- Packages are permitted
- Phone calls are permitted - disinfect between each use
- Religious programs shall be cell front or deliver materials to housing unit/dorm/cells
- Educational materials to be provided either cell front or to dorm
- Request for Health Care Services Forms, CDCR-Form 7362, will be distributed and picked up in the housing units by staff

During this time, I would like to see our Community Resource Managers and Education Department facilitate the delivery of increased games, program materials, reading books, or other items to the housing units. Housing unit/dorm officers and supervisors are expected to conduct additional rounds and spot checks of inmates in an effort to reduce self-harm and/or suicide attempts.

All institutions will be required to provide a copy of their Program Status Report, Part-A, to their respective Associate Director each day for this 14-day period. Institutions are expected to brief staff and inmate advisory committees on this directive as this modified program is currently only slated to be in effect for 14-days, through April 21, 2020.

During the past couple of weeks there have been some best practices coming forward that I would like to see implemented or considered such as placing markers on the ground in six foot intervals as a reminder for staff and inmates to maintain social distancing, and the placement of acrylic glass (e.g. Plexiglas) at staff entrances as a barrier between the screener and the person entering the prison.

Thank you for you continued efforts in managing this COVID-19 event. If you have any additional questions, please contact your respective Associate Director.

CONNIE GIPSON
Director
Division of Adult Institutions

cc: Kimberly Seibel
Patrice Davis
Justin Penney

Memorandum

Date: April 7, 2020

To: Associate Director, Division of Adult Institutions
Wardens

Subject: **REVISED COVID-19 MANDATORY 14-DAY MODIFIED PROGRAM**

The California Department of Corrections and Rehabilitation's priority is to protect the health and well-being of our staff and the offender population as well as providing a safe environment. The purpose of the memorandum is to reduce staff and inmate exposure to the coronavirus (COVID-19) by increasing more restrictive measures.

Effective Wednesday, April 8, 2020, all institutions will implement a mandatory 14-day modified program. Each institution will be responsible for either creating or amending their current Program Status Report taking all of the following information into consideration:

- The entire institution will be affected, except for Restricted Housing Units, Correctional Treatment Centers, and Psychiatric Inpatient Programs, etc.
- Movement will be via escort - maintain increased social distancing unless security would dictate otherwise (i.e. Administrative Segregation Unit placement). Movement will be in such a fashion as to not mix inmates from one housing unit with another housing unit.
- Feeding – Cell feeding or one housing unit at a time, maintaining social distancing and disinfecting tables between each use
- Ducats – priority only – includes mental health groups and individual clinical contacts
- Visiting – none
- Family visiting – none
- Legal visits – urgent/emergency, via telephone or video conference where available. Board of Parole Hearings will continue with attorney contacts as required
- Workers – critical and porters
- Showers – maintain distancing and disinfect between each use
- Health care services - conduct rounds in housing units
- Medication(s) distribution – Wardens, please work with your CEO's to establish a process, recommend if cell feeding, medication line is conducted within the unit. If doing controlled feeding within the dining halls, utilize medication windows on the yard
- Law Library – PLU or paging option while maintaining social distancing in library
- Dayroom – numbers need to be reduced to allow for increased social distancing which may result in no dayroom activities if unable to maintain social distancing numbers to accommodate showers and phones

- Recreation - One housing unit/dorm at a time
- Canteen is permitted – if unable to accommodate during scheduled yard time facilitate delivery method
- Packages are permitted
- Phone calls are permitted - disinfect between each use
- Religious programs shall be cell front or deliver materials to housing unit/dorm/cells
- Educational materials to be provided either cell front or to dorm
- Request for Health Care Services Forms, CDCR-Form 7362, will be distributed and picked up in the housing units by staff

During this time, I would like to see our Community Resource Managers and Education Department facilitate the delivery of increased games, program materials, reading books, or other items to the housing units. Housing unit/dorm officers and supervisors are expected to conduct additional rounds and spot checks of inmates in an effort to reduce self-harm and/or suicide attempts.

All institutions will be required to provide a copy of their Program Status Report, Part-A, to their respective Associate Director each day for this 14-day period. Institutions are expected to brief staff and inmate advisory committees on this directive as this modified program is currently only slated to be in effect for 14-days, through April 21, 2020.

During the past couple of weeks there have been some best practices coming forward that I would like to see implemented or considered such as placing markers on the ground in six foot intervals as a reminder for staff and inmates to maintain social distancing, and the placement of acrylic glass (e.g. Plexiglas) at staff entrances as a barrier between the screener and the person entering the prison.

Thank you for you continued efforts in managing this COVID-19 event. If you have any additional questions, please contact your respective Associate Director.

CONNIE GIPSON
Director
Division of Adult Institutions

cc: Kimberly Seibel
Patrice Davis
Justin Penney

State of California Department of Corrections and Rehabilitation

Memorandum

Date: April 7, 2020

To: Wardens
Principals
Vice Principals

Subject: **CLARIFICATION REGARDING MODIFIED PROGRAMMING IN RESPONSE TO COVID-19**

The purpose of this memorandum is to provide clarification to the institution schools regarding suggested modifications and guidance to support programming and services as a result of the COVID-19 pandemic.

Materials and Supplies
Under the direction of the warden, school administrators and/or teachers shall coordinate with the warehouse manager and be available to receive from the warehouse staff educational equipment, supplies and materials.

Hardback/Hardcover Books
A memorandum regarding the use of hardback/hardcover textbooks distributed in August 2019 advised that these types of books are permissible only in education areas (i.e., classrooms) and are not permissible in housing units. Due to COVID-19, a temporary exception may be made to this policy, to allow inmate access to educational material for College, CTE, Adult Basic Education, and English Language Development. Hardbound textbooks may be provided to enrolled students for use in the housing units on class assignments so long as a signed Trust Account Withdrawal Form is completed and submitted to the teacher. This exception would be at the discretion of the Warden and may vary based upon safety concerns at some level IV institutions.

Library Services
Following the direction of the local warden on how to best provide access to the library, below are some possible options for meeting inmate patron need.

At some institutions, inmate patrons may continue to physically come to the library. If that is the case, please maintain social distancing of six feet when possible between staff and inmate patrons and among inmate patrons. When there is a need for library staff to interact with inmates at a proximity less than six feet, please use protective measures include wearing gloves and washing hands frequently. As able, please clean and sanitize surfaces between sessions.

Inmates may access the library and law library in groups of no greater than ten and so long as social distancing is maintained, at the direction of the warden. At those institutions where inmate patrons are not authorized to physically go to the Library/Law Library, paging service is to be provided. In order to assist with paging in this emergency, it is authorized for Library

Technical Assistants to have temporary access to Lexis Advance. Priority Legal User (PLU) requests, case citations, and copy requests should be sent by institutional mail to the library, including a signed trust withdrawal. The requests are to be reviewed by library staff within seven days. Granted requests will be sent to inmate patrons by institutional mail. Requests that are not granted shall be returned to the inmate patrons by institutional mail with information on what needs to be changed in order to grant the request. Priority during this period will be requests made by PLU status inmate patrons.

Recreational reading books shall be available for check out using institutional mail. Inmate patrons should send a signed trust withdrawal form along with a specific title or genre. Library staff shall check one book out to inmate patrons and return by institutional mail. A new book will not be provided until the first book is returned.

Developmental Disability Program (DDP) inmates shall continue to be offered a library orientation within the first 30 days of their arrival at an institution. If unable to bring the inmate to the library, library staff may either provide orientation at cell front or provide the inmate a written orientation. The orientation shall include explaining what paging is and how the DDP inmate may access it. Working with other DDP staff, library staff shall also identify the DDP inmates at their institution who have already received orientation and provide additional information, namely how paging works. DDP staff shall assist DDP inmates with reading and scribing forms/documents.

College

The Office of Correctional Education (OCE) partners with the California Community College Chancellors Office (CCCCO) to provide college at CDCR institutions. Positive programming keeps institutions safer and reduces recidivism. It is requested that each institution continue to support college classes as much as feasible so that college students have an opportunity to finish the semester.

Students in face-to-face courses will be transitioning to correspondence modality for the remainder of the semester. As feasible at each institution, college coordinators/PSCE teachers shall work with the college liaison for in-person direct transfer of materials rather than mailing. Security review of the materials proceed. Institutions should not require written approval of packets or other materials prior to distribution to students. Completing the semester will also require that college coordinators proctor final exams. The colleges will work with each institution to determine how exams can be proctored in a way that maintains staff and inmate health and safety.

As the CDCR response to COVID-19 evolves, decisions regarding future semesters will proceed. The goal of CDCR is to continue supporting face-to-face college classes for students as agency and state response to COVID-19 evolves.

Recreation Programs
Physical Education teachers shall coordinate with school administrators to continue outdoor physical education and recreation programs to the extent possible while maintaining social distancing. Where feasible, indoor recreation activities for inmates may continue in areas able to maintain social distancing for groups of fewer than ten participants. The Physical Education teacher will be responsible for ensuring all equipment used for recreation activity is sanitized following use.

If you have any questions regarding this memorandum, please contact:

Library and Law Library Services: Brandy Buenafe at Brandy.Buenafe@cdcr.ca.gov
Curriculum and Instruction: Martin Griffin at Martin.Griffin@cdcr.ca.gov
Post-Secondary Education: Sarita Mehtani at Sarita.Mehtani@cdcr.ca.gov
Student Support Services: Alicia Legarda at Alicia.Legarda@cdcr.ca.gov

You may also contact your OCE Regional Associate Superintendent:

Central Region	Southern Region	Northern Region
Rod Braly	Jennie Wynn	Jennifer Winistorfer
(916) 708-7398	(916) 508-5954	(916) 217-7643
Rod.Braly@cdcr.ca.gov	Jennifer.Wynn@cdcr.ca.gov	Jennifer.Winistorfer@cdcr.ca.gov

CONNIE GIPSON
Director
Division of Adult Institutions

BRANT R. CHOATE, Ed.D
Director
Division of Rehabilitative Programs

cc: Shannon Swain
Kimberly Seibel
DAI Associate Directors
Ryan Souza
Hillary Iserman

ATTACHMENT G

CALIFORNIA CORRECTIONAL
HEALTH CARE SERVICES

MEMORANDUM

Date:	April 10, 2020
To:	Secretary Ralph DIaz
From:	J. Clark Kelso, Receiver
Subject:	CCHCS Guidelines for Achieving and Maintaining Social Distancing in California Prisons

In the face of the ongoing COVID-19 pandemic, California Correctional Health Care Services (CCHCS) will continue to be guided by the developing scientific and medical consensus regarding social distancing in correctional settings, as well as by the Receiver's authority under the Order Appointing Receiver and the applicable regulatory provisions of Title 15 of the California Code of Regulations. Accordingly, the Receiver has determined that CCHCS and California Department of Corrections and Rehabilitation (CDCR) should implement the following steps in their ongoing efforts to mitigate the risks associated with transmission of the COVID-19 coronavirus.

1. CDCR should not authorize or undertake any further movements of inmates between institutions to achieve necessary social distancing without the approval of Health Care Placement Oversight Program (HCPOP) in consultation with the CCHCS public health team. Inter-institution moves risk carrying the virus from one institution to another.

2. The Center for Disease Control's "Interim Guidance on Management of Coronavirus Disease 2019 (COVID-19) in Correctional and Detention Facilities," dated March 23, 2020 (https://www.cdc.gov/coronavirus/2019-ncov/community/correction-detention/guidance-correctional-detention.html), recommends maintaining social distance of 6 feet between inmates while acknowledging that "Strategies will need to be tailored to the individual space in the facility and the needs of the population and staff. Not all strategies will be feasible in all facilities." Necessary social distancing is already being achieved in both single- and double-celled units. In double cells, cell mates constitute one another's "social distancing cohort" for correctional purposes and are analogous to a family unit in the free world. With respect to housing in dorm settings, the Receiver has determined that necessary social distancing can be achieved by creating 8-person housing cohorts. Each cohort is to be separated from the others by a distance of at least six feet in all directions.

3. Any movement of inmates out of the dorms to achieve necessary cohort social distancing must be coordinated with, and may not occur without the concurrence of,

MEMORANDUM

HCPOP to ensure to the extent feasible that such movement does not cause, contribute to or exacerbate the potential spread of the disease.

4. CCHCS will continue to monitor developments closely and will modify these guidelines as necessary and appropriate.

CALIFORNIA CORRECTIONAL
HEALTH CARE SERVICES

MEMORANDUM

Date:	April 12, 2020
To:	Secretary Ralph Diaz
From:	J. Clark Kelso, Receiver
Subject:	CCHCS Guidelines for Achieving and Maintaining Social Distancing in California Prisons

This memorandum supplements my memorandum dated April 10, 2020 and clarifies my intention regarding the steps set forth in that memorandum.

I had not intended for my April 10, 2020 memorandum to affect any inter-institution transfers that are to address either medical, mental health, or dental treatment needs that are not available at the sending institution, such as to provide a higher level of care or to reduce or prevent morbidity or mortality, or a safety or security issue that cannot be managed by the sending institution.

If you have any questions, please do not hesitate to contact me.

ATTACHMENT H

Pictures of Social Distancing Markings at CDCR Institutions

Richard J. Donovan Correctional Facility

Richard J. Donovan Correctional Facility

California Men's Colony- East Clinic Waiting Area

California Correctional Institution- Facility C

Chuckawalla Valley State Prison

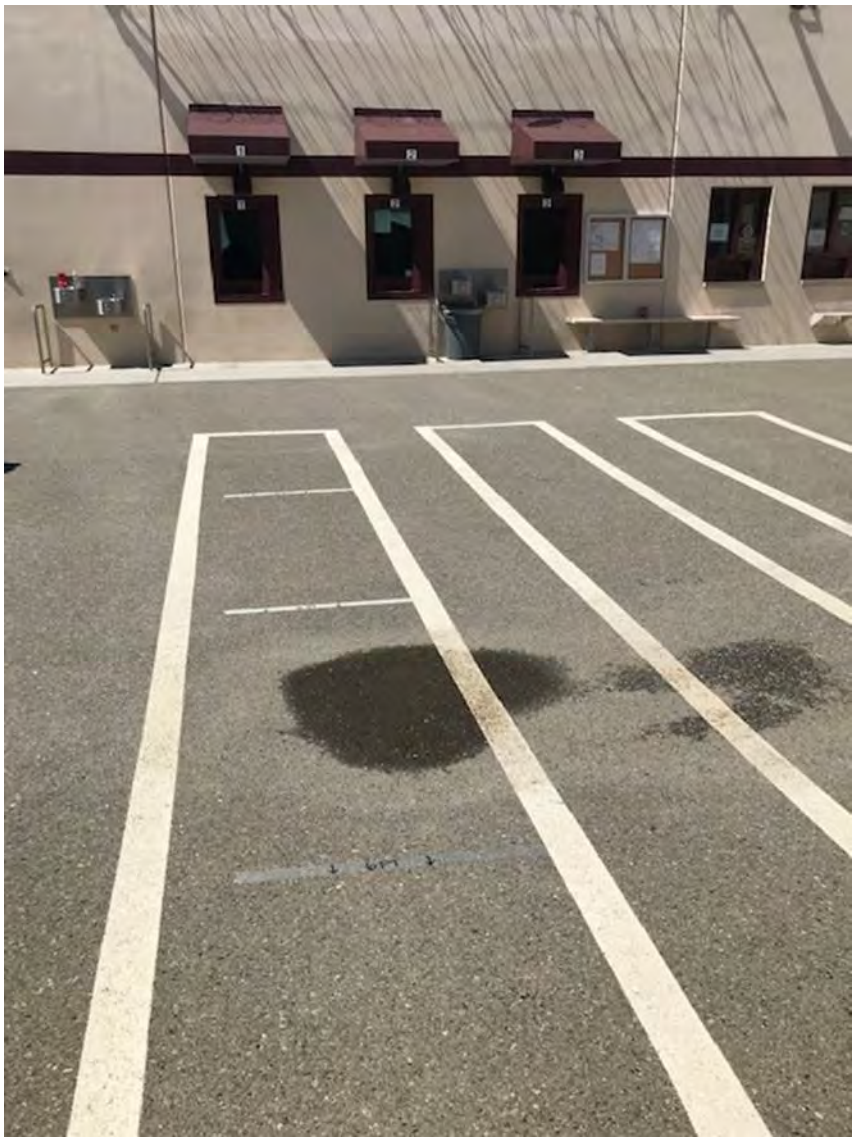
Salinas Valley State Prison- Facility D

Salinas Valley State Prison- Facility D

California Institution for Women

Central California Women's Facility

California Substance Abuse Treatment Facility and State Prison, Corcoran



California Substance Abuse Treatment Facility and State Prison, Corcoran

ATTACHMENT I

DIVISION OF ADULT INSTITUTIONS
P.O. Box 942883
Sacramento, CA 94283-0001

March 17, 2020

Dear Program Service Providers:

The California Department of Corrections and Rehabilitations (CDCR) is dedicated to the safety of everyone who lives in, works in, and visits our state prisons. For the safety and protection of the incarcerated population; volunteers; and staff, effective March 17, 2020, all volunteer-led inmate activity group programs are suspended. This will restrict all volunteers from entering the institutions until further notice.

The Department remains agile in our response to addressing COVID-19, with safety being the top priority. I would like to express my appreciation for your patience and understanding through these challenging times.

For the latest information regarding CDCR's preparedness efforts for the novel coronavirus (COVID-19) please visit the CDCR COVID-19 Preparedness page at www.cdcr.ca.gov/covid19.

CDCR has activated an email box, COVID19@cdcr.ca.gov to answer questions from the public, employees, and stakeholders related to COVID-19. This email address will be monitored and questions will be triaged to the appropriate divisions.

Sincerely,

CONNIE GIPSON
Director
Division of Adult Institutions

ATTACHMENT J

EXECUTIVE DEPARTMENT
STATE OF CALIFORNIA

EXECUTIVE ORDER N-33-20

WHEREAS on March 4, 2020, I proclaimed a State of Emergency to exist in California as a result of the threat of COVID-19; and

WHEREAS in a short period of time, COVID-19 has rapidly spread throughout California, necessitating updated and more stringent guidance from federal, state, and local public health officials; and

WHEREAS for the preservation of public health and safety throughout the entire State of California, I find it necessary for all Californians to heed the State public health directives from the Department of Public Health.

NOW, THEREFORE, I, GAVIN NEWSOM, Governor of the State of California, in accordance with the authority vested in me by the State Constitution and statutes of the State of California, and in particular, Government Code sections 8567, 8627, and 8665 do hereby issue the following Order to become effective immediately:

IT IS HEREBY ORDERED THAT:

1) To preserve the public health and safety, and to ensure the healthcare delivery system is capable of serving all, and prioritizing those at the highest risk and vulnerability, all residents are directed to immediately heed the current State public health directives, which I ordered the Department of Public Health to develop for the current statewide status of COVID-19. Those directives are consistent with the March 19, 2020, Memorandum on Identification of Essential Critical Infrastructure Workers During COVID-19 Response, found at: https://covid19.ca.gov/. Those directives follow:

ORDER OF THE STATE PUBLIC HEALTH OFFICER
March 19, 2020

To protect public health, I as State Public Health Officer and Director of the California Department of Public Health order all individuals living in the State of California to stay home or at their place of residence except as needed to maintain continuity of operations of the federal critical infrastructure sectors, as outlined at https://www.cisa.gov/identifying-critical-infrastructure-during-covid-19. In addition, and in consultation with the Director of the Governor's Office of Emergency Services, I may designate additional sectors as critical in order to protect the health and well-being of all Californians.

Pursuant to the authority under the Health and Safety Code 120125, 120140, 131080, 120130(c), 120135, 120145, 120175 and 120150, this order is to go into effect immediately and shall stay in effect until further notice.

The federal government has identified 16 critical infrastructure sectors whose assets, systems, and networks, whether physical or virtual, are considered so vital to the United States that their incapacitation or

destruction would have a debilitating effect on security, economic security, public health or safety, or any combination thereof. I order that Californians working in these 16 critical infrastructure sectors may continue their work because of the importance of these sectors to Californians' health and well-being.

This Order is being issued to protect the public health of Californians. The California Department of Public Health looks to establish consistency across the state in order to ensure that we mitigate the impact of COVID-19. Our goal is simple, we want to bend the curve, and disrupt the spread of the virus.

The supply chain must continue, and Californians must have access to such necessities as food, prescriptions, and health care. When people need to leave their homes or places of residence, whether to obtain or perform the functions above, or to otherwise facilitate authorized necessary activities, they should at all times practice social distancing.

2) The healthcare delivery system shall prioritize services to serving those who are the sickest and shall prioritize resources, including personal protective equipment, for the providers providing direct care to them.

3) The Office of Emergency Services is directed to take necessary steps to ensure compliance with this Order.

4) This Order shall be enforceable pursuant to California law, including, but not limited to, Government Code section 8665.

IT IS FURTHER ORDERED that as soon as hereafter possible, this Order be filed in the Office of the Secretary of State and that widespread publicity and notice be given of this Order.

This Order is not intended to, and does not, create any rights or benefits, substantive or procedural, enforceable at law or in equity, against the State of California, its agencies, departments, entities, officers, employees, or any other person.

IN WITNESS WHEREOF I have hereunto set my hand and caused the Great Seal of the State of California to be affixed this 19th day of March 2020.

GAVIN NEWSOM
Governor of California

ATTEST:

ALEX PADILLA
Secretary of State

ATTACHMENT K

CALIFORNIA CORRECTIONAL HEALTH CARE SERVICES

MEMORANDUM

Date:	March 26, 2020
To:	California Department of Corrections and Rehabilitation (CDCR) All Staff California Correctional Health Care Services (CCHCS) All Staff
From:	*Original Signed By* Connie Gipson Director, Division of Adult Institutions California Department of Corrections and Rehabilitation *Original Signed By* Barbara Barney-Knox, MBA, MA, BSN, RN Deputy Director of Nursing (A), Statewide Chief Nurse Executive (A) California Correctional Health Care Services *Original Signed By* Heather C. Bowlds Psy.D. Deputy Director Department of Corrections & Rehabilitation Juvenile Justice, Health Care Services
Subject:	**NOVEL CORONAVIRUS DISEASE 2019 (COVID-19) and INFLUENZA-LIKE-ILLNESS FACILITY ENTRANCE SCREENING**

The purpose of this memorandum is to direct all staff and visitors entering California Department of Corrections and Rehabilitation (CDCR) correctional institutions shall be screened for Novel Coronavirus Disease 2019 (COVID-19) and Influenza-Like-Illness (ILI) symptoms. All staff and visitors shall have a measurement of their temperature prior to being allowed access into the correctional facility or any other assigned location. Staff shall follow all screening requirements for CDCR and our community partners.

The screening will begin on Friday, March 27, 2020, during third watch. At this time the CDC has not released any recommendations for the use of PPE for screening. Out of an abundance of caution, screeners shall be offered surgical masks, eye protection and hand sanitizer. Screening shall be performed at the points of entry agreed upon by CDCR and California Correctional Health Care Services (CCHCS). Each institution shall reduce points of entry to a minimum.

Nursing staff shall perform temperature measurements during the first two hours of every shift. Thereafter, Custody staff shall notify nursing if additional screening is required.

MEMORANDUM

Each point of entry shall have two touch free infrared thermometers. An additional thermometer shall be available as a backup unit in case of thermometer failure. This would make three thermometers per point of entry. Extra batteries for each unit shall be available at all times to the screeners. Training on the use of the touch free thermometers will be forthcoming on Lifeline.

- This screening shall include 1 and 2 below:

    1. Symptom questions:
        - Do you have a new or worsening cough?
        - Do you have a fever?
        - Do you have new or worsening difficulty breathing?

    2. Temperature measurement

Staff performing temperature screening shall use the following recommendations:

- Use of a surgical mask, eye protection and hand sanitizer.
- If there is no physical contact with an individual or body fluid contamination, the PPE does not need to be changed before the next check.
- Staff performing symptoms screening more than 6 feet away from the individual being screened do not need to wear PPE.
    - Individuals with no symptoms of COVID-19 or ILI, and a temperate measured less than 100.0 Fahrenheit shall be granted entry into in the CDCR correctional institution.
    - Individuals who respond "yes" to any COVID-19 or ILI questions and/or has a temperate measured equal or greater than 100.0 Fahrenheit shall be denied entry into in the CDCR correctional institution.
    - Individuals who respond "no" to any of the COVID-19 or ILI questions but have observed symptoms shall have further triage with a nurse. Based on the clinical judgement of the nurse, the employee may be denied entry into the CDCR correctional facility, and a recommendation to follow up with their personal medical provider given.
    - Individuals who respond "yes" to any COVID-19 or ILI questions that may be related to underlining medical conditions, shall have further triage with the nurse. Based on the clinical judgement of the nurse, the employee may be allowed entry into the CDCR correctional facility.
    - Individuals screened by a non-health care staff member with a temperature measuring 100.0 Fahrenheit or greater shall have a secondary evaluation by a licensed health care staff member.
- Employees denied entry will follow established procedure for notifying their supervisor of their absence.

