ATTACHMENT A

Comparison of Centers for Disease Control and Prevention Guidance for Correctional Systems and Status of CCHCS/CDCR Implementation

Data Current as of April 15, 2020

OPERATIONAL PREPAREDNESS	
Centers For Disease Control and Prevention (CDC) Guidance	**CCHCS/CDCR Implementation Status**
COMMUNICATION AND COORDINATION	
Develop information-sharing systems with partners.	
• Identify points of contact in relevant state, local, tribal, and/or territorial public health departments before cases develop. Actively engage with the health department to understand in advance which entity has jurisdiction to implement public health control measures for COVID-19 in a particular correctional or detention facility.	Completed with respect to State and Local public health departments.
• Create and test communications plans to disseminate critical information to incarcerated/detained persons, staff, contractors, vendors, and visitors as the pandemic progresses.	CDCR has long-standing communications platforms and mechanisms to communicate with all stakeholders, and those platforms and mechanisms are being employed. Location in Plan: Pages 2- 3 Section III(A); Attachment C; Attachment D.
• Communicate with other correctional facilities in the same geographic area to share information including disease surveillance and absenteeism patterns among staff.	CDCR institutions are regularly in contact with each other, with their respective regional offices, and with headquarters. The Department Operations Center (DOC) is also monitoring absenteeism. Location in Plan: Page 2-3, Section III(A)(i).
• Where possible, put plans in place with other jurisdictions to prevent confirmed and suspected COVID-19 cases and their close contacts from being transferred between jurisdictions and facilities unless	CDCR coordinated with local jails and closed intake on March 24, 2020. Internal movement has been suspended except for transfer necessary to save life or address a safety/security concern. Location in Plan: Page 4, Section III(B)(i)(a)(1); Page 5-6,

necessary for medical evaluation, medical isolation/quarantine, clinical care, extenuating security concerns, or to prevent overcrowding. • Stay informed about updates to CDC guidance via the CDC COVID-19 website as more information becomes known.	Section III(B)(i)(c); Page 12, Section IV(B); Pages 13-14, Section IV(C)(ii) and (iii); Attachment E; Attachment G; Attachment V; Attachment W; Attachment Y; Attachment Z Done on an ongoing basis
Review existing pandemic flu, all-hazards, and disaster plans, and revise for COVID-19. • Ensure that physical locations (dedicated housing areas and bathrooms) have been identified to isolate confirmed COVID-19 cases and individuals displaying COVID-19 symptoms, and to quarantine known close contacts of cases. (Medical isolation and quarantine locations should be separate). The plan should include contingencies for multiple locations if numerous cases and/or contacts are identified and require medical isolation or quarantine simultaneously. See Medical Isolation and Quarantine sections below for details regarding individual medical isolation and quarantine locations (preferred) vs. cohorting. • Facilities without onsite healthcare capacity should make a plan for how they will ensure that suspected COVID-19 cases will be isolated, evaluated, tested (if indicated), and provided necessary medical care. • Make a list of possible social distancing strategies that could be implemented as needed at different stages of transmission intensity.	Issued "CCHCS COVID-19 Interim Guidance for Health Care and Public Health Providers," which includes direction on quarantining patients. Location in Plan: Attachment M, referenced on pages 17 and 34. Not applicable to CDCR. CDCR/CCHCS leadership have been considering, and continue to review and consider, all options to improve social distancing. Location in Plan: Pages 5-7, Section III(B)(i)(c)(2)-(d); Attachment G; Attachment H

• Designate officials who will be authorized to make decisions about escalating or de-escalating response efforts as the epidemiologic context changes.	CDCR/CCHCS activated the Department Operations Center on March 15, 2020 to coordinate all COVID-19 related activities. Location in Plan: Page 2-3, Section III(A)(i).
Coordinate with local law enforcement and court officials. • Identify lawful alternatives to in-person court appearances, such as virtual court, as a social distancing measure to reduce the risk of COVID-19 transmission. • Explore strategies to prevent over-crowding of correctional and detention facilities during a community outbreak.	Most out-to-court transfers were stopped on March 26, 2020. California's courts have reduced all unnecessary hearings. Location in Plan: Page 5, Section III(B)(i)(c)(1); see also https://newsroom.courts.ca.gov/news/court-emergency-orders-6794321 Being done on an ongoing basis. Location in Plan: Pages 5-7, Section III(B)(i)(c)(2)-(d); Attachment G; Attachment H
Post signage throughout the facility communicating the following: • For all: symptoms of COVID-19 and hand hygiene instructions • For incarcerated/detained persons: report symptoms to staff • For staff: stay at home when sick; if symptoms develop while on duty, leave the facility as soon as possible and follow CDC-recommended steps for persons who are ill with COVID-19 symptoms including self-isolating at home, contacting their healthcare provider as soon as possible to determine whether they need to be evaluated and tested, and contacting their supervisor. • Ensure that signage is understandable for non-English speaking persons and those with low literacy, and make necessary accommodations for those	Provided handouts and posted information around institutions. Also put information on inmate television. Location in Plan: Page 1, Section I; Page 3, Section III(A)(iii); Attachment D. Done. Also placed on system-wide website dedicated to the outbreak. See https://www.cdcr.ca.gov/covid19/information/ Handouts and videos provided in multiple languages and available to those with disabilities.

with cognitive or intellectual disabilities and those who are deaf, blind, or low-vision.	Location in Plan: Page 1, Section I; Page 3, Section III(A)(iii); Attachment D.
PERSONNEL PRACTICES	
Review the sick leave policies of each employer that operates in the facility. • Review policies to ensure that they actively encourage staff to stay home when sick. • If these policies do not encourage staff to stay home when sick, discuss with the contract company. • Determine which officials will have the authority to send symptomatic staff home.	 In place. Also implemented staff screening for symptoms of COVID 19 at all entrances. Location in Plan: Page 7, Section III(B)(ii)(c); Attachment K. Not applicable. Done and disseminated.
Identify staff whose duties would allow them to work from home. • Discuss work from home options with these staff and determine whether they have the supplies and technological equipment required to do so. • Put systems in place to implement work from home programs (e.g., time tracking, etc.).	 Done. IT departments have made sure adequate equipment is available for work-from-home. Done. Location in Plan: Page 7, Section III(B)(ii)(b); Attachment J.
Plan for staff absences. • Allow staff to work from home when possible, within the scope of their duties. • Identify critical job functions and plan for alternative coverage by cross-training staff where possible.	 Done pursuant to Governor's Executive Order. Location in Plan: Page 7, Section III(B)(ii)(b); Attachment J. This has not been an issue for CDCR/CCHCS to date. Trigger points for nursing and mental health services for additional coverage have been set.

• Determine minimum levels of staff in all categories required for the facility to function safely. If possible, develop a plan to secure additional staff if absenteeism due to COVID-19 threatens to bring staffing to minimum levels. • Consider increasing keep on person (KOP) medication orders to cover 30 days in case of healthcare staff shortages.	CDCR/CCHCS are monitoring this issue on a daily basis and have been identifying the full range of options to respond if this becomes a problem. Movement plans of staff between institutions have been developed. Location in Plan: Pages 10-11, Section III(E); Attachment T. This was reviewed and pharmaceutical supplies are sufficient, so increasing this was not implemented. KOP meds are already set at a 30-day supply.
Consider offering revised duties to staff who are at higher risk of severe illness with COVID-19. • Facility administrators should consult with their occupational health providers to determine whether it would be allowable to reassign duties for specific staff members to reduce their likelihood of exposure to COVID-19.	Done. Return to work plan in place. Process in place for allowing staff to work from, be reassigned, or take Administrative Time Off. Location in Plan: Page 7, Section III(B)(ii)(b); Attachment J.
Offer the seasonal influenza vaccine to all incarcerated/detained persons (existing population and new intakes) and staff throughout the influenza season. • Symptoms of COVID-19 are similar to those of influenza. Preventing influenza cases in a facility can speed the detection of COVID-19 cases and reduce pressure on healthcare resources.	Flu vaccines are already available to all incarcerated/detained persons throughout the influenza season.
Reference the Occupational Safety and Health Administration website for recommendations regarding worker health.	Done. CDCR and CCHCS regularly consult with relevant public health sources.
Review CDC's guidance for businesses and employers to identify any additional strategies the facility can use within its role as an employer.	Done. CDCR and CCHCS regularly consult with relevant public health sources.

OPERATIONS & SUPPLIES	
Ensure that sufficient stocks of hygiene supplies, cleaning supplies, PPE, and medical supplies (consistent with the healthcare capabilities of the facility) are on hand and available, and have a plan in place to restock as needed if COVID-19 transmission occurs within the facility. Standard medical supplies for daily clinic needs: • Tissue • Liquid soap when possible. If bar soap must be used, ensure that it does not irritate the skin and thereby discourage frequent hand washing. • Hand drying supplies	No shortages identified. Central monitoring of system-wide supply with redistribution as needed system-wide. Location in Plan: Pages 9-10, Section III(C)(ii).
• Alcohol-based hand sanitizer containing at least 60% alcohol (where permissible based on security restrictions)	California Prison Industry Authority (CALPIA) is manufacturing sanitizer and dispensers placed throughout the facilities where water is not readily available. Location in Plan: Pages 9-10, Section III(C)(ii).
• Cleaning supplies, including EPA-registered disinfectants effective against the virus that causes COVID-19	More frequent disinfection schedules in place. Location in Plan: Page 10, Section III(D); Attachment R; Attachment S.
• Recommended PPE (facemasks, N95 respirators, eye protection, disposable medical gloves, and disposable gowns/one-piece coveralls). See PPE section and Table 1 for more detailed information, including recommendations for extending the life of all PPE categories in the event of shortages, and when face masks are acceptable alternatives to N95s. Visit CDC's website for a calculator to help determine rate of PPE usage.	Available and resupply mechanisms in place. Central monitoring of system-wide supply with redistribution as needed system-wide. Location in Plan: Pages 9-10, Section III(C)(ii).

• Sterile viral transport media and sterile swabs to collect nasopharyngeal specimens if COVID-19 testing is indicated	Available throughout all facilities
Make contingency plans for the probable event of PPE shortages during the COVID-19 pandemic, particularly for non-healthcare workers. See CDC guidance optimizing PPE supplies.	CDCR/CCHCS procurement offices are constantly securing and monitoring supply contracts. The DOC communicates any additional needs to the State Operations Center. Location in Plan: Pages 9-10, Section III(C)(ii); Attachment M; Attachment O; Attachment P.
Consider relaxing restrictions on allowing alcohol-based hand sanitizer in the secure setting where security concerns allow. • If soap and water are not available, CDC recommends cleaning hands with an alcohol-based hand sanitizer that contains at least 60% alcohol. Consider allowing staff to carry individual-sized bottles for their personal hand hygiene while on duty.	Restrictions on personal alcohol-based hand sanitizers were suspended in early March 2020. Staff allowed to possess sanitizer on grounds. CDCR approved alcohol-based sanitizers in secure settings in 2017. CALPIA is producing hand sanitizer for CDCR. Location in Plan: Pages 9-10, Section III(C)(ii).
Provide a no-cost supply of soap to incarcerated/detained persons, sufficient to allow frequent hand washing. • Provide liquid soap where possible. If bar soap must be used, ensure that it does not irritate the skin and thereby discourage frequent hand washing.	Done.
If not already in place, employers operating within the facility should establish a respiratory protection program as appropriate, to ensure that staff and incarcerated/detained persons are fit tested for any respiratory protection they will need within the scope of their responsibilities.	Respiratory Protection Plan (RPP) was in place prior to outbreak. Staff not covered by the RPP were trained in the use of N95 type masks as needed.
Ensure that staff and incarcerated/detained persons are trained to correctly don, doff, and dispose of PPE that they will need to use within the scope of their responsibilities. See	Done for both healthcare and custody prior to outbreak as part of annual training. Location in Plan: Pages 9-10, Section III(C)(ii);

Table 1 for recommended PPE for incarcerated/detained persons and staff with varying levels of contact with COVID-19 cases or their close contacts.	Attachment M; Attachment O; Attachment P; Attachment Q.

PREVENTION	
Centers For Disease Control and Prevention (CDC) Guidance	**CCHCS/CDCR Implementation Status**
OPERATIONS	
1. Stay in communication with partners about your facility's current situation.	
Stay in communication with partners about your facility's current situation. • State, local, territorial, and/or tribal health departments • Other correctional facilities	Department Operations Center in continuous communication with all state and federal partners. CDCR institutions are regularly in contact with each other, with their respective regional offices, and with headquarters. The Department Operations Center (DOC) is also monitoring absenteeism. Location in Plan: Pages 2-3, Section III(A)(i).
Communicate with the public about any changes to facility operations, including visitation programs.	This is done both through the CDCR COVID-19 website, regular press releases and availability to telephone and email press inquiries. See https://www.cdcr.ca.gov/covid19/
Restrict transfers of incarcerated/detained persons to and from other jurisdictions and facilities unless necessary for medical evaluation, medical isolation/quarantine, clinical care, extenuating security concerns, or to prevent overcrowding.	Done as of March 24, 2020. The Department of State Hospitals will allow admissions starting April 17, 2020, subject to screening and referral guidelines developed as a response to the COVID 19 pandemic. Location in Plan: Pages 5-6 Section III(B)(i)(c); Pages 12-14 Section IV(B)-(C); Attachment E; Attachment G; Attachment V; Attachment W; Attachment X; Attachment Y; Attachment Z.
• Strongly consider postponing non-urgent outside medical visits.	Done as of March 24, 2020.
• If a transfer is absolutely necessary, perform verbal screening and a	Screening prior to mental health transfer policy put in place April 5, 2020 and reiterated

temperature check as outlined in the Screening section below, before the individual leaves the facility. If an individual does not clear the screening process, delay the transfer and 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. If the transfer must still occur, ensure that the receiving facility has capacity to properly isolate the individual upon arrival. Ensure that staff transporting the individual wear recommended PPE (see Table 1) and that the transport vehicle is cleaned thoroughly after transport.	on April 10, 2020. Location in Plan: Page 12, Section IV(B); Attachment V; Attachment W.
Implement lawful alternatives to in-person court appearances where permissible.	Not an issue for CDCR in light of reduced hearings in California and federal courts.
Where relevant, consider suspending co-pays for incarcerated/detained persons seeking medical evaluation for respiratory symptoms.	Does not apply to CDCR since co-pays were previously abolished.
Limit number of operational entrances and exits	Operational entrances for staff were reduced consistent with the physical plant.
CLEANING AND DISINFECTING PRACTICES	
Even if COVID-19 cases have not yet been identified inside the facility or in the surrounding community, begin implementing intensified cleaning and disinfecting procedures according to the recommendations below. These measures may prevent spread of COVID-19 if introduced.	CDCR directed increased cleaning and disinfection procedures to all institutions and mandated cleaning at a minimum of every three hours. Location in Plan: Page 10, Section III(D); Attachment R; Attachment S.
Adhere to CDC recommendations for cleaning and disinfection during the COVID-	All CDCR institutions have been instructed to conduct additional deep-cleaning efforts in high-traffic, high-volume areas, including

19 response**.** Monitor these recommendations for updates. • Several times per day, clean and disinfect surfaces and objects that are frequently touched, especially in common areas. Such surfaces may include objects/surfaces not ordinarily cleaned daily (e.g., doorknobs, light switches, sink handles, countertops, toilets, toilet handles, recreation equipment, kiosks, and telephones). • Staff should clean shared equipment several times per day and on a conclusion of use basis (e.g., radios, service weapons, keys, handcuffs). • Use household cleaners and EPA-registered disinfectants effective against the virus that causes COVID-19external icon as appropriate for the surface, following label instructions. This may require lifting restrictions on undiluted disinfectants. • Labels contain instructions for safe and effective use of the cleaning product, including precautions that should be taken when applying the product, such as wearing gloves and making sure there is good ventilation during use.	health care facilities. Communal areas such as dayrooms, showers, restrooms, and officers are cleaned at a minimum of twice per shift during second and third watch, and more if needed. Location in Plan: Page 10, Section III(D); Attachment R; Attachment S. EPA registered disinfectants are in use. Location in Plan: Attachment R.
Consider increasing the number of staff and/or incarcerated/detained persons trained and responsible for cleaning common areas to ensure continual cleaning of these areas throughout the day**.**	Increased staff are being used for cleaning. Appropriate training is in place. Inmates who assist with cleaning high-traffic areas of the institutions have received direct instruction on proper cleaning and disinfecting procedures in order to eliminate COVID-19. Critical inmate worker are screened. Location in Plan: Page 10, Section III(D); Attachment R; Attachment S.
Ensure adequate supplies to support intensified cleaning and disinfection	Stock is available and resupply plans are in place.

practices, and have a plan in place to restock rapidly if needed.	
HYGIENE	
Reinforce healthy hygiene practices, and provide and continually restock hygiene supplies throughout the facility, including in bathrooms, food preparation and dining areas, intake areas, visitor entries and exits, visitation rooms and waiting rooms, common areas, medical, and staff-restricted areas (e.g., break rooms).	CDCR has posted signs on hygiene throughout the institutions and has increased cleaning schedules to minimize the spread of COVID-19. Location in Plan: Page 1, Section I; Page 3, Section III(A)(iii); Page 10, Section III(D); Attachment D; Attachment R; Attachment S.
Encourage all persons in the facility to take the following actions to protect themselves and others from COVID-19. Post signage throughout the facility, and communicate this information verbally on a regular basis. Sample signage and other communications materials are available on the CDC website. • Ensure that materials can be understood by non-English speakers and those with low literacy, and make necessary accommodations for those with cognitive or intellectual disabilities and those who are deaf, blind, or low-vision. • Practice good cough etiquette: Cover your mouth and nose with your elbow (or ideally with a tissue) rather than with your hand when you cough or sneeze, and throw all tissues in the trash immediately after use. • Practice good hand hygiene: Regularly wash your hands with soap and water for at least 20 seconds, especially after coughing, sneezing, or blowing your nose; after using the bathroom; before eating or preparing food; before taking medication; and after touching garbage.	Posters have been placed throughout the institution containing information regarding symptoms, appropriate social distancing in communal areas, COVID facts and frequently asked questions, and preventing the spread of illness. Both Secretary Diaz and the *Plata* Receiver, Clark Kelso, have recorded videos for the inmate population that have been added to the Division of Rehabilitative Programs institutional television wellness channel. The videos, which provide information regarding COVID-19 and the steps CDCR and CCHCS have taken in response, can be viewed on CDCR/CCHCS's COVID-19 Preparedness website. (https://www.cdcr.ca.gov/covid19/population-communications/). All printed material, as well as all videos, are available in both English and Spanish, including closed captioning. Staff also meet with Inmate Advisory Council on a regular basis. Location in Plan: Page 1, Section I; Page 3, Section III(A)(iii); Attachment D.

• Avoid touching your eyes, nose, or mouth without cleaning your hands first. • Avoid sharing eating utensils, dishes, and cups. • Avoid non-essential physical contact.	
Provide incarcerated/detained persons and staff no-cost access to: • Soap – Provide liquid soap where possible. If bar soap must be used, ensure that it does not irritate the skin, as this would discourage frequent hand washing. • Running water, and hand drying machines or disposable paper towels for hand washing • Tissues and no-touch trash receptacles for disposal • Provide alcohol-based hand sanitizer with at least 60% alcohol where permissible based on security restrictions. Consider allowing staff to carry individual-sized bottles to maintain hand hygiene.	CDCR provides inmates with no-cost access to soap, running water, paper towels, and tissue. No touch receptacles are not in use statewide. Hand sanitizer has been distributed at institutions. CALPIA is manufacturing sanitizer and dispensers placed throughout the facilities where water is not readily available. Location in Plan: Pages 9-10, Section III(C)(ii).
Communicate that sharing drugs and drug preparation equipment can spread COVID-19 due to potential contamination of shared items and close contact between individuals.	Part of ISUDT messaging. See https://www.cdcr.ca.gov/covid19/memos-guidelines-messaging/
PREVENTION PRACTICES FOR INCARCERATED / DETAINED PERSONS	
Perform pre-intake screening and temperature checks for all new entrants. Screening should take place in the sallyport, before beginning the intake **process**, in order to identify and immediately place individuals with symptoms under medical isolation. See	Intake screening procedures are in place for all new entrants, transfers, and returnees from outside medical visits. CDCR has stopped intake from county jails. Location in Plan: Page 4, Section III(B)(i)(a)(1); Attachment E.

Screening section below for the wording of screening questions and a recommended procedure to safely perform a temperature check. Staff performing temperature checks should wear recommended PPE (see PPE section below). If an individual has symptoms of COVID-19 (fever, cough, shortness of breath)**:** • Require the individual to wear a face mask. • Ensure that staff who have direct contact with the symptomatic individual wear recommended PPE. • Place the individual under medical isolation (ideally in a room near the screening location, rather than transporting the ill individual through the facility), and refer to healthcare staff for further evaluation. (See Infection Control and Clinical Care sections below.) • Facilities without onsite healthcare staff should contact their state, local, tribal, and/or territorial health department to coordinate effective medical isolation and necessary medical care. If an individual is a close contact of a known COVID-19 case (but has no COVID-19 symptoms)**:** • Quarantine the individual and monitor for symptoms two times per day for 14 days. (See Quarantine section below.) • Facilities without onsite healthcare staff should contact their state, local, tribal, and/or territorial health department to coordinate effective quarantine and necessary medical care.	Facilities without onsite healthcare is not applicable. Medical isolation guidance in place in COVID-19 Interim Guidance for Health Care and Public Health Providers. Location in Plan: Attachment M. Facilities without onsite healthcare is not applicable. Quarantine guidance in place in COVID-19 Interim Guidance for Health Care and Public Health Providers. Location in Plan: Attachment M.
Implement social distancing strategies to increase the physical space between incarcerated/detained persons (ideally 6 feet	Currently underway. CDCR and CCHCS have defined housing cohorts of 8 in dorm settings to increase social distancing in sleeping areas.

between all individuals, regardless of the presence of symptoms). 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. Example strategies with varying levels of intensity include:	Yard release is done with smaller groups and social distancing is encouraged. Location in Plan: Page 6, Section III(B)(i)(c)(2); Page 7, Section III(B)(i)(d); Attachment G; Attachment H.
• Common areas**:** Enforce increased space between individuals in holding cells, as well as in lines and waiting areas such as intake (e.g., remove every other chair in a waiting area)	Social distancing is encouraged in yard, chow, and dayroom. Many locations have tape or paint markings six feet apart – e.g. pill lines, telephone waiting areas. Location in Plan: Page 7, Section III(B)(i)(d); Attachment H.
• Recreation**:** Choose recreation spaces where individuals can spread out; Stagger time in recreation spaces; Restrict recreation space usage to a single housing unit per space (where feasible)	On April 7, 2020, DAI issued a memorandum implementing a mandatory 14-day statewide modified program impacting yard time and size. Location in Plan: Page 5, Section III(B)(i)(b); Attachment F.
• Meals**:** Stagger meals; Rearrange seating in the dining hall so that there is more space between individuals (e.g., remove every other chair and use only one side of the table); Provide meals inside housing units or cells	Done with a mixture of in cell feeding and cohorted chow halls. Location in Plan: Attachment F.
• Group activities**:** Limit the size of group activities; Increase space between individuals during group activities; Suspend group programs where participants are likely to be in closer contact than they are in their housing environment; Consider alternatives to existing group activities, in outdoor areas or other areas where individuals can spread out	Done. All medical and rehabilitative group programming has been suspended. Mental health groups continue based on the mental health tier plan. Location in Plan: Pages 11-14, Section IV(A)-(C); Attachment F; Attachment U; Attachment W; Attachment X; Attachment Y; Attachment Z.
• Housing**:** If space allows, reassign bunks to provide more space between individuals, ideally 6 feet or more in all directions. (Ensure that bunks are cleaned thoroughly if assigned to a	Receiver memo of April 10, 2020, specifies that cohorts of 8 within dorms are sufficient for social distancing. Use of gyms and alternative housing being investigated. Inmates have been moved into the CIM

new occupant.); Arrange bunks so that individuals sleep head to foot to increase the distance between them; Rearrange scheduled movements to minimize mixing of individuals from different housing areas	gymnasium. Location in Plan: Pages 5-7, Section III(B)(i)(c)(2)-(d); Attachment G; Attachment H.
• Medical**:** If possible, designate a room near each housing unit to evaluate individuals with COVID-19 symptoms, rather than having them walk through the facility to be evaluated in the medical unit. If this is not feasible, consider staggering sick call. Designate a room near the intake area to evaluate new entrants who are flagged by the intake screening process for COVID-19 symptoms or case contact, before they move to other parts of the facility.	Most health encounters are being performed cell front where appropriate to minimize clinic entrance. All clinics have designated space to evaluate suspected respiratory cases. Mental health care provided under tiered plan issued March 25, 2020, and Temporary Mental Health Units plan issued April 10, 2020. Location in Plan: Pages 11-14, Section IV(A)-(C); Attachment U; Attachment W; Attachment X; Attachment Y; Attachment Z.
Communicate clearly and frequently with incarcerated/detained persons about changes to their daily routine and how they can contribute to risk reduction.	Posters have been placed throughout the institution containing information regarding symptoms, appropriate social distancing in communal areas, COVID facts and frequently asked questions, and preventing the spread of illness. Both Secretary Diaz and the Plata Receiver, Clark Kelso, have recorded videos for the inmate population that have been added to the Division of Rehabilitative Programs institutional television wellness channel. The videos, which provide information regarding COVID-19 and the steps CDCR and CCHCS have taken in response, can be viewed on CDCR/CCHCS's COVID-19 Preparedness website. (https://www.cdcr.ca.gov/covid19/population-communications/). All printed material, as well as all videos, are available in both English and Spanish, including closed captioning. Staff also meet with Inmate Advisory Council on a regular basis. Location in Plan: Page 1, Section I; Page 3, Section III(A)(iii); Attachment D.

Note that if group activities are discontinued, it will be important to identify alternative forms of activity to support the mental health of incarcerated/detained persons.	Mental Health program has identified alternatives to group therapy based on clinical needs. And mental health has developed a tiered plan for treatment. Location in Plan: Pages 11-12, Section IV(A)-(B); Attachment U; Attachment W; Attachment X.
Consider suspending work release programs and other programs that involve movement of incarcerated/detained individuals in and out of the facility.	Only critical food service, porters and essential on-site PIA assignments continue such as food production, production of cloth masks, cleaning of healthcare spaces, and laundry. Location in Plan: Page 5, Section III(B)(i)(b); Attachment F.
Provide updates on symptoms of COVID-19 to incarcerated/detained persons on a regular basis, including: • Symptoms of COVID-19 and its health risks • Reminders to report COVID-19 symptoms to staff at the first sign of illness	Posters have been placed throughout the institution containing information regarding symptoms, appropriate social distancing in communal areas, COVID facts and frequently asked questions, and preventing the spread of illness. Both Secretary Diaz and the Plata Receiver, Clark Kelso, have recorded videos for the inmate population that have been added to the Division of Rehabilitative Programs institutional television wellness channel. The videos, which provide information regarding COVID-19 and the steps CDCR and CCHCS have taken in response, can be viewed on CDCR/CCHCS's COVID-19 Preparedness website. (https://www.cdcr.ca.gov/covid19/population-communications/). All printed material, as well as all videos, are available in both English and Spanish, including closed captioning. Staff also meet with Inmate Advisory Council on a regular basis. Updated information will be provided as needed. Location in Plan: Page 1, Section I; Page 3, Section III(A)(iii); Attachment D.
Consider having healthcare staff perform rounds on a regular basis to answer questions about COVID-19.	Done two times/day on isolated and quarantined cases – see COVID-19 Interim Guidance for Health Care and Public Health Providers. Location in Plan: Attachment M.
PREVENTION PRACTICES FOR STAFF	

Remind staff to stay at home if they are sick. Ensure that staff are aware that they will not be able to enter the facility if they have symptoms of COVID-19, and that they will be expected to leave the facility as soon as possible if they develop symptoms while on duty.	Done. See staff COVID-19 webpage. https://www.cdcr.ca.gov/covid19/information/
Perform verbal screening (for COVID-19 symptoms and close contact with cases) and temperature checks for all staff daily on entry. See Screening section below for wording of screening questions and a recommended procedure to safely perform temperature checks. • In very small facilities with only a few staff, consider self-monitoring or virtual monitoring (e.g., reporting to a central authority via phone). • Send staff home who do not clear the screening process, and advise them to follow CDC-recommended steps for persons who are ill with COVID-19 symptoms.	Done for all persons entering a facility. Location in Plan: Page 7, Section III(B)(ii); Attachment K. Not applicable Screening of all staff began March 14, 2020. Location in Plan: Page 7, Section III(B)(ii); Attachment K.
Provide staff with up-to-date information about COVID-19 and about facility policies on a regular basis, including: • Symptoms of COVID-19 and its health risks • Employers' sick leave policy • If staff develop a fever, cough, or shortness of breath while at work: immediately put on a face mask, inform supervisor, leave the facility, and follow CDC-recommended steps for persons who are ill with COVID-19 symptoms. • If staff test positive for COVID-19: inform workplace and personal	Done. See communications detailed plan and COVID-19 webpages. Accessible at https://www.cdcr.ca.gov/covid19/memos-guidelines-messaging/ Done. We are following CDC guidance of return to work for critical healthcare workers

contacts immediately, and do not return to work until a decision to discontinue home medical isolation precautions is made. Monitor CDC guidance on discontinuing home isolation regularly as circumstances evolve rapidly. • If a staff member is identified as a close contact of a COVID-19 case (either within the facility or in the community): self-quarantine at home for 14 days and return to work if symptoms do not develop. If symptoms do develop, follow CDC-recommended steps for persons who are ill with COVID-19 symptoms.	for those with close contact with cases at this phase of the outbreak. Completed and monitored by CDCR/CCHCS Employee Wellness.
If a staff member has a confirmed COVID-19 infection, the relevant employers should inform other staff about their possible exposure to COVID-19 in the workplace, but should maintain confidentiality as required by the Americans with Disabilities Act. Employees who are close contacts of the case should then self-monitor for symptoms (i.e., fever, cough, or shortness of breath).	Completed and monitored by CDCR/CCHCS Employee Wellness.
When feasible and consistent with security priorities, encourage staff to maintain a distance of 6 feet or more from an individual with respiratory symptoms while interviewing, escorting, or interacting in other ways.	Done.
Ask staff to keep interactions with individuals with respiratory symptoms as brief as possible.	Done.
PREVENTION PRACTICES FOR VISITORS	
Visitors	Currently no visitors or volunteers are permitted to enter facilities. Location in Plan: Page 7, Section III(B)(ii)(a); Page 8, Section III(B)(iii); Attachment I; Attachment L.

