



**Office of
Mental Health**

New York State Office of Mental Health Infection Control Manual for Public Mental Health System Programs

September 21, 2021

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.

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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 for the treatment of individuals with known or suspected COVID-19 in the public mental health system.

Symptoms of COVID-19 can appear 2-14 days after exposure and may include a temperature of 100.4 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. Please check the [CDC website](#) for the most up-to-date list of symptoms. Please see the CDC's definitions of severe and critical COVID-19 illness [here](#).

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, sneezed on, touching used tissues with a bare hand);
- Being within six feet of the individual for 15 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 six feet 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 and DOH guidelines for infection control basics and vaccination:

- <https://covid19vaccine.health.ny.gov/>
- <https://www.cdc.gov/coronavirus/2019-ncov/vaccines/your-vaccination.html>
- <https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html>
- [CDC](#) and [DOH](#)

COVID-19 Vaccination is available through the O-Agency Link-Outreach-Vaccinate (OLOV) Program and a variety of other community locations. Clients and staff of OMH, OASAS, OPWDD, OCFS, and OTDA programs are eligible to become vaccinated through OLOV.. <https://omh.ny.gov/omhweb/o-lov-covid19-vaccine/index.html> .

An individual is considered full vaccinated when

- Two weeks have passed since the final vaccine in the series (second dose in a two-dose series or one dose of single-dose vaccine)
- Work restrictions should still be considered for fully vaccinated HCP who have underlying immunocompromising conditions which might impact the level of protection provided by the vaccine

Regardless of vaccination status, all individuals who work for or receive services in programs that are operated, licensed, funded, and/or designated by the Office of Mental Health should:

- Get vaccinated if not already vaccinated for COVID-19 and influenza.
- Always maintain at least six feet of distance from all individuals who do not live in their household.
- Frequently wash hands with soap and water for at least 20 seconds or use 60% alcohol-based 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.
- Individuals older than two years of age should always wear a mask when in proximity with individuals from outside their household. Masks should fully cover the nose and mouth.
- Wearing masks is to be done in addition to physical distancing NOT instead of physical distancing.
- Stay home if sick.
- If not wearing a mask, cough or sneeze into the elbow or into a tissue, then discard into the trash and wash hands afterwards.

Additional Resources: [Additional OMH Guidance](#)

Please note Emergency Regulation Part 556 requiring use of masks in all inpatient, residential, and ambulatory programs licensed, certified, designated, or funded by the Office of Mental Health as determined by the Commissioner:

https://omh.ny.gov/omhweb/policy_and_regulations/emergency/556-masks.pdf

Infection Control Practices for Outpatient, Support, Crisis, and Forensic Transition Programs, including Mobile and Home and Community-Based Services

- 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)
- CASES Homeless Forensic Case Management Program
- 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)
- OMH Forensic Case Management Program
- 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)
- Parole Support and Treatment Program (PSTP)
- 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)

Telehealth

Programs are encouraged to continue utilizing telehealth services in a way that balances the various risks and benefits for clients. OMH has issued extensive guidance on telehealth that can be found [here](#). All clients should be screened for vaccination status, COVID-19 symptoms, and recent sick contacts at every telehealth encounter and educated about appropriate infection control precautions and how to obtain COVID-19 vaccination if not yet vaccinated.

In-Person Encounters

Providers must ensure in-person access to clients when necessary (e.g. clients who are deemed to not be appropriate for telehealth encounters, who are receiving long-acting injectable medications, those who need laboratory testing or clozapine monitoring, and those receiving any other clinical services that can only be performed in person) or to avoid disruptions in care. Programs should also offer and accommodate in-person services when preferred by the client and when such services can be delivered with the appropriate infection control precautions.

