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KATHY HOCHUL
Governor

CHINAZO CUNNINGHAM, MD
Commissioner

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COVID-19 Infection Control Guidance for

Non-hospital-based Inpatient and Residential Addiction Treatment Providers

Currently, reported COVID-19 infections are down significantly in the US compared with earlier this year (however, notably, positive test results reported do not reflect tests done at home, so are an undercount of the true number of infections). The OASAS infection control guidance has been updated to reflect that. However, programs should be poised to pivot quickly back to previous infection control precautions in case of significant community transmission of COVID-19 locally and the emergence of a COVID-19 surge and/or the emergence of a new/potentially more transmissible variant or subvariant in the United States (US) including in New York State (NYS). The situation with respect to COVID-19 infections identified in the US and NYS continues to evolve and changes rapidly.

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 procedures. The information 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), and OASAS. It is important for all providers to keep apprised of current guidance by regularly visiting the CDC and NYS DOH websites

- CDC: https://www.cdc.gov/coronavirus/2019-ncov/index.html
- NYS DOH: https://health.ny.gov/diseases/communicable/coronavirus/providers.htm
- OASAS: https://oasas.ny.gov/keywords/coronavirus

Program leadership and management also must keep their staff updated as the situation changes frequently and educate them about COVID-19 infection, its signs and symptoms, and the necessary infection control measures to protect themselves and their patients.

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 a COVID-19 outbreak, critical staffing shortages, local governmental unit (LGU) directive (i.e., local health department order), or for any other reason, they should contact immediately their OASAS Regional Office to inform them.

Please note that masking requirements *for patients* are now limited to 816, 817, 818, and 822 programs. See OASAS masking guidance: https://oasas.ny.gov/guidance-mask-wearing-requirements. Should patients choose to mask in 819 and 820 programs and/or the programs opt to go beyond this guidance and require masking, both are permissible. If 816/818 and 819 or 820 program are co-located in the same building and using the same entrance, then consideration should be given to requiring masking for all patients. Such decisions should be delineated in your program's infection control policies and procedures.

Infection Control Policy:

Key definitions:

Symptoms of COVID-19 *may* include a temperature of >=100.4 degrees Fahrenheit, subjective symptoms of a fever (e.g., malaise, fatigue, myalgias/muscle aches, chills), and/or respiratory symptoms including a sore throat, cough, shortness of breath, rhinorrhea/runny nose, headache, nausea/vomiting, diarrhea, and loss of taste or smell. Some people experience no symptoms, 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, even if COVID-19 vaccinated and boosted.

Close contact is defined as "being within 6 ft of a person displaying symptoms of COVID-19 or someone who has tested positive for 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 a gathering 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 exposed directly 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, 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 10 days in congregate settings, either within the facility, or for 5 days in the community should they leave before the 10-day quarantine has ended.

Physical (i.e., social) distancing is what everyone is encouraged 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. Physical distancing means being >= 6 feet separating you from another person.

Fully vaccinated means a person has received their primary series of COVID-19 vaccines. This is defined as being 2 or more weeks after the final dose in the primary series (e.g., single dose for Janssen/Johnson & Johnson, second dose for Pfizer and Moderna, completion of the primary series of any other COVID-19 vaccine approved by the FDA and CDC for use in the US) of the vaccine approved by the FDA or authorized by the FDA for emergency use (EUA). This definition does not take into consideration a person's booster dose status.

In January 2022, the CDC adopted different terminology to reflect the importance of booster dosing to prevent COVID-19 infection from more infectious variants.

Up to Date means a person has received all recommended COVID-19 vaccines including any booster(s) when eligible. Booster dosing recommendations evolve over time. See the CDC page Stay Up to Date with Your Vaccines here for current recommendations.

Not Up to Date means a person has NOT received all recommended COVID-19 vaccines which may include the primary series of COVID-19 vaccines and/or any booster(s) when eligible. Healthcare personnel (HCP) who are not up to date, whether unvaccinated or vaccinated but not boosted are treated the same with respect to COVID-19 exposure.

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 recommended Personal Protective Equipment (PPE);
- 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). NYS OMH and OASAS released an informational document about COVID-19 testing *In June 2020****. Programs should review carefully this document and update program policies and procedures accordingly before proceeding with COVID-19 testing. For more information about COVID-19 testing, please see CDC guidance here. OASAS has released guidance specific to SARS-CoV-2 (COVID-19) Point of Care Antigen Testing, which can be found at*** https://oasas.ny.gov/antigen-testing-inpatient-and-residential-facilities-and-otps***.***

- ***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. The plan should include having a negative pressure room on site.***
- 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 communicate a method to screen for, identify, and manage patients on admission and/or currently in the program who are or become exposed to or test positive for COVID-19;
- Group meetings can occur within the following parameters: all staff and clients participating in groups must wear a surgical mask or face covering; group size is limited only by the program's physical space: physical distancing is encouraged, but not required; group duration still must be less than 60 minutes. Try to 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 procedures 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 surgical 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 googles) 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.)