Thank you all for your cooperation and support of this intervention to keep our staff and our patients healthy. By working together, we can guard against the spread of COVID-19 in our workplace, in our communities, and in our families.

ATTACHMENT L

Memorandum

Date: April 8, 2020

To: Associate Directors, Division of Adult Institutions
Wardens
Chief Executive Officers
Chiefs of Mental Health
Chief Psychiatrists
Senior Psychiatrists, Supervisors

Subject: **REVISED RESTRICTED HOUSING, RECEPTION CENTERS, PSYCHIATRIC INPATIENT PROGRAM PHONE CALLS**

This memorandum is in response to the Coronavirus (COVID-19) and current allowable phone call privileges for inmates housed in restricted housing, Reception Centers (RCs), and Psychiatric In-Patient Programs (PIPs). The Division of Adult Institutions (DAI) recognizes the need for inmates to be able to maintain communication with family and friends and is taking proactive measures in an effort to assist inmates with increased communication.

This memorandum is to provide direction in regards to providing inmates housed in restricted housing, RCs, and PIPs the ability to make phone calls above their current privilege group. Wardens are directed to implement these additional phone call privileges. Institutions will utilize the current inmate phone equipment that already exists. Precautions are to be taken for both staff and inmate safety to include procedures to limit risk of exposure and transmittal of illness from inmate to inmate as phone calls are provided.

General strategies for providing all restricted housing, RC and PIP inmates' phone calls will need to be tailored by each respective institution based on physical plant design along with taking the following recommendations into consideration:

- All Non-Disciplinary Segregation (NDS) inmates will be allowed to make a phone call once a week (currently NDS A inmates are permitted one phone call a week, and NDS B inmates are permitted one phone call a month)
- All other inmates in restricted housing units will be allowed to make a phone call once every two weeks (currently no phone calls are permitted)
- C status inmate will be allowed to make a phone call once every two weeks
- RC inmates will be provided one phone call a week (currently one phone call within first seven days of arrival and one phone call per month afterwards)
- PIP inmates will be allowed to make one phone call a week unless restricted by the Interdisciplinary Treatment Team with clinical justification documented in the health record

As a result of COVID-19, the Office of Correctional Education, the Division of Rehabilitative Programs (DRP) classes, and Visiting have been temporarily closed. Correctional staff assigned to the Office of Correctional Education, DRP, or visiting positions as an example may be redirected to help facilitate the phone calls in the RCs, restricted housing units, and PIPs.

This policy memorandum will remain in effect until this COVID-19 crisis is no longer in effect or rescinded.

This situation remains fluid and ever changing, thank you for your patience and cooperation. If you have any questions, please contact Justin Penney, Special Assistant to Deputy Director, Facility Operations, DAI, at (916) 323-1029 or Justin.penney@cdcr.ca.gov.

CONNIE GIPSON
Director
Division of Adult Institutions

EUREKA C. DAYE, Ph.D., MPH, MA, CCHP
Deputy Director (A)
Statewide Mental Health Program

cc: Kimberly Seibel
Patrice Davis
Justin Penney
Angela Ponciano
Michael Golding
Travis Williams
Laura Ceballos
Mental Health Regional Administrators
Regional Health Care Executives

Memorandum

Date: April 13, 2020

To: Associate Directors, Division of Adult Institutions
Wardens
Chief Executive Officers
Chiefs of Mental Health
Chief Psychiatrists
Senior Psychiatrists, Supervisors

Subject: **REVISED RESTRICTED HOUSING, RECEPTION CENTERS, PSYCHIATRIC INPATIENT PROGRAM PHONE CALLS**

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General strategies for providing all restricted housing, RC and PIP inmates' phone calls will need to be tailored by each respective institution based on physical plant design along with taking the following recommendations into consideration:

- All Non-Disciplinary Segregation (NDS) inmates will be allowed to make a phone call at least once a week (currently NDS A inmates are permitted one phone call a week, and NDS B inmates are permitted one phone call a month)
- All other inmates in restricted housing units will be allowed to make a phone call at least once every week (currently no phone calls are permitted)
- C status inmate will be allowed to make a phone call at least once every week
- RC inmates will be provided at least one phone call a week (currently one phone call within first seven days of arrival and one phone call per month afterwards)
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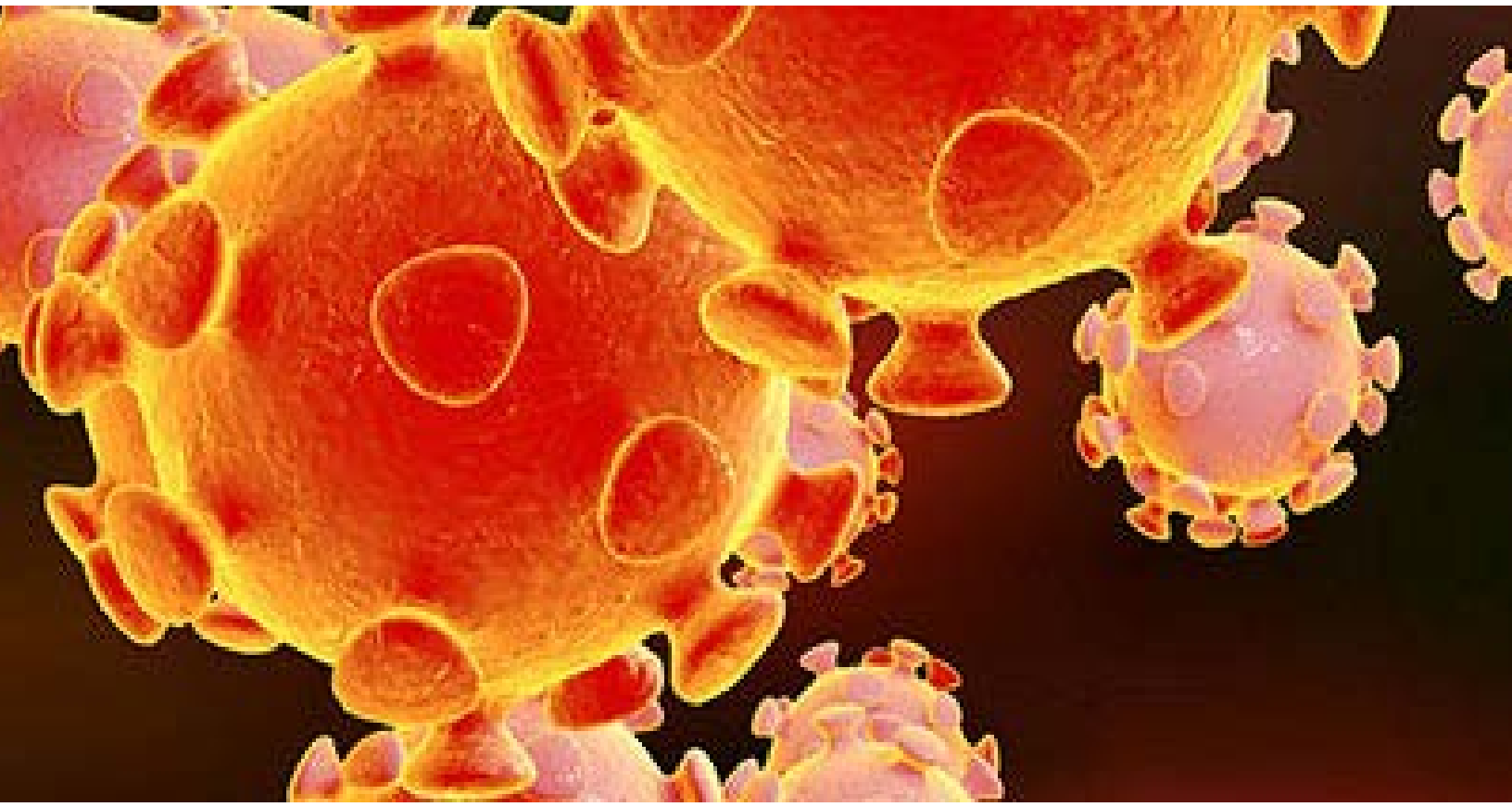
CONNIE GIPSON
Director
Division of Adult Institutions

EUREKA C. DAYE, Ph.D., MPH, MA, CCHP
Deputy Director (A)
Statewide Mental Health Program

cc: Kimberly Seibel
Patrice Davis
Justin Penney
Angela Ponciano
Michael Golding
Travis Williams
Laura Ceballos
Mental Health Regional Administrators
Regional Health Care Executives

ATTACHMENT M

COVID-19: Interim Guidance for Health Care and Public Health Providers



Public Health Nursing Program

Version 2.0

CALIFORNIA CORRECTIONAL
HEALTH CARE SERVICES

Table of Contents

ACRONYM LIST

AHRQ	Agency for Healthcare Research and Quality
AIDS	Acquired Immune Deficiency Syndrome
AOD	Administrative Officer of the Day
AIIR	Airborne infection isolation room
BMI	Body Mass Index
CCHCS	California Correctional Health Care Services
CDC	Centers for Disease Control and Prevention
CDCR	California Department of Corrections and Rehabilitation
CDPH	California Department of Public Health
CLIA	Clinical Laboratory Improvement Amendments
CME	Chief Medical Executive
CNE	Chief Nurse Executive
COVID-19	Coronavirus Disease 2019
DON	Director of Nurses
EHRS	Electronic Health Record System
EPA	Environmental Protection Agency
HCP	Heath Care Personnel
HCW	Health Care Worker
HIV	Human Immunodeficiency Virus
HLOC	Higher Level of Care
ICN	Infection Control Nurse
ILI	Influenza-like illness
LHD	Local Health Department
MDI	Metered-dose Inhalers
NCPR	Nurse Consultant Program Review
NIOSH	National Institute for Occupational Safety and Health
NP	Nasopharyngeal
OSHA	Occupational Safety and Health Administration
OEHW	Office of Employee Health and Wellness OEHW
OP	Oropharyngeal
PPE	Personal protective equipment
PAPR	Powered air purifying respirator
PORS	Preliminary Report of Infectious Disease or Outbreak form
PHB	Public Health Branch
PHN	Public Health Nurse
PhORS	Public Health Outbreak Response System
QM	Quality Management
RIDT	Rapid Influenza Diagnostic Test
RSV	Respiratory syncytial virus
RT-PCR	Reverse Transcription Polymerase Chain Reaction
RTWC	Return to Work Coordinator
TAT	Turnaround time
URI	Upper Respiratory Infection
VCM	Viral Culture Media
WHO	World Health Organization

RECORD OF CHANGES

Version 2.0 Changes:

Diagnostic Testing includes updated lab test names, ordering instructions for Coronavirus Disease 2019 (COVID-19) and rapid influenza point of care testing, new stability data, Saturday pick-ups, and a new testing algorithm.

The Treatment section was expanded.

Transmission information was updated to highlight possible asymptomatic shedding.

A definition was added for the end of a COVID-19 outbreak.

Updated isolation and quarantine distancing to include space shortages.

Additional clarification was added regarding reporting and notifications.

Additional PPE scenarios were added.

The General Infection Control Precautions section was updated to include supply shortage strategies.

Expanded Contact Investigation section.

Evaluation and Treatment Algorithm for suspect and confirmed COVID-19 patients.

The criteria for release from isolation was changed to require COVID-19 laboratory testing based on updated CDC guidance.

The guidance for when patients are paroling during the outbreak has been expanded.

Environmental control guidance has been expanded.

This document serves to provide INTERIM guidance for the clinical management of SARS-CoV-2 virus pandemic at CDCR facilities. Due to the quickly changing guidelines from the Centers for Disease Control (CDC), the World Health Organization (WHO), and other scientific bodies, information may change rapidly and will be updated in subsequent versions. Revision dates are located at the bottom left of the document. Substantive changes will be posted to the website if occurring before release of updated versions.

This guidance supersedes the COVID-19 Interim Guidance for Health Care and Public Health Providers, Document 1.0.

This guidance supersedes the 2019 Seasonal Influenza Guidance except where noted.

INTRODUCTION

Coronaviruses are a large family of viruses that are common in many different species of animals; some coronaviruses cause respiratory illness in humans. COVID-19 is caused by the novel (new) coronavirus SARS-CoV-2. It was first identified during the investigation of an outbreak in Wuhan, China, in December 2019. Early on, many ill persons with COVID-19 were linked to a live animal market indicating animal to person transmission. There is now evidence of person to person spread, as well as community spread (i.e., persons infected with no apparent high risk exposure contact). On March 11, 2020, the WHO recognized COVID-19 to be a pandemic.

CLINICAL MANIFESTATIONS / CASE PRESENTATION OF COVID-19

People with COVID-19 generally develop signs and symptoms, including respiratory symptoms and fever, 5 days (average) after exposure, with a range of 2-14 days after infection.

Typical Signs and Symptoms

- **Common:** Fever, dry cough, fatigue, shortness of breath.
- **Less common:** sputum production, sore throat, headache, myalgia or arthralgia, chills.
- **<5% occurrence:** nausea, vomiting, diarrhea, nasal congestion
- **Note:** 50% of cases are afebrile at time of testing, but develop fever during the course of the illness. Therefore, patients may not be febrile at initial presentation.

Mild to Moderate Disease

Approximately 80% of laboratory confirmed patients have had mild to moderate disease, which includes non-pneumonia and pneumonia cases. Most people infected with COVID-19 related virus have mild disease and recover.

Severe Disease

Approximately 14% of laboratory confirmed patients have severe disease (dyspnea, respiratory rate ≥30/minute, blood oxygen saturation ≤93%, and/or lung infiltrates >50% of the lung field within 24-48 hours).

Critical Disease

Approximately 6% of laboratory confirmed patients are critical (respiratory failure, septic shock, and/or multiple organ dysfunction/failure).

Older patients and patients with co-morbid conditions (see list below) are at higher risk of mortality and morbidity with COVID-19.

Persons at High Risk for Severe Morbidity and Mortality from COVID-19 Disease*	
Age >65	Most important risk factor and risk increases with each decade
Diabetes	All carry increased risk if uncontrolled
Hypertension	
Cardiovascular disease	
Chronic lung disease or moderate to severe asthma	
Chronic Kidney Disease	ESRD/Hemodialysis and End Stage Liver Disease carry increased risk
Liver Disease/Cirrhosis	
Cerebrovascular disease	
Cancer	
Immunocompromised patients	Transplants, immune deficiencies, HIV, Prolonged use of corticosteroids, chemotherapy or other immunosuppressing medications
Severe obesity (Body mass index [BMI] > 40)	
Pregnancy	
Patients with multiple chronic conditions	
Consider those patients categorized as High Risk in the Quality Management (QM) Master Registry QM Master Registry. For more information on the risk definitions for each condition, see: Clinical Risk Condition Specifications	
*Quality Management has released a COVID-19 Registry and Patient Risk Assessment Tool. The COVID-19 registry lists every patient at a specific institution and indicates which risk factors apply to each patient. **The registry is updated twice daily** and draws from multiple data sources, including the electronic health record system, claims data, and the Strategic Offender Management System (SOMS) to compile risk factor data. This tab of the registry also includes release date information for each individual, in the even that patients are considered for early release during the pandemic. Please refer to the COVID-19 Registry.	

DIFFERENTIAL DIAGNOSIS

All patients presenting with influenza-like illness (ILI) should be tested using the approach detailed below. Fevers can be intermittent or absent. Dyspnea is not always perceived. Hence, a low threshold for identifying ILI, especially for those with cough, should be enacted.

Influenza is currently still widespread in California. The Respiratory syncytial virus (RSV) season generally coincides with that of influenza. Regardless of the known disease signs, symptoms, and epidemiology that may distinguish influenza or other viral respiratory infections from COVID-19, **no clinical factors can be relied upon to rule out COVID-19** and laboratory testing is required.

When influenza is no longer prevalent in the community, it is less likely to be the cause of ILI. Until California Department of Public Health (CDPH) downgrades influenza transmission to "sporadic" for the region where your institution is located, assume influenza is prevalent (see CDPH Weekly Influenza Report). In 2019, influenza remained widespread through early April, regional in mid-April, and sporadic in May

RSV testing is indicated if it will affect clinical management. Consider testing for RSV in vulnerable populations, including those with heart or lung disease, bone marrow and lung transplant recipients, frail older adults, and those with multiple underlying conditions.

Please refer to the California Correctional Health Care Services (CCHCS) Public Health Branch Influenza Guidance Document for further direction on Influenza diagnosis and management and the California Department of Public Health's webpage on Influenza and other respiratory pathogens.

DIAGNOSTIC TESTING

Testing for influenza and the virus that causes COVID-19 is important for establishing the etiology of ILI. **During the COVID-19 pandemic, testing for respiratory pathogens shall be ordered by providers as part of the evaluation of all patients with ILI.** See Figure 1 for the testing algorithm and more details in the text below.

To be inclusive of the need for testing with both influenza and COVID-19 in the differential, ILI can be defined by having a fever >100ºF, OR cough OR unexplained/new dyspnea.

Two approaches can be taken to testing: concurrent COVID-19 and influenza testing; or a tiered approach using a point of care influenza test followed by COVID-19 testing if the influenza test is negative.

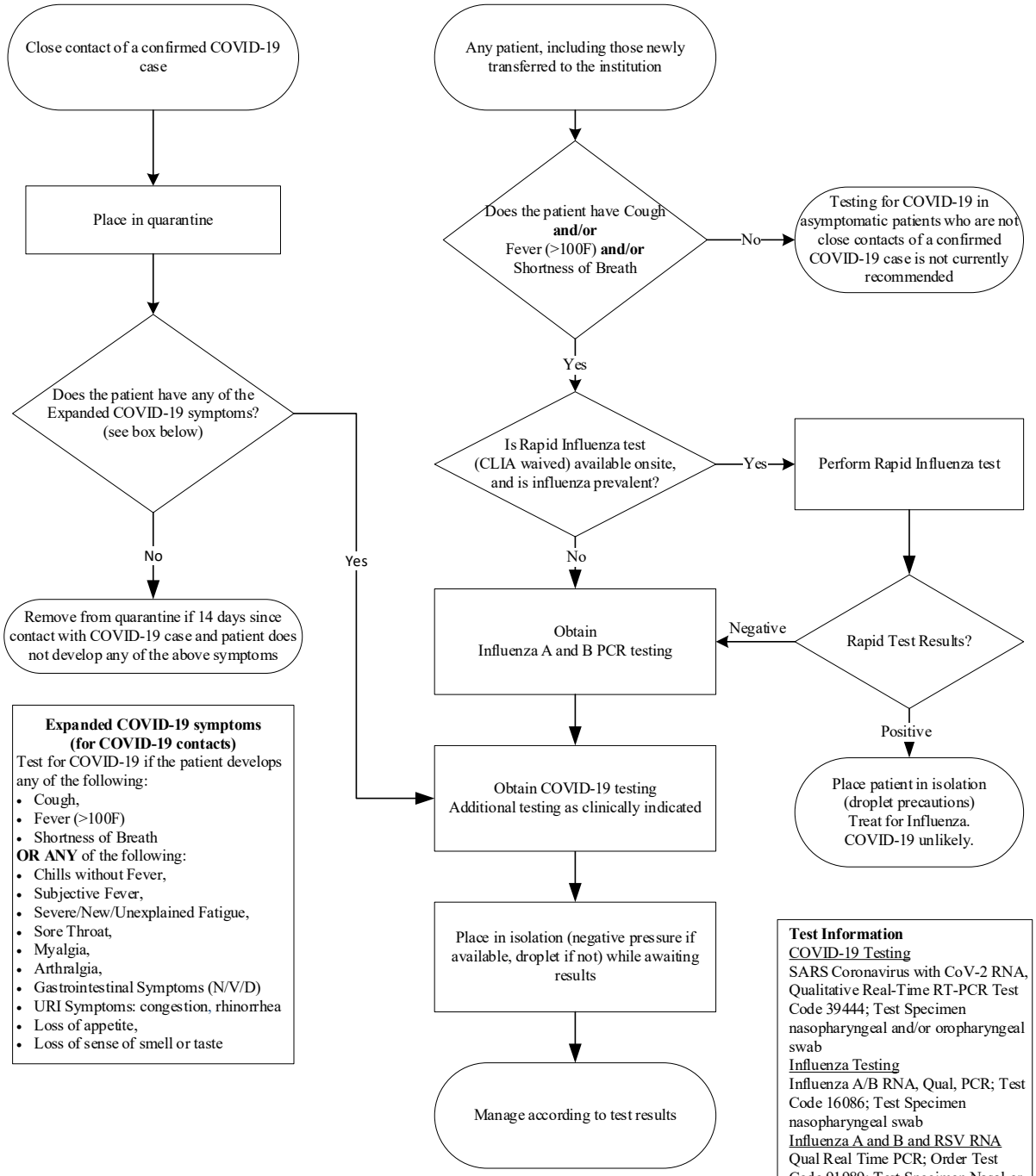
The following patients should be tested immediately for COVID-19:

- Patients who are close contacts of confirmed cases (should be in quarantine) who develop any symptoms of illness, even if mild or not classic for COVID-19. Such symptoms include: chills without fever/subjective fever, severe/new/unexplained fatigue, sore throat, myalgia, arthralgia, gastrointestinal symptoms (Nausea/Vomiting/Diarrhea/loss of appetite), upper respiratory infection (URI) symptoms like nasal/sinus congestion and rhinorrhea, and loss of the sense of smell or taste.

Patients without symptoms do not need testing at this time. This guidance may change with emerging science.

Clinicians should use their judgment in testing for other respiratory pathogens.

FIGURE 1: ALGORITHM FOR RESPIRATORY VIRAL TESTING IN SYMPTOMATIC PATIENTS



Note: Guidelines cannot replace personalized evaluation and management decisions based on individual patient factors

RAPID INFLUENZA CLINICAL LABORATORY IMPROVEMENT AMENDMENTS (CLIA) WAIVED DIAGNOSTIC TEST (RIDT)

Please refer to RIDT ordering instructions.

While influenza remains prevalent, rapid test kits for point of care influenza testing may be used to quickly identify influenza infections. Patients with influenza or a respiratory ailment of another etiology are unlikely to be co-infected with COVID-19 related virus. Therefore, COVID-19 testing is unnecessary if influenza is confirmed.

1. If RIDT is available at your facility and influenza prevalence is high, test symptomatic patients.

    a. RIDT is only useful for ruling in influenza when prevalence is high. When the CDPH specifies that **influenza transmission has downgraded to "sporadic" for your institution's geographic area, DO NOT USE the RIDT tests** any longer and instead use only the reverse transcription polymerase chain reaction (RT-PCR). CDPH Weekly Influenza Report

    b. Headquarters Public Health Branch (PHB) will send notification of when RIDT is no longer useful due to decreased prevalence in your geographic area.

2. Due to unreliable sensitivity, if the RIDT result is negative, further testing is always indicated. Order the influenza A/B RNA Qualitative PCR and COVID-19 RNA Qualitative PCR (see below).

COVID-19 TESTING

IMPORTANT: COVID-19 RT-PCR testing should be ordered as "ASAP". Please do not order as "routine" (delays one week) or "STAT" (will not process). Please refer to the COVID-19 Testing Fact Sheet on Lifeline.

CDC recommends that specimens should be collected as soon as possible once a suspect case is identified, regardless of the time of symptom onset.

For initial diagnostic testing for COVID-19, **the preferred specimen is a nasopharyngeal (NP) swab**. Only one swab is needed and the NP specimen has the best sensitivity. Oropharyngeal (OP) swabs may also be obtained. NP or OP swabs should be collected in a Viral Culture Media (VCM) tube (green-cap provided by Quest). E-swabs (system kit with swab collection and medium all-in-one) may be used if VCM is not available.

Testing both NP and OP further increases sensitivity. If collecting both a NP and OP swab, they both can be put in the same VCM tube. When testing supplies/swabs are in short supply, test using only one NP specimen.

Please note: Use a separate order and collect a separate specimen for each viral test being conducted (e.g., one or two swabs for influenza, and one or two swabs for SARS-CoV-2 RT-PCR).

Patients may self-swab. The patient should be educated that NP is best, however, if NP is too challenging, a nares samples may be collected. ONLY FOAM SWABS can be used for NARES collection: for example: Puritan 6' Sterile Standard Foam Swab w/ Polystyrene Handle.

Nares Collection instructions: Use a single foam swab for collecting specimens from both nares of a symptomatic patient. Insert foam swab into 1 nostril straight back (not upwards). Once the swab is in place, rotate it in a circular motion 2 times and keep it in place for 15 seconds. Repeat this step for the second nostril using the same swab. Remove foam swab and insert the swab into an acceptable viral transport medium listed in this guide.

NP Swab Technique: Insert the swab into one nostril parallel to the palate, gently rotating the swab inward until resistance is met at the level of the turbinates; rotate against the nasopharyngeal wall (approximately 10 sec) to absorb secretions.

