NEW YORK STATE OF OPPORTUNITY. Office of Mental Health

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MEMORANDUM

To: NYS Public Mental Health Programs (Program applicability defined by section)

From: Dr. Thomas Smith, Chief Medical Officer, NYS OMH
Robert Myers, PhD, Senior Deputy Commissioner, NYS OMH
Moira Tashjian, MPA, Associate Commissioner, NYS OMH
Donna Bradbury, MA, LMHC, Associate Commissioner, NYS OMH

Date: June 25, 2020

RE: Infection Control Guidance for Reopening Public Mental Health System Sites

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Note: The situation regarding the COVID-19 public health emergency is rapidly changing, as is our knowledge of this new disease. The guidance in this document is based on the best information currently available. Visit the New York State Department of Health and The Centers for Disease Control and Prevention for more information. Department of Health 24/7 Hotline: 1-888-364-3065

NEW UPDATES

1. Merger of "Infection Control Guidance for Reopening Public Mental Health System Sites" and "Infection Control Guidance for OMH Residential Programs" guidance documents into a single guidance document.
2. Alignment with New York Forward Phases in regards to the resumption of group treatment.
3. Careful resumption of recreational and social outings in residential settings.

GENERAL INFORMATION

The following guidance is based on the most current Centers for Disease Control and Prevention (CDC) and NYS Department of Health (DOH) recommendations for prevention of the spread of the novel coronavirus of 2019 disease (COVID-19) and the management of Persons Under Investigation (PUI).

As different New York Regions begin to transition from New York PAUSE to New York Forward, program administrators must plan accordingly. Specific additional guidance for outpatient treatment and support as well as residential programs is documented below. Please review this information including the links below with your program's leadership and staff and make any necessary adjustments to your program policies and protocols. Detailed information is available HERE about the different phases of NY Forward, including specific instructions to businesses. Healthcare settings never closed during the pandemic. This guidance is aimed at helping programs recalibrate how to resume some in-person services.

Symptoms of COVID-19 can appear 2-14 days after exposure and may include a temperature of 100.0 degrees Fahrenheit or greater, subjective symptoms of a fever (e.g., malaise, fatigue, muscle aches, chills), and/or respiratory symptoms including a sore throat, cough, and/or shortness of breath. Less common symptoms include 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.

Individuals should seek immediate emergency medical care if they experience:

- Trouble breathing;
- Persistent pain or pressure in the chest;
- New confusion;
- Inability to wake or stay awake;
- Bluish lips or face;
- Any other severe or concerning symptom.

Physical distancing is a prevention technique aimed at slowing the spread of the virus. People are asked to stay at home and limit contact with those who do not live in their home. Public health measures to close schools, eat-in restaurant dining, gyms, libraries, theaters, and so forth are all part of this approach. This action is meant to prevent people from getting sick and overwhelming the healthcare system.

A close contact of someone with known or suspected COVID-19 is defined as:

- Sharing the same household;
- Direct physical contact (e.g., handshake) with the individual;
- Direct contact with infectious secretions of the individual (e.g., being coughed on, touching used tissues with a bare hand);
- Being within 6 feet of the individual for 10 minutes or more (e.g., in a small psychotherapy office, car, etc.).

A 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 personal protective equipment (PPE), within 48 hours prior to symptom onset, for a duration of time greater than 1 hour. Please note that a “contact of a contact” (i.e., contact with an asymptomatic person who has had a close or proximate contact) does not qualify as a contact for infection control purposes.

All providers should follow the CDC’s guidelines for infection control basics including hand hygiene:

- Infection Control Basics
- Hand Hygiene in Health Care Settings
- Handwashing: Clean Hands Save Lives
- How to Protect Yourself and Your Family from Coronavirus (COVID-19)

Providers are advised to provide and post educational materials (see links above) to encourage and educate their patients and staff to:

- Always maintain at least six feet of distance from all individuals who do not live in their household.
- Wash hands with soap and water for at least 20 seconds or use hand sanitizer when soap and water are not available.
- Avoid close contact with people with COVID-like illnesses (CLI) symptoms or who recently tested positive for COVID-19.
- Always wear a cloth face covering or surgical mask when out in public. Masks should fully cover the nose and mouth.
- Stay home if sick.
- Cover coughs or sneezes with a tissue, then discard into the trash.
- Clean and disinfect frequently touched objects and surfaces.

