



Last updated: 10/1/21

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

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 service 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 (cumulative time, i.e., it does not need to be consecutive time). 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.

Fully vaccinated is defined as being 2 or more weeks after the final dose (e.g., single dose for Janssen/Johnson & Johnson, second for Pfizer and Moderna) of the vaccine approved by the FDA or authorized by the FDA for emergency use.

All providers are strongly urged to review very regularly 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.

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

Additionally:

- Providers should have the recommended Personal Protective Equipment (PPE);;

501 7th Avenue | New York, New York 10018-5903 | oasas.ny.gov | 646-728-4760

1450 Western Avenue | Albany, New York 12203-3526 | oasas.ny.gov | 518-473-3460

- 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 N95 respirator masks and eye protection (face shields and/or goggles). 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: Protocol for COVID-19 Testing Applicable to All Health Care Providers and Local Health Departments](#).” OASAS also has released guidance specific to SARS-CoV-2 (COVID-19) Point of Care Antigen Testing, which can be found [here](#).***
- ***In addition, no procedures that have the potential to generate aerosols (e.g., nebulizer treatments, CPAP, BIPAP, high flow oxygen) 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 post widely handwashing signs;
- COVID-19 materials, including posters, can be requested from the NYS DOH by using the [request form](#) or may be downloaded from the CDC website [here](#);
- Providers should maintain enough supplies for appropriate environmental cleaning and disinfection. All frequently touched surfaces in the facility must be cleaned thoroughly 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;
- Group meetings can occur within the following parameters: all staff and clients participating in groups must wear a mask or face covering; group size is limited by the physical space to allow for physical distancing; group duration still must be less than 60 minutes. Avoid larger groups of patients congregating such as during mealtimes and medication administration.

Universal infection control precautions:

Because of the possibility of significant pre-and-asymptomatic transmission, the following measures should be incorporated into policies and protocols to minimize exposure risk to staff and other patients:

1. All staff (including vendors, contractors, interns, students, etc.) must wear a mask that fits snugly and covers completely the nose and mouth.
 - a. Staff who have direct physical contact with patients (nurses, medical providers, medical assistants, phlebotomists, etc.) which includes the following activities (this is not an exhaustive list): administering medications, performing vital signs,

- giving injections, performing phlebotomy, performing physical exams, etc. should wear a surgical mask.
- b. Staff who may be exposed to potentially infectious materials or body substances (via contaminated medical supplies, devices, and equipment; contaminated environmental surfaces; or contaminated air) though not doing direct patient care (e.g., dietary, environmental services, laundry, security, engineering and facilities management, etc.) should wear a surgical mask.
 - c. Staff who are operating vehicles in which other staff and/or clients/residents are transported should wear a mask.
 - d. All other staff who do not meet the aforementioned criteria may wear a cloth face covering that fits snugly and must cover completely the nose and mouth in lieu of a surgical mask.
2. All staff should wear, at a minimum, masks (as per the above criteria in #1) when interacting with anyone. Eye protection (face shield or goggles) is recommended for staff when interacting with anyone but is required when there is physical contact with patients (see #1a above).
- a. Staff should maintain proper procedure to put on and remove masks and eye protection (face shield or goggles).
 - b. Masks should fit snugly, covering both the mouth and nose at all times.
 - c. Masks 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 mask or eye protection (face shield or goggles).
 - e. Ensure removal is not from the front of the surgical mask, but by the ear elastic or back of the head ties.
 - f. Surgical masks should be replaced if wet, visibly soiled or damaged. Eye protection (face shield or goggles) should be replaced as per manufacturer's guidelines.
3. Staff should wear gloves, a surgical mask and eye protection (face shield or goggles) during any direct physical contact (i.e., physical touching) with any patients. This includes taking blood pressures, taking pulses, and doing necessary physical examinations, etc. Full PPE as appropriate (see CDC guidance on PPE [here](#)) 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 and after using gloves, masks, and eye protection (face shield or goggles).
 - b. It is recommended that providers follow the Centers for Disease Control and Prevention's (CDC's) guidelines for infection control basics including hand hygiene:
 - i. [Infection Control Basics](#)
 - ii. [Hand Hygiene in Health Care Settings](#)
 - iii. [Handwashing: Clean Hands Save Lives](#)
4. Visitation to and from the facility may occur as per OASAS reopening guidance, see [here](#). Patients and residents in addiction treatment facilities who visit the community for a variety of reasons must be screened upon re-entry to the facility, by having their temperatures taken and asked regarding any current symptoms possibly consistent with COVID-19 and potential exposure to COVID-19 while outside the facility. Patients and residents should be educated on

precautionary methods, including hand hygiene, mask/face covering use, and social/physical distancing while out of the facility in the community. See CDC handouts on hand hygiene ([here](#)), wearing a mask/face covering ([here](#) and [here](#) and [here](#) and [here](#) and [here](#) and [here](#)), social/physical distancing ([here](#) and [here](#)), and Getting Back to Normal Is Going to Take Using All of Our Tools ([here](#)).

