

ANDREW M. CUOMO
Governor

ANN MARIE T. SULLIVAN, M.D.
Commissioner

THOMAS E. SMITH, MD
Chief Medical Officer

MEMORANDUM

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

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

Date: June 15, 2020

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

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 the management of Persons Under Investigation (PUI).

As different New York Regions begin to transition from New York PAUSE to New York Forward, program administrators must plan accordingly. Specific additional guidance for outpatient treatment and support as well as residential programs is documented below. Please review this information including the links below with your program's leadership and staff and make any necessary adjustments to your program policies and protocols.

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

Individuals should seek immediate emergency medical care if they experience:

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

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

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

A proximate contact is being in the same enclosed environment such as a classroom, office, or gatherings but greater than 6 ft from a person displaying symptoms of COVID-19 or someone who has tested positive for COVID-19, without necessary personal protective equipment (PPE), within 48 hours prior to symptom onset, for a duration of time greater than 1 hour. Please note that a “contact of a contact” (i.e., contact with an asymptomatic person who has had a close or proximate contact) does not qualify as a contact for infection control purposes.

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

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

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

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

Additional Resources:

- [NYS Department of Health Key Infection Control Practices in Inpatient and Outpatient Medical Care Settings](#)

- [Interim Guidance for Cleaning and Disinfection of Public and Private Facilities for COVID-19](#)
- [Additional OMH Guidance](#)

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

Applicability

- Adult BH HCBS Community Psychiatric Support and Treatment (CPST) (4720)
- Adult BH HCBS Education Support Services (ESS) (4660)
- Adult BH HCBS Empowerment Services - Peer Supports (4650)
- Adult BH HCBS Family Support and Training (FST) (4690)
- Adult BH HCBS Habilitation (4700)
- Adult BH HCBS Intensive Supported Employment (ISE) (4620)
- Adult BH HCBS Ongoing Supported Employment (OSE) (4610)
- Adult BH HCBS Pre-Vocational Services (4640)
- Adult BH HCBS Psychosocial Rehabilitation (PSR) (4710)
- Adult BH HCBS Self-Directed Care (4740)
- Adult BH HCBS Transitional Employment (4630)
- Adult Home Supportive Case Management (6820)
- Advocacy/Support Services (1760)
- Affirmative Business/Industry (2340)
- Assertive Community Treatment (ACT) (0800)
- Assisted Competitive Employment (1380)
- CFTSS: Children's Mental Health Rehabilitation Program (4960)
- CFTSS: Community Psychiatric Support and Treatment (CPST) (4950)
- CFTSS: Family Peer Support Services (FPSS) (4900)
- CFTSS: Mobile Crisis Intervention (CI) (4910)
- CFTSS: Other Licensed Practitioner (OLP) (4940)
- CFTSS: Psychosocial Rehabilitation (PSR) (4930)
- CFTSS: Youth Peer Support and Training (YPST) (4920)
- Children and Youth Assertive Community Treatment (4800)
- Clinic Treatment (2100)
- Comprehensive PROS with Clinical Treatment (6340)
- Comprehensive PROS without Clinical Treatment (7340)
- Continuing Day Treatment (1310)
- Coordinated Children's Service Initiative (2990)
- Crisis Intervention (2680)
- Day Treatment (0200)
- Drop-In Centers (1770)
- Early Recognition Coordination and Screening Services (1590)
- Family Support Services - Children & Family (1650)
- FEMA Crisis Counseling Assistance and Training (1690)

- Geriatric Demo Gatekeeper (1410)
- Geriatric Demo Physical Health - Mental Health Integration (1420)
- Home Based Crisis Intervention (3040)
- Home-Based Family Treatment (1980)
- Homeless Placement Services (1960)
- Intensive Case Management (1810)
- MICA Network (5990)
- Mobile Integration Team (7030)
- Mobile Mental Health Team (7000)
- Multi-Cultural Initiative (3990)
- Non-Medicaid Care Coordination (2720)
- Nursing Home Support (7020)
- Ongoing Integrated Supported Employment Services (4340)
- On-Site Rehabilitation (0320)
- Outreach (0690)
- Partial Hospitalization (2200)
- Peer Wellness Center (3750)
- Promise Zone (1530)
- Psychosocial Club (0770)
- Recovery Center (2750)
- Recreation and/or Fitness (0610)
- School Mental Health Program (1510)
- Self-Help Programs (2770)
- Supported Education (5340)
- Transformed Business Model (6140)
- Transition Management Services (1970)
- Transitional Employment Placement (TEP) (0380)
- Transportation (0670)
- Vocational Services - Children & Family (C&F) (1320)
- Work Program (3340)

Telemental Health

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

<https://omh.ny.gov/omhweb/guidance>.