Additional Resources:

- Ensuring Access to Health Care Services During COVID19
- NYS Department of Health Key Infection Control Practices in Inpatient and Outpatient Medical Care Settings
- Interim Guidance for Cleaning and Disinfection of Public and Private Facilities for COVID-19
- Additional OMH Guidance

INFECTION CONTROL PRACTICES FOR OUTPATIENT, SUPPORT, AND CERTAIN EMERGENCY PROGRAMS, INCLUDING MOBILE AND HOME AND COMMUNITY-BASED SERVICES

Applicability

- Adult BH HCBS Community Psychiatric Support and Treatment (CPST) (4720)
- Adult BH HCBS Education Support Services (ESS) (4660)
- Adult BH HCBS Empowerment Services - Peer Supports (4650)
- Adult BH HCBS Family Support and Training (FST) (4690)
- Adult BH HCBS Habilitation (4700)
- Adult BH HCBS Intensive Supported Employment (ISE) (4620)
- Adult BH HCBS Ongoing Supported Employment (OSE) (4610)
- Adult BH HCBS Pre-Vocational Services (4640)
- Adult BH HCBS Psychosocial Rehabilitation (PSR) (4710)
- Adult BH HCBS Self-Directed Care (4740)
- Adult BH HCBS Transitional Employment (4630)
- Adult Home Supportive Case Management (6820)
- Advocacy/Support Services (1760)
- Affirmative Business/Industry (2340)
- Assertive Community Treatment (ACT) (0800)
- Assisted Competitive Employment (1380)
- CFTSS: Children's Mental Health Rehabilitation Program (4960)
- CFTSS: Community Psychiatric Support and Treatment (CPST) (4950)

- CFTSS: Family Peer Support Services (FPSS) (4900)
- CFTSS: Mobile Crisis Intervention (CI) (4910)
- CFTSS: Other Licensed Practitioner (OLP) (4940)
- CFTSS: Psychosocial Rehabilitation (PSR) (4930)
- CFTSS: Youth Peer Support and Training (YPST) (4920)
- Children and Youth Assertive Community Treatment (4800)
- Clinic Treatment (2100)
- Comprehensive PROS with Clinical Treatment (6340)
- Comprehensive PROS without Clinical Treatment (7340)
- Continuing Day Treatment (1310)
- Coordinated Children's Service Initiative (2990)
- Crisis Intervention (2680)
- Day Treatment (0200)
- Drop-In Centers (1770)
- Early Recognition Coordination and Screening Services (1590)
- Family Support Services - Children & Family (1650)
- FEMA Crisis Counseling Assistance and Training (1690)
- Geriatric Demo Gatekeeper (1410)
- Geriatric Demo Physical Health - Mental Health Integration (1420)
- Home Based Crisis Intervention (3040)
- Home-Based Family Treatment (1980)
- Homeless Placement Services (1960)
- Intensive Case Management (1810)
- MICA Network (5990)
- Mobile Integration Team (7030)
- Mobile Mental Health Team (7000)
- Multi-Cultural Initiative (3990)
- Non-Medicaid Care Coordination (2720)
- Nursing Home Support (7020)
- Ongoing Integrated Supported Employment Services (4340)
- On-Site Rehabilitation (0320)
- Outreach (0690)
- Partial Hospitalization (2200)
- Peer Wellness Center (3750)
- Promise Zone (1530)
- Psychosocial Club (0770)
- Recovery Center (2750)
- Recreation and/or Fitness (0610)
- School Mental Health Program (1510)
- Self-Help Programs (2770)
- Supported Education (5340)
- Transformed Business Model (6140)
- Transition Management Services (1970)
- Transitional Employment Placement (TEP) (0380)
- Transportation (0670)
- Vocational Services - Children & Family (C&F) (1320)

- Work Program (3340)

Telemental Health

Programs are encouraged to continue utilizing telemental health services as much as possible. However, programs must maintain capacity for in-person services to treat individuals who are unable to connect via telemental health or who require long-acting injectable medications, or laboratory testing. OMH has issued extensive guidance on telemental health: https://omh.ny.gov/omhweb/guidance.

Due to the COVID-19 declared emergency period, there has been significant relaxation of Federal and State regulations regarding use of telemental health. To ensure continued telemental health services in the event of changes to these regulations, programs should take steps to implement HIPAA-compliant video conferencing technologies and develop policies and practices that adhere to 14 CRR-NY 596.

All clients should be screened for CLI at every telemental health encounter and educated about appropriate infection control precautions.

General Information for In-Person Encounters

One day prior to any in-person appointment all clients should be contacted by telephone and be asked the following three questions. If a client cannot be reached by phone, these screening questions must be asked upon arrival before the client enters the facility:

1. Have you had contact with any persons with confirmed or suspected CLI within the last 14 days?
2. Have you had any symptoms of CLI within the last 14 days (see list above)? and
3. Have you had a positive diagnostic PCR COVID-19 test in the last 14 days?

If the client answers YES to any of these questions, the client should as much as possible be seen via telemental health. The client should be instructed to remain at home as much as possible and contact their healthcare provider. Positive COVID screenings must be entered into client's medical record in a brief note or as part of the documentation of a clinical encounter.