Agencies and programs must make informed decisions about which clients must be seen in-person. Providers should have clear policies and procedures outlining processes for decision-making regarding the balance of in-person and telehealth services that will best meet the needs of each client. Such decisions should be made deliberately and jointly between the clinical team and the client, be documented in the record, and should take the following areas into account:

- Factors related to the client's appropriateness for telehealth, including:
 - An individual's cognitive capacity, especially as it relates to ability to engage in remote care and to navigate telehealth platforms;
 - Issues related to access (phone ownership, privacy, data plan, minutes, broadband access, etc.);
 - Ability to establish privacy;
 - The consent process and discussion of circumstances around session management so that if an individual can no longer be safely managed through telehealth, the individual is aware that in-person service may be required;
 - Ability to maintain rapport, engagement, and communication; and
 - Ability to take a more active role in the treatment process than may be the case for in-person contacts.
- Factors related to infection control, including:
 - Whether the client has been vaccinated; whether individuals living with the client have been vaccinated.

- Results of recent COVID-19 tests;
 - Whether client currently has COVID-19 symptoms or has come into contact with anyone with COVID-19
 - Whether client has recently travelled outside the United States;
 - The program's physical layout, including the ability to limit density, maintain physical distancing, etc.;
 - The program's ability to access PPE;
 - Rate of vaccination among program staff;
 - Client medical comorbidities and risk for worse outcomes if they become ill with COVID-19;
 - Considerations of whether risk of travel to and from the program in determining if the benefits of an in-person visit outweigh the risks; and
 - Risk factors in people living in same household as client.
- Clinical factors and personal preference, including:
 - Need for laboratory testing or physical examination
 - Need for long-acting injectable medications;
 - Strength of relationship, engagement and continuity of care. Is the client new to the program? Was there a recent change in clinician assignment? Were there any other care transitions?
 - Assessment for risk in self harm, suicide, violence, housing instability, addiction relapse;
 - Recent hospital or CPEP/ER discharge, recent increase in hospital/ER admissions, recent re-entry from incarceration,
 - For individuals returning to the community from prison, it is recommended that in-person warm handoffs be facilitated on the day of release to ensure safe transition to housing and access to psychiatric medication, food/clothing, and telephone for telehealth contacts. Community re-entry is a critical juncture, and many clients will require in-person assistance to reconnect to services as they readjust to the community environment; and
 - Geographic distance to the nearest emergency medical facility, efficacy of patient's support system, and current medical status.

If the client poses an infection risk to others in the program, the client should preferably be seen via telehealth. The client should be instructed to remain at home and contact their healthcare provider. Positive COVID screenings must be entered into a 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 telehealth 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](#).

In-Person Clinical Services:

1. Use every client encounter as an opportunity to promote vaccination. All ambulatory staff are responsible to connect patients to the O-LOV program or other community resources.
2. Promote the use of telehealth unless there is a clinical determination that an in-person encounter is preferable or necessary (based on above criteria).
3. Continue efforts to limit staff density in facility.

4. Agencies must develop a process to procure PPE and make it available at each program site.
5. All staff must wear a mask that covers the nose and mouth at every interaction with every client, family member, or other staff. A face shield is also recommended at every client interaction.
6. Clients who recently tested positive for COVID-19 or are otherwise suspected as having COVID-19 should only be seen in an outdoor private area or well-ventilated room with the door closed and must agree to wear a mask. They should be assessed by a program physician or nurse practitioner; 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 maintain at least six feet of distance from the client at all times other than during the physical exam and wear a surgical facemask and eye shield. These clients should be given information on where to obtain COVID-19 testing, if not already tested.
7. It is recommended for programs to take clients' (and their escorts') temperatures prior to entering the treatment site. Clients may also be asked to check their own temperature prior to coming for a visit. Programs should follow process described above for any individual with a temperature equal to or over 100.4 degrees Fahrenheit.
8. When providing services, staff should 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.** Staff and clients should always observe BOTH. It is also recommended for staff to wear a faceshield. **NOTE:** fully vaccinated staff must still wear a mask when treating fully vaccinated clients because there remains a low, but non-zero, risk of asymptomatic transmission.
9. All clients should wear a mask while in the facility. If the client does not bring one, staff should provide the patient with a disposable surgical mask to wear throughout the visit.