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

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

In-Person Encounters

In addition to maintaining essential in-person individual services, in areas of the State that have progressed in reopening, and where clinically indicated, in-person meetings outside or off-site may be considered. If peer socialization is critical to the well-being of a client, groups smaller than five may have an out-of-doors meeting if clients have capability and have agreed to wear facemasks and maintain physical distancing during such meeting. For minors, parent/guardian would also need to agree to such a meeting.

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

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

If the client answers YES to any of these questions, the client should as much as possible be seen via telemental health. The client should be instructed to remain at home as much as possible and contact their healthcare provider.

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

If the client must be seen in person, follow guidance below.

1. Upon the client's arrival, repeat above three questions from telephone screen. Clients must agree to screen in order to be allowed inside the facility. If clients refuse to participate, they should only be seen in an outdoor private area and must agree to wear a mask or cloth face covering. Staff should also wear masks.
2. Clients who answer YES to any of the above questions should be seen in a private, well-ventilated room with the door closed or, preferably, in a private outdoor area, and assessed by a program physician or nurse practitioner using appropriate PPE. If no qualified program medical staff is available, ask the client to contact their own healthcare provider as soon as possible. These clients should not wait with other clients in a waiting area.
3. Programs can use their discretion regarding whether to take clients' temperatures prior to entering the treatment site. This decision should be made based upon each program's staff capabilities and resources. If programs do not have thermometers available for screening on arrival to facility, clients may be asked to check their own temperature prior to coming for a visit. If a program decides to monitor temperatures, any individual with a temperature > 100.0 should be given a mask and instructed to return home and contact their healthcare provider.
4. All clients should wear a mask or cloth facial covering while in the facility. If the client does not bring a cloth facial covering, staff should provide the patient with a disposable surgical mask to wear throughout the visit.
5. When providing services, staff should attempt to maintain physical distancing, wear a mask, and meet clients in well-ventilated spaces. If room ventilation is a concern, staff can meet with clients in a private outdoor area, weather permitting. Physical distancing is never a replacement for wearing a mask or facial covering. Staff and clients should always observe BOTH.

6. When administering long-acting injectable medications (LAIs) to clients, or when conducting other procedures that require close physical contact, staff should follow [droplet precautions](#). As always, staff should wear gloves when administering injections. This is not only for protection against COVID-19 but is universal protocol for protection against blood-borne pathogens. While there is community spread of COVID-19, staff should also wear surgical masks and clients should wear a mask or cloth facial covering. N95 respirators are not appropriate for LAIs and are only needed for procedures that result in aerosolizing of sputum, such as nebulizer treatments. Frequent-contact surfaces in the examination room must be disinfected after every patient encounter. Outpatient programs can consider administering injections outdoors, particularly if the client is a PUI or has tested positive for COVID-19. Whenever possible, staff can provide gluteal injections instead of deltoid injections to increase distance from the client's face. An eye shield is recommended, if available.
7. Frequent-contact office surfaces (such as tabletops, door knobs, chair arms, clip boards, pens, etc.) must be [disinfected](#) in between every patient.
8. The office must be [thoroughly cleaned](#) at least daily.
9. Sufficient hand sanitizer must be available throughout the facility, including in waiting areas, and be available for staff and clients.
10. Chairs in outdoor and indoor waiting areas should be spaced at least six feet apart. If possible, clients should wait outside for their appointment.
11. As much as possible, clients should come unaccompanied to visits. If this is not possible, escorts should wait outside or wear a mask or other facial covering while in the facility. Programs should provide the escort with a facemask if they do not already have one.

Prioritize Scheduled Encounters

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

Home and Off-Site Visits

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

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

4. If the staff member encounters clients or family members who refuse to observe physical distancing (or are in any other way aggressive or menacing), it is acceptable for the staff member to disengage from the contact.