As much as possible, unavoidable in-person visits for clients should be alternated with telemental health visits when appropriate, to reduce density in the facility and to reduce exposure risks in home or community visits.

Post educational materials from the Department of Health throughout your facility to further educate your staff and clients. Printable materials can be found here: https://coronavirus.health.ny.gov/information-healthcare-providers?f%5B0%5D=filter_term%3A46

In-Person Clinical Services in NY Forward Phase 1 and 2 Regions:

1. Promote telecommuniting or work-from-home for all staff who are able to fulfill their functions remotely. This will reduce the density in the facility. Programs can also consider alternate hours, staggered schedules, and so forth.
2. Upon the client's arrival, repeat above three questions from telephone screen. Clients must agree to screen in order to be allowed inside the facility. If clients refuse to participate or if they answer YES to any of the above questions, they should only be seen in an outdoor private area or well-ventilated room with the door closed and must agree to wear a mask or cloth face covering. They should be assessed by a program physician or nurse practitioner

using appropriate PPE. If no qualified program medical staff is available, ask the client to contact their own healthcare provider as soon as possible. These clients should not wait with other clients in a waiting area. Any other staff who interact with these individuals must wear a mask and maintain at least 6 feet distance from client at all times. These clients should be given information on where to obtain COVID-19 diagnostic testing.

3. Programs can use their discretion regarding whether to take clients' temperatures prior to entering the treatment site. This decision should be made based upon each program's staff capabilities and resources. If programs do not have thermometers available for screening on arrival to facility, clients may be asked to check their own temperature prior to coming for a visit. If a program decides to monitor temperatures, any individual with a temperature over 100.0 should be given a mask and instructed to return home and contact their healthcare provider.
4. When providing services, staff should attempt to maintain physical distancing, wear a mask, and meet clients in well-ventilated spaces. If room ventilation is a concern, staff can meet with clients in a private outdoor area, weather permitting. Physical distancing is never a replacement for wearing a mask or facial covering. Staff and clients should always observe BOTH.
5. All clients should wear a mask or cloth facial covering while in the facility. If the client does not bring a cloth facial covering, staff should provide the patient with a disposable surgical mask to wear throughout the visit.
6. As much as possible, clients should come unaccompanied to visits. If this is not possible, escorts should wait outside or wear a mask or other facial covering while in the facility. Programs should provide the escort with a facemask if they do not already have one.
7. When administering long-acting injectable medications (LAIs) to clients, or when conducting other procedures that require close physical contact, staff should follow droplet precautions. As always, staff should wear gloves when administering injections. This is not only for protection against COVID-19 but is universal protocol for protection against blood-borne pathogens. While there is community spread of COVID-19, staff should also wear surgical masks and clients should wear a mask or cloth facial covering. N95 respirators are not appropriate for LAIs and are only needed for procedures that result in aerosolizing of sputum, such as nebulizer treatments. Frequent-contact surfaces in the examination room must be disinfected after every patient encounter. Outpatient programs can consider administering injections outdoors, particularly if the client has confirmed or suspected COVID-19 illness. Whenever possible, staff can provide gluteal injections instead of deltoid injections to increase distance from the client's face. An eye shield is recommended, if available.
8. Frequent-contact office surfaces (such as tabletops, door knobs, chair arms, clip boards, pens, etc.) must be disinfected in between every patient.
9. The office must be thoroughly cleaned at least daily.
10. Sufficient hand sanitizer must be available throughout the facility, including in waiting areas, and be available for staff and clients.
11. Chairs in outdoor and indoor waiting areas should be spaced at least six feet apart. If possible, clients should wait outside for their appointment.
12. If peer socialization is critical to the well-being of a client, small groups may have out-of-doors meetings if clients have capability and have agreed to wear facemasks and maintain physical distancing during such meeting. For minors, parent/guardian would also need to agree to such a meeting.

In-Person Clinical Services in NY Forward Phase 3 and 4 Regions:

1. Promote the use of telemental health as much as possible.
2. Continue efforts to reduce staff density in facility.
3. Ensure that individual services continue to adhere to infection control best practices (see #2-11 in Phase 1-2 guidance above).
4. Groups of ten clients or fewer can be held indoors in a large and well-ventilated space provided that at least 6 feet distance can be maintained between all individuals present; if adequate distance cannot be maintained, groups must be smaller. Group should not last more than one hour. Every group participant must screen negative for CLI symptoms and wear appropriate facial coverings.
5. Larger groups may be held outdoors provided a least 6 feet can be maintained between all individuals present and all wear appropriate face coverings.
6. In the event that the State Department of Health or the Local Health Department report increasing local COVID-19 infection rates, programs should again suspend group programming until local infection rates again stabilize and fall.