Please note: Sputum inductions are not recommended as a means for sample collection.

Quest is accepting specimens for SARS-CoV-2 RNA, Qualitative Real-Time RT-PCR testing (Enter "covid" into the order search menu and choose: "**CoV-2 RNA Qual RT-PCR**" in Cerner; Quest Test Code: **39444**). ***Order as "ASAP".***

1. Samples can be sent to Quest Monday through Saturday. There is NO Sunday pick up.
2. Preferred specimen: NP swab or OP swab collected in, VCM medium (green-cap) tube. If collecting two swabs, both can be put in one transport medium tube.
3. Separate NP/OP Swab: Collect sample using a separate NP or OP swab for other tests (i.e., influenza test) requiring NP or OP swab. DO NOT COMBINE swabs in one tube for both COVID-19 and influenza test.
4. Storage and Transport: COVID-19 specimens are stable at room temperature (not >77°F) or refrigerated (35.6°F between 46.4°F) for 5 days.
5. Frozen (-20°C or -68°F) specimens are stable for 7 days.
6. Follow standard procedure for storage and transport of refrigerated samples.
7. Cold packs/pouches must be utilized if samples are placed in a lockbox.
8. COVID-19 is not a STAT test and a STAT pick-up cannot be ordered.
9. Turnaround time (TAT), published as 3-4 days, may be delayed initially due to high demand

Testing policy may change as CDC recommendations change. See: CDC Guidelines for Collecting, Handling and Testing Clinical Specimens

PRECAUTIONS FOR SPECIMEN COLLECTION:

- When collecting diagnostic respiratory specimens (e.g., NP swab) from a possible COVID-19 patient, the Heath Care Personnel (HCP) in the room should wear an N-95 respirator, eye protection, gloves, and a gown during collection HCP present during the procedure

should be limited to only those essential for that patient's care and procedure support. Specimen collection should be performed in a normal examination room with the door closed.

- Clean and disinfect procedure room surfaces promptly as described in the environmental infection control section of the CDC Interim Infection Prevention and Control Recommendations for Patients with Suspected or Confirmed Coronavirus Disease 2019 (COVID-19) in Healthcare Settings

OTHER DIAGNOSTICS

Chest X-ray, CT scans, and lab testing (e.g., CBC, D-Dimer, CRP and Procalcitonin) are generally used in the inpatient setting and found to assist in prediction of progression to respiratory failure.

TREATMENT

While certain medications show the potential to have modest benefit, at this point the treatment of COVID-19 is largely supportive. Key treatment considerations are below:

- Oxygen: use if needed to maintain O_2 saturation at or above 92% or near baseline.

  *Note: the use of **routine nasal cannula or face tent is preferred** to high-flow nasal cannula as the latter has the potential to aerosolize respiratory droplets.*

- Analgesia and antipyretics: consider acetaminophen and/or NSAIDs if needed and not contraindicated.

  Note: there have been theoretical concerns about the use of NSAIDs for fever or pain in COVID-19, however clinical data have not demonstrated an increased risk of adverse outcomes and the WHO has clarified that is does not recommend against NSAID use in patients with COVID-19.

- Bronchodilators: if bronchodilators are needed (i.e. reactive airway disease or wheezing and respiratory distress), nebulized medications should be avoided given the potential to aerosolize the virus; **metered-dose inhalers (MDIs) are preferred** and older clinical data suggest equivalence between MDIs and nebulized medications in patients who are able to use them.

- IV fluids: IVFs are not needed for most patients but dehydration can occur due to nausea and vomiting or lack of appetite. Those in need for IVF due to inability to take oral hydration or in suspected sepsis should immediately be transferred to a higher level of care (HLOC).

- Corticosteroids: many patients in China received steroids for severe COVID-19, however the clinic benefit of steroids is not clear and there is data for other respiratory pathogens suggesting prolonged viral shedding in patients receiving steroids; **currently steroids are not recommended** and most US providers are not using them unless clinically indicated for another reason.

- Antivirals:

- Hydroxychloroquine: favorable toxicity profile, demonstrates potent *in* vitro *activity* but currently has limited clinical data (below); if no contraindications, providers could consider using hydroxychloroquine to treat COVID-19 in patients with lower respiratory tract infections requiring hospitalization (as some other health systems are doing).
    - Dose: 400mg PO q12 x2 on day one, then 200mg PO q12 on days 2-5
    - Dosing in renal dysfunction: no adjustment
    - Pregnancy/lactation: no known risk in limited human data
    - Adverse effects: QTc prolongation, hemolytic anemia in those with G6PD deficiency, increased risk of hypoglycemia in patients with diabetes on glucose-lowering agents

  Note: a retrospective study of 26 patients receiving hydroxychloroquine (with or without azithromycin for bacterial superinfection) compared to 16 untreated controls in patients with COVID-19 showed shortened viral shedding but 6 patients in the treatment arm were dropped due from the analysis with poor outcomes (death, transfer to ICU, no follow up) and clinical outcomes have not been reported.

  Note: chloroquine suspected to have similar activity but availability is limited

- Lopinavir/ritonavir (Kaletra): showed no improvement in clinical outcomes or the duration of viral shedding in a placebo controlled trial of patients with severe COVID-19.
- Remdesivir: experimental IV therapy (not FDA approved) that showed no efficacy against Ebola but does have potent *in vitro* activity against SARS-CoV-2; is currently only available through a compassionate use protocol and as part of a phase II clinical trial.

TRANSMISSION

The virus is thought to spread mainly from person-to-person via infected droplets. This direct transmission occurs between people who are in close proximity with one another (within 3.6 feet). The policy for 6 foot distancing has been adopted to be conservative. When an infected individual breathes, coughs, or sneezes, infectious respiratory droplets land in the mouths, noses or airways of people who are nearby.

The virus is highly transmissible, even when only having mild symptoms. Viral shedding is highest around the time of symptom onset.

More evidence is emerging regarding asymptomatic transmission. Studies have demonstrated viral shedding 1 to 3 days prior to symptom onset. Among patients infected with COVID-19 who were asymptomatic at the time of testing, the mean time to symptom development was 3 days. Further, among patients whose infection has resolved, viral shedding may continue for two or more weeks after recovery. Transmission from asymptomatic individuals has been demonstrated

and may be responsible for 6-13% of COVID-19 cases. The infectious period for this virus is now considered to be 48 hours prior to symptom onset.

Airborne transmission (virus suspended in air or carried by dust that may be transported further than 6 feet from the infectious individual) is a possible mode of transmission, but not currently thought to be a major driver of the pandemic However, aerosol generating procedures will cause significant airborne transmission.

Contact transmission is when a person becomes infected with the COVID-19 virus by touching a contaminated surface (fomite) or person, and then touching their own mouth, nose, or their eyes. Research shows longevity of viable virus particles on fomites, but infectiousness of this modality is unclear at this time

Fecal shedding during and after symptom resolution has been found; however, the infectiousness of the fecal viral particles is unclear.

COVID-19 RELATED PUBLIC HEALTH DEFINITIONS

TABLE 1: CASE DEFINITIONS

CONFIRMED COVID-19 CASE	A positive laboratory test for the virus that causes COVID-19 in at least one respiratory specimen. The tests no longer need to be confirmed by CDC
CONFIRMED INFLUENZA CASE	A positive point-of-care or laboratory test for influenza virus in a respiratory specimen in a patient with influenza-like illness
SUSPECTED COVID-19 / INFLUENZA CASE HIGH SUSPECT	**HIGH SUSPECT**: Any fever, respiratory symptoms, or evidence of a viral syndrome in a patient who had close (within 6 feet and prolonged [generally ≥30 minutes]) contact with a confirmed case of COVID-19 within 14 days of onset **OR** Linkage to a high risk group defined by public health during an outbreak (for example: an affected dorm, housing unit, or yard) but without a test result for COVID-19
SUSPECTED COVID-19 / INFLUENZA CASE LOW SUSPECT	**LOW SUSPECT**: Fever **OR** cough **OR** shortness of breath (dyspnea) with evidence of a viral syndrome (ILI) of unknown etiology in a person without test results for COVID-19 or influenza and without high-risk exposure

TABLE 2: NON-CASE DEFINITIONS

ASYMPTOMATIC CONTACT OF COVID-19	A person without symptoms who has had close (within 6 feet and prolonged [generally ≥30 minutes]) contact with a confirmed COVID-19 case **OR** Direct contact with secretions with a confirmed case of COVID-19 within the past 14 days, who has had no symptoms of COVID-19 AND who has had no positive tests for COVID-19
ASYMPTOMATIC CONTACT OF INFLUENZA	A person who has had close contact (within 6 feet) with an infectious influenza case within the past five days
CONTACT OF A CONTACT	The contact of an asymptomatic contact is NOT to be included in the exposure cohort. The patient does not need to wear a mask. Health care workers do not need PPE

OUTBREAK OF COVID-19

Two or more confirmed cases of COVID-19 in patients with symptom onset dates within 14 days of each other in the same housing unit OR at least one confirmed case of COVID-19 in a patient with epidemiological linkage (e.g., close contact during infectious period) to another confirmed COVID-19 case in a patient or a staff member at the same institution.

CLOSE CONTACT	Within 6 feet and prolonged [generally ≥30 minutes]) contact with a confirmed case of COVID-19 within 14 days of onset Examples: – Occupying the same 2-4 bed unit as the infected case – Occupying adjacent beds in a large ward with the infected case – Sharing indoor space, e.g., classroom, friends, groups, yard, or shower – Exposure to the infected case in an entire housing unit(s) where the infected case was housed while infectious – Being directly coughed or sneezed upon (even though may be transient encounter) – Inmate worker/volunteer caring for a patient with COVID-19 without PPE – Resident transferring from a facility with sustained COVID-19 transmission in the last 14 days

ISOLATION

Separation of ill persons who have a communicable disease (confirmed or suspected) from those who are healthy. People who have different communicable diseases (e.g., one patient with COVID-19 and one with influenza), or who may have different diseases should not be isolated together. Isolation setting depends on the type of transmission-based precautions that are in effect. For airborne precautions, an airborne infection isolation room (AIIR) is the ideal setting; a private room with a solid, closed door is an alternative. Precautionary signs and PPE appropriate to the level of precautions should be placed outside the door to the isolation room.

QUARANTINE

The separation and restriction of movement of well persons who may have been exposed to a communicable disease. Quarantine facilitates the prompt identification of new cases and helps limit the spread of disease by preventing new people from becoming exposed. In CDCR, patients who are quarantined are not confined to quarters, but they do not go to work or other programs. They may go to the dining hall as a group and go to the yard as a group, but not mix with others who are not quarantined. Social distancing between quarantined individuals should be implemented when at all possible.

COHORTING

Cohorting is the practice of grouping together patients who are infected with the same organism to confine their care to one area and prevent contact with other patients. It also can conserve respirator use in times of shortage. Cohorts are created based on clinical diagnosis, microbiologic confirmation when available, epidemiology, and mode of transmission of the infectious agent. When single patient rooms are not available, patients with a confirmed viral respiratory pathogen may be placed in the same room.

For more information on cohorting of isolated patients, CDC currently refers to the following: 2007 Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settingspdf icon, or https://www.cdc.gov/coronavirus/2019-ncov/hcp/respirators-strategy/conventional-capacity-strategies.html

PROTECTIVE SHELTER IN PLACE

During the COVID-19 pandemic, CCHCS institutions may implement additional measures to protect vulnerable patients who are at increased risk for severe COVID-19 disease (e.g., single-cell or protected housing area, limited movement, separate dining and yard time, and telemedicine services). Patients in protective shelter in place should be educated regarding their risk and how to protect themselves, early symptom recognition and request for medical attention, and the availability of testing for COVID-19. These patients are not on quarantine and do not need daily symptom surveillance rounds.

MEDICAL HOLD

Prohibition of the transfer of a patient to another facility except for legal or medical necessity. In CDCR, medical holds are employed for both isolation and quarantine.

END OF AN INFLUENZA OUTBREAK

- An influenza outbreak ends when there are no new cases in the housing unit for 5-7 days since the onset of symptoms in the last identified new case. Refer to CCHCS Influenza Guidance Document, 2019 Influenza Guidance.

END OF A COVID-19 OUTBREAK

- A COVID-19 outbreak ends when there are no new cases in the housing unit for 14 days since the onset of symptoms in the last identified new case.

INITIAL NOTIFICATIONS

- If health care or custody staff become aware of or observe symptoms consistent with COVID-19 (e.g., fever, cough, or shortness of breath) in a patient, staff person, or visitor to the institution, they should immediately notify the Public Health Nurse (PHN) or PHN alternate (often the Infection Control Nurse[ICN]).
    - For employee exposures, please refer to Health Care Department Operations Manual (HCDOM) section on Employee Exposure Control.

- When a patient with fever or cough or shortness of breath is identified, institutional processes for notification to the PHN or PHN alternated must be established for ongoing surveillance and reporting.
- Laboratory confirmed COVID-19 cases and suspect cases of COVID-19 shall immediately be reported to the PHN or PHN alternate by phone or Electronic Health Record System (EHRS) messaging.
- A patient with symptoms consistent with COVID-19 should be immediately referred to a provider for evaluation.
- If a patient has a confirmed case of COVID-19, the PHN, ICN, or designee should immediately notify institutional leadership, including the Chief Executive Officer (CEO), Chief Medical Executive (CME), Chief Nurse Executive (CNE), Warden, and Public Information Officer (PIO).
- Institutional leadership is responsible for notifying the Office of Employee Health and Wellness (OEHW) and Return to Work Coordinator (RTWC) of the possibility of employees exposed to COVID-19 related virus.

REPORTING

The PHN or PHN alternate is responsible for reporting of respiratory illness and outbreaks to the PHB and the local health department (LHD).

- Single or hospitalized cases of COVID-19, outbreaks of ILI, and influenza should be reported to the PHB via the Public Health Outbreak Response System (PhORS) http://pors/. Single cases of lab-confirmed influenza and single cases of ILI that result in hospitalization or death should be reported to PhORS.

- Confirmed COVID-19 cases should be immediately reported by telephone to the LHD. Outbreaks of COVID-19 should also be immediately reported to the LHD. Follow usual guidelines for reporting influenza to the LHD. CCHCS Influenza Guidance Document 2019 on Lifeline. See Appendix 11 for a LHD contact list.

- Notify CCHCS PHB immediately at CDCRCCHCSPublicHealthBranch@cdcr.ca.gov if there are significant developments at the institution (e.g., first time the institution is monitoring one or more contacts, first confirmed case at the institution, or first COVID-19 contact investigation at the institution.)
- The following events require same-day reporting to the COVID-19 SharePoint: https://cdcr.sharepoint.com/sites/cchcs_ms_phos. No report is needed if there are no new cases/contacts and no significant updates to existing cases/contacts.
    - **All new suspected and confirmed COVID-19 cases.**
    - **All new COVID-19 contacts.**
    - For previously reported cases: new lab results, new symptoms, new hospitalizations, transfers between institutions, discharges/paroles, releases from isolation, and deaths.

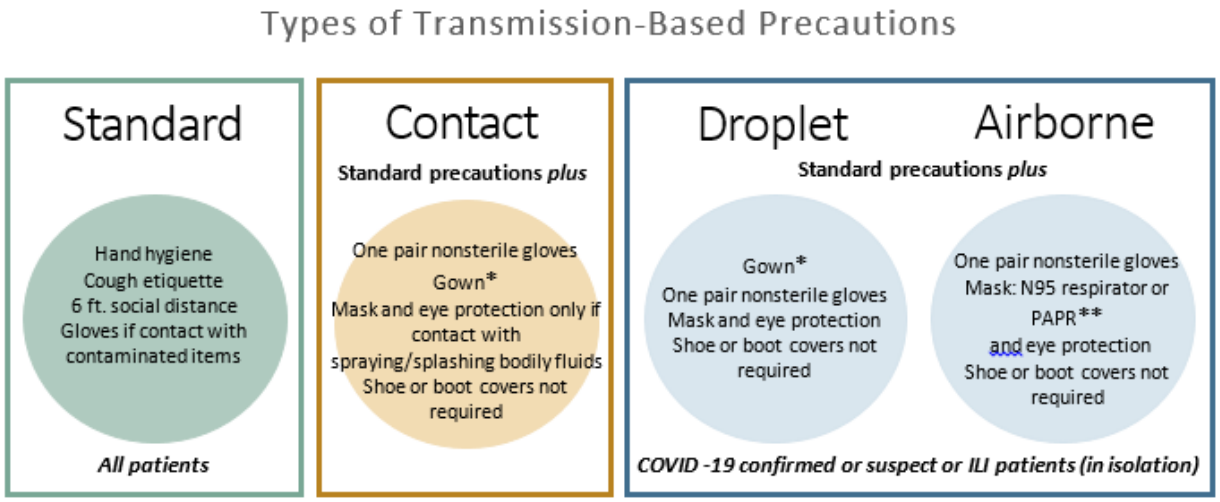
- For previously reported contacts of cases: new exposures, transfers between institutions, discharges/paroles, and releases from quarantine.

- Refer to the COVID-19 Case and Contact SharePoint Reporting tool (Appendix 5) for step-by-step instructions on using the tool and definitions.

COVID-19 INFECTION CONTROL PRECAUTIONS

As a general principle, at all times, staff and inmates should practice standard precautions and staff should be familiar with the different types of transmission-based precautions needed to protect themselves and perform their duties. See Table 3.

TABLE 3: STANDARD, AIRBORNE, AND DROPLET PRECAUTIONS PPE



** Due to shortages, Gowns will be reserved for specific procedures, e.g., aerosol generating and, transport of patients with respiratory symptoms.*

*** Due to shortages, N-95 respirators will be reserved for aerosol generating procedures, procedures generating splashes and sprays, procedures that are very close and involve prolonged exposure to a COVID-19 case, and vehicular transport of patients with respiratory symptoms*

PPE SCENARIOS FOR ILI, INFLUENZA, and COVID-19

This section describes the PPE recommended for several of the patient-care activities being conducted by staff. See Table 4 "Recommended Personal Protective Equipment (PPE) for Incarcerated/Detained Persons and Staff in a Correctional Facility during the COVID-19 Response."

During this time period, when there may be a shortage of some PPE supplies, consult Table 4 for suggested alternatives. When the recommendation is for a N95, surgical/procedure masks are acceptable alternative when the supply chain of respirators cannot meet the demand. The available N95 respirators should be prioritized for procedures that pose a high risk to staff. These procedures or activities include the following:

- **Procedures with splashes and sprays**
- **Aerosol generating procedures (anyone in the room)**
- **Procedures where very close or prolonged exposure to a COVID-19 case**
- **CDCR staff engaged in vehicle transport of patients with respiratory symptoms**

STAFF PPE FOR ILI / SYMPTOMATIC PATIENT

Patients presenting with ILI should be considered infectious for COVID-19 until proven otherwise. Standard, contact, droplet, and airborne precautions, plus eye protection are recommended for any patient with ILI symptoms. A N95 Respirator, gloves, gown, face shield or other eye protection are recommended. A N95 is preferred, however, based on potential supply shortages, surgical/procedure masks are an acceptable alternative when the supply chain cannot meet the demand. During this time, available N95s and gowns should be prioritized for health care workers (HCW) engaged in procedures that are likely to generate respiratory aerosols or HCWs and custody engaged in vehicle transport.

STAFF PPE FOR SUSPECTED AND CONFIRMED COVID-19 CASE

Standard, contact, droplet, and airborne precautions, plus eye protection are recommended for any patient with suspected or confirmed COVID-19 infection. A N95 Respirator, gloves, gown, face shield or other eye protection are the recommended PPE. A N95 is preferred, however, based on potential supply shortages, surgical/procedure masks are an acceptable alternative when the supply chain cannot meet the demand. During this time, available N95s and gowns should be prioritized for HCWs engaged in procedures that are likely to generate respiratory aerosols or HCWs and custody engaged in vehicle transport.

STAFF PPE FOR CONFIRMED INFLUENZA CASE

Standard, contact, and droplet precautions are recommended for patients with confirmed influenza. A surgical/procedure mask, gloves, and gown are the recommended PPE. During this time, if there is a shortage of gowns, gowns should be prioritized for HCWs engaged in procedures that are likely to generate respiratory aerosols or HCWs and custody engaged in vehicle transport.

STAFF PPE FOR SURVEILLANCE OF ASYMPTOMATIC CONTACT OF A CASE

Standard, contact, and droplet precautions are recommended. A surgical/procedure mask, eye protection, and gloves are the recommended PPE.

PPE FOR CONTACT OF A CONTACT

Standard precautions are sufficient for the patient who is a contact of a contact.

For further information on standard, contact, and airborne precautions:
Refer to HCDOM, Chapter 3 Article 8, Communicating Precautions from Health Care Staff to Custody Staff and
https://www.cdc.gov/coronavirus/2019-ncov/infection-control/infection-prevention-control-faq.html

N95 SHORTAGE GUIDANCE

- N95 and other disposable respirators should not be shared by multiple HCW.
- Existing CDC and National Institute for Occupational Safety and Health (NIOSH) guidelines recommend a combination of approaches to conserve supplies while safeguarding health care workers in such circumstances. https://www.cdc.gov/niosh/topics/hcwcontrols/recommendedguidanceextuse.html and https://www.cdc.gov/coronavirus/2019-ncov/hcp/respirators-strategy/index.html
    - **Extended use** refers to the practice of wearing the same N95 respirator for repeated close contact encounters with several different patients, without removing the respirator between patient encounters. Extended use is well suited to situations wherein multiple patients with the same infectious disease diagnosis, whose care requires use of a respirator, are cohorted (e.g., housed on the same hospital unit). HCP remove only gloves and gowns (if used) and perform hand hygiene between patients with the same diagnosis (e.g., confirmed COVID-19) while continuing to wear the same eye protection and respirator.
    - **Re-use** refers to the practice of using the same N95 respirator by one HCW for multiple encounters with different patients but removing it after each encounter. Restrict the number of reuses to the maximum recommended by the manufacturer or to the CDC recommended limit of no more than five uses per device.
    - To maintain the integrity of the respirator, it is important for HCP to hang used respirators in a designated storage area or keep them in a clean, breathable container such as a paper bag between uses. It is not recommended to modify the N95 respirator by placing any material within the respirator or over the respirator. Modification may negatively affect the performance of the respirator and could void the NIOSH approval.
    - All reusable respirators, must be cleaned and disinfected according to manufacturer's reprocessing instructions prior to re-use.
- Examples of N95 alternatives:
    - Powered air-purifying respirator (PAPR) which is reusable and has a whole/partial head and face shield breathing tube and battery operated blower and particulate filters, can be used if available. Loose fitting PAPRs do not require fit-testing and can be worn by people with facial hair. Do not use in surgical settings.
    - N95 respirators or respirators that offer a higher level of protection should be used (instead of a facemask) when performing or present for an aerosol-generating procedure. Such procedures should be prioritized in times of N95 shortages, and extended wear not employed.

When the supply chain is restored, staff should adhere to the PPE recommendations for specific transmission-based precaution.

TABLE 4. RECOMMENDED PERSONAL PROTECTIVE EQUIPMENT (PPE) FOR INCARCERATED/DETAINED PERSONS AND STAFF IN A CORRECTIONAL FACILITY DURING THE COVID-19 RESPONSE*

Classification of Individual Wearing PPE	N95 respirator	Surgical mask	Eye Protection	Hand Hygiene or Gloves (if contact)	Gown/ Coveralls
Incarcerated/Detained Persons					
Asymptomatic incarcerated/detained persons (under quarantine as close contacts of a COVID-19 case)	Apply face masks for source control as feasible based on local supply, especially if housed as a cohort				
Incarcerated/detained persons who are confirmed or suspected COVID-19 cases, or showing symptoms of COVID-19.		✓			
Incarcerated/detained persons in a work placement handling laundry or used food service items from a COVID-19 case or case contact.				✓	✓
Incarcerated/detained persons in a work placement cleaning areas where a COVID-19 case has spent time.	Additional PPE may be needed based on the product label.			✓	✓
Staff					
Staff having direct contact with asymptomatic incarcerated/detained persons under quarantine as close contacts of a COVID-19 case (but not performing temperature checks or providing medical care).		✓	✓	✓	
Staff performing temperature checks on any group of people (staff, visitors, or incarcerated/detained persons), or providing medical care to asymptomatic quarantined persons.		✓	✓	✓	
Staff having direct contact with symptomatic persons or offering medical care to confirmed or suspected COVID-19 cases.		✓**	✓	✓	
Persons accompanying any patients with respiratory symptoms in a transport vehicle.	✓		✓	✓	✓
Staff present during a procedure on a confirmed or suspected COVID-19 case that may generate respiratory aerosols and other procedures (e.g. COVID-19 testing, CPR, etc.) or high contact patient care (bathing, etc.).	✓		✓	✓	✓
Staff handling laundry or used food service items from a COVID-19 case or case contact				✓	✓
Staff cleaning an area where a COVID-19 case has spent time.	Additional PPE may be needed based on the product label.			✓	✓

* Table created using recommendations from the Centers for Disease Control and Prevention "Interim Guidance on Management of Coronavirus Disease 2019 (COVID-19) in Correctional and Detention Facilities", March 23, 2020.

