



**Office of
Mental Health**

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

Version Date: November 12, 2020

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

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.

It is difficult to predict how COVID-19 will affect different communities and it is likely that different communities in New York will have shifting rates of infection and burden of disease. Program administrators must plan for this ongoing uncertainty. Please review this information including the links below with your program's leadership and staff and make any necessary adjustments to your program policies and protocols. Detailed information is available [here](#) about the different phases of NY Forward, including specific instructions to businesses. On October 26, 2020, the NYS Department of Health issued new guidance regarding a [Cluster Action Initiative](#) that includes specific recommendations regarding testing and [visitation procedures in health care and congregate settings](#). Healthcare settings never closed during the pandemic. This guidance is aimed at helping programs recalibrate how to resume some in-person services.

Symptoms of COVID-19 can appear 2-14 days after exposure and may include a temperature of 100.0 degrees Fahrenheit or greater, subjective symptoms of a fever (e.g., malaise, fatigue, muscle aches, chills), and/or respiratory symptoms including a sore throat, cough, and/or shortness of breath. Less common symptoms include runny nose, headache, nausea/vomiting, diarrhea, and loss of taste or smell. Atypical presentations have been described, and older adults and persons with medical comorbidities may have delayed presentation of fever and respiratory symptoms. Some people experience only mild symptoms or have vague symptoms of not feeling well. Older adults, people with underlying health conditions, and people with compromised immune systems are at high risk of severe illness from this virus. Please check the [CDC website](#) for the most up-to-date list of symptoms.

Individuals should seek immediate emergency medical care if they experience:

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

Please see the CDC's definitions of severe and critical COVID-19 illness [here](#).

Physical distancing is a prevention technique aimed at slowing the spread of the virus. People are asked to stay at home and limit contact with those who do not live in their home. Public health measures to close schools, eat-in restaurant dining, gyms, libraries, theaters, and so

forth are all part of this approach. This action is meant to prevent people from getting sick and overwhelming the healthcare system.

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

- Sharing the same household;
- Direct physical contact (e.g., handshake) with the individual;
- Direct contact with infectious secretions of the individual (e.g., being coughed on, 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 guidelines for infection control basics including hand hygiene:

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

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

- Always maintain at least six feet of distance from all individuals who do not live in their household.
- Wash hands with soap and water for at least 20 seconds or use 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 cloth face covering or surgical mask when out in public, unless there is a strong medical reason that prevents wearing a mask. Masks should fully cover the nose and mouth. This is in addition to physical distancing NOT instead of physical distancing.
- Stay home if sick.
- Cover coughs or sneezes with a tissue, then discard into the trash and wash hands afterwards.
- Clean and disinfect frequently touched objects and surfaces.

Additional Resources:

- [Ensuring Access to Health Care Services During COVID19](#)
- [NYS Department of Health Key Infection Control Practices in Inpatient and Outpatient Medical Care Settings](#)

- [Information on COVID-19 Testing for OMH and OASAS Programs](#)
- [OMH and OASAS Ambulatory and Residential Program COVID-19 Testing, Record Keeping, and Notification Instructions](#)
- [Additional OMH Guidance](#)

ENHANCED PRECAUTIONS DETERMINATION

After the initial COVID crisis in the spring and early summer of 2020, public mental health agencies must begin to make plans for the possibility that individual programs may be in geographic regions with higher rates of COVID-19 community transmission and pre-emptively have plans on how to respond. Agencies will need to return to enhanced precautions in certain situations (described below) to keep their clients and staff safe. For more information on the NY Cluster Action Initiative, please see the website: <https://forward.ny.gov/cluster-action-initiative>.