Preferably, adult clients should come unaccompanied to visits. If this is not possible, escorts should wait outside the facility or wear a mask and maintain physical distance while in the facility. Programs should provide the escort with a mask if they do not already have one. Parents or guardians of children and adolescents should be given masks if they do not already have one from home.
10. 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. Staff and clients must wear surgical masks and staff should also wear a faceshield. Staff should minimize time spent within six feet of the client. Enclosed spaces should be thoroughly ventilated in between clients. If appropriate privacy can be maintained, 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.
11. Frequent-contact surfaces (such as examination tables, tabletops, door knobs, chair arms, clip boards, pens, etc.) in the examination, consultation, or waiting rooms must be disinfected after every patient encounter.
12. The office must be thoroughly cleaned at least daily as per [DOH guidance](#).
13. Sufficient hand sanitizer must be available throughout the facility, including in waiting areas, and be available for staff and clients.

14. Chairs in outdoor and indoor waiting areas should be spaced at least six feet apart. If possible, clients should wait outside for their appointment.
15. Educate clients about how to reduce their risk of exposure while on public transportation traveling to and from their appointments. Emphasize the need to always wear a mask and continue hand hygiene.
16. Groups of ten clients or fewer can be held indoors in a large and well-ventilated space provided that all parties wear masks and at least six feet of distance can be maintained between each individual present; if adequate distance cannot be maintained, groups must be smaller. Groups should last less than one hour. Individuals with known or suspected COVID-19 infection may not attend groups until after they complete required isolation period.
17. Larger groups may be held outdoors provided at least six feet can be maintained between all individuals present and all wear masks. Individuals with known or suspected COVID-19 infection may not attend groups until after they complete required isolation period.

Assertive Community Treatment (ACT), Mobile Crisis, Forensic Transition Programs, and Other Specialty Services that Rely on Home and Off-Site Visits

Programs such as ACT are specifically designed to serve vulnerable, high-risk individuals who have not been able to engage in traditional outpatient services. These clients are the least likely to use telehealth platforms and are at high risk of disengaging from care as the system adjusts to more virtual services. These clients also have a high burden of medical comorbidities that place them at significant risk if they become ill. Balancing competing risk factors presents an important challenge. ACT and similar programs must meet with each client and conduct an informed analysis to review each client's risk and capacity to engage in and benefit from telehealth to determine when telehealth encounters are an acceptable alternative to in-person encounters (see considerations above). ACT, mobile crisis, and other mental health specialty service providers that traditionally rely on home and off-site visits should aim to resume in-person visits for as many clients as possible.

Staff should take the following precautions to protect staff and clients from possible infection during home and off-site visits:

1. Whenever possible, staff should call ahead and inform clients they will be wearing PPE and verify if client has their own mask. Staff should also use these pre-visit calls to screen clients for COVID-19 symptoms and recent travel.
2. Staff should use every client encounter to encourage vaccination and help clients access vaccines through the O-LOV program or other community resources. Every team member is responsible to promote vaccination as the best strategy to prevent COVID illness and death in this vulnerable population.
3. Staff must always wear a mask when interacting with clients or family members. Staff should wear face shields.
4. Clients should be educated to wear a mask. If supplies are available, the program can offer to give clients face coverings or facemasks at each encounter.
5. 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.

Other Recommendations

To the extent practicable, programs should:

1. Remove magazines, toys, and other shared objects from waiting areas.
2. Institute policies and protocols so that no more than 2-4 individuals ride in shared elevators at any time, considering the size of the elevator.
3. Develop protocols to ensure that physical distancing can be maintained in tight workspaces (e.g. chart rooms, supply closets, etc.) or hallways. Programs can consider marking floors for where individuals can stand, etc.
4. 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).
5. Administrative staff (i.e. staff who do not interact directly with clients) who must work in the facility (and cannot work effectively from home) must also maintain physical distancing. Whenever possible, work schedules should be staggered to reduce workplace density. Administrative staff must wear a mask when in a shared space.
6. 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, including a mask and eye protection and instruction on infection control.
7. Agencies should encourage their clients and staff to access primary care and obtain an influenzavaccine in addition to the COVID vaccine.