MANAGEMENT	
Centers For Disease Control and Prevention (CDC) Guidance	**CCHCS/CDCR Implementation Status**
OPERATIONS	
Implement alternate work arrangements deemed feasible in the Operational Preparedness	Done via Governor's Executive Order. Location in Plan: Page 7, Section III(B)(ii)(b); Attachment J.
Suspend all transfers of incarcerated/detained persons to and from other jurisdictions and facilities (including work release where relevant), unless necessary for medical evaluation, medical isolation/quarantine, care, extenuating security concerns, or to prevent overcrowding. • If a transfer is absolutely necessary, perform verbal screening and a temperature check as outlined in the Screening section below, before the individual leaves the facility. If an individual does not clear the screening process, delay the transfer and 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. If the transfer must still occur, ensure that the receiving facility has capacity to appropriately isolate the individual upon arrival. Ensure that staff transporting the individual wear recommended PPE (see Table 1) and that the transport vehicle is cleaned thoroughly after transport.	Done March 24, 2020. Intake stopped for sixty days. Location in Plan: Page 5, Section III(B)(i)(c)(1); Attachment E. Done. See medical guidance plan. Location in Plan: Attachment M.
If possible, consider quarantining all new intakes for 14 days before they enter the facility's general population (SEPARATELY from other individuals who are quarantined due to contact with a COVID-19 case).	This was in place until the closure of intake.

Subsequently in this document, this practice is referred to as routine intake quarantine**.**	
When possible, arrange lawful alternatives to in-person court appearances.	Most out-to-court transfers were stopped on March 26, 2020. California's courts have reduced all unnecessary hearings. See https://newsroom.courts.ca.gov/news/court-emergency-orders-6794321 Location in Plan: Page 5, Section III(B)(i)(c)(1).
Incorporate screening for COVID-19 symptoms and a temperature check into release planning. • Screen all releasing individuals for COVID-19 symptoms and perform a temperature check. (See Screening section below.) • 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. • If the individual is released before the recommended medical isolation period is complete, 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	Done. Done. Done. All positive releases and releases of those in quarantine are coordinated with the local public health department via notification. Medical coordination with the receiving county is made for those with known medical needs. All coordination is done in conjunction with paroles or county probation depending on which entity will be responsible for post-release supervision. Done. See above.

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.	
Coordinate with state, local, tribal, and/or territorial health departments • When a COVID-19 case is suspected, work with public health to determine action. See Medical Isolation section below. • When a COVID-19 case is suspected or confirmed, work with public health to identify close contacts who should be placed under quarantine. See Quarantine section below. • 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 Facilities with Limited Onsite Healthcare Services section.	Done using CCHCS public health team in conjunction with the local public health departments. See COVID-19 Interim Guidance for Health Care and Public Health Providers. Location in Plan: Attachment M.
HYGIENE	
Continue to ensure that hand hygiene supplies are well-stocked in all areas of the facility. (See above.)	Additional soap available in institutions. California Prison Industry Authority (CALPIA) is manufacturing sanitizer and dispensers placed throughout the facilities where water is not readily available. Location in Plan: Pages 9-10, Section III(C)(ii).

Continue to emphasize practicing good hand hygiene and cough etiquette. (See above.)	Done. Posted signage on hand hygiene and on cough etiquette. Location in Plan: Attachment D.
CLEANING AND DISINFECTING PRACTICES	
Continue adhering to recommended cleaning and disinfection procedures for the facility at large. (See above.)	CDCR directed increased cleaning and disinfection procedures to all institutions and mandated cleaning at a minimum of every three hours. Location in Plan: Page 10, Section III(D); Attachment R; Attachment S.
Reference specific cleaning and disinfection procedures for areas where a COVID-19 case has spent time (below).	All CDCR institutions have been instructed to conduct additional deep-cleaning efforts in high-traffic, high-volume areas, including health care facilities. Communal areas such as dayrooms, showers, restrooms, and officers are cleaned at a minimum of twice per shift during second and third watch, and more if needed. Location in Plan: Page 10, Section III(D); Attachment R; Attachment S.
MEDICAL ISOLATION OF CONFIRMED OR SUSPECTED COVID-19 CASES	
As soon as an individual develops symptoms of COVID-19, they should wear a face mask (if it does not restrict breathing) and should be immediately placed under medical isolation in a separate environment from other individuals.	Done. All facilities have identified isolation and quarantine areas. See COVID-19 Interim Guidance for Health Care and Public Health Providers. Location in Plan: Attachment M.
Keep the individual's movement outside the medical isolation space to an absolute minimum. • Provide medical care to cases inside the medical isolation space. See Infection Control and Clinical Care sections for additional details.	Done. See COVID-19 Interim Guidance for Health Care and Public Health Providers. Location in Plan: Attachment M.

• Serve meals to cases inside the medical isolation space. • Exclude the individual from all group activities. • Assign the isolated individual a dedicated bathroom when possible.	
Ensure that the individual is wearing a face mask at all times when outside of the medical isolation space, and whenever another individual enters. Provide clean masks as needed. Masks should be changed at least daily, and when visibly soiled or wet.	See COVID-19 Interim Guidance for Health Care and Public Health Providers. Location in Plan: Attachment M.
Facilities should make every possible effort to place suspected and confirmed COVID-19 cases under medical isolation individually. Each isolated individual should be assigned their own housing space and bathroom where possible. Cohorting should only be practiced if there are no other available options. If cohorting is necessary: • Only individuals who are laboratory confirmed COVID-19 cases should be placed under medical isolation as a cohort. Do not cohort confirmed cases with suspected cases or case contacts. • Unless no other options exist, do not house COVID-19 cases with individuals who have an undiagnosed respiratory infection. • Ensure that cohorted cases wear face masks at all times. 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	Done. Cohorting is done as outlined for laboratory confirmed disease where single cells are not available. Patients do not transfer solely for isolation. Isolation cells follow the order of preference recommended. See COVID-19 Interim Guidance for Health Care and Public Health Providers. Location in Plan: Attachment M.

• 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 related to housing in the Prevention section above. • As a cohort, in a large, well-ventilated cell with solid walls but without a solid door. Employ social distancing strategies related to housing in the Prevention section above. • 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 related to housing in the Prevention section above.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	This situation has not yet developed. Our medical guidance document envisions this

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.) • Persons at higher risk may include older adults and persons of any age with serious underlying medical conditions such as lung disease, heart disease, and diabetes. See CDC's website for a complete list, and check regularly for updates as more data become available to inform this issue. • 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.	situation and outlines priorities to follow. See COVID-19 Interim Guidance for Health Care and Public Health Providers. Location in Plan: Attachment M.
Custody staff should be designated to monitor these individuals exclusively where possible. • These staff should wear recommended PPE as appropriate for their level of contact with the individual under medical isolation (see PPE section below) and should limit their own movement between different parts of the facility to the extent possible.	Not currently in place due to staffing capabilities.
Minimize transfer of COVID-19 cases between spaces within the healthcare unit.	Patients who have been exposed to COVID-19 or are showing symptoms or have a confirmed case of COVID-19 are put on quarantine or isolation as clinically appropriate. See COVID-19 Interim Guidance for Health Care and Public Health Providers. Location in Plan: Attachment M.

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.	Tissues available, no-touch trash receptacle not available. Cough hygiene instructions given. Posted signage on cough etiquette. Location in Plan: Attachment D.
Maintain medical isolation until all the following criteria have been met. Monitor the CDC website for updates to these criteria. For individuals who will be tested to determine if they are still contagious**:** • The individual has been free from fever for at least 72 hours without the use of fever-reducing medications **AND** • The individual's other symptoms have improved (e.g., cough, shortness of breath) **AND** • The individual has tested negative in at least two consecutive respiratory specimens collected at least 24 hours apart For individuals who will NOT be tested to determine if they are still contagious**:** • The individual has been free from fever for at least 72 hours without the	CDCR and CCHCS are currently following the California Department of Public Health (CDPH) on testing guidance for releasing patients from isolation, which are slightly different but are consistent with the spirit of these CDC recommendations.

use of fever-reducing medications **AND** • The individual's other symptoms have improved (e.g., cough, shortness of breath) **AND** • At least 7 days have passed since the first symptoms appeared For individuals who had a confirmed positive COVID-19 test but never showed symptoms**:** • At least 7 days have passed since the date of the individual's first positive COVID-19 test **AND** • The individual has had no subsequent illness	
Restrict cases from leaving the facility while under medical isolation precautions, unless released from custody or if a transfer is necessary for medical care, infection control, lack of medical isolation space, or extenuating security concerns. • If an incarcerated/detained individual who is a COVID-19 case is released from custody during their medical isolation period, contact public health to arrange for safe transport and continuation of necessary medical care and medical isolation as part of release planning.	CDCR is moving patients only for medical treatment beyond the capability of the institution or to address safety/security concerns that can be met at the institution. Done via coordination with the receiving county's local health department and medical care system.
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	Currently disinfection occurs; CDCR does not wait to disinfect. CDCR has directed increased cleaning and disinfection procedures to all institutions and mandated cleaning at a minimum of every three hours. Location in Plan: Page 10, Section III(D); Attachment R.

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-19. 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	All CDCR institutions have been instructed to conduct additional deep-cleaning efforts in high-traffic, high-volume areas, including health care facilities. Communal areas such as dayrooms, showers, restrooms, and officers are cleaned at a minimum of twice per shift during second and third watch, and more if needed. EPA registered disinfectants are used. Location in Plan: Page 10, Section III(D); Attachment M at page 39; Attachment R.

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 (1/3rd 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.	All CDCR institutions have been instructed to conduct additional deep-cleaning efforts in high-traffic, high-volume areas, including health care facilities. Communal areas such as dayrooms, showers, restrooms, and officers are cleaned at a minimum of twice per shift during second and third watch, and more if needed. EPA registered disinfectants are used. Location in Plan: Page 10, Section III(D); Attachment M at page 40; Attachment R.
Electronics cleaning and disinfection For electronics such as tablets, touch screens, keyboards, and remote controls, remove visible contamination if present.	Done. Alcohol based disinfectants are not currently in use.

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.	
Ensure that staff and incarcerated/detained persons performing cleaning wear recommended PPE. (See PPE section below.)	Done.
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.	This guidance has been passed to food services via the Department Operations Center.
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.	All institutions will increase laundry services in order to accommodate proper washing and drying of barrier masks. Location in Plan: Pages 9-10, Section III(C)(ii); Attachment N.

• 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.	Done.
QUARANTINING CLOSE CONTACTS OF COVID-19 CASES	
Incarcerated/detained persons who are close contacts of a confirmed or suspected COVID-19 case (whether the case is another incarcerated/detained person, staff member, or visitor) should be placed under quarantine for 14 days (see CDC guidelines). • If an individual is quarantined due to contact with a suspected case who is subsequently tested for COVID-19 and receives a negative result, the quarantined individual should be released from quarantine restrictions.	Done. CCHCS quarantine guidelines follow CDC and CDPH current guidance. See COVID-19 Interim Guidance for Health Care and Public Health Providers. Location in Plan: Attachment M.
In the context of COVID-19, an individual (incarcerated/detained person or staff) is considered a close contact if they**:** • Have been within approximately 6 feet of a COVID-19 case for a prolonged period of time **OR** • Have had direct contact with infectious secretions of a COVID-19 case (e.g., have been coughed on) Close contact can occur while caring for, living with, visiting, or sharing a common space with a COVID-19 case. Data to inform the definition of close contact are limited. Considerations when assessing close contact	Done. CCHCS quarantine guidelines follow CDC and CDPH current guidance. See COVID-19 Interim Guidance for Health Care and Public Health Providers. Location in Plan: Attachment M.

include the duration of exposure (e.g., longer exposure time likely increases exposure risk) and the clinical symptoms of the person with COVID-19 (e.g., coughing likely increases exposure risk, as does exposure to a severely ill patient).	
Keep a quarantined individual's movement outside the quarantine space to an absolute minimum. • Provide medical evaluation and care inside or near the quarantine space when possible. • Serve meals inside the quarantine space. • Exclude the quarantined individual from all group activities. • Assign the quarantined individual a dedicated bathroom when possible.	Done, although some cohorted quarantined individuals have group feeding and share bathrooms. See COVID-19 Interim Guidance for Health Care and Public Health Providers. Location in Plan: Attachment M.
Facilities should make every possible effort to quarantine close contacts of COVID-19 cases individually. Cohorting multiple quarantined close contacts of a COVID-19 case could transmit COVID-19 from those who are infected to those who are uninfected. Cohorting should only be practiced if there are no other available options. • If cohorting of close contacts under quarantine is absolutely necessary, symptoms of all individuals should be monitored closely, and individuals with symptoms of COVID-19 should be placed under medical isolation • If an entire housing unit is under quarantine due to contact with a case from the same housing unit, the entire housing unit may need to be treated as a cohort and quarantine in place.	Currently the majority of quarantines are cohorted. All are monitored twice a day. See COVID-19 Interim Guidance for Health Care and Public Health Providers. Location in Plan: Attachment M.

• Some facilities may choose to quarantine all new intakes for 14 days before moving them to the facility's general population as a general rule (not because they were exposed to a COVID-19 case). Under this scenario, avoid mixing individuals quarantined due to exposure to a COVID-19 case with individuals undergoing routine intake quarantine. • If at all possible, do not add more individuals to an existing quarantine cohort after the 14-day quarantine clock has started.	
If the number of quarantined individuals exceeds the number of individual quarantine spaces available in the facility, be especially mindful of those who are at higher risk of severe illness from COVID-19. Ideally, they should not be cohorted with other quarantined individuals. If cohorting is unavoidable, make all possible accommodations to reduce exposure risk for the higher-risk individuals. (For example, intensify social distancing strategies for higher-risk individuals.) In order of preference, multiple quarantined individuals 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, a solid door that closes fully, and at least 6 feet of personal space assigned to each individual in all directions	Done. CCHCS's quarantine guidance follows this prioritization schema. See COVID-19 Interim Guidance for Health Care and Public Health Providers. Location in Plan: Attachment M.

• As a cohort, in a large, well-ventilated cell with solid walls and at least 6 feet of personal space assigned to each individual in all directions, but without a solid door • 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 creating at least 6 feet of space between individuals. (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 related to housing in the Prevention section to maintain at least 6 feet of space between individuals housed in the same cell. • As a cohort, in individuals' regularly assigned housing unit but with no movement outside the unit (if an entire housing unit has been exposed). Employ social distancing strategies related to housing in the Prevention section above to maintain at least 6 feet of space between individuals. • Safely transfer to another facility with capacity to quarantine 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.)	

Quarantined individuals should wear face masks if feasible based on local supply, as source control, under the following circumstances: • If cohorted, quarantined individuals should wear face masks at all times (to prevent transmission from infected to uninfected individuals). • If quarantined separately, individuals should wear face masks whenever a non-quarantined individual enters the quarantine space. • All quarantined individuals should wear a face mask if they must leave the quarantine space for any reason. • Asymptomatic individuals under routine intake quarantine (with no known exposure to a COVID-19 case) do not need to wear face masks.	Done. Face coverings are made available via PIA for quarantined individuals. Surgical masks are utilized for those patients in isolation. See COVID-19 Interim Guidance for Health Care and Public Health Providers. Location in Plan: Attachment M.
Staff who have close contact with quarantined individuals should wear recommended PPE if feasible based on local supply, feasibility, and safety within the scope of their duties (see PPE section and Table 1). • Staff supervising asymptomatic incarcerated/detained persons under routine intake quarantine (with no known exposure to a COVID-19 case) do not need to wear PPE.	PPE is reserved for isolated individuals based on our current supply. Face coverings are available for staff and quarantined patients. See COVID-19 Interim Guidance for Health Care and Public Health Providers. Location in Plan: Attachment M.
Quarantined individuals should be monitored for COVID-19 symptoms twice per day, including temperature checks. • If an individual develops symptoms, they should be moved to medical isolation immediately and further evaluated. (See Medical Isolation section above.)	Done. See COVID-19 Interim Guidance for Health Care and Public Health Providers. Location in Plan: Attachment M.

• See Screening section for a procedure to perform temperature checks safely on asymptomatic close contacts of COVID-19 cases.	
If an individual who is part of a quarantined cohort becomes symptomatic: • If the individual is tested for COVID-19 and tests positive: the 14-day quarantine clock for the remainder of the cohort must be reset to 0. • If the individual is tested for COVID-19 and tests negative**:** the 14-day quarantine clock for this individual and the remainder of the cohort does not need to be reset. This individual can return from medical isolation to the quarantined cohort for the remainder of the quarantine period. • If the individual is not tested for COVID-19**:** the 14-day quarantine clock for the remainder of the cohort must be reset to 0.	Treatment and quarantine practices are consistent with CCHCS COVID-19 Interim Guidance for Health Care and Public Health Providers. Location in Plan: Attachment M.
Restrict quarantined individuals from leaving the facility (including transfers to other facilities) during the 14-day quarantine period, unless released from custody or a transfer is necessary for medical care, infection control, lack of quarantine space, or extenuating security concerns.	Quarantine shall last at least fourteen days. See COVID-19 Interim Guidance for Health Care and Public Health Providers. Location in Plan: Attachment M at page 24, 36.
Quarantined individuals can be released from quarantine restrictions if they have not developed symptoms during the 14-day quarantine period.	Quarantine shall last at least fourteen days. See COVID-19 Interim Guidance for Health Care and Public Health Providers. Location in Plan: Attachment M at page 24, 36.
Meals should be provided to quarantined individuals in their quarantine spaces. Individuals under quarantine should throw disposable food service items in the trash. Non-disposable food service items should be	Quarantined individuals either receive cell feeding or eat as a quarantined cohort based on facility design. Quarantine shall last at least fourteen days. See COVID-19 Interim Guidance for Health Care and Public Health

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.	Providers. Location in Plan: Attachment M at page 34.
Laundry from quarantined individuals can be washed with other individuals' laundry. • Individuals handling laundry from quarantined persons 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.	Laundry process follows CDC recommendations. See COVID-19 Interim Guidance for Health Care and Public Health Providers. Location in Plan: Attachment M at page 40-41.
MANAGEMENT OF INCARCERATED / DETAINED PERSONS WITH COVID-19 SYMPTOMS	
If possible, designate a room near each housing unit for healthcare staff to evaluate individuals with COVID-19 symptoms, rather than having them walk through the facility to be evaluated in the medical unit.	Done. Most evaluations are conducted cell front or in a designated area.
Incarcerated/detained individuals with COVID-19 symptoms should wear a face mask and should be placed under medical isolation immediately. Discontinue the use of a face mask if it inhibits breathing. See Medical Isolation section above.	See COVID-19 Interim Guidance for Health Care and Public Health Providers. Location in Plan: Attachment M.

Medical staff should evaluate symptomatic individuals to determine whether COVID-19 testing is indicated. Refer to CDC guidelines for information on evaluation and testing. See Infection Control and Clinical Care sections below as well.	See COVID-19 Interim Guidance for Health Care and Public Health Providers. Location in Plan: Attachment M.
If testing is indicated (or if medical staff need clarification on when testing is indicated), contact the state, local, tribal, and/or territorial health department. Work with public health or private labs as available to access testing supplies or services. • If the COVID-19 test is positive, continue medical isolation. (See Medical Isolation section above.) • If the COVID-19 test is negative, return the individual to their prior housing assignment unless they require further medical assessment or care.	CCHCS uses contract testing via Quest, and current tests return results in 48-72 hours. We are working with the Governor's Office to obtain in-house rapid testing capability.
MANAGEMENT STRATEGIES FOR INCARCERATED / DETAINED PERSONS WITHOUT COVID-19 SYMPTOMS	
Provide clear information to incarcerated/detained persons about the presence of COVID-19 cases within the facility, and the need to increase social distancing and maintain hygiene precautions. • Consider having healthcare staff perform regular rounds to answer questions about COVID-19. • Ensure that information is provided in a manner that can be understood by non-English speaking individuals and those with low literacy, and make necessary accommodations for those with cognitive or intellectual	Posters have been placed throughout the institution containing information regarding symptoms, appropriate social distancing in communal areas, COVID facts and frequently asked questions, and preventing the spread of illness. Both Secretary Diaz and the Plata Receiver, Clark Kelso, have recorded videos for the inmate population that have been added to the Division of Rehabilitative Programs institutional television wellness channel. The videos, which provide information regarding COVID-19 and the steps CDCR and CCHCS have taken in response, can be viewed on CDCR/CCHCS's COVID-19 Preparedness website. (https://www.cdcr.ca.gov/covid19/population-communications/). All printed material, as

disabilities and those who are deaf, blind, or low-vision.	well as all videos, are available in both English and Spanish, including closed captioning. Staff also meet with Inmate Advisory Council on a regular basis. Location in Plan: Page 1, Section I; Page 3, Section III(A)(iii); Attachment D.
Implement daily temperature checks in housing units where COVID-19 cases have been identified, especially if there is concern that incarcerated/detained individuals are not notifying staff of symptoms. See Screening section for a procedure to safely perform a temperature check.	Twice daily evaluations including temperature checks are done on isolated and quarantined individuals. They are not being done in the general population. Location in Plan: Attachment M.
Consider additional options to intensify social distancing within the facility.	CDCR continues to move inmates out of dorm housing and educating the population about the importance of communal social distancing. CDCR and CCHCS continue to assess the institutions and determine what more may need to be done. Location in Plan: Pages 4-7, Section III(B)(i)(a)-(d); Attachment E; Attachment F; Attachment G; Attachment H.
MANAGEMENT STRATEGIES FOR STAFF	
Provide clear information to staff about the presence of COVID-19 cases within the facility, and the need to enforce social distancing and encourage hygiene precautions. Consider having healthcare staff perform regular rounds to answer questions about COVID-19 from staff.	Posters have been placed throughout the institution containing information regarding symptoms, appropriate social distancing in communal areas, COVID facts and frequently asked questions, and preventing the spread of illness. Information for staff is available at https://www.cdcr.ca.gov/covid19/information/. Information regarding positive inmate cases in the institutions is available at https://www.cdcr.ca.gov/covid19/population-status-tracking/. Information regarding positive staff cases at the institutions is available at https://www.cdcr.ca.gov/covid19/cdcr-cchcs-covid-19-status/.

Staff identified as close contacts of a COVID-19 case should self-quarantine at home for 14 days and may return to work if symptoms do not develop. See above for definition of a close contact. Refer to CDC guidelines for further recommendations regarding home quarantine for staff.	Currently following CDPH guidance regarding return to work for critical healthcare workers for all facility staff.
INFECTION CONTROL	
All individuals who have the potential for direct or indirect exposure to COVID-19 cases or infectious materials (including body substances; contaminated medical supplies, devices, and equipment; contaminated environmental surfaces; or contaminated air) should follow infection control practices outlined in the CDC Interim Infection Prevention and Control Recommendations for Patients with Suspected or Confirmed Coronavirus Disease 2019 (COVID-19) in Healthcare Settings. Monitor these guidelines regularly for updates. • Implement the above guidance as fully as possible within the correctional/detention context. Some of the specific language may not apply directly to healthcare settings within correctional facilities and detention centers, or to facilities without onsite healthcare capacity, and may need to be adapted to reflect facility operations and custody needs. • Note that these recommendations apply to staff as well as to incarcerated/detained individuals who may come in contact with contaminated materials during the course of their work placement in the facility (e.g., cleaning).	Done. See COVID-19 Interim Guidance for Health Care and Public Health Providers. Location in Plan: Attachment M.

Staff should exercise caution when in contact with individuals showing symptoms of a respiratory infection. Contact should be minimized to the extent possible until the infected individual is wearing a face mask. If COVID-19 is suspected, staff should wear recommended PPE (see PPE section).	Done. PPE policy memos and quick reference guide distributed April 6, 2020, with link to CDC guidelines. Location in Plan: Pages 9-10, Section III(C)(ii); Attachment M; Attachment O; Attachment P.
Refer to PPE section to determine recommended PPE for individuals persons in contact with confirmed COVID-19 cases, contacts, and potentially contaminated items.	Done. PPE policy memos and quick reference guide distributed April 6, 2020, with link to CDC guidelines. Location in Plan: Pages 9-10, Section III(C)(ii); Attachment M; Attachment O; Attachment P.
CLINICAL CARE OF COVID-19 CASES	
Facilities should ensure that incarcerated/detained individuals receive medical evaluation and treatment at the first signs of COVID-19 symptoms. • If a facility is not able to provide such evaluation and treatment, a plan should be in place to safely transfer the individual to another facility or local hospital. • The initial medical evaluation should determine whether a symptomatic individual is at higher risk for severe illness from COVID-19. Persons at higher risk may include older adults and persons of any age with serious underlying medical conditions such as lung disease, heart disease, and diabetes. See CDC's website for a complete list, and check regularly for updates as more data become available to inform this issue.	Done. See COVID-19 Interim Guidance for Health Care and Public Health Providers. Location in Plan: Attachment M.
Staff evaluating and providing care for confirmed or suspected COVID-19 cases should follow the CDC Interim Clinical Guidance for Management of Patients with Confirmed Coronavirus Disease (COVID-19)	Done. See COVID-19 Interim Guidance for Health Care and Public Health Providers. Location in Plan: Attachment M.

and monitor the guidance website regularly for updates to these recommendations.	
Healthcare staff should evaluate persons with respiratory symptoms or contact with a COVID-19 case in a separate room, with the door closed if possible, while wearing recommended PPE and ensuring that the suspected case is wearing a face mask. If possible, designate a room near each housing unit to evaluate individuals with COVID-19 symptoms, rather than having them walk through the facility to be evaluated in the medical unit.	Done. PPE policy memos and quick reference guide distributed April 6, 2020, with link to CDC guidelines. Location in Plan: Pages 9-10, Section III(C)(ii); Attachment M; Attachment O; Attachment P.
Clinicians are strongly encouraged to test for other causes of respiratory illness (e.g., influenza).	Done. Local influenza testing capability in place on site.
The facility should have a plan in place to safely transfer persons with severe illness from COVID-19 to a local hospital if they require care beyond what the facility is able to provide.	CDCR is able to transfer patients to an outside hospital if clinically necessary.
When evaluating and treating persons with symptoms of COVID-19 who do not speak English, using a language line or provide a trained interpreter when possible.	Done under existing procedures including sign language interpreters.
RECOMMENDED PPE AND PPE TRAINING FOR STAFF AND INCARCERATED / DETAINED PERSONS	
Ensure that all staff (healthcare and non-healthcare) and incarcerated/detained persons who will have contact with infectious materials in their work placements have been trained to correctly don, doff, and dispose of PPE relevant to the level of contact they will have with confirmed and suspected COVID-19 cases. • Ensure that staff and incarcerated/detained persons who require respiratory protection (e.g.,	Done. PPE policy memos and quick reference guide distributed April 6, 2020, with link to CDC guidelines. Location in Plan: Pages 9-10, Section III(C)(ii); Attachment M; Attachment O; Attachment P.

N95s) for their work responsibilities have been medically cleared, trained, and fit-tested in the context of an employer's respiratory protection program. • For PPE training materials and posters, please visit the CDC website on Protecting Healthcare Personnel.	
Ensure that all staff are trained to perform hand hygiene after removing PPE.	Done. PPE policy memos and quick reference guide distributed April 6, 2020, with link to CDC guidelines. Location in Plan: Pages 9-10, Section III(C)(ii); Attachment M; Attachment O; Attachment P.
If administrators anticipate that incarcerated/detained persons will request unnecessary PPE, consider providing training on the different types of PPE that are needed for differing degrees of contact with COVID-19 cases and contacts, and the reasons for those differences (see Table 1). Monitor linked CDC guidelines in Table 1 for updates to recommended PPE.	CDCR and CCHCS have provided extensive education regarding this topic to both patients and staff. PPE policy memos and quick reference guide distributed April 6, 2020, with link to CDC guidelines. Further, posters have been provided to the institutions regarding PPE and differing degrees of contact with persons with COVID-19. Location in Plan: Page 3, Section III(A)(iii); Pages 9-10, Section III(C)(ii); Attachment D; Attachment M; Attachment O; Attachment P.
Keep recommended PPE near the spaces in the facility where it could be needed, to facilitate quick access in an emergency.	PPE is currently secured to prevent theft.
Recommended PPE for incarcerated/detained individuals and staff in a correctional facility will vary based on the type of contact they have with COVID-19 cases and their contacts (see Table 1). Each type of recommended PPE is defined below. As above, note that PPE shortages are anticipated in every category during the COVID-19 response. N95 respirator • See below for guidance on when face masks are acceptable alternatives for	Current PPE procedures are consistent with this guidance. Location in Plan: Attachment M.