5. Social/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. If shared rooms are necessary, re-arrange furniture/beds to allow for social/physical distancing.
 - c. Whenever and wherever possible, in-person groups should be small enough to allow for ideally 6-foot separation between persons and should be limited in duration to no more than one hour.
 - d. Increase ventilation in rooms where group events are held by opening windows.
 - e. Stagger mealtimes.
 - f. Stagger medication administration times.
 - 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 the patient to self-administer medication(s) and observe/oversee self-administration per program policy and protocols.
 - h. Minimize room changes.
 - i. Use single patient rooms where possible and minimize shared bathrooms as much as possible.
 - j. Staff providing care for patients 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. Adapt the program to allow for more individually directed learning, reflection, and coping skill development through online resources.
6. Source prevention (i.e., the person with symptoms always wearing a surgical mask) should be considered an effective protective strategy in addition to staff PPE.
7. Telepractice services should be utilized when appropriate, even within the same facilities (e.g., calling a patient's room or even personal cell phones).
8. 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. If cohorting is absolutely necessary due to facility spacing issues, the facility should consult with the LHD to ensure that appropriate infection control measures are taken. Also, to the extent possible, rooms used for isolation should be clustered together in the same area or wing of the facility, as should rooms used for quarantine.
 - b. Personnel entering rooms where individuals are isolated or quarantined should maintain social/physical 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 the room/in the doorway when safe and appropriate and give the 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 the 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.

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 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. Screening should include a review of the following statements (see 1-3 below) and staff should quarantine or isolate and contact their health provider for further guidance as appropriate.

1. **International travel in the past 10 days for staff who are not fully vaccinated or not recovered from COVID-19 infection in the last 3 months.**

See NYS DOH guidance [here](#). NYS DOH *requires* work furlough for healthcare personnel in this category. See OASAS Return to Work (RTW) guidance [here](#).

2. Known close contact with someone who has a confirmed positive COVID-19 test OR someone with symptoms suspicious for COVID-19 within the last 14 days, within 48 hours prior to symptom onset or the positive test for COVID-19.

Fully vaccinated healthcare personnel do not need to quarantine or work furlough after exposure, but it is recommended that they be tested for COVID-19; however, unvaccinated healthcare personnel do need to quarantine or work furlough unless the facility has a current or imminent staffing shortage and the provider agency has completed the necessary steps outlined in the OASAS RTW guidance [here](#).

3. New signs and symptoms of respiratory illness (fever, subjective or objective, i.e., $T \geq 100.4$ F), sore throat, cough, shortness of breath; *please see list of all potential symptoms on page 1 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.

Symptomatic staff, regardless of vaccination status, should be assessed by their healthcare provider before returning to work. See OASAS RTW guidance [here](#).

Guideline for Healthcare Entities with Current or Imminent Staffing Shortages that Threaten Provision of Essential Patient Services

See OASAS Guidance for Personnel in Clinical and Direct Care Settings to Return to Work Following COVID-19 Exposure or Infection or Travel [here](#) and the OASAS Return to Work Staff Attestation [here](#).

Staff that endorse recent international travel (screening question 1) must be furloughed and quarantine for 10 days. See OASAS RTW guidance [here](#).

Staff who endorse a recent exposure to COVID-19 must be furloughed and quarantine per [OASAS RTW guidance](#). *However, please note that asymptomatic fully vaccinated healthcare personnel do not need to quarantine or work furlough after exposure, and there is an exemption process for staff who are exposed and not fully vaccinated when a facility has a current or imminent staffing shortage.* See the NYS DOH full document addressing this [here](#).

General Personal Protective Precautions for Patients:

On admission patients should be informed of the patient surgical mask/cloth face covering wearing and social distancing policy. The surgical mask or cloth face covering should fit snugly on the face and should cover completely the nose and mouth.

- Patients are required to wear a [surgical mask or cloth face covering](#) at all times when in the inpatient or residential facility, except when they are in their room alone.
- Patients are required to follow physical distancing guidelines (maintaining a distance of 6 feet and not congregating)
- On a routine basis and during hourly rounds at the inpatient or residential facility, staff should monitor patients for social/physical distancing and wearing of surgical masks or cloth face coverings.
- When patients are nonadherent with these guidelines, it must be addressed with a patient-centered approach emphasizing public health and safety.
- Patients should be informed that non-clinical staff should be wearing surgical masks or cloth face coverings at all times in the facility. Clinical staff should be wearing surgical masks and eye protection (face shield or goggles) with direct physical patient contact. See [OASAS Masking Guidance](#) for more details. Staff should not be meeting with patients who are not wearing surgical masks or face coverings.

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 also should monitor continuously patients in their care for emerging symptoms, at least on a daily basis for all patients.