Infection Control Practices for Congregate Residential Programs without Frequent New Admissions

- Apartment/Support (7080)
- Children & Youth Community Residence (7050)
- Congregate/Support (6080)
- Congregate/Treatment (6070)
- Family Care (0040)
- Residential Treatment Facility - Children & Youth (1080)

Mental health housing programs should consider the following additional efforts to protect clients and staff in these programs:

1. Obtaining the COVID vaccine is the best way for individuals to protect themselves and their communities. It is strongly encouraged for all individuals in residential programs, staff and clients, to obtain the COVID vaccine. Programs may reach out to the O-LOV program to access vaccination. Other community resources are also available.
2. Clients should be educated and frequently reminded of importance of maintaining physical distancing. Socializing among individuals who live in the residence should preferably occur outdoors or in large, well-ventilated spaces.
3. Socializing with individuals who do not live in the program should occur outdoors as much as possible. Masks should be worn by all whenever clients are socializing with individuals who do not live in the residence. Physical distancing of 6 feet should be maintained at all times. Prior to entering the residence, visitors should be asked if they have any COVID-19 symptoms, if they recently tested positive for COVID-19, or if they recently came into contact with anyone with COVID-19. 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.
4. All staff who work in congregate residential programs must always wear a mask when at work unless alone in their own office with the door closed. Staff should wear faceshields while interacting with clients, if available. Staff should endeavor to always maintain

- physical distancing of six feet from all clients and other staff.
5. 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 faces.
 6. Programs should cancel all planned social or recreational outings where adequate physical distancing and appropriate hand hygiene cannot be maintained,
 7. Long-term residents do not need to wear a mask around other long-term residents if there are no known concerns for COVID-19 exposure, COVID-19 symptoms, or recent positive COVID-19 tests. Congregate residential programs are permanent or long-term homes to many individuals, and it is not an expectation that people wear a mask at home with their families, housemates, and roommates. However, in order to prevent hospitalization and deaths of clients, particularly unvaccinated clients, it is imperative that residential programs continuously educate and enforce the importance of masking and distancing whenever residents interact with individuals who do not live in the program, including staff, visitors, relatives, contractors, neighbors, visiting providers, etc. It is important to preserve the home-like atmosphere in residential programs, but it must not be forgotten that any congregate setting can pose a risk of infection, illness, and death if appropriate infection control precautions are not maintained when outsiders come into the program.
 8. Please see below for guidance when a new resident is admitted to a program.
 9. Frequently touched surfaces (for example: tables, doorknobs, light switches, handles, desks, toilets, faucets, sinks) should be disinfected daily.
 10. Clients and staff should be instructed to report symptoms as soon as possible. Staff specifically should ask all clients daily about COVID-19 symptoms (see list in [General Information](#) section of this document).
 11. Agencies must develop a process to procure PPE and make it available at each program site.
 12. Agencies should encourage their clients to access primary care and obtain an influenza vaccine.
 13. Programs should work with local health departments and local healthcare providers to access COVID testing if there is concern of a possible exposure or outbreak.
 14. Agencies may apply for multi-site Limited Service Laboratory Certificate to do onsite rapid COVID-19 testing. <https://www.wadsworth.org/regulatory/clep/limited-service-lab-certs>

Infection Control Practices for Congregate Residential Programs with Frequent New Admissions

- Adult BH HCBS Intensive Crisis Respite (4670)
- Adult BH HCBS Short-term Crisis Respite (4680)
- Community Residence for Eating Disorder Integrated Treatment Program (6110)
- Crisis Residence (0910)
- Crisis/Respite Beds (1600)
- Private Inpatient Psychiatric Hospital (2010)
- Respite Services (0650)

Mental health housing or inpatient programs with frequent turnover should consider the following additional efforts to protect clients and staff in these programs:

1. Obtaining the COVID vaccine is the best way for individuals to protect themselves and

- their communities. It is strongly encouraged for all individuals in residential programs, staff and clients, to obtain the COVID vaccine. Programs may reach out to the O-LOV program to access vaccination. Other community resources are also available.
2. Clients should be educated and frequently reminded of importance of maintaining physical distancing. Socializing among individuals who live in the residence should preferably occur outdoors or in large, well-ventilated spaces.
 3. All residents should wear a mask in common areas unless actively eating, drinking, or showering.
 4. Socializing with individuals who do not live in the program should occur outdoors as much as possible. Masks should be worn by all whenever clients are socializing with individuals who do not live in the residence. Physical distancing of 6 feet should be maintained at all times. Prior to entering the residence, visitors should be asked if they have any COVID-19 symptoms, if they recently tested positive for COVID-19, or if they recently came into contact with anyone with COVID-19. If any of these are present, the visitor should not be allowed into the residence.
 5. Programs must check the temperature of all visitors on arrival. Individuals whose temperature is above 100.4 degrees should not be allowed indoors and should be referred to a healthcare provider.
 6. All staff who work in congregate residential programs must always wear a mask when at work unless alone in their own office with the door closed. Staff should wear faceshields while interacting with clients, if available. Staff should endeavor to always maintain physical distancing of six feet from all clients and other staff.
 7. Upon entering the facility, all clients and 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 faces.
 8. Programs should cancel all planned social or recreational outings where adequate physical distancing and appropriate hand hygiene cannot be maintained,
 9. Please see below for guidance when a new resident is admitted to a program.
 10. Frequently touched surfaces (for example: tables, doorknobs, light switches, handles, desks, toilets, faucets, sinks) should be disinfected daily.
 11. Clients and staff should be instructed to report symptoms as soon as possible. Staff specifically should ask all clients daily about COVID-19 symptoms (see list in [General Information](#) section of this document).
 12. Agencies must develop a process to procure PPE and make it available at each program site.
 13. Agencies should encourage their clients to access primary care and obtain an influenza vaccine.
 14. Programs should work with local health departments and local healthcare providers to access COVID testing if there is concern of a possible exposure or outbreak.
 15. Agencies may apply for multi-site Limited Service Laboratory Certificate to do onsite rapid COVID-19 testing. <https://www.wadsworth.org/regulatory/clep/limited-service-lab-certs>
 16. Free-standing Article 31 hospitals should implement surveillance rapid testing of all staff:
 - a. Surveillance testing should be implemented twice per week for staff who work where that have been active COVID-19 cases in patients or staff in prior two weeks
 - b. Surveillance testing should be implemented once a week for staff who work in settings where there are NO active COVID-19 patient or staff cases
 - c. Surveillance testing should be increased to twice a week for unvaccinated staff when the county COVID-19 positivity is greater than 3%

Infection Control Practices for ALL Congregate Residential Programs

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 infection.
3. Programs accepting new clients may require a COVID-19 diagnostic PCR test within 72 hours prior to transfer. Staff should screen all new arrivals for symptoms or recent exposures.
4. For clients who previously tested positive for the COVID-19 virus, diagnostic PCR tests may remain positive for many weeks after the client is no longer at risk of transmitting COVID. Programs do not need to request a new PCR diagnostic test if there is evidence the client recovered from a COVID-19 infection within the prior 3 months. The program should confirm the date(s) of the last positive COVID-19 virus test and any subsequent tests as part of the application process, along with documentation that 10 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 symptoms have significantly improved. There is no need to wait for test results to become negative prior to accepting the client.
5. If a program accepts a client without a negative PCR test or proof of recent recovery from COVID-19, the program should arrange for the client to be tested right away. Alternatively, the client 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. All clients and staff should wear a mask pending the conclusion of the new client's quarantine.

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 must be asked to wear a mask. Meals should be taken in the room.
2. All clients in the program must wear a mask at all times when in proximity of individuals who are showing symptoms of COVID-19.
3. Ventilation in common rooms, bathrooms, and bedrooms should be maximized. If possible, leave windows open to allow air circulation with the outside of the building. Electric fans close to windows may enhance circulation. Programs with sophisticated HVAC systems should modify settings to ensure that air from within the residence is channeled outside, and not to other parts of the building.
4. Case-based testing of clients and staff, regardless of vaccination status, should be implemented **twice a week for all patients and staff**, at least three days apart, who live and work in an OMH-operated inpatient or on-campus residential setting and free-standing Article 31 hospitals.
5. Other congregate residential programs without in-house testing capacity must work with their local health departments and local provider networks to plan for testing for the affected client as soon as possible. Other residents in the program and staff should also be tested, preferably twice per week until all cases resolve.
6. Agencies may apply for multi-site Limited Service Laboratory Certificate to do onsite

rapid COVID-19 testing. <https://www.wadsworth.org/regulatory/clep/limited-service-lab-certs>

7. If a client with COVID-19 requires close support from a staff member (within sixfeet), the staff member and client must wear a surgical facemask and the staff member must also wear gloves and eye-protection. 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.
8. Roommates should be moved to another room, if possible. Roommates should, if possible, have their own rooms for 14 days or for two negative tests three days apart. If they remain symptom-free or have two negative tests, they can then share a room with another.
9. 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. The hospital should be contacted prior to transport
10. If more than one client has a positive test, then these individuals can share a room if the program has shared bedrooms.
11. Clients who test positive or develop COVID symptoms may be taken off isolation when:
 - a. The person has had no fever for at least 24 hours without the use of fever-reducing medications; AND
 - b. There is a significant improvement of symptoms; AND
 - c. At least 10 days have passed since symptoms first appeared (or, if asymptomatic and never developed symptoms, since the date of COVID-19 test collection).
(this is consistent with current DOH guidance for discontinuing isolation in hospital and other congregate settings after asymptomatic or mild-to-moderate illness).
12. In clients who are severely immunocompromised (see <https://www.cdc.gov/coronavirus/2019-ncov/hcp/disposition-hospitalized-patients.html#definitions>) for definition, isolation may be discontinued when
 - a. The person has had no fever for at least 24 hours without the use of fever-reducing medications; AND
 - b. There is a significant improvement of symptoms; AND
 - c. At least 20 days have passed since symptoms first appeared (or, if asymptomatic and never developed symptoms, since the date of COVID-19 test collection).
13. When coming into potential contact with an individual with COVID-19, other residents must always wear masks, increase frequency of hand hygiene, and attempt to maintain physical distancing, particularly if elderly or with other medical problems, even if fully vaccinated.
14. In programs with several bathroom facilities, one bathroom should be set aside for the client(s) with known or suspected COVID-19. Surfaces, faucets, 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 continuously and leave the window open to facilitate clearing of

droplets.

17. 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.
18. 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.

Supporting Clients Returning from The Hospital

1. Residential program or Family Care clients are admitted to psychiatric or medical hospitals for a variety of reasons. It is possible that these clients are exposed to the virus while in the hospital. Of note, this section applies to patients who have been admitted to an inpatient unit in a hospital. Patients who go to the Emergency Department (ED) or a CPEP and are discharged without an inpatient admission are not considered to have been hospitalized.
2. Programs may ask that a medical ED obtain a sample for COVID-19 testing, but must take the patient back if they are discharged from the ED, even prior to receiving the test results, provided the ED makes arrangements to forward the test result when it is available.
3. Programs can work with local hospitals to vaccinate residents who are being discharged. For vaccines requiring two doses, arrangements must be made to help the individual obtain the second dose, in a timely manner.
4. For clients who previously tested positive for the COVID-19 virus, diagnostic PCR tests may remain positive for many weeks after the client is no longer at risk of transmitting COVID-19. The program should confirm the date(s) of the last positive COVID-19 virus test and any subsequent tests as part of the discharge process. The program may request that the patient completes their isolation period prior to a discharge to a congregate setting. There is no need to wait for COVID test results to become negative prior to accepting the client back.
5. Programs may require a negative test within 72 hours prior to discharge from the hospital if the individual was hospitalized for a reason other than COVID-19.
6. Programs should reach out to their OMH Field Office or 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.