1. Agencies should require individual programs to apply enhanced precautions when one or more of the following occurs within that program:
 - a. The program's region has been designated a Phase 1 or 2 NY Forward Region;
 - b. The program is located in a red micro-cluster zone or an orange warning zone.
 - c. The Local Health Department (LHD) of the county where the program is located recommends the program implement enhanced precautions.
 - d. The OMH Medical Directors Office, in consultation with the the local OMH Field Office Director, recommends the program implement enhanced precautions.
2. Agencies should strongly consider enhanced precautions if
 - a. The program itself is experiencing a cluster of 2 or more confirmed COVID-19 cases among clients and or staff;
 - b. The program is located in a yellow precautionary zone.
3. Once it is determined a program needs to implement enhanced precautions, program leadership will immediately begin implementing necessary changes (described below and throughout the document).
4. Programs may discontinue enhanced precautions two weeks after above conditions are no longer met.
5. OMH State-Operated Programs must adhere to separate, additional guidance issued by OMH Central Office in implementing infection control measures.

INFECTION CONTROL PRACTICES FOR OUTPATIENT, SUPPORT, CRISIS, AND FORENSIC TRANSITION PROGRAMS, INCLUDING MOBILE AND HOME AND COMMUNITY-BASED SERVICES

Applicability

- Adult BH HCBS Community Psychiatric Support and Treatment (CPST) (4720)
- Adult BH HCBS Education Support Services (ESS) (4660)
- Adult BH HCBS Empowerment Services - Peer Supports (4650)
- Adult BH HCBS Family Support and Training (FST) (4690)
- Adult BH HCBS Habilitation (4700)
- Adult BH HCBS Intensive Supported Employment (ISE) (4620)
- Adult BH HCBS Ongoing Supported Employment (OSE) (4610)
- Adult BH HCBS Pre-Vocational Services (4640)

- Adult BH HCBS Psychosocial Rehabilitation (PSR) (4710)
- Adult BH HCBS Self-Directed Care (4740)
- Adult BH HCBS Transitional Employment (4630)
- Adult Home Supportive Case Management (6820)
- Advocacy/Support Services (1760)
- Affirmative Business/Industry (2340)
- Assertive Community Treatment (ACT) (0800)
- Assisted Competitive Employment (1380)
- 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 as much as possible. This applies to programs in every [NY Forward](#) reopening phase. However, programs must maintain capacity for in-person services to treat individuals who clinically are determined to need an in-person visit, are unable to connect via telehealth, who require long-acting injectable medications or laboratory testing, or to accommodate client choice. OMH has issued extensive guidance on telehealth that can be found [here](#).

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

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

In-Person Encounters

Providers must ensure in-person access to clients who are deemed to not be appropriate for telehealth encounters, who receiving long-acting injectable medications, those who need laboratory testing (e.g., for clozapine prescribing), and those receiving any other clinical services that can only be performed in person, are seen as needed 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, 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 remote platforms;

- Issues related to access (phone ownership, privacy, data plan, minutes, broadband access, etc.);
 - Ability to establish a private space;
 - 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 face-to-face service may be required;
 - Attention to the impact of different technology platforms on patient rapport and communication; and
 - Client ability to take a more active role in the treatment process than may be the case for face-to-face contacts.
- Factors related to infection control, including:
 - Whether client has recent travel to a location on the [DOH Travel Advisory](#); whether client currently has COVID-19-like illness (CLI) symptoms; or whether client has had close contact to anyone with confirmed or suspected CLI;
 - The program's physical plant, including the ability to limit density, maintain physical distancing, etc.;
 - The program's ability to access PPE;
 - 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:
 - Presence of medical aspects of care that would require in-person examination including physical exams. If the provider cannot manage the medical aspects for the patient without being able to conduct initial or recurrent physical exams, this shall be documented in the record, and arrangements shall be made to perform physical exams onsite as clinically indicated;
 - Strength of relationship, engagement and continuity of care. Is the client new to the program? Was there a recent change in clinician assignment?;
 - Static and dynamic risk factors, such as risk for suicide or self-injurious behavior, risk for violence, new housing instability, impact of substance use, re-entry from incarceration, increased frequency of CPEP or hospital admissions, etc.; and
 - Ability to identify and participate in effective remote safety management.
- System factors, including:
 - Attention to issues regarding continuity of and transitions in care, including in-person visits as needed to avoid disruptions in care;
 - 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.

