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

March 4, 2022

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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Agency leadership must follow COVID-19 guidance issued by the NYS Department of Health (DOH) and the Centers for Disease Control and Prevention (CDC) for healthcare settings. Agency clinical leadership must meet regularly and develop policies and procedures for mental health programs that are consistent with guidance for healthcare settings (not for the general public) issued by the CDC and DOH. Policy and procedures must be individualized for each program and take into considerations the particular needs of the population served (e.g. rates of medical comorbidities), the physical plant, particulars of the staff, the CDC COVID-19 Community Level, and the biology of the SARS-CoV-2 virus (i.e. asymptomatic transmission, spread by aerosolized droplets, etc).

Part 556 details OMH Emergency Regulations on mask requirements. https://omh.ny.gov/omhweb/policy_and_regulations/emergency/556-masks.pdf

The March 1st, 2022 update to the "Interim NYSDOH Guidance for Classroom Instruction in P-12 Schools During the 2021-2022 Academic Year," ends the statewide mask requirement in schools. Programs operating on school campuses should follow masking requirements of the school in which they are located. In schools that do not require a mask, parents and guardians may still choose to send children with masks. Similarly, staff may choose to continue to wear masks. The DOH update also provides guidance as to when masking is required (post isolation during days 6 through 10 after COVID-19 infection) and when mask wearing is recommended.

Agencies and programs should consider every clinical encounter, whether in-person or virtual, as an opportunity to encourage vaccination and boosting for individuals who are not fully protected and for education on infection control practices.

Programs are encouraged to continue utilizing telehealth services in a way that balances the various risks and benefits for clients. Video platforms are always preferable to audio-only platforms because they allow a more complete mental status exam.

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. Partial Hospital Programs and other programs designed to offer intensive ambulatory treatment as a stepdown or alternative to inpatient psychiatric admissions should be offered in-person because it is difficult to replicate the immersive nature of the program virtually.

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. Agencies may not have across-the-board policies that forbid in-person visits for non-vaccinated clients. Such decisions should be made deliberately and jointly between the clinical teamand the client, be documented in the record, and should take all 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, establish rapport and communicate clearly, and to navigate technology platforms.

- o Issues related to access (phone ownership, privacy, data plan, minutes, broadband access, etc.).
- o Ability to establish a private space, whether circumstances within the household are conducive to treatment.
- o 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.
- o Ability to maintain rapport, engagement, and communication; and
- o Ability to take a more active role in the treatment process than may be the case for in-person contacts.
- o For children and adolescents:
  - the individual's capacity to engage in telehealth alone or jointly with parent/caregiver.
  - the capability of accessing parent/caretaker or other identified support for immediate communication during telehealth encounters.
  - the parent/caregiver's capacity to effectively supervise and ensure safety of the child during sessions.
  - client and family's ability to take a more active role in the treatment process than may be the case for in-person contacts; in the case of a child, the capability of accessing parent/caretaker or other identified support for immediate communication during telehealth encounters

- Factors related to infection control, including:
  - o Whether the client has been vaccinated; whether individuals living with the client have been vaccinated.
  - o Results of recent COVID-19 tests.
  - o Whether client currently has COVID-19 symptoms or has come into contact with anyone with COVID-19
  - o Whether client has recently travelled to a place where COVID-19 is widespread.
  - o The program's physical layout, including the ability to limit density, maintain physical distancing, specifics of ventilation, etc.
  - o The program's ability to access PPE.
  - o Rate of vaccination among program staff.
  - o Client medical comorbidities and risk for worse outcomes if they become ill with COVID-19.
  - o 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
  - o Risk factors in people living in same household as client.

- Clinical factors and personal preference, including:
  - o Need for laboratory testing or physical examination
  - o Need for long-acting injectable medications.
  - o Use of medications that could result in extrapyramidal symptoms or tardive dyskinesia.
  - o 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?
  - o Enrollment and engagement with a Health Home or other care coordination program
  - o Assessment for risk in self harm, suicide, violence, housing instability, addiction relapse.
  - o Recent hospital or CPEP/ER discharge, recent increase in hospital/ER admissions, recent re-entry from incarceration,

    o Geographic distance to the nearest emergency medical facility, efficacy of patient's support system, and current medical status.

    o The nature of the clinical approach or evidence-based practice to be implemented and whether it is consistent with telehealth.

    o Attention to issues regarding continuity of and transitions in care, including consideration of in-person visits to avoid disruptions in care.

Assertive Community Treatment (ACT), Mobile Crisis, Forensic Transition Programs, and other specialty services that rely on home and off-site visits 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. As agencies develop Community Oriented Recovery and Empowerment (CORE) services, similar consideration must be taken for when clients will be served in-person or virtually.

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 and boosters.
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.
4. Prior to entering the residence, visitors should be asked if they have any COVID-19 symptoms (see appendix), 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. Preferably, programs will only allow indoor visitors who can present proof of being fully vaccinated or a negative test within the last 24 hours.
5. 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. High-quality, securely-fitting masks are preferable to surgical masks, which in turn are preferable to cloth masks. Staff should endeavor to always maintain physical distancing of six feet from all clients

and other staff.

6. 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.

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, to prevent hospitalization and deaths of clients, particularly unvaccinated clients, program leadership should continuously monitor the program's COVID-19 Community Level. In programs located in medium- or high-level communities, 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.

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, local healthcare providers, and pharmacies toaccess COVID testing if there is concern of a possible exposure our outbreak.

14. Residential Treatment Facility administrators must implement policies and procedures consistent with Federal COVID-19 Vaccination Mandates: https://omh.ny.gov/omhweb/guidance/guidance-federal-cv-19-vaccination-mandates.pdf

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)

Crisis or inpatient programs with frequent turnover are more traditional healthcare settings and should consider the following additional efforts to protectclients 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.

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. High-quality, securely-fitting masks are preferable to surgical masks, which in turn are preferable to cloth masks.
5. Socializing with individualswho 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 always maintained. 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 theseare present, the visitor should not be allowed into the residence.
6. Prior to entering the residence, visitors should be screened for COVID-19 symptoms (see appendix) or recent contacts with individuals sick with COVID-19. If yes, the visitor should not be allowed into the residence. Programs should also require proof of vaccination or negative test within 24 hours for all visitors.
7. 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 endeavor to always maintain physical distancing of six feet from all clients and other staff.
8. 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.
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.
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, local healthcare providers, and pharmacies toaccess COVID testing if there is concern of a possible exposure our outbreak.
15. 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 whowork 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%
    d. Hospitals 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. Competency evaluations for testing is necessary.
16. Free-standing Article 31 hospital administrators must implement Part 557 on vaccination requirements for staff:
    https://omh.ny.gov/omhweb/policy_and_regulations/emergency/557-vaccination.pdf

17. Free-standing Article 31 hospital administrators must implement policies and procedures consistent with Federal COVID-19 Vaccination Mandates: https://omh.ny.gov/omhweb/guidance/guidance-federal-cv-19-vaccination-mandates.pdf

Accepting New Clients (ALL Congregate Residential Programs)
1. Programs accepting new clients may require a COVID-19 diagnostic PCR test within 72 hours prior to transfer from another institutional setting. Staff should screen all new arrivals for symptoms or recentexposures.
2. 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 that 10 days have passed since the first COVID-19 symptom (or positive test result if the individual was asymptomatic), that the individual has been fever-free for at least 24 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 negativeprior to accepting the client.
3. 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 and wear a high-quality, securely-fitting mask.

Responding When Client Develops Symptoms (ALL Congregate Residential Programs)
1. When a client in the residential program develops symptoms of a COVID-19 infection, the client should be asked to stay in their room. If possible, theclient should be assigned a single room. The client must be asked to wear a mask. Meals should be taken in the room.
2. High-quality, securely-fitting masks are preferable to surgical masks, which in turn are preferable to cloth masks. It is strongly recommended that when working with clients with known or suspected COVID-19, staff wear N95s that have been fit-tested to them.
3. All clients in the program must always wear a mask when in proximity of individuals who are showing symptoms of COVID-19.
4. 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.
5. 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.
6. Programs who have at-home testing kits should test clients and staff exposed to clients showing symptoms twice weekly until all infections resolve and everyone completes their isolation periods. Congregate residential programs without in-house testing capacity must work withtheir 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.

7. If a client with COVID-19 requires close support from a staff member (within sixfeet), the staff member and client must wear a tight-fitting, high-quality 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 for14 days or for two negative tests three days apart. If they remain symptom-free or havetwo negative tests, they can then share a room with another.

9. If more than one client has a positive test, then these individuals can share a room if the program has shared bedrooms.

10. 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) OR the client has a negative rapid test at least 7 days after the start of isolation.

11. 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).

12. 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. High-quality, securely fitting masks are preferable to surgical masks, which in turn are preferable to cloth masks.

13. 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.

14. 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 fansshould remain on and windows should remain open during that time, and no steam should remain when the next resident uses the bathroom.

15. 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.

16. 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.

Supporting Clients Returning from The Hospital (ALL Congregate Residential Programs)

1. Residential program or Family Care clients are admitted to psychiatric or medical hospitals for a variety of reasons. It ispossible that these clients are exposed to the virus while in the hospital.
2. For clients who tested positive for COVID-19 in the prior three months, diagnostic PCR testsmay remain positive for many weeks after the client is no longer at risk of transmitting COVID-19. 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 negativeprior to accepting the client back.
3. 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.
4. 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.

Guidance for Child and Youth-Serving Residential Programs

Home-time leaves should continue to 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. During this public healthemergency, the following should also be considered:

1. Programs should facilitate vaccination for their clients who are five years old or older.
2. Programs should encourage family members and guardians to obtain the COVID-19 vaccine.
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. 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).
6. Information on general infection control strategies should be provided to the youth and parents/guardians.
7. 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.
8. 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).
9. 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.
10. 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 and booster.
2. Programs should educate all clients about their CDC COVID-19 Community Level and help clients take appropriate masking precautions in medium or high level communities. Staff should also educate clients about practicing appropriate hand hygiene, avoiding touching their faces, and practicing basic disinfecting at home.
3. 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.
4. High-quality, securely fitting masks are preferable to surgical masks, which in turn are preferable to cloth masks. Staff should avoid using cloth masks when visiting clients.
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 (and any ambulatory programs located in and run by Article 28 Hospitals)

- 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 or in proximity to an Article 28 General Hospital

Program medical leadership must meet regularly and develop infection control policies and procedures that are consistent with guidance for healthcare settings (not for the general public) issued by the CDC, DOH, and the Article 28 Hospital's Infection Control Department. Program medical leadership should consider obtaining consultation from colleagues in the Infection Control or Infectious Diseases Departments. Policy and procedures must be individualized for each program and take into considerations the particular needs of the population served (i.e. rates of medical comorbidities), the physical plant, particulars of the staff, the CDC COVID-19 Community Level, and the biology of the SARS-CoV-2 virus (i.e. asymptomatic transmission, spread by aerosolized droplets, etc).

Hospital administrators must implement policies and procedures consistent with Federal COVID-19 Vaccination Mandates: https://omh.ny.gov/omhweb/guidance/guidance-federal-cv-19-vaccination-mandates.pdf

Guidance for Staff

Agencies should follow guidance issued by DOH and the CDC for healthcare personnel:
1. Updated Advisory on Return-to-Work Protocols for Healthcare Personnel with SARS-CoV-2 Infection or Exposure to SARS-CoV-2 https://coronavirus.health.ny.gov/system/files/documents/2022/02/hcp_rtw_guidance_matrix_update-2042022_0.pdf
2. Interim Guidance for Managing Healthcare Personnel with SARS-CoV-2 Infection or Exposure to SARS-CoV-2. https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-

risk-assesment-hcp.html
3. Strategies to Mitigate Healthcare Personnel Staffing Shortages.
   https://www.cdc.gov/coronavirus/2019-ncov/hcp/mitigating-staff-shortages.html
4. High-quality, securely fitting masks are preferable to surgical masks, which in turn are preferable to cloth masks. Staff may need to be advised that facial hair or large piercings/jewelry may prevent tight seal to form and negate benefit of high-quality masks. Staff should avoid wearing cloth masks.

Guidance on Non-Emergent Transportation

1. When transporting clients in a vehicle, all individuals must wear a mask.
2. High-quality, securely fitting masks are preferable to surgical masks, which in turn are preferable to cloth masks.
3. Whenever possible, have no more than two individuals, including the driver, in a sedan or three individuals in a van.
4. 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.
5. 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).
6. If using heating or air-conditioning, NEVER use the recirculation setting. Always have air come into vehicle from outside.
7. Disinfect all high contact inside surfaces after every trip, in front and rear seats. Ensure hand sanitizer is available in vehicle for staff and client use.
8. Staff who have COVID-19 must isolate away from work until isolation period ends. These individuals should never be in a vehicle with clients.
9. 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.

Appendix A: Vaccine Guidance Table

To use: Starting with the Age Range column, select the appropriate age group for the individual. Move right to the Immunocompromised column to select their immunocompromised status (Yes or No). Move to the Primary Vaccine Manufacturer column and select the manufacturer of their primary vaccinations if they have already been vaccinated, or, if they are unvaccinated, to see which vaccines are appropriate. Follow the remaining columns to determine eligibility for any additional doses of COVID-19 vaccines.

Age	Immuno-compromised	Primary Vaccination Manufacturer	Additional Dose Options (if Immuno-compromised)	Booster Options	Max. total doses
5-11*	Y	Pfizer pediatric formulation (only option) – 2 doses 21 days apart	N/A	N/A	2
5-11*	N	Pfizer pediatric formulation (only option) – 2 doses 21 days apart	N/A	N/A	2
12-15	Y	Pfizer (only option) – 2 doses 21 days apart	Pfizer only – 28days after 2nd dose	Pfizer – 5mos after 3rd dose	4
12-15	N	Pfizer (only option) – 2 doses 21 days apart	N/A	Pfizer – 5mos after 2nd dose	3
16-17	N	Pfizer (only option) – 2 doses 21 days apart	N/A	Pfizer – 5mos after 2nd dose	3
16-17	Y	Pfizer (only option) – 2 doses 21 days apart	Pfizer only – 28 days after 2nd dose	Pfizer – 5mos after 3rd dose	4
18+	N	Pfizer – 2 doses 21 days apart	N/A	Pfizer, Moderna, J&J – 5mos after 2nd dose	3
18+	N	Moderna – 2 doses 28 days apart	N/A	Pfizer, Moderna, J&J – 5mos after 2nd dose	3
18+	N	J&J – one dose	N/A	Pfizer, Moderna, J&J – 2mos after 1st shot	2
18+	Y	Pfizer– 2 doses 21 days apart	Pfizer or Moderna – 28 days after 2nd dose	Pfizer, Moderna, J&J – 5mos after 3rd dose	4
18+	Y	Moderna – 2 doses 28 days apart	Pfizer or Moderna – 28 days after 2nd dose	Pfizer, Moderna, J&J – 5mos after 3rd dose	4
18+	Y	J&J – one dose	N/A	Pfizer, Moderna, J&J – 2mos after 1st shot	2

*If a child who received their first dose at 11 years old turns 12 years old by the time they are due for their second dose, the child can receive either a dose of the pediatric Pfizer COVID-19 vaccine or the standard Pfizer COVID-19 vaccine as their second dose.

Appendix B: COVID-19 Symptoms

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

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

When to Seek Emergency Medical Attention:

- Trouble breathing
- Persistent pain or pressure in the chest
- New confusion
- Inability to wake or stay awake
- Pale, gray, or blue-colored skin, lips, or nail beds, depending on skin tone