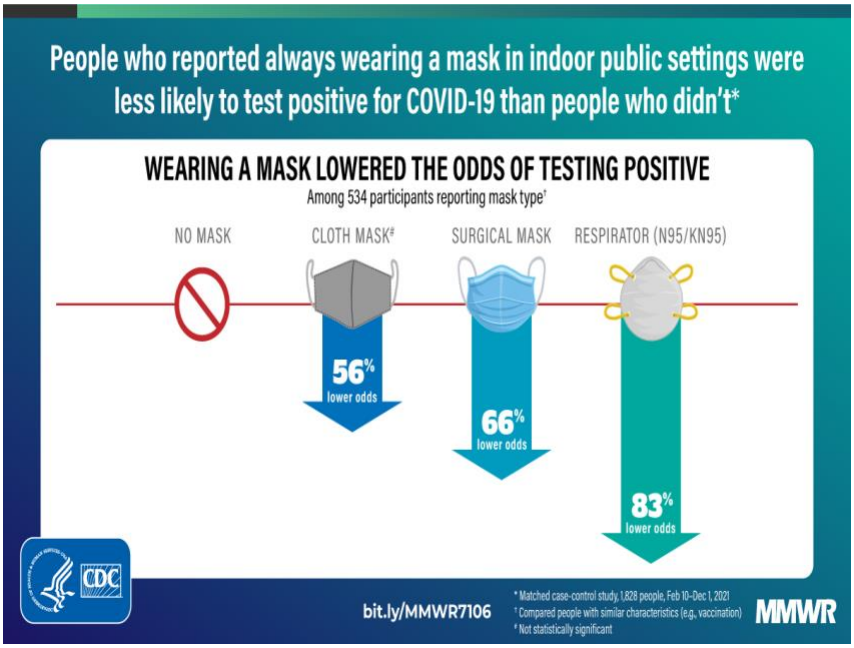
d. Staff always must perform hand hygiene immediately before removing and after touching the mask or eye protection (face shield or goggles).

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.

The CDC has updated its masking recommendations. See the full CDC guidance here and here.

- Masks and respirators (i.e., specialized filtering masks such as "N95s") can provide different levels of protection depending on the type of mask and how they are used. Loosely woven cloth products provide the least protection, layered finely woven products offer more protection, well-fitting disposable surgical masks and KN95s offer even more protection, and well-fitting NIOSH-approved respirators (including N95s) offer the highest level of protection.
- Whatever product you choose, it should provide a good fit (i.e., fitting closely on the face without any gaps along the edges or around the nose) and be comfortable enough when worn properly (covering your nose and mouth) so that you can keep it on when you need to. Learn how to improve how well your mask protects you by visiting CDC's Improve How Your Mask Protects You page.
- A respirator has better filtration, and if worn properly the whole time it is in use, can provide a higher level of protection than a cloth or procedural mask. A mask or respirator will be less effective if it fits poorly or if you wear it improperly or take it off frequently. Individuals may consider the situation and other factors when choosing a mask or respirator that offers greater protection.



OASAS is not requiring that programs have their staff wear KN95s or N95s but is recommending that programs inform their staff regarding updated CDC guidance and consider providing higher-grade mask options (KN95s, N95s) for staff who would prefer to wear them.

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 https://oasas.ny.gov/oasas-reopening-guidance
5. 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 physical distancing while out of the facility in the community. See CDC handouts on hand hygiene (here) and wearing a mask/face covering (here and here and here).
6. Physical distancing is encouraged 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 significant COVID-19 outbreak in the facility. In-person groups should be limited in duration to no more than one hour and all persons should be masked. Physical distancing is encouraged.

c. Increase ventilation in rooms where group events are held by opening windows.
d. Administer medications to patients one at a time and avoid all direct contact, maintaining physical distancing (a 6-foot distance) is encouraged 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.
e. Minimize room changes.
f. Staff providing care for patients are encouraged to maintain at least 6 feet of distance whenever possible and should avoid patient interactions in small, enclosed spaces as much as possible.
g. Adapt the program to allow for more individually directed learning, reflection, and coping skill development through online and other resources.