Prioritize Scheduled Encounters

1. While drop-in hours are generally an excellent strategy to reduce no-show rates and help with engagement, programs should prioritize scheduled encounters to ensure that clients can be adequately screened.
2. For programs that continue drop-in hours, it is imperative to ensure optimal physical distancing in waiting areas and offices. Programs should follow screening guidance described above.
3. If programs serve individuals that are particularly high-risk who must be seen in-person, consider blocking off a time period at the end of the workday only for these individuals to reduce risk of their exposure to others.

Home and Off-Site Visits

Programs such as Mobile Crisis, ACT, HCBS, CFTSS, and others require that staff visit clients in their homes or other locations in the community. Staff should take the following precautions to protect staff and clients from possible infection during home and off-site visits:

1. Staff must always wear a surgical mask or cloth facial covering when interacting with clients or family members.
2. Clients should be educated to wear a cloth facial covering (such as a bandana). If supplies are available, the program can offer to give clients facial coverings or facemasks at each encounter.
3. If the client's home is crowded or the client lives with elderly or other vulnerable individuals, staff should use clinical judgment on pros and cons of entering the home. An acceptable alternative is to take a walk with the client or see the client outside when it is safe to do so.
4. If the staff member encounters clients or family members who refuse to observe physical distancing (or are in any other way aggressive or menacing), it is acceptable for the staff member to disengage from the contact.

Other Recommendations

To the extent practicable, programs should:

1. Consider installing plexiglass shield in reception areas to protect staff in high-traffic areas.
2. Remove magazines and other shared objects from waiting areas.

3. Institute policies and protocols so that only 2-4 individuals ride in shared elevators at any time.
4. Develop protocols to ensure that physical distancing can be maintained in tight workspaces (e.g. chart rooms, supply closets, etc.).
5. Ensure that adequate physical distance can be maintained in public bathrooms (e.g. urinals and sinks should be blocked off to ensure that individuals stay six feet apart at all times).
6. Administrative staff (i.e. staff who do not directly interact with clients) who must work in the facility (and cannot effectively work from home) must also maintain distancing. Whenever possible, work schedules should be staggered to reduce workplace density. Administrative staff should wear a mask or cloth facial covering when physical distancing cannot be adequately maintained.
7. When it is unavoidable for staff to have proximate contact (see above) with each other, all staff should wear facial coverings.
8. Janitorial staff should be provided with adequate PPE as per previously released guidance: Interim Guidance for Cleaning and Disinfection of Public and Private Facilities for COVID-19
9. Staff who interact with outside vendors, deliveries, contractors, etc., or whose work requires close contact with each other (such as for lifting heavy objects) should be given adequate protection and instruction on infection control.

INFECTION CONTROL PRACTICES FOR RESIDENTIAL AND SITE-BASED PROGRAMS, INCLUDING RESIDENTIAL TREATMENT FACILITIES

Applicability

- Adult BH HCBS Intensive Crisis Respite (4670)
- Adult BH HCBS Short-term Crisis Respite (4680)
- Apartment/Support (7080)
- Apartment/Treatment (7070)
- Children & Youth Community Residence (7050)
- Community Residence for Eating Disorder Integrated Treatment Program (6110)
- Congregate/Support (6080)
- Congregate/Treatment (6070)
- Crisis Residence (0910)
- Crisis/Respite Beds (1600)
- Family Care (0040)
- Private Inpatient Psychiatric Hospital (2010)
- Residential Treatment Facility - Children & Youth (1080)
- Respite Services (0650)
- Shelter Plus Care Housing (3070)
- SRO Community Residence (8050)
- Supported Housing Community Services (6060)
- Supported Housing Rental Assistance (6050)
- Supported/Single Room Occupancy (SRO) (5070)
- Transient Housing (2070)

Section 1: General Information

Mental health housing programs should consider the following additional efforts to protect

clients and staff in these programs:

1. Clients should be educated and encouraged to stay in the residence as much as possible. If they do go out, they should stay outdoors and keep a distance of at least six feet away from anyone else, including relatives who do not live in the program. Upon returning home, residents and any accompanying staff should immediately wash their hands with soap and water for at least 20 seconds or use an alcohol-based hand sanitizer with at least 60% alcohol. Cell phones and other frequently handled items should be sanitized daily. All residents should be reminded to avoid touching their face.
2. Programs should cancel all planned social or recreational outings where adequate physical distancing and appropriate hand hygiene cannot be maintained.
3. By Executive Order, as of April 17, 2020, all New Yorkers must wear a cloth mask or facial covering when out in public. Programs should advise residents they should adhere to this order.
4. Providers should display the "NYS DOH Protect Yourself " poster available here (scroll to the bottom). Translations to other languages are also available on same site.
5. Programs should prevent non-residents from visiting residences unless it is deemed necessary to the direct support of a resident's health and wellness. Prior to entering the residence, visitors should be asked if they have any of the CLI symptoms listed above. If any of these are present, the visitor should not be allowed into the residence. If the program has a thermometer, then the visitor's temperature should be checked at the door. All visitors should be asked to wear a cloth face covering or surgical mask while in the residence. Physical distancing should be practiced during visits to the extent possible and if the visit occurs indoors, only well-ventilated locations should be utilized.
6. Frequently touched surfaces (for example: tables, doorknobs, light switches, handles, desks, toilets, faucets, sinks) should be disinfected daily with cleaning products effective against rhinoviruses or human coronavirus. See CDC Guidance for Home and Community Locations for further details.
7. To the extent possible, programs should work with clients' healthcare providers to institute telemedicine appointments. Blood draws and monthly injections will still need to be done in person.
8. Clients and staff should be reminded of the importance of hand hygiene and of not touching their faces while visiting their providers.
9. Clients and staff should be instructed to report symptoms as soon as possible. Staff should specifically ask all clients daily about CLI symptoms (see list above).
10. For individuals who have not developed symptoms and are in shared bedrooms, ensure that the beds are at least six feet apart, if possible. It is recommended that clients sleep head-to-toe.