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

501 7th Avenue | New York, New York 10018-5903 | oasas.ny.gov | 646-728-4760

1450 Western Avenue | Albany, New York 12203-3526 | oasas.ny.gov | 518-473-3460

1. Individuals with new signs or symptoms of respiratory infection, such as fever (subjective or objective, i.e., T \geq 100.4 F), cough, shortness of breath, or sore throat. *Please see list of all potential symptoms on page 1 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. Note: Any individuals, regardless of vaccine status, who have been exposed to COVID-19 should be tested. However, fully vaccinated individuals who have been exposed, but test negative and are asymptomatic, do not need to be quarantined. See CDC guidance [here](#).
3. Individuals who have traveled internationally in the last 10 days, who are not fully vaccinated or have not recovered from COVID-19 in the last 3 months, per CDC guidance, **are recommended** to get tested 3-5 days after arrival in New York, consider non-mandated self-quarantine (7 days if tested on day 3-5, otherwise 10 days), and avoid contact with people at higher risk for severe disease for 14 days, regardless of test result. See CDC International Travel Guidance [here](#).

Residential treatment providers must facilitate this quarantine.

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 either question or present with/develop symptoms consistent with COVID-19, should be isolated in a private room and asked to wear 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 (e.g., 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.

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. Persons who are confirmed COVID-19-positive ideally should not be isolated together. Asymptomatic persons who have had a COVID-19 contact ideally should not be quarantined together. Persons in isolation should *never* be in contact with persons being quarantined. Should a facility have physical space issues and must cohort isolated individuals together and/or quarantined individuals together, the program must work in conjunction with their local health department (LHD) to ensure adherence to all proper infection control precautions.

For patients who will be isolated or quarantined, rooms preferably should have a private bathroom. In situations where a private bathroom is not available, a shared bathroom can be used if cleaning occurs after each 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. Guidance about working with LHDs can be found [here](#).

The NYS DOH has issued guidance about isolation and discontinuation thereof for people in congregate care settings with confirmed or suspected COVID-19. See the guidance [here](#).

Recommendations for Interacting with Isolated Patients in Congregate Care Settings:

1. *Isolate the patient from other patients in a room by themselves with the door closed.*
2. *Use full 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 the patient's 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 ($T < 100.4 F$) 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. See full guidance [here](#).*
7. *Any other patients, who are not fully vaccinated, 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 Visitors:

All providers should post visiting signs outside their programs alerting people to visitor screening and risk factors during the COVID-19 epidemic. *Visitor limitations are described in [reopening guidance](#) from OASAS. The program should facilitate online options for face-to-face interaction with family members and other visitors if they are unable to visit in person.*

For all visitors, providers should attempt to pre-screen/schedule visits. All visitors should be screened on the phone for the following and rescreened when they arrive for the visit:

1. Known contact in the last 14 days 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.
2. Any signs or symptoms of illness in the past 14 days: fever (subjective or objective, i.e., $T \geq 100.4 F$), cough, shortness of breath, or sore throat. *Please see list of all potential symptoms on page 1 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.
3. Any international travel in the last 10 days if the visitor is not fully vaccinated or has not recovered from COVID-19 in the past 3 months. This would require asking the potential visitor two questions: Have you had any international travel in the last 10 days? If yes, then have you

been vaccinated against COVID-19 or recovered from COVID-19 in the past 3 months? If the potential visitor has traveled internationally in the last 10 days and is not fully vaccinated and/or has not recovered from COVID-19 in the past 3 months, then they cannot visit. See CDC International Travel Guidance [here](#).

- 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 arrival 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 advised to leave or screened outside the program if they must visit the program.
- Visitors should be informed of the need to wear a face covering the entire time they are in the residential facility and of the need to maintain social distancing (keep at least six feet from the patient whenever possible). When guests arrive, they should be advised to minimize gestures that promote close contact.
- 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). Outdoor visits between vaccinated parties may occur without masking. If outdoor visits consist a mixed group of vaccinated and unvaccinated persons, it is still recommended that all parties be masked and physically distanced.
- Indoor visits of limited size (depending on the size of the room to allow physical distancing) and short 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 inpatient or residential facility.
- Patients in isolation or quarantine are not permitted visitors. If visitors attempt to visit such individuals, the inpatient or residential facility should ask them to leave and contact their administrator.
- Visitors who fail to wear a face covering and maintain social/physical distancing will be asked to leave the facility. Inpatient and residential facilities may provide visitors with a face covering if needed.
- If a facility meets any criteria for restricted visiting as mentioned in the OASAS reopening guidance, then visitation must be restricted. See the OASAS reopening guidance [here](#).

Guidance on Non-emergent Transportation:

Non-emergent transportation should still be limited. All staff should be wearing a surgical mask and eye protection (face shield or goggles) and all clients should be wearing a face covering during any transportation. Staff and clients must be physically distanced in the vehicle.

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](#)

501 7th Avenue | New York, New York 10018-5903 | oasas.ny.gov | 646-728-4760

1450 Western Avenue | Albany, New York 12203-3526 | oasas.ny.gov | 518-473-3460