7. Source prevention (i.e., the person with symptoms always wearing a surgical mask or higher-grade mask) should be considered an effective protective strategy in addition to staff PPE.
8. Telepractice services should be utilized when appropriate, even within the same facilities (e.g., calling a patient's room or personal cell phones).
9. 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 or OASAS RO 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 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.

      *This does NOT include COVID-19 testing which is potentially aerosol-generating. COVID-19 testing should be done in a testing room that is properly ventilated or outside (where feasible to do so).

   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 5 days for staff who are not Up to Date with CDC COVID-19 vaccine and booster recommendations or not recovered from COVID-19 infection in the last 3 months.**
   From the CDC, "Health care personnel (HCP) with travel or community exposures should consult their occupational health program for guidance on need for work restrictions." Any exposure to COVID-19 during travel would warrant following the RTW protocols. Travel alone, without a known exposure, would not constitute an exposure.

See OASAS Return to Work (RTW) guidance https://oasas.ny.gov/return-to-work-guidance**.**

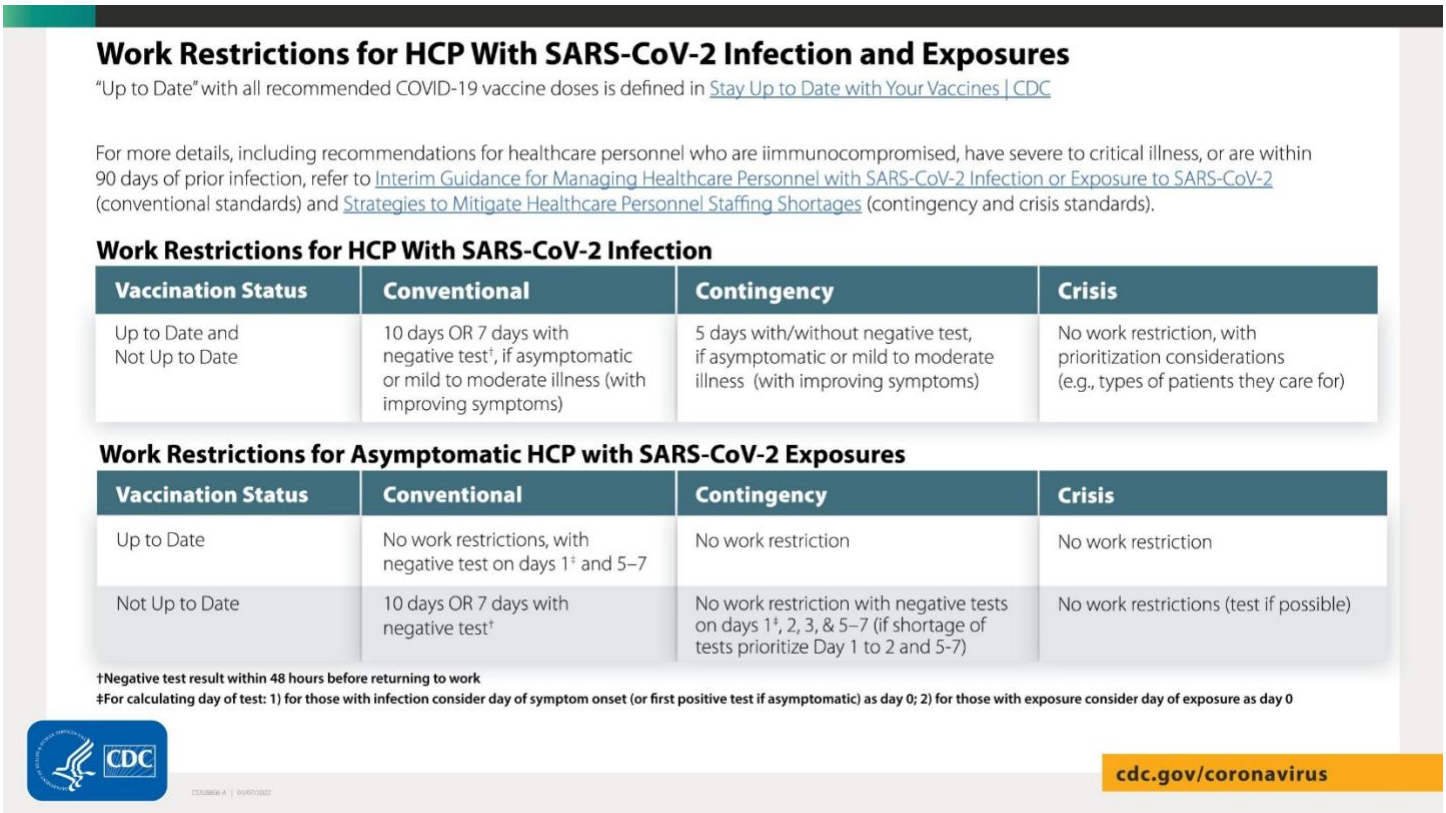
2. Known close contact with someone who has a confirmed positive COVID-19 test OR someone with symptoms suspicious for COVID-19 within the last 5 days, within 48 hours prior to symptom onset or the positive test for COVID-19.