Section 2: Accepting New Clients

1. Programs should continue accepting new client referrals. It is important for clients with mental illness to find homes even during this public health emergency.
2. Programs should request referring facilities to attest that the client has not had any new symptoms consistent with COVID-19 infections. Upon arrival, staff should ask the clients themselves if they have had any known contact with individuals who tested positive or who have experienced CLI symptoms. Staff should also ask all clients upon arrival if they currently or recently experienced any CLI symptoms. Clients with cognitive difficulties may not be able to fully answer.
3. Programs accepting new clients from Article 28 or Article 31 inpatient hospital settings may require a negative COVID-19 diagnostic PCR test within 72 hours prior to transfer. Programs may require the test result to be sent prior to transfer.

4. For clients who previously tested positive for the COVID-19 virus, the program should confirm the date(s) of the last positive COVID-19 virus test and any subsequent negative tests as part of the application process, along with documentation that 14 days have passed since the first CLI symptom (or positive test result if the individual was asymptomatic), that the individual has been fever-free for at least 72 hours without the aid of fever-reducing medications, and that the individual's respiratory symptoms have significantly improved. Repeat testing is not necessary because a repeat positive result does not indicate continued risk of transmission if 14 days have passed since first symptoms and client has clinically recovered.
5. Given the limitations in accessing testing in community settings, programs may not require a negative test result for clients coming from non-inpatient hospital settings.
6. If CLI symptoms develop or if the client recently had contact with someone who potentially had COVID, a surgical or cloth mask should be worn for a period of 14 days, and the client should remain in their room.
7. If possible, any new client should have their own room.
8. New clients should remain in their room as much as possible during the first 14 days and maintain six feet of distance from all other clients and staff to the extent practicable.
9. Programs may not require results of serum antibody tests as a condition of admission.

Section 3: Responding When Client Develops Symptoms

1. When a client in the residential program develops symptoms that could indicate a COVID-19 infection, the client should be asked to stay in their room. If possible, the client should be assigned a single room. The client should be asked to wear a surgical or cloth mask. Meals should be taken in the room.
2. If a client with COVID-like illness requires close support from a staff member (within 6 feet), the staff member and client should wear a surgical facemask, gloves (if available), eye-protection (commercially available non-medical goggles are acceptable if medical face shield is not available). Goggles should be washed frequently. Outer clothing that becomes soiled or possibly soiled with a client's saliva, urine, blood, or stool should be removed immediately and set aside until washed. Programs may consider supplying staff with lab coats or staff may bring a change of clothes from home.
3. Exposed roommates should, if possible, have their own rooms for 14 days. If they remain symptom-free, they can then share a room with others.
4. The program administrator (or Family Care provider) should immediately contact their local health department (LHD) (New York County Health Department Directory) for notification and for information on how to proceed with testing. The NYS Department of Health also operates a Novel Coronavirus Hotline 24/7 at 1-888-364-3065 and website https://coronavirus.health.ny.gov/form/ask-us-a-question for additional questions. The program must also follow OMH guidance on local health department notification and contact tracing: https://omh.ny.gov/omhweb/guidance/.
5. If the client is critically ill (see list above) and is having difficulty breathing, it may be necessary to transport the client by ambulance to the hospital. Programs serving children and adolescents should be familiar with DOH guidance on Pediatric Multi-System Inflammatory Syndrome. The hospital should be contacted prior to transport.
6. LHDs may have alternate housing arrangements for individuals with CLI. Programs should coordinate with their LHDs.
7. Most individuals who test positive for COVID-19 will never need to be hospitalized. Hospitalization is only necessary if the individual has difficulty breathing or otherwise appears critically ill. It is important to reduce unnecessary visits to hospital ERs to help reduce the spread of COVID -19.

8. If more than one client has a positive test, then these individuals can share a room if the program has shared bedrooms.
9. Clients may be taken off isolation when:
    a. The person has had no fever for at least three days (72 hours) without the use of fever-reducing medications; AND
    b. There is a significant improvement of cough, sore throat, and difficulty breathing; AND
    c. At least 14 days have passed since symptoms first appeared.
10. Program staff (or Family Care providers) should work with the client's mental health or primary care provider to secure enough nicotine replacement therapy (NRT) to help eliminate nicotine withdrawal and the desire to leave their room to smoke or vape.
11. Other clients who are over 50 years old, have significant respiratory comorbidity, or who smoke or vape should increase the frequency of hand hygiene practices and wear surgical masks. If masks are not available, more vulnerable clients should maintain at least six feet of distance from other clients and staff. They should refrain from using common areas such as kitchens and lounges.
12. Staff members (or Family Care providers) should wear surgical masks or cloth face coverings and increase frequency of hand hygiene practices. Staff should whenever possible remain six feet away from positive or potentially positive individuals.
13. Surfaces, knobs, handles, and other items that come into frequent hand contact should be sanitized three times per day.
14. In programs with several bathroom facilities, one bathroom should be set aside for the client(s) who is suspected to have COVID-19 or has tested positive for COVID-19. Surfaces, shower knobs, curtains, handles, and other high-contact surfaces should be sanitized after each time these clients use the facilities. If possible, leave the bathroom window open to help reduce aerosolized droplets.
15. In programs with one bathroom, it is critical to clean and disinfect surfaces after clients who test positive or who are suspected to have COVID-19 use the facility. Exhaust fans should remain on and windows should remain open during that time, and no steam should remain when the next resident uses the bathroom.
16. In programs with only one bathroom, all clients and staff should use masks while in the bathroom (unless showering). If possible, stagger shower times, ensuring that bathroom exhaust fans run for at least 20 minutes between all showers and leave the window open to facilitate clearing of droplets.
17. If programs have the capacity and the client is cooperative, implementing in-room commodes and/or sponge baths is recommended.
18. Clients who test positive or who are suspected to have COVID-19 should not use shared spaces such as kitchens, common areas, etc. Arrangements need to be made to change existing house routines that require clients to use common spaces.
19. Dishes and linens do not need to be cleaned in a different manner if used by individuals who test positive for COVID-19. However, they should be washed thoroughly after use. When washing clothes, staff (or Family Care providers) should be instructed to not "hug" dirty laundry while transporting it, to maintain distance from their own clothes and face. Use of a hamper is recommended. After handling linens or clothing of someone who tested positive for COVID-19, staff are encouraged to wash their hands with soap and water.

<u>Section 4: Clients Returning From The Hospital</u>

1. Residential program or Family Care clients are admitted to psychiatric or medical hospitals for a variety of reasons. During the COVID-19 public health emergency, it is possible that these clients are exposed to the virus while in the hospital. Of note, this section applies

when patients are admitted to an inpatient unit in a hospital. Patients who go to the emergency room or a CPEP and discharged without an inpatient admission are not considered to have been hospitalized.

2. Programs may ask that a medical emergency room obtains a sample for COVID-19 PCR testing, but must take the patient back if they are discharged from the emergency room, even prior to receiving the test results, provided the emergency room makes arrangements to forward the test result when it is available.
3. Most individuals who become very ill with COVID-19 and require hospitalization will recover. Individuals must be discharged once they are no longer ill enough to warrant ongoing medical admission, though they may still have mild COVID-19 symptoms.
4. Individuals who are discharged from the hospital after an admission for CLI should be treated with the same precautions as someone who is suspected to have COVID-19 or who tests positive but is never hospitalized (see Section 6 #9 above).
5. COVID-19 virus testing within 72 hours prior to transfer will not be required for any client who tested positive for COVID-19 virus at any time prior to the requested transfer. Instead, the program should confirm the date(s) of the last positive COVID-19 virus test and any subsequent negative tests as part of the application process.
6. Local health departments may have alternate housing arrangements for individuals who are ready for hospital discharge and may still need a period of isolation. Programs should review options with their local health departments.
7. Clients will need to come home to their residential program or family care home after being discharged from the hospital. It is important that staff help manage not only the individual client's fears, but also the anxieties of all other housemates.
8. Individuals who return from the hospital and who are not showing symptoms of COVID -19 should be considered in the same category as a new client (see Section 5 above).
9. Programs may require a negative diagnostic PCR test within 72 hours prior to discharge from the hospital if the individual was hospitalized for a reason other than COVID-19 (e.g a psychiatric admission) (unless #4 and #5 above apply).
10. Programs may not require results of serum antibody tests as a condition for client returning to residential program.
11. Programs should reach out to their OMH Field Office of Central Office Housing staff if there are questions or concerns about admissions or discharges. Hospitals are also encouraged to reach out with questions or concerns about transfers back to residential programs.

<u>Section 5: Scattered-Site Housing Programs</u>

1. Programs should educate all their clients in scattered-site housing about the importance of avoiding socializing indoors, restricting visitors to their homes, practicing appropriate hand hygiene, avoiding touching their faces, practicing basic disinfecting at home, keeping at least six feet away from others while out in public, when possible, and wearing a cloth mask when out in public.
2. Programs need to determine on a case-by-case basis when it is clinically necessary to continue visiting clients. Possible reasons include, but are not limited to, helping the client access medical treatment, access food or other basic supplies, or mitigating risk of disengagement or hospitalization in absence of direct contacts.
3. Face-to-face visits should be replaced with telephonic or video visits for as long as the recommendation for physical distancing is in place, unless it is clinically necessary to visit the client in person.
4. When visiting a client, staff should use alcohol-based sanitizer prior to entering the client's home and should wear a surgical face mask or cloth facing covering.
5. Staff should attempt to keep at least six feet away from the client during the visit.

6. Staff should remind the client to practice appropriate hand hygiene and to avoid touching their face.
7. Staff should use alcohol-based sanitizer immediately upon leaving the client's building.
8. If community testing is available, staff should assist clients to obtain a test and help client interpret result correctly.

Section 6: Guidance For Child And Youth Serving Residential Programs

While under normal circumstances home-time leaves are encouraged, during this public health emergency, home-time leaves should be limited and occur only when deemed medically necessary or when discharge is imminent, and home-time contributes to the advancement of the youth's readiness for discharge. The following should also be considered:

1. The youth and family must agree that the home-time leave is appropriate and safe. Staff should ask families whether anyone at home has CLI symptoms or is in a high-risk category.
2. Home-time leaves must be clinically appropriate and included as part of the youth's treatment plan.
3. If the youth is going on a home-time leave, the youth should not have close contact beyond family members in the home setting (must adhere to physical distancing guidance).
4. Information on general infection control strategies should be provided to the youth and parents/guardians.
5. For all youth, if the home-time is directly connected to discharge planning (i.e., an interview at an outpatient program, a therapeutic assessment for readiness for next level of care, etc.), home-time leave may be granted. This would require input from both the youth's psychiatric, general medical, and nursing staff as well as individuals at the destination site.
6. As an alternative to home-time leaves, staff should encourage the family/guardian to join in-person interactions on program grounds (but maintain physical distancing).
7. Every effort should be made to utilize technology as often as needed to promote engagement, support, and treatment with children and families, whether the youth is on site or on home-time leave.
8. Any youth in quarantine or isolation may not leave the program site for community or home-time.

INFECTION CONTROL PRACTICES FOR PROGRAMS BASED IN ARTICLE 28 HOSPITALS, INCLUDING CPEP AND INPATIENT UNITS

Applicability

- CPEP Crisis Beds (2600)
- CPEP Crisis Intervention (3130)
- CPEP Crisis Outreach (1680)
- CPEP Extended Observation Beds (1920)
- Inpatient Psychiatric Unit of a General Hospital (3010)

Please follow the policies and protocols of your hospital's infection control departments.

INFECTION CONTROL PRACTICES FOR ARTICLE 31 PRIVATE PSYCHIATRIC INPATIENT HOSPITALS

Hospitals should reach out their local OMH Field Office to discuss questions and concerns about infection control.

INFECTION CONTROL PRACTICES BEST PRACTICES DURING NON-EMERGENT TRANSPORTATION

Applicability: All programs

As different regions progress through re-opening, it is important to consider the risks of close contact posed by transportation in cars and vans. However, there are times when clients of outpatient programs or individuals living in congregate settings need to be transported non-emergently by staff for medical appointments or other essential purposes. For example, as testing sites open around the state, programs may want to transport their clients for testing.

Recent studies have shown that a significant portion of individuals infected with the virus are asymptomatic. Asymptomatic individuals, even if they eventually develop symptoms, can transmit the virus to others before showing symptoms.

There is risk of infection for both the staff member driving the vehicle and the client being transported. Special precautions must be taken to help protect both:

1. Staff should wear a surgical facemask. Clients should wear a cloth facial covering. If a client does not have a facial covering, the program should provide them with a mask.
2. As much as possible, separate the driver from the client. It is preferable to use a larger vehicle such as a van as opposed to a smaller car, to increase distance between individuals. It may be possible to purchase large, transparent plastic sheets (i.e. thick plastic cling wrap) that can be securely taped to seal off the front seats from the rear seats of the vehicle. If safe to do so, programs can consider outfitting their vehicles with this.
3. If another staff member is in the vehicle to help ensure the client's safety, the staff member should sit as far away from the client and driver as is safely possible. Any other staff members in the vehicle should also wear a surgical facemask.
4. When driving at a low speed, the vehicle's windows should remain open to maximize ventilation. At higher speeds where sheer wind forces may interfere with wearing a facemask, utilize climate control systems in a non-recirculating setting (air should blow in from outside the vehicle) with the fan on its maximum setting. At high speeds, opened side windows may create positive air pressure inside the vehicle and promote recirculation of the same air.
5. If the vehicle has a rear window (i.e. a window on the rear windshield), it should always remain open while the vehicle is in motion to create negative air pressure inside the vehicle and facilitate air moving out of the vehicle.
6. After use, thoroughly clean all surfaces with which staff or clients may have come into contact. If available, the vehicle used for non-emergent transportation should have disinfectant wipes available for immediate use on frequently touched surfaces when the vehicle arrives at its destination, before the return trip. After the return trip, the vehicle should be thoroughly cleaned.
7. As much as possible, avoid transporting more than one client at a time. If this is not possible, always attempt to maximize distance between all individuals in the vehicle during the trip, including when entering and exiting the vehicle.
8. Staff and clients should be reminded to not touch their faces and to wash their hands (or use hand sanitizer with at least 60% alcohol) as soon as possible after reaching their destination. Hand sanitizer should be available in all vehicles used for non-emergent transportation.
9. Clients with confirmed or suspected COVID-19 illness should remain in isolation and should

not be transported to any appointments unless absolutely necessary.

10. If it is unavoidable, when transporting individuals with confirmed or suspected COVID-19 illness, or with known contact with confirmed or suspected COVID-19-positive individuals, staff members and clients should all wear surgical facemasks. The vehicle speed should remain at lower speeds to allow for the windows to remain open. However, every effort should be made to avoid transporting with known or suspected COVID-19 illness in a personal or agency vehicle.

GUIDANCE FOR STAFF

Applicability: All programs

1. Staff members must stay home if they are sick.
2. All staff must wear a mask or cloth facial covering while at the facility, this includes staff who do not have direct contact with clients. Staff may remove their face covering if they are working alone in their own office.
3. If programs are experiencing significant staffing shortages and exhausted other solutions (as is very likely the case for most programs, particularly in areas of the state that still face community spread of COVID-19), the DOH and CDC advise that staff who have had direct contact with individuals who tested positive or PUIs may continue to work provided that
   a. The staff member is asymptomatic;
   b. The staff member is deemed essential and critical for the operation or safety of the workplace;
   c. The determination is documented by their supervisor and a human resources (HR) representative in consultation with appropriate state and local health authorities;
   d. Working from home would not be feasible for job duties;
   e. Staff quarantine themselves when not at work;
      i. After work, immediately upon returning home, staff should remove their clothes and wash their hands with soap and water prior to coming into contact with any family members;
      ii. Clothes should be washed after each shift; and
      iii. If staff member works closely with a client with COVID-like illness, they are encouraged to try to maintain physical distance from all friends and family with risk factors mentioned above.
   f. Staff undergo temperature monitoring and symptom checks upon arrival to work and at least every 12 hours while at work, and self-monitor (i.e. take temperature, assess for symptoms) twice a day when at home;
   g. Staff members may use their own home thermometers to check their own temperatures; they are considered to have a fever if their temperature is over 100.0 degrees; If programs have infrared thermometers available, then staff temperatures may be checked using facility thermometers.
   h. Staff should wear a surgical facemask;
   i. To the extent possible, staff working under these conditions should preferentially be assigned to patients at lower risk for severe complications.
   j. Staff whose job duties permit a separation of greater than 6 feet should have environmental controls in place to ensure adequate separation is maintained;
   k. If staff develop symptoms consistent with COVID-19 (see list above) while working, they should immediately stop work and isolate at home;
   l. Staff should contact https://covid19screening.health.ny.gov/ for testing; and
   m. When the program is not facing any difficulty with staffing, program leadership may

decide that staff may self-quarantine away for 14 days after having a close contact with someone with CLI. These staff may work from home during quarantine if it is possible for them to fulfill their job functions.

4. Symptomatic or COVID-19 positive staff can return to work when:
   a. At least 3 days (72 hours) have passed since recovery, defined as resolution of fever (greater than or equal to 100.0) without the use of fever-reducing medications; AND
   b. Improvement in respiratory symptoms (e.g., cough, shortness of breath); AND
   c. At least 10 days have passed since symptoms attributed to COVID-19 first appeared. For staff who were asymptomatic at the time of their first positive test and remain asymptomatic, at least 10 days have passed since the first positive test.
5. Names and contact information of staff who developed confirmed or suspected CLI must be provided to the local health department.
6. If a staff member becomes sick and has had prolonged contact with clients, the program does not need to disclose the identity of the staff member to clients; only that they have had an extended contact and that the clients should be in quarantine for 14 days.