N95s. N95 respirators should be prioritized when staff anticipate contact with infectious aerosols from a COVID-19 case. Face mask Eye protection • Goggles or disposable face shield that fully covers the front and sides of the face A single pair of disposable patient examination gloves • Gloves should be changed if they become torn or heavily contaminated. Disposable medical isolation gown or single-use/disposable coveralls, when feasible. • If custody staff are unable to wear a disposable gown or coveralls because it limits access to their duty belt and gear, ensure that duty belt and gear are disinfected after close contact with the individual. Clean and disinfect duty belt and gear prior to reuse using a household cleaning spray or wipe, according to the product label. • If there are shortages of gowns, they should be prioritized for aerosol-generating procedures, care activities where splashes and sprays are anticipated, and high-contact patient care activities that provide opportunities for transfer of pathogens to the hands and clothing of staff.	
Note that shortages of all PPE categories are anticipated during the COVID-19 response, particularly for non-healthcare workers. Guidance for optimizing the supply of each category can be found on CDC's website: • Guidance in the event of a shortage of N95 respirators	Done. At present, we do not have a shortage of N95 masks.

○ 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 staff engaging in activities that would expose them to respiratory aerosols, which pose the highest exposure risk. • Guidance in the event of a shortage of face masks • Guidance in the event of a shortage of eye protection • Guidance in the event of a shortage of gowns/coveralls	
VERBAL SCREENING AND TEMPERATURE CHECK PROTOCOLS FOR INCARCERATED/DETAINED PERSONS, STAFF, AND VISITORS	
Verbal screening for symptoms of COVID-19 and contact with COVID-19 cases should include the following questions: Today or in the past 24 hours have you had any of the following symptoms? • Fever, felt feverish, or had chills? • Cough? • Difficulty Breathing? In the past 14 days have you had contact with a person known to be infected with COVID-19?	All CCHCS and CDCR locations currently conduct screening. All CDCR institutions conduct touchless temperature testing. Location in Plan: Page 7, Section III(B)(ii)(c); Attachment K.
The following is a protocol to safely check an individual's temperature:	All CCHCS and CDCR locations currently conduct screening. All CDCR institutions

• Perform hand hygiene • Put on a face mask, eye protection (goggles or disposable face shield that fully covers the front and sides of the face), gown/coveralls, and a single pair of disposable gloves • Check individual's temperature • If performing a temperature check on multiple individuals, ensure that a clean pair of gloves is used for each individual and that the thermometer has been thoroughly cleaned between each check. If disposable or non-contact thermometers are used and the screener did not have physical contact with an individual, gloves do not need to be changed before the next check. If non-contact thermometers are used, they should be cleaned routinely as recommended by CDC for infection control. • Remove and discard PPE • Performa hand hygiene	conduct touchless temperature testing. Location in Plan: Page 7, Section III(B)(ii)(c); Attachment K.

ATTACHMENT B

CALIFORNIA DEPARTMENT OF CORRECTIONS AND REHABILITATION COVID-19 RESPONSE TIMELINES AS OF APRIL 15, 2020

The below is a comprehensive timeline of all of CDCR's efforts to respond to the COVID-19 pandemic:

March 11, 2020:

- CDCR suspended Normal Contact Visiting statewide, along with all events of 250 attendees or more.
- CDCR also delivered messaging information (Fact Sheets and Posters) on the COVID-19 pandemic to inmate population.
- All CDCR institutions were instructed to order 10 additional hand sanitizer dispenser stations. The purchased dispensers have begun arriving at the institutions and are being placed inside institution dining halls, work change areas, housing units, and where sinks/soap are not immediately available. The dispensers contain the type of alcohol-based hand sanitizer recommended by the Centers for Disease Control and Prevention to help eliminate coronavirus. Additional dispensers may be placed in high-need areas where they can be monitored for safety and security of the institution.

March 12, 2020:

- CDCR cancelled all tours within the prisons.

March 13, 2020:

- To ensure social distancing amongst our employees, CDCR postponed the March 21, 2020 Correctional Sergeant written examination until further notice.

March 14, 2020:

- Expanded precautions at institutions by implementing mandatory verbal screening for all entering state prisons.

March 15, 2020:

- Activated the Department Operations Center.
- Suspended in-person observers at parole suitability hearings.

March 16, 2020:

- Suspended the family visiting program statewide.
- Cancelled all Advanced Learning Institute trainings to afford staff the ability to better social distance.
- Disseminated updated guidance to employees who are 65 and up or who have chronic health conditions.

CALIFORNIA DEPARTMENT OF CORRECTIONS AND REHABILITATION COVID-19 RESPONSE TIMELINES AS OF APRIL 15, 2020

March 17, 2020:

- Suspended all transfers of all parolees to other states or receiving parolees from other states into California for 30 days.
- Suspended all volunteers or rehabilitative program provider to enter prisons.
- Secured two days of free telephone calls for March 19 and March 26 through GTL. JPay agrees to provide two free electronic stamps per week for all inmates registered at the pilot institutions: High Desert State Prison, Kern Valley State Prison, California Institution for Women, Central California Women's Facility, and Substance Abuse Treatment Facility.
- Released updated guidance for our staff who reside in the Bay Area.
- Parole suitability hearings postponed through April 6, 2020.
- COVID19@cdcr.ca.gov email address goes live.

March 18, 2020:

- All CDCR/CCHCS staff given verbal screenings before entering all CDCR/CCHCS work locations.
- Implemented temporary travel and meeting restrictions.

March 19, 2020:

- Secretary Diaz initiated a task force to start developing all options for inmate releases to allow more social distancing within the institutions. The task force was to look at all inmates who were within 12 months of release.
- Postponed written peace officer exams through April 6, 2020.
- Limited Inmate transfers to only essential movement.
- To ensure appropriate social distancing, directed Ramadan, Passover, and Easter services to be provided in-cell.
- Standardized academic testing postponed.

March 20, 2020:

- CCHCS issues Interim Guidance for Health Care and Public Health Providers.

CALIFORNIA DEPARTMENT OF CORRECTIONS AND REHABILITATION COVID-19 RESPONSE TIMELINES AS OF APRIL 15, 2020

March 21, 2020:

- Directed all inmates received into Reception Centers to be quarantined for 14 days to ensure they are not showing symptoms.
- Basic Correctional Officer Academy scheduled for March 24 postponed.
- Current Basic Correctional Officer Academy accelerated.

March 22, 2020:

- First CDCR inmate tests positive for COVID-19.

March 23, 2020:

- Social Distancing posters to message staying at least 6 feet apart was provided to prisons for posting.
- All TB testing for staff was postponed to later in the year.
- CDCR/CCHCS-created educational video released for population, which provides the inmate population information on COVID-19 and how to prevent the spread.

March 24, 2020:

- Further limited inmate movement by stopping all transfers of inmates to and from Conservation Camps, MCRPs, CCTRP, and ACPs.
- Reached out to CALFIRE to devise strategies to continue populating the Fire Camps and to continue training in anticipation of the Fire Season.
- Governor issues Executive Order with directives to CDCR to suspend Adult, DJJ intake from counties for 30 days, BPH to develop process for videoconferencing parole hearings, and In-person parole hearings suspended for 60 days.

March 25, 2020:

- Population COVID-19 Tracking released.
- CDCR Statewide Mental Health Program issues tiered plan to provide guidance for the delivery of mental health care during COVID-19.
- Secretary Diaz releases video message to staff and inmate population.

CALIFORNIA DEPARTMENT OF CORRECTIONS AND REHABILITATION COVID-19 RESPONSE TIMELINES AS OF APRIL 15, 2020

March 26, 2020:

- CDCR secured 3 days of free calls per week from GTL from March 31, 2020 through April 30, 2020. CDCR Is also developing a solution for increased access to calling for offenders in restricted housing or hospice beds, similar to how calls are delivered in condemned housing.

- CALPIA was licensed by the California Department of Public Health to begin producing hand sanitizer at its chemical enterprise in California State Prison-Los Angeles County.

- CALPIA has designed and initiated production of barrier masks to be utilized by CALPIA mission critical operations and for CCHCS to supply currently quarantined offenders. CALPIA began shipping barrier masks. CDCR is working CALPIA to expand barrier mask production for staff use.

March 27, 2020:

- Temperature screenings were implemented for all entering prisons and community correctional facilities.

- CDCR released guidance for COVID-19 for PPE controls.

March 29, 2020:

- CALPIA announces new production of both alcohol- and non-alcohol-based hand sanitizer. CALPIA has shipped the first delivery, 3852 bottles (1,000 Gallons) of the alcohol-based product to 28 CDCR locations.

March 30, 2020:

- CDCR announces free phone calls through GTL for inmates three days per week beginning March 31, 2020 through the end of April 2020.

- JPay announces reduced-priced emails to registered users at pilot institutions. Free emails will be available for those are unable to pay.

March 31, 2020:

- Plan announced to expedite transition to parole for certain eligible inmates with 60 days or less to serve.

- *Plata* Receiver Clark Kelso releases video message to all staff.

April 1, 2020:

- CCHCS launches internal patient registry to assist in monitoring patients with suspected or confirmed COVID-19.

CALIFORNIA DEPARTMENT OF CORRECTIONS AND REHABILITATION COVID-19 RESPONSE TIMELINES AS OF APRIL 15, 2020

- CDCR issues a memoranda implementing an Electronic Appliance Loaner Program in all restricted housing areas.
- CDCR issues a memoranda allowing evening yard for patients in the Mental Health Services Delivery System.
- DAI issues directive to transfer inmates from Level II dormitories to vacant housing units.

April 3, 2020:

- CCHCS provides revised guidelines related to COVID-19.

April 5, 2020:

- CDCR issues a memoranda requiring COVID-19 screening prior to mental health transfers.

April 6, 2020:

- CCHCS provides guidance to staff regarding PPE.
- CALPIA to continue only critical operations effective April 8, 2020.

April 7, 2020:

- Transfers from Reception Centers are suspended through April 22, 2020.

April 8, 2020:

- CDCR partners with JPay to provide inbound email print services to all institutions at a reduced rate.
- CDCR implements a mandatory statewide 14-day modified program.
- CDCR issues a memoranda to increase telephone call privileges for the following inmates: non-disciplinary segregation inmates; all other inmates in restricted housing; C status inmates; reception center inmates; inmates housed in the Psychiatric Inpatient Program.

April 9, 2020:

- Secretary Diaz releases video messages to staff, stakeholders, and inmate population on steps CDCR is taking to combat the spread of COVID-19.

April 10, 2020:

- All institutions increase laundry services.

CALIFORNIA DEPARTMENT OF CORRECTIONS AND REHABILITATION COVID-19 RESPONSE TIMELINES AS OF APRIL 15, 2020

- The *Plata* Receiver issue memoranda to Secretary Diaz with recommendation for 8-person cohorts and direction that transfers to facilitate physical distancing shall occur in consultation and concurrence with the Health Care Placement Oversight Program.

- CDCR Statewide Mental Health Program issues a memo providing guidelines for patient transfer to higher levels of mental health care and mental health treatment.

- CDCR issues direction regarding screening of critical inmate workers.

April 12, 2020:

- The *Plata* Receiver issues a supplement memoranda to his April 10, 2020 memoranda clarifying that the cessation of movement does not affect any inter-institution transfers that are necessary to address medical, mental health, or dental treatment needs that are not available at the inmate's current institution.

April 13, 2020:

- CDCR re-issued the memoranda increase telephone call privileges clarifying that inmates will be provided call at least at the frequency required by the memoranda.

April 14, 2020:

- CDCR and CCHCS launch an enhanced version of the population case tracker to provide further details by institution.

- CDCR announces that inmates who transfer to county jails pending court hearings will not be accepted back into CDCR custody until intake is resumed.

April 15, 2020:

- Expedited release of inmates completed.

- CDCR issues a memoranda requiring staff and inmates to wear a mask at all times when in the vicinity of others.

- As of this date, 69 inmates have tested positive for COVID-19. The inmates are located at the following institutions: 69 at California Institution for Men; 18 at California State Prison – Los Angeles County; 1 at Centinela State Prison; 1 at California Institution for Women; 1 at California Men's Colony; 1 at North Kern State Prison; and 1 at the Substance Abuse Treatment Facility and State Prison – Corcoran.

CALIFORNIA DEPARTMENT OF CORRECTIONS AND REHABILITATION COVID-19 RESPONSE TIMELINES AS OF APRIL 15, 2020

- As of this date, 81 staff members have self-reported positive for COVID-19. The staff members work at the following locations: 1 at California Correctional Institution, 5 at California Heath Care Facility; 21 at California Institution for Men; 2 at California Institution for Women; 12 at California State Prison – Los Angeles County; 5 at California State Prison – Sacramento; 2 at Calipatria State Prison; 3 at CDCR/CCHCS Worksite Location – Sacramento County; 2 at CDCR/CCHCS Worksite Location – San Bernardino County; 2 at Centinela State Prison; 1 at Central California Women's Facility; 4 at Folsom State Prison; 1 at Mule Creek State Prison; 1 at North Kern State Prison; 2 Northern California Youth Correctional Center; 3 at Richard A. McGee Correctional Training Center; 6 at San Quentin State Prison; 1 at Salinas Valley State Prison; 2 at the Substance Abuse Treatment Facility and State Prison – Corcoran; 1 at Valley State Prison; and 4 at Wasco State Prison.

ATTACHMENT C

CALIFORNIA CORRECTIONAL
HEALTH CARE SERVICES

MEMORANDUM

Date:	March 11, 2020
To:	Regional Health Care Executives Deputy Medical Executives Chief Nurse Executives Chief Executive Officers Chief Medical Executives Chief Nurse Executives Chief Physician & Surgeons Chief Support Executives Infection Control Nurses Public Health Nurses
From:	Heidi M. Bauer, MD MS MPH Public Health Epi/Surveillance Lead Public Health Branch Diane O'Laughlin, FNP-BC, DNP Headquarters Chief Nurse Executive Public Health and Infection Prevention
Subject:	**2019 NOVEL CORONAVIRUS (COVID-19)**

The 2019 Novel Coronavirus (COVID-19 related virus, aka SARS-CoV-2) was identified in Wuhan, Hubei Province, China, in December 2019 and is now being detected in many parts of the world, including the United States. For up-to-date information regarding the novel coronavirus, see the Centers for Disease Control (CDC) Novel Coronavirus webpage.

Currently, there is no vaccine or pharmaceutical treatments for COVID-19. Person-to-person transmission has been demonstrated and is thought to occur by respiratory droplets, similar to how influenza or a cold is transmitted. At this time, the health risk to the general public in California from novel coronavirus remains low and there are no confirmed cases of COVID-19 among patients or staff within the California Department of Corrections & Rehabilitation (CDCR).

The purpose of this memorandum is to advise California Correctional Health Care Services (CCHCS) healthcare providers of new guidance released by the Centers for Disease Control and Prevention (CDC), California Department of Public Health (CDPH) and California Occupational Safety and Health Administration (CalOSHA) and to share resources for future updates that come available.

1. Risk assessment and initial management of patients with respiratory illness
2. Laboratory testing for COVID-19 related virus (SARS-CoV-2)
3. Surveillance and reporting requirements
4. Resources for up to date information (COVID-19 page on Lifeline and others)

RISK ASSESSMENT AND INITIAL MANAGEMENT OF PATIENTS WITH RESPIRATORY ILLNESS

- Risk factors for COVID-19: Close contact to a laboratory-confirmed COVID-19 patient in the past 14 days, or exposure in an affected geographic area or cruise ship are the strongest risk factors. To date, there are no confirmed cases of COVID-19 among CDCR patients or staff; however, community transmission is now recognized in at least 7 counties in California.
- Incubation period: People with COVID-19 generally develop signs and symptoms on average 5 days after exposure (range 2-14 days).
- Clinical spectrum of COVID-19 ranges from mild disease with non-specific signs and symptoms of acute respiratory illness, to severe pneumonia with respiratory failure and septic shock.
- Signs and symptoms of COVID-19 typically include:
  - Fever (100.4° F, 38° C)
  - Cough, dry or productive
  - Fatigue
  - Myalgia
  - Dyspnea occurs in a third of patients hospitalized for COVID-19
  - Upper respiratory symptoms (sore throat, congestion) are less common
  - Nausea, vomiting and diarrhea also have been reported
- COVID-19 is an influenza-like illness (ILI). Be alert to clusters of patients with ILI who test negative for influenza and other respiratory pathogens as they could represent an outbreak of COVID-19.
  - Ensure that infection control recommendations are followed for all ILI patients awaiting diagnosis and disposition:
    - The patient is using a surgical mask
    - The patient is isolated in an airborne isolation or **single room with closed door**
    - Standard, contact, and airborne precautions are followed
    - Personal protective equipment for health care workers includes fit-tested N-95 mask, gloves, gown, and eye protection (face shield or goggles)

LABORATORY TESTING FOR COVID-19 RELATED VIRUS (SARS-COV-2)

- Testing for patients with ILI:
  - COVID-19 related and influenza viral testing is important for establishing the etiology of ILI.
  - Patients with laboratory-confirmed influenza or other etiology are unlikely to be co-infected with COVID-19 related virus.

  - While influenza remains prevalent, patients with fever (>100° F) and cough who are not at high risk for severe disease (below) may undergo testing for influenza as a first-line test, with reflex to COVID-19 testing if negative for influenza. Rapid Influenza Diagnostic Tests (RIDTs) are valuable in identifying patients infected with influenza.
  - Who to consider immediate testing for COVID-19 related virus:
    - Patients of Concern: Because early diagnosis may improve clinical outcomes, priority for COVID-19 related virus testing should be given to symptomatic individuals who are **older (age ≥ 65 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 disease, receiving immunosuppressive medications, chronic lung disease, chronic kidney disease).
    - Clinicians should use their judgment in testing patients with ILI for other respiratory pathogens.
- Quest is now accepting specimens for SARS-CoV-2 RNA, Qualitative Real-Time RT-PCR testing:
  - Quest Test Code: **39433**
  - Preferred specimen: 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)
  - Use a separate NP or OP swab for COVID-19 testing; use a separate NP or OP swab for other tests (i.e. influenza). Do not combine swabs in the same tube.
  - Storage & Transport: SARS-CoV-2 RNA specimens must be refrigerated (refrigerated stability is up to 72 hour)
  - Follow standard procedure for storage and transport of refrigerated samples
  - Cold packs/pouches must be utilized if samples are placed in a lockbox
  - SARS-CoV-2 RNA is not a STAT test and a STAT pick-up cannot be ordered
  - Turnaround time (TAT) may be delayed: TAT (published as 3-4 days) may be impacted initially due to high demand
  - The induction of sputum is not recommended
- **Precaution for specimen collection:**
  - When collecting diagnostic respiratory specimens (e.g., nasopharyngeal swab) from a possible COVID-19 patient, the following should occur: Heath Care Personnel (HCP) in the room should wear an N-95 or higher-level respirator (or facemask if a respirator is not available), 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. Visitors should not be present for specimen collection. 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 below. CDC Interim Infection Prevention and Control Recommendations for Patients with Suspected or Confirmed Coronavirus Disease 2019 (COVID-19) in Healthcare Settings

- Laboratory-confirmed cases of COVID-19 should be reported immediately to the institution public health nurse, who will conduct a contact investigation and institute quarantine for those exposed. Institution leadership should also be notified immediately.

SURVEILLANCE AND REPORTING REQUIREMENTS

Effective immediately, California Correctional Health Care Services (CCHCS) Public Health Branch (PHB) will be assessing, monitoring and making a statewide report for leadership. This will require the institutions experiencing an outbreak or monitoring contact to report COVID-19 data *seven days a week, including holidays*. Reporting will be done via a SharePoint system described later in this memo.

Use the COVID-19 Case Definitions below to guide data reporting:

- **Confirmed COVID-19 Case**
  - A positive laboratory test for the virus that causes COVID-19 in at least one respiratory specimen (whether or not the positive test has been confirmed by the CDC).
- **Suspected COVID-19 Case**
  - Fever and cough or shortness of breath (dyspnea) with evidence of a viral syndrome (influenza-like illness [ILI]) in a person without high risk exposure and without a positive test for influenza **OR**
  - Any fever, respiratory symptoms, or evidence of a viral syndrome in a patient with epidemiologic linkage to a confirmed case of COVID-19 or linkage to a group defined by public health during an outbreak.
- **Close Contact to COVID-19 Case**
  - Close proximity (within approximately 6 feet) to an individual with confirmed COVID-19 for a prolonged period of time without the use of recommend Personal Protective Equipment
  - Direct contact with infectious secretions from an individual with confirmed COVID-19

Reporting: Every institution shall report daily, *seven days a week including holidays*:

- 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 suspect case at the institution, first confirmed case at the institution, first COVID-19 contact investigation at the institution.
- By noon, report all new suspected and confirmed COVID-19 cases and all new COVID-19 contacts to the COVID-19 SharePoint: https://cdcr.sharepoint.com/sites/cchcs_ms_phos
- By noon, update all case records on the COVID-19 SharePoint to reflect up-to-date information on lab results, symptoms, and patient status.

- By noon, update all contact records on the COVID-19 SharePoint to reflect up-to-date information on date of last exposure and monitoring status.

Training on use of the COVID-19 SharePoint reporting tool will be provided several times over the course of the next two weeks. Currently, institution Chief Nurse Executives, Public Health Nurses (PHN), PHN backup (including Infection Prevention and Control Nurses), Utilization Management (UM) nurses, and UM backup have access to the SharePoint. To ensure seven-day a week, including holiday coverage for SharePoint reporting, institutions should request SharePoint access for additional nurses who will be reporting the above data by sending their email addresses to CDCRCCHCSPublicHealthBranch@cdcr.ca.gov. Please allow one business day for SharePoint access to be granted.

RESOURCES FOR UP TO DATE INFORMATION

COVID-19 PAGE ON LIFELINE:
For updates and guidance, please visit:

- COVID-19 Page on Lifeline

CDC GUIDANCE FOR COVID-19:

- Interim Clinical Guidance for Management of Patients with Confirmed Coronavirus Disease (COVID-19)
- Interim Infection Prevention and Control Recommendations for Patients with Confirmed Coronavirus Disease 2019 (COVID-19) or Persons Under Investigation for COVID-19 in Healthcare Settings
- Interim Guidance for Healthcare Facilities: Preparing for Community Transmission of COVID-19 in the United States

CDPH GUIDANCE FOR COVID-19:

- Guidance Documents: Coronavirus Disease 2019 (COVID-19)

CDPH ALL FACILITIES COVID-19 LETTERS:

- CDPH AFL 20-17: Guidance for Healthcare Facilities on Preparing for Coronavirus Disease 2019 (COVID-19)
- CDPH AFL 20-15: Infection Control Recommendations for Facilities with Suspect Coronavirus (COVID-19) Patients
- CDPH AFL 20-14: Environmental Infection Control for the Coronavirus Disease 2019 (COVID-19)

CalOSHA GUIDANCE:

- Interim Guidance for Protecting Health Care Workers from Exposure to 2019 Novel Coronavirus (2019-nCoV)
- Interim Guidance on Coronavirus for Health Care Facilities: Efficient Use of Respirator Supplies

MEMORANDUM

Cc: Diana Toche, Undersecretary, Healthcare Services
Steven Tharratt, MD, MPVM, FACP, Director of Health Care Operations
Renee Kanan, MD, MPH, Chief Quality Officer, Deputy Director of Medical Services
Barbara Barney-Knox, Deputy Director of Nursing Services (A)
Morton Rosenberg, Deputy Director of Dental Service
Deputy Medical Executives
Wardens

ATTACHMENT D

Help prevent the spread of illness... Wash your Hands!

PREVENT THE SPREAD OF ILLNESS

Good health habits like covering your cough and washing your hands often can help stop the spread of germs and prevent respiratory illnesses. Protect yourself and others from viral illnesses and help stop the spread of germs.

Avoid close contact

Avoid close contact with people who are sick. When you are sick, keep your distance from others to protect them from getting sick too.

Keep your germs to yourself

As much as possible, stay in your housing area away from others when you are sick. This will help prevent spreading your illness to others.

Cover your nose and mouth

Cover your mouth and nose with a tissue when coughing or sneezing. It may prevent those around you from getting sick. Flu and other serious respiratory illnesse are spread by cough, sneezing, or unclean hands.

Handwashing: clean hands save lives!

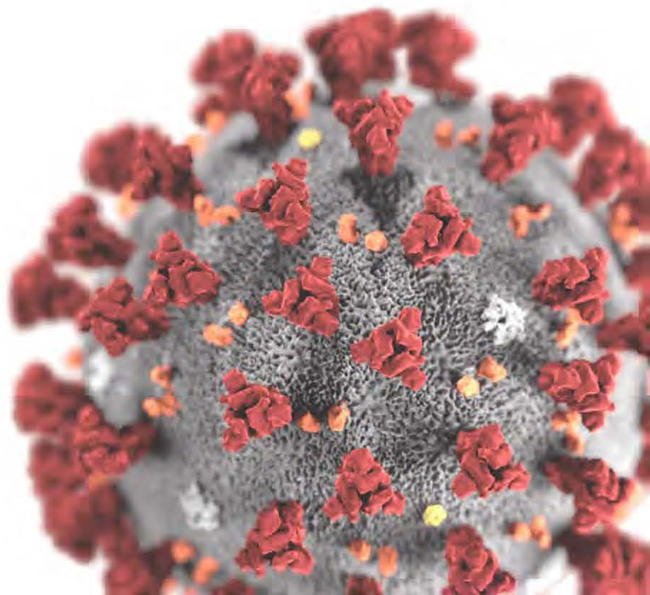
Washing your hands is easy, and it's one of the most effective ways to prevent the spread of germs. Clean hands can stop germs from spreading from one person to another and throughout an entire community. If soap and water are not available, use hand sanitizer.

Avoid touching your eyes, nose or mouth

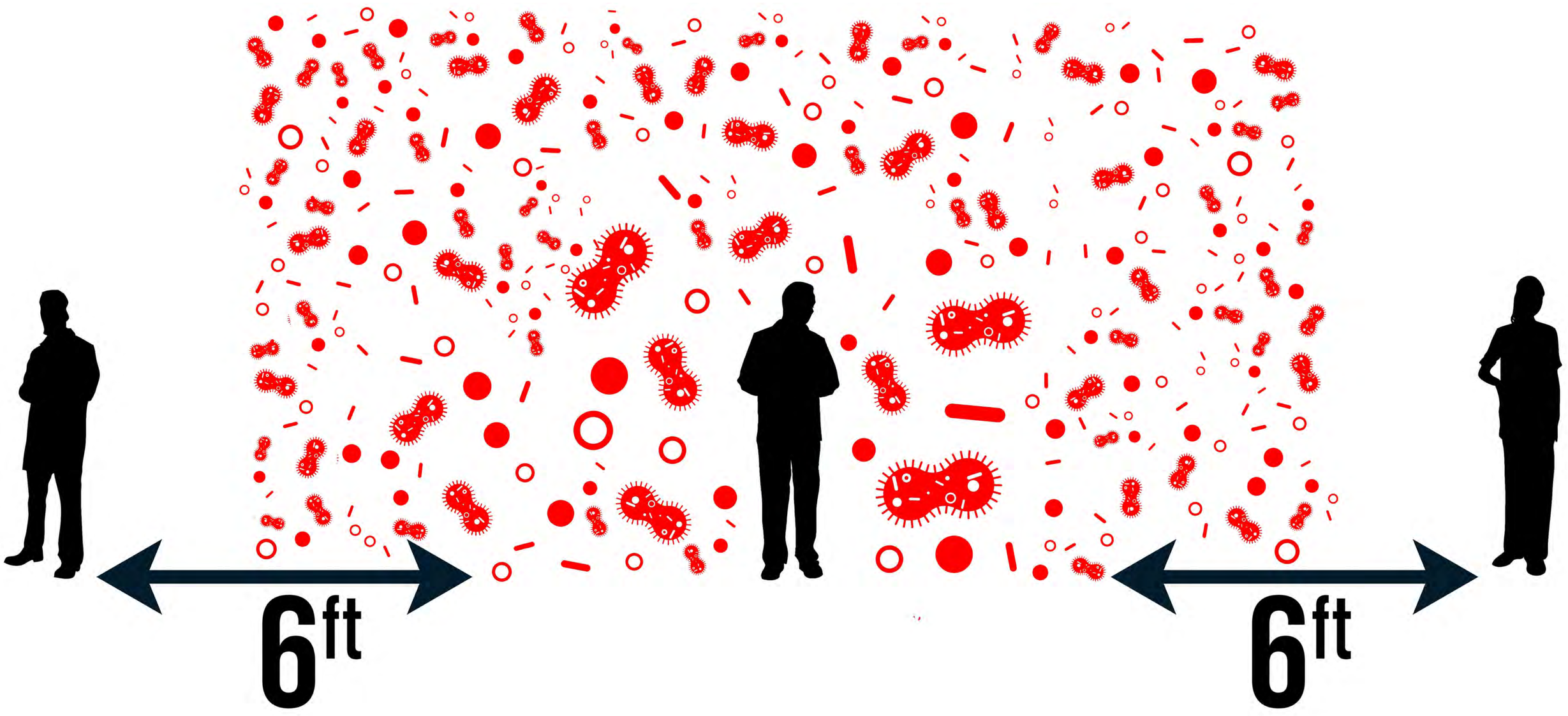
Germs are often spread when a person touches something that is contaminated with germs and then touches his or her eyes, nose, or mouth.