   Updated Advisory on Return-to-Work Protocols for Healthcare Personnel with SARS-CoV-2 Infection or Exposure to SARS-CoV-2, updated 2/4/22: see the NYS DOH guidance here.

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

   The CDC has released an HCP Return to Work (RTW) Matrix to allow for HCP TO RTW after exposure to COVID-19 or after testing positive for COVID-19 earlier using Contingency or Crisis Strategies. ***If there is not a current or imminent staffing shortage in your facility, then the Conventional Strategy should be utilized instead.***

   CDC HCP RTW Matrix: see below and here:



Work Restrictions for HCP With SARS-CoV-2 Infection and Exposures

"Up to Date" with all recommended COVID-19 vaccine doses is defined in Stay Up to Date with Your Vaccines | CDC

For more details, including recommendations for healthcare personnel who are iimmunocompromised, have severe to critical illness, or are within 90 days of prior infection, refer to Interim Guidance for Managing Healthcare Personnel with SARS-CoV-2 Infection or Exposure to SARS-CoV-2 (conventional standards) and Strategies to Mitigate Healthcare Personnel Staffing Shortages (contingency and crisis standards).

Work Restrictions for HCP With SARS-CoV-2 Infection

Vaccination Status	Conventional	Contingency	Crisis
Up to Date and Not Up to Date	10 days OR 7 days with negative test†, if asymptomatic or mild to moderate illness (with improving symptoms)	5 days with/without negative test, if asymptomatic or mild to moderate illness (with improving symptoms)	No work restriction, with prioritization considerations (e.g., types of patients they care for)

Work Restrictions for Asymptomatic HCP with SARS-CoV-2 Exposures

Vaccination Status	Conventional	Contingency	Crisis
Up to Date	No work restrictions, with negative test on days 1‡ and 5–7	No work restriction	No work restriction
Not Up to Date	10 days OR 7 days with negative test†	No work restriction with negative tests on days 1‡, 2, 3, & 5–7 (if shortage of tests prioritize Day 1 to 2 and 5-7)	No work restrictions (test if possible)

†Negative test result within 48 hours before returning to work

‡For calculating day of test: 1) for those with infection consider day of symptom onset (or first positive test if asymptomatic) as day 0; 2) for those with exposure consider day of exposure as day 0

CDC

cdc.gov/coronavirus

Up to Date HCP do not need to quarantine or work furlough after exposure, but it is recommended that they be tested for COVID-19 on days 1 and days 5-7; however, Not Up to Date (*which includes persons who are fully vaccinated but not boosted*) HCP do need to quarantine or work furlough for 10 days or for 7 days with a negative test 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 https://oasas.ny.gov/return-to-work-guidance.

Quarantine and Isolation for Congregate Settings and Special Populations

Correctional Facilities, Adult Care Facilities, Group Homes, Other Congregate Settings

The CDC's recommendations for shortened quarantine and isolation ***do not apply*** to correctional facilities, detention facilities, homeless shelters, and cruise ships. Those settings, as well as ***other congregate settings with high-risk individuals or at high risk for transmission, should continue to follow previous guidance for a 10-day quarantine or isolation for residents/clients.*** Other congregate settings that should continue to implement 10-day quarantine or isolation for residents/clients include adult care facilities, OPWDD facilities, OASAS facilities, and some OMH facilities, depending on ability of residents/clients in the OMH facilities to wear a mask, socially distance, and follow other mitigation measures.

While staff in these same facilities can isolate or quarantine for 5 days according to the guidance in this document, they should furlough (not work) for 10-days following infection or exposure due to the high-risk population served in these facilities. If staffing shortages jeopardize the safe provision of services or resident health and safety, facilities may implement a 5-day duration of furlough to the extent necessary. **The OASAS RO would need to approve use of a Crisis Strategy in a program. The OASAS RO does not need to approve use of a Contingency Strategy in a program.**

See full NYS DOH guidance here.

3. New signs and symptoms of respiratory illness (fever, subjective or objective, i.e., T >/= 100.4 F), sore throat, cough, shortness of breath, nasal congestion; *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 and booster status, should be assessed by their healthcare provider before returning to work. See OASAS RTW guidance https://oasas.ny.gov/return-to-work-guidance.

