XAVIER BECERRA
Attorney General of the State of California
MONICA N. ANDERSON
Senior Assistant Attorney General
DAMON C. MCCLAIN
ADRIANO HRVATIN
Supervising Deputy Attorneys General
NASSTARAN RUHPARWAR - 263293
ELISE OWENS THORN - 145931
TYLER V. HEATH - 271478
KYLE A. LEWIS - 201041
LUCAS HENNES - 278361
Deputy Attorney General
455 Golden Gate Avenue, Suite 11000
San Francisco, CA 94102-7004
Telephone: (415) 703-5500
Facsimile: (415) 703-5843
Email: Nasstaran.Ruhparwar@doj.ca.gov

HANSON BRIDGETT LLP
PAUL B. MELLO - 179755
SAMANTHA D. WOLFF - 240280
KAYLEN KADOTANI - 294114
425 Market Street, 26th Floor
San Francisco, California 94105
Telephone: (415) 777-3200
Facsimile: (415) 541-9366
pmello@hansonbridgett.com

Attorneys for Defendants

UNITED STATES DISTRICT COURT

EASTERN DISTRICT OF CALIFORNIA

AND THE NORTHERN DISTRICT OF CALIFORNIA

UNITED STATES DISTRICT COURT COMPOSED OF THREE JUDGES

PURSUANT TO SECTION 2284, TITLE 28 UNITED STATES CODE

RALPH COLEMAN, et. al., Plaintiffs, v. GAVIN NEWSOM, et al., Defendants.	CASE NO. 2:90-cv-00520 KJM P **THREE-JUDGE COURT**
MARCIANO PLATA, et al., Plaintiffs, v. GAVIN NEWSOM, et al., Defendants.	CASE NO. C01-1351 JST **THREE-JUDGE COURT** **DECLARATION OF JOSEPH BICK, M.D., IN THE MATTER OF DEFENDANTS' OPPOSITION TO PLAINTIFFS' EMERGENCY MOTION TO MODIFY POPULATION REDUCTION ORDER**

I, Joseph Bick, M.D., declare:

1. I am currently the Director of Health Care Services for the California Department of Corrections and Rehabilitation (CDCR). In this capacity, I oversee the mental health and dental programs providing services to CDCR's inmate patients. Before holding this position, I served as the Chief Medical Executive at CDCR's California Medical Facility from 2010-2020, the facility's Chief Deputy for Clinical Services from 2007-2010, and the facility's Chief Medical Officer from 1994-2007. I submit this declaration in support of Defendants' Opposition to Plaintiffs' Emergency Motion to Modify the Population Reduction Order.

2. I received a Medical Doctorate from the University of Michigan Medical School in 1987, and am a board certified internist and infectious diseases specialist. I completed an infectious diseases fellowship at St. Luke's Medical Center in Chicago, Illinois in 1993, and am a Fellow in the Infectious Diseases Society of America. In addition to my work at CDCR, I have served as a Visiting Associate Professor for Infectious Diseases at the University of Malaya Medical Centre, Kuala Lumpur, Malaysia from 2012-2013; an International Technical Expert on Prisons with the United Nations Office for Project Services, Myanmar from 2013-2014; an Infectious Diseases Consultant for Kajang Prison in Kajang, Malaysia from 2012-2016; and a Court-Appointed Medical Monitor in *Leatherwood, et al. v. Campbell, et al.*, No. CV-02-BE-2812-W (W.D. Ala.), a class action concerning human immunodeficiency virus (HIV) infected prisoners in the Alabama Department of Corrections, from 2005-2007. I have contributed to various publications addressing infectious diseases in the correctional setting, and was the Assistant Editor of the "Infectious Diseases in Corrections Report" from 1997-2008, and have lectured on infectious diseases including Mycobacterium Tuberculosis, Hepatitis C, Methicillin Resistant Staphylococcus aureus, Coccidioidomycosis (Valley fever), and HIV.

3. Coronavirus disease 2019 (COVID-19) is a respiratory illness caused by a novel (new) coronavirus. COVID-19 was first identified in China in late 2019, and over the past few months it has rapidly spread to many other nations, including the United States. On March 11, 2020, the World Health Organization declared COVID-19 a pandemic. (https://www.who.int/dg/speeches/detail/who-director-general-s-opening-remarks-at-the-media-

briefing-on-covid-19---11-march-2020, last retrieved March 28, 2020.) According to the Centers for Disease Control and Prevention (CDC), the virus that causes COVID-19 is spread by both respiratory and person-to-person contact. (https://www.cdc.gov/coronavirus/2019-ncov/prevent-getting-sick/how-covid-spreads.html, last retrieved Mar. 28, 2020.) This can include close contact (within about 6 feet) with an infected person when that person coughs or sneezes, producing respiratory droplets that are inhaled into the lungs by nearby persons. The virus can also spread from contact with surfaces or objects that have the virus on them. The virus appears to be spreading easily and sustainably among communities in some affected geographic areas, with persons not sure how or where they became infected. This is known as "community spread." (https://www.nih.gov/health-information/coronavirus, last retrieved Mar. 28, 2020.)

4. Persons infected by the coronavirus have experienced symptoms including fever, cough, and shortness of breath, which can appear 2-14 days after exposure. (https://www.cdc.gov/coronavirus/2019-ncov/symptoms-testing/symptoms.html, last retrieved Mar. 28, 2020.) Infected persons may feel a range of illness, from mild symptomology to more severe illness that can cause death. Other infected persons can also be asymptomatic after exposure. According the California Department of Public Health, approximately 80% of persons whom have tested positive for COVID-19 do not exhibit symptoms that would require hospitalization. (https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/Immunization/ncov2019.aspx, last retrieved March 28, 2020.)

5. The CDC has advised people take a variety of precautions to protect themselves from COVID-19 illness, including washing hands often; avoiding touching their eyes, nose, or mouth with unwashed hands; avoiding close contact with people who are sick; and putting physical distance between themselves and other persons. (https://www.cdc.gov/coronavirus/2019-ncov/prevent-getting-sick/prevention.html, last retrieved Mar. 29, 2020.) It is widely accepted that certain population groups are at a higher risk for severe illness, including people aged 65 years and older; people living in nursing homes or long-term care facilities; people with chronic lung disease, moderate to severe asthma, heart conditions, or compromised immunity systems; and

people experiencing homelessness. (https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/people-at-higher-risk.html; https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/Immunization/ncov2019.aspx, last retrieved March 28, 2020.) As of March 30, 2020, the CDC reports 160,813 total cases and 2,960 deaths in the United States. (https://www.cdc.gov/coronavirus/2019-ncov/cases-updates/cases-in-us.html#reporting-cases, last retrieved March 29, 2020.) As of March 30, 2020, the California Department of Public Health reports 6,895 total positive cases and 142 deaths in the state. (https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/Immunization/ncov2019.aspx.)

6. The COVID-19 pandemic presents a serious and unprecedented risk to public health. In addition to the community at large, COVID-19 also threatens prison inmates because, similar to persons living in nursing homes or group settings, inmates are at a higher risk for contracting the virus given the circumstances of incarceration, including closer living quarters. The State of California has taken a number of steps in response to the emerging, rapidly evolving COVID-19 pandemic, among them declaring a State of Emergency directing state agencies take actions to protect public health and safety, including in its prisons. Staff at CDCR and the California Correctional Health Care Services (CCHCS) are working closely with infectious disease control experts to minimize the impact of COVID-19 on the Department's operations and prevent harm to inmates and staff. Many of the responsive actions taken by CDCR correspond to the interim COVID-19 guidance for correctional facilities issued by the Centers for Disease Control and Prevention promoting increased operational preparedness, prevention measures, and clinical management of confirmed and suspected COVID-19 cases inside a facility. (https://www.cdc.gov/coronavirus/2019-ncov/community/correction-detention/guidance-correctional-detention.html, last retrieved March 29, 2020.) As the Director of Health Care Services, I am monitoring CDCR's mental health program's response to the extraordinary COVID-19 pandemic, including closely coordinating the mental health program's activities with CCHCS and CDCR's Division of Adult Institutions, which is in charge of custody operations. Based on my review of those interim guidelines and operational observations, CDCR's response to COVID19 includes steps that are similar to those advised by the CDC and adapted to the

specific realities faced by CDCR.

7. CDCR has taken a number of steps to implement the tactics recommended by public health authorities to prevent the spread of COVID-19 among its inmate population and continue provision of mental health services to inmate-patients. To reduce the threat of introduction of the virus into its institutions, all staff and persons entering CDCR facility now undergo verbal symptom screening and a touchless temperature screening. Immediately upon entry at an institution, all inmates are screened for symptoms of influenza-like illness, including COVID-19, and quarantined for 14 days to ensure that they show no symptoms. As a further protective measure, Governor Newsom issued an executive order on March 24, 2020 directing CDCR to temporarily halt the intake of inmates into its institutions. These important measures mitigate the risk of COVID-19 from entering CDCR's institutions, thus protecting the health and safety of inmates, staff, and the general public. Further, on March 30, 2020, CDCR Secretary Ralph Diaz announced the expedited transition to parole of nearly 3,500 inmates who have 60 days or less remaining on their sentences, are not serving a current term for a violent felony offense, are not required to register under California Penal Code section 290, and are not serving a current term of incarceration for a domestic-violence offense. This action will facilitate physical distancing within the prisons and more effective implementation of appropriate public health measures. Reduced population density is an important component of slowing and perhaps reducing the number of inmates and staff who will become infected. The actions the Secretary is taking will allow staff to more effectively attend to the health and safety of the remaining inmates.

8. In accordance with public health guidelines, CDCR has implemented various practices to encourage physical distancing among inmates and staff to stop the spread of COVID-19. Some actions taken in recent weeks include posting signage throughout institutions; creation of education videos describing methods to prevent virus spread, including physical distancing; limiting group activities to no more than 10 persons; and reducing the number of inmates released to yard, day room, or dining activities to permit adequate space between persons during these periods; stopping other forms of inmate movement; and increased staff and inmate hygienic and cleaning efforts. These are also reasonable actions to protect medically high-risk patients from

potential exposure to the virus.

9. To standardize the diagnosis and treatment of COVID-19 among CDCR's inmate population, CCHCS issued interim guidance for its clinicians in March 2020. A true and correct copy of CCHCS's "COVID-19: Interim Guidance for Health Care and Public Health Providers," is attached hereto as Exhibit A. It assists CDCR's health care professionals concerning identification, diagnostic testing, precautions, and management of COVID-19 for the health and safety of both inmate-patients and staff. CDCR is utilizing its external laboratory provider for COVID-19 testing and applying protocols consistent with public health officials' guidance, which prioritize testing among different groups. (https://www.cdc.gov/coronavirus/2019-nCoV/hcp/clinical-criteria.html, last retrieved March 28, 2020.) CCHCS does not currently have the ability to test all inmates for COVID-19 infections, and indeed, testing of asymptomatic individuals is not recommended by public health authorities. Moreover, clinicians are strongly encouraged to test patients demonstrating influenza-like illnesses, which symptoms can resemble the coronavirus disease, for other causes of respiratory illness. CCHCS guidance states that priority for COVID-19 related testing is given to symptomatic individuals who are 65 years and older, have a chronic medical condition, or are otherwise immunocompromised, and to patients who have had close contact with an infectious case of COVID-19. While influenza remains prevalent, patients demonstrating symptoms who are not at high risk for severe disease may undergo testing for influenza as a first-line test, with a COVID-19 testing if negative for influenza. As of March 30, 2020, 22 inmate-patients have been tested for COVID-19, with 3 inmates at California State Prison – Los Angeles County and 1 inmate at California Institution for Men testing positive. https://www.cdcr.ca.gov/covid19/population-status-tracking/

10. CCHCS's COVID-19 interim guidance also provides direction for clinicians concerning management of suspected and confirmed cases of COVID-19. An inmate-patient with suspected or confirmed COVID-19 will be placed on medical hold, a contact investigation initiated, and all inmates housed in the same unit, and any other identified close contacts, will be placed on a medical hold as part of quarantine measures. These inmate-patients will be regularly assessed and monitored by institution medical staff, and these patients' movements will limited to

decrease the risk of spreading COVID-19 to other parts of a facility. CCHCS's interim guidance further describes the necessary steps and decision points for providers concerning appropriate isolation, surveillance, and release from isolation measures. These informed disease control efforts are based on recommendations from the CDC and California Department of Public Health.

11. Serious public health concerns are posed by COVID-19, including the risk of severe illness; widespread transmission; debilitating strains placed on public healthcare systems, emergency medical services, and first responders; and elevated rates of hospitalizations and death. Based on my understanding of California's public health care system, I believe that the COVID-19 pandemic, if unchecked by current efforts, will place a similar burden on hospitals to cope with the crisis.

12. With respect to the delivery of mental health services to CDCR's inmate-patients during the COVID-19 pandemic, on March 25, 2020, CDCR's mental health program leadership issued a memorandum titled "COVID-19 – Mental Health Delivery of Care Guidance," which provides institutional guidance and a tiered response plan to ensure continued care. A true copy of the Mental Health Delivery of Care Guidance is attached hereto as Exhibit B. CDCR's guidance takes into account how inmate mental health resources, treatment, and operations may be impacted as the pandemic evolves throughout the state, and was extensively briefed to the *Coleman* Special Master and Plaintiffs' counsel. Since the guidance was distributed to CDCR's institutions, mental health program leadership are continually communicating with institutions regarding the status of mental health services, programming, and staffing in accordance with the tiered plan at their respective locations. This guidance will be continually assessed and adapted to the ever-changing situation posed by the COVID-19 pandemic.

13. CDCR's COVID-19 mental health guidance recognizes the challenges and limitations that may be placed on mental health programming and practices during the pandemic, as well as the increased mental health risks that patients may encounter. Mental health clinicians are directed to focus on preserving life, stabilizing mental health deterioration, and helping mental health patients cope during this significant event. Institutions are directed to follow current policies and procedures concerning the provisions of treatment in the Mental Health Services

Delivery System Program Guide, to the extent possible given operational limitations, and reflects CDCR's commitment to ensuring that patients receive essential care and support services during possible periods of reduced onsite staffing that may result from the pandemic, restrictions on patient movement, and increased physical distancing necessary to prevent the spread of COVID-19. As part of its suicide prevention measures, CDCR will continue to perform Suicide Risk Assessment per policy, but in the event that operational limitations arise due to staff reductions, clinicians are directed to take additional actions to provide care and observation of patients, including regular rounding by designated clinicians and distribution of workbooks to patients in various housing units and at different levels of care.

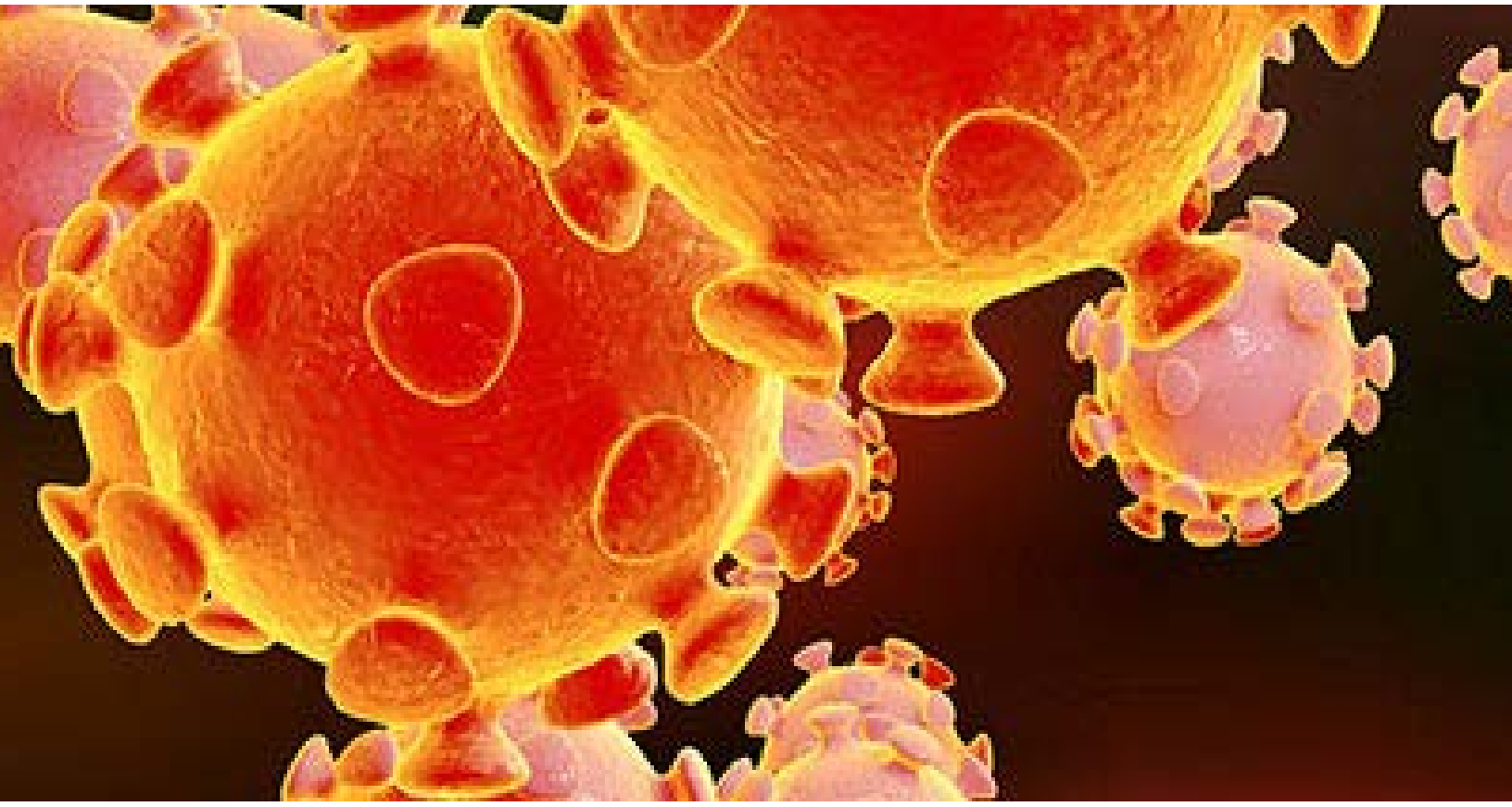
14. The guidance also addresses changes to CDCR's inpatient referral system caused by COVID-19, including the temporary suspension of the Department of State Hospital's patient transfers to and from CDCR. The mental health program's COVID-19 response plan also places clinical focus on patient education and communication, and details a number of actions that institutions shall take to ensure physical distancing during mental health treatment encounters or programming. In accordance with public health authorities' guidance, institutions are instructed to consider smaller groups, physical settings, and communication strategies to ensure that patients continue to receive care and understand the reasons for distancing. Finally, the guidance recognizes the benefits of telepsychiatry—for both patients and providers—in light of COVID-19 physical distancing measures, and permits institutions to expand its use. Mental health program staff are currently working with CDCR information technology staff to expand provider and institution telepsychiatry capabilities. I strongly support these efforts to create greater physical distancing coupled with enhanced social interactions, whether in person or by remote means, which still provide necessary mental health care services to CDCR's patients. The measures outlined in CDCR's mental health care delivery guidance, which will be continually examined and adjusted according to operational realities, are an attempt to ensure continued services during the COVID-19 crisis.

I declare under penalty of perjury that the foregoing is true and correct. Executed on March 31, 2020 in Davis, California

/s/ Joseph Bick

Joseph Bick, M.D.
(Original signature retained by counsel)

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



Public Health Nursing Program

Version 1.0

CALIFORNIA CORRECTIONAL
HEALTH CARE SERVICES

Table of Contents

Record of Change

Date	Change	Approved By

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

INTRODUCTION

Coronaviruses are a large family of viruses that are common in many different species of animals; some coronaviruses cause respiratory illness in humans. Coronavirus disease 2019 (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 World Health Organization recognized COVID-19 to be a pandemic.

This guidance supersedes the Seasonal Influenza Guidance except where noted.

CLINICAL MANIFESTATIONS OF COVID-19

People with COVID-19 generally develop signs and symptoms, including respiratory symptoms and fever, average 5 days, range 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

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).

Asymptomatic infection has been reported, but the majority of the relatively rare cases who were asymptomatic on the date of identification/report, went on to develop disease.

DIFFERENTIAL DIAGNOSIS

Viral pneumonia can be caused by many respiratory pathogens. When Influenza is present (e.g., the height of seasonal influenza), it is the likely cause of influenza-like illness (ILI). 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. Hence, laboratory testing is required.

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.**

To be inclusive of both influenza and COVID-19 in the differential, ILI can be defined by any combination of fever or cough; sore throat is more common with influenza whereas difficulty breathing is more common with COVID-19.

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.

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

Respiratory syncytial virus (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.

Additional considerations:

1. Patients of Concern: Because early diagnosis may improve clinical outcomes, priority for COVID-19 testing should be given to symptomatic individuals who are **older (age ≥60 years)** or have **chronic medical conditions and/or an immunocompromised** state that may put them at higher risk for poor outcomes (e.g., diabetes, heart failure, cerebrovascular disease, chronic lung disease, chronic kidney disease, cancer, liver disease, and pregnancy).
2. COVID-19 Contacts: Patients who have had close contact with an infectious case of COVID-19 are at increased risk of developing the disease. If a contact develops symptoms of COVID-19, they should be tested for COVID-19 immediately.
3. Outbreaks of ILI: Early identification of a COVID-19 outbreak may be key to mitigating its impact on staff, patients, and the surrounding community (including community hospitals). Therefore, if a cluster of ILI occurs and the Rapid Influenza Diagnostic Test (RIDT) is not available, use concurrent testing for subset of patients (a sentinel approach).
4. Influenza No Longer Prevalent: 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.

Rapid Influenza Diagnostic Test (CLIA waived)

While influenza remains prevalent, Rapid Influenza Diagnostic Testing (RIDT) may be used to quickly identify influenza infections. Patients with influenza or 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 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

For initial diagnostic testing for COVID-19, **the preferred specimen is a nasopharyngeal (NP) swab**. NP or oropharyngeal (OP) swabs should be collected in multi microbe media (M4), VCM medium (green-cap provided by Quest) tube or equivalent (UTM). Only one swab is needed and the NP specimen has the best sensitivity. Testing both NP and OP also increases sensitivity. If collecting both a NP and OP swab, they both can be put in the same VCM tube. Specimens should be collected as soon as possible, regardless of the time of symptom onset.

Please note: Sputum inductions are not recommended as a means for sample collection. Collection of sputum should only be done for those patients with productive coughs.

Please note: **A different order will be needed if or when collecting a specimen for any other tests, e.g., influenza, use a different swab and the swab goes into a different tube.**

Quest is accepting specimens for SARS-CoV-2 RNA, Qualitative Real-Time RT-PCR testing (Quest Test Code: 39433).

1. Preferred specimen: NP swab or OP swab collected in multi microbe media (M4), VCM medium (green-cap) tube or equivalent (UTM). If collecting two swabs, both can be put in one tube.
2. 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.**
3. Storage and Transport: COVID-19 specimens must be refrigerated. Refrigerated stability is up to 72 hour.
4. Follow standard procedure for storage and transport of refrigerated samples.
5. Cold packs/pouches must be utilized if samples are placed in a lockbox.
6. COVID-19 is not a STAT test and a STAT pick-up cannot be ordered.
7. Turnaround time (TAT), published as 3-4 days, may be delayed initially due to high demand
8. The induction of sputum is not recommended.

SARS-CoV-2 RNA, Qualitative Real-Time RT-PCR- Quest Test Code 39433:

Test Purpose: Aids in presumptive detection of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) RNA

Collect via Nasopharyngeal (NP) Swab or Oropharyngeal (OP) swab

Collected in multi microbe media (M4), VCM medium (green-cap) tube or equivalent (UTM) (one swab per tube)

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 or conducting RIDT, the Heath Care Personnel (HCP) in the room should wear an N-95 or higher-level respirator, eye protection, gloves, and a gown.

- The number of HCP present during the procedure should be limited to only those essential for patient 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 section on environmental infection control. CDC Interim Infection Prevention and Control Recommendations for Patients with Suspected or Confirmed Coronavirus Disease 2019 (COVID-19) in Healthcare Settings

TREATMENT

Currently, there is no approved vaccine or medication treatments for COVID-19. Treatment is supportive, especially for respiratory distress. Experimental drugs may be available through compassionate use or clinical trials. See: CDC Confirmed Case Management

TRANSMISSION

- The virus that causes COVID-19 seems to be spreading easily and sustainably in the community ("community spread") in some affected geographic areas. Community spread means people have been infected with the virus in an area, including some who are not sure how or where they became infected.
- The virus is thought to spread mainly from person-to-person (airborne, contact or droplet transmission), between people who are in close contact with one another (within 6 feet).
- People are thought to be most contagious when they are most symptomatic (the sickest).
- Except with the risk of exposure from aerosol generating procedures, airborne transmission is not the main route of transmission.
- Infectious respiratory droplets can land in the mouths or noses of people who are nearby and possibly be inhaled into the lungs.
- It may be possible that a person can get COVID-19 by touching a contaminated surface 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.
- Symptoms of COVID-19 may appear in as few as two days or as long as 14 days after exposure (mean six days, median five days).
- Fecal shedding after symptom resolution has been found; however, the infectiousness of the fecal viral particles is unclear.

COVID-19 RELATED PUBLIC HEALTH DEFINITIONS

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 an influenza virus in respiratory specimen in a patient with influenza-like illness.

SUSPECTED COVID-19 / INFLUENZA CASE
HIGH SUSPECT: Any fever, respiratory symptoms, or evidence of a viral syndrome in a patient who had close 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 and 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.

NON-CASE DEFINITIONS

ASYMPTOMATIC CONTACT OF COVID-19
A person who has had close (within 6.6 feet [2 meters]) and prolonged (generally ≥30 minutes) contact with the COVID-19 patient **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 contacts should be monitored for symptoms; ideally, two times daily, and containment measures should be in place [e.g., housing with a cohort of asymptomatic contacts, “Confined To Quarters” (CTQ), etc.]

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.

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 chow as a group and go to the yard as a group, but not mix with others who are not quarantined.

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.

REPORTING

- When a patient with fever and respiratory symptoms is identified, institutional processes for notification to the Public Health Nurse (PHN) and/or PHN alternate must be established for ongoing surveillance and reporting. The PHN and/or PHN alternate is responsible for reporting of respiratory illness and outbreaks.
- Laboratory confirmed COVID-19 cases and suspect cases of COVID-19 shall immediately be reported to the PHN or PHN alternate.
- 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. Follow usual guidelines for reporting influenza to the LHD. The LHD is responsible for reporting to CDPH.
- During the COVID-19 pandemic:
  - Notify CCHCS Public Health Branch (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 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.

- 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.

INFECTIOUSNESS OF PATIENTS BY CASE TYPE

A patient with a confirmed or suspected case of COVID-19 is considered to be infectious from the time of symptom onset until symptoms resolve AND they are cleared by the local health department for release from isolation. See Criteria for Release from Isolation section of this document.

A patient with a confirmed or suspected case of influenza is considered infectious for seven days after the onset of symptoms or for 24 hours after the resolution of fever and respiratory symptoms, whichever is longer.

An asymptomatic contact is not considered to be infectious.

PRECAUTIONS

Standard, contact, and airborne precautions, plus eye protection are required for any patient with suspected or confirmed COVID-19, or any asymptomatic contact to COVID-19.

For patients with confirmed influenza, **standard, contact, and droplet precautions** are required.

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

PERSONAL PROTECTIVE EQUIPMENT (PPE)

Gloves

- Perform hand hygiene, then put on clean, non-sterile gloves upon entry into the patient room or care area. Change gloves if they become torn or heavily contaminated.
- Remove and discard gloves when leaving the patient room or care area, and immediately perform hand hygiene.

Gowns

- Put on a clean isolation gown upon entry into the patient room or area. Change the gown if it becomes soiled. Remove and discard the gown in a dedicated container for

waste or linen before leaving the patient room or care area. Disposable gowns should be discarded after use.

Respiratory Protection for Airborne Precautions

- Use respiratory protection that is at least as protective as a fit-tested NIOSH-certified disposable N95 filtering face piece respirator before entry into the patient room or care area.
- Disposable respirators (e.g., N95s) should be removed and discarded after exiting the patient's room or care area and closing the door. Perform hand hygiene after discarding the respirator. In cases of N95 respirator shortage, extended N95 use may be implemented per CDC and National Institute for Occupational Safety and Health (NIOSH) parameters. (https://www.cdc.gov/niosh/ topics/hcwcontrols/recommendedguidanceextuse.html)
- If reusable respirators, such as powered air purifying respirator (PAPR) are used, they must be cleaned and disinfected according to manufacturer's reprocessing instructions prior to re-use.
- Respirator use must be in the context of a complete respiratory protection program in accordance with Occupational Safety and Health Administration (OSHA) Respiratory Protection standard (29 CFR 1910.134 Respiratory Protection). Staff should be medically cleared and fit-tested if using respirators with tight-fitting face pieces (e.g., a NIOSH-certified disposable N95) and trained in the proper use of respirators, safe removal and disposal, and medical contraindications to respirator use.

Respiratory Protection for Droplet Precautions

- Staff should wear a surgical mask when entering the room or area of a patient with confirmed influenza (where COVID-19 has been ruled out). After leaving the patient's room or area staff should remove the mask, dispose of the mask in a waste container, and perform hand hygiene.

Eye Protection

- Put on eye protection (e.g., goggles, a disposable face shield that covers the front and sides of the face) upon entry to the patient room or care area. Remove eye protection before leaving the patient room or care area. Reusable eye protection (e.g., goggles) must be cleaned and disinfected according to manufacturer's reprocessing instructions prior to re-use. Disposable eye protection should be discarded after use.

For further information on standard, contact, and airborne precautions, refer to Health Care Department Operational Manual, Chapter 3 Article 8, Communicating Precautions from Health Care Staff to Custody Staff.

SUMMARY TABLE OF TRANSMISSION-BASED PRECAUTIONS

Type of case or Non-Case	Isolation or Quarantine	Precautions	PPE Recommendations
Confirmed COVID-19 Case	ISOLATION (AIIR if available) alone or with other confirmed cases of COVID-19	Standard, contact, droplet, and airborne	**Health Care Worker (HCW):** N95 Respirator, gloves, gown, face shield or other eye protection **Patient:** surgical or procedure mask
Confirmed Influenza Case	ISOLATION alone or with other confirmed cases of influenza	Standard, contact, and droplet	**HCW:** surgical mask, gloves, gown **Patient:** surgical or procedure mask
Suspected Case (ILI of unknown etiology)	ISOLATION alone	Standard, contact, droplet, and airborne	**HCW:** N95 Respirator, gloves, gown, face shield or other eye protection **Patient:** surgical or procedure mask
Asymptomatic Contact to a COVID-19 Case (Non-Case)	QUARANTINE alone or with others who had the same exposure	Standard, contact, droplet, and airborne	**HCW:** N95 Respirator, gloves, gown, face shield or other eye protection **Patient:** surgical or procedure mask for transport or interactions with HCW
Asymptomatic Contact to an Influenza Case (Non-Case)	QUARANTINE alone or with others who had the same exposure	Standard, contact, and droplet	**HCW:** Surgical Mask, Gloves, Gown **Patient:** Surgical or Procedure Mask for transport
Asymptomatic Contact of a Contact (Non-Case)	NO INTERVENTION	Standard	**HCW:** No PPE **Patient:** No Mask

SUMMARY FIGURE OF INTERVENTIONS

MANAGEMENT OF SUSPECTED AND CONFIRMED CASES OF COVID-19

For management of confirmed cases of influenza, see CCHCS Seasonal Influenza Infection Prevention and Control Guidance

- Immediately mask patients when COVID-19 is suspected. Surgical or procedure masks are appropriate for patients.
- Patients should be placed in AIIR as soon as possible. If AIIR is not immediately available, the patient shall be placed in a private room with the door closed. Appropriate signage indicating precautions should be visible outside the patient's room.
- Standard, contact, and airborne precautions plus eye protection should be implemented immediately (see PPE section).
- 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 COVID-19 utilize appropriate PPE: N95 respirator or PAPR, gloves, gown, and face shield or goggles.
- 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. 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.

MONITORING PATIENTS SUSPECTED OR CONFIRMED WITH 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
  - Lung auscultation
  - Assessing for signs and symptoms of dehydration (rapid pulse, sluggish skin tugor; dry mucous membranes, sunken eyes, confusion)
- 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
  - Altered mental status or confusion

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

ISOLATION

Promptly separate patients who are sick with fever and 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 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.

  - 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.
  - 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 during transport of these patients.

MEDICAL HOLD AND CONTACT INVESTIGATION

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

- The patient should be placed on a medical hold,
- A contact investigation should be conducted, and
- 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.

RESPONSE TO AN OUTBREAK

When one or more laboratory confirmed cases of COVID-19 have been reported, surveillance should be conducted throughout the institution to identify contacts.

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 Chief Medical Executive (CME), PHN, Chief Nurse Executive (CNE), Director of Nurses (DON), Infection Control Nurse (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.

INITIAL NOTIFICATIONS

- If health care or custody staff become aware of or observe symptoms consistent with COVID-19 in a patient, staff, or visitor to the institution, they should immediately notify institutional leadership: a supervisor, manager or AOD (Administrative Officer of the Day). Institutional leadership should notify the Public Health Nurse (PHN) or PHN alternate (often the Infection Control Nurse) and the local health department.
- 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.

CRITERIA FOR RELEASE FROM ISOLATION

1. Individuals with laboratory-confirmed COVID-19 who have are asymptomatic:
    a. Discontinue isolation when at least seven days have passed since the date of their first positive COVID-19 diagnostic test and remain asymptomatic.
2. Individuals with symptomatic COVID-19 under isolation, considerations to discontinue Transmission-Based Precautions include:
    a. Resolution of fever, without use of antipyretic medication; **AND**

b. Improvement in illness signs and symptoms; **AND**

c. While ample testing supplies and laboratory capacity are available, negative results of an FDA Emergency Use Authorized molecular assay for COVID-19 from at least two consecutive sets of paired nasopharyngeal and throat swabs specimens collected ≥24 hours apart (total of two negative specimens).

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

MANAGEMENT OF ASYMPTOMATIC CONTACTS OF COVID-19

Patients with exposure to a confirmed or suspected COVID-19 case shall be placed in quarantine.

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 Chief Medical Executive (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).
- 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 must conduct twice daily surveillance on quarantined patients for the duration of the quarantine period to identify any new cases. If new case(s) are identified, the symptomatic patient must be masked 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.

- 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 patients from the well quarantined patients.

PATIENT SURVEILLANCE WHILE IN QUARANTINE

Correctional nursing leadership is responsible for assigning nursing teams to conduct surveillance to identify new suspected cases. Twice daily 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.

- Surveillance Rounds must be conducted twice daily on quarantined patients.
- All quarantined patients shall be evaluated on a twice daily basis, including weekends and holidays.
- Using the electronic Surveillance Rounds form in EHRS, temperatures and any respiratory symptoms must be recorded to identify influenza-like illness (temperature > 100°F [37.8°C], cough,).
- Patients with symptoms should be promptly masked and escorted to a 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.
- Surveillance may uncover patients in housing units with respiratory symptoms but 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 Electronic Health Record System (EHRS) Message Center.

RELEASE FROM QUARANTINE

For COVID-19, the period of quarantine is 14 days from the last date of exposure, 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

MANAGEMENT OF CONTACTS TO CONTACTS

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 ETTIQUETTE

- 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).
- 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 at a 1:10 dilution.
- 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: Communicating Precautions from Health Care Staff to Custody Staff HCDOM, Chapter 3, Article 8 - Communicating Precautions from Health Care Staff to Custody Staff.

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

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).

CALIFORNIA CORRECTIONAL
HEALTH CARE SERVICES

MEMORANDUM

Date: March 25, 2020

To: Chief Executive Officers
Chief Psychiatrists
Chief of Mental Health
Senior Psychiatrist, Supervisors

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

Subject: **COVID-19 – MENTAL HEALTH DELIVERY OF CARE GUIDANCE**

In response to the current coronavirus disease 2019 (COVID-19) pandemic and out of an abundance of caution the California Department Corrections and Rehabilitation (CDCR) Statewide Mental Health Program (SMHP) is taking necessary precautions to reduce exposure to Coleman patients and mental health staff by addressing exceptional allowances provided. This memorandum provides guidance for the delivery of mental health care with the understanding that new challenges and impacts of COVID-19 may permit more restrictions at some institutions than others as we move through this difficult time and may likewise lead to interim changes in practice and/or policy exceptions not otherwise allowed by the *Mental Health Services Delivery System Program Guide 2009 Revision.*

Clinical leadership (to include Chief Executive Officers, Chiefs of Mental Health, Chief Nurse Executives, Chief Medical Executives, and the Chief Psychiatrist) shall assess program capacity and make determinations on admission and discharge practices based on factors to include available workforce, known COVID-19 exposure, etc.. Leadership must consider individual patient needs, facility-system flows, and the degrees of risk when making these decisions.

To ensure patients continue to receive the most appropriate and effective interventions necessary to meet their needs, each clinical provider shall assess the patient's needs and continue to deliver services as appropriate in person, or via tele-health technology such as WebEx, Citrix, and other solutions.

The attached chart serves as a guide and provides a tiered approach on the delivery of care dependent upon each institution's staffing and operational circumstances. The CEOs, in consultation with the Wardens, will determine which tier shall be applied each day. Tier One

represents operating close to Program Guide requirements, while Tier Four represents dramatically decreased resources. The following factors shall be taken into consideration when determining the tier an institution will operate within:

- Clinical and custodial staffing levels
- Space availability
- Social distancing requirements
- Local and statewide restrictions on movement
- Quarantines and Isolations

Mental Health Patients

Mental health patients are at increased risk for escalation in depression, anxiety, panic attacks, psychomotor agitation, psychotic symptoms, delirium, and suicidality during this COVID-19 pandemic. Sources of stress include social isolation, decreased sensory stimulation, lack of access to standard clinical programing, diminished coping strategies, and limited outdoors or out-of-cell exercise and activities. We are focused on three critical areas during this COVID-19 pandemic: 1) Preserving life; 2) Stabilizing of acute mental health deterioration; 3) Helping the mental health population cope.

Provisions of Treatment

To the extent possible, institutions shall follow current Program Guide policies and procedures including, but not limited to: clinical contacts, group and treatment requirements, emergent and urgent referral processes, crisis intervention, suicide prevention, and inpatient referrals. However, to ensure patients receive the essential care and support services during this time of fewer onsite staff and various restrictions on patient movement the below and attached guidelines provide direction on ways to provide services and minimize the risk to both patients and staff:

- Individual clinical contacts shall continue while maintaining social distancing. As institutions move toward less patient movement measures and staffing levels decrease, individual contacts should be triaged by emergent referrals, patient acuity and levels of care.
- Interdisciplinary Treatment Teams (IDTT) shall continue while maintaining social distancing. In lieu of the tradition setting, the use of technology should be optimized to ensure attendance by all IDTT members. The best solution is to turn team meetings into teleconference meetings, with staff calling in from their individual offices.
- Groups shall continue but may be reduced in size in order to adhere to social distancing requirements. In addition, alternative locations should be explored. Larger classrooms or vocational space, temporarily closed during this time, could be used to allow for social distancing for groups. Develop in-cell Recreational Therapy and other group activities that can be conducted and distributed.
- Patients in isolation and/or quarantine will not attend groups but shall be provided with therapeutic treatment packets, workbooks, and other in cell activities and shall receive

daily rounding by at least one of the following designated staff to include: CNA, Psychologist, LVN, Recreational Therapists, PTs, RNs, or Social Workers.

- Psychiatry and primary care clinicians should be consulted urgently on patients expressing suicidal ideation or intent, psychosis, medication side effects, incomplete symptom control, or acute agitation.
- Psychiatry should also be consulted for other non-urgent significant psychiatric symptoms as usual.
- In the event of severe staffing shortages, frequent mental health wellness and surveillance rounding is required with liaison between psychiatrists, psychologists, suicide prevention coordinators and recreational therapists to identify significant concern for a patient's mental health sequelae. These rounds are to identify any urgent/emergent clinical issues including but not limited to acute suicidality.
- Issues identified through these rounds are to be promptly brought to the attention of the assigned psychiatrist.
- Staff performing rounds shall use appropriate personal protective equipment (PPE) as determined by public health.
- Psychiatry encounters may be via tele-psychiatry during the COVID-19 pandemic as approved by the hiring authority (See section on tele-psychiatry below for details).

Suicide Prevention

As much as possible, all Suicide Risk Assessments shall continue per policy and patients identified as a suicide risk will receive an in-person mental health evaluation. As operational abilities are impacted due to staff reductions, the clinician assessing the patient for suicidality will conduct the Columbia screener and a full mental health status exam and do the following:

1. If the patient screens positive, he/she shall be placed in alternative housing and be referred to a Mental Health Crisis Bed (MHCB). Within 24 hours of placement in the MHCB or if the patient remains in alternative housing longer than 24 hours, a full Suicide-Risk and Self-Harm Evaluation shall be completed.
2. If the patient screens negative, the clinician shall establish a safety plan with the patient and he/she can be returned to housing with a consult order for the primary clinician to see the patient with an urgent or routine referral.
   - All (5) five-day follow-ups will be completed in person, per policy, while maintaining social distancing.
   - As the operational abilities begin to limit clinical contacts and services, Administrative Segregated Unit workbooks shall be distributed to Enhanced Out-Patient housing units and the Correctional Clinical Case Management System population for in-cell activities.
   - Suicide Prevention and Response Focus Improvement Team Coordinators shall distribute the high risk list to all primary clinicians and psychiatrists. Cell visit check-ins with these patients shall be conducted by a mental health provider, in addition to the required scheduled appointments.

Inpatient Referrals and Services

As of March 17, 2020, the Department of State Hospitals (DSH) has temporarily suspended patient transfers to and from CDCR. As a result, patients referred to a higher level of care of at least a restrictive housing of a DSH facility will remain at CDCR. The below information and reminders are critical to ensure all patients currently housed or awaiting placement to an inpatient bed receive the appropriate care and oversight during this time.

- All referrals to higher levels of care shall continue as clinically indicated and determined by the IDTT.
- Patients housed out of their least-restrictive housing due to the inability to transfer to DSH, shall be placed in the least restrictive housing available within CDCR.
- As wait times increase, every effort shall be made to provide these patients with the services commensurate with their level of care. This includes providing enhanced out-of-cell time and therapeutic activities as well as daily rounds, as operations allow, while awaiting transfer.
- Patients housed in an MHCB awaiting transfer to a higher level of care and patients in alternative housing awaiting transfer to an MHCB will be provided enhanced out-of-cell time and therapeutic activities as well as daily rounds, as operations allow, while awaiting transfer.
- Inpatient licensed beds shall not be closed to admissions by the institutions without going through the proper authorization and notification process.

Patient Education

Clinical focus shall be on supporting patients by encouraging questions and helping them understand the current pandemic situation. Clarify misinformation and misunderstandings about how the virus is spread and that not every respiratory disease is COVID-19. Provide comfort and extra patience. Check back with patients on a regular basis or when the situation changes. Recognize that feelings such as loneliness, boredom, fear of contracting disease, anxiety, stress, and panic are normal reactions to a stressful situation such as a disease outbreak.

Key communication messages to mental health patients:

- The importance of reporting fever and/or cough or shortness of breath along with reporting if another patient is coughing in order to protect themselves. Indicate how these reports should be made.
- Reminders about good-health habits to protect themselves, emphasizing hand hygiene.
- Plans to support communication with family members if visits are curtailed.
- Plans to keep patients safe, including social distancing.

Patient Isolation (Symptomatic Patients)

A critical infection control measure for COVID-19 is to promptly separate patients who are sick with fever or respiratory symptoms away from other patients in the general population. Precautionary signs shall be placed outside the isolation cell and PPE appropriate protocols shall be followed.

Quarantine (Asymptomatic Exposed Patients)

The purpose of quarantine is to assure that patients who are known to have been exposed to the virus are kept separated from other patients with restriction of movement to assess whether they develop viral infection symptoms.

- Exposure is defined as having been in a setting where there was a high likelihood of contact with respiratory droplets and/or body fluids of a person with suspected or confirmed COVID19.
- Examples of close contact include sharing eating or drinking utensils, riding in close proximity in the same transport vehicle, or any other contact between persons likely to result in exposure to respiratory droplets.
- The door to the Quarantine Unit should remain closed. A sign should be placed on the door of the room indicating that it is a Quarantine Unit which lists recommended personal protective equipment (PPE).
- Medical Holds are employed for both isolation and quarantine. A temporary prohibition of the transfer of patients with the exception of legal or medical necessity is now in place.

Social Distancing

To stop the spread of COVID-19, social distancing must be employed. CDC officials recommend avoiding large gatherings of more than 10 people and maintaining a distance of 6 feet from other people. This reduces the chance of contact with those knowingly or unknowingly carrying the infection.

Patient-to-Patient; Patient-to-Staff Social Distancing

If group spaces are too small to accommodate the 6-feet rule, consider smaller group sizes in the interim. Groups can be smaller with higher frequency or this may mean needing to decrease the number of treatment offerings. Say to the patients that because of the COVID19, "We have a policy of keeping at least 6 feet of distance between patients and staff and patients and each other, which is why I'm sitting here and you're sitting there." If you don't say it, many patients may misinterpret social distancing (i.e. "my clinician is scared of me"). Maximize disinfection of all areas used for group and 1:1 treatment.

Tele-Psychiatry and Social Distancing

With the latest expansion of tele-psychiatry waivers, exceptions issued by the Center for Medicare and Medicaid Services (CMS), tele-psychiatry may be used to minimize any COVID-19 impacts that could disrupt the daily psychiatric services to patients. Psychiatrists who are unable to come into the institution because of personal risk factors (age > 65, chronic medical condition, etc.) or are under a personal quarantine who are otherwise fit to work can be authorized to use WebEx to conduct patient visits from a home computer that has a camera, speaker, and microphone. A state laptop with a VPN or any home computer with Citrix can access the EHRS.

- Each clinician who is providing tele-services will require a tele-presenter within the institution.
- Tele-presenters can include Medical Assistant, Certified Nursing Assistant, Licensed Vocational Nurse, Registered Nurse, or any other healthy employee who is available to assist. This could include support staff who are on Administrative Time Off.
- Presenters shall be provided PPE as needed based upon public health recommendations. Successful use of tele-psychiatry will require clinic space, tele-health equipment, IT assistance, scheduling organization, escort support, frequently updated telephone and email contact lists, and local executive leadership support.

cc: Diana Toche, DDS, Undersecretary
Joseph Bick, MD, CCHP, Director
Connie Gipson, Director
Regional Health Care Executives
Deputy Directors

Tier	Inpatient Referrals	Suicide Prevention	Provision of Treatment	Evaluations (Pre-Release, MDO)
Tier One: Delivery of care continues with minor modifications up to and including: • Patient movement permitted between and within CDCR facilities. • Minor movement restrictions within specific housing units or yards. • Temporary suspension of transfers to DSH. • Adequate clinical staff are on site and available to provide services • Sufficient beds and staff are available for 1:1 watch and alternative housing. • Social Distancing Required	Referrals continue per policy. Patients out of LRH, due to bed unavailability (DSH unlocked dorm) will be placed in the least restrictive housing available within CDCR.	**Suicide Risk Assessments:** Continue to complete per policy. **Five day follow ups:** Complete in person per policy, while maintaining social distancing. **Referrals:** Continue to respond to referrals in accordance with MHPG timelines.	**IDTT:** Continue with social distancing. Optimize use of technology including VTC, SKYPE, conference calls, or other electronic alternatives. **Groups:** Continue but may be reduced in size or in alternative non confidential locations (e.g. day room, class rooms) for social distancing. **Individual contacts:** Continue, with social distancing. **Patients on isolation:** Provide with treatment packets/therapeutic activities to complete in cell. Treatment team members visit cell daily. **Personal Protective Equipment:** Those rounding in quarantined and isolated areas must be provided appropriate personal protective equipment (PPE) based upon the most recent public health recommendations. All staff shall receive training in the appropriate use of PPE.	**Pre-Release Planning:** All required activities to occur when social distancing can be followed. **MDO Evaluations:** MDO evaluations will continue and patients meeting MDO criteria will be admitted to DSH. If MDO evaluator cannot enter a facility review will occur remotely and the evaluator will work with the MDO Coordinator (CCI) at the facility to arrange for a telephonic interview.

Tier	Inpatient Referrals	Suicide Prevention	Provision of Treatment	Evaluations (Pre-Release, MDO)
Tier Two: Minor movement restrictions and staff limitations impacting daily operations. • Patient movement permitted between and within CDCR facilities • Minor movement restrictions within specific housing units and/or yards • Temporary suspension of transfers to DSH. • Minor clinical staffing shortages requires triage for services • Sufficient beds and staff are available for 1:1 watch and alternative housing. • Social distancing required	Referrals continue per policy. As wait times increase, patients shall be provided enhanced care, which may include, but not limited to, daily rounds, out of cell time, and therapeutic activities as operations allow, while awaiting transfer. Patients awaiting MHCB will be placed in alternative housing on 1:1 status per current policy. Treatment frequency should be that of MHCB patients, when operations allow, while awaiting transfer.	**Suicide Risk Assessments:** Columbia Screener may be used with a mental status examination for suicide screening when staffing shortages prevent use of SRASHE. Patients identified as suicide risk will receive in person evaluation. **Five day follow ups:** Complete in person per policy, while maintaining social distancing. **Referrals:** Triage referrals responding to emergent and urgent first, and triage routine referrals for urgency. **Prevention:** Distribute ASU Workbooks to outpatient housing units (EOP) for in-cell activities. SPRFIT Coordinators distribute the high risk list to all primary clinicians. PCs to conduct cell visits for check-ins with individuals on this list. These visits should be in addition to required scheduled appointments. If decompensation is noted, patients should be brought out for assessment.	**Treatment may be triaged as follows as staffing shortages and space access are decreased:** **Triage Guidelines:** Individual contacts as follows: - Emergent referrals - Patients on high risk list - Patients in inpatient facilities - Patients awaiting transfer to inpatient LOC - Patients in segregated housing - Patients in EOP level of care - Patients in CCCMS level of care **IDTT:** Continue with social distancing. Optimize use of technology including VTC, SKYPE, conference calls, or other electronic alternatives. **Groups:** Continue but may be reduced in size or in alternative non confidential locations (e.g. day room, class rooms) for social distancing. May be triaged. - CCCMS groups may be reduced or cancelled to redirect resources to EOP and inpatient programs. -Consider altering work schedules to stagger groups and offer into late evenings and weekends.	**Pre-Release Planning:** Prioritize the ROIs to those releasing only to L.A. county and San Diego county Prioritize completion of the PRPA for those releasing to L.A. and San Diego counties first. The assigned psychiatrist will continue to be notified of the release date. Provide groups in accordance with group guidelines in treatment activities section of this document Complete 5150 requests per standard process Complete transportation Chrono's per standard process Conduct pre-release CCAT when possible (dependent upon outside clinician availability) **MDO Evaluations:** MDO evaluations will continue and patients meeting MDO criteria will be admitted to DSH. Evaluators will bundle evaluations for a single visit to reduce the number of trips to a facility. If MDO evaluator cannot enter a facility review will occur remotely and the evaluator will work with the MDO Coordinator (CCI) at the

Tier	Inpatient Referrals	Suicide Prevention	Provision of Treatment	Evaluations (Pre-Release, MDO)
			-Develop in cell RT and other group activities and distribute when group offerings decrease. **Patients on isolation:** Provide with treatment packets to complete in cell. Treatment team members visit cell daily. **Psychiatry:** Psychiatrists check in & check out daily with Chief Psychiatrist to track availability and coverage. Updated contact lists and workflows will be determined and provided by each institution up to and including contact list for: - Nursing - MHCB/TTA/CTC - Institutional leadership (Chief Psychiatrist, CMH, CEO) - Medical providers - Pharmacists - Custody command chain - Telepsychiatry Seniors - Medication lines Begin to Triage as follows: Admissions and discharges and related inpatient processes Suicide watch assessments and orders - Suicide precaution assessments and orders - Emergency Medication orders during patient crisis, PC 2602s - Seclusion and Restraints "Face to Face" assessments or renewals - Stat Labs for patients with suspected toxicity e.g. Lithium)	facility to arrange for a telephonic interview.

Tier	Inpatient Referrals	Suicide Prevention	Provision of Treatment	Evaluations (Pre-Release, MDO)
			- Renewing expiring psychiatric medications - Medication changes as necessary - Confirming lack of psychiatric medication-related medical issues - IDTT participation - Routine psychiatric follow up **Telepsychiatry:** Psychiatrists who are assigned to work on-site who are no longer able to come into the institution (for example >65 years old, high risk medical condition, quarantine but still able to work) can use WebEx to conduct patient visits from any home computer with a camera/ speaker/ microphone. A state laptop with a VPN (or any home computer with Citrix) can access EHRS. - Staff that could be used as telepresenters is decided by each institution to include: • MA or CNA • Any staff unable to perform their assigned duties during the crisis (with training), e.g. - Dental - ATO - support staff - any healthy state personnel - Any Mental Health provider (Group leader, RT, SW, LCSW, PhD/ PsyD) - LVN, RN	

Tier	Inpatient Referrals	Suicide Prevention	Provision of Treatment	Evaluations (Pre-Release, MDO)
			- Any medical provider (PA, NP, MD) All telepresenters require personal protective equipment as in Tier 1 This will also require: office space, tele-health equipment, IT assistance, OT organization, Custody escort support, contact lists as in tier 2, and local leadership support	

Tier	Inpatient Referrals	Suicide Prevention	Provision of Treatment	Evaluations (Pre-Release, MDO)
Tier Three Movement restrictions within facilities and staffing shortages requires substantial change in standard practice • Patient movement permitted between most CDCR facilities. • Movement restrictions are in effect within the institutions. • Temporary suspension of transfers to DSH. • Substantial clinical staffing shortages requires increased triage for services • There may be insufficient beds and/or staff for alternative housing and 1:1 watch.	Referrals continue per policy. **If staffing and space become unavailable:** **Alt Housing Location:** Patients who can be safely watched in their existing cell will be placed on 1:1 watch (must be single cell status, items removed per watch policy). These patients will be treated as MHCB patients for all clinical contacts as operations allow. **1:1 Watch:** When there are not enough staff for 1:1 watch, patients in alternative housing may be placed on 2:1 watch if the location allows for good line of sight and patients are next door to one another, allowing continuous watch of each. CEO to determine when this can be applied and will provide the direction above with oversight for safety.	**Suicide Risk Assessments:** *See Tier two* **Five day follow ups:** *See Tier Two* **Referrals:** *See Tier Two* **Prevention:** *See Tier Two and Provision of Treatment Column*	**Rounding:** Every day, every patient in the Mental Health Services Delivery System (CCCMS, EOP, MHCB, ICF, ACUTE) shall be rounded on by at least one of the following designated staff to include: CNA, Psychologist, LVN, Recreational Therapists, PTs, RNs, or Social Workers, by building and yard. The review includes questions of immediate, acute suicidality and/or medical concerns. Patients who answer in the affirmative must be brought to the attention of the assigned psychiatrist at least once a day (preferably twice) at fixed times for treatment. When patients respond in the affirmative: - A consult order shall be placed per current policy. - MH clinicians will address emergent issues per current policy. - Patients will be placed on a list for discussion with the psychiatrist. Rounds shall be documented in the healthcare record as follows: Nursing: Iview psych tech daily rounds. MH Clinicians: MH PC Progress note. Personal protective equipment required as in tier 1.	**Pre-Release Planning:** ROIs to those releasing only to L.A. county and San Diego county ONLY. Complete the PRPA for those releasing to L.A. and San Diego counties. For releases to other counties, the IMHPC or PC or other clinician who knows the patient, will determine if exigent circumstances related to release exist, and if so, will attempt to communicate those needs to the respective community stakeholders via email. Document efforts in a pre-release planning progress note. The assigned psychiatrist will continue to be notified of the release date. Provide groups in accordance with group guidelines in treatment activities section of this document. Complete 5150 requests per standard process Complete transportation Chrono's per standard process Conduct pre-release CCAT when possible (dependent upon outside clinician availability) **MDO Evaluations:** *See Tier Two*

Tier	Inpatient Referrals	Suicide Prevention	Provision of Treatment	Evaluations (Pre-Release, MDO)
			As ability to provide out of cell groups decreases: - RTs play music and conduct other activities on the unit - Continue to replenish supply of in cell treatment materials. Direct Staff and Care as follows: - Emergent referrals - Five Day Follow Ups - Patients on high risk list - Patients in inpatient facilities - Patients awaiting transfer to inpatient facility - Patients in segregated housing - Patients in EOP level of care - Patients in CCCMS level of care **Telepsychiatry: As per tier 2 above**	

Tier	Inpatient Referrals	Suicide Prevention	Provision of Treatment	Evaluations (Pre-Release, MDO)
Tier Four Patient movement restrictions between and within facilities is suspended and significant staffing shortages require substantial change in standard practice • Patient movement is not permitted between most CDCR facilities. • Patient movement restrictions in most units and/or yards within facilities • Temporary suspension of transfers to DSH. • Substantial clinical staffing shortages requires further triage for services • Insufficient beds and/or staff available for 1:1 watch and alternative housing.	*See Tier Three*	*See Tier Three*	*See Tier Three* **Psychiatry Services** Any physician, NP, or PA serves as psychiatrists for the plans in Tier 2 and 3 above. Laptops with VPN (or home computers with Citrix) provide for chart access from home, for the equivalent of basic on-call coverage. Local triage (by Chief Psychiatrist and CMH) to establish referral priority for tele-health.	**Pre-Release Planning:** - ROIs will not be completed - The PRPA will not be completed For releases, the IMHPC or PC or other clinician who knows the patient, will determine if exigent circumstances related to release exist, and if so, will attempt to communicate those needs to the respective community via email. The assigned psychiatrist will continue to be notified of the release date. - Complete 5150 requests per standard process - Complete transportation Chrono's per standard process - Conduct pre-release CCAT when possible (dependent upon outside clinician availability) **MDO Evaluations:** *See Tier Two*