** A NIOSH-approved N95 is preferred. However, based on local and regional situational analysis of PPE supplies, face masks are an acceptable alternative when the supply chain of respirators cannot meet the demand. During this time, available respirators should be prioritized for procedures that are likely to generate respiratory aerosols, which would pose the highest exposure risk to staff.

CONTROL STRATEGY FOR SUSPECTED AND CONFIRMED CASES OF COVID-19

ILI CASE AND OUTBREAK IDENTIFICATION

Currently, influenza and COVID-19 are prevalent. When patients from facilities are transferred from a facility with known influenza or COVID-19, they will not require quarantine unless notified by the sending facility that the patient has had a potential exposure. Incoming patients with a potential exposure should be quarantined for 14 days.

In new seasons, screening for ILI should begin as soon as seasonal influenza or COVID-19 is identified in any correctional facility. Patients should be triaged as soon as possible upon arrival to a facility (right after leaving the transportation bus) for symptom assessment prior to allowing patients to gather together in groups. If a patient presents with ILI symptoms, place a surgical facemask on the patient and isolate them until a health care provider can clinically assess and evaluate them.

For the control strategy for confirmed cases of influenza, see CCHCS Seasonal Influenza Infection Prevention and Control Guidance

CHECKLIST FOR IDENTIFYING COVID-19 SUSPECTS

- ☐ Examine test results provided by laboratory looking for positive COVID-19 and other communicable diseases requiring public health action.
- ☐ Examine COVID-19 tests ordered in the last 24 hours to identify patients with ILI.
- ☐ Examine TTA logs for patients who had respiratory symptoms.
- ☐ Coordinate with Utilization Management (UM) nurse on patients who are out to medical with ILI/pneumonia.
- ☐ Review the daily movement sheet to identify patients that may have been sent out for HLOC due to ILI/respiratory symptoms.
- ☐ Attend daily Patient Care (PC) clinic huddles, as time permits, to identify any patients being seen that day with complaints of ILI symptoms.
- ☐ Establish a sustainable process by which Public Health and Infection Control staff are notified of patients that are put on precautions for ILI after hours.

ILI/ SUSPECTED COVID-19 STRATEGIC CONTROL STEPS

- Immediately mask patients when COVID-19 is suspected. Surgical or procedure masks are appropriate for patients. If there is a shortage of surgical/procedure masks, have the patients use tissue when coughing and/or cloth/bandana.
- Patients should be placed in AIIR as soon as possible (can order in EHRS). If AIIR is not immediately available, the patient shall be placed in a private room with the door closed.

Appropriate signage indicating precautions and required PPE to enter should be visible outside the patient's room.

- Standard, contact, and airborne precautions plus eye protection should be implemented immediately (see Infection Control Precautions and PPE Scenarios). HCW should use a surgical/procedure mask, unless N95 respirators are in abundant supply.
- When possible, assign dedicated health care staff to provide care to suspected or confirmed cases.
- Ensure staff caring for or transporting patients with respiratory symptoms meeting criteria for suspected COVID-19 utilize appropriate PPE: Use procedure/surgical masks, unless N95 respirator or PAPR are in abundant supply, gloves, gown, and face shield covering sides and front of face or goggles. In times of respirator shortages
- Limit movement of designated staff between different parts of the institution to decrease the risk of staff spreading COVID-19 to other parts of the facility.
- Patients shall only be transported for emergent medically necessary procedures or transfers, and shall wear a surgical or procedure mask during transport. During vehicle transport, custody or HCW will use an N-95 mask for symptomatic patients. Limit number of staff that have contact with suspected and/or confirmed cases.
    - Assess and treat as appropriate soon-to-be released patients with suspected COVID-19 and make direct linkages to community resources to ensure proper isolation and access to medical care. Notify LHD of patients to be released who have suspect or confirmed cases and are still isolated. Case patients should not be released without the coordination of CDCR discharge planning and LHD guidance. See the "Parole and Discharge to the Community during a COVID-19 Outbreak" section of this document.
    - Once COVID-19 has been ruled out, airborne precautions can be stopped. Follow the CCHCS Influenza Guidance document for general ILI and Influenza management. http://lifeline/HealthCareOperations/MedicalServices/PublicHealth/Influenza/Ca-Seasonal-influenza-Guidance.pdf

ISOLATION

Promptly separate patients who are sick with fever or lower respiratory symptoms from well-patients. Patients with these symptoms should be isolated until they are no longer infectious and have been cleared by the health care provider.

- The preference is for isolation in a negative pressure room; second choice would be isolation in private room with a solid, closed door.
- When a negative pressure room or private, single room is not available, cohorting symptomatic patients who meet specific criteria is appropriate (see below). Groups of symptomatic patients can be cohorted in a separate area or facility away from well-patients. Possible areas to cohort patients could be an unused gym or section of a gym or chapel. When it is necessary to cohort patients in a section of a room or area with the general population of well-patients (e.g., dorm section) there should be at least 6 feet (3.6 feet minimum for severe space shortages) between

the symptomatic patients and the well patient population. Tape can be placed on the floor to mark the isolation section with a second line of tape 6 feet away to mark the well-patient section which can provide a visual sign and alert well-employees and patients to remain outside of the isolation section unless they are wearing appropriate PPE.

In order of preference, individuals under medical isolation should be housed:

- Separately, in single cells with solid walls (i.e., not bars) and solid doors that close fully
- Separately, in single cells with solid walls but without solid doors
- As a cohort, in a large, well-ventilated cell with solid walls and a solid door that closes fully. Employ social distancing strategies.
- As a cohort, in a large, well-ventilated cell with solid walls but without a solid door. Employ social distancing strategies.
- As a cohort, in single cells without solid walls or solid doors (i.e., cells enclosed entirely with bars), preferably with an empty cell between occupied cells. (Although individuals are in single cells in this scenario, the airflow between cells essentially makes it a cohort arrangement in the context of COVID-19.)
- As a cohort, in multi-person cells without solid walls or solid doors (i.e., cells enclosed entirely with bars), preferably with an empty cell between occupied cells. Employ social distancing strategies. Use tape to mark off safe distances between patients.
- Safely transfer individual(s) to another facility with available medical isolation capacity in one of the above arrangements.
    - (NOTE – Transfer should be avoided due to the potential to introduce infection to another facility; proceed only if no other options are available.)
- If the ideal choice does not exist in a facility, use the next best alternative.

If the number of confirmed cases exceeds the number of individual medical isolation spaces available in the facility, be especially mindful of cases who are at higher risk of severe illness from COVID-19. Ideally, they should not be cohorted with other infected individuals. If cohorting is unavoidable, make all possible accommodations to prevent transmission of other infectious diseases to the higher-risk individual. (For example, allocate more space for a higher-risk individual within a shared medical isolation space.)

- Note that incarcerated/detained populations have higher prevalence of infectious and chronic diseases and are in poorer health than the general population, even at younger ages.

Provide individuals under medical isolation with tissues and, if permissible, a lined no-touch trash receptacle. Instruct them to:

- **Cover** their mouth and nose with a tissue when they cough or sneeze.
- **Dispose** of used tissues immediately in the lined trash receptacle.

- **Wash hands** immediately with soap and water for at least 20 seconds. If soap and water are not available, clean hands with an alcohol-based hand sanitizer that contains at least 60% alcohol (where security concerns permit). Ensure that hand washing supplies are continually restocked.
    - Patients with ILI of unknown etiology should be isolated alone. If they cannot be isolated alone, they should be isolated with other sick patients from the same housing unit or other sick ILI patients of unknown etiology. When cohorting ILI patients, if at all possible, separate patients 6 feet from each other, with 3.6 feet minimum if space is limited.
    - Patients with confirmed COVID-19 or influenza can safely be isolated in a cohort with other patients who have the same confirmed diagnosis.
- Correctional facilities should review their medical isolation policies, identify potential areas for isolation, and anticipate how to provide isolation when cases exceed the number of isolation rooms available.
- If possible, the isolation area should have a bathroom available for the exclusive use of the identified symptomatic patients. When there is no separate bathroom available, symptomatic patients should wear a surgical or procedure mask when outside the isolation room or area, and the bathroom should be sanitized frequently.
- A sign should be placed on the door or wall of an isolation area to alert employees and patients. All persons entering the isolation room or areas need to follow the required transmission-based precautions.
- When possible, assign dedicated health care staff to provide care to suspected or confirmed cases.
- If a patient with ILI or confirmed COVID-19 or influenza must be moved out of isolation, ensure a surgical or procedure mask is worn during transport. Staff shall wear an appropriate respirator (or surgical mask in times of shortage) during transport of these patients.
- Facilities should also ensure that plans are in place to communicate information about suspect and confirmed influenza cases who are transferred to other departments (e.g., radiology, laboratory) or another prison or county jail.

MEDICAL HOLD

When a patient with a **suspected case of COVID-19 is identified**

- The patient should be isolated and placed on a medical hold.
- All patients housed in the same unit, and any other identified close contacts, should be placed on a medical hold as part of quarantine measures.
- If the contact with the case that occurred was a very high risk transmission, consideration can be given to a preliminary contact investigation as if it was a confirmed case, time and resources permitting.
- Separate and isolate any symptomatic contacts.

- Initiate surveillance measures detailed in the surveillance section.

  Any persons identified through the contact investigation to have symptoms, should be immediately reported to the headquarters PHB: CDCRCCHCSPublicHealthBranch@cdcr.ca.gov , and immediately isolated and masked.

- **If COVID-19 case is confirmed, initiate a contact investigation.**

CONTACT INVESTIGATION

Contact investigation for suspected COVID-19 cases should not be initiated while Influenza and COVID-19 test results are pending, except in consultation with the PHB (e.g., highly suspicious suspect case or multiple suspect cases with known contact to a confirmed case).

A contact investigation should be conducted for all confirmed cases of COVID-19.

- Determine the dates during the case-patient's infectious period during which other patients and staff may have been exposed (from 2 days [48 hours] prior to the date of symptom onset to the date the patient was isolated).
- Interview the case-patient to identify all close contacts based on exposure (within 6 feet for ≥30 minutes) during the infectious period
  - Identify all activities and locations where exposure may have occurred (e.g., classrooms, group activities, social activities, work, dining hall, day room, church, clinic visits, yard, medication line, and commissary line).
  - Determine the case-patient's movement history, including cell/bed assignments and transfers to and from other institutions or outside facilities.
  - Identify close contacts associated with each activity and movement.
- Use the COVID-19 Contact Investigation Tool (Appendix 6) and the Index Case-Patient Interview Checklist (Appendix 7) and to guide and document the interview and identification of the case-patient's close contacts.
- Determine the last date of exposure for each of the contacts for the purpose of placing them in quarantine for a full incubation period (14 days). If a contact is subsequently exposed to another confirmed COVID-19 case, the quarantine period should be extended for another 14 days after the last exposure.
- Initiate and submit a contacts line list to the PHB in the COVID-19 SharePoint. https://cdcr.sharepoint.com/sites/cchcs_ms_phos (see Reporting section above).
- Use the COVID-19 SharePoint contacts line list to track the date of last exposure, date the quarantine began, and the end date for quarantine.
- Asymptomatic contacts should be monitored for symptoms two times daily, unless severe staffing or resource issues necessitate once daily (see Management of Asymptomatic Contacts of COVID-19 below).
- Any contact who develops symptoms consistent with COVID-19 should be immediately isolated (see Isolation above).

Institutional leadership is responsible for notifying the OEHW and RTWC of the possibility of employees exposed to COVID-19.

MONITORING PATIENTS WITH SUSPECTED OR CONFIRMED COVID-19

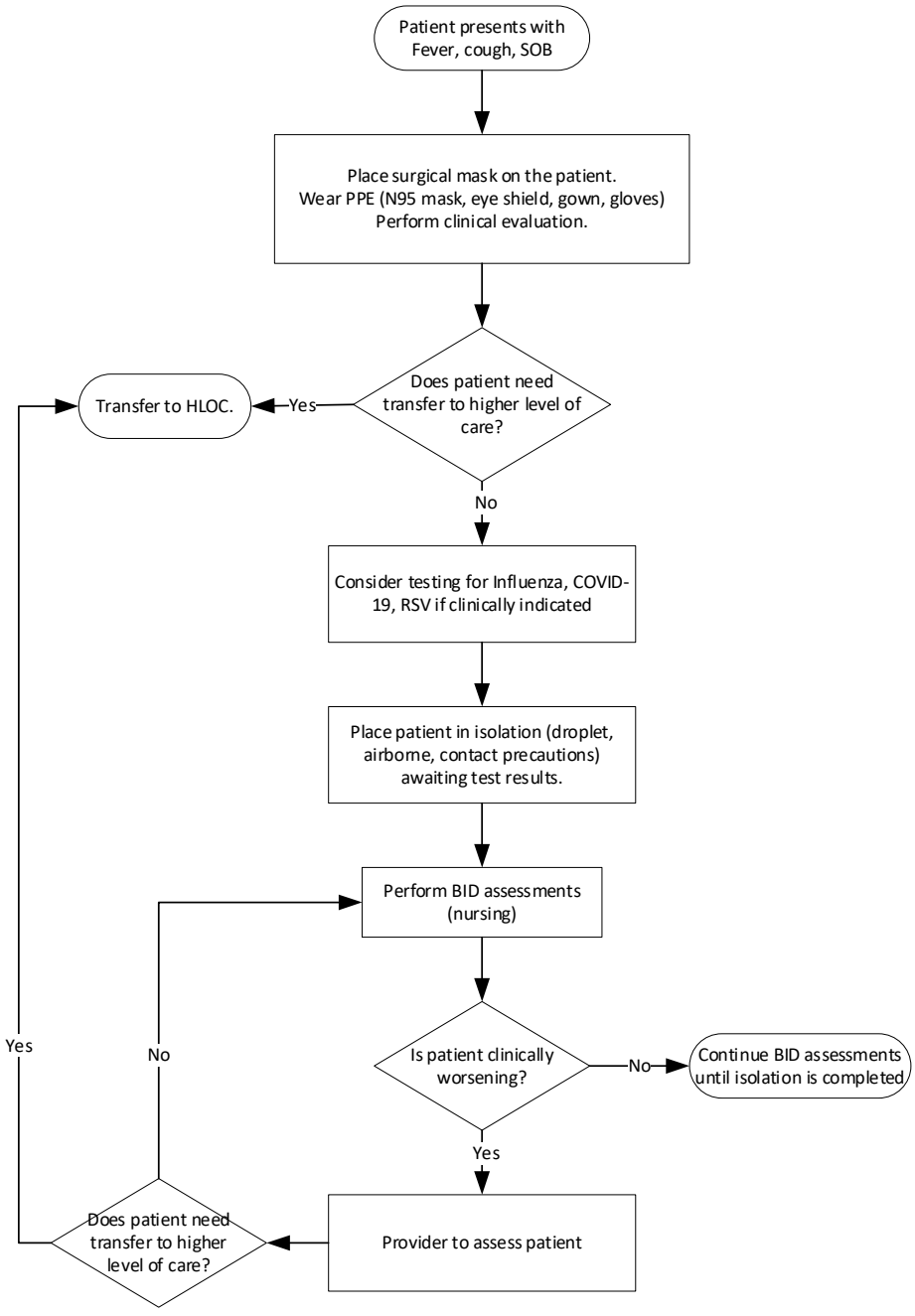
- Patients with suspected COVID-19 require a minimum of twice daily nursing assessment, including, but not limited to:
  - Temperature monitoring
  - Pulse oximeter monitoring
  - Blood pressure checks
  - Respiratory rate and heart rate
- Monitor patients for complications of COVID-19 infection, including respiratory distress and sepsis:
  - Fever and chills
  - Low body temperature
  - Rapid pulse
  - Rapid breathing
  - Labored breathing
  - Low blood pressure
  - Low oxygen saturation (highest association with the development of pneumonia)
  - Altered mental status or confusion

Patients with abnormal findings should be immediately referred to a provider for further evaluation.

- Keep in mind the risk factors for severe illness: older age and those with medical conditions described in the High Risk Conditions section of the document.
- Patients tend to deteriorate rapidly and may occur after a day of feeling better. Typical evolution of severe disease (based on analysis of multiple studies by Arnold Forest)
  - Dyspnea ~6 days post exposure.
  - Admission after ~8 days post exposure.
  - ICU admission/intubation after ~10 days post exposure.
  - This timing may be *variable* (some patients are stable for several days, but subsequently deteriorate rapidly)
  - Please refer to the COVID-19 Monitoring Registry which tracks patients either confirmed or suspected of COVID-19 infection. The COVID-19 Monitoring Registry helps health care staff stay apprised of COVID-19 testing results and ensure that rounding is occurring as required across shifts, as well flags certain symptoms, such as fever.

See algorithm on the following page regarding evaluation of suspect COVID-19 cases

Evaluation of COVID-19 Suspect Patients



RESPONSE TO A COVID-19 OUTBREAK

When one or more laboratory confirmed cases of COVID-19 have been reported, surveillance should be conducted throughout the institution to identify contacts. The institutional PHN and NCPR will confer and implement the investigation. A standardized approach to stop COVID-19

transmission is necessary by identifying people who have been exposed to a laboratory confirmed COVID-19 case.

Containment: Stopping transmission will require halting movement of exposed patients. The goal is to keep patients who are ill or who have been exposed to someone who is ill from mingling with patients from other areas of the prison, from food handling and duties in healthcare settings. Close as many affected buildings/units as needed to confine the outbreak. Remind patients not to share eating utensils, food or drinks. Stop large group meetings such as religious meetings and social events. Patients who are housed in the same affected building/unit may have pill line or yard time together.

Communication within the Institution: Establish a central command center to include CME, PHN, CNE, Director of Nurses (DON), ICN, Warden and key custody staff. Call for an Exposure Control meeting with the Warden, CME, Facilities Captains, Department Heads and Employee Union Representatives to inform them of outbreak, symptoms of disease, number of patients affected and infection control measures.

Reporting and Notification: As soon as outbreak is suspected, contact your Statewide Public Health Nurse Consultant by telephone or email within 24 hours. Complete the Preliminary Report of Infectious Disease or Outbreak form (PORS). Report outbreak by telephone to the Local Health Department as soon as possible to assist with contact investigation, if needed. If your facility is considering halting all movement in and out of your institution, please consult with the PHB warmline at (916) 691-9901.

Tracking: For the duration of the outbreak, collect patient information systematically to ensure consistency in the data collection process. Assign back up staff for days off, to be responsible for tracking cases and reporting.

CRITERIA FOR RELEASE FROM ISOLATION CONFIRMED COVID-19 CASES

1. Individuals with asymptomatic or symptomatic laboratory confirmed COVID-19 under isolation, considerations to discontinue Transmission-Based Precautions include:
    a. Negative results of an FDA Emergency Use Authorized molecular assay for COVID-19 from at least two consecutive N/P specimens collected ≥24 hours apart (total of 2 negative specimens).
2. **In cases where there is severe shortage of testing materials/swabs, then the clinical criteria designed for community home isolation may be used**:
    i. At least 7 days**(**minimum**) from after the onset of symptoms **AND**
    ii. At least 72 hours after resolution of fever without use of antipyretic medication **AND**
    iii. Improvement in illness signs and symptoms; *whichever is longer*

3. **CMEs may choose to lengthen the criteria time for symptom resolution to 14 days or beyond at their discretion.
4. Given studies showing prolonged shedding after resolution of symptoms, all patients should wear a surgical mask after release.

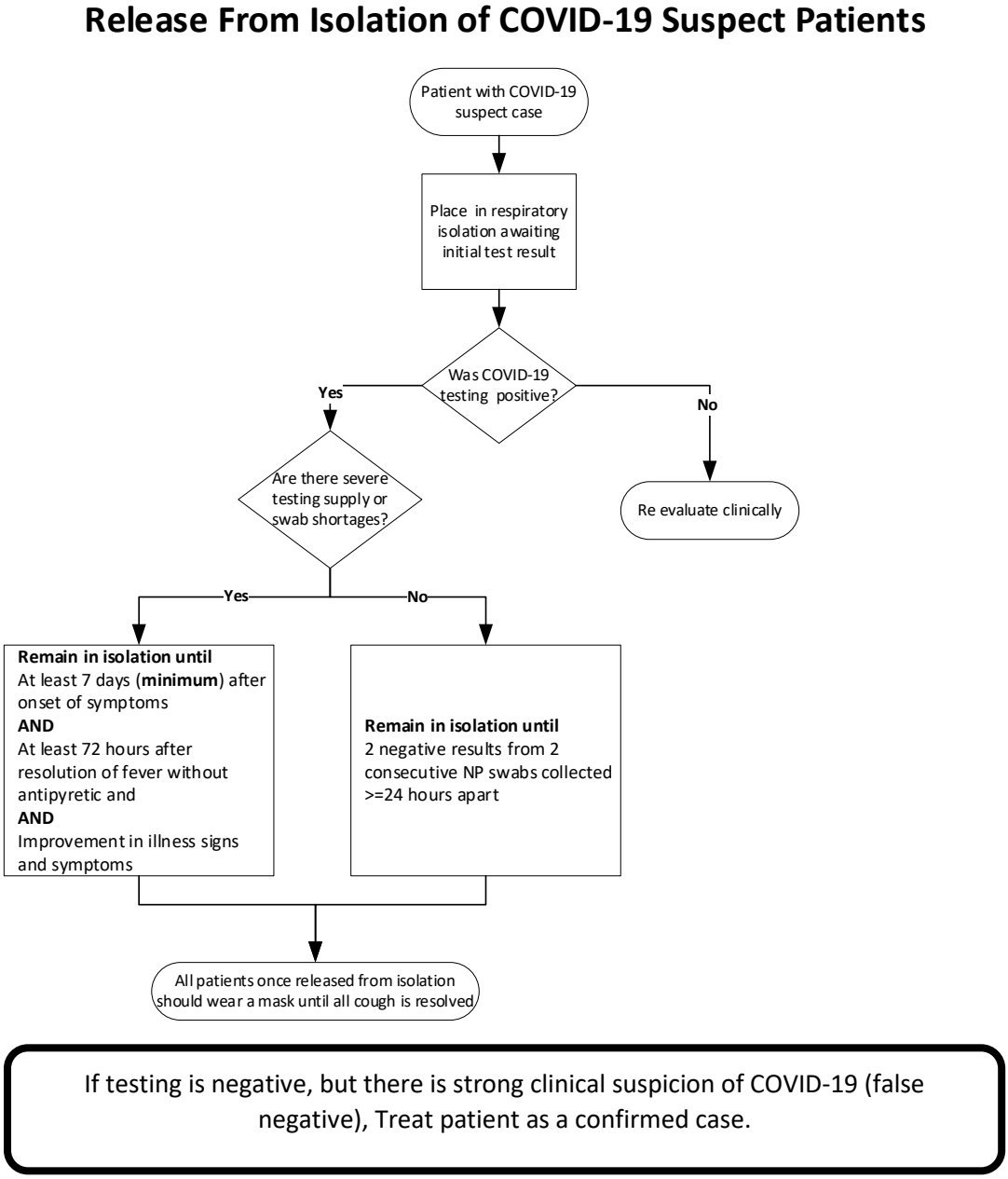
Resolution of cough, is not necessary, however people with residual cough should always wear a mask once released, until completely without cough.

Check for updates: https://www.cdc.gov/coronavirus/2019-ncov/hcp/disposition-hospitalized-patients.html

CRITERIA FOR RELEASE FROM ISOLATION CONFIRMED **INFLUENZA** CASES

Remain in isolation for 7 days from symptom onset and 24 hours after resolution of fever and respiratory symptoms

FIGURE 2: ISOLATION REQUIREMENTS OF PATIENTS WITH SUSPECT COVID-19 CASE



CONTROL STRATEGIES FOR CONTACTS TO CASES OF COVID-19

SURVEILLANCE OF ASYMPTOMATIC CONTACTS OF COVID-19 CASES

Patients with exposure to a confirmed or suspected COVID-19 case shall be placed in quarantine. If a suspected COVID-19 case tests negative for COVID-19 and clinicians release the suspected patient from COVID-19 protocols, quarantined patients should also be released.