Practice other good health habits

Clean frequently touched surfaces especially when you or someone you share space with is ill. Get plenty of sleep, be physically active, manage your stress, drink plenty of fluids, and eat nutritious food.



SOCIAL DISTANCING

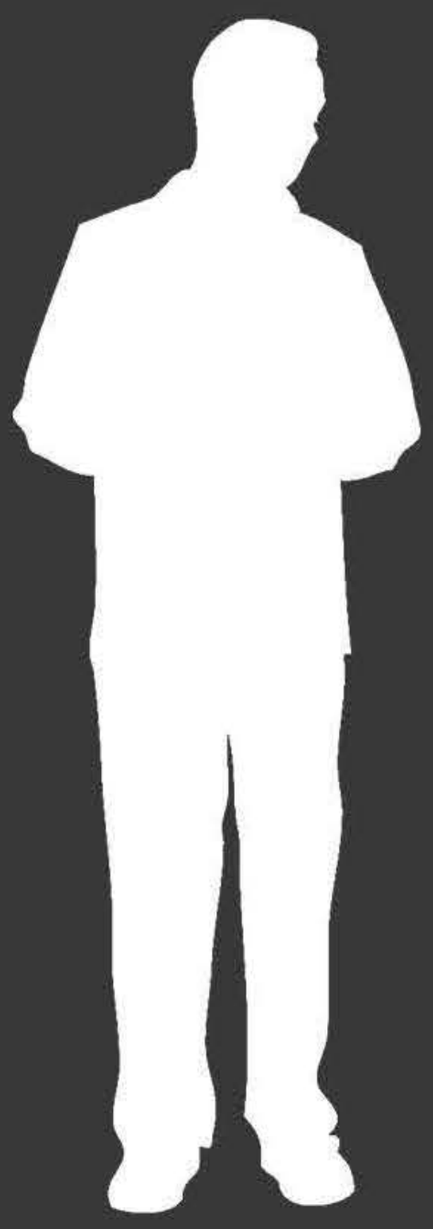


The distance between you and COVID-19 is

SIX FEET

PRACTICE SOCIAL DISTANCING

THE DISTANCE BETWEEN YOU AND COVID-19 IS



SIX FEET

To curb the spread of COVID-19, CDCR and the California Department of Public Health recommend keeping a six foot distance between yourself and others at all times.

COVID 19 CORONAVIRUS DISEASE

SYMPTOMS OF CORONAVIRUS DISEASE 2019

Patients with COVID-19 have experienced mild to severe respiratory illness.

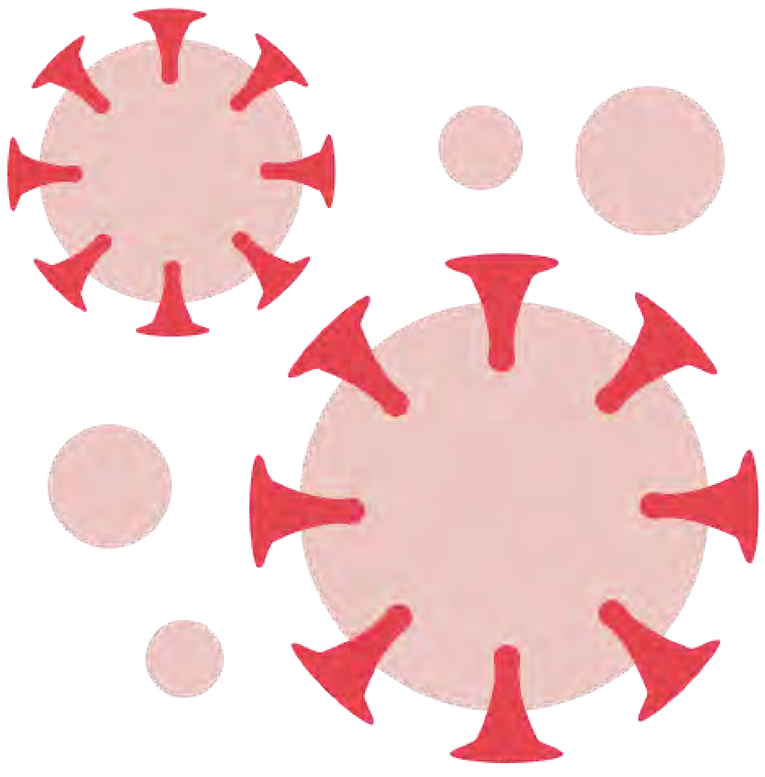
Symptoms* can include

*Symptoms may appear 2-14 days after exposure.

Seek medical advice if you develop symptoms, and have been in close contact with a person known to have COVID-19 or if you live in or have recently been in an area with ongoing spread of COVID-19.

If you have symptoms of COVID-19, please complete a form 7362 and let someone know immediately.

COVID-19 QUICK GUIDE



QUARANTINED

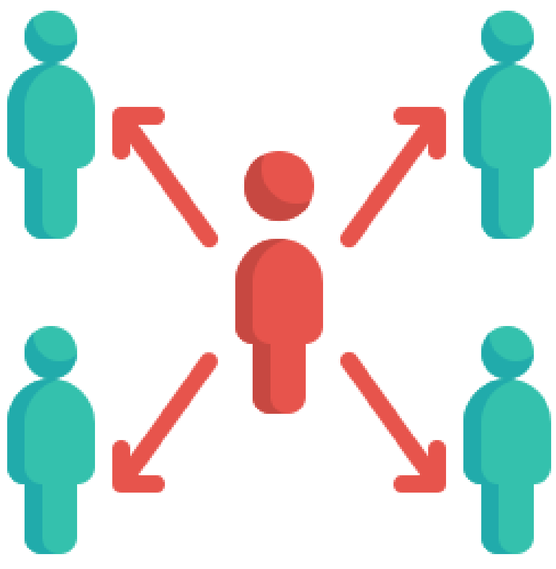
Exposed to confirmed COVID-19 case with no signs or symptoms.

Screening questions and temperatures twice daily. In cases of extreme hardship, screening and temperatures a minimum of once daily may be approved jointly by the local CEO, CNE and CME.

SUSPECTS: ISOLATED ALONE

Sick – Individuals with signs and symptoms.

Test for Influenza and COVID-19 immediately. Vital signs and 02 SATS twice daily. Await diagnoses & monitor symptoms. (DO NOT house with other sick people, as we DO NOT know the pathogen). If suspect confirmed as positive for COVID-19, move to COVID-19 CASE status below.



COVID-19 CASE: ISOLATED

Sick – Individuals with confirmed COVID-19 diagnosis.

Vitals signs and 02 SATS twice daily. Assess for worsening symptoms & recovery. (DO isolate CONFIRMED COVID-19 together, as we DO know the pathogen. DO NOT house COVID-19 cases with influenza cases).

Lo que necesita saber sobre la enfermedad del coronavirus 2019 (COVID-19)

¿Qué es la enfermedad del coronavirus 2019 (COVID-19)?

La enfermedad del coronavirus 2019 (COVID-19) es una afección respiratoria que se puede propagar de persona a persona. El virus que causa el COVID-19 es un nuevo coronavirus que se identificó por primera vez durante la investigación de un brote en Wuhan, China.

¿Pueden las personas en los EE. UU. contraer el COVID-19?

Sí. El COVID-19 se está propagando de persona a persona en partes de los Estados Unidos. El riesgo de infección con COVID-19 es mayor en las personas que son contactos cercanos de alguien que se sepa que tiene el COVID-19, por ejemplo, trabajadores del sector de la salud o miembros del hogar. Otras personas con un riesgo mayor de infección son las que viven o han estado recientemente en un área con propagación en curso del COVID-19.

¿Ha habido casos de COVID-19 en los EE. UU.?

Sí. El primer caso de COVID-19 en los Estados Unidos se notificó el 21 de enero del 2020.

¿Cómo se propaga el COVID-19?

Es probable que el virus que causa el COVID-19 haya surgido de una fuente animal, pero ahora se está propagando de persona a persona. Se cree que el virus se propaga principalmente entre las personas que están en contacto cercano unas con otras (dentro de 6 pies de distancia), a través de las gotitas respiratorias que se producen cuando una persona infectada tose o estornuda. También podría ser posible que una persona contraiga el COVID-19 al tocar una superficie u objeto que tenga el virus y luego se toque la boca, la nariz o posiblemente los ojos, aunque no se cree que esta sea la principal forma en que se propaga el virus.

¿Cuáles son los síntomas del COVID-19?

Los pacientes con COVID-19 han tenido enfermedad respiratoria de leve a grave con los siguientes síntomas:

- fiebre
- tos
- dificultad para respirar

¿Cuáles son las complicaciones graves provocadas por este virus?

Algunos pacientes presentan neumonía en ambos pulmones, insuficiencia de múltiples órganos y algunos han muerto.

¿Qué puedo hacer para ayudar a protegerme?

Las personas se pueden proteger de las enfermedades respiratorias tomando medidas preventivas cotidianas.

- Evite el contacto cercano con personas enfermas.
- Evite tocarse los ojos, la nariz y la boca con las manos sin lavar.
- Lávese frecuentemente las manos con agua y jabón por al menos 20 segundos. Use un desinfectante de manos que contenga al menos un 60 % de alcohol si no hay agua y jabón disponibles.

Si está enfermo, para prevenir la propagación de la enfermedad respiratoria a los demás, debería hacer lo siguiente:

- Quedarse en casa si está enfermo.
- Cubrirse la nariz y la boca con un pañuelo desechable al toser o estornudar y luego botarlo a la basura.
- Limpiar y desinfectar los objetos y las superficies que se tocan frecuentemente.

¿Qué debo hacer si he regresado recientemente de un viaje a un área con propagación en curso del COVID-19?

Si ha llegado de viaje proveniente de un área afectada, podrían indicarle que no salga de casa por hasta 2 semanas. Si presenta síntomas durante ese periodo (fiebre, tos, dificultad para respirar), consulte a un médico. Llame al consultorio de su proveedor de atención médica antes de ir y dígales sobre su viaje y sus síntomas. Ellos le darán instrucciones sobre cómo conseguir atención médica sin exponer a los demás a su enfermedad. Mientras esté enfermo, evite el contacto con otras personas, no salga y postergue cualquier viaje para reducir la posibilidad de propagar la enfermedad a los demás.

¿Hay alguna vacuna?

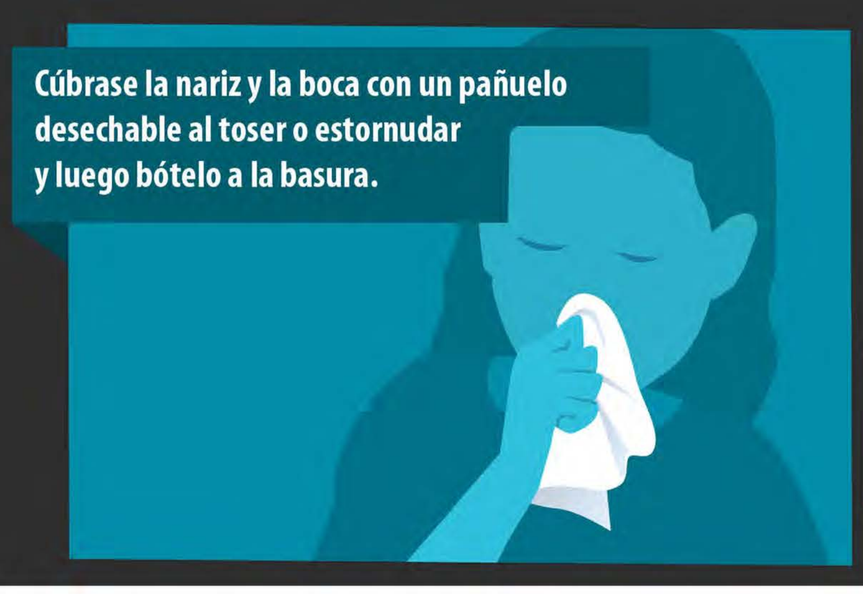
En la actualidad no existe una vacuna que proteja contra el COVID-19. La mejor manera de prevenir infecciones es tomar medidas preventivas cotidianas, como evitar el contacto cercano con personas enfermas y lavarse las manos con frecuencia.

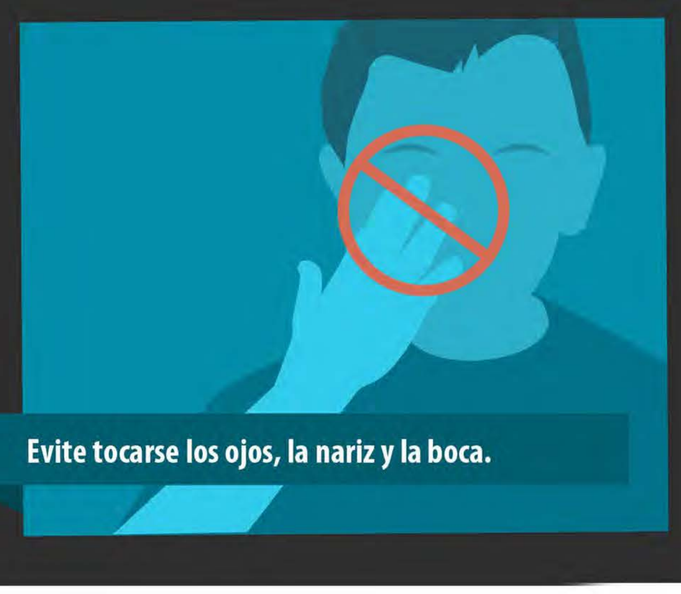
¿Existe un tratamiento?

No hay un tratamiento antiviral específico para el COVID-19. Las personas con el COVID-19 pueden buscar atención médica para ayudar a aliviar los síntomas.

DETENGA LA PROPAGACIÓN DE LOS MICROBIOS

Ayude a prevenir la propagación de virus respiratorios como el nuevo COVID-19.





COVID-19 SICK TIPS

S

Symptoms

Interview Patient Immediately!
Assess for coughing, fever, shortness of breath, fatigue. Ask patient how long they have had these symptoms & who they have had contact with.

I

Isolate & Instruct

Instruct to remain in cell or isolation area, wash hands in & out of cell, when coughing use tissue & discard or cover mouth with elbows. Complete a 7362 if symptoms worsen.

C

Calls & Cancellations

Cancel all appointments and patient movement. Call and notify the PHN, PCP and Custody of patient restrictions. Screen roommates.

K

Keep patients protected

Keep patient isolated & roommates quarantined. Keep screening and monitoring patients/roommates for worsening symptoms. Take temperatures twice daily.

Quick Tips

•See all patients immediately, regardless of refusals. A cell front assessment is required.

•Provide a mask to coughing patients prior to any interviews or interaction.

•Teach proper handwashing & ensure patients have hand soaps and tissue in cell and dorms.

•Educate patients on social distancing.

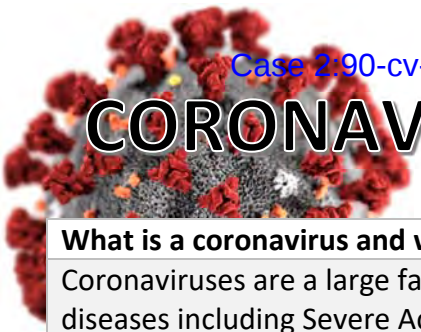
•Explain to patient the importance of preventing the disease from spreading (Quarantine Vs. Isolation).

•Provide reassurance to the patient.

•Utilize current processes for identifying patients i.e. 7362, clinical rounds etc.

•Remember to quarantine patients for 14 days who have been in contact with someone who had symptoms of ILI or is in isolation for COVID-19.

•Isolate patients with new or worsening symptoms or temperatures of 100 F and above.



CORONAVIRUS/COVID-19 FACTS AND FAQS

What is a coronavirus and what is COVID-19?

Coronaviruses are a large family of viruses that cause illnesses ranging from the common cold to more severe diseases including Severe Acute Respiratory Syndrome (SARS) and Middle East Respiratory Syndrome (MERS). COVID-19 is the infectious disease caused by the most recently discovered coronavirus. This new virus and disease were unknown before the outbreak began in Wuhan, China, in December 2019.

How did this virus get its name?

On Feb. 11, 2020, the World Health Organization announced the official name for the new coronavirus virus would be COVID-19. "CO" stands for "corona," "VI" stands for "virus," D stands for "disease" and 19 indicates the year the virus was first discovered. Before this, the virus was referred to as the "2019 novel coronavirus," which means it was a new strain not previously identified in humans.

Where did COVID-19 come from?

The World Health Organization states that coronaviruses are zoonotic, which means they are transmitted from animals to people. A specific animal source of COVID-19 has not been identified, but the virus has been linked to a large seafood and live animal market.

What are the symptoms of COVID-19?

According to the Center for Disease Control (CDC), individuals diagnosed with this coronavirus experience a mild to severe respiratory illness. Symptoms include fever, cough and shortness of breath. Individuals with severe complications from the virus often develop pneumonia in both lungs.

How does the virus spread?

The virus is spread person-to-person. According to the CDC, spread is happening mainly between people who are in close contact (within 6 feet) of each other via respiratory droplets produced when an infected person coughs or sneezes. The droplets land on the noses and mouths of other people, who then inhale them. The CDC says it may be possible for the virus to spread by touching a surface or object with the virus and then a person touching their mouth, nose or eyes, but this is not thought to be the main method of spread. As the virus was discovered just a few months ago, more research is required to learn more about the spread pattern of the virus. The incubation period ranges from 2 to 14 days after exposure (most cases occurring at approximately 5 days.) People are thought to be most contagious when they are most symptomatic (the sickest.) Some spread might be possible before people show symptoms.

Do I need to wear a protective mask?

There is no need for healthy individuals to wear surgical masks to guard against coronavirus. Individuals should only wear a mask if they are ill or if it is recommended by a health care professional. Masks must be used and disposed of properly to be effective.

Is there a cure for the virus?

There is no specific medication to treat COVID-19; supportive care is provided to treat symptoms. There is currently no vaccine to protect against COVID-19. Individuals should take care to avoid being exposed to the virus through hygiene and sanitary practices. Please seek immediate medical care to relieve symptoms if infected with the virus.

How do I protect myself and others?

There is currently no vaccine to prevent COVID-19 or medication to directly treat COVID-19. The best way to protect yourself is to avoid being exposed to the virus that causes COVID-19. The CDC recommends maintaining personal preventative actions such as:

- Avoiding close contact with those who are sick
- Not touching your eyes, mouth or nose, especially with unwashed hands
- Washing your hands often with soap and warm water for last least 20 seconds
- Clean objects and surfaces that are frequently touched
- Limit your exposure to others if you are sick
- Cover your coughs and sneezes with a tissue
- Do not share food, drinks, utensils, or toothbrushes

What should I do if I think I have COVID-19?

Avoid direct contact with other people and immediately request to be seen by health care if you feel sick with a fever, cough or difficulty breathing. Make sure to give your provider details of any symptoms and potential contact with individuals who may have recently traveled.

Will I be tested for COVID-19?

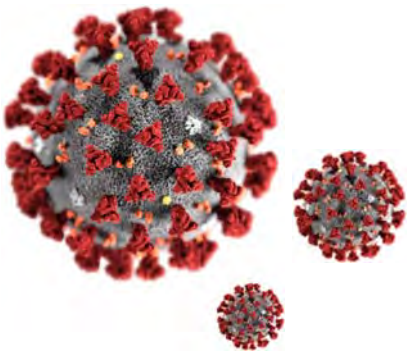
You will be tested if your provider suspects you have COVID-19.

What is CDCR/CCHCS doing to prepare for a potential outbreak?

CDCR and CCHCS are dedicated to the safety of everyone who lives, works, and visits our state prisons. We have longstanding emergency response plans in place to address communicable disease outbreaks such as influenza, measles, mumps, norovirus, as well as coronavirus. Based on guidance from the CDC, and to ensure we are as prepared as possible to respond to any exposure to COVID-19 specifically, we are building upon the robust influenza infection control guidelines already in place at each institution. These guidelines clearly define procedures for prevention of transmission, management of suspected and confirmed cases including isolation and quarantine protocols, surveillance of patients, and routine cleaning and disinfection procedures.

If there is a suspected case of COVID-19, we will follow the policies and procedures already in place for modified programming for any affected housing units and areas. We will continue to update guidelines for COVID-19 response based on CDC recommendations and will maintain cooperation with local and state health departments and the law enforcement community.

COVID-19 is new, but the most important aspect of preparedness is remaining calm. Don't panic. We understand staff, families, and those who visit state prisons as program providers or volunteers may have concerns and anxiety about COVID-19, but please be assured that there is no need for alarm. All should follow the precautions recommended by CDC, which expand upon precautions advised during cold and flu season. The spread of COVID-19 can be significantly reduced with proper infection control measures and good individual hygiene practices.



ATTACHMENT E

EXECUTIVE DEPARTMENT
STATE OF CALIFORNIA

EXECUTIVE ORDER N-36-20

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

WHEREAS despite sustained efforts, COVID-19 continues to spread and is impacting nearly all sectors of California; and

WHEREAS, state and local correctional and public safety leaders are building on their longstanding partnership, to protect public health and safety in the context of the COVID-19 crisis; and

WHEREAS the California Department of Corrections and Rehabilitation (CDCR) has infectious disease management plans in place to address communicable disease outbreaks such as influenza, measles, mumps, norovirus, and varicella, and CDCR has taken a series of additional proactive steps to reduce the risk of introducing and spreading COVID-19 in CDCR facilities, including:

- educating staff, inmates, and visitors regarding ways they can protect themselves and those around them from COVID-19;
- screening staff before they enter work locations;
- increasing cleaning and sanitation of CDCR facilities and providing staff and inmates with access to additional soap and sanitizing products;
- quarantining inmates arriving from county jails;
- restricting visitors and volunteers, and offering free methods for inmates to communicate with family members, friends, and attorneys;
- limiting inmate transfers including suspending out-of-state parole or inmate transfers to California for 30 days; and
- suspending scheduled in-person parole visits, except when statutorily required, for critical needs, or in emergencies; and
- eliminating parole revocations in many cases; and

WHEREAS the Governor's Office of Emergency Services has operated and continues to operate a multi-agency correctional task force to identify additional steps necessary, as this emergency develops, for action to protect health and safety; and

WHEREAS many inmates who are confined in state prison are entitled to timely parole hearings under the California Constitution, the Penal Code, and a federal three-judge court order; and

WHEREAS COVID-19 and the response thereto have impaired the Board of Parole Hearings' ability to meet the usual statutory and regulatory requirements to timely conduct parole hearings in person; and

WHEREAS inmates, inmates' counsel, victims and their representatives, and representatives of the people have the right to be heard at parole hearings, but such hearings must be secure and safe for all participants; and

WHEREAS under the provisions of Government Code section 8571, I find that strict compliance with various statutes and regulations specified in this order would prevent, hinder, or delay appropriate actions to prevent and mitigate the effects of the COVID-19 pandemic.

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 8627, 8567, and 8571, do hereby issue the following order to become effective immediately:

IT IS HEREBY ORDERED THAT:

1. To protect the health, safety, and welfare of inmates in the custody of CDCR and staff who work in the facilities, I direct the Secretary of CDCR to use his emergency authority under California Penal Code section 2900(b) to suspend intake into state facilities for 30 days by directing that all persons convicted of felonies shall be received, detained, or housed in the jail or other facility currently detaining or housing them for that period. Consistent with California Penal Code section 2900(b), the time during which such person is housed in the jail or other facility shall be computed as part of the term of judgment. I further order the Secretary to suspend intake into Division of Juvenile Justice (DJJ) facilities for 30 days. To the extent that any statutory or other provisions require DJJ to accept new juveniles into its facilities, such provisions are waived or suspended. The Secretary may grant one or more 30-day extensions of the suspension of intake or commitment if suspension continues to be necessary to protect the health, safety, and welfare of inmates and juveniles in CDCR's custody and staff who work in the facilities.

2. The Board of Parole Hearings is directed to develop a process for conducting parole hearings by videoconference and shall confer with stakeholders in developing this process. The Board of Parole Hearings shall endeavor to make parole hearings conducted via videoconference accessible to all participants specified in the Penal Code and the California Code of Regulations. This process shall be operational no later than April 13, 2020.

3. To protect the health and welfare of inmates, hearing board officers, inmates' counsel, victims and their representatives, and representatives of the people, the Board of Parole Hearings is directed to cease conducting in-person parole hearings for 60 days and shall postpone any scheduled parole hearings until April 13, 2020, or an earlier date at which it is able to accommodate conducting parole hearings by video conference. The Secretary may grant one or more 30-day extensions of the prohibition on in-person parole hearings if it continues to be necessary to protect the health, safety, and welfare of inmates in CDCR's custody, staff who work in the facilities, hearing officers, victims and their representatives, and representatives of the people.

4. For the next 60 days, and for the term of any extensions, inmates scheduled for a parole hearing can elect to continue with their timely parole hearing by videoconference, to accept a postponement of their parole hearing, or to waive their hearing.
    a. Any parole hearing postponed under this provision shall be rescheduled for the earliest practicable date.

    b. All rights for all participants delineated by state law will be applied to hearings postponed and rescheduled.

    c. To the extent that an inmate is required to show good cause to waive or postpone his or her hearing under California Code of Regulations, title 15, section 2253, subdivisions (b)(3) and (d)(2), such requirements are suspended for the next 60 days, and for the term of any extensions.

5. For the next 60 days, and for the term of any extensions, to the extent that any law or regulation gives any person the right to be present at a parole hearing, that right is satisfied by the opportunity to appear by videoconference. Specifically:
    a. For inmates who choose to go forward with their parole hearing by videoconference during the next 60 days, and during the term of any extensions, the inmate's right to be present and to meet with a Board of Parole Hearing's panel under Penal Code sections 3041, subdivision (a)(2), 3041.5, subdivision (a)(2), and California Code of Regulations, title 15, section 2247, is satisfied by appearance through videoconference.

    b. For inmates who choose to go forward with their parole hearing by videoconference during the next 60 days, and during the term of any extensions, Penal Code section 3041.7 and California Code of Regulations, title 15, section 2256, which provide that an inmate has the right to be represented by an attorney at parole hearings, will be satisfied by the attorney appearing by videoconference and by providing for privileged teleconferencing between the inmate and attorney immediately before and during the hearing. Such inmates will also be provided reasonable time and opportunity for privileged communications by telephone with their retained or appointed counsel prior to the hearing at no charge to either party.

    c. For hearings conducted by videoconference during the next 60 days, and during the term of any extensions, the right of victims, victims' next of kin, members of the victims' family and victims' representatives to be present at a parole hearing will be satisfied by the opportunity to appear by videoconference, teleconference, or by written or electronically recorded statement, consistent with California Constitution, Article I, section 28, subdivision (b)(7), Penal Code section 3043, subdivision (b)(1) and California Code of Regulations, title 15, section 2029, and as provided in Penal Code sections 3043.2 and 3043.25.

d. For hearings conducted by videoconference during the next 60 days, and during the term of any extensions, Penal Code section 3041.7 providing that the prosecuting attorney may represent the interests of the people at the hearing will be satisfied by the opportunity to appear by videoconference, teleconference, or a written statement.

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 24th day of March 2020.