Other Recommendations

To the extent practicable, programs should:

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

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

Applicability

- Adult BH HCBS Intensive Crisis Respite (4670)
- Adult BH HCBS Short-term Crisis Respite (4680)
- Apartment/Support (7080)
- Apartment/Treatment (7070)
- Children & Youth Community Residence (7050)
- Community Residence for Eating Disorder Integrated Treatment Program (6110)
- Congregate/Support (6080)
- Congregate/Treatment (6070)
- Crisis Residence (0910)
- Crisis/Respite Beds (1600)
- Family Care (0040)
- Private Inpatient Psychiatric Hospital (2010)
- Residential Treatment Facility - Children & Youth (1080)
- Respite Services (0650)

- Shelter Plus Care Housing (3070)
- SRO Community Residence (8050)
- Supported Housing Community Services (6060)
- Supported Housing Rental Assistance (6050)
- Supported/Single Room Occupancy (SRO) (5070)
- Transient Housing (2070)

Residential Programs should follow [COVID-19 Infection Control Guidance for OMH Residential and Site-Based Programs](#).

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

Applicability

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

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

INFECTION CONTROL PRACTICES FOR ARTICLE 31 PRIVATE PSYCHIATRIC INPATIENT HOSPITALS

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

INFECTION CONTROL PRACTICES BEST PRACTICES DURING NON-EMERGENT TRANSPORTATION

Applicability: All programs

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

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

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

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

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

GUIDANCE FOR STAFF

Staff Infection Control

1. Staff members must stay home if they are sick.
2. All staff must wear a mask or cloth facial covering while at the facility, this includes staff who do not have direct contact with clients.
3. If programs are experiencing significant staffing shortages and exhausted other solutions (as is very likely the case for most programs, particularly in areas of the state that still face community spread of COVID-19), the DOH and CDC advise that staff who have had direct contact with individuals who tested positive or PUIs may continue to work provided that
 - a. The staff member is asymptomatic;

- b. The staff member is deemed essential and critical for the operation or safety of the workplace;
 - c. The determination is documented by their supervisor and a human resources (HR) representative in consultation with appropriate state and local health authorities;
 - d. Working from home would not be feasible for job duties;
 - e. Staff quarantine themselves when not at work;
 - i. After work, immediately upon returning home, staff should remove their clothes and wash their hands with soap and water prior to coming into contact with any family members;
 - ii. Clothes should be washed after each shift; and
 - iii. If staff member works closely with a client with COVID-like illness, they are encouraged to try to maintain physical distance from all friends and family with risk factors mentioned above.
 - f. Staff undergo temperature monitoring and symptom checks upon arrival to work and at least every 12 hours while at work, and self-monitor (i.e. take temperature, assess for symptoms) twice a day when at home;
 - g. Staff members may use their own home thermometers to check their own temperatures; they are considered to have a fever if their temperature is over 100.0 degrees; If programs have infrared thermometers available, then staff temperatures may be checked using facility thermometers.
 - h. Staff should wear a surgical facemask;
 - i. To the extent possible, staff working under these conditions should preferentially be assigned to patients at lower risk for severe complications.
 - j. Staff whose job duties permit a separation of greater than 6 feet should have environmental controls in place to ensure adequate separation is maintained;
 - k. If staff develop symptoms consistent with COVID-19 (see list above) while working, they should immediately stop work and isolate at home;
 - l. Staff should contact <https://covid19screening.health.ny.gov/> for testing; and
 - m. When the program is not facing any difficulty with staffing, program leadership may decide that staff may self-quarantine away for 14 days after having a close contact with someone with CLI. These staff may work from home during quarantine if it is possible for them to fulfill their job functions.
4. Symptomatic or COVID-19 positive staff can return to work when:
 - a. At least 3 days (72 hours) have passed since recovery, defined as resolution of fever (greater than or equal to 100.0) without the use of fever-reducing medications; AND
 - b. Improvement in respiratory symptoms (e.g., cough, shortness of breath); AND
 - c. At least 10 days have passed since symptoms attributed to COVID-19 first appeared. For staff who were asymptomatic at the time of their first positive test and remain asymptomatic, at least 10 days have passed since the first positive test.
 5. Names and contact information of staff who developed confirmed or suspected CLI must be provided to the local health department.
 6. If a staff member becomes sick and has had prolonged contact with clients, the program does not need to disclose the identity of the staff member to clients; only that they have had an extended contact and that the clients should be in quarantine for 14 days.