QUARANTINE

The criteria for imposing quarantine in a correctional facility will remain a dynamic process with possible re-direction and re-strategizing of disease control efforts based on recommendations from the LHD, CDPH, CCHCS PHB and CME. **Quarantine should be implemented for patients who are contacts to a COVID-19 case and are not ill.**

- Quarantined patients shall be placed on medical hold.
- Transport of patients in quarantine should be limited. If transport becomes necessary, assign dedicated staff to the extent possible. Patients under quarantine, and those transporting quarantined patients, must use appropriate PPE (quarantined patient should wear a surgical or procedure mask, transport staff should wear an N-95 respirator or other approved respirator or a surgical/procedure mask in N95 shortage.)
- Quarantine does not include restricting the patient to his own cell for the duration of the quarantine without opportunity for exercise or yard time. Quarantined patients can have yard time as a group but should not mix with patients not in quarantine.
- Nursing staff are advised to conduct twice daily surveillance on quarantined patients for the duration of the quarantine period to identify any new cases. The minimum surveillance frequency is once per day if severe staffing or resource shortages occur. If new case(s) are identified, the symptomatic patient must be masked, isolated and evaluated by a health care provider as soon as possible.
- Quarantined patients may be given meals in the chow hall as a group;
  - If they do not congregate with other non-quarantined patients,
  - are the last group to get meals, and
  - the dining room can be cleaned after the meal.
  - If these parameters cannot be met in the chow hall, the patients shall be given meals in their cells.

Movement in or out of the quarantined area should be restricted for the duration of the quarantine period. When transport and non-essential movement is allowed, limit patient transports outside of the facility, permitting transport only for medical or legal necessity (e.g., specialty clinics, outside medical appointments, mental health crisis, or out-to-court) and with 3 days of surveillance recommended after exit from the possible exposure. Out-to-court and medical visits should be evaluated on a case by case basis. With CME or CME designee approval, a quarantined or held patient may keep the necessary appointments or transfers provided that the court, medical provider and/or clinic have been notified the patient is in quarantine or was on hold for ILI exposure and they have agreed to see the patient.

Follow the guidance regarding spacing and rooms in the Isolation section of this document.

To reduce the number of health care staff potentially exposed to any new cases of influenza, limit the number of health care staff (when possible) who interact with quarantined patients.

- In the event of a more severe outbreak, involving multiple suspected or confirmed cases or involving neighboring community, visitor entry and patient visits for well patients may be greatly restricted or even temporarily halted, if necessary.

- If one or more patients in quarantine develops symptoms consistent with COVID-19 infection, follow recommendations for isolation for ill patient(s). Separate the ill-quarantined patients from the well-quarantined patients immediately.

PATIENT SURVEILLANCE WHILE IN QUARANTINE

Correctional nursing leadership is responsible for assigning nursing teams to conduct surveillance to identify new suspected cases. Surveillance rounds and the evaluation of well patients who have been exposed must be done in all housing units that have housed one or more patients with suspected or confirmed COVID-19.

- All quarantined patients shall be evaluated on a twice daily basis, including weekends and holidays. If staff or resource shortages are severe, once a day testing is the minimum.
- Using the new COVID-19 electronic Surveillance Rounds form tool in EHRS, The COVID-19 Screening Powerform see instructions in the appendix and instructional webinar http://10.192.193.84/Nursing/EHRS/COVID19-Doc-Orders/Webinar.html. Temperatures and any symptoms must be recorded to identify illness (temperature > 100°F [37.8°C], cough). List symptoms (see below list) not on the EHRS tool checklist in the free text box:
    - Note influenza (and other microorganism) surveillance still uses the "Surveillance Round" in EHRS (Adhoc > All Items > CareMobile Nursing Task > Surveillance Round)
    - The only vital sign for quarantine is the temperature
    - Keep a very low threshold for symptoms, including those listed below. Any symptoms of illness necessitates a provider evaluation:
        - Chills without fever or subjective fever
        - Severe/New/Unexplained fatigue
        - Malaise (difficult to describe unpleasant feeling of being ill)
        - Sore throat
        - Myalgia or Arthralgia
        - Gastrointestinal symptoms such as: nausea, vomiting, diarrhea, or loss of appetite
        - URI symptoms such as nasal or sinus congestion and rhinorrhea
        - Loss of sense of smell or taste
- Patients with symptoms should be promptly masked and escorted to an isolation designated clinical area for medical follow up as soon as possible during the same day symptoms are identified, including weekends and holidays.
- Educate all patients about signs and symptoms of respiratory illness, possible complications, and the need for prompt assessment and treatment. Instruct patients to report respiratory symptoms at the first sign of illness. See patient education handouts on the CCHCS Coronavirus Webpage.

- Surveillance may uncover patients in housing units with upper respiratory symptoms, without fever and who do not meet the case presentation for COVID-19. Consult with the treating provider and/or CME to determine if these patients should be isolated.
- Each correctional facility should ensure the PHN (or designee) is aware of any patients with ILI, and any suspected or confirmed COVID-19 cases. PHNs should be notified by phone and via the EHRS Message Center.
- The *7362 Patient-Generated Request for Care System* should not be relied on for alerting clinicians of symptomatic patients in housing units under quarantine. New patients with ILI symptoms must be assessed daily, treated, and isolated as soon as possible to prevent further spread of influenza in the facility.

RELEASE FROM QUARANTINE

For COVID-19, the period of quarantine is 14 days from the last date of exposure of a confirmed case, because 14 days is the longest incubation period seen for similar coronaviruses. Someone who has been released from COVID-19 quarantine is not considered a risk for spreading the virus to others because they have not developed illness during the incubation period. **Quarantine must be extended by 14 days for every new exposure.**

Check for updates From CDC:
https://www.cdc.gov/coronavirus/2019-ncov/faq.html#basics

PAROLE AND DISCHARGE TO THE COMMUNITY DURING A COVID-19 OUTBREAK

Stay in communication with partners about your facility's current situation.

- State, local, territorial, and/or tribal health departments

Incorporate screening for COVID-19 symptoms and a temperature check into general release planning.

- Screen all paroling individuals for COVID-19 symptoms and perform a temperature check. Refer to the COVID-19 Screening Powerform Appendix 10.
  - If an individual does not clear the screening process, follow the protocol for a suspected COVID-19 case - including putting a face mask on the individual, immediately placing them under medical isolation, and evaluating them for possible COVID-19 testing.
- Individuals who parole before Isolation or Quarantine are over:
  - Notify the LHD and coordinate with discharge planning.
    - Use the Case-Contact Notification Form (Appendix 9) for release of a person with exposure to a confirmed or suspected case or a suspected or confirmed case to the community).
  - Discuss release of the individual with state, local, tribal, and/or territorial health departments to ensure safe medical transport and continued shelter and medical care, as part of release planning.
    - Make direct linkages to community resources to ensure proper medical isolation and access to medical care.

- Before releasing an incarcerated/detained individual with COVID-19 symptoms to a community-based facility, such as a homeless shelter, contact the facility's staff to ensure adequate time for them to prepare to continue medical isolation, or contact local public health to explore alternate housing options.
  - Community facilities with limited onsite medical isolation, quarantine, and/or healthcare services should coordinate closely with state, local, tribal, and/or territorial health departments when they encounter a confirmed or suspected case, in order to ensure effective medical isolation or quarantine, necessary medical evaluation and care, and medical transfer if needed. See CDC's webpage on: Facilities with Limited Onsite Healthcare Services section.

CONTROL STRATEGY FOR CONTACTS TO CONTACTS

The CDC does **not** recommend testing, symptom monitoring, quarantine, or special management for people exposed to asymptomatic people who have had high-risk exposures to COVID-19, e.g., Contacts to Contacts.

STAFF AND VISITOR PRECAUTIONS AND RESTRICTIONS DURING THE PANDEMIC

See COVID-19: Infection Control for Health Care Professionals

- Correctional facilities should have signage posted at entry points in English and Spanish alerting staff and visitors that if they have fever and respiratory symptoms, they should not enter the facility.
- Visitor web sites and telephone services are updated to inform potential visitors of current restrictions and/or closures before they travel to the facility.
- Instruct staff to report fever and/or respiratory symptoms at the first sign of illness.
- Staff with respiratory symptoms should stay home (or be advised to go home if they develop symptoms while at work). Ill staff should remain at home until they are cleared by their provider to return to work.
- Advise visitors who have fever and/or respiratory symptoms to delay their visit until they are well.
- Consider temporarily suspending visitation or modifying visitation programs, when appropriate.
- Visitor signage and screening tools are available from the CCHCS PHB and can be distributed to visiting room staff.
- Initiate other social distancing procedures, if necessary (e.g., halt volunteer and contractor entrance, discourage handshaking).
- Post signage and consider population management initiatives throughout the facility encouraging vaccination for influenza.

RESPIRATORY HYGIENE AND COUGH ETIQUETTE

- Post visual alerts in high traffic areas in both English and Spanish instructing patients to report symptoms of respiratory infection to staff.
- Encourage coughing patients with respiratory symptoms to practice appropriate respiratory hygiene and cough etiquette (e.g. cover your cough, sneeze into your sleeve, use a tissue when available, dispose of tissue appropriately in designated receptacles, and hand hygiene).
    - Additionally, coughing patients should not remain in common or waiting areas for extended periods of time and should wear a surgical or procedure mask and remain 6 feet from others.
- Ensure that hand hygiene and respiratory hygiene supplies are readily available.
- Encourage frequent hand hygiene.

ENVIRONMENTAL INFECTION CONTROL

- Routine cleaning and disinfection procedures should be used. Studies have confirmed the effectiveness of routine cleaning (extraordinary procedures not recommended at this time).
- CellBlock 64 is effective in disinfecting for COVID-19 related virus.
- After pre-cleaning surfaces to remove pathogens, rinse with water and follow with an EPA-registered disinfectant to kill coronavirus. Follow the manufacturer's labeled instructions and always follow the product's dilution ratio and contact time. (for a list of EPA- registered disinfectant products that have qualified for use against SARS-CoV-2, the novel coronavirus that causes COVID-19, go to: https://www.epa.gov/pesticide-registration/list-n-disinfectants-use-against-sars-cov-2
- If an EPA-registered disinfectant is not available, use a fresh chlorine bleach solution by mixing 5 tablespoons (1/3 cup) bleach per gallon water or 4 teaspoons bleach per quart of water.
- Focus on cleaning and disinfection of frequently touched surfaces in common areas (e.g., faucet handles, phones, countertops, bathroom surfaces).
- If bleach solutions are used, change solutions regularly and clean containers to prevent contamination.
- Special handling and cleaning of soiled linens, eating utensils and dishes is not required, but should not be shared without thorough washing.
- Linens (e.g., bed sheets and towels) should be washed by using laundry soap and tumbled dried on a hot setting. Staff should not hold laundry close to their body before washing and should wash their hands with soap and water after handling dirty laundry.
- Follow standard procedures for Waste Handling.

For further sanitation information please refer to HCDOM, Chapter 3, Article 8 - Communicating Precautions from Health Care Staff to Custody Staff.

CLEANING SPACES WHERE COVID-19 CASES SPENT TIME

- **Thoroughly clean and disinfect all areas where the confirmed or suspected COVID-19 case spent time. Note – these protocols apply to suspected cases as well as confirmed cases, to ensure adequate disinfection in the event that the suspected case does, in fact, have COVID-19. Refer to the Definitions section for the distinction between confirmed and suspected cases.**
    - Close off areas used by the infected individual. If possible, open outside doors and windows to increase air circulation in the area. Wait as long as practical, up to 24 hours under the poorest air exchange conditions (consult CDC Guidelines for Environmental Infection Control in Health-Care Facilities for wait time based on different ventilation conditions), before beginning to clean and disinfect, to minimize potential for exposure to respiratory droplets.
    - Clean and disinfect all areas (e.g., cells, bathrooms, and common areas) used by the infected individual, focusing especially on frequently touched surfaces (see list above in Prevention section).
- **Hard (non-porous) surface cleaning and disinfection**
    - If surfaces are dirty, they should be cleaned using a detergent or soap and water prior to disinfection.
    - For disinfection, most common EPA-registered household disinfectants should be effective. Choose cleaning products based on security requirements within the facility.
        - Consult a list of products that are EPA-approved for use against the virus that causes COVID-19external icon. Follow the manufacturer's instructions for all cleaning and disinfection products (e.g., concentration, application method and contact time, etc.).
        - Diluted household bleach solutions can be used if appropriate for the surface. Follow the manufacturer's instructions for application and proper ventilation, and check to ensure the product is not past its expiration date. Never mix household bleach with ammonia or any other cleanser. Unexpired household bleach will be effective against coronaviruses when properly diluted. Prepare a bleach solution by mixing:
            - 5 tablespoons (1/3 cup) bleach per gallon of water or
            - 4 teaspoons bleach per quart of water

- **Soft (porous) surface cleaning and disinfection**
    - For soft (porous) surfaces such as carpeted floors and rugs, remove visible contamination if present and clean with appropriate cleaners indicated for use on these surfaces. After cleaning:
        - If the items can be laundered, launder items in accordance with the manufacturer's instructions using the warmest appropriate water setting for the items and then dry items completely.
        - Otherwise, use products that are EPA-approved for use against the virus that causes COVID-19external icon and are suitable for porous surfaces.
- **Electronics cleaning and disinfection**
    - For electronics such as tablets, touch screens, keyboards, and remote controls, remove visible contamination if present.
        - Follow the manufacturer's instructions for all cleaning and disinfection products.
        - Consider use of wipeable covers for electronics.
        - If no manufacturer guidance is available, consider the use of alcohol-based wipes or spray containing at least 70% alcohol to disinfect touch screens. Dry surfaces thoroughly to avoid pooling of liquids.

Additional information on cleaning and disinfection of communal facilities such can be found on CDC's website.

- **Ensure that staff and incarcerated/detained persons performing cleaning wear recommended PPE.** (See PPE CHART)
- **Food service items.** Cases under medical isolation should throw disposable food service items in the trash in their medical isolation room. Non-disposable food service items should be handled with gloves and washed with **hot water or in a dishwasher**. Individuals handling used food service items should clean their hands after removing gloves.
- **Laundry from a COVID-19 cases can be washed with other individuals' laundry.**
    - Individuals handling laundry from COVID-19 cases should wear disposable gloves, discard after each use, and clean their hands after.
    - Do not shake dirty laundry. This will minimize the possibility of dispersing virus through the air.

- Launder items as appropriate in accordance with the manufacturer's instructions. If possible, launder items **using the warmest appropriate water setting for the items and dry items completely**.
- Clean and disinfect clothes hampers according to guidance above for surfaces. If permissible, consider using a bag liner that is either disposable or can be laundered.

- **Consult cleaning recommendations above to ensure that transport vehicles are thoroughly cleaned after carrying a confirmed or suspected COVID-19 case.**

RESOURCES

For additional COVID-19 information refer to the following internal and external resources:
CCHCS: COVID-19 Lifeline Page
CDC Websites:

https://www.cdc.gov/coronavirus/2019-nCoV/hcp

https://www.cdc.gov/coronavirus/2019-ncov/hcp/hcp-personnel-checklist.html

https://www.cdc.gov/coronavirus/2019-nCoV/hcp/clinical-criteria.html

REFERENCES

1. Influenza and Other Respiratory Viruses Weekly Report. California Influenza Surveillance Program. https://www.cdph.ca.gov/programs/cid/dcdc/cdph%20document%20library/immunization/week2019-2009_finalreport.pdf
2. CDC Tests for COVID-19: https://www.cdc.gov/coronavirus/2019-ncov/about/testing.html
3. Interim Clinical Guidance for Management of Patients with Confirmed Coronavirus Disease (COVID-19): https://www.cdc.gov/coronavirus/2019-ncov/hcp/clinical-guidance-management-patients.html
4. Interim Infection Prevention and Control Recommendations for Patients with Suspected or Confirmed Coronavirus Disease 2019 (COVID-19) in Healthcare Settings: https://www.cdc.gov/coronavirus/2019-ncov/infection-control/control-recommendations.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fcoronavirus%2F2019-ncov%2Fhcp%2Finfection-control.html
5. California Department of Corrections and Rehabilitation California Correctional Health Care Services, Health Care Department Operations Manual. Chapter 3, Article 8; 3.8.8: Communication Precautions from Health Care to Custody Staff. http://lifeline/PolicyandAdministration/PolicyandRiskManagement/IMSPP/HCDOM/HCDOM-Ch03-art8.8.pdf
6. Recommended Guidance for Extended Use and Limited Reuse of N95 Filtering Facepiece Respirators in Healthcare Settings: https://www.cdc.gov/niosh/topics/hcwcontrols/recommendedguidanceextuse.html

7. United States Department of Labor, Occupational Safety and Health Administration https://www.osha.gov/laws-regs/regulations/standardnumber/1910/1910.134
8. Public Health Outbreak Response System (PhORS) http://phuoutbreak/
9. Interim Guidance for Discontinuation of Transmission-Based Precautions and Disposition of Hospitalized Patients with COVID-19 https://www.cdc.gov/coronavirus/2019-ncov/hcp/disposition-hospitalized-patients.html
10. Centers for Disease Control Coronavirus Disease 2019 (COVID-19) Healthcare Professionals: Frequently Asked Questions and Answers https://www.cdc.gov/coronavirus/2019-ncov/hcp/faq.html
11. Centers for Disease Control Coronavirus Disease 2019 (COVID-19) Healthcare Professionals: Frequently Asked Questions and Answers About: **When can patients with confirmed COVID-19 be discharged from the hospital?** https://www.cdc.gov/coronavirus/2019-ncov/faq.html#basic
12. List N: Disinfectants for Use Against SARS-CoV-2: https://www.epa.gov/pesticide-registration/list-n-disinfectants-use-against-sars-cov-2
13. Dr. David Sears, UCSF Clinical Guidelines for Evaluation and Treatment of Suspected and Confirmed Cases of COVID-19 in Correctional Facilities
14. Interim Guidance on Management of Coronavirus Disease 2019 (COVID-19) in Correctional and Detention Facilities https://www.cdc.gov/coronavirus/2019-ncov/community/correction-detention/guidance-correctional-detention.html
15. Forst, Arnold, COVID-19 (SARS-CoV-2) epidemic www.louisvillelectures.org/imblog/2020-coronavirus/forest-arnold

APPENDIX 1: CORONAVIRUS DISEASE 2019 (COVID-19) CHECKLIST

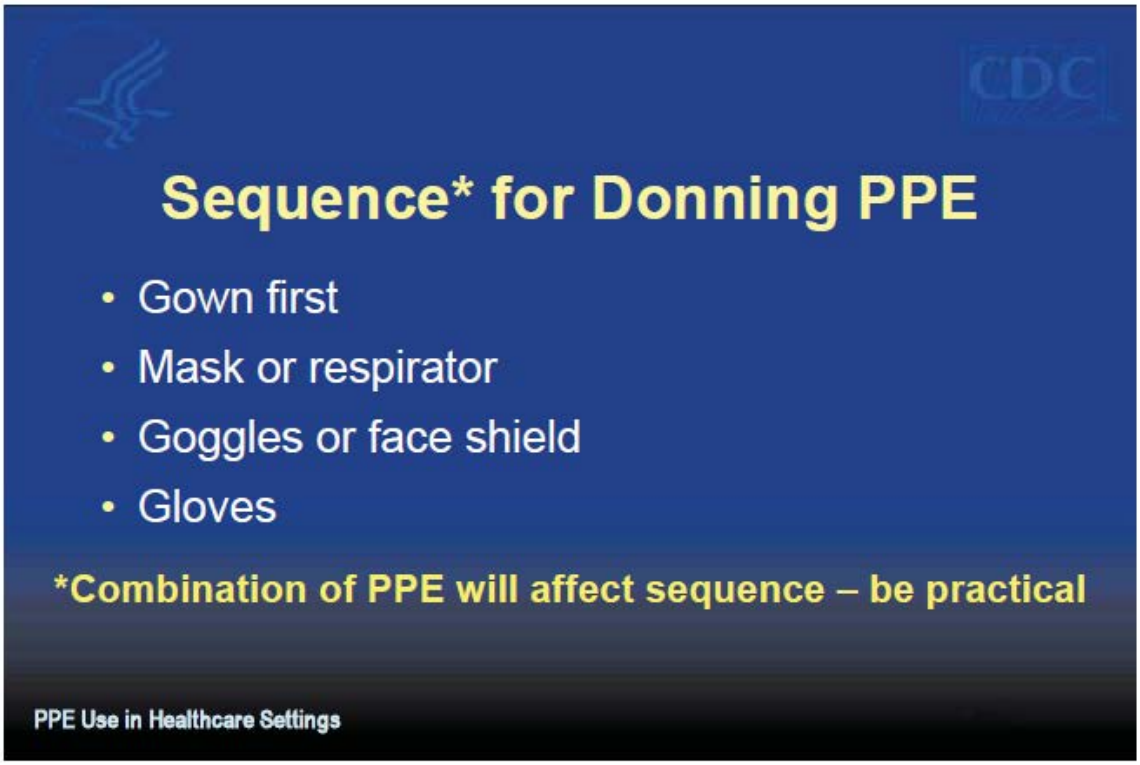
1. RECOGNITION, REPORTING, AND DATA COLLECTION	
	a. Be on alert for patients presenting with fever or symptoms of respiratory illness.
	b. Report suspect cases to institutional leadership, local health department, and the Public Health Branch.
2. INFECTION PREVENTION AND CONTROL MEASURES	
	a. Isolate symptomatic patients immediately in airborne infection isolation room (AIIR). Implement Standard, Contact, and Airborne Precautions, plus eye protection.
	b. Educate staff & patients about outbreak. Emphasize importance of hand hygiene, respiratory etiquette, and avoiding touching eye, nose, or mouth. Post signage about the outbreak in high traffic areas.
	c. Increase available of hand hygiene supplies in housing units and throughout the facility.
	d. Separate patients identified as contacts from other patients and implement quarantine as appropriate.
	e. Increase cleaning schedule for high-traffic areas and high-touch surfaces (faucets, door handles, keys, telephones, keyboards, etc.). Ensure available cleaning supplies.
3. CARING FOR THE SICK	
	a. Implement plan for assessing ill patients. Limit number of staff providing care to ill patients, if possible.
	b. Ensure Personal Protective Equipment is available and accessible to staff caring for ill patients.
4. POSSIBLE ADMINISTRATIVE CONTROLS DURING OUTBREAKS	
	a. Institute screening for respiratory symptoms.
	b. Encourage patients to report respiratory illness.
	c. Halt patient movement between affected and unaffected units.
	d. Screen for respiratory illness in patient workers in Food Service and Health Services; exclude from work if symptomatic.
	e. Minimize self-serve foods in Food Service (e.g., eliminate salad bars).
	f. Do controlled movement by unit to chow hall (cleaning between units), or feed on the units.
	g. Temporarily discontinue group activities, e.g., recreation, chapel, activity therapy groups, education.
	h. Schedule daily status meetings involving custody and medical leadership; other stakeholders should attend as appropriate.
	i. Do controlled movement by unit to pill line, or administer medication on the units.
	j. Encourage ill staff to stay home until symptoms resolve and/or they are cleared to return to work by their provider.
	k. Post visitor notifications regarding outbreak. Advise visitors with respiratory symptoms to not enter the facility (If large outbreak, consider suspending visits).
	l. During large outbreaks, consider halting patient movement in and out (in consultation with local health department).

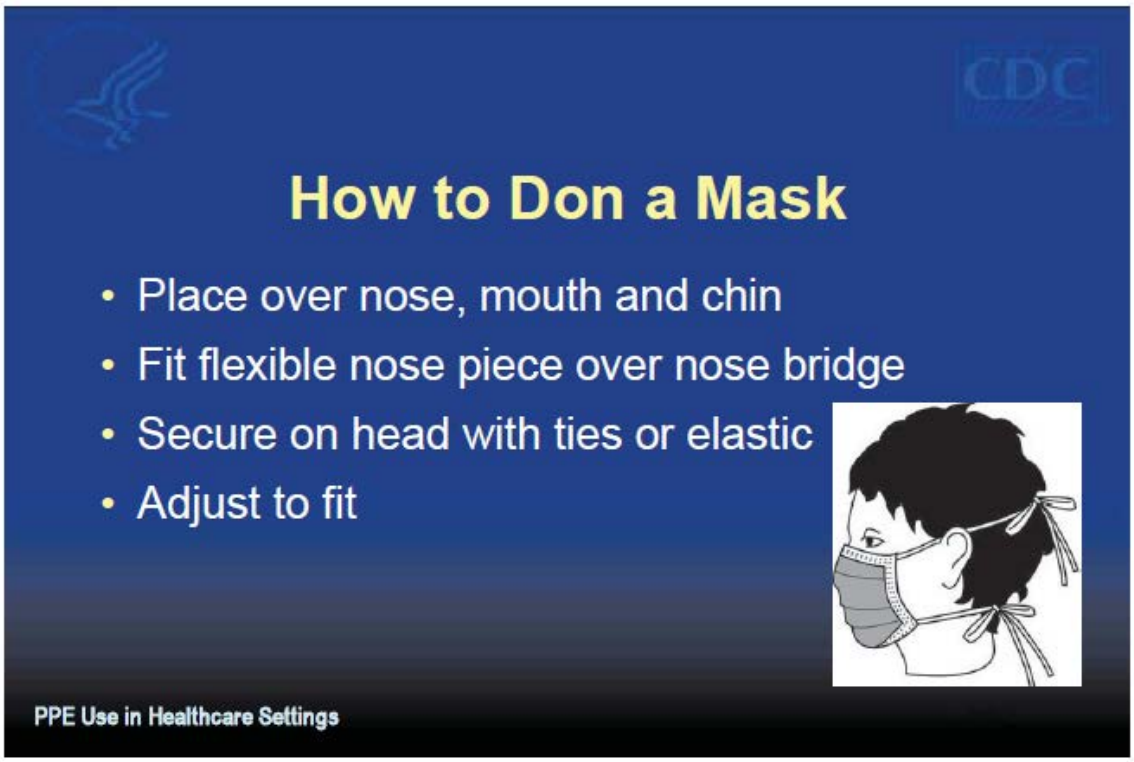
APPENDIX 2: DROPLET PRECAUTIONS CHECKLIST

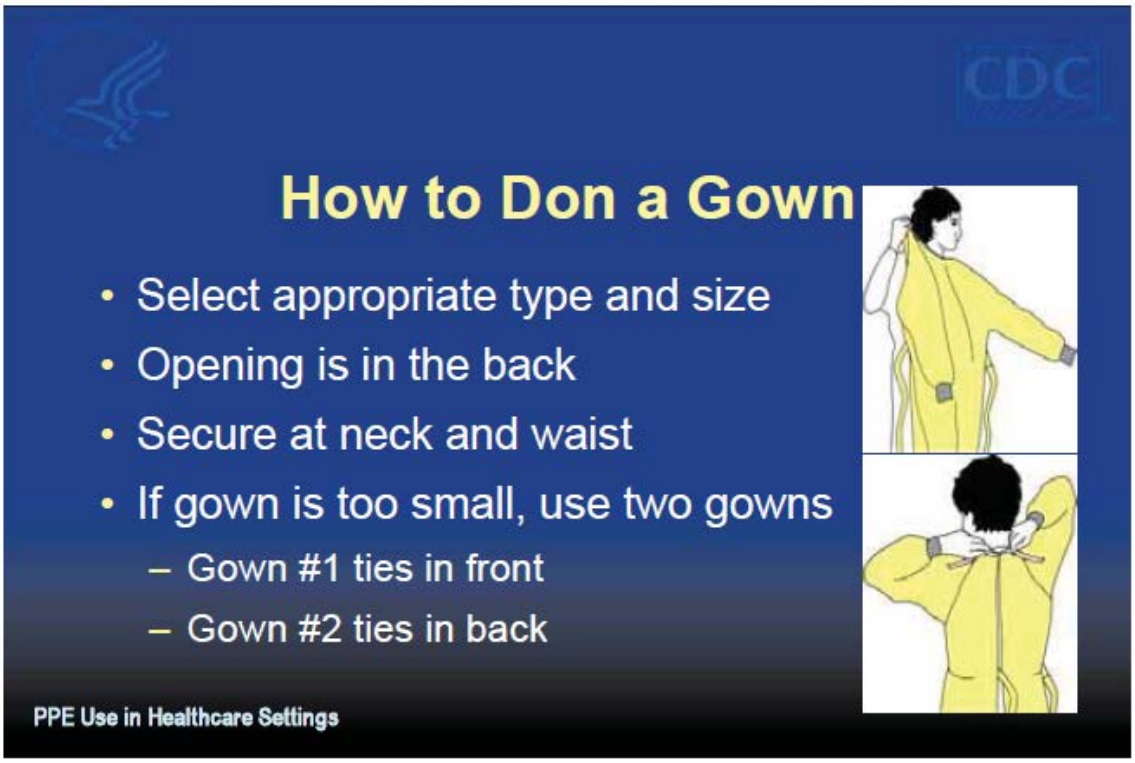
CONTROL MEASURE	INDICATED	ADDITIONAL INFORMATION
Hand Washing	Yes	• After touching contaminated items, after removing gloves. • Between Inmate/Patient contact.
Personal Protective Equipment (PPE)	Yes	• Follow Standard Precautions Guideline. • Don mask upon entry into patient room.
Single Cell	Yes	• A single Inmate/Patient room.
Housing	Yes	• Place together those who are infected with the same pathogen.
Sanitation	Yes	• Instruct and encourage Inmate/Patient to practice frequent hand hygiene. • Instruct patient on respiratory etiquette.
Laundry	Yes	• Do not shake items or handle laundry in any way that may aerosolize infectious agents. • Avoid contact of one's body and personal clothing with the soiled items being handle. • Contain soiled items in a laundry bag or designated bin.
Activities	Yes	• Patient must wear mask upon existing his or her cell. • Permit routine showering, last one then disinfect.
Inmate Hygiene	Yes	• Instruct and encourage Inmate/Patient to practice frequent hand hygiene. • Instruct patient on respiratory etiquette.
Transports	Yes	• Limit transport on patients on contact precautions to essential purposes such as diagnostic and therapeutic procedures that cannot be performed in the Inmate/Patient's room. • When transport is necessary, using appropriate barriers on the Inmate/Patient. • Staff in close contact (less than 3 feet) should wear surgical mask.

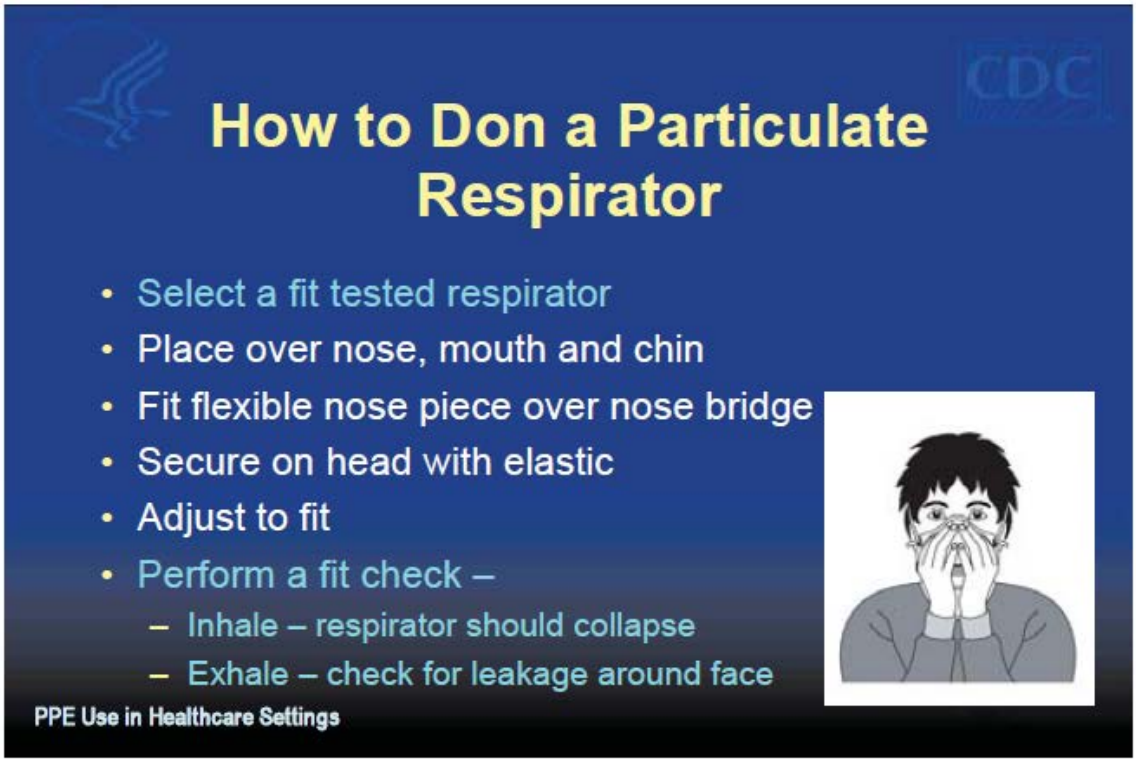
Revised 10/18

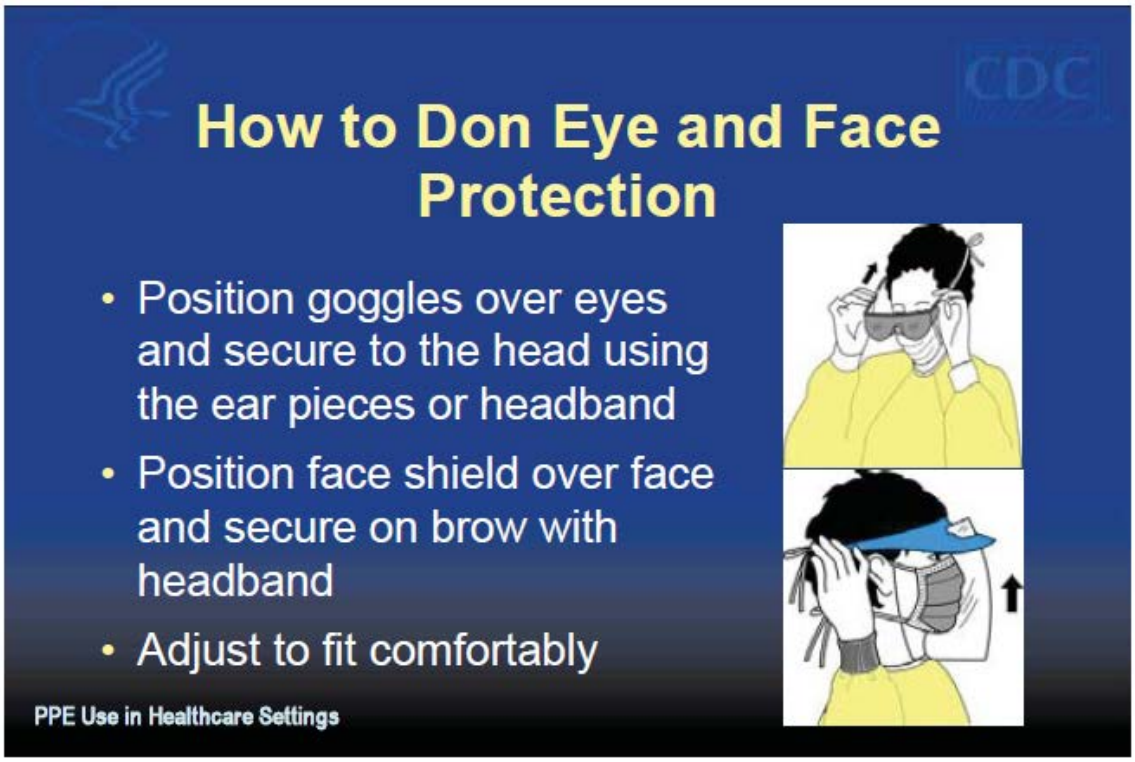
APPENDIX 3: HOW TO DOFF AND DON PPE






How to Don a Gown
• Select appropriate type and size
• Opening is in the back
• Secure at neck and waist
• If gown is too small, use two gowns
– Gown #1 ties in front
– Gown #2 ties in back
PPE Use in Healthcare Settings


How to Don a Particulate Respirator
• Select a fit tested respirator
• Place over nose, mouth and chin
• Fit flexible nose piece over nose bridge
• Secure on head with elastic
• Adjust to fit
• Perform a fit check –
– Inhale – respirator should collapse
– Exhale – check for leakage around face
PPE Use in Healthcare Settings


How to Don Eye and Face Protection
• Position goggles over eyes and secure to the head using the ear pieces or headband
• Position face shield over face and secure on brow with headband
• Adjust to fit comfortably
PPE Use in Healthcare Settings

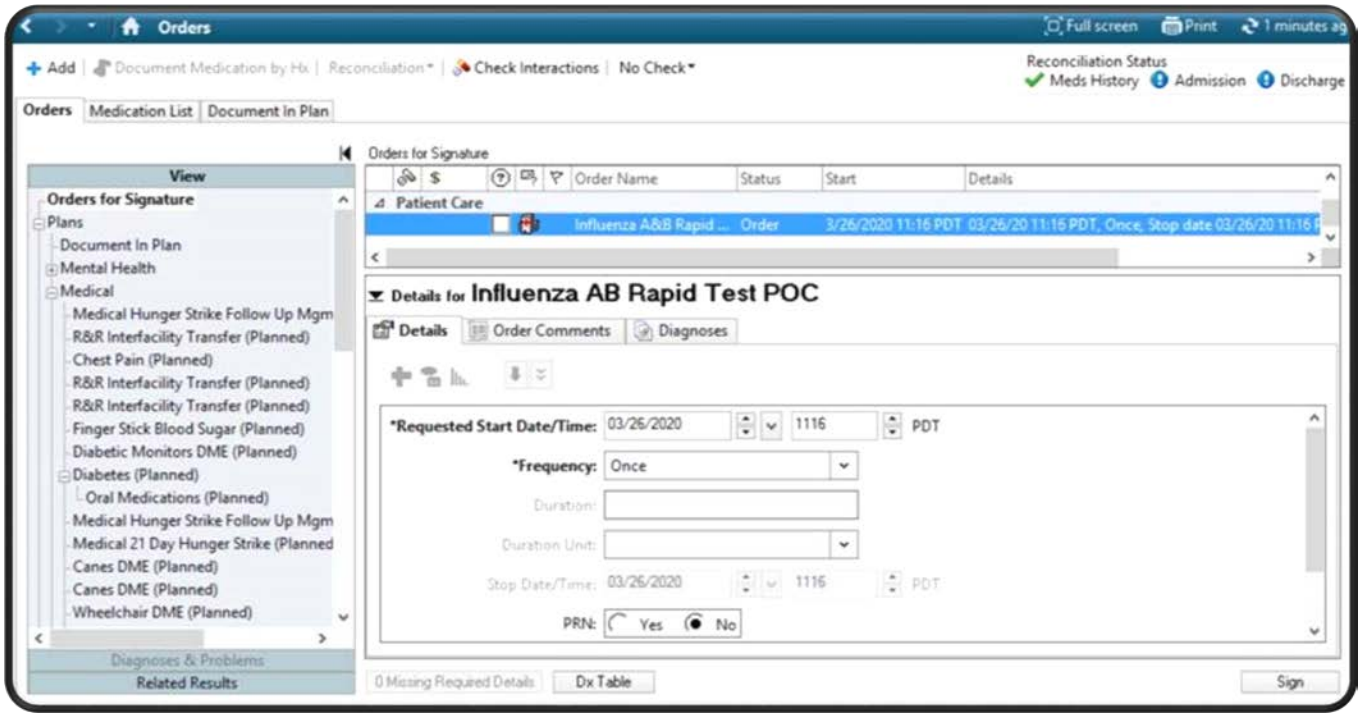

How to Don Gloves
• Don gloves last
• Select correct type and size
• Insert hands into gloves
• Extend gloves over isolation gown cuffs
PPE Use in Healthcare Settings

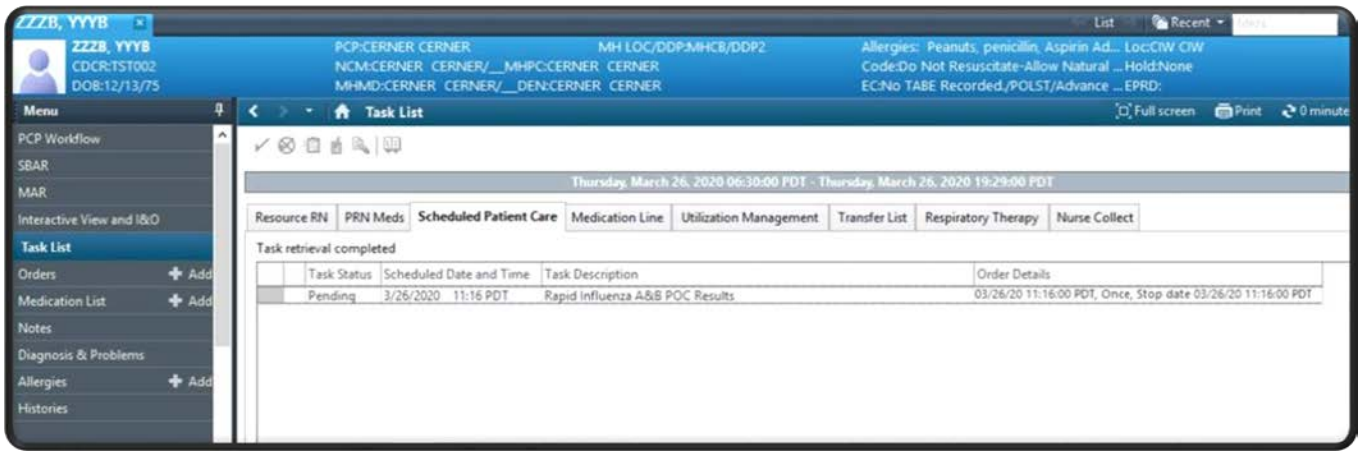
APPENDIX 4: HOW TO ORDER RAPID INFLUENZA DIAGNOSTIC TESTING IN THE EHR

The Influenza A&B Rapid Test Point of Care (POC) order and documentation have been placed into the Cerner EHRS production domain.

Once ordered a task fires to the "Scheduled Patient Care" tab of the task list and is linked to the corresponding documentation for capturing results. These orders are not schedulable, therefore staff shall complete the test at point of care or upon order by the provider.

Screen shots below reference the order that shall be placed and the task that fires as a result. Document the results of the new Influenza A&B Rapid Test POC that is being ordered by providers.





APPENDIX 5: COVID-19 CASE AND CONTACT SHAREPOINT REPORTING TOOL

DAILY COVID-19 CASE & CONTACT LINE LIST REPORTING IN SHAREPOINT

During the COVID-19 pandemic, the California Correctional Health Care Services (CCHCS) institutions shall report to the Public Health Outbreak Surveillance COVID-19 SharePoint **all cases of COVID-19 among patients (suspected and confirmed) and all patients identified as contacts to confirmed cases**. *Seven days a week, including holidays,* same-day reporting is required for newly identified cases and contacts, and for significant updates to existing cases or contacts. No report is needed if there are no new cases/contacts and no significant updates to existing cases/contacts.

CASE DEFINITIONS TO GUIDE REPORTING

CONFIRMED COVID-19 CASE
A positive laboratory test for the virus that causes COVID-19 in at least one respiratory specimen.

SUSPECTED COVID-19 CASE
HIGH SUSPECT: Any fever, respiratory symptoms, or evidence of a viral syndrome in a patient who had close (within 6 feet and prolonged [generally ≥30 minutes]) contact with a confirmed case of COVID-19 within 14 days of onset **OR** linkage to a high risk group defined by public health during an outbreak (for example: an affected dorm, housing unit, or yard) but without a test result for COVID-19.

LOW SUSPECT: Fever or cough or shortness of breath (dyspnea) with evidence of a viral syndrome (ILI) of unknown etiology in a person without test results for COVID-19 or influenza and without high-risk exposure.

ASYMPTOMATIC CONTACT OF COVID-19
A person who has had close (within 6 feet and prolonged [generally ≥30 minutes]) contact with a confirmed case of COVID-19 **OR** direct contact with secretions with a confirmed case of COVID-19 within the past 14 days, who has had no symptoms of COVID-19 and who has had no positive tests for COVID-19.

OUTBREAK OF COVID-19
Two or more confirmed cases of COVID-19 in patients with symptom onset dates within 14 days of each other in the same housing unit **OR** at least one confirmed case of COVID-19 in a patient with epidemiological linkage (e.g., close contact during infectious period) to another confirmed COVID-19 case in a patient or a staff member at the same institution.

REPORTING REQUIREMENTS

Confirmed COVID-19 cases should be immediately reported to the Local Health Department (LHD). Outbreaks of COVID-19 should also be immediately reported to the LHD. Notify the CCHCS PHB immediately at CDCRCCHCSPublicHealthBranch@cdcr.ca.gov if there are significant developments at the institution (e.g., first time the institution is monitoring one or more

contacts, first confirmed case at the institution, first COVID-19 contact investigation at the institution).
The following events require same-day reporting to the COVID-19 SharePoint:

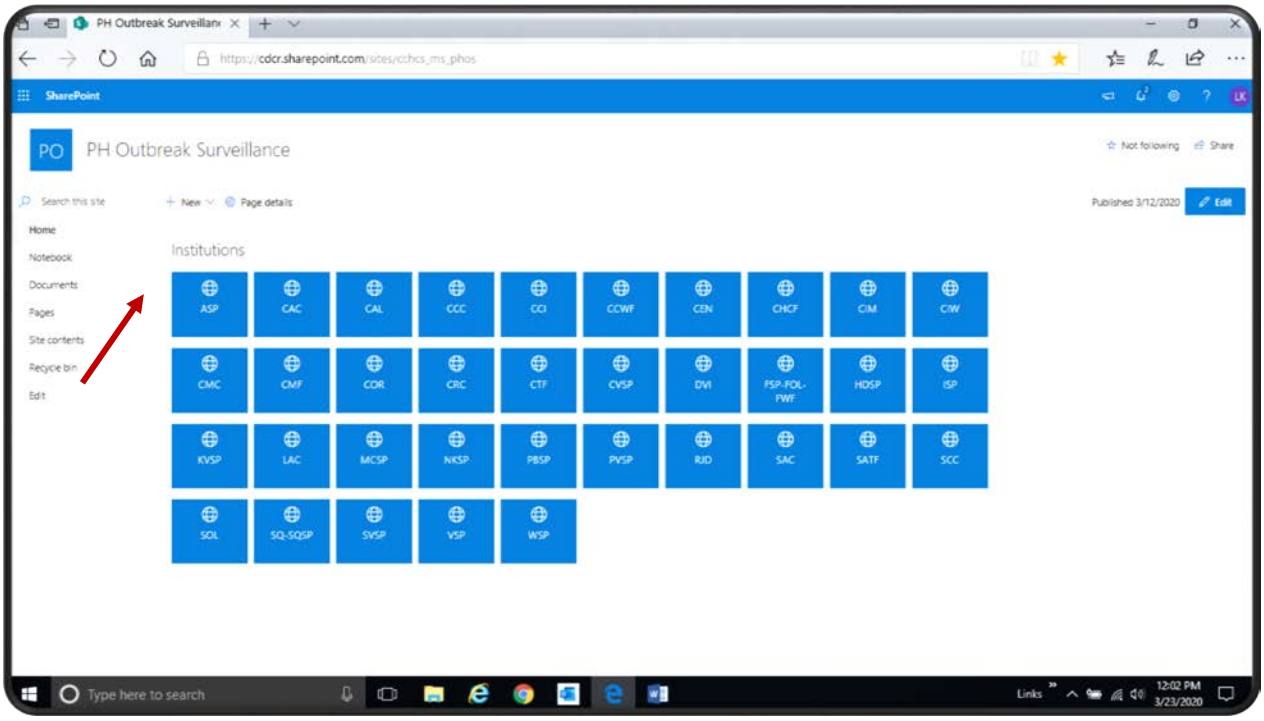
https://cdcr.sharepoint.com/sites/cchcs_ms_phos

- **All new suspected and confirmed COVID-19 cases.**
- **All new COVID-19 contacts.**
- For previously reported cases: new lab results, new symptoms, new hospitalizations, transfers between institutions, discharges/paroles, releases from isolation, deaths.
- For previously reported contacts: new exposures, transfers between institutions, discharges/paroles, releases from quarantine.

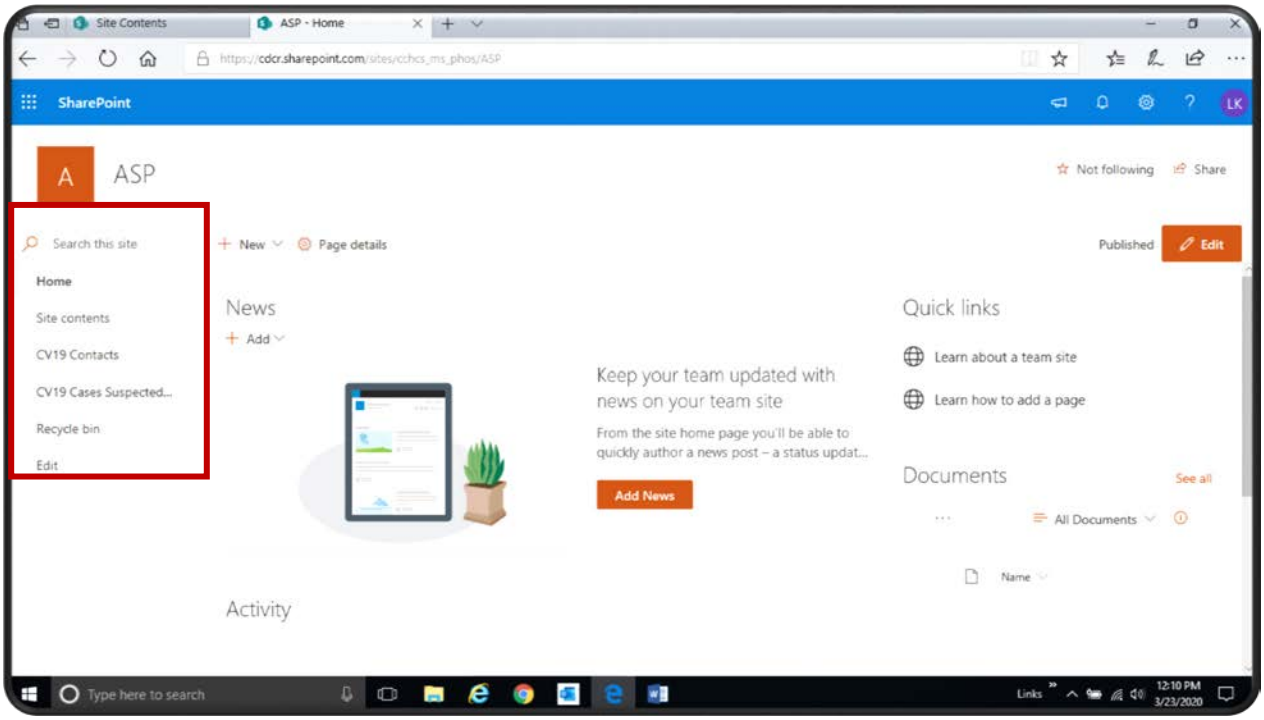
No report is needed if there are no new cases/contacts and no significant updates to existing cases/contacts.

REPORTING IN SHAREPOINT

https://cdcr.sharepoint.com/sites/cchcs_ms_phos Click on your institution.

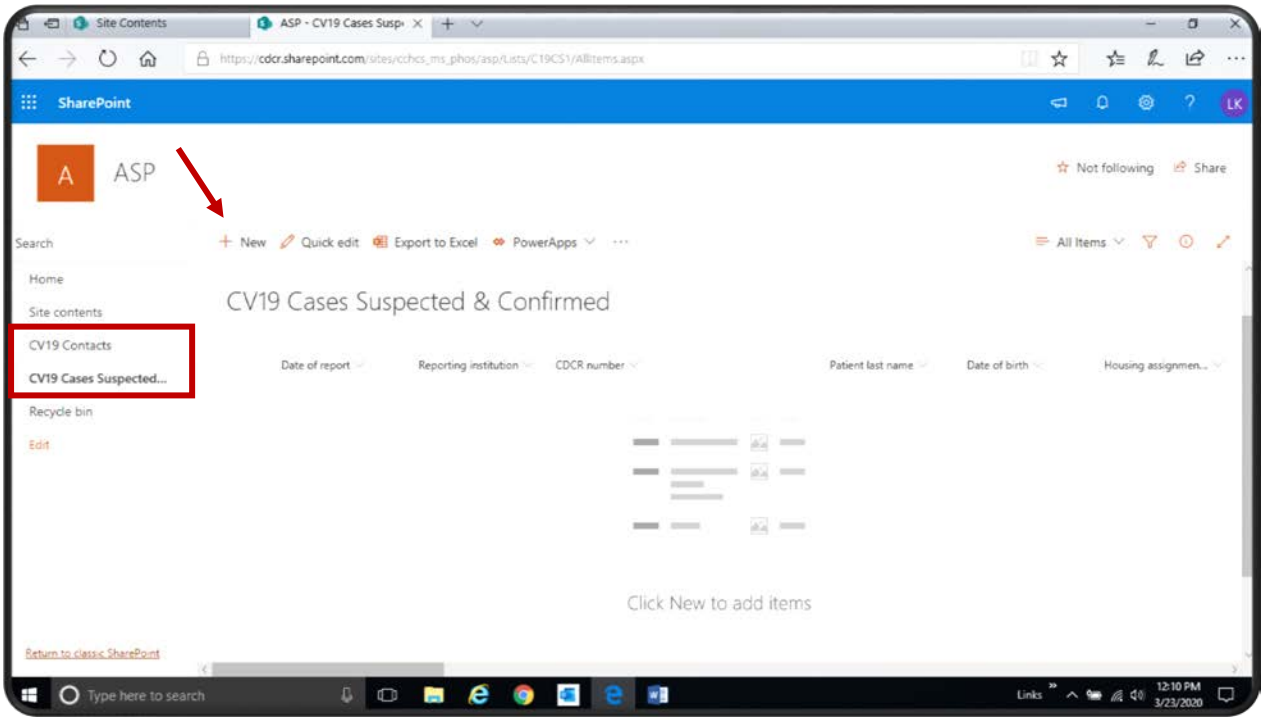


Each institution has a home page with a navigation panel on the left.

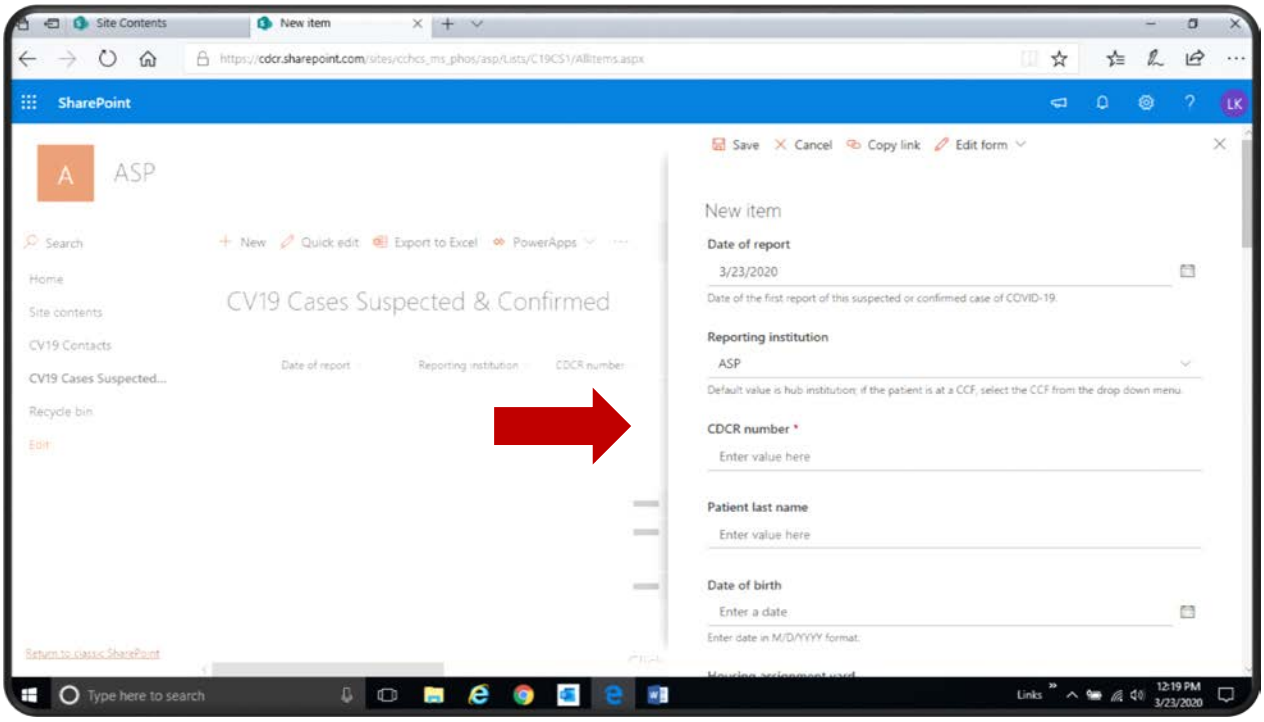


To access the CASES line list, click on **CV19 Cases Suspected & Confirmed**. To access the CONTACTS line list, click on **CV19 Contacts**. This guide applies to both the CASES and CONTACTS line lists.

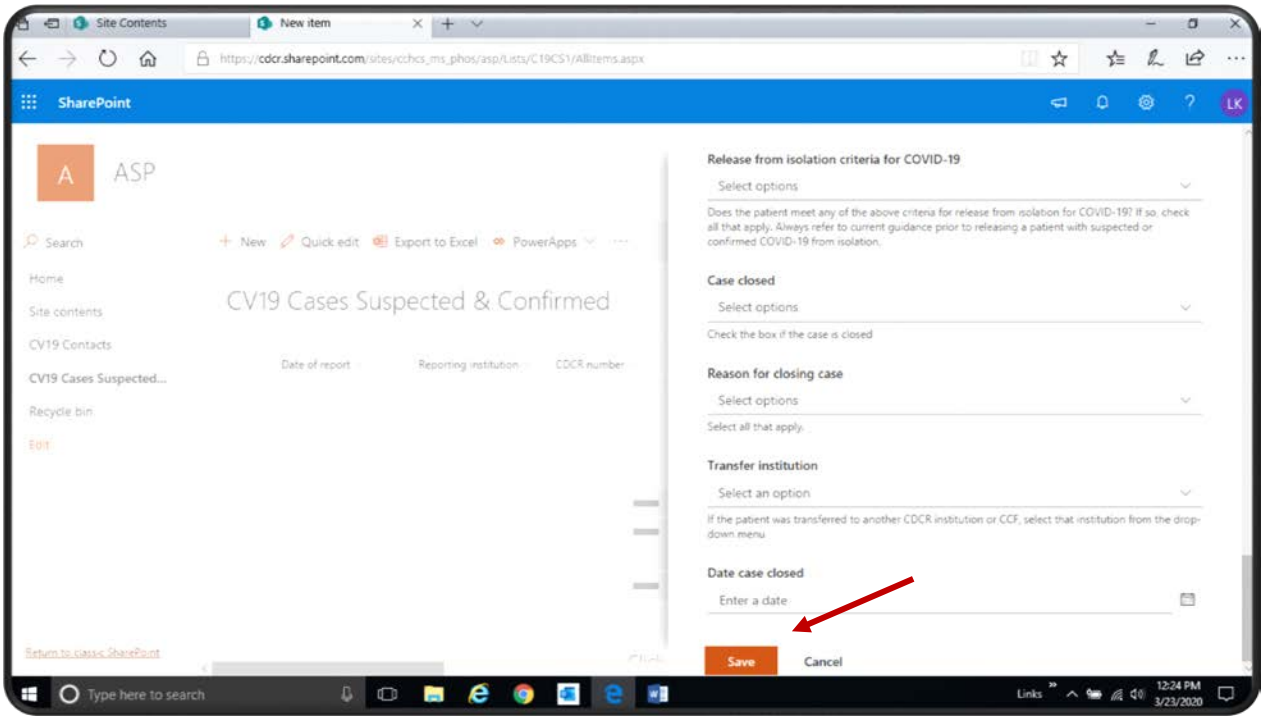
To add a new patient to a line list, click on **New**



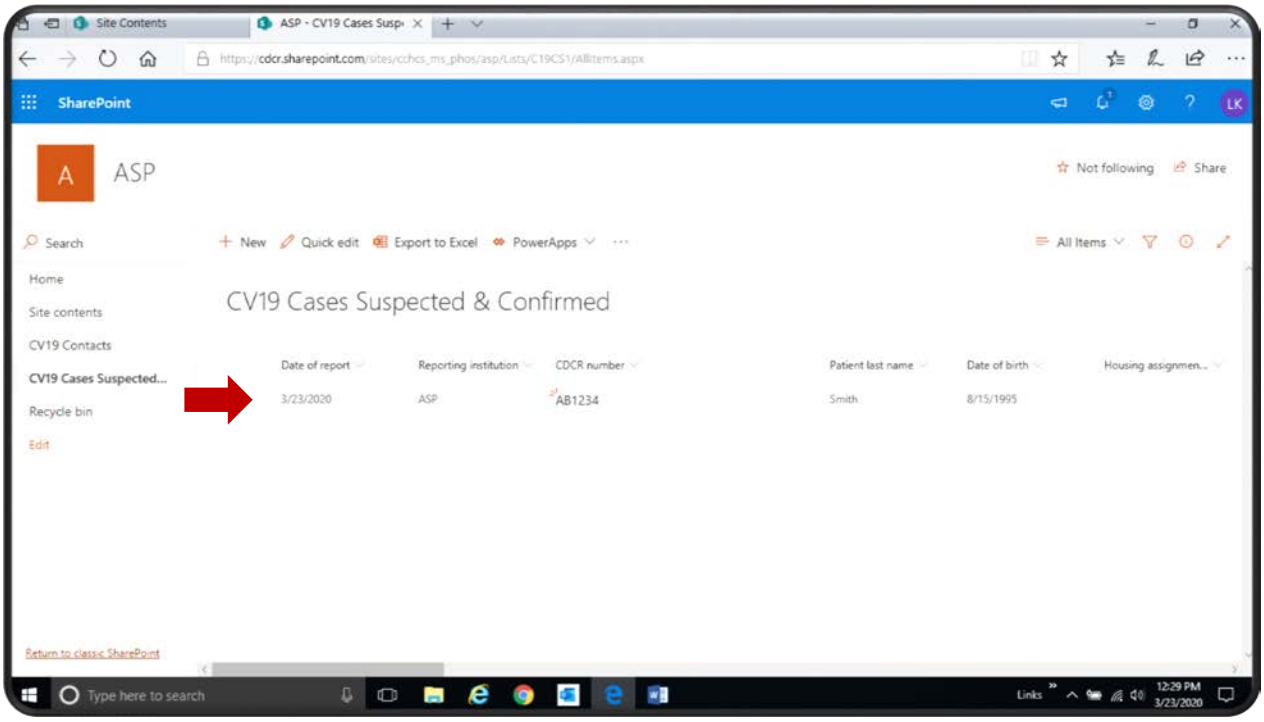
A new record (data entry form) will open on the right.



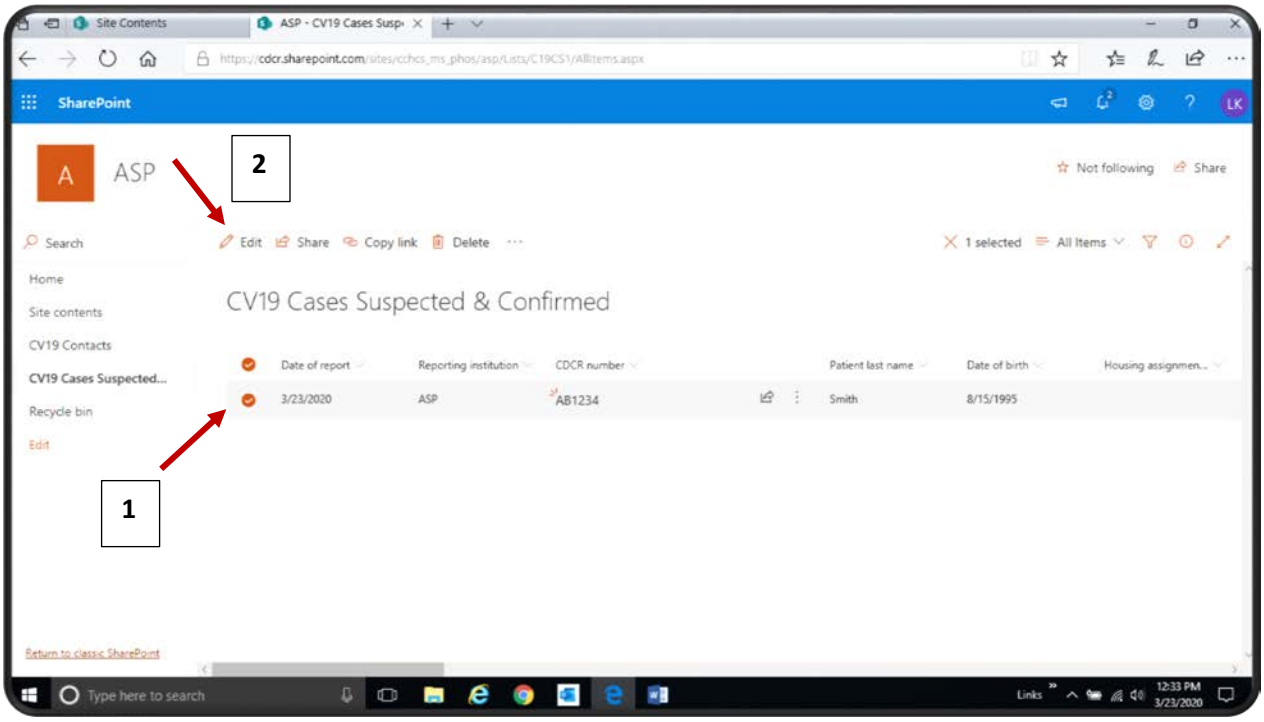
Scroll through the form to enter data. Brief instructions are provided below the form fields. Refer to the **Data Definitions** section on page 9 for detailed instructions for each field in the CASES and CONTACTS line lists. Click on **Save** at the bottom of the form to add the report to the line list.



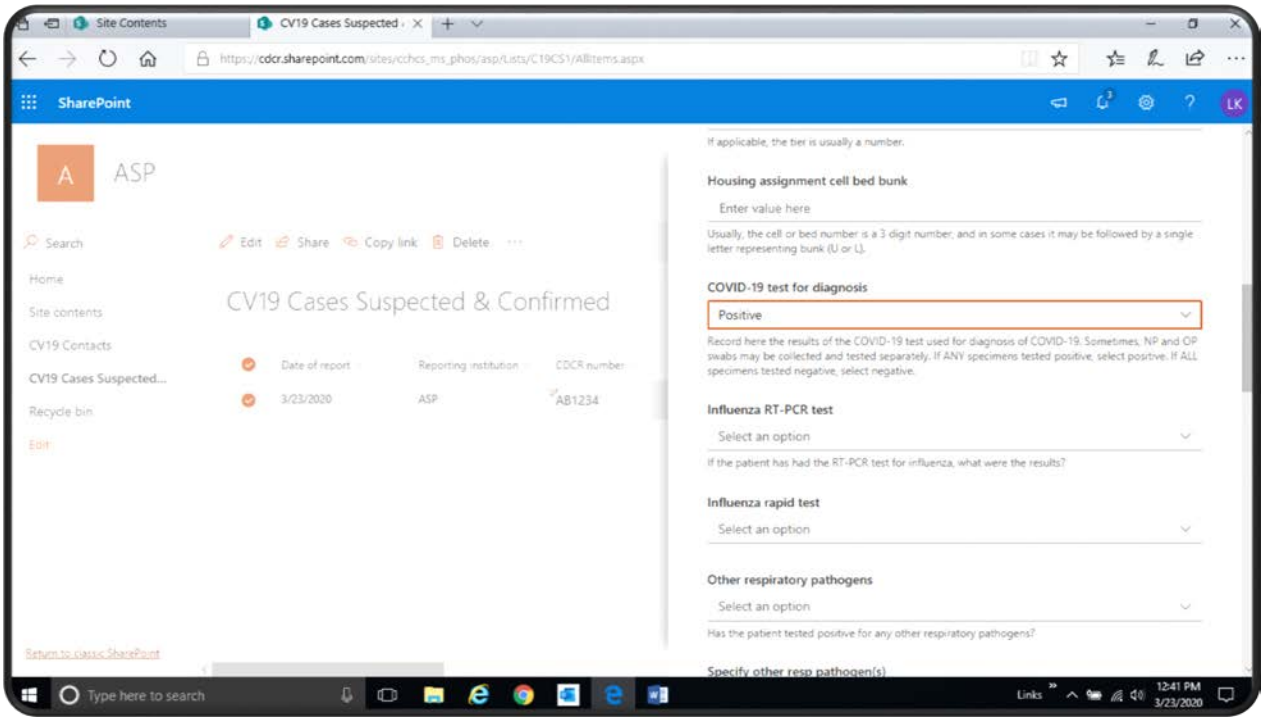
Saving the form adds the report to the line list.



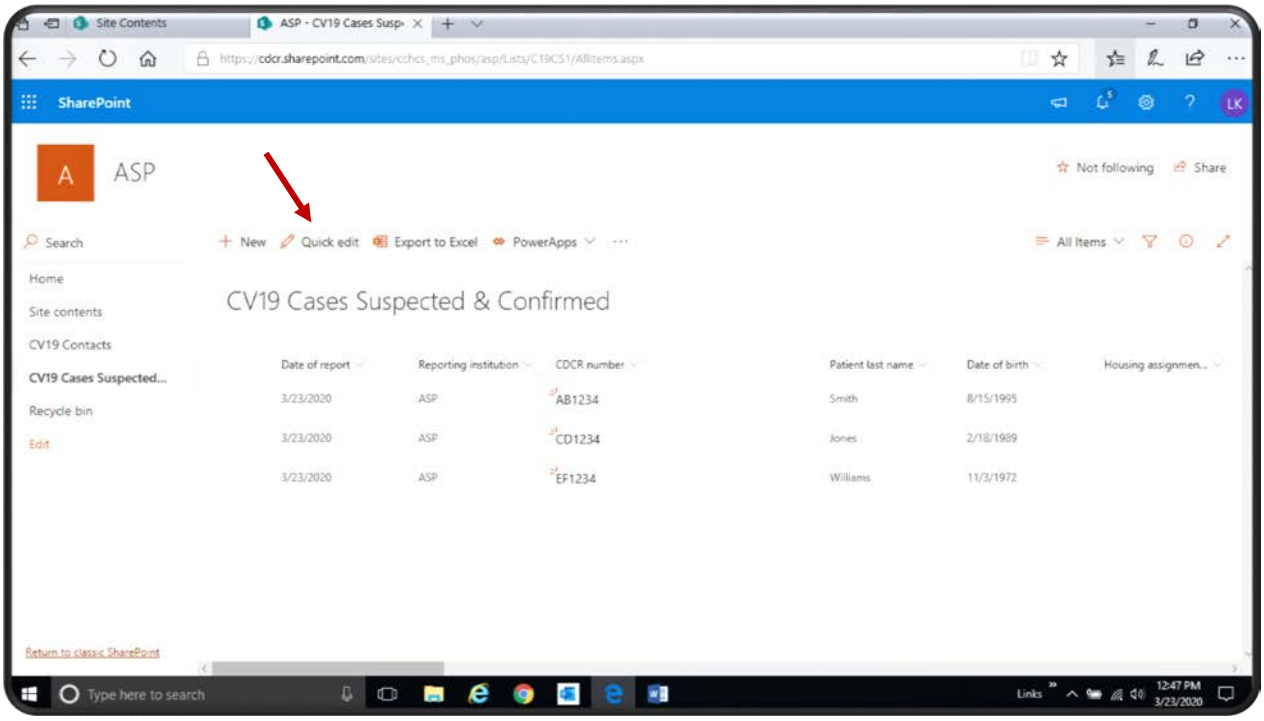
To enter updated information after saving the form, click on the row [1] to select the record in the line list, then click on **Edit** [2] to re-open the form.



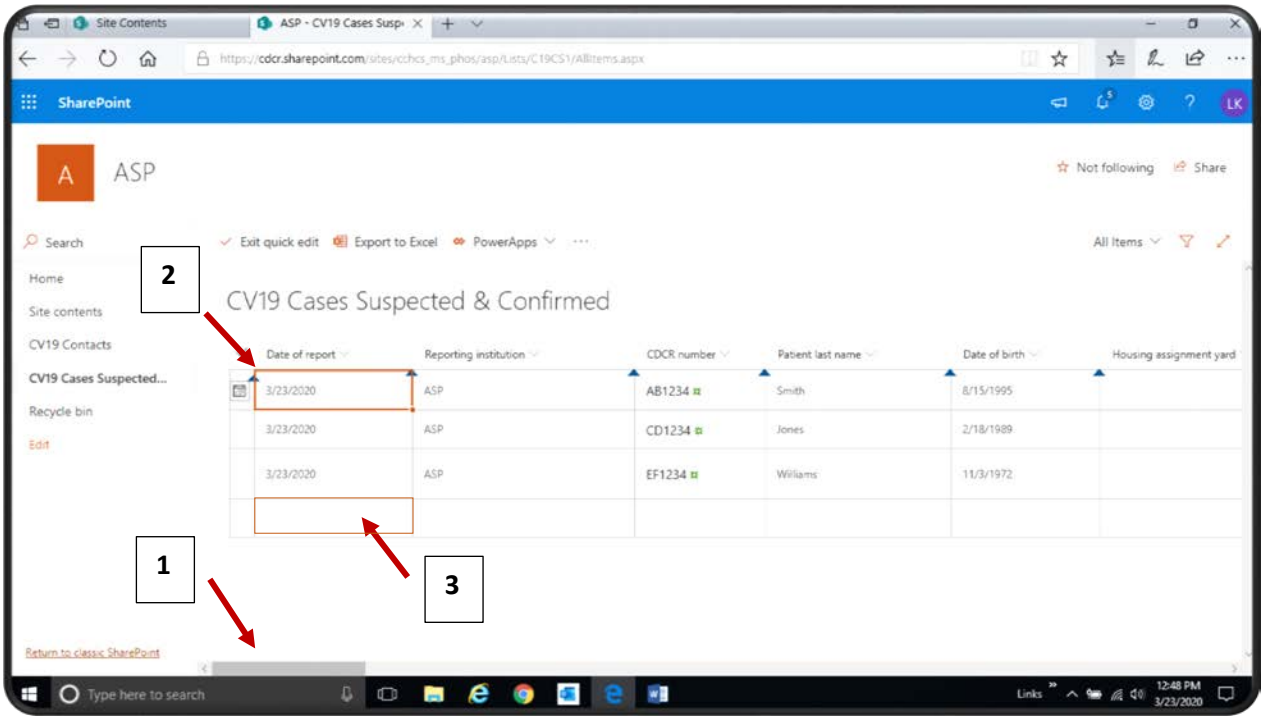
Enter your new information (e.g., diagnostic test, isolation dates) and click on **Save** (as above).