GAVIN NEWSOM
Governor of California

ATTEST:

ALEX PADILLA
Secretary of State

ATTACHMENT F

Memorandum

Date: April 7, 2020

To: Associate Director, Division of Adult Institutions
Wardens

Subject: **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 – cell front or at podium
- 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

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

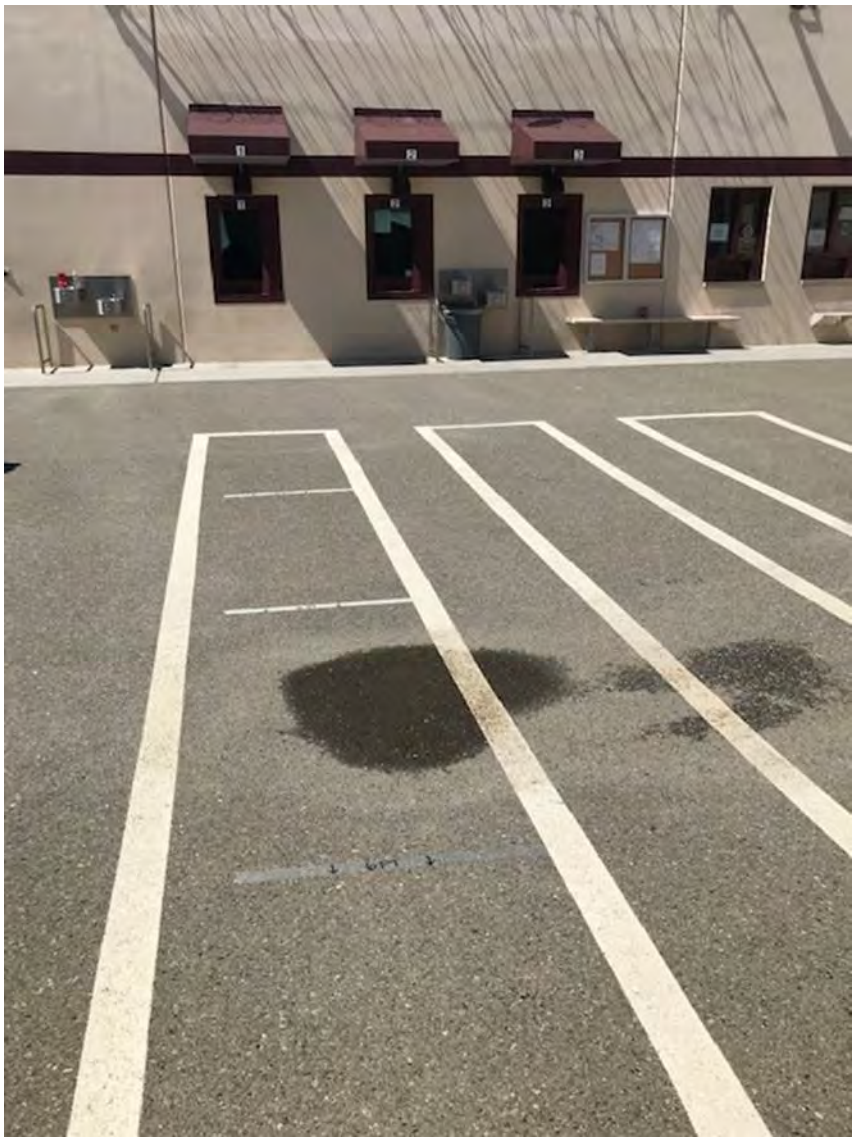
Salinas Valley State Prison- Facility D

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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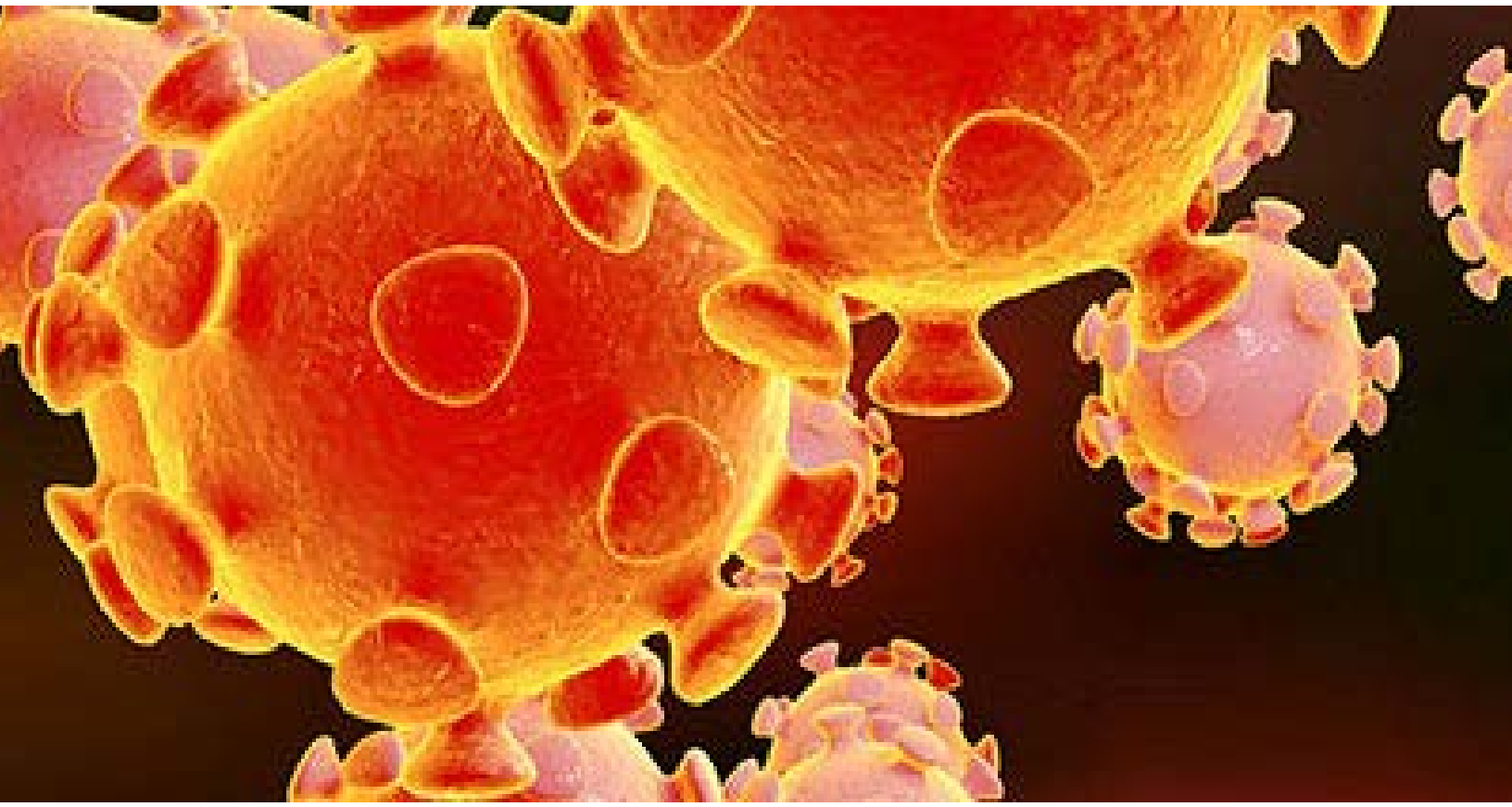
CONNIE GIPSON
Director
Division of Adult Institutions

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.

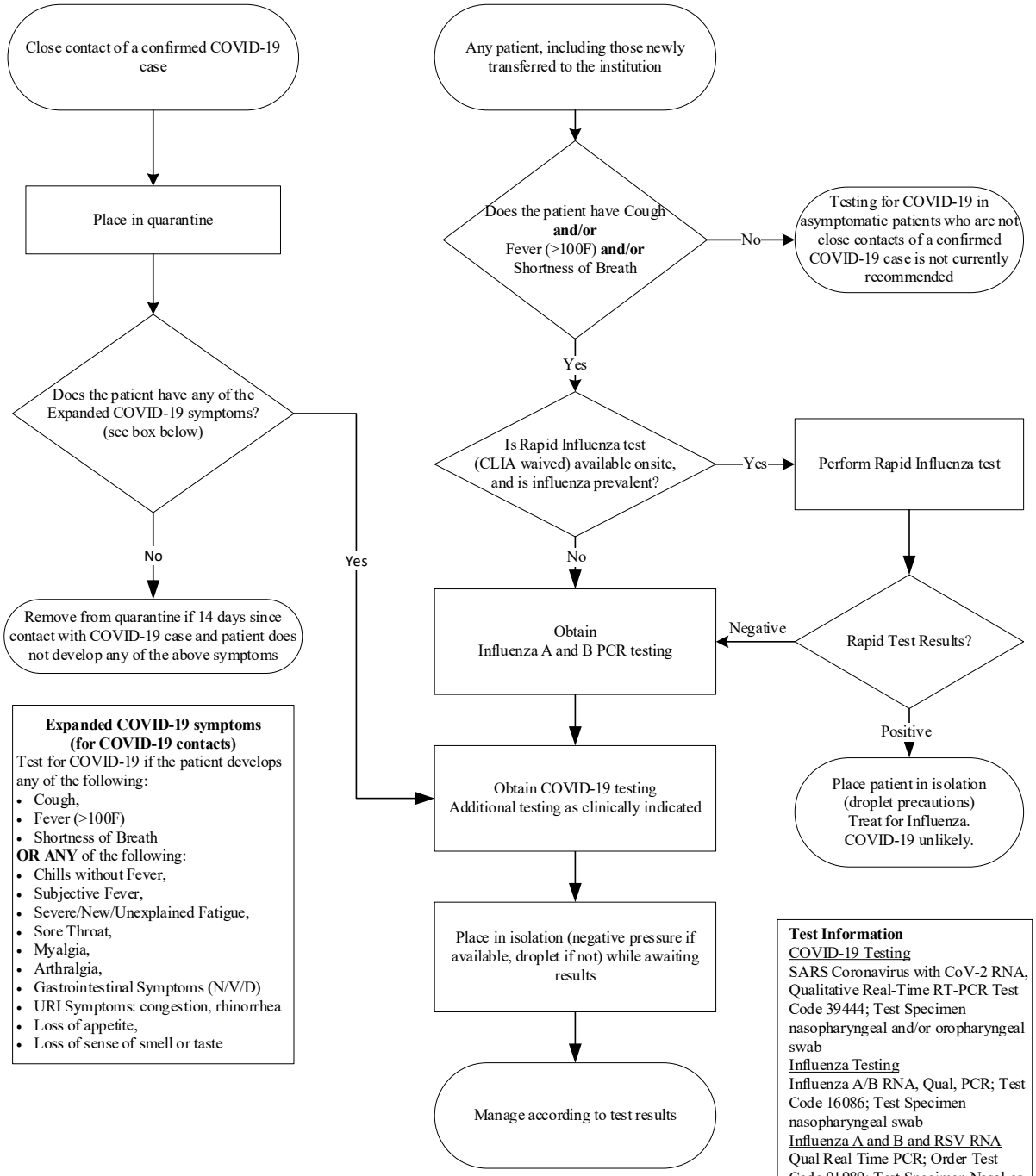
The following patients should be tested immediately for COVID-19:

- 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.

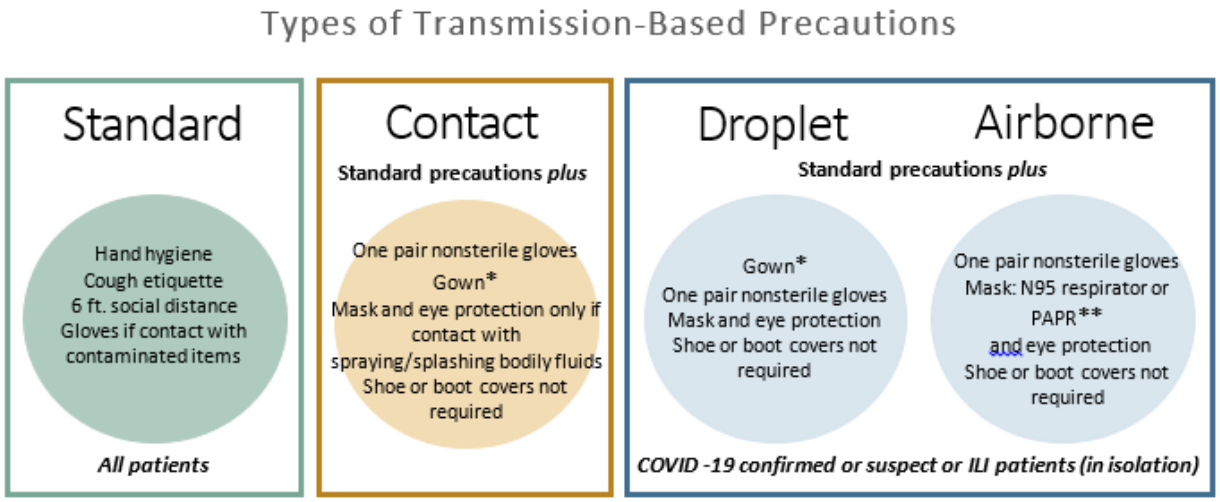
- For previously reported contacts of cases: new exposures, transfers between institutions, discharges/paroles, and releases from quarantine.

- 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

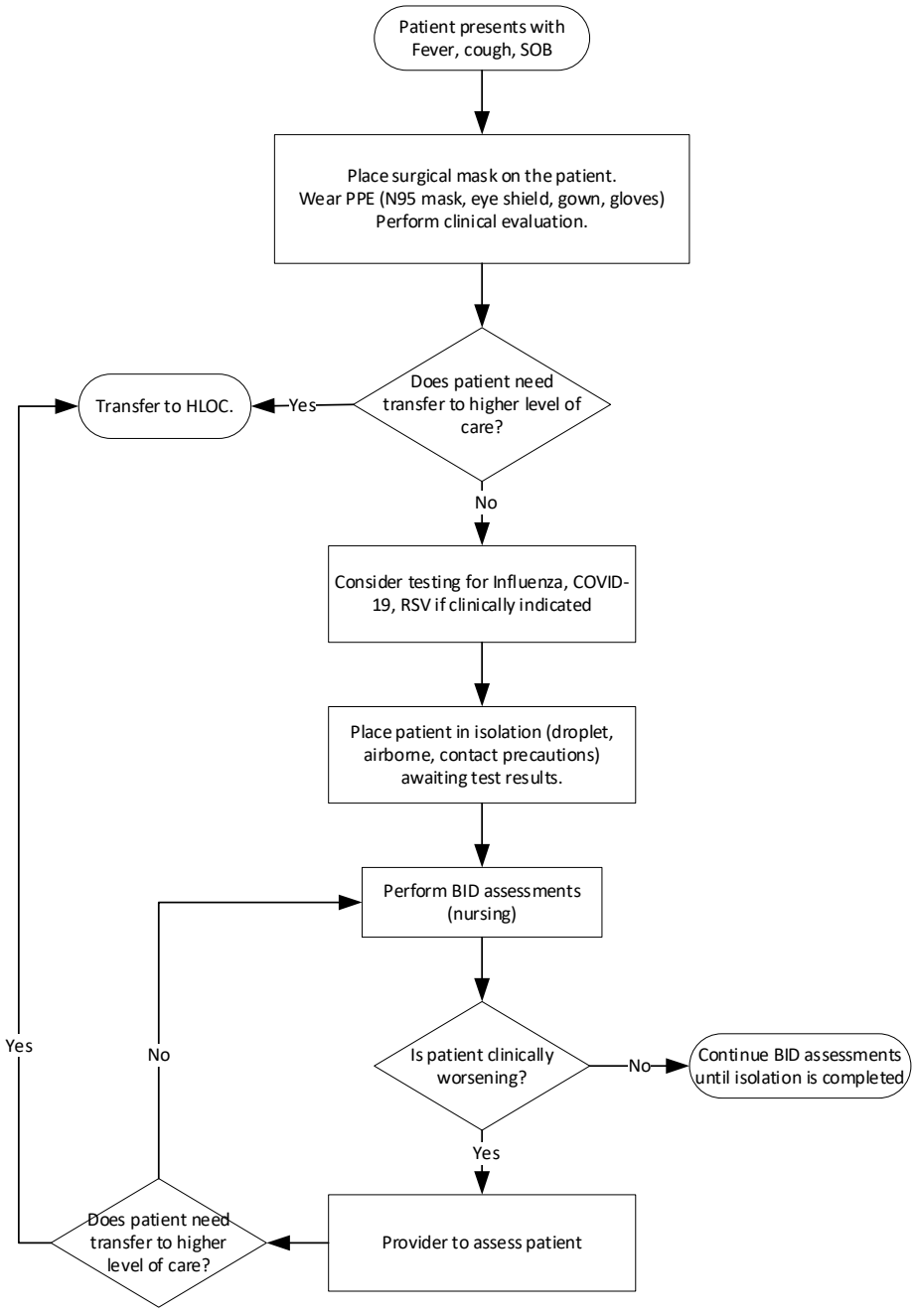
- Patients with suspected COVID-19 require a minimum of twice daily nursing assessment, including, but not limited to:
  - Temperature monitoring
  - Pulse oximeter monitoring
  - Blood pressure checks
  - Respiratory rate and heart rate
- Monitor patients for complications of COVID-19 infection, including 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.

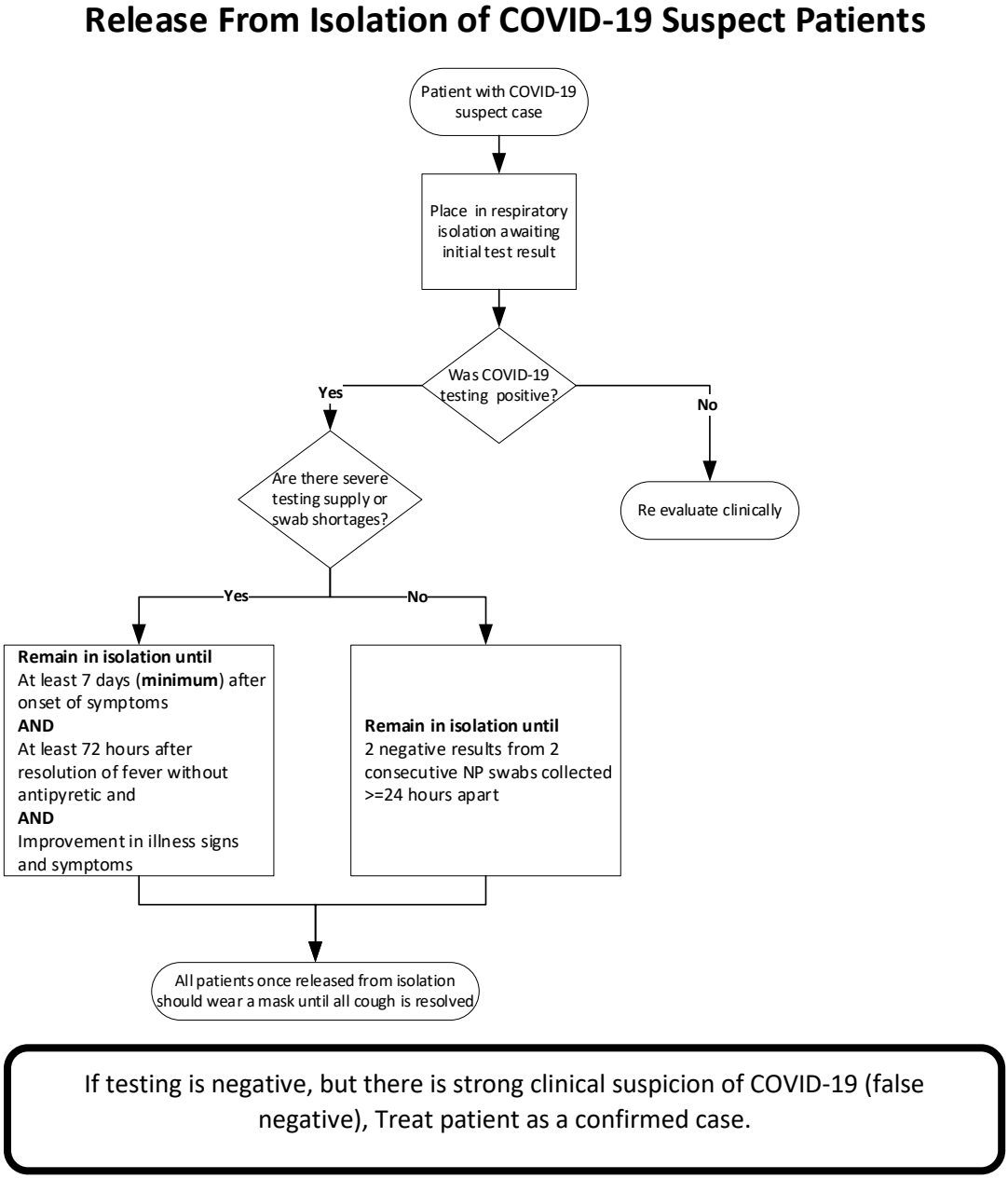
Resolution of cough, is not necessary, however people with residual cough should always wear a mask once released, until completely without cough.

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

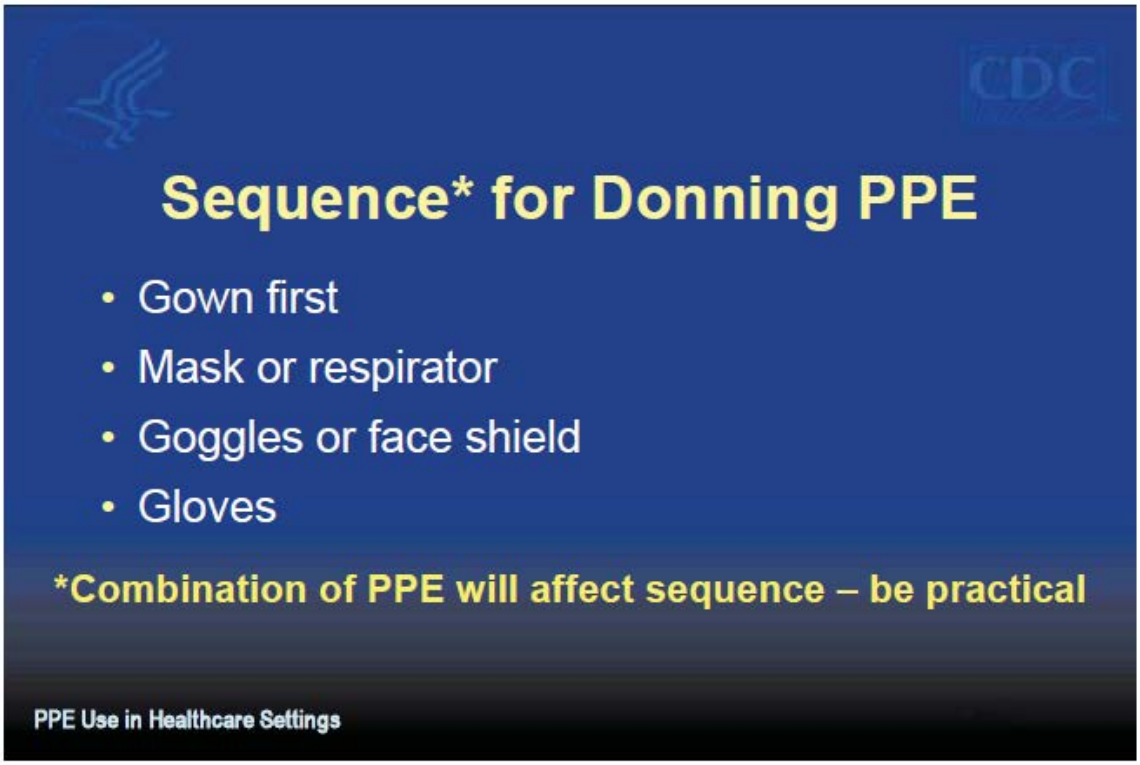
1. RECOGNITION, REPORTING, AND DATA COLLECTION	
	a. Be on alert for patients presenting with fever or symptoms of respiratory illness.
	b. Report suspect cases to institutional leadership, local health department, and the Public Health Branch.
2. INFECTION PREVENTION AND CONTROL MEASURES	
	a. Isolate 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).

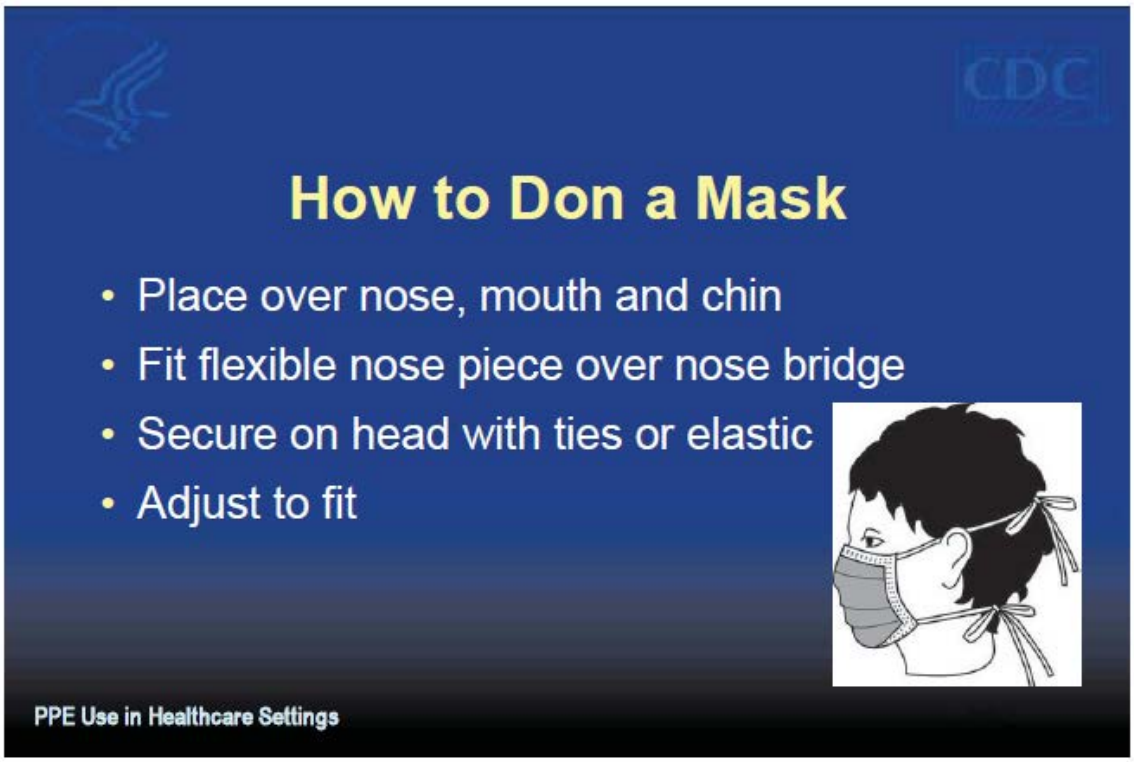
APPENDIX 2: DROPLET PRECAUTIONS CHECKLIST

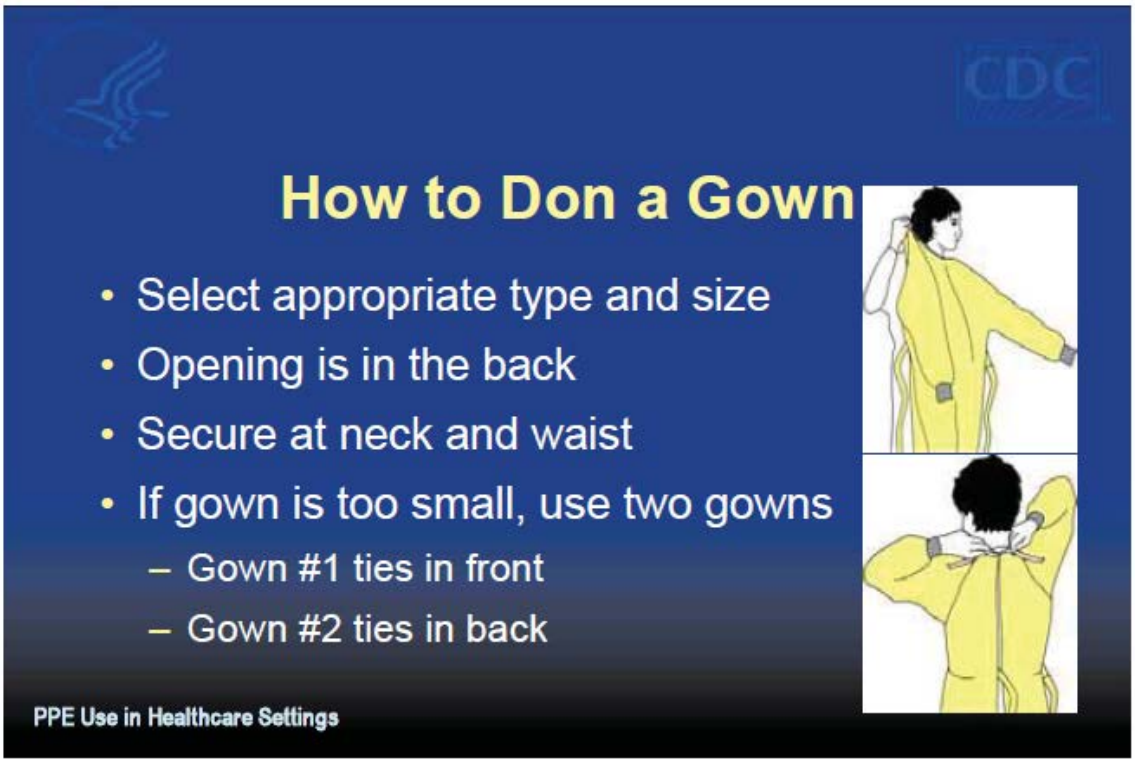
CONTROL MEASURE	INDICATED	ADDITIONAL INFORMATION
Hand Washing	Yes	• After touching contaminated items, after removing gloves. • Between Inmate/Patient contact.
Personal Protective Equipment (PPE)	Yes	• Follow Standard Precautions Guideline. • Don mask upon entry into patient room.
Single Cell	Yes	• A 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.

