essential purposes. There is risk of infection for both the staff member driving the vehicle and the client being transported. Special precautions must be taken to help protect both:

1. Staff should wear a surgical face covering. Clients should wear a cloth or other (eg., surgical) facial covering.
2. As much as possible, separate the driver from the client. It is preferable to use a larger vehicle such as a van as opposed to a smaller car, to increase distance between individuals. It may be possible to purchase large, transparent plastic sheets (i.e. thick plastic cling wrap) that can be securely taped to seal off the front seats from the rear seats of the vehicle. If safe to do so, programs can consider outfitting their vehicles with this.
3. If another staff member is in the vehicle to help ensure the client's safety, the staff member should sit as far away from the client and driver as is safely possible. Any other staff members in the vehicle should also wear a surgical facemask.
4. When driving at a low speed, the vehicle's windows should remain open to maximize ventilation. At higher speeds where sheer wind forces may interfere with wearing a facemask, utilize climate control systems in a non-recirculating setting (air should blow in from outside the vehicle) with the fan on its maximum setting. At high speeds, opened side windows may create positive air pressure inside the vehicle and promote recirculation of the same air.
5. If the vehicle has a rear window (i.e. a window on the rear windshield), it should always remain open while the vehicle is in motion to create negative air pressure inside the vehicle and facilitate air moving out of the vehicle.
6. After use, thoroughly clean all surfaces with which staff or clients may have come into contact. If available, the vehicle used for non-emergent transportation should have disinfectant wipes on hand for immediate use on frequently touched surfaces when the vehicle arrives at its destination, before the return trip. After the return trip, the vehicle should be thoroughly cleaned and disinfected.
7. As much as possible, avoid transporting more than one client at a time. If this is not possible, always attempt to maximize distance between all individuals in the vehicle during the trip, including when entering and exiting the vehicle.

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8. Staff and clients should be reminded to not touch their faces and to wash their hands (or use hand sanitizer with at least 60% alcohol) as soon as possible after reaching their destination. Hand sanitizer should be available in all vehicles used for non-emergent transportation.
9. Clients with confirmed or suspected COVID-19 illness should remain in isolation and should not be transported to any appointments unless absolutely necessary.
10. If it is unavoidable, when transporting individuals with confirmed or suspected COVID-19 illness, or with known contact with confirmed or suspected COVID-19-positive individuals, staff members and clients should all wear surgical facemasks. The vehicle speed should remain at lower speeds to allow for the windows to remain open. However, every effort should be made to avoid transporting individuals with known or suspected COVID-19 illness in a personal or agency vehicle.

All residential facilities should stock up on non-perishable food supplies but should only use these supplies when and if their usual way of supplying food to their patients is disrupted for any reason.

It is recommended that providers follow the Centers for Disease Control and Prevention's (CDC's) guidelines for infection control basics including hand hygiene:

- [Infection Control Basics](#)
- [Hand Hygiene in Health Care Settings](#)
- [Handwashing: Clean Hands Save Lives](#)

Environmental Guidance from NYS OASAS and DOH:

- [Interim Guidance for Cleaning and Disinfection for Non-hospital-based Inpatient, Residential, and Outpatient Treatment Settings where Individuals Under Movement Restriction for COVID-19 are Admitted or Have Visited](#)