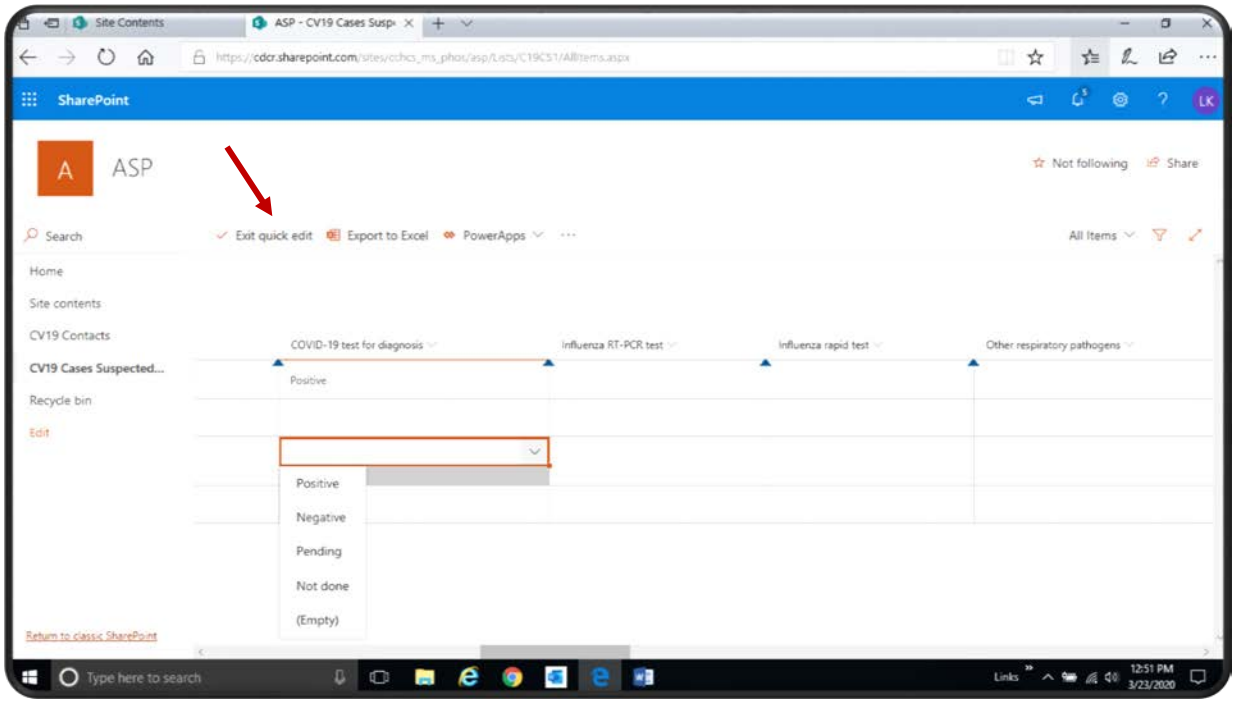
To edit a record directly in the line list, you can also click on **Quick Edit**.



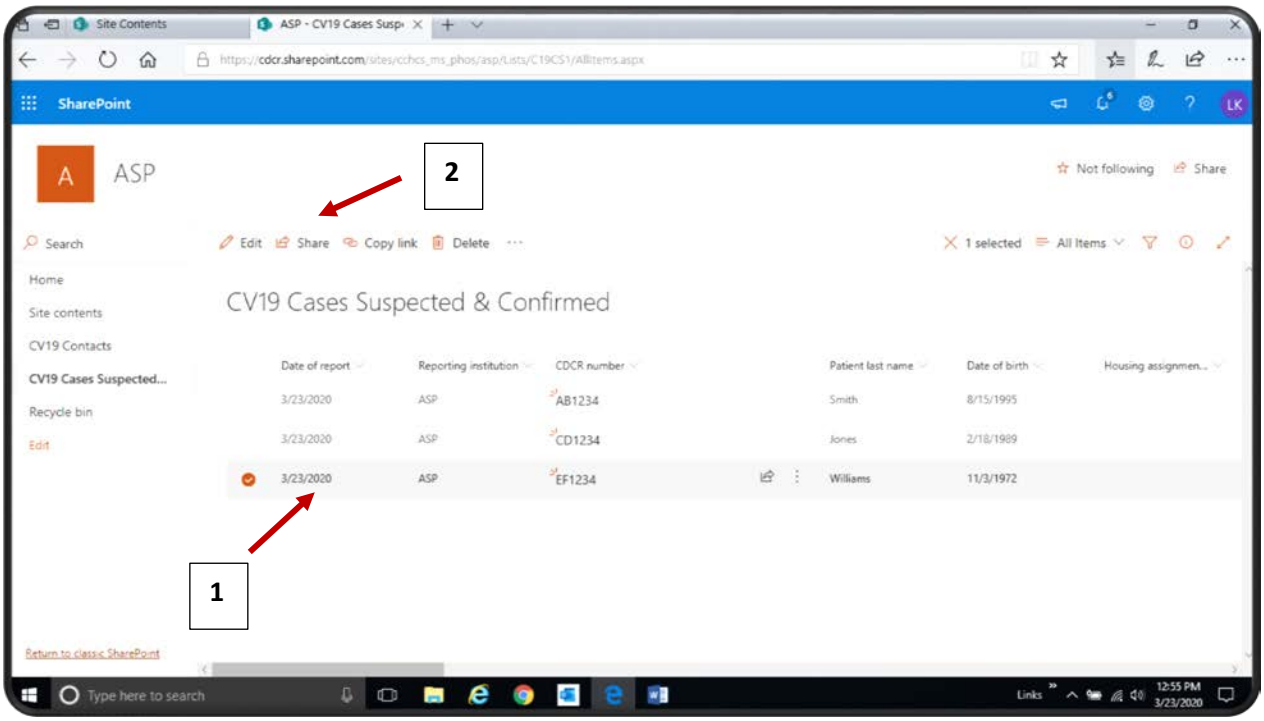
Use the scroll bar [1] to move across the line list. Clicking on any field [2] will highlight it and enable an update to be entered. You can also cut and paste from an Excel spreadsheet into a blank row [3] in SharePoint (e.g., to add a list of CDCR numbers to initiate reports for new patients).



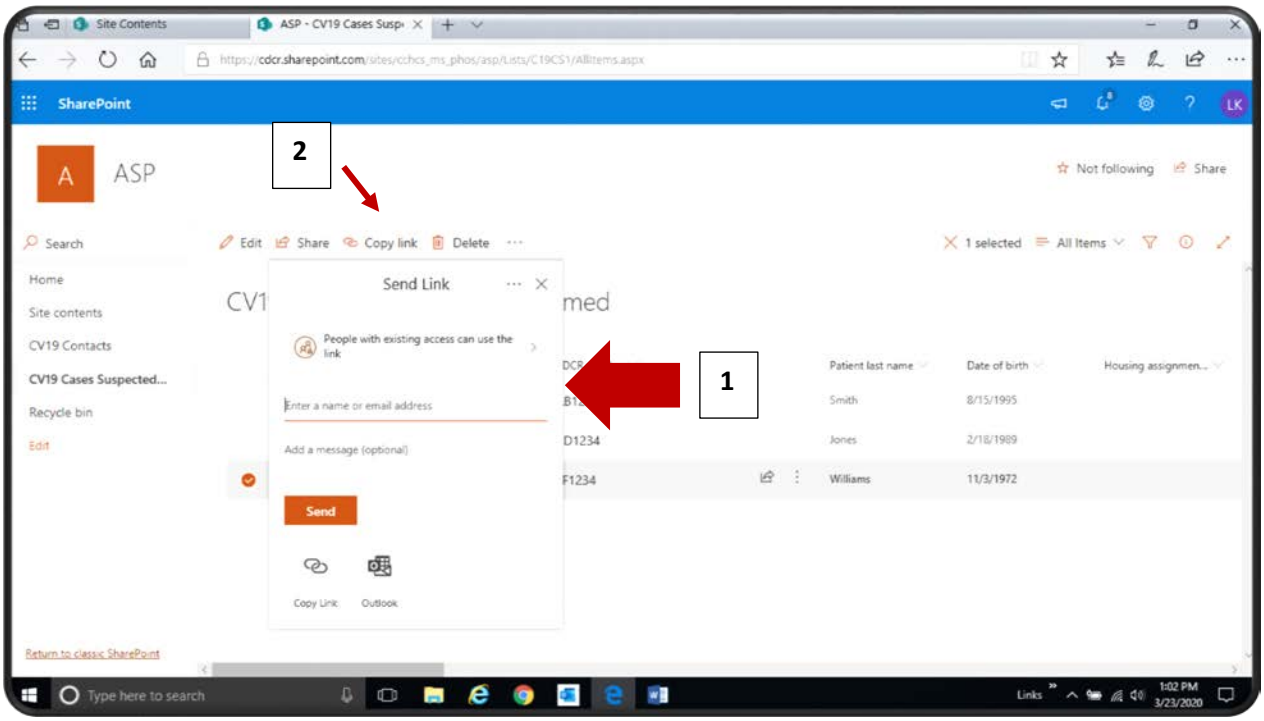
After entering new information into the line list, click on **Exit Quick Edit** to save the update.



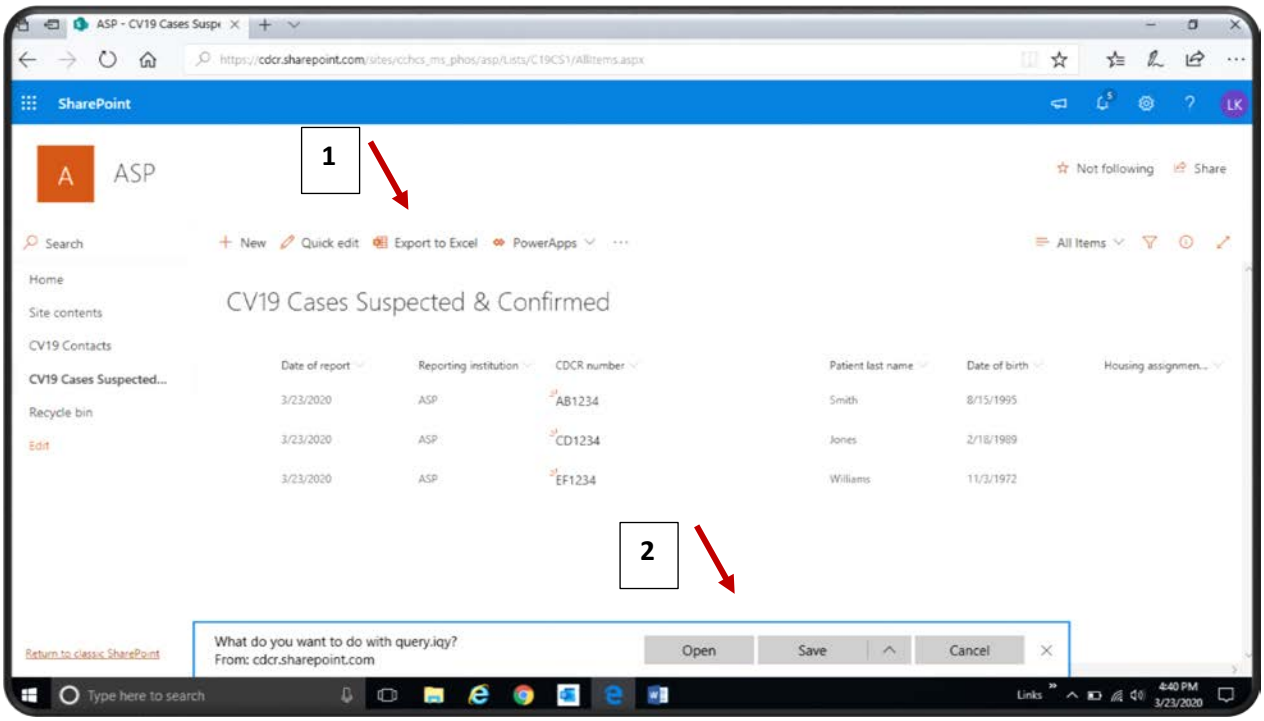
To share a link to an individual case report (e.g., to communicate with other health staff in the institution), select the record by clicking on it [1] and then click on **Share** [2].



A link to the case or contact report can be sent by entering an email address in the pop-up [1] or by clicking on **Copy Link** [2] and pasting the generated link into a separate email thread.



Click on **Export to Excel** [1] to create a copy of your CASES or CONTACTS line lists into a spreadsheet that can be saved for other non-reporting activities. Click on **Open** or **Save** [2] to view or save the spreadsheet in Excel.



DATA DICTIONARY

COVID-19 CASES SUSPECTED AND CONFIRMED

Field	Definition / Instruction
Date of Report	Date that the suspect or confirmed case-patient was initially reported. This field is auto-populated and should not be edited.
Reporting Institution	The default value (auto-populated) is the hub institution. If the patient is at a Community Correctional Facility (CCF), select the CCF from the drop-down menu.
CDCR number Patient last name Date of birth	In addition to the CDCR number, enter the patient's last name and date of birth. These are needed for PHB identification if the CDCR number is entered in error. Enter the birth date in M/D/YYYY format.
Housing assignment yard Housing assignment building Housing assignment tier Housing assignment cell bed bunk	Enter the patient's housing location (optional, for institutional use). Usually, the cell bed or number is a 3-digit number. In some cases it may be followed by a single letter representing upper or lower bunk (U or L).

Field	Definition / Instruction
COVID-19 test for diagnosis	Select an option from the drop-down list to record the result or status of the COVID-19 test used for diagnosis. Sometimes NP and OP swabs may be collected and tested separately. If ANY specimens tested positive, select Positive. If ALL specimens tested negative, select Negative.
Influenza RT-PCR test	Did the patient have the RT-PCR test for influenza? Select the result or status from the drop-down list.
Influenza rapid test	Did the patient have the rapid test for influenza? Select the result or status from the drop-down list.
Other respiratory pathogens	Did the patient test positive for any other respiratory pathogen besides COVID-19 or influenza? Select and option from the drop-down list.
Specify other resp pathogen(s)	If the patient tested positive for another respiratory pathogen, enter the pathogen(s) in the text box.
Symptoms	Select all symptoms that apply at any time during this illness from the drop-down list.
Date of symptom onset	Enter the first date that the patient had any of the symptoms checked above. Enter the date in M/D/YYYY format.
Date of symptom resolution	Enter the last date that the patient had any of the symptoms checked above. Enter the date in M/D/YYYY format.
Close contact	In the 14 days prior to symptom onset, did the patient have close contact with a confirmed case of COVID-19? Refer to the current COVID-19 guidance for definitions of close contact. Select an option from the drop-down list.
Cluster of influenza like illness	Is the patient linked to a cluster of influenza like illness? Select a response from the drop-down list.
Patient hospitalized (outside hospital)	Has the patient been hospitalized at an outside hospital for this illness? Select an option from the drop-down list.
Isolation status	Select the patient's current isolation status (e.g., alone in AIIR, at an outside hospital, released from isolation) from the drop-down list.
Date isolation began	Enter the date the patient was isolated. Enter the date in M/D/YYYY format.
Date released from isolation	Enter the date the patient was released from isolation (M/D/YYYY). Enter the date in M/D/YYYY format.
Release from isolation criteria for COVID-19	Check all that apply to indicate the criteria the patient met to be released from isolation or indicate the patient does not currently meet any criteria for release from isolation.
Case closed	Check if the case has been closed (i.e., the patient is no longer an active case in your institution).

Field	Definition / Instruction
Reason for closing case	If the case has been closed, select all reasons that apply from the drop-down list (e.g., the patient was ruled out for COVID-19, recovered, died, or was transferred or released).
Transfer institution	If the patient was transferred to another institution or CCF before the case was closed, select the institution or CCF from the drop-down list.
Date case closed	Enter the date that the case was closed in M/D/YYYY format.
Modified	Auto-populated date and time of the most recent edit/update to the report. This date/time cannot be edited by the user.
Modified by	Auto-populated user who last edited the report. This entry cannot be edited by the user.

COVID-19 CONTACTS

Field	Definition / Instruction
Date of report	Date that the contact to a confirmed case of COVID-19 was initially reported. This field is auto-populated and should not be edited.
Reporting institution	The default value (auto-populated) is the hub institution. If the patient is at a Community Correctional Facility (CCF), select the CCF from the drop-down menu.
CDCR number Patient last name Date of birth	In addition to the CDCR number, enter the patient's last name and date of birth (M/D/YYYY). These are needed for PHB identification if the CDCR number is entered in error. Enter the birth date in M/D/YYYY format.
Housing assignment yard Housing assignment building Housing assignment tier Housing assignment cell bed bunk	Enter the patient's housing location (optional, for institutional use). Usually, the cell bed or number is a 3-digit number. In some cases it may be followed by a single letter representing upper or lower bunk (U or L).
Quarantine reason	Select all reasons that apply to the current quarantine from the drop-down list. Use "close contact" as defined by the current COVID-19 guidance.
Date of last exposure	This date is used to calculate the end of the quarantine period. This value must be updated if the patient is re-exposed to COVID-19. Enter the date in M/D/YYYY format.
Quarantine start date	Enter the earliest date that the patient was placed on quarantine. Enter the date in M/D/YYYY format.
Quarantine end date	Enter the anticipated (future) or actual (past) end date of the quarantine for this patient. Enter the date in M/D/YYYY format.
Type of quarantine	How is (or was) the patient being quarantined. Select an option from the drop-down list.
Reason quarantine ended	Select all options that apply for reason(s) the patient's quarantine ended (e.g., the patient completed the quarantine without re-exposure, developed symptoms [i.e., suspect case], transferred) from the drop-down list.

Field	Definition / Instruction
Transfer institution	If the patient transferred to another CDCR institution or CCF before completing quarantine, select the institution or CCF from the drop-down list.
Modified	Auto-populated date and time of the most recent edit/update to the report. This date/time cannot be edited by the user.
Modified by	Auto-populated user who last edited the report. This entry cannot be edited by the user.

REQUESTING ACCESS TO THE COVID-19 SHAREPOINT

1. Each person who needs access must individually fill out a Secure Area Access Form.
    a. This form may not be completed on the behalf of another person.
    b. The form is located at http://cchcssites/SitePages/NewSecureRequest.aspx
    c. The name of the SharePoint is PH Outbreak Surveillance.
2. The delegated approver for the institution submit the name(s) of the person(s) requesting access to the SharePoint Team by email.
    a. The CNE for each institution has been delegated the authority to approve users from their institution. If the CNE is not available, the Public Health Branch can delegated the authority to another supervising nurse or to the PHN.
    b. The email address for the SharePoint team is m_SharePointTeam@cdcr.ca.gov.
3. Verify access by visiting the URL for the SharePoint: https://cdcr.sharepoint.com/sites/cchcs_ms_phos.

APPENDIX 6: COVID-19 INDEX CASE - PATIENT CONTACT INVESTIGATION TOOL

COVID-19 Case-Patient Contact Investigation Tool

Institution:
Interviewer:
Interview Date:

CDCR#
Last Name
First Name
DOB
Nicknames / aliases

Symptom onset date:
- Cough (new onset/worsenting of chronic cough)
- Shortness of breath (dyspnea)
- Fever >100.4 °F (38 °C)
- Subjective fever (felt feverish)
- Other symptoms

Date isolated:

Diagnostic specimen date:

Infectious period dates (from/to):
(from 2 days prior to symptom onset to isolation date)

Locations during infectious period (housing, out to hospital, other)

Yard / Facility	Building	Cell/Bed	Dates From	Dates To

Case-patient activities and close contacts during infectious period

Activity*	Location	Indoors (Yes/No)	First Date	Last Date	Time Spent / Day	# Contacts Identified	# Contacts developed symptoms	# Contacts Isolated	# Contacts COVID-19 Positive	Notes
Housing close contacts (cells/bunks within 6 feet)										
					Totals					

* Examples: work, vocational, education, dining, library, groups, appointments (medical, dental, mental health, legal), religious, day room, recreational, socializing, visiting

v. 4/1/2020

APPENDIX 7: COVID-19 INDEX CASE - PATIENT INTERVIEW CHECKLIST

Prior to the index case-patient interview, a review of the case presentation or physician conference should take place. The interviewer should be prepared to gather a detailed account of the case-patient's movements and activities during their infectious period to identify individuals who had close contact (within 6 feet and prolonged [generally ≥30 minutes]) with the patient or direct contact with any of the patient's secretions during the infectious period (from 2 days prior to symptom onset to isolation).

The index case-patient interview should take place as soon as possible after laboratory confirmation. If the patient is at an outside hospital, coordination with the local health department (LHD) or hospital should occur, to ensure timely completion of the interview so that close contacts can be identified and placed on quarantine.

Use the COVID-19 Index Case-Patient Contact Investigation Tool and this Interview Checklist to guide and document the interview. Initiate the contacts line list in the COVID-19 SharePoint:

Interview Objectives

- Confirmation of medical information (e.g., symptoms and onset date)
- Determination of the infectious period
- Determination of where the patient spends time
- Identification of all close contacts during the infectious period
- Providing patient education and answering the patient's questions
- Conveying the importance of sharing information about close contacts to help stop the spread

Pre-Interview Activities

- Review medical record and consult with physician as necessary for case presentation
- Establish a preliminary infectious period
- Collect housing, movement history, and work or program assignments from SOMS
- Determine if the patient is expected to be released from CDCR within the next 30 days
- Arrange interview time, space, and interpreter, if needed

Defining the Infectious Period

The infectious period during which others may have been exposed to COVID-19 starts 1 day before the onset of symptoms and ends when the patient was isolated or hospitalized at an outside facility.

INTERVIEW CHECKLIST

Personal Information

- ☐ Full name
- ☐ Aliases

Symptoms / Onset Date

- ☐ Cough (new onset or worsening)
- ☐ Shortness of breath (dyspnea)
- ☐ Fever >100.4°F (38°C)
- ☐ Subjective fever (felt feverish)
- ☐ Other symptoms

Contact Information

Identify and list contacts exposed for each group and activity. Document approximate duration of exposure during the activity.

Friends and Family

- ☐ Friends the patient spends the most time with
- ☐ Cell/dorm mates patient spends the most time with
- ☐ Family visits
- ☐ Visitors

Routine Activities and Assignments

- ☐ Work
- ☐ Vocational training
- ☐ Educational classes
- ☐ Dining areas
- ☐ Library time
- ☐ Group activities
- ☐ Regular appointments (medical, dental, legal)
- ☐ Committee presentation
- ☐ Religious, worship or spiritual activities
- ☐ TV room / day room
- ☐ Exercise
- ☐ Sports team participation
- ☐ Other

Notes

Any other relevant information

APPENDIX 8: EMPLOYEE CASE VERIFICATION AND CONTACT INVESTIGATION

COVID-19 Patient Positive Verification and Contact Investigation

PART 1 Initial steps to determine valid COVID -19 CASE
Notification to employee, health to begin an investigation

1. **Receive Notification from institution(s), name and contact information of suspected positive COVID-19 patient.**
2. **Nurse Consultant gathers available information on the patient**
    a. Nurse Consultant contacts the patient for interview
        i. Patient provides evidence of Positive test if available
        ii. Patient provides dates of symptom onset
        iii. Patient provides the dates of the work schedule.
    b. Determine initial dates of the infectious period
        i. Review patient interview
    c. Contact the local Public Health Department to determine positive status if needed
        i. Confirm the status of Patients test
        ii. Refine infectious period if necessary
3. **Determine if this referral is a valid positive case for COVID-19**
    a. Verified positive continue on as a case
    b. Verified negative; conclude the investigation

PART 2 VERIFIED POSITIVE COVID-19 CASE

1. **Develop plan for investigation**
    a. Prepare contacts list based on the refined infectious period
    b. Prioritize contacts
    c. Conduct contact assessments
2. **Determine need to expand or conclude an investigation based on evaluation of the information gathered.**
    a. Expand investigation
        i. Repeat steps in Part 1 (steps 1-3 for each contact)
    b. Conduct contact assessments
        i. Complete all report forms and forward to appropriate staff.