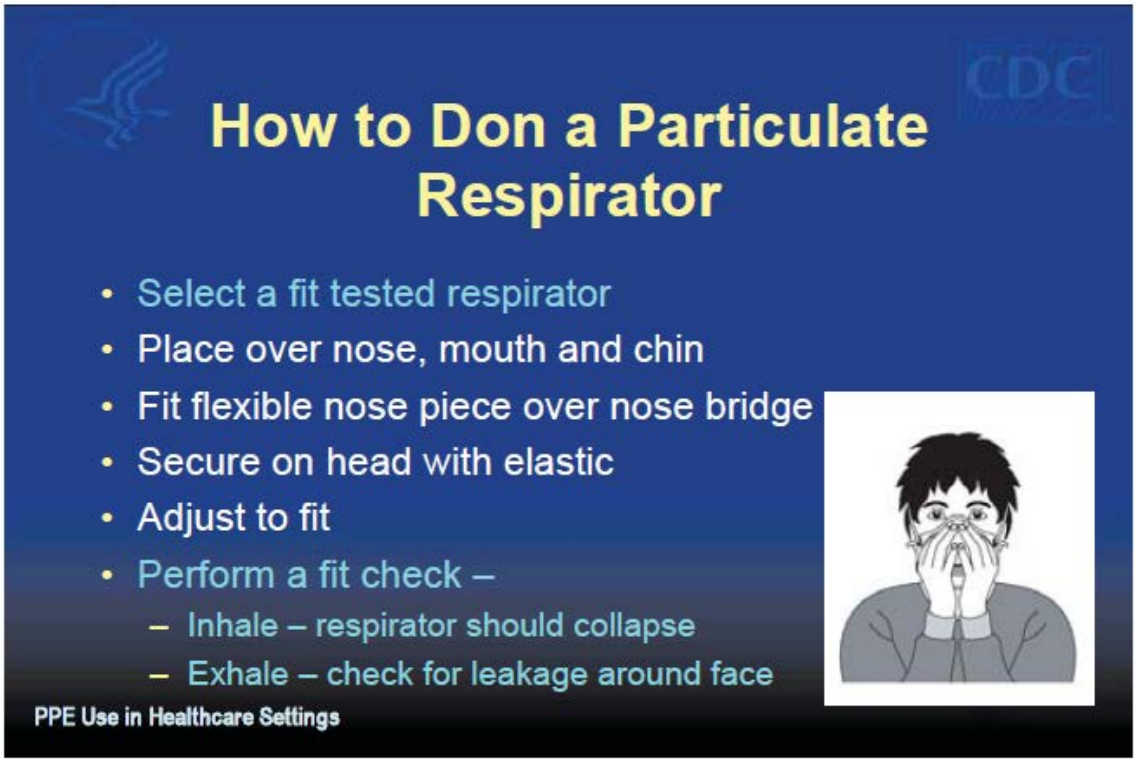
Revised 10/18

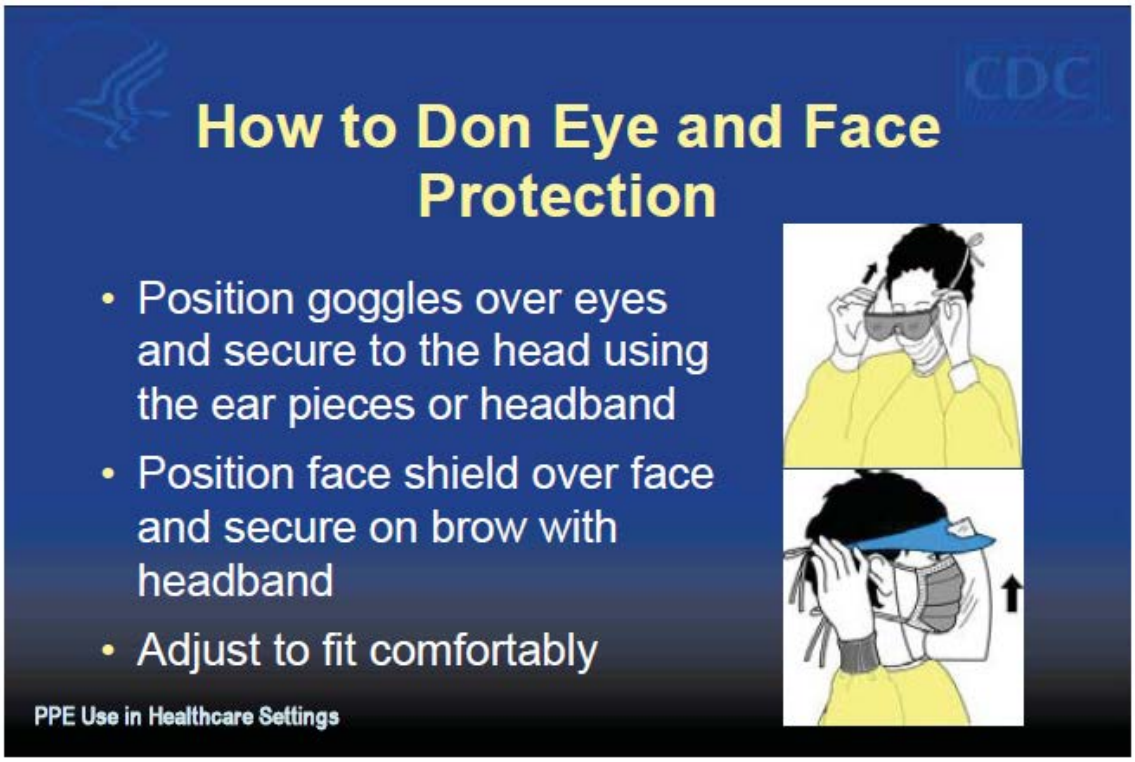
APPENDIX 3: HOW TO DOFF AND DON PPE






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

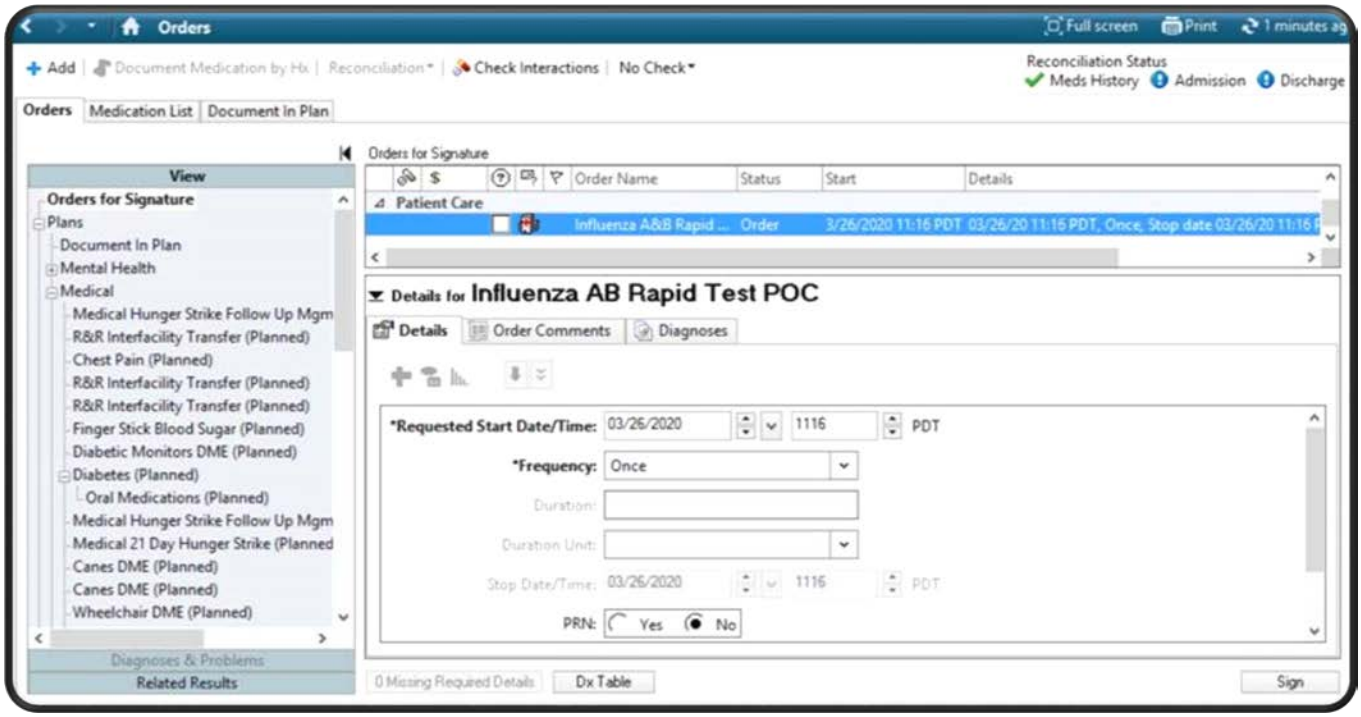

How to Don Gloves
• Don gloves last
• Select correct type and size
• Insert hands into gloves
• Extend gloves over isolation gown cuffs
PPE Use in Healthcare Settings

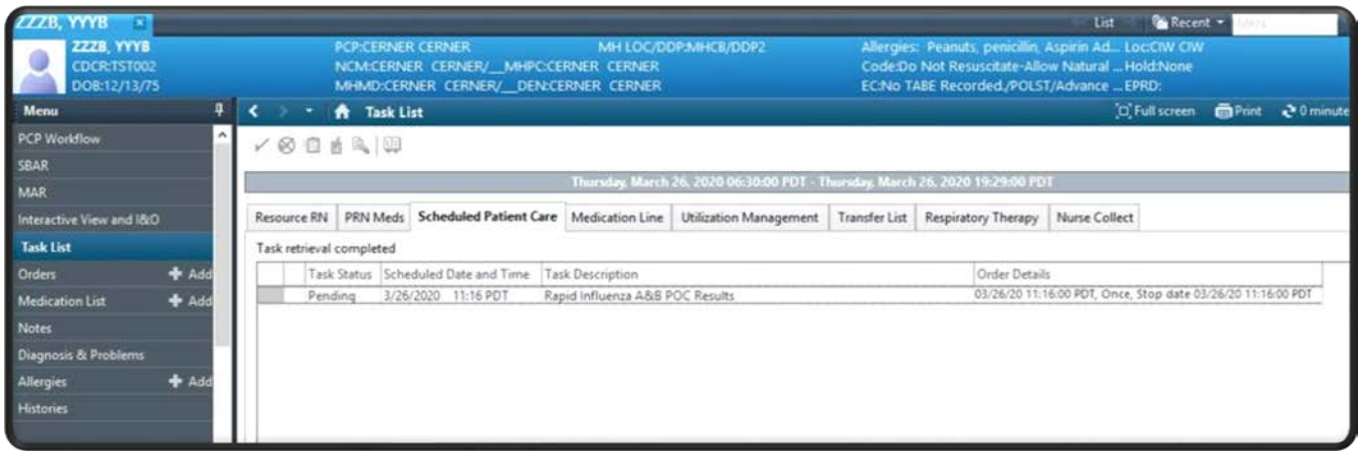
APPENDIX 4: HOW TO ORDER RAPID INFLUENZA DIAGNOSTIC TESTING IN THE EHR

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:

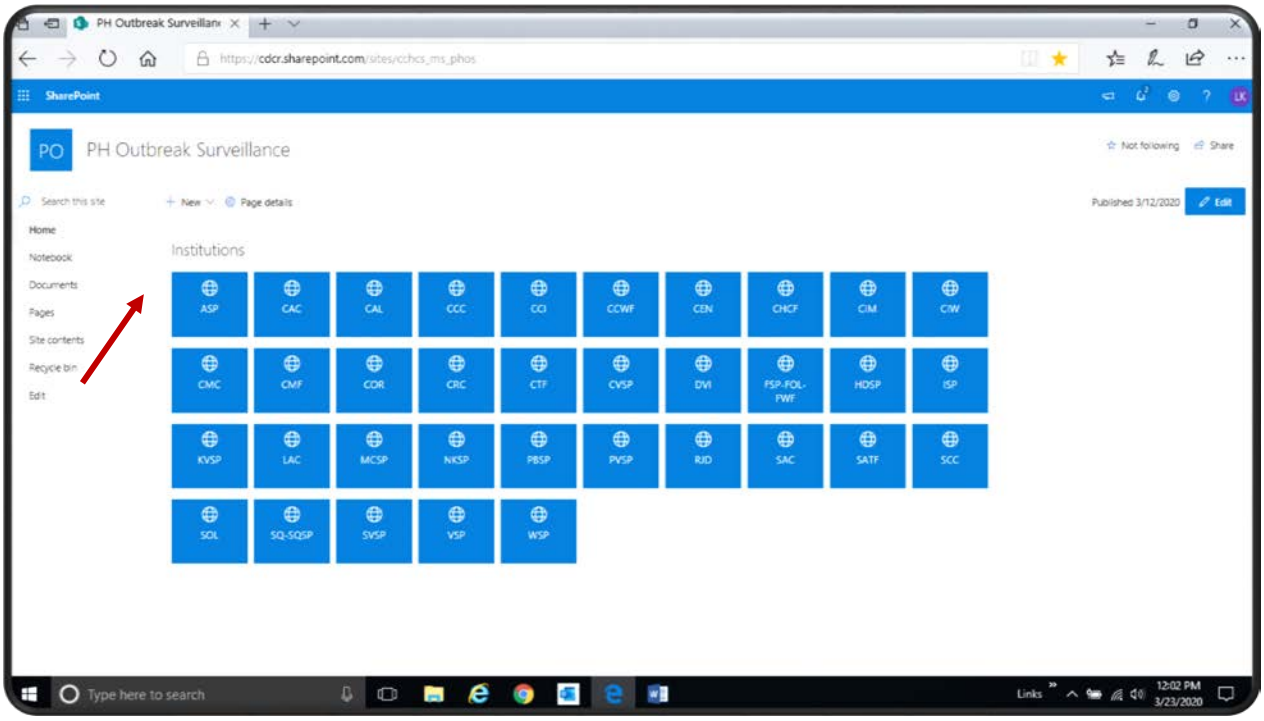
https://cdcr.sharepoint.com/sites/cchcs_ms_phos

- **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.

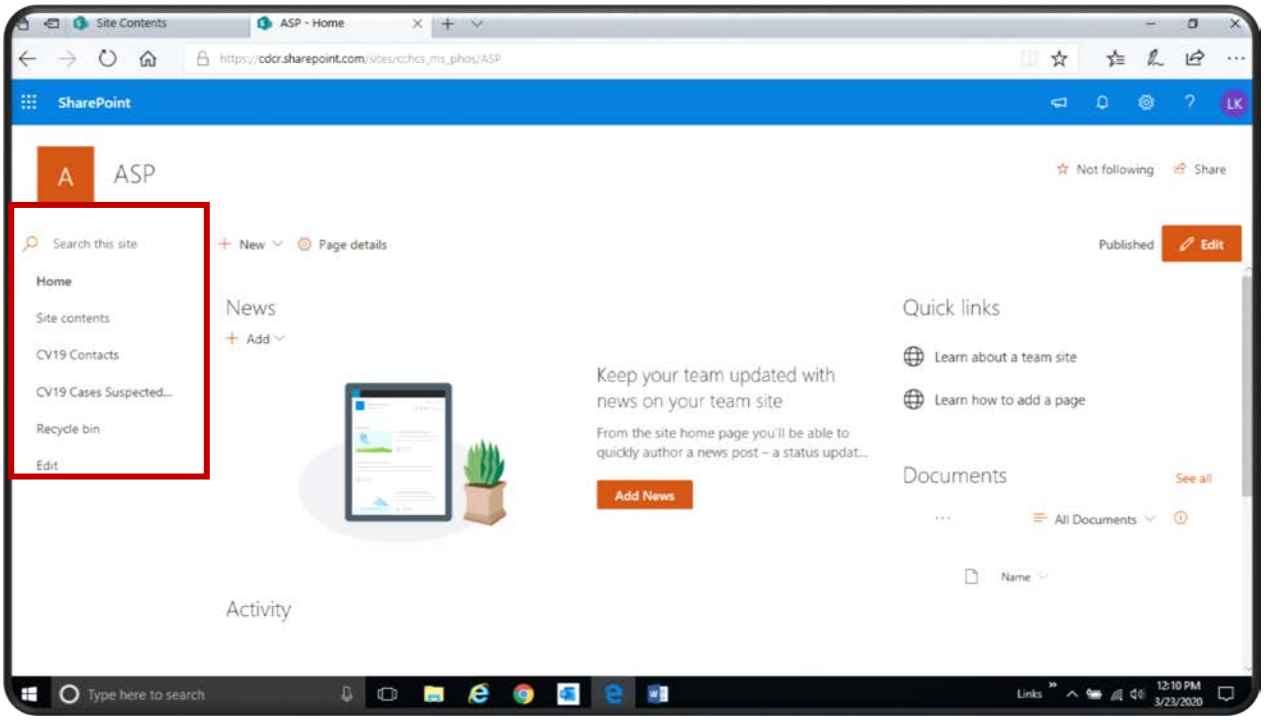
No report is needed if there are no new cases/contacts and no significant updates to existing cases/contacts.

REPORTING IN SHAREPOINT

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

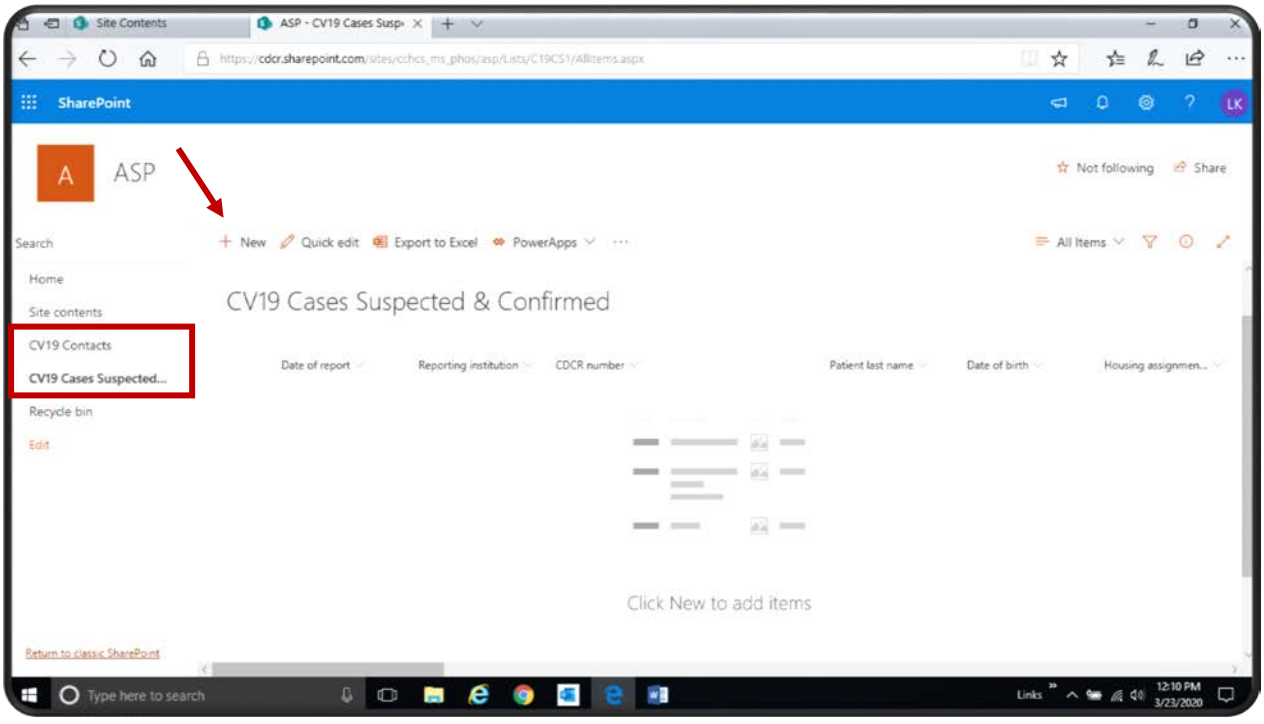


Each institution has a home page with a navigation panel on the left.

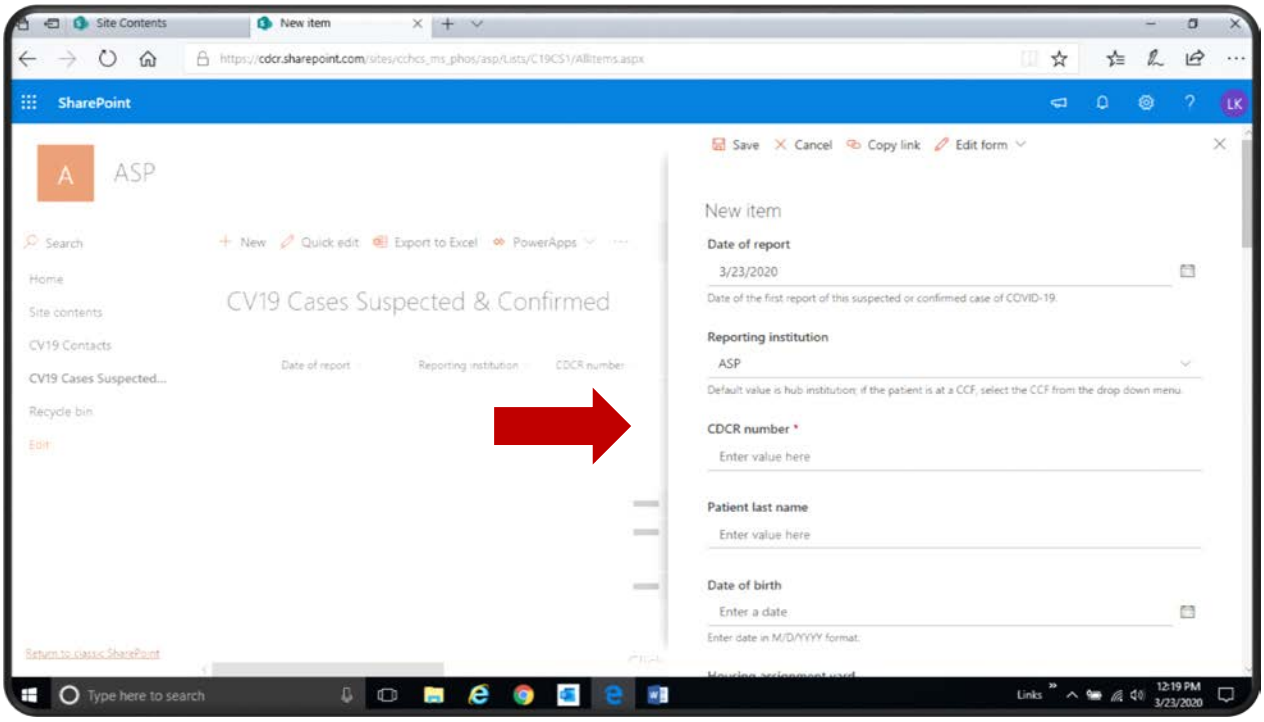


To access the CASES line list, click on **CV19 Cases Suspected & Confirmed**. To access the CONTACTS line list, click on **CV19 Contacts**. This guide applies to both the CASES and CONTACTS line lists.

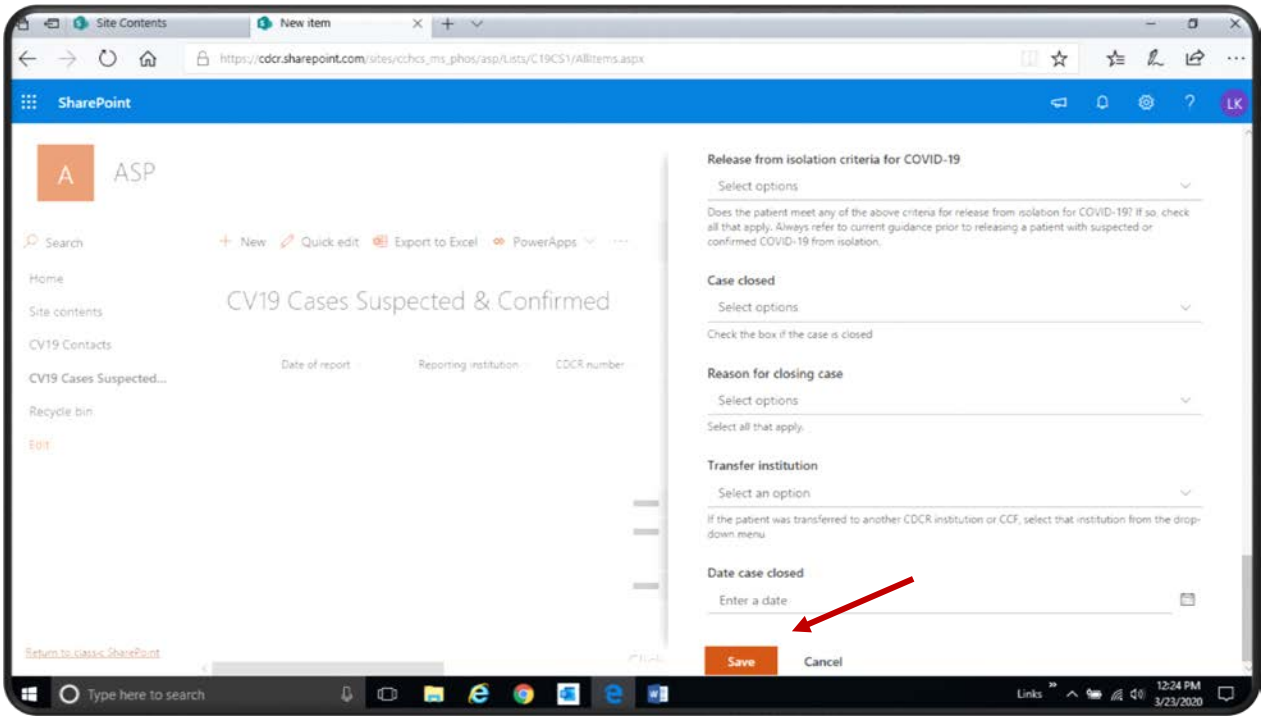
To add a new patient to a line list, click on **New**



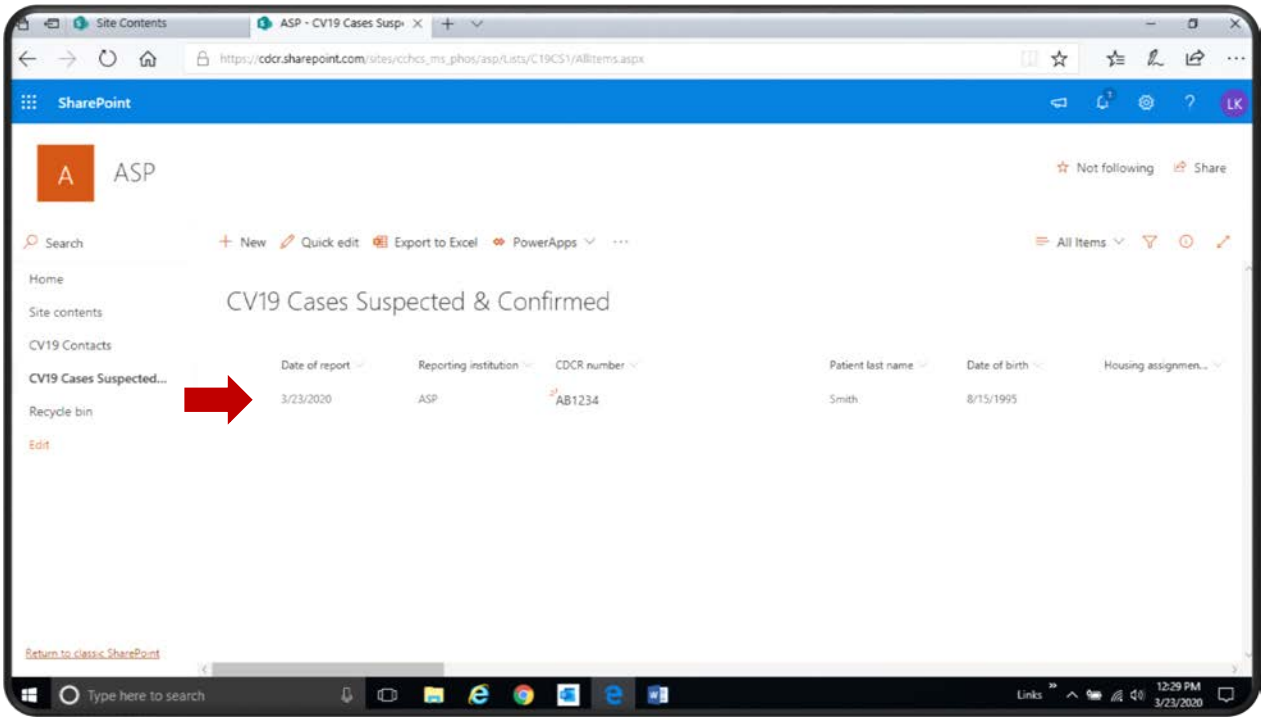
A new record (data entry form) will open on the right.



