NEW YORK STATE | Office of Addiction Services and Supports
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COVID-19 Infection Control Guidance for

Non-hospital-based Inpatient and Residential Addiction Treatment Providers

The purpose of this guidance update is to ensure the health and safety of provider staff to deliver and support patient care, while limiting the interruption of services, and to protect the health and safety of patients and the public. Hospital-based OASAS programs should follow their own institution's infection control policies and procedures.

Program leadership and management also must keep their staff updated frequently and educate them about 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 immediately notify their OASAS Regional Office.

Masking in OASAS programs is recommended rather than required for all staff, visitors, and patients. Programs are responsible for creating policies and procedures regarding infection control in their own facilities. Programs may choose to go beyond this guidance and require masking should they choose to do so. With the end of the federal public health emergency on 5/11/23, the CDC no longer tracks county COVID-19 transmission levels. HOWEVER, programs should be aware of local outbreaks that may affect their facilities. The CDC still does track hospitalizations due to COVID-19 and programs may wish to keep abreast of local hospitalizations. See CDC information here. In the event of elevated local hospitalizations due to COVID-19, programs may want to consider reinstating masking.

Infection Control Policy:

Key definitions:

Symptoms of COVID-19 People with COVID-19 can have a wide range of symptoms – ranging from mild symptoms to severe illness. Symptoms may appear 2-14 days after exposure to the virus. Anyone can have mild to severe symptoms. Possible symptoms include:

- Fever or chills
- Cough
- Shortness of breath or difficulty breathing
- Fatigue
- Muscle or body aches
- Headache
- New loss of taste or smell
- Sore throat
- Congestion or runny nose
- Nausea or vomiting

- Diarrhea

This list does not include all possible symptoms. Symptoms may change with new COVID-19 variants and can vary depending on vaccination status. CDC will continue to update this list as needed. Older adults and people who have underlying medical conditions like heart or lung disease or diabetes are at higher risk for getting ill from COVID-19. See CDC guidance here.

Close contact **is defined through proximity and duration of exposure:** Someone who was less than 6 feet away from an infected person (laboratory-confirmed or a clinical diagnosis) for a total of 15 minutes or more over a 24-hour period (for example, *three separate 5-minute exposures for a total of 15 minutes*). An infected person can spread the virus that causes COVID-19 starting 2 days before they have any symptoms (or, for people without symptoms, 2 days before the positive specimen collection date). See CDC guidance here.

Isolation is defined as the separation of a person or group of people known or reasonably believed to be infected with a communicable disease and potentially infectious from those who are not infected to prevent spread of the communicable disease. See CDC guidance here.

Quarantine is defined as the separation of a person or group of people reasonably believed to have been exposed to a communicable disease but not yet symptomatic from others who have not been so exposed to prevent the possible spread of the communicable disease. See CDC guidance here.

Physical 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.

Up to Date: You are **up to date** with your COVID-19 vaccines if you have completed a COVID-19 vaccine primary series and received all booster doses recommended for you by CDC. Vaccine recommendations are based on your age, the vaccine you first received, and time since last dose. People who are moderately or severely immunocompromised have different recommendations for COVID-19 vaccines.

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.

All providers are strongly urged to review frequently and reinforce their policies and procedures regarding infection control with all staff. See CDC guidance here.

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, NIOSH-approved N95 or higher-rated respirators and eye protection (face shields and/or goggles). 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***. See FDA guidance here.***

- ***Procedures that have the potential to generate aerosols (e.g., nebulizer treatments, CPAP, BIPAP, high flow oxygen) are now allowable in all OASAS programs. While it is preferred that these procedures are done in an airborne infection isolation room (AIIR) or negative pressure room on site, it is allowable that these procedures are done without an AIIR or negative pressure room. Staff performing these procedures or engaging with a patient while a procedure is being performed, should wear full PPE. See CDC guidance on PPE here.***
- Providers should post NYS DOH Protect Yourself from COVID-19 signage throughout their facilities;
- Providers should have supplies for hand hygiene throughout their facilities available for patients and staff as appropriate, and should post widely hand hygiene 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 should be cleaned and disinfected thoroughly on a regular basis;
- 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;

Universal infection control precautions:

Because of the possibility of pre- and asymptomatic transmission, standard infection control measures should be incorporated into program policies and procedures to minimize exposure risk to staff and other patients. These measures include the recommendation of masking for all staff; hand hygiene recommendations; and the use of full PPE as appropriate (e.g., when having direct or close contact with any patients in isolation or quarantine or when performing potentially aerosol-generating procedures). Staff must practice hand hygiene before and after using PPE. See CDC guidance on PPE here.