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

1. Have you had contact with any persons with confirmed or suspected CLI within the last 14 days?
2. Have you had any symptoms of CLI within the last 14 days (list of symptoms found in General Information section)? Have you had a positive diagnostic COVID-19 test in the last 14 days?
3. In the last 14 days, have you traveled to any state or country currently listed in New York's COVID-19 [Travel Advisory](#)?
 - a. If so, did the person have a negative COVID-19 diagnostic test within three days prior to departure from that state; and
 - b. Did the person have a negative COVID-19 diagnostic test on day 4 after arriving in New York?
 - c. If the individual has had two negative diagnostic COVID-19 tests, the individual may leave travel-related quarantine early upon receipt of negative results of second test.
 - d. Detailed DOH travel advisory may be found here: <https://coronavirus.health.ny.gov/covid-19-travel-advisory>

If the client answers YES to any of these questions, 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. Information about symptomatic clients must be shared with the local health department.

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 in Standard Precaution Zones:

1. Promote the use of telehealth unless there is a clinical determination that an in-person encounter is preferable or necessary (based on above criteria).
2. Continue efforts to limit staff density in facility.
3. Agencies must develop a process to procure PPE and make it available at each program site.
4. All staff must wear appropriate PPE at every interaction with every client. For most staff, a facemask (that covers the nose and the mouth) is sufficient. Staff in programs in yellow precautionary zones should wear a face shield as well.
5. Staff who must closely examine or remain in close proximity (see definition above) to the client need additional protection (e.g. a physician performing a COVID test), such as a face-shield or goggles and gloves.
6. Upon the client's arrival, repeat above questions from the telephone screen. Clients must agree to screen in order to be allowed inside the facility. If clients refuse to participate or if they answer YES to any of the above questions, they should only be seen in an outdoor private area or well-ventilated room with the door closed and must

agree to wear a facemask or cloth face covering. 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 facemask and eye shield. These clients should be given information on where to obtain COVID-19 diagnostic testing.

7. It is recommended for programs to take clients' (and their escorts') temperatures prior to entering the treatment site. This decision should be made based upon each program's staff capabilities and resources. If programs do not have thermometers available for screening on arrival to facility, clients may be asked to check their own temperature prior to coming for a visit. Programs should follow process described in #6 above for any individual with a temperature equal to or over 100.0 degrees Fahrenheit.
8. When providing services, staff should maintain physical distancing, wear a facemask, 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 facemask or face covering. Staff and clients should always observe BOTH. If it is essential for staff to see in-person an individual with known or suspected CLI, the staff member should also wear a faceshield or goggles.
9. All clients should wear a facemask or cloth face covering while in the facility. If the client does not bring a facemask or cloth face covering, staff should provide the patient with a disposable surgical mask to wear throughout the visit.
10. Preferably, adult clients should come unaccompanied to visits. If this is not possible, escorts should wait outside the facility or wear a facemask or other face covering and maintain social distance while in the facility. Programs should provide the escort with a facemask if they do not already have one. Parents or guardians of children and adolescents should be given masks if they do not already have a cloth face covering from home.
11. 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. In all NY Forward Phases, staff and clients must wear surgical masks. If available, an eye shield is recommended for staff. N95 respirators are not appropriate for LAIs and are only needed for procedures that result in aerosolizing of sputum, such as nebulizer treatments. Staff should minimize time spent within six feet of the client. Enclosed spaces should be thoroughly ventilated in between clients.
12. Frequent-contact surfaces in the examination room must be disinfected after every patient encounter. 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.
13. Frequent-contact office surfaces (such as tabletops, door knobs, chair arms, clip boards, pens, etc.) must be disinfected in between every patient.
14. The office must be thoroughly cleaned at least daily as per DOH guidance.
15. Sufficient hand sanitizer must be available throughout the facility, including in waiting areas, and be available for staff and clients.

16. Chairs in outdoor and indoor waiting areas should be spaced at least six feet apart. If possible, clients should wait outside for their appointment.
17. 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 face covering or facemask and continue hand hygiene.
18. Groups of ten clients or fewer can be held indoors in a large and well-ventilated space provided that all parties wear facemasks or face coverings 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. Every group participant must screen negative for CLI symptoms.
19. Larger groups may be held outdoors provided at least six feet can be maintained between all individuals present and all wear appropriate face coverings.