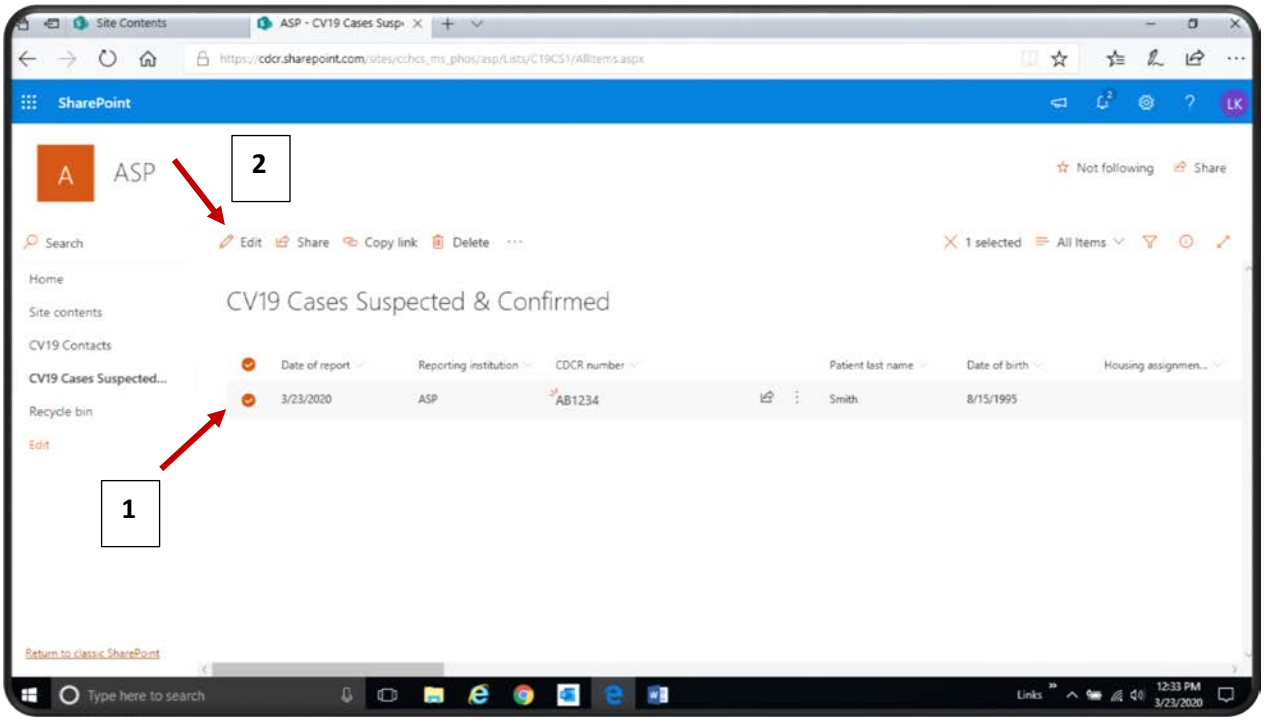
Scroll through the form to enter data. Brief instructions are provided below the form fields. Refer to the **Data Definitions** section on page 9 for detailed instructions for each field in the CASES and CONTACTS line lists. Click on **Save** at the bottom of the form to add the report to the line list.



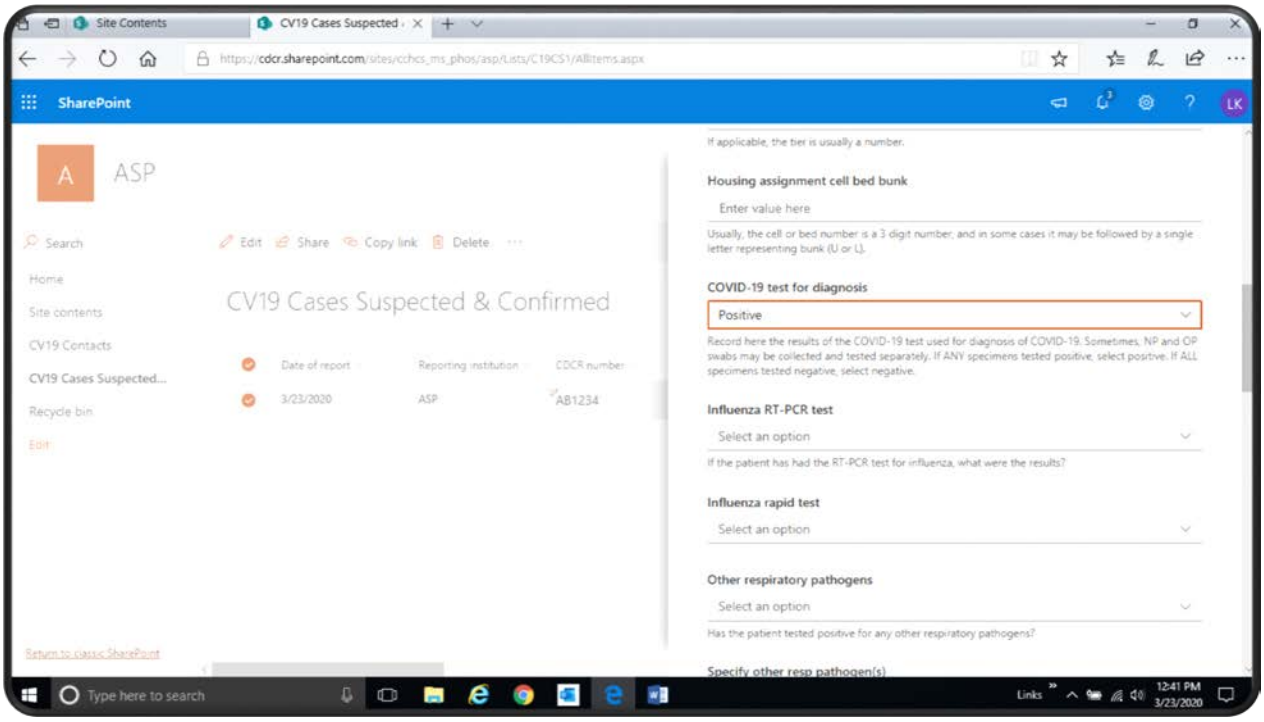
Saving the form adds the report to the line list.



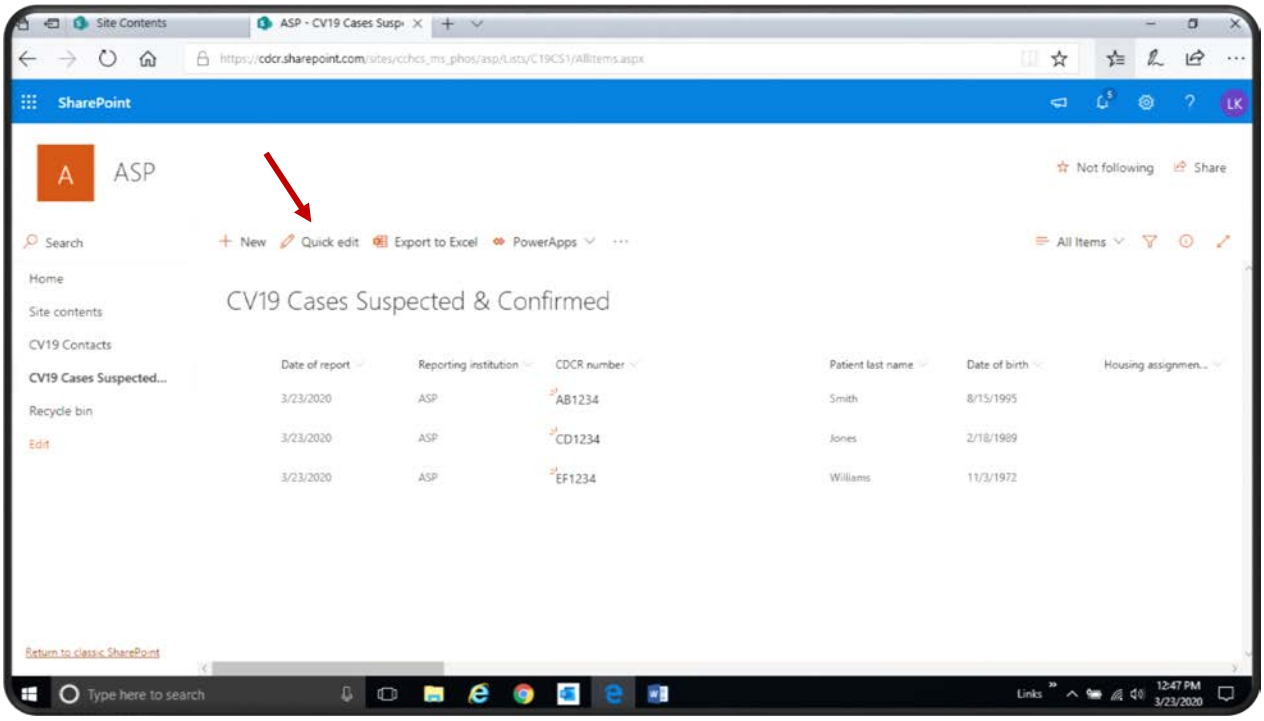
To enter updated information after saving the form, click on the row [1] to select the record in the line list, then click on **Edit** [2] to re-open the form.



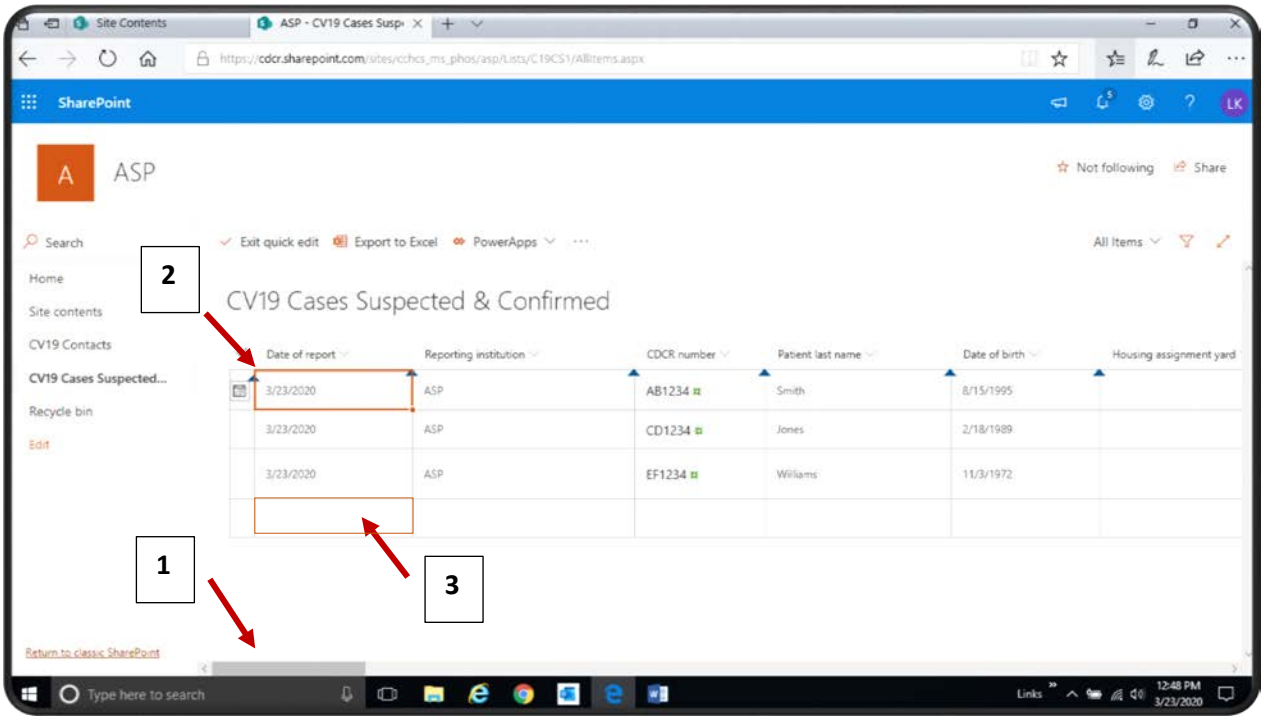
Enter your new information (e.g., diagnostic test, isolation dates) and click on **Save** (as above).



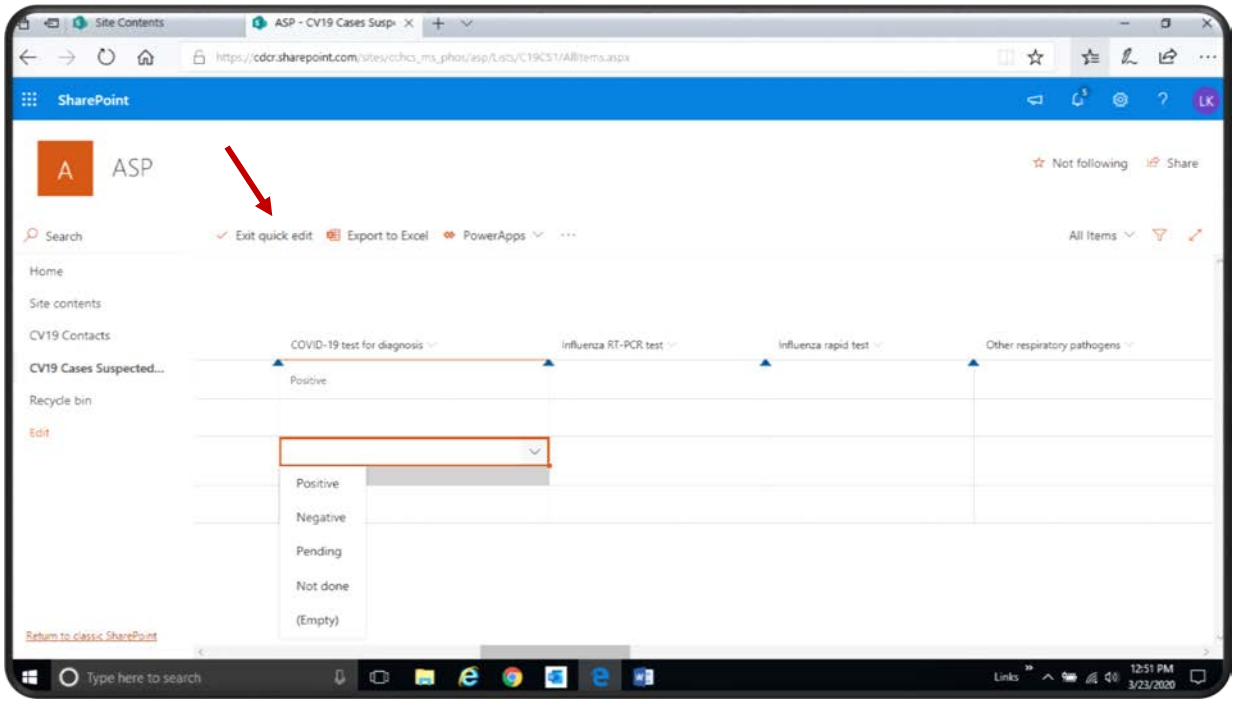
To edit a record directly in the line list, you can also click on **Quick Edit**.



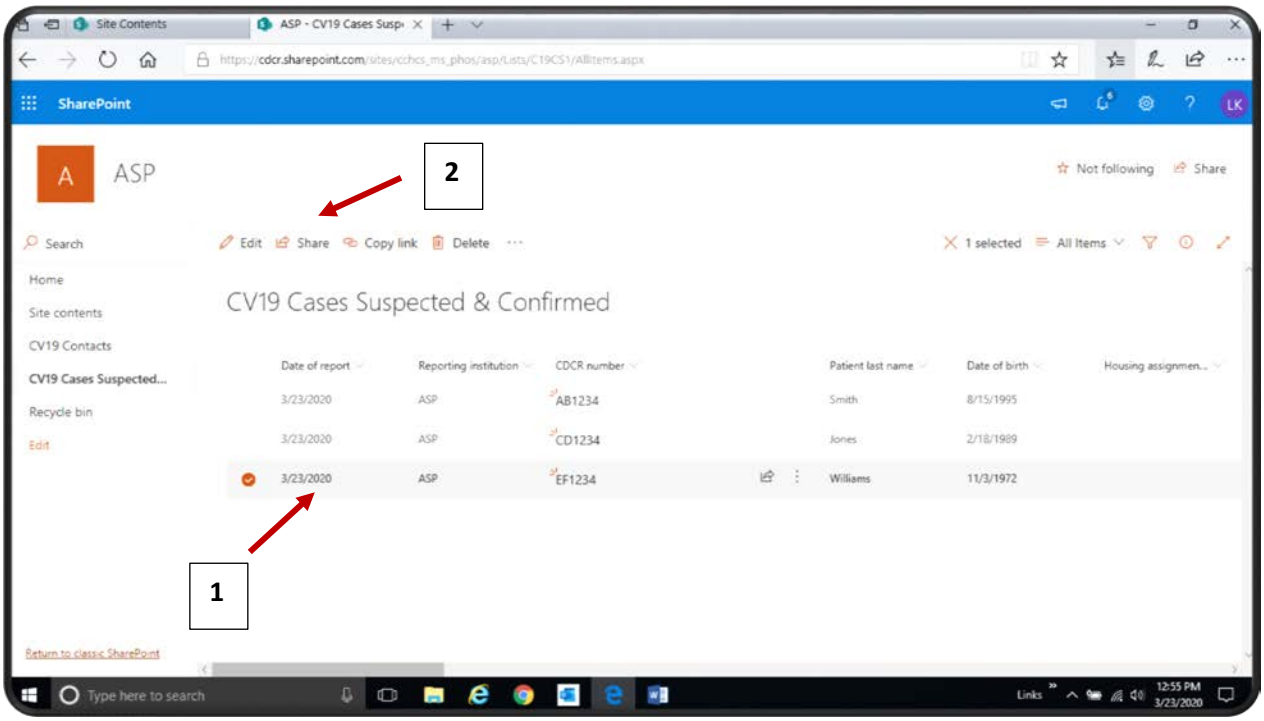
Use the scroll bar [1] to move across the line list. Clicking on any field [2] will highlight it and enable an update to be entered. You can also cut and paste from an Excel spreadsheet into a blank row [3] in SharePoint (e.g., to add a list of CDCR numbers to initiate reports for new patients).



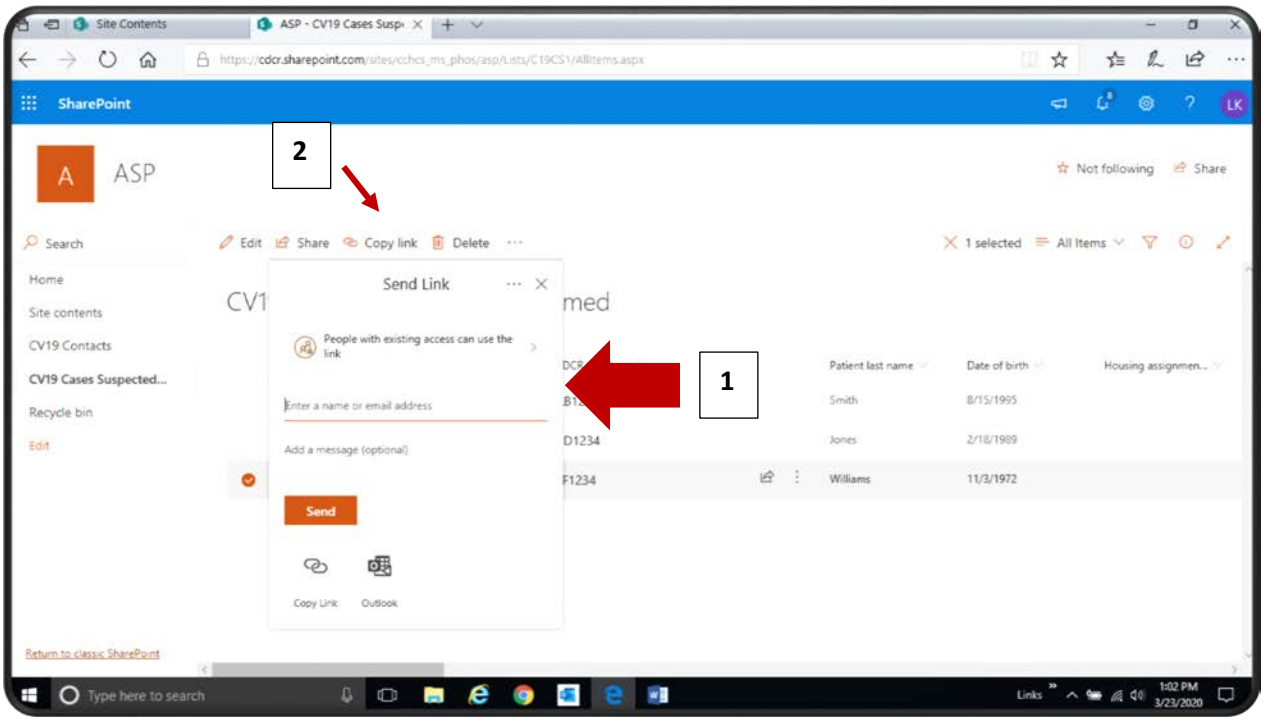
After entering new information into the line list, click on **Exit Quick Edit** to save the update.



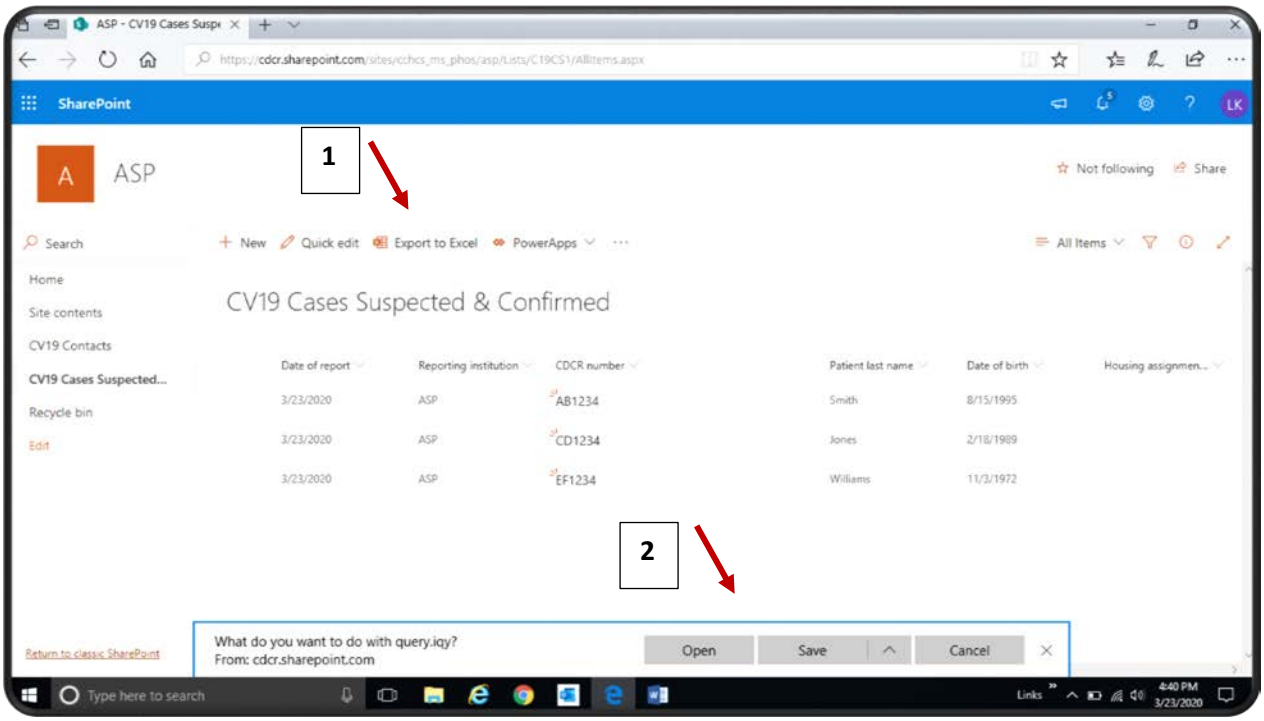
To share a link to an individual case report (e.g., to communicate with other health staff in the institution), select the record by clicking on it [1] and then click on **Share** [2].



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.

APPENDIX 9: MEMO TEMPLATE FOR NOTIFICATION OF COVID-19 CASES AND CONTACTS RELEASED TO THE COMMUNITY

State of California
Department of Corrections and Rehabilitation

CALIFORNIA CORRECTIONAL HEALTH CARE SERVICES

Memorandum

CONFIDENTIAL

Date :

To : Local Health Officer: _____
OR Designee: _____
Local Heath Jurisdiction: _____
Fax # or email: _____

Subject: **COVID-19 Contact or Case (Confirmed or Suspected)**

The person identified below was or will be ☐ *transferred* ☐ *paroled* ☐ *released to post-release community supervision (PRCS)* to your institution/region on _____ (Date).

☐ The person is a **contact** to a confirmed case of COVID-19. The last date of exposure was _____(Date). The incubation period will end on _____(Date).

☐ The person has a ☐ *confirmed* ☐ *suspected* **case of COVID-19.**

The date of symptom onset was _____(Date).

Symptoms ☐ *have improved.* ☐ *have not improved.*

☐ Fever resolved w/out antipyretics on _____(Date).

☐ The patient subsequently tested negative for COVID-19 on _____(Date/s).

Identifying information for the person:

Name (Last, First): _____ Date of Birth: _____
Soc Sec #: _____-_____-_____ CDCR #: _____
Address and phone (if available): _____

If paroled or released to PRCS, contact info for parole or probation officer:

_____

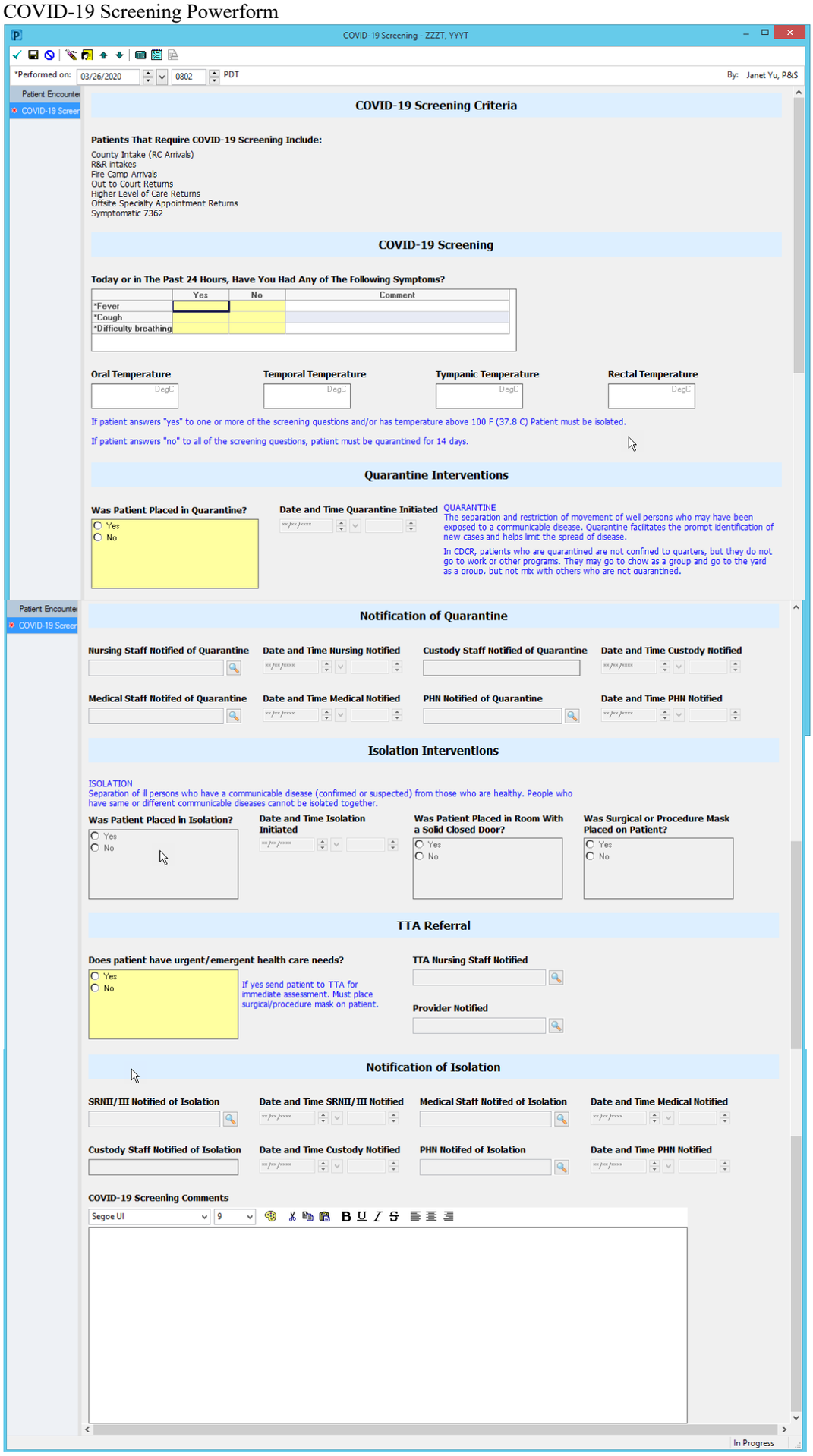
For further information contact:
Institution: _____
Name of Public Health Nurse or Designee: _____
Phone Number: _____ Fax Number: _____

March 2020 *Page 1 of 1*

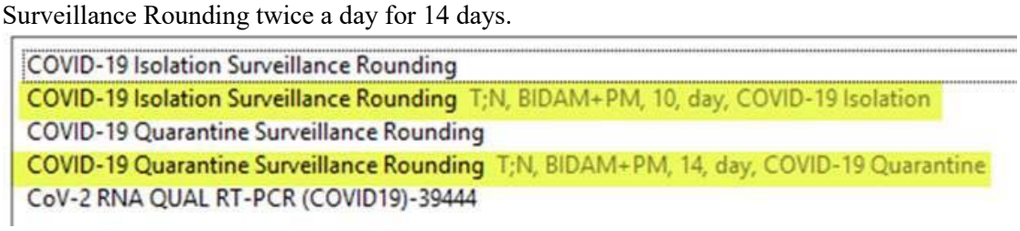
APPENDIX 10: COVID-19 POWERFORM INSTRUCTIONS; SCREENING, ISOLATION, AND QUARANTINE SURVEILLANCE