It is recommended that providers follow the 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

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, a person with known or suspected COVID-19 should be housed in the same room for the duration of their individual 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. 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.

Passive Screening of Staff, Patients, and Visitors:

Active screening of staff, patients, and visitors no longer needs to occur. Passive screening should occur. Signage in the facility should encourage staff, patients, and visitors to report any recent travel, any symptoms consistent with COVID-19, or known exposure to someone with COVID-19 within the last 5 days.

1. Updated CDC Travel Guidance:

Consider getting a COVID-19 test if you:

- Develop COVID-19 symptoms before, during, or after travel.
- Will be traveling to visit someone who is at higher risk of getting very sick from COVID-19.
- Were in a situation with a greater risk of exposure during travel (e.g., in an indoor, crowded space like an airport terminal while not wearing a mask).

If you traveled and feel sick, particularly if you have a fever, talk to a healthcare professional, and tell them about your recent travel.

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 return to work (RTW) protocols. Travel alone, without a known exposure, does not constitute an exposure.

See CDC travel 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 5 days, within 48 hours prior to symptom onset or the positive test for COVID-19. COVID-19 testing recommendations are the same for patients and staff.

   Interim Guidance for Managing Healthcare Personnel with SARS-CoV-2 Infection or Exposure to SARS-CoV-2

   CDC Guidance for Managing Healthcare Personnel has not changed:

   - In most circumstances, asymptomatic HCP with higher-risk exposures **do not** require work restriction.
   - Updated recommendations for testing frequency to detect potential for variants with shorter incubation periods and to address the risk for false negative antigen tests in people without symptoms. In general, asymptomatic HCP who have had a higher-risk exposure do not require work restriction, regardless of vaccination status, if they do not develop symptoms or test positive for SARS-CoV-2.
   - See CDC Guidance here.
   - On November 1, 2022, the U.S. Food and Drug Administration (FDA) informed developers of SARS-CoV-2 antigen tests that they are revising the authorized use of SARS-CoV-2 antigen tests. **Serial testing is required when testing both symptomatic and asymptomatic individuals.**

- For symptomatic individuals, SARS-CoV-2 antigen tests will now be authorized for use on symptomatic individuals when tested at least twice over three (3) days with at least 48 hours between tests. Serial (repeat) testing on symptomatic individuals is a requirement.
- For asymptomatic individuals, SARS-CoV-2 antigen tests will now be authorized for use on asymptomatic individuals when tested at least three (3) times over five (5) days with at least 48 hours between tests. Performing serial (repeat) testing 3 times is a requirement.
- Manufacturers will be updating instructions to reflect these new serial testing requirements. See FDA guidance here.

Manufacturers will also be required to update instructions on how test results are interpreted test when serial testing is performed.

Status on first day of Testing	First Result Day 1	Second Result Day 3	Third Result Day 5	Interpretation
With Symptoms	Positive	N/A	N/A	Positive for COVID-19
	Negative	Positive	N/A	Positive for COVID-19
	Negative	Negative	N/A	Negative for COVID-19
Without Symptoms	Positive	N/A	N/A	Positive for COVID-19
	Negative	Positive	N/A	Positive for COVID-19
	Negative	Negative	Positive	Positive for COVID-19
	Negative	Negative	Negative	Negative for COVID-19

Evaluating Healthcare Personnel (HCP) with Symptoms of SARS-CoV-2 Infection

HCPs with even mild symptoms of COVID-19 should be prioritized for viral testing with nucleic acid or serial antigen detection assays.

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With Symptoms	Positive	N/A	N/A	Positive for COVID-19
	Negative	Positive	N/A	Positive for COVID-19
	Negative	Negative	N/A	Negative for COVID-19
Without Symptoms	Positive	N/A	N/A	Positive for COVID-19
	Negative	Positive	N/A	Positive for COVID-19
	Negative	Negative	Positive	Positive for COVID-19
	Negative	Negative	Negative	Negative for COVID-19

See CDC guidance here. See FDA guidance here.

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

Quarantine and Isolation for Patients in Congregate Settings and Special Populations

OASAS congregate settings with high-risk individuals or at high risk for transmission, should follow the following guidance for quarantine or isolation for residents/clients. Aligning with guidance for shelters and detention facilities, OASAS settings may decrease quarantine to 5 days (if the client/resident tests negative after the 5th day) and isolation to 7 days (if COVID-19 symptoms are improving and the client/resident has been fever-free for 24 hours without antipyretic medications, the client/resident was not hospitalized, and the client/resident does not have an immunocompromising condition). If the client/resident does not meet the above factors for shortened isolation, then they should remain in isolation for 10 days. The shortening of the quarantine and isolation periods is taking into consideration how disruptive isolation/quarantine can be due to limitations on access to programs/care.

Adapted from CDC guidance here.

OASAS programs may continue to implement longer quarantine or isolation periods depending on ability of clients/residents in their facilities to wear a mask, physically distance, and abide by other infection control risk mitigation

measures. As noted in CDC guidance, facilities can base their infection control policies on risk tolerance, including factors such as the health and well-being of their staff and client/resident populations and the impact of isolation/quarantine on mental health and staffing coverage. It is expected that individual facilities work with their local health departments as indicated and adjust their infection control protocols as necessary.

3. New signs and symptoms of potential COVID-19. People with COVID-19 have had a wide range of symptoms reported – ranging from mild symptoms to severe illness. Symptoms may appear 2-14 days after exposure to the virus. Anyone can have mild to severe symptoms. Possible symptoms include fever or chills, cough, shortness of breath or difficulty breathing, fatigue, muscle or body aches, headache, new loss of taste or smell, sore throat, congestion or runny nose, nausea or vomiting, and diarrhea. **This list does not include all possible symptoms.** Symptoms may change with new COVID-19 variants and can vary depending on vaccination status. CDC will continue to update this list as needed. Older adults and people who have underlying medical conditions like heart or lung disease or diabetes are at higher risk for getting ill from COVID-19. See CDC guidance here. COVID-19 testing recommendations are the same for patients and staff.

Programs no longer need to hold open rooms in case of the need to quarantine or isolate patients. However, should quarantining or isolating patients need to occur, programs should have a plan in place to accommodate patients. Persons who are confirmed COVID-19-positive can be cohorted while in isolation. 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, the program must work in conjunction with the OASAS RO and the LHD to ensure adherence to all proper infection control precautions. *It is not recommended that quarantined individuals be cohorted together.*

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 and disinfection occurs after each individual uses it. Isolated persons *should not* use the same bathroom as quarantined persons, so each population ideally would need a dedicated bathroom/s.

Patients who become ill during their treatment stay should be isolated and evaluated by a medical provider and treated based on their presentation and history. Medical providers may 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. **If using POC Ag tests for testing, serial testing is now required. See FDA guidance here.**

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 and disinfection.*
4. *Create a method to track staff who enter the patient's room and maintain this information for 7 days.*
5. *Care for patients who are ill symptomatically/supportively and send to a higher-level medical facility if they develop worsening/serious symptoms.*
6. People who are infected but asymptomatic or people with mild COVID-19 should isolate through at least day 7 (day 0 is the day symptoms appeared or the date the specimen was collected for the positive test for people who are asymptomatic). They should wear a higher-grade respirator (N95 or KN95) through day 10. A test-based strategy may be used to remove a higher-grade respirator sooner. People with moderate or severe COVID-19 can be considered for isolation through at least day 10. Those with severe COVID-19 may remain infectious

beyond 10 days and may need to extend isolation for up to 20 days. People who are moderately or severely immunocompromised should isolate through at least day 20. Use of serial testing and consultation with an infectious disease specialist is recommended in these patients prior to ending isolation. See CDC guidance here.

7. *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 OR tests positive for COVID-19 (even if asymptomatic) will need to be treated as a presumed direct/close contact and quarantined for 5 days.*

Guidance on Non-emergent Transportation:

It is recommended strongly that all staff wear a surgical mask and all clients wear a face covering during any transportation. Physical distancing is encouraged, but not required, for staff and clients while in the vehicle.