All healthcare facilities are expected to know which of their staff have been vaccinated and boosted. Any vaccinated or boosted staff who did not receive the vaccine(s) through their workplace must inform the facility of their vaccination and booster status through the same process the facility uses to maintain information on annual influenza immunizations and tuberculosis tests.

General Personal Protective Precautions for Patients:

On admission, patients should be informed of the patient surgical mask/cloth face covering wearing requirement and physical distancing encouragement policies. 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 facility, except when they are in their room either alone or with their roommates.
- Patients are encouraged 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 adherence with the wearing of surgical masks or cloth face coverings and encourage physical distancing.
- When patients are nonadherent with these mask wearing 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 https://oasas.ny.gov/guidance-mask-wearing-requirements 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 daily for all patients.

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

1. Individuals with new signs or symptoms of respiratory infection, such as fever (subjective or objective, i.e., T >/= 100.4 F), cough, shortness of breath, nasal congestion or sore throat. *Please see list of all potential symptoms on page 1 and incorporate into screening.*
2. Individuals who have, in the last 5 days, had contact with someone with a confirmed diagnosis (positive test) of COVID-19, or someone suspected as having COVID-19, such as someone ill with respiratory illness, within 48 hours prior to symptom onset. Note: Any individuals, regardless of COVID-19 vaccination or booster status, who have been exposed to COVID-19 should be tested. However, up to date individuals who have been exposed, but test negative (serial testing recommended: see OASAS POC Ag testing guidance https://oasas.ny.gov/antigen-testing-inpatient-and-residential-facilities-and-otps) and are asymptomatic are recommended to be quarantined for 10 days due to the high-risk congregate setting. See NYS DOH guidance here.
3. Individuals who have traveled internationally in the last 5 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 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 the screening questions or present with/develop symptoms consistent with COVID-19, should be isolated in a private room and asked to wear a surgical face mask. The program medical provider should use appropriate PPE and evaluate the patient, and the program should consult with the OASAS RO for guidance as needed.
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 the OASAS RO 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. Isolated persons *cannot* use the same bathroom as quarantined persons, so each population would need a dedicated bathroom/s.

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 the OASAS RO for appropriate guidance on isolation and quarantine (in addition, the LHD can issue quarantine or isolation orders) and potential recommendations for COVID-19 testing. There should be a very low threshold for COVID-19 testing with any potential COVID-19 exposure given the variability in symptoms and/or lack of symptoms due to COVID-19.

Recommendations for Interacting with Isolated Patients in Congregate Care Settings:

1. *Ideally, isolate the patient from other patients in a room **by themselves** with the door closed. Modifications, like plastic shields instead of doors, are not acceptable from an infection control perspective.*
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 COVID-19 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 24 hours with resolving respiratory symptoms (e.g., nonproductive cough and no rhinorrhea/runny nose), AND for at least 10 days from first symptom onset or they received a positive COVID-19 test result.*
7. *Any other patients, who are not up to date (meaning not fully vaccinated **and** boosted), who come into direct contact within 48 hours prior to symptom onset of another patient who becomes ill with symptoms of possible COVID-19 OR tests positive for COVID-19 (even if asymptomatic) will need to be treated as a presumed direct/close contact and quarantined for 10 days.*
   All healthcare facilities are expected to know the vaccination and booster status of their patients.

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 the OASAS reopening guidance found* https://oasas.ny.gov/oasas-reopening-guidance. *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 5 days with someone with a confirmed diagnosis (positive test) of COVID-19 or someone suspected as having COVID-19, such as someone ill with respiratory illness or cold symptoms, within 48 hours prior to symptom onset.

2. Any signs or symptoms of illness in the past 5 days: fever (subjective or objective, i.e., T >/= 100.4 F), cough, shortness of breath, nasal congestion 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 5 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 5 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 5 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 facility and be encouraged to maintain physical distancing (keep at least six feet from the patient whenever possible).
- 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). For visits outdoors, even if parties are vaccinated and boosted, wearing a mask or face covering is still recommended for all parties.
- Indoor visits may occur, masks are required, and physical distancing is encouraged. Visits should be of short duration (less than an hour).
- 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 will be asked to leave the facility. 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 https://oasas.ny.gov/oasas-reopening-guidance.

Guidance on Non-emergent Transportation:

All staff should be wearing a surgical mask and all clients should be wearing a face covering during any transportation. Physical distancing is encouraged, but not required, for staff and clients while 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