ORDERING PATHWAY: Adhoc > All Items > CareMobile Nursing Task > Surveillance Round

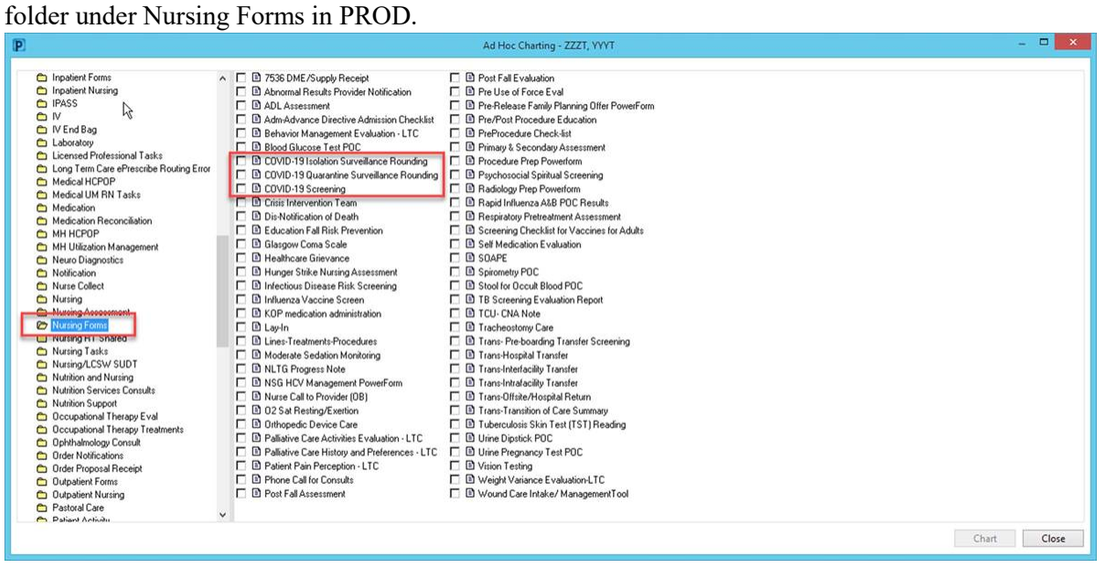
1. COVID-19 Screening Powerform



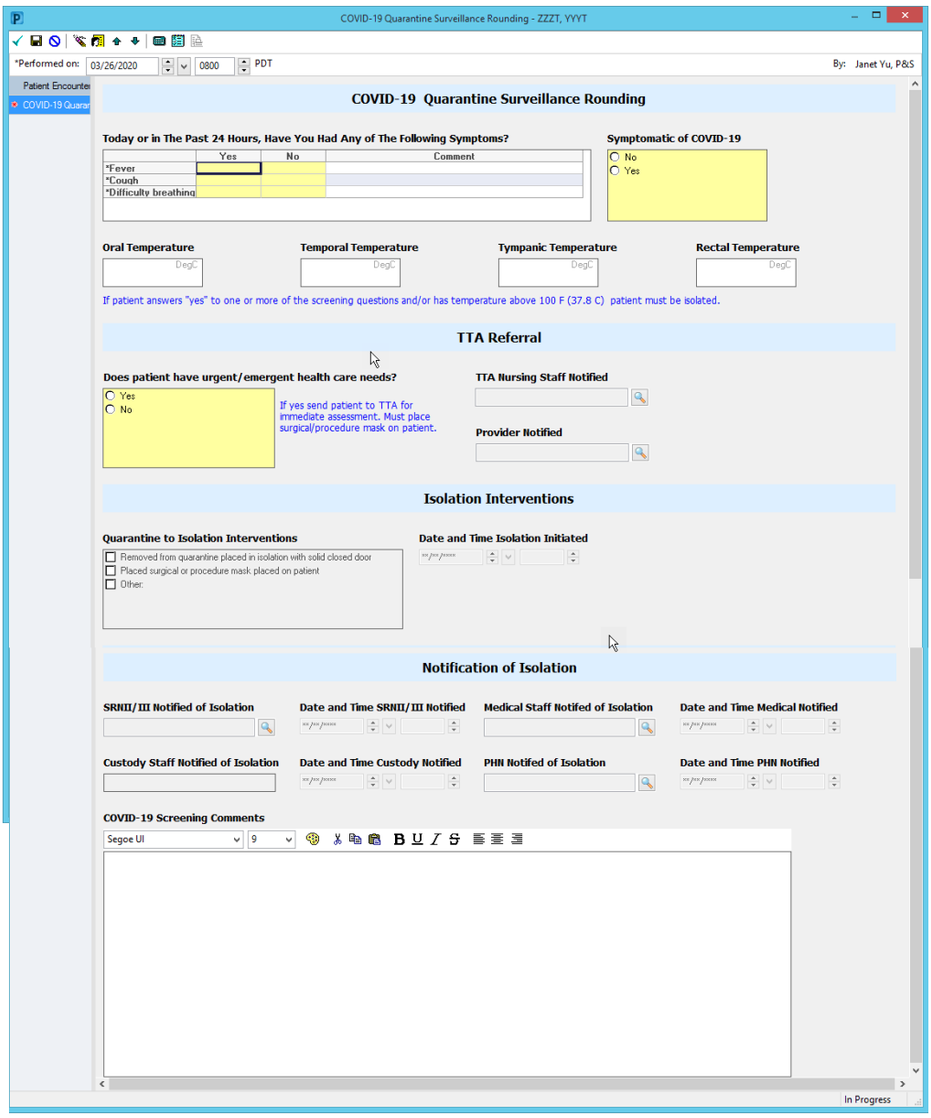
2. COVID-19 Isolation Surveillance Rounding twice a day for 10 days and COVID-19 Quarantine Surveillance Rounding twice a day for 14 days.



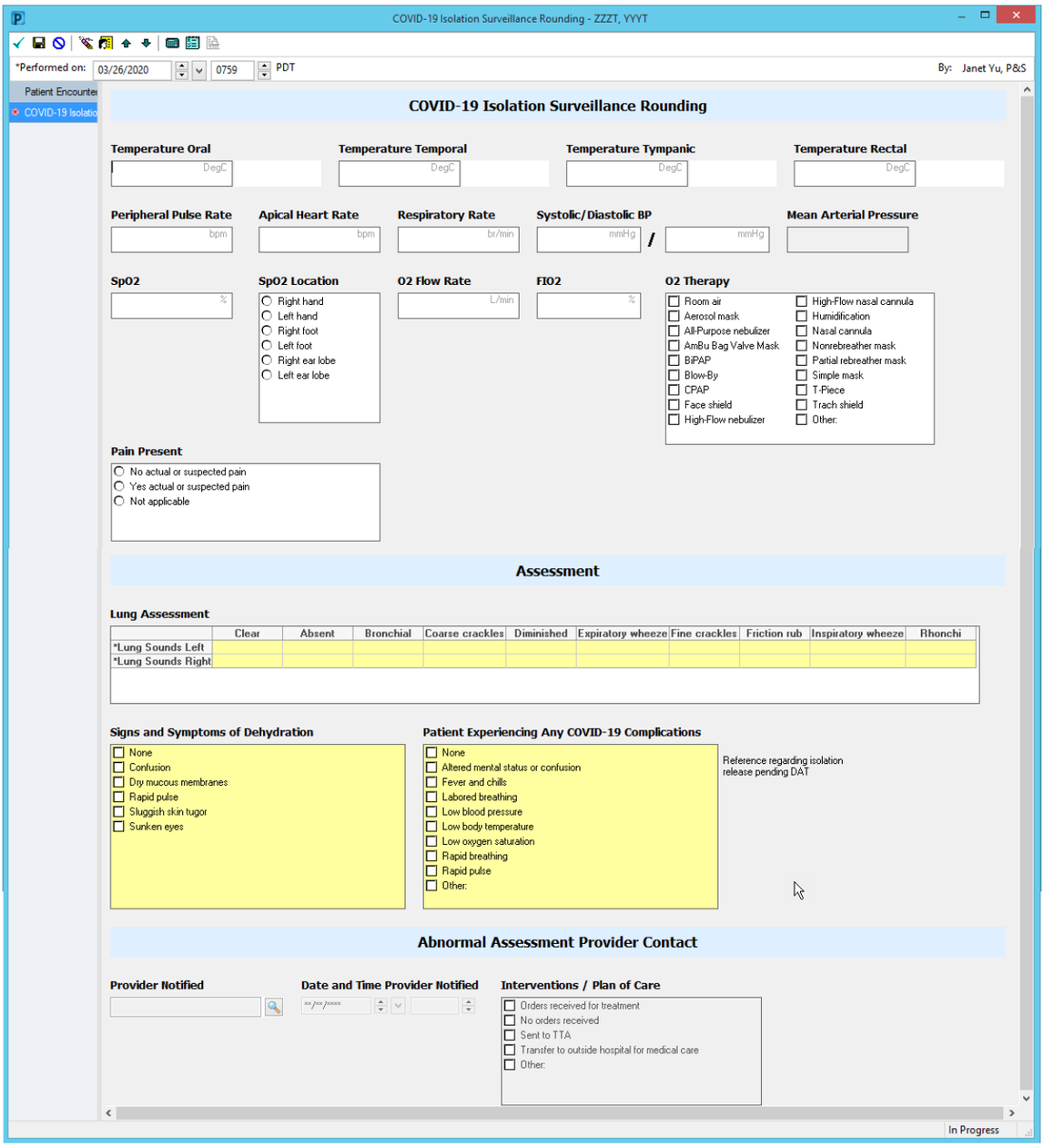
3. Once these orders are placed, it will trigger a task for the nurse to complete the appropriate Surveillance Rounding Powerform. These powerforms are currently viewable in the Adhoc folder under Nursing Forms in PROD.



COVID-19 Quarantine Surveillance Rounding



COVID-19 Isolation Surveillance Rounding



ATTACHMENT N

State of California Department of Corrections and Rehabilitation

Memorandum

Date: April 10, 2020

To: CDCR Extended Executive Staff

Subject: **INCREASE IN LAUNDRY SERVICES IN RESPONSE TO COVID-19 FACE MASKS DISTRIBUTION**

This memorandum is to notify all institutions that washable cloth barrier face masks will be issued to all inmates as a result of COVID-19. Masks will be manufactured by California Prison Industry Authority (CalPIA), received by CalPIA Administrators, and delivered to Wardens at each institution. Institutions will initially receive three face masks per inmate for immediate distribution, with a later distribution providing two additional face masks per inmate, for a total of five face masks per inmate per institution.

Masks should be laundered before being issued to inmates. Institutions will be notified by the Department Operations Center (DOC) of face mask deliveries no sooner than three days before the shipment is due to arrive.

As each institution receives their order, laundry services will be required to increase to a daily basis. If an increase in funding and the encumbered Purchase Order (PO) is needed, please complete the attached survey to note the increased funding needs. **Please return this spreadsheet to the DOC via email at DOCCOVID19@cdcr.ca.gov by COB Monday 4/13/20**. The DOC will coordinate funding allotments with the Budget Management Branch. In addition, please submit the required Encumbrance Adjustment Request – OBS450 to the ICSHelpdesk.

CalPIA is aware of the increased need and is prepared to provide the additional services. The following institutions do not participate in the agreement with CalPIA and therefore will need to increase the laundry services at their institutions, as applicable:

Adult

- California City Correctional Facility (CAC) - Laundering facility onsite.
- California Correctional Center (CCC) - Laundering facility onsite.
- California Correctional Institution (CCI) - Laundering facility onsite.
- Correctional Training Facility (CTF) - Laundering facility onsite.
- High Desert State Prison (HDSP) - Laundering facility onsite.
- Northern California Women's Facility (NCWF) - Services not needed. Warm shutdown site, no inmates/wards.
- Sierra Conservation Center (SCC) - Laundering facility onsite.

Juvenile

- Estrella (ECF) - Services not needed. Warm shutdown site, no inmates/wards.
- Stark (HGS) - Services not needed. Warm shutdown site, no inmates/wards

- Pine Grove (PGYCC) - Laundering facility onsite for youth items. Kitchen has an S&E for towels and aprons.
- Sierra Youth (SYCRCC)
- Ventura Youth (VYCF) - Laundering facility onsite.

For institutions utilizing an outside contractor for laundry services, the contractor must be noticed to inform them of an increase in services. **Notify the contact below if the contractor is unable to meet the increased need in services.** Following the assignment above, please ensure there is sufficient funding in current year laundry POs to accommodate the increase.

Increased laundry services are expected to continue until all inmates have been issued a total of five masks, as detailed above. Upon completion of distribution, laundry services will revert back to their normal schedule, as each inmate will have enough face masks to rotate into the normal laundry schedule and maintain a clean mask in their possession for usage.

As a reminder, the increased costs in laundry services should be documented on an Attachment I, COVID-19 Cost Reporting, as directed by the Budget Management Branch assignment issued on March 13, 2020.

For any questions or concerns, please contact Bedeth Victorioso, Staff Services Manager III, at **Bedeth.Victorioso@cdcr.ca.gov** or (916) 255-6208, or the DOC via email at **DOCCOVID19@cdcr.ca.gov.**

VIRUS SAFETY LAUNDRY GUIDE

Health experts advise washing your cloth face covering frequently, ideally after each use, or at least daily, along with your clothes.

Have a bag or bin to keep cloth face coverings and clothes in until they can be laundered.

Machine wash all clothes, coverings with detergent, hot water and dry on a hot cycle.

If you must re-wear your cloth face covering before washing, wash your hands immediately after putting it back on and avoid touching your face.

ATTACHMENT O

CALIFORNIA CORRECTIONAL
HEALTH CARE SERVICES

MEMORANDUM

Date:	April 6, 2020
To:	California Department of Corrections and Rehabilitation (CDCR) - All Staff California Correctional Health Care Services (CCHCS) - All Staff
From:	*Original signed by:* Heidi M. Bauer, MD MS MPH Public Health Epi/Surveillance Lead Public Health Branch *Original signed by:* Diane O'Laughlin, FNP-BC, DNP Headquarters Chief Nurse Executive Public Health and Infection Prevention
Subject:	**COVID-19 Personal Protective Equipment (PPE) Guidance and Information**

The purpose of this memo is to provide information and resources related to COVID-19 and the continuously evolving status personal protective equipment (PPE) supply availability. The information below is intended to guide the use of PPE as we move forward in responding to this pandemic. In-depth guidance is provided in the COVID-19: Interim Guidance for Healthcare and Public Health Providers.

TYPES OF MASKS

Filtering facepiece respirator N95: An "N95" is a type of respirator which removes at least 95 percent of particles from the air that are breathed through it. An N95 currently has two recommended uses:

- Staff person accompanying individuals with respiratory symptoms in a transportation vehicle.
- A staff person present during "aerosol producing procedures" on suspect or confirmed COVID19 cases such as COVID-19 testing, CPR, etc. or providing high-contact patient care such as bathing someone confirmed to have COVID-19.

More information about N95 and surgical masks:

- Understanding the difference between N95 and Surgical Masks
- Proper use and disposal of PPE
- Facial hair and PPE use

Use of Privately Owned Masks and Respirators and Reusable barrier masks (cloth/washable): "The Joint Commission (TJC) issued a statement on March 31, 2020, supporting the use of standard face masks and/or respirators provided from home when health care organizations cannot provide access to protective equipment that is commensurate with the risk health care workers are exposed to amid the COVID-19 pandemic. The CDCR/CCHCS will follow the TJC recommendations for privately owned PPE,

MEMORANDUM

including N95 and surgical masks. Please wash reusable cloth masks between each use using hot water with regular detergent and dry completely on hot setting.

EXTENDING THE USE OF PPE (MEDICAL EQUIPMENT MASKS)

The CDC has put out guidance on extending the use of medical equipment masks. There is not an exact determination on the number of safe reuses for these masks and those decisions must be made based on a number of variables per CDC guidelines such as impact respirator function and contamination over time.

RESOURCES

The **COVID-19 Quick Guide Poster** follows Center for Disease Control (CDC) guidelines for COVID-19 management. This quick guide defines quarantine, who to isolate, COVID-19 case actions and how to perform appropriate surveillance during the COVID-19 pandemic. The COVID-19 Quick Guide Poster pairs with the Personal Protective Equipment (PPE) Guide Poster, number 2 below, to inform staff on what type of PPE they will need.

The **COVID-19 Protective Equipment (PPE) Guide Poster** adopts CDC guidelines as of March 29, 2020, which reflect the CDC's recommendations for optimizing PPE supplies (link below). The PPE guide poster reinforces 6 foot social distancing, and gives guidance for individuals who must be within 6 feet for a prolonged period of time of suspected/confirmed COVID-19 individuals.

A **COVID-19 Quick Reference Pocket Guide** is intended to keep on person as a resource for PPE, quarantine, isolation and surveillance.

The CDC also provides recommendations for optimizing PPE supplies.

These resource tools, TJC statement on privately owned face masks, and current available supplies should all be considered when determining the type of PPE staff will use for the safety of staff and the population. Please place the posters in high traffic staff areas to remind staff of these key concepts for COVID-19 management. Please assure your staff is aware of these resource tools.

Thank you all for your cooperation, as we continue to work together to guard against the spread of COVID-19 and to keep our staff and patients protected.

CALIFORNIA CORRECTIONAL HEALTH CARE SERVICES

MEMORANDUM

Date:	April 6, 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* R. Steven Tharratt, MD, MPVM, FACP Director of Health Care Operations and Statewide Chief Medical Executive California Correctional Health Care Services
Subject:	**STAFF USE OF PERSONAL PROTECTIVE EQUIPMENT (PPE)**

We understand the importance and urgency surrounding the availability and use of personal protective equipment (PPE), particularly masks, for CDCR/CCHCS staff and the incarcerated population. Our top priority is doing everything we can to provide appropriate protection to slow the spread of COVID-19 within our institutions.

We must face the reality that during this global pandemic, CDCR and CCHCS are not immune from the unprecedented demand for more PPE to protect those on the frontlines. While we are not the only organization impacted by this shortage, we are working every day to increase our supplies, including reusable barrier cloth masks manufactured by the California Prison Industry Authority (CALPIA). While we work to expand our supply, we all need to do our part to make sure that PPE, especially masks, are utilized in the most appropriate and efficient way possible. We need a mutual understanding of PPE and develop innovative solutions to help increase our supply.

See COVID-19 Personal Protective Equipment (PPE) Guidance and Information from CDCR/CCHCS Public Health.

PPE including “medical grade” masks (N95 and surgical) should only be used by both CDCR and CCHCS staff as recommended in the memo above. The Centers for Disease Control and Prevention (CDC) and California Department of Public Health (CDPH) issued guidance recommending face cloth covering in the general public and in close quarters. We understand that additional facial protection can potentially limit “droplet” transmission while also offering some peace of mind to our staff, their families, stakeholders and our population. To help address this moment of need, CALPIA has

started manufacturing two-ply, cotton, reusable barrier masks that we will start distributing to our population in quarantine settings this week. Distribution of the masks will begin for inmates in quarantine and medically fragile inmates. As CALPIA continues to expand the production of these masks, we will also make them available to the general population and staff who do not have access to face coverings as a precautionary measure as supply allows. CALPIA is making 800 masks per day between two locations and will continue to ramp up to full production to meet the expected needs.

CALPIA also began ramping up their brand new production of hand sanitizer, which has already started arriving at most institutions and locations. We are extremely grateful for CALPIA and our population workers providing these valuable services in such a short time frame.

FACE COVERINGS (REUSABLE BARRIER CLOTH MASKS)

While we continue internal production and procurement of PPE, CDCR and CCHCS will also follow the recently released guidance from The Joint Commission (TJC), a trusted health care accreditation organization, by allowing staff to bring in a personal supply of reusable barrier (cloth) masks and approved medical masks if supply is not readily available. Any personally provided mask must be appropriate for the workplace and cannot contain any inherently offensive logos, graphics or text. Designer face masks that have skulls, "gate keeper," "punisher," logos, etc. on them (motorcycle type) would not be appropriate and employees will not be permitted to wear while on duty. The Department assumes no responsibility for personally owned face coverings. Staff will be required to remove face coverings for identification purposes at entry points.

Recommended PPE as described should be utilized first; if recommended PPE is not available use the most comparable coverage.

EXPANDING SUPPLY

The CDCR and CCHCS procurement teams are rigorously searching for PPE supplies, especially masks, to purchase. If you have a lead, please send the information to COVID19@cdcr.ca.gov. We are looking into innovative solutions we may never have considered before, such as smaller supply vendors and more. Our top priority is the safety of all those who live and work in our facilities, and we are doing all we can to get you the protection you need.

Please continue to provide feedback to the local leadership at your facility, headquarters and the CDCR/CCHCS COVID-19 Department Operations Center.

We truly appreciate all of our staff working hard on the front lines as we are making unprecedented changes to our operations to keep everyone healthy and safe. There are sure to be changes over the next several weeks, and so we thank you for the flexibility, patience and support for that you all have provided to each other. We are all CDCR Strong.

ATTACHMENT P

COVID-19 QUICK GUIDE

QUARANTINE
Exposed to confirmed COVID-19 case with no signs or symptoms. Screening questions and temperatures twice daily. In cases of extreme hardship, screening and temperatures a minimum of once daily may be approved jointly by the local CEO, CNE and CME

SUSPECT: ALONE
Sick – Individuals with signs and symptoms. Test for Influenza and COVID-19 immediately. Vital signs and 02 SATS twice daily. Await diagnoses & monitor symptoms. (DO NOT house with other sick people, as we DO NOT know the pathogen). If suspect confirmed as positive for COVID-19, move to COVID-19 CASE status.

COVID-19: ISOLATE
Sick – Individuals with confirmed COVID-19 diagnosis. Vitals signs and 02 SATS twice daily. Assess for worsening symptoms & recovery. (DO isolate CONFIRMED COVID-19 together, as we DO know the pathogen. DO NOT house COVID-19 cases with influenza cases).

COVID-19 QUICK GUIDE

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COVID-19 QUICK GUIDE

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COVID-19 STAFF PPE GUIDE

Screener less than 6 feet from staff or visitor	Surgical mask, eye protection, hand hygiene
Person less than 6 feet from quarantined individual	Surgical mask, eye protection, hand hygiene (gloves if contact)
Person less than 6 feet from suspect individual	Surgical mask, eye protection, gloves, hand hygiene
Person less than 6 feet from confirmed COVID-19 case	Surgical mask, eye protection, gloves, hand hygiene
Person accompanying any patients with respiratory symptoms in transport vehicle	Respirator N95, eye protection, gown, gloves
Person less than 6 feet from confirmed COVID-19 case & aerosol producing procedure (COVID-19 testing, CPR etc.) OR high contact patient care (bathing, etc.)	Respirator N95, eye protection, gown, gloves

COVID-19 STAFF PPE GUIDE

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Person accompanying any patients with respiratory symptoms in transport vehicle	Respirator N95, eye protection, gown, gloves
Person less than 6 feet from confirmed COVID-19 case & aerosol producing procedure (COVID-19 testing, CPR etc.) OR high contact patient care (bathing, etc.)	Respirator N95, eye protection, gown, gloves

ATTACHMENT Q

CALIFORNIA CORRECTIONAL HEALTH CARE SERVICES

MEMORANDUM

Date: April 15, 2020

To: Wardens
Chief Executive Officers

From:
Original Signed By
Connie Gipson
Director, Division of Adult Institutions
California Department of Corrections and Rehabilitation

Original Signed By
R. Steven Tharratt, MD, MPVM, FACP
Director of Health Care Operations and Statewide Chief Medical Executive
California Correctional Health Care Services

Subject: **CALPIA CLOTH FACE BARRIER/MASK**

As an on ongoing effort to prevent further exposure of COVID-19, the following information is intended to provide guidance on the use of cloth masks by staff and inmates/patients who are performing day-to-day activities within our institutions. This guidance is not a substitute for health care and custody staff following current Centers for Disease Control and Prevention or county health department recommendations in dealing with suspected, quarantine or diagnosed patients. Staff and inmates/patients are required to wear a face barrier once a supply of two (2) face barriers/masks per correctional staff and inmate/patient has been delivered to the institution. Staff may bring in their own face coverings as previously communicated.

Staff working or performing duties on institutional grounds shall wear a cloth face covering at a minimum. In addition, maintaining social distancing requirements when moving about the institution for routine tasks is still recommended. These masks are not intended for direct patient care scenarios.

Inmates shall use a cloth face covering within the institution during the following activities:

- Any situation that requires movement outside of cell or while in a dorm setting
- During interactions with other inmates (ex: yard time, canteen, dayroom)
- Movement to and from for health care appointments
- Movement to and from medication administration areas

MEMORANDUM

Wardens and Chief Executive Officers should work together in developing an informational directive to all staff and inmate/patients on this wear requirement. Institutions, CIM, LAC, CHCF, have received their masks and therefore this expectation is effective immediately.

If you have any questions, please email DOCCOVID19@cdcr.ca.gov.

ATTACHMENT R

Memorandum

Date: April 8, 2020

To: Associate Directors, Division of Adult Institutions
Wardens

Subject: **COVID-RELATED CLEANING PROTOCOLS FOR INSTITUTIONS**

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) within our institutions by providing guidance on cleaning and disinfection protocols as recommended by the Centers for Disease Control and Prevention (CDC). Due to the current COVID-19 pandemic, and out of an abundance of caution, we are distributing information on best practices for cleaning and disinfecting your work areas.

According to the CDC definitions, retrieved March 3, 2020, from: https://cdc.gov/Coronavirus/2019-ncov/comunity/organizations/cleaning-disinfection:

Cleaning - refers to the removal of dirt and impurities, including germs, from surfaces. Cleaning alone does not kill germs. But by removing the germs, it decreases their number and therefore any risk of spreading infection.

Disinfecting - works by using chemicals, for example EPA-registered disinfectants, to kill germs on surfaces. This process does not necessarily clean dirty surfaces or remove germs. But killing germs remaining on a surface after cleaning further reduces any risk of spreading infection.

Staff are to ensure that assigned porters are thoroughly cleaning communal areas (dayrooms, showers, restrooms, offices, etc.) a minimum of twice per shift during second and third watches with the option to clean more often if needed. The area porters will initial the cleaning schedule template (see attachment) documenting the time it was complete. Staff will sign the sheet verifying that they have reviewed and ensured the additional cleaning was completed. As we increase our cleaning times, we must continue to practice social distancing when possible.

It is recommended staff increase the frequency in which they disinfect the touchpoints (i.e. telephones, tables, door knobs, desk areas, etc.) by using Sani Guard 24/7 in their work area. Once the Sani Guard has been applied to a surface, it should be allowed to set for 10 minutes to maximize its effectiveness.

Attached is essential information on the cleaning solutions used in the institutions, and dilution ratios for mixing Cell Block and Sani Guard 24/7.

If you have any additional questions, please contact your Mission Associate Director.

CONNIE GIPSON
Director
Division of Adult Institutions

PROTOCOL: CLEAN AND DISINFECT for emerging pathogen COVID-19

Best Practices : CLEAN AND DISINFECT for emerging pathogen COVID-19

Option 1 -

CELL BLOCK 64 - Refer to label instructions for Adenovirus type7. Mix 8oz of CELL BLOCK 64 to one gallon of water. Apply to surface, lightly agitate and let disinfectant set on the surface for a minimum of 10 minutes, then wipe clean.

Option 2 -

Clean with Cell Block 64 at the normal dilution ratio of 2 oz per gallon of water (chemical dispensers are set to this ratio). Apply Cell Block 64, agitate and let set on surface for a minimum of 10 minutes and wipe dry. Apply SANI-GUARD 24/7 at 3 oz per 5 gallons of water (refer to Sani Guard 24/7 label instructions for H1N1). Allow disinfectant to remain wet on the surface for a minimum of 10 minutes and wipe off or let air dry.

Option 3-

Disinfect only - **PLEASE NOTE**, surface must be free of debris and clean before applying Sani Guard 24/7.

Refer to product label instructions for H1N1. Dilute 3oz of Sani Guard 24/7 to 5 gallons of water. Apply solution to non porous surfaces and remain wet for a minimum of 10 minutes. Wipe or let air dry.

CELL BLOCK 64 LABEL

Please review the entire bottle label before use.

From the Cell Block 64 Label:

DILUTION (1:64)	2 oz. per gallon of water	8 oz. per 4 gallons of water	12 oz. per 6 gallons of water
(660 ppm quat)	4 oz. per 2 gallons of water	10 oz. per 5 gallons of water	

DIRECTIONS FOR USE

It is a violation of Federal law to use this product in a manner inconsistent with its labeling.
This product is not for use on medical device surfaces.

DISINFECTION /CLEANING/DEODORIZING DIRECTIONS: Remove heavy soil deposits from surface, then thoroughly wet surface with a use-solution of 2 ounces of the concentrate per gallon of water. Use 8 oz. per gallon of water to kill Adenovirus Type 7.
The use-solution can be applied with a cloth, mop, sponge, or coarse spray or by soaking. For sprayer applications, use a coarse spray device. Spray 6-8 inches from the surface, rub with a brush, cloth or sponge. Do not breathe spray. Let solution remain on surface for a minimum of 10 minutes. Rinse or allow to air dry. Rinsing of floors is not necessary unless they are to be waxed or polished.
Food contact surfaces must be thoroughly rinsed with potable water. This product must not be used to clean the following food contact surfaces: utensils, glