Last updated: 12/27/22

COVID-19 Infection Control Guidance for

Non-hospital-based Inpatient and Residential Addiction Treatment Providers

The purpose of this guidance is to ensure the health and safety of provider staff to deliver and support patient care, while limiting the interruption of services, and to protect the health and safety of patients and the public. Hospital-based OASAS programs should follow their own institution's infection control policies and procedures. This information has been compiled, summarized, and adapted entirely from other official sources, including guidance from the Centers for Disease Control and Prevention (CDC), the NYS Department of Health (NYS DOH), and OASAS. It is the responsibility of providers to keep apprised of current guidance by regularly visiting the CDC and NYS DOH websites:

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

Program leadership and management also must keep their staff updated frequently and educate them about the SARS-CoV-2 virus and COVID-19 disease, its signs and symptoms, and the necessary infection control measures to protect themselves and their patients.

If any program determines that it is necessary to take additional measures to change service delivery other than those described below and/or detailed in other guidance from NYS OASAS, due to a COVID-19 outbreak, critical staffing shortages, local governmental unit (LGU) directive (i.e., local health department order), or for any other reason, they should immediately notify their OASAS Regional Office.

Effective September 7, 2022, masking is required *for staff and patients* in 816, 817, 818, and 822 programs pursuant to New York State Department of Health Commissioner's 2.60 Determination. See OASAS masking guidance: https://oasas.ny.gov/guidance-mask-wearing-requirements.

Should staff and patients choose to mask in 819 and 820 programs and/or the programs opt to go beyond this guidance and require masking, both are permissible. If 816/818 and 819 or 820 programs are co-located in the same building and using the same entrance, then consideration should be given to strongly recommending masking for all staff and patients. Such decisions should be delineated in your program's infection control policies and procedures.

Infection Control Policy:

Key definitions:

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

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

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

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

Isolation is defined as the separation of a person or group of people known or reasonably believed to be infected with a communicable disease and potentially infectious from those who are not infected to prevent spread of the communicable disease. Isolation for public health purposes may be voluntary or compelled by federal, state, or local public health order. See CDC guidance here.

Quarantine is defined as the separation of a person or group of people reasonably believed to have been exposed to a communicable disease but not yet symptomatic from others who have not been so exposed to prevent the possible spread of the communicable disease. Quarantine may be voluntary or compelled by federal, state, or local public health order. See CDC guidance here.

Physical (i.e., social) distancing is what everyone is encouraged to do as much as possible to limit transmission of COVID-19, especially in the context of significant pre-symptomatic and asymptomatic transmission of COVID-19. Physical distancing means being >= 6 feet separating you from another person.

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

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

Not Up to Date means a person has NOT received all recommended COVID-19 vaccines which may include the primary series of COVID-19 vaccines and/or any booster(s) when eligible.

All providers are strongly urged to review frequently and reinforce their policies and procedures regarding infection control for Standard Precautions (applicable for the care of all patients), as well as droplet and contact precautions with all staff.

NYS DOH: https://www.health.ny.gov/professionals/diseases/reporting/communicable/infection/

Additionally:

- Providers should have recommended personal protective equipment (PPE);
- More information from the CDC about infection control strategies and appropriate PPE can be found here;

Programs are encouraged to perform diagnostic testing for COVID-19. However, any COVID-19 test sample collection or any other test sample collection involving potential exposure to droplets or aerosols (e.g., influenza testing) should be done with full PPE including fit-tested, NIOSH-approved N95 or higher-rated respirators and eye protection (face shields and/or goggles). For more information about COVID-19 testing, please see CDC guidance here. OASAS has released guidance specific to SARS-CoV-2 (COVID-19) Point of Care Antigen Testing, which can be found at https://oasas.ny.gov/antigen-testing-inpatient-and-residential-facilities-and-otps***. See FDA guidance here.***

- ***In addition, no procedures that have the potential to generate aerosols (e.g., nebulizer treatments, CPAP, BIPAP, high flow oxygen) should be performed, without first discussing a specific plan to protect staff and other patients with the LHD and/or NYS OASAS Regional Office. The plan should include having an airborne infection isolation room (AIIR) or negative pressure room on site. If a facility does not have an AIIR on site, then the patient should be transferred to a facility that does have an AIIR on site; or the patient can be accommodated on site without use of the potentially aerosolizing procedure (e.g., a metered dose inhaler may be utilized instead of a nebulizer).***
- Providers should post NYS DOH Protect Yourself from COVID-19 signage throughout their facilities;
- Providers should have supplies for handwashing and hand sanitizing throughout their facilities available for patients and staff as appropriate, and should post widely hand hygiene signs;
- COVID-19 materials, including posters, can be requested from the NYS DOH by using the request form or may be downloaded from the CDC website here;
- Providers should maintain enough supplies for appropriate environmental cleaning and disinfection. All frequently touched surfaces in the facility must be cleaned thoroughly on a regular basis;
- Providers should have, update, and communicate a method to screen for, identify, and manage patients on admission and/or currently in the program who are or become exposed to or test positive for COVID-19;
- Group meetings can occur within the following parameters: all staff and clients participating in groups must wear a surgical mask or face covering; group size is limited only by the program's physical space: physical distancing is encouraged, but not required; group duration no longer must be less than 60 minutes. Try to avoid larger groups of patients congregating such as during mealtimes and medication administration.

Universal infection control precautions:

Because of the possibility of significant pre-and-asymptomatic transmission, the following measures should be incorporated into policies and procedures to minimize exposure risk to staff and other patients:

1. All staff (including vendors, contractors, interns, students, etc.) should wear a mask that fits snugly and covers completely the nose and mouth.
    a. Staff who have direct physical contact with patients (nurses, medical providers, medical assistants, phlebotomists, etc.) which includes the following activities (this is not an exhaustive

list): administering medications, performing vital signs, giving injections, performing phlebotomy, performing physical exams, etc. should wear a surgical mask.

b. Staff who may be exposed to potentially infectious materials or body substances (via contaminated medical supplies, devices, and equipment; contaminated environmental surfaces; or contaminated air) though not doing direct patient care (e.g., dietary, environmental services, laundry, security, engineering and facilities management, etc.) should wear a surgical mask.

c. Staff who are operating vehicles in which other staff and/or clients/residents are transported should wear a surgical mask.

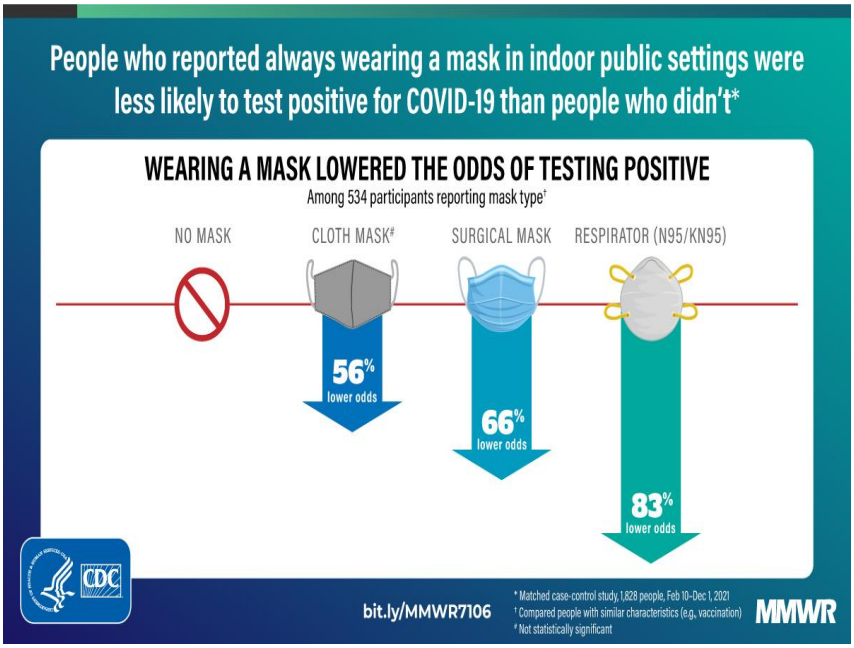
d. All other staff who do not meet the aforementioned criteria may wear a cloth face covering that fits snugly and must cover completely the nose and mouth in lieu of a surgical mask.

2. All staff should wear, at a minimum, masks (as per the above criteria in #1) when interacting with anyone. Eye protection (face shield or googles) is recommended for staff when interacting with anyone but is required when there is physical contact with patients (see #1a above). Gowns and gloves are recommended for any physical contact with patients.

   a. Staff should maintain proper procedure to don and doff masks and eye protection (face shield or goggles).
   b. Masks should fit snugly, covering both the mouth and nose at all times.
   c. Staff must perform hand hygiene immediately before donning and after doffing any PPE.
   d. Surgical masks should be replaced after each patient encounter or if wet, visibly soiled or damaged.
   e. Eye protection (face shield or goggles) should be replaced as per manufacturer's guidelines.
   f. See CDC guidance here.

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

- Masks and respirators (i.e., specialized filtering masks such as "N95s") can provide different levels of protection depending on the type of mask and how they are used. Loosely woven cloth products provide the least protection, layered finely woven products offer more protection, well-fitting disposable surgical masks and KN95s offer even more protection, and well-fitting NIOSH-approved respirators (including N95s) offer the highest level of protection.
- Whatever product you choose, it should provide a good fit (i.e., fitting closely on the face without any gaps along the edges or around the nose) and be comfortable enough when worn properly (covering your nose and mouth) so that you can keep it on when you need to. For N95 respirators, a good fit ideally would include fit-testing and a wearer fit-check each time the device is donned. Learn how to improve how well your mask protects you by visiting CDC's Improve How Your Mask Protects You page.
- A respirator has better filtration, and if worn properly the whole time it is in use, it can provide a higher level of protection than a cloth or procedural mask.
- A mask or respirator will be less effective if it fits poorly or if you wear it improperly or take it off frequently. Individuals may consider the situation and other factors when choosing a mask or respirator that offers greater protection.



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

3. Staff should wear gloves, a surgical mask, a gown, and eye protection (face shield or goggles) during any direct physical contact (i.e., physical touching) with any patients. This includes taking blood pressures, taking pulses, and doing necessary physical examinations, etc. Full PPE as appropriate (see CDC guidance on PPE here) to the specific circumstance should be utilized when having direct or close contact with any patient, including those in isolation or quarantine.
    a. Staff must practice hand hygiene before and after using PPE.
    b. It is recommended that providers follow the CDC's guidelines for infection control basics including hand hygiene:
        i. Infection Control Basics
        ii. Hand Hygiene in Health Care Settings
        iii. Handwashing: Clean Hands Save Lives

4. Visitation to and from the facility may occur as per OASAS reopening guidance, see https://oasas.ny.gov/oasas-reopening-guidance

5. Patients and residents in addiction treatment facilities who leave the facility should be screened upon re-entry to the facility, by asking regarding any current symptoms possibly consistent with COVID-19 and potential exposure to COVID-19 while outside the facility. Patients and residents should be educated on precautionary methods, including hand hygiene, mask/face covering use, and physical distancing while out of the facility in the community. See CDC handouts on hand hygiene (here) and wearing a mask/face covering (here and here).

6. Physical distancing is strongly encouraged for both patients and staff whenever possible.
    a. Consider temporarily canceling groups and/or running them remotely, delivering meals to rooms, and administering medications in rooms for all patients when there is a significant COVID-19 outbreak in the facility. During in-person groups, all persons should be masked. Physical distancing is encouraged.

c. Increase ventilation in rooms where group events are held by opening windows.
d. Administer medications to patients one at a time and avoid all direct contact, maintaining physical distancing (a 6-foot distance) is encouraged as much as is possible. For instance, place medication in a cup on a disinfected surface, step back, instruct the patient to self-administer medication(s) and observe/oversee self-administration per program policies and procedures.
e. Minimize room changes.
f. Staff providing care for patients are encouraged to maintain at least 6 feet of distance whenever possible and should avoid patient interactions in small, enclosed spaces as much as possible.
g. Adapt the program to allow for more individually directed learning, reflection, and coping skill development through online and other resources as needed.

7. Source prevention (i.e., the person with symptoms always wearing a surgical mask or higher-grade mask) should be considered an effective protective strategy in addition to staff PPE.
8. Telepractice services should be utilized when appropriate, even within the same facilities (e.g., calling a patient's room or personal cell phone).
9. For patients with respiratory illness, suspected COVID-19, or known COVID-19:
   a. To the extent possible, when enough private rooms with private bathrooms for isolation purposes are not available, a person with known or suspected COVID-19 should be housed in the same room for the duration of their individual stay in the facility. If cohorting is absolutely necessary due to facility spacing issues, the facility should consult with the LHD or OASAS RO to ensure that appropriate infection control measures are taken. Also, to the extent possible, rooms used for isolation should be clustered together in the same area or wing of the facility, as should rooms used for quarantine.
   b. Personnel entering rooms where individuals are isolated or quarantined should maintain physical distancing where possible when interacting with the patient.
   c. Whenever possible, medicate and perform procedures/tests* in the patients' rooms rather than in common areas, or even leave medications outside the room/in the doorway when safe and appropriate and give the patient instructions to self-administer medications.

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

   d. Leave meal trays outside patient doors, knock to alert them that their food is ready, and step away from the room while ensuring they get their food. Instruct patients to leave food trays when finished outside the room and alert staff remotely that they are ready for pickup. Staff should use gloves to handle trays and should perform hand hygiene immediately when the gloves are removed.
   e. Once a patient under isolation or quarantine has been discharged or transferred, the door to the patient's room should be closed and marked with a "do not enter" sign and staff, including environmental services personnel, should refrain from entering the vacated room until sufficient time has elapsed for enough air changes to remove potentially infectious particles (more information on clearance rates under differing ventilation conditions is available). After this time has elapsed, the room should undergo appropriate cleaning and surface disinfection before it is returned to routine use.

Screening Provider Staff:

Provider staff are exposed to the general community each day and are at risk of infection with an acute respiratory illness including influenza and COVID-19. Staff must be screened on at least a daily basis for respiratory and fever symptoms. It is recommended that staff self-screen prior to coming to work or returning from any leave. Screening should include a review of the following statements (see 1-3 below) and staff should quarantine or isolate and contact their health provider for further guidance as appropriate.

1. **International travel in the past 5 days for all traveler staff.**

a. Get tested with a viral test 3-5 days after arrival. See FDA guidance here. Serial testing is now required: For asymptomatic individuals, SARS-CoV-2 antigen tests will now be authorized for use on asymptomatic individuals when tested at least three (3) times over five (5) days with at least 48 hours between tests. Performing serial (repeat) testing 3 times is a new requirement.
b. Find a U.S. COVID-19 testing location near you or use a self-test. See FDA guidance here.
c. If you already had COVID-19 within the past 90 days, see specific testing recommendations.
d. Monitor yourself for COVID-19 symptoms.
e. Follow additional guidance if you know you were exposed to a person with COVID-19.
f. Follow all state, tribal, local and territorial recommendations or requirements after arrival.
g. If you are going to be around someone who is at higher risk of getting very sick with COVID-19, consider additional precautions.

From the CDC, "Health care personnel (HCP) with travel or community exposures should consult their occupational health program for guidance on need for work restrictions." Any exposure to COVID-19 during travel would warrant following the RTW protocols. Travel alone, without a known exposure, would not constitute an exposure.

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

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

Updated Advisory on Return-to-Work Protocols for Healthcare Personnel with SARS-CoV-2 Infection or Exposure to SARS-CoV-2, updated 11/30/22: see the NYS DOH guidance here .

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

CDC Updates:

- In most circumstances, asymptomatic HCP with higher-risk exposures **do not** require work restriction.

- Updated recommendations for testing frequency to detect potential for variants with shorter incubation periods and to address the risk for false negative antigen tests in people without symptoms. In general, asymptomatic HCP who have had a higher-risk exposure do not require work restriction, regardless of vaccination status, if they do not develop symptoms or test positive for SARS-CoV-2.
- See CDC Guidance here.
- On November 1, 2022, the U.S. Food and Drug Administration (FDA) informed developers of SARS-CoV-2 antigen tests that they are revising the authorized use of SARS-CoV-2 antigen tests. **Serial testing will now be required when testing both symptomatic and asymptomatic individuals.**
- For symptomatic individuals, SARS-CoV-2 antigen tests will now be authorized for use on symptomatic individuals when tested at least twice over three (3) days with at least 48 hours between tests. Serial (repeat) testing on symptomatic individuals is a new requirement.
- For asymptomatic individuals, SARS-CoV-2 antigen tests will now be authorized for use on asymptomatic individuals when tested at least three (3) times over five (5) days with at least 48 hours between tests. Performing serial (repeat) testing 3 times is a new requirement.

- Manufacturers will be updating instructions to reflect these new serial testing requirements. See FDA guidance here.

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

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

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

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

On November 1, 2022, the U.S. Food and Drug Administration (FDA) informed developers of SARS-CoV-2 antigen tests that they are revising the authorized use of SARS-CoV-2 antigen tests. **Serial testing will now be required when testing both symptomatic and asymptomatic individuals.**

- For symptomatic individuals, SARS-CoV-2 antigen tests will now be authorized for use on symptomatic individuals when tested at least twice over three (3) days with at least 48 hours between tests. Serial (repeat) testing on symptomatic individuals is a new requirement.

- For asymptomatic individuals, SARS-CoV-2 antigen tests will now be authorized for use on asymptomatic individuals when tested at least three (3) times over five (5) days with at least 48 hours between tests. Performing serial (repeat) testing 3 times is a new requirement.

Manufacturers will be updating instructions to reflect these new serial testing requirements.

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

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

See CDC guidance here. See NYS DOH guidance here. See FDA guidance here.

Quarantine and Isolation for Congregate Settings and Special Populations

OASAS congregate settings with high-risk individuals or at high risk for transmission, should follow the following guidance for quarantine or isolation for residents/clients. Aligning with guidance for shelters and detention facilities, OASAS settings may decrease quarantine to 5 days (if the client/resident tests negative after the 5th day) and isolation to 7 days (if COVID-19 symptoms are improving and the client/resident has been fever-free for 24 hours, the client/resident was not hospitalized, and the client/resident does not have an immunocompromising condition). If the client/resident does not meet the above factors for shortened isolation, then they should remain in isolation for 10 days. The shortening of the quarantine and isolation periods is taking into consideration how disruptive isolation/quarantine can be due to limitations on access to programs/care.

Adapted from CDC guidance here.

OASAS programs may continue to implement longer quarantine or isolation periods depending on ability of clients/residents in their facilities to wear a mask, physically distance, and abide by other infection control risk mitigation measures. As noted in CDC guidance, facilities can base their infection control policies on risk tolerance, including factors such as the health and well-being of their staff and client/resident populations and the impact of isolation/quarantine on mental health and staffing coverage. It is expected that individual facilities work with their local health departments as indicated and adjust their infection control protocols as necessary based on COVID-19 community transmission levels.

3. New signs and symptoms of potential COVID-19. People with COVID-19 have had a wide range of symptoms reported – ranging from mild symptoms to severe illness. Symptoms may appear 2-14 days after exposure to the virus. Anyone can have mild to severe symptoms. Possible symptoms include fever or chills, cough, shortness of breath or difficulty breathing, fatigue, muscle or body aches, headache, new loss of taste or smell, sore throat, congestion or runny nose, nausea or vomiting, and diarrhea. **This list does not include all possible**

symptoms. Symptoms may change with new COVID-19 variants and can vary depending on vaccination status. CDC will continue to update this list as we learn more about COVID-19. Older adults and people who have underlying medical conditions like heart or lung disease or diabetes are at higher risk for getting very sick from COVID-19. See CDC guidance here.

General Personal Protective Precautions for Patients:

On admission, patients should be informed of the patient surgical mask/cloth face covering wearing policies and physical distancing encouragement policies. The surgical mask or cloth face covering should fit snugly on the face and should cover completely the nose and mouth.

- Patients should wear a surgical mask or cloth face covering at all times when in the inpatient facility, except when they are in their room either alone or with their roommates.
- Patients are encouraged to follow physical distancing guidelines (maintaining a distance of 6 feet and not congregating)
- On a routine basis and during hourly rounds at the inpatient or residential facility, staff should monitor patients for adherence with the wearing of surgical masks or cloth face coverings and encourage physical distancing.
- When patients are nonadherent with these mask wearing guidelines, it must be addressed with a patient-centered approach emphasizing public health and safety.
- Patients should be informed that non-clinical staff should be wearing surgical masks or cloth face coverings at all times in the facility. Clinical staff should be wearing surgical masks and eye protection (face shield or goggles) with direct physical patient contact. See https://oasas.ny.gov/guidance-mask-wearing-requirements for more details. Staff should not be meeting with patients who are not wearing surgical masks or face coverings.

Screening Patients:

Providers should monitor patients in their care for emerging symptoms, at least daily for all patients.

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

1. Individuals with new signs and symptoms of potential COVID-19. People with COVID-19 have had a wide range of symptoms reported – ranging from mild symptoms to severe illness. Symptoms may appear 2-14 days after exposure to the virus. Anyone can have mild to severe symptoms. Possible symptoms include fever or chills, cough, shortness of breath or difficulty breathing, fatigue, muscle or body aches, headache, new loss of taste or smell, Sore throat, Congestion or runny nose, Nausea or vomiting, and Diarrhea. **This list does not include all possible symptoms.** Symptoms may change with new COVID-19 variants and can vary depending on vaccination status. CDC will continue to update this list as we learn more about COVID-19. Older adults and people who have underlying medical conditions like heart or lung disease or diabetes are at higher risk for getting very sick from COVID-19. See CDC guidance here.
2. Individuals who have, in the last 5 days, had contact with someone with a confirmed diagnosis (positive test) of COVID-19, or someone suspected as having COVID-19, such as someone ill with respiratory illness, within 48 hours prior to symptom onset. Note: Any individuals, regardless of COVID-19 vaccination or booster status, who have been exposed to COVID-19 should be tested serially if using POC Ag testing. However, individuals who have been exposed, but test negative (serial testing ***required***: see OASAS POC Ag testing guidance https://oasas.ny.gov/antigen-testing-inpatient-and-residential-facilities-and-otps) and are asymptomatic are recommended to be quarantined for 5 days due to the high-risk congregate setting. Adapted from CDC guidance see here. See FDA guidance on the requirements of POC Ag testing here.

3. For individuals who have traveled internationally in the last 5 days, the CDC recommendations are to:

a. Get tested with a viral test 3-5 days after arrival. See FDA guidance here. Serial testing is now required for POC Ag testing. For asymptomatic individuals, SARS-CoV-2 antigen tests will now be authorized for use on asymptomatic individuals when tested at least three (3) times over five (5) days with at least 48 hours between tests. Performing serial (repeat) testing 3 times is a new requirement.
b. Find a U.S. COVID-19 testing location near you or use a self-test. See FDA guidance here.
c. If you already had COVID-19 within the past 90 days, see specific testing recommendations.
d. Monitor yourself for COVID-19 symptoms.
e. Follow additional guidance if you know you were exposed to a person with COVID-19.
f. Follow all state, tribal, local and territorial recommendations or requirements after arrival.
g. If you are going to be around someone who is at higher risk of getting very sick with COVID-19, consider additional precautions.

See CDC International Travel Guidance here. Patients who cannot be screened prior to presenting to the provider for admission should be screened as above upon presentation. Any patients who answer yes to the screening questions or present with/develop symptoms consistent with COVID-19, should be isolated in a private room and asked to wear a surgical face mask. The program medical provider should use appropriate PPE and evaluate the patient, and the program should consult with the OASAS RO for guidance as needed.

For patients who develop serious symptoms (e.g., high fever, rapid breathing, chest pain) that require immediate transfer to a medical facility, the program should alert the medical facility in advance that the person being transported has symptoms consistent with possible COVID-19.

Programs will need to have at least one room, identified and available at all times, for temporary isolation of patients as soon as symptoms begin pending medical evaluation, in addition to any rooms currently being used for isolation or quarantine of other individuals. Persons who are confirmed COVID-19-positive may be cohorted while in isolation. Asymptomatic persons who have had a COVID-19 contact ideally should *not* be quarantined together. Persons in isolation should *never* be in contact with persons being quarantined. Should a facility have physical space issues and must cohort isolated individuals together, the program must work in conjunction with the OASAS RO to ensure adherence to all proper infection control precautions. *It is not recommended that quarantined individuals be cohorted together.*

For patients who will be isolated or quarantined, rooms preferably should have a private bathroom. In situations where a private bathroom is not available, a shared bathroom can be used if cleaning occurs after each individual uses it. Isolated persons *cannot* use the same bathroom as quarantined persons, so each population would need a dedicated bathroom/s.

Providers should screen all patients at least daily for symptoms of potential COVID-19. Patients who become ill during their treatment stay should be isolated and evaluated by a medical provider and treated based on their presentation and history. Medical providers should consult with the OASAS RO for appropriate guidance on isolation and quarantine (in addition, the LHD can issue quarantine or isolation orders) and potential recommendations for COVID-19 testing. There should be a very low threshold for COVID-19 testing with any potential COVID-19 exposure given the variability in symptoms and/or lack of symptoms due to COVID-19. **If using POC Ag tests for testing, serial testing is now required. See FDA guidance here.**

Recommendations for Interacting with Isolated Patients in Congregate Care Settings:

1. *Ideally, isolate the patient from other patients in a room **by themselves** with the door closed. Modifications, like plastic shields instead of doors, are not acceptable from an infection control perspective.*
2. *Use full PPE for staff, as appropriate to the specific situation/interaction.*

3. *Ensure frequent appropriate environmental cleaning (see guidance from OASAS and the NYS DOH on the OASAS COVID-19 page).*
4. *Create a method to track staff who enter the patient's room.*
5. *Care for patients who are ill symptomatically/supportively and send to a higher-level medical facility if they develop worsening/serious symptoms.*
6. People who are infected but asymptomatic or people with mild COVID-19 should isolate through at least day 7 (day 0 is the day symptoms appeared or the date the specimen was collected for the positive test for people who are asymptomatic). They should wear a higher-grade mask (N95 or KN95) through day 10. A test-based strategy may be used to remove a higher-grade mask sooner. People with moderate or severe COVID-19 can be considered for isolation through at least day 10. Those with severe COVID-19 may remain infectious beyond 10 days and may need to extend isolation for up to 20 days. People who are moderately or severely immunocompromised should isolate through at least day 20. Use of serial testing and consultation with an infectious disease specialist is recommended in these patients prior to ending isolation. See CDC guidance here.
7. *Any other patients, who come into direct contact within 48 hours prior to symptom onset of another patient who becomes ill with symptoms of possible COVID-19 OR tests positive for COVID-19 (even if asymptomatic) will need to be treated as a presumed direct/close contact and quarantined for 5 days.*

Screening Visitors:

All providers should post visiting signs outside their programs alerting people to visitor screening and risk factors during the COVID-19 epidemic. *Visitor limitations are described in the OASAS reopening guidance found* https://oasas.ny.gov/oasas-reopening-guidance. *The program should facilitate online options for face-to-face interaction with family members and other visitors if they are unable to visit in person.*
For all visitors, providers should attempt to pre-screen/schedule visits. All visitors should be screened on the phone for the following and rescreened when they arrive for the visit:

1. Known contact in the last 5 days with someone with a confirmed diagnosis (positive test) of COVID-19 or someone suspected as having COVID-19, such as someone ill with respiratory illness or cold symptoms, within 48 hours prior to symptom onset.
2. Any signs or symptoms of potential COVID-19. People with COVID-19 have had a wide range of symptoms reported – ranging from mild symptoms to severe illness. Symptoms may appear 2-14 days after exposure to the virus. Anyone can have mild to severe symptoms. Possible symptoms include Fever or chills, Cough, Shortness of breath or difficulty breathing, Fatigue, Muscle or body aches, Headache, New loss of taste or smell, Sore throat, Congestion or runny nose, Nausea or vomiting, and Diarrhea. **This list does not include all possible symptoms.** Symptoms may change with new COVID-19 variants and can vary depending on vaccination status. CDC will continue to update this list as we learn more about COVID-19. Older adults and people who have underlying medical conditions like heart or lung disease or diabetes are at higher risk for getting very sick from COVID-19. See CDC guidance here.
3. Any international travel in the last 5 days? For individuals who have traveled internationally in the last 5 days, the CDC recommendations are to:
    a. Get tested with a viral test 3-5 days after arrival. See FDA guidance here. Serial testing is now required for POC Ag testing. For asymptomatic individuals, SARS-CoV-2 antigen tests will now be authorized for use on asymptomatic individuals when tested at least three (3) times over five (5) days with at least 48 hours between tests. Performing serial (repeat) testing 3 times is a new requirement.
    b. Find a U.S. COVID-19 testing location near you or use a self-test. See FDA guidance here.
    c. If you already had COVID-19 within the past 90 days, see specific testing recommendations.
    d. Monitor yourself for COVID-19 symptoms.
    e. Follow additional guidance if you know you were exposed to a person with COVID-19.

f. Follow all state, tribal, local and territorial recommendations or requirements after arrival.
g. If you are going to be around someone who is at higher risk of getting very sick with COVID-19, consider additional precautions.
h. See CDC International Travel Guidance here.

- Any visitors meeting any of the above criteria should not be allowed a scheduled visit. Prescreened visitors should be informed they will be screened again upon arrival to the program. Screening upon arrival will include inquiring about signs and symptoms. Any visitors arriving without pre-screening/scheduling should be screened ideally outside the program if they must visit the program.
- Visitors should be informed of the need to wear a face covering the entire time they are in the facility and be encouraged to maintain physical distancing (keep at least six feet from the patient whenever possible).
- One-on-one visits and visits outdoors should be encouraged where appropriate space is available, weather permitting, and at the discretion of the staff (with patient agreement). For visits outdoors, wearing a mask or face covering is still recommended for all parties.
- Indoor visits may occur, masks are required, and physical distancing is encouraged. Visits no longer need to be of short duration (less than an hour).
- Consider whether patients in isolation or quarantine should be permitted visitors. How ill the individual in isolation is should factor into the facility's consideration.
- Visitors who fail to wear a face covering will be asked to leave the facility. Facilities may provide visitors with a face covering if needed.

If a facility meets any criteria for restricted visiting as mentioned in the OASAS reopening guidance, then visitation must be restricted. See the OASAS reopening guidance https://oasas.ny.gov/oasas-reopening-guidance.

Guidance on Non-emergent Transportation:

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

Environmental Guidance from NYS OASAS and DOH:

- Interim Guidance for Cleaning and Disinfection for Non-hospital-based Inpatient, Residential, and Outpatient Treatment Settings where Individuals Under Movement Restriction for COVID-19 are Admitted or Have Visited