In-Person Clinical Services in Enhanced Precaution Zones:

1. These precautions apply when a program is in a red micro-cluster zone or an orange warning zone, or if the program meets criteria for enhanced precautions described above.
2. Maintain precautions listed in #1-17 in [Standard Precaution section above](#). All staff must wear appropriate PPE at every interaction with every client. All staff should wear an eye shield for extra protection.
3. If peer socialization is critical to the well-being of a client, small groups may have outdoor meetings if clients have capability and have agreed to wear face coverings and maintain physical distancing of six feet during such meetings. Groups may have no more than five members. For minors, parent/guardian would also need to agree to such a meeting.
4. No indoor groups are permitted.

Prioritize Scheduled Encounters

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

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). In regions designated New York Forward phase 3 or 4 or in areas that are not designated as red micro-cluster zones, 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 face covering. Staff should also use these pre-visit calls to screen clients for COVID-19 symptoms and recent travel (per the questions above).
2. Staff must always wear a surgical mask or cloth face covering when interacting with clients or family members. Staff should wear eye-shields if they are available.
3. Clients should be educated to wear a cloth face covering (such as a bandana). If supplies are available, the program can offer to give clients face coverings or facemasks at each encounter.
4. 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.
5. If the staff member encounters clients or family members who refuse to observe physical distancing (or if for whatever other reason the staff member feels unsafe), it is acceptable for the staff member to disengage from the contact and report the incident to a supervisor so the client's needs can be met in an alternative way.

Other Recommendations

To the extent practicable, programs should:

1. Consider installing plexiglass shields in reception areas to protect staff in high-traffic areas.
2. Remove magazines, toys, and other shared objects from waiting areas.
3. 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.
4. Develop protocols to ensure that physical distancing can be maintained in tight workspaces (e.g. chart rooms, supply closets, etc.).
5. Ensure that adequate physical distance can be maintained in public bathrooms (e.g. urinals and sinks should be blocked off to ensure that individuals stay six feet apart at all times).
6. Administrative staff (i.e. staff who do not 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 should wear a mask or cloth face covering when physical distancing cannot be maintained adequately and/or when they share an unventilated work space.
7. Janitorial staff should be provided with adequate PPE as per previously released guidance: [Interim Guidance for Cleaning and Disinfection of Public and Private Facilities for COVID-19](#).

8. 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 face mask and eye protection (if available), and instruction on infection control.
9. Review OMH guidance on how to collaborate with Local Health Departments on Contact Tracing Efforts which can be found [here](#).
10. Agencies should encourage their clients to access primary care and obtain an influenza vaccine.

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

Applicability

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

General Information

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

1. Clients should be educated and encouraged to stay in the residence as much as possible. If they do go out, they should stay outdoors and keep a distance of at least six feet away from anyone else, including relatives who do not live in the program. Upon returning home, residents and any accompanying staff should immediately wash their hands with soap and water for at least 20 seconds or use an alcohol-based hand sanitizer with at least 60% alcohol. Cell phones and other frequently handled items should be sanitized daily. All residents should be reminded to avoid touching their faces.
2. Programs should cancel all planned social or recreational outings where adequate physical distancing and appropriate hand hygiene cannot be maintained. When a program is observing enhanced precautions (described above), all outings should be

- canceled.
3. By Executive Order, as of April 17, 2020, all New Yorkers must wear a cloth mask or face covering when out in public. Programs should advise residents that they should adhere to this order.
 4. Providers should display the “NYS DOH Protect Yourself ” poster available [here](#) (scroll to the bottom). Translations to other languages are also available on the same site.
 5. Programs should prevent non-residents from visiting residences unless it is deemed necessary to the direct support of a resident’s health and wellbeing. Prior to entering the residence, visitors should be asked if they have any of the CLI symptoms listed in [General Information](#) section of this document or if they have traveled abroad or to any state in the [NYS COVID-19 Travel Advisory \(and if they have visited states on the Travel Advisory, whether they have had the two required negative diagnostic COVID test results for early quarantine exit\)](#). 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.
 6. All visitors are required to wear a cloth face covering or surgical mask while in the residence. Physical distancing should be practiced during visits and if the visit occurs indoors, only well-ventilated locations should be utilized.
 7. All visitation is suspended in residential congregate facilities located in red micro-cluster zones, except for in the following instances: compassionate care (including end of life/hospice situations), medically or clinically necessary (i.e. visitor is essential to the care of the patient), accompanying a minor in a pediatric facility, labor/delivery/post-partum care, necessary legal representatives, and essential companions to individuals with intellectual and/or developmental disabilities or with cognitive impairments, including dementia. See https://forward.ny.gov/system/files/documents/2020/10/congregate_facility_visitation_in_zones_10_23_2020.pdf for text of Department of Health’s order.
 8. Visitation shall be suspended at a residential congregate facility in an orange warning zone if a staff member or resident in the facility has tested positive for COVID-19 in the last 14 days, except for in the following instances: compassionate care (including end of life/hospice situations), medically or clinically necessary (i.e. visitor is essential to the care of the patient), accompanying a minor in a pediatric facility, labor/delivery/post-partum care, necessary legal representatives, and essential companions to individuals with intellectual and/or developmental disabilities or with cognitive impairments, including dementia. See https://forward.ny.gov/system/files/documents/2020/10/congregate_facility_visitation_in_zones_10_23_2020.pdf for text of Department of Health’s order.
 9. Frequently touched surfaces (for example: tables, doorknobs, light switches, handles, desks, toilets, faucets, sinks) should be disinfected daily with cleaning products effective against rhinoviruses or human coronaviruses. See [EPA List N](#) for appropriate products.
 10. To the extent possible, programs should work with clients’ healthcare providers to institute telemedicine appointments. Blood draws and monthly injections will still need to be done in person.
 11. Clients and staff should be reminded of the importance of hand hygiene and of not touching their faces while visiting their providers.
 12. Clients and staff should be instructed to report symptoms as soon as possible. Staff specifically should ask all clients daily about CLI symptoms (see list in [General Information](#) section of this document).
 13. For individuals who have not developed symptoms and are in shared bedrooms, ensure that the beds are at least six feet apart. It is recommended that clients sleep head-to-toe.

14. Staff must wear a mask that covers their nose and mouth while on shift in the residence.
15. Agencies must develop a process to procure PPE and make it available at each program site.
16. Agencies should encourage their clients to access primary care and obtain an influenza vaccine.

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. Upon arrival, staff should ask the clients themselves if they have had any known contact with individuals who tested positive or who have experienced CLI symptoms. Staff should ask all clients upon arrival if they currently or recently experienced any CLI symptoms. Clients with cognitive difficulties may not be able to answer fully.
3. Programs accepting new clients from Article 28 or Article 31 inpatient hospital settings may require a negative COVID-19 diagnostic PCR test within 72 hours prior to transfer. Programs may require the test result to be sent prior to transfer.
4. For clients who previously tested positive for the COVID-19 virus, the program should confirm the date(s) of the last positive COVID-19 virus test and any subsequent negative tests as part of the application process, along with documentation that 14 days have passed since the first CLI symptom (or positive test result if the individual was asymptomatic), that the individual has been fever-free for at least 72 hours without the aid of fever-reducing medications, and that the individual's symptoms have significantly improved.
5. Given the limitations in accessing testing in community settings, programs are not permitted to require a negative test result for clients coming from non-inpatient hospital settings.
6. If the client recently had contact with someone who potentially had COVID, a surgical mask or cloth face covering must be worn for a period of 14 days, and the client should remain in their room. If CLI symptoms develop, see [section below](#).
7. If possible, any new client should have their own room.
8. New clients should remain in their room as much as possible during the first 14 days and maintain six feet of distance from all other clients and staff to the extent practicable.
9. Programs may not require results of serum antibody tests as a condition of admission.

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 surgical mask or cloth face covering. Meals should be taken in the room.
2. If a client with COVID-like illness requires close support from a staff member (within six feet), 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. Programs may consider supplying staff with lab coats or staff may bring a change of clothes from home.
3. Exposed roommates should, if possible, have their own rooms for 14 days. If they remain symptom-free, they can then share a room with others.

4. The program administrator (or Family Care provider) should immediately contact their local health department (LHD) ([New York County Health Department Directory](#)) for notification and for information on how to proceed with testing. The NYS Department of Health also operates a Novel Coronavirus Hotline 24/7 at 1-888-364-3065 and [website](#) for additional questions. The program must also follow OMH guidance on local health department notification and contact tracing which can be found [here](#).
5. Programs serving children and adolescents should be familiar with DOH guidance on [Pediatric Multi-System Inflammatory Syndrome](#). The hospital should be contacted prior to transport.
6. LHDs may have alternate housing arrangements for individuals with CLI. Programs should coordinate with their LHDs.
7. Most individuals who test positive for COVID-19 will never need to be hospitalized. Hospitalization is only necessary if the individual has difficulty breathing or otherwise appears critically ill. It is important to reduce unnecessary visits to hospital EDs to help reduce the spread of COVID -19.
8. If the client is critically ill (see list in [General Information](#) section of this document) and is having difficulty breathing, it may be necessary to transport the client by ambulance to the hospital.
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 with symptoms must be isolated and may be taken off isolation when:
 - a. The person has had no fever for at least three days (72 hours) without the use of fever-reducing medications; AND
 - b. There is a significant improvement of CLI symptoms; AND
 - c. At least 14 days have passed since symptoms first appeared (or, if asymptomatic, since the date of diagnostic COVID-19 test collection).(this is consistent with current DOH guidance for discontinuing isolation in hospital and other congregate settings).
11. For clients who use tobacco products, program staff (or Family Care providers) should work with the client's mental health or primary care provider to secure enough nicotine replacement therapy (NRT) to help eliminate nicotine withdrawal and the desire to leave their room to smoke or vape.
12. Other clients who are over 50 years old, have significant respiratory comorbidity, or who smoke or vape should increase the frequency of hand hygiene practices and wear surgical masks.
13. Staff members (or Family Care providers) should wear surgical masks or cloth face coverings and increase frequency of hand hygiene practices. Staff should whenever possible remain six feet away from positive or potentially positive individuals.
14. Surfaces, doorknobs, handles, and other items that come into frequent hand contact should be sanitized three times per day.
15. In programs with several bathroom facilities, one bathroom should be set aside for the client(s) who is/are suspected to have COVID-19 or has/have tested positive for 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.
16. 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.
17. In programs with only one bathroom, all clients and staff should use masks while in the bathroom (unless showering). If possible, stagger shower times, ensuring that bathroom exhaust fans run for at least 20 minutes between all showers and leave the window open to facilitate clearing of droplets.
 18. If programs have the capacity and the client is cooperative, implementing in-room commodes and/or sponge baths is recommended.
 19. 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.
 20. Dishes and linens do not need to be cleaned in a different manner if used by individuals who test positive for COVID-19. However, they should be washed thoroughly after use. When washing clothes, staff (or Family Care providers) should be instructed not to “hug” dirty laundry while transporting it and to maintain distance from their own clothes and face. Use of a hamper is recommended. After handling linens or clothing of someone who tested positive for COVID-19, staff should wash their hands with soap and water.

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. During the COVID-19 public health emergency, it is possible that these clients are exposed to the virus while in the hospital. Of note, this section applies 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 PCR 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. Most individuals who become very ill with COVID-19 and require hospitalization will recover. Individuals must be discharged once they are no longer ill enough to warrant ongoing medical admission, though they may still have mild COVID-19 symptoms.
4. Individuals who are discharged from the hospital after an admission for CLI should be treated with the same precautions as someone who is suspected to have COVID-19 or who tests positive but is never hospitalized (see #9 in [section above](#)).
5. COVID-19 virus testing within 72 hours prior to transfer will not be required for any client who tested positive for COVID-19 virus at any time prior to the requested transfer. Instead, the program should confirm the date(s) of the last positive COVID-19 virus test and any subsequent negative tests as part of the application process.
6. Local health departments may have alternate housing arrangements for individuals who are ready for hospital discharge and may still need a period of isolation. Programs should review options with their local health departments.
7. Clients will need to come home to their residential program or family care home after being discharged from the hospital. It is important that staff help manage not only the individual client’s fears, but also the anxieties of all other housemates.
8. Individuals who return from the hospital and who are not showing symptoms of COVID - 19 should be considered in the same category as a new client (see [section above](#)).
9. Programs may require a negative diagnostic PCR test within 72 hours prior to discharge

from the hospital if the individual was hospitalized for a reason other than COVID-19 (e.g. a psychiatric admission) unless #4 and #5 of this section apply.

10. Programs may not require results of serum antibody tests as a condition for a client returning to the residential program.
11. Programs should reach out to their OMH Field Office of Central Office Housing staff if there are questions or concerns about admissions or discharges. Hospitals are also encouraged to reach out with questions or concerns about transfers back to residential programs.

Scattered-Site Housing Programs

1. Programs should educate all clients in scattered-site housing about the importance of avoiding socializing indoors, restricting visitors to their homes, practicing appropriate hand hygiene, avoiding touching their faces, practicing basic disinfecting at home, keeping at least six feet away from others while out in public, when possible, and wearing a cloth face covering when out in public.
2. Programs need to determine on a case-by-case basis when it is clinically necessary to continue visiting clients. Possible reasons include, but are not limited to, helping the client access medical treatment, access food or other basic supplies, or mitigating risk of disengagement or hospitalization in the absence of direct contacts.
3. When visiting a client, staff should use alcohol-based sanitizer prior to entering the client's home and should wear a surgical face mask or cloth face covering. If the client has confirmed or suspected CLI, staff should also wear a face shield if an in-person visit is unavoidable.
4. Staff should keep at least six feet away from the client during the visit.
5. Staff should remind the client to practice appropriate hand hygiene and to avoid touching their faces.
6. Staff should use alcohol-based sanitizer immediately upon leaving the client's building.
7. See guidance for ACT and Mobile Crisis teams above.

Guidance For Child And Youth-Serving Residential Programs

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

1. The youth and family must agree that the home-time leave is appropriate and safe. Staff should ask families whether anyone at home has CLI symptoms or is in a high-risk category.
2. Home-time leaves must be clinically appropriate and included as part of the youth's treatment plan.
3. If the youth is going on a home-time leave, the youth should not have close contact beyond family members in the home setting (must adhere to physical distancing guidance).
4. Information on general infection control strategies should be provided to the youth and parents/guardians.
5. For all youth, if the home-time is directly connected to discharge planning (i.e., an interview at an outpatient program, a therapeutic assessment for readiness for next level of care, etc.), home-time leave may be granted. This would require input from the youth's

psychiatric, general medical, and nursing staff as well as individuals at the destination site.

6. As an alternative to home-time leaves, staff should encourage the family/guardian to join in-person interactions on program grounds (but maintain physical distancing and mask wearing).
7. Every effort should be made to utilize technology as often as needed to promote engagement, support, and treatment with children and families, whether the youth is on site or on home-time leave.
8. Any youth in quarantine or isolation may not leave the program site for community or home-time leave.
9. Programs in red micro-cluster, orange warning, or yellow precautionary zones or who otherwise implemented increased infection control precautions should consider diagnostic COVID testing of youth coming or going on home visits to reduce the risk of transmission in the program or to the families. Collaboration with a local healthcare provider or local health department is necessary to obtain testing.

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

Applicability

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

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

INFECTION CONTROL PRACTICES BEST PRACTICES DURING NON-EMERGENT TRANSPORTATION

Applicability

- All programs

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

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

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

1. Staff must wear a surgical facemask. Clients must wear a cloth face covering. If a client does not have a face covering, the program should provide them with a mask.

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

GUIDANCE FOR STAFF

Applicability

- All programs
1. Staff members who are ill must contact their supervisors immediately; programs must provide instructions to supervisors on how to screen employees who report symptoms. If

the staff member has had close contact with an individual with confirmed or suspected COVID-19 and they are an essential employee, follow #3 below.

2. All staff must wear a mask or cloth face covering while at the facility; this includes staff who do not have direct contact with clients. Staff may remove their face covering if they are working alone in their own office.
3. If programs are experiencing significant staffing shortages and exhausted other solutions, the NYS DOH and CDC advise that staff who have had direct contact with individuals with known or suspected COVID-19 illness or who traveled to states on the [New York COVID-19 travel advisory](#) may continue to work provided that they observe the following for 14 days since the last contact:
 - a. The staff member is asymptomatic;
 - b. The staff member is deemed essential and critical for the operation or safety of the workplace;
 - c. The determination is documented by their supervisor and a human resources (HR) representative in consultation with appropriate state and local health authorities;
 - d. Working from home would not be feasible for job duties;
 - e. Staff quarantine themselves when not at work;
 - i. After work, immediately upon returning home, staff should remove their clothes and wash their hands with soap and water prior to coming into contact with any family members;
 - ii. Clothes should be washed after each shift; and
 - iii. If staff member works closely with a client with COVID-like illness, they are encouraged to try to maintain physical distance from all friends and family with risk factors mentioned above.
 - f. Staff undergo temperature monitoring and symptom checks upon arrival to work and at least every 12 hours while at work, and self-monitor (i.e. take temperature, assess for symptoms) twice a day when at home;
 - g. Staff members may use their own home thermometers to check their own temperatures; they are considered to have a fever if their temperature is over 100.0 degrees Fahrenheit; if programs have infrared thermometers available, then staff temperatures may be checked using facility thermometers.
 - h. As in all cases, staff must wear a surgical facemask;
 - i. To the extent possible, staff working under these conditions should preferentially be assigned to patients at lower risk for severe complications.
 - j. Staff whose job duties permit a separation of greater than six feet should have environmental controls in place to ensure adequate separation is maintained;
 - k. If staff develop symptoms consistent with COVID-19 (see list above) while working, they should immediately stop work and isolate at home;
 - l. Staff should complete an [online assessment](#) for testing; and
 - m. When the program is not facing any difficulty with staffing, program leadership may decide that staff may self-quarantine away for 14 days after having a close contact with someone with CLI. These staff may work from home during quarantine if it is possible for them to fulfill their job functions.
 - n. DOH Guidance can be accessed here:
https://coronavirus.health.ny.gov/system/files/documents/2020/07/health_advisory_rtn_to_work_7-24.pdf

- o. Guidance on how and when to quarantine after travel to a state on the Travel Advisory can be found here: <https://coronavirus.health.ny.gov/covid-19-travel-advisory>.
4. Symptomatic or COVID-19 positive staff can return to work when:
 - a. At least 3 days (72 hours) have passed since recovery, defined as resolution of fever (greater than or equal to 100.0 degrees Fahrenheit) without the use of fever-reducing medications; AND
 - b. Improvement in respiratory symptoms (e.g., cough, shortness of breath); AND
 - c. At least 10 days have passed since symptoms attributed to COVID-19 first appeared. For staff who were asymptomatic at the time of their first positive test and remain asymptomatic, at least 10 days have passed since the first positive test (date of test collection).
 - d. If staff is asymptomatic but tested and found to be positive, they must maintain isolation for at least 10 days after the date of the positive test (from the date the test was collected) and, if they develop symptoms during that time, they must maintain isolation for at least 10 days after illness onset and must have been at least 72 hours fever-free without fever reducing medications and with other symptoms improving.
 - e. Staff who are recovering from COVID-19 and return to work after 10 days must wear a facemask while working until symptoms have completely resolved, so long as mild symptoms are improving, if they persist.
 - f. This guidance remains consistent with DOH Guidance from July 24).
5. Names and contact information of staff who developed confirmed or suspected CLI must be provided to the local health department.
6. If a staff member becomes sick and has had prolonged contact with clients, the program does not need to disclose the identity of the staff member to clients; only that they have had an extended contact and that the clients should be in quarantine for 14 days.
7. Agencies should encourage their staff to obtain an influenza vaccine.