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. Programs should facilitate vaccination for their clients who are 12 or over.
2. Programs should encourage family members and guardians to obtain the COVID-19 vaccine. Family members and guardians who also receive services from OMH- or OASAS-operated or licensed programs may receive their vaccination through the O-LOV program.
3. The youth and family must agree that the home-time leave is appropriate and safe. Staff should ask families whether anyone at home has COVID-19 symptoms or is in a high-risk category.
4. Programs are encouraged to obtain testing before and after home visits.
5. Agencies may apply for multi-site Limited Service Laboratory Certificate to do onsite rapid

- COVID-19 testing. <https://www.wadsworth.org/regulatory/clep/limited-service-lab-certs>
6. 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).
 7. Information on general infection control strategies should be provided to the youth and parents/guardians.
 8. 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 the youth's psychiatric, general medical, and nursing staff as well as individuals at the destination site.
 9. 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 and mask wearing).
 10. 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.
 11. Any youth in quarantine or isolation may not leave the program site for community or home-time leave.

Infection Control Practices for Scatter-Site Residential Programs

- Apartment/Treatment (7070)
 - Shelter Plus Care Housing (3070)
 - Supported Housing Community Services (6060)
 - Supported/Single Room Occupancy (SRO) (5070)
 - SRO Community Residence (8050)
1. Programs should encourage all staff and residents to obtain the COVID vaccine.
 2. Programs should educate all clients in scattered-site housing about the importance of avoiding socializing indoors, wearing a mask when socializing with others or entering indoor spaces outside their home, restricting visitors to their homes, practicing appropriate hand hygiene, avoiding touching their faces, practicing basic disinfecting at home, and keeping at least six feet away from others while out in public.
 3. 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 the absence of direct contacts.
 4. When visiting a client, staff should use alcohol-based sanitizer prior to entering the client's home and should wear a mask. If the client has confirmed or suspected COVID-19, staff should also wear a face shield if an in-person visit is unavoidable.
 5. Staff should keep at least six feet away from the client during the visit.
 6. Staff should use alcohol-based sanitizer immediately upon leaving the client's building.
 7. See guidance for ACT and Mobile Crisis teams above.

Infection Control Practices for Programs Based In Article 28 Hospitals, including CPEP and Inpatient Units

- 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)
- Ambulatory Programs run by and located in an Article 28 General Hospital

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

Guidance for Staff

1. All programs should encourage staff to become vaccinated. Infection control precautions must be maintained until population herd immunity is reached. Staff may access vaccines through the O-LOV program. All volunteers and interns are also able to access vaccines through the O-LOV program.
2. Follow institutional policies on vaccine requirements.
3. Staff members who are ill must contact their supervisors immediately; programs must provide instructions to supervisors on how to screen employees who report symptoms.
4. All staff must wear a mask 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.
5. Please see Revised Protocols for Personnel in Clinical and Direct Care Settings to Return to Work Following COVID-19 Exposure or Infection for detailed guidance for staff. <https://omh.ny.gov/omhweb/guidance/omh-voluntary-return-to-work-guidelines.pdf>
6. Agencies should encourage their staff to obtain an influenza vaccine.
7. OMH-operated programs must follow additional guidance issued separately. Psychiatric Centers and other state operated programs must consult with Central Office on all staff-related policies and procedures. Staff-related directives issued by OMH Central Office to Psychiatric Centers supersede this guidance manual.

Guidance on Non-Emergent Transportation

1. When transporting clients in a vehicle, all individuals must wear a surgical facemask.
2. Whenever possible, have no more than two individuals, including the driver, in a sedan or three individuals in a van.
3. If client or staff is in any way immunocompromised (chemotherapy, AIDS, other), do not have more than two people in vehicle and all must wear masks. If program has capacity to provide staff with accurately fitted N95 respirators, staff should wear N95.
4. To maximize safe air circulation, client should sit directly behind the driver. Open the driver's window (front left) and the rear window opposite the passenger (rear right).
5. If using heating or air-conditioning, NEVER use the recirculation setting. Always have air come into vehicle from outside.
6. Disinfect all high-contact inside services after every trip, in front and rear seats. Ensure hand sanitizer is available in vehicle for staff and client use.
7. Staff who have COVID-19 must isolate away from work until isolation period ends. These individuals should never be in a vehicle with clients.
8. If a client has COVID-19 and needs transportation, both staff and client must wear masks, no more than two people should be in vehicle, ensure windows are open as described above, if possible, use a van to maximize distance between client and staff. If program has access to fitted N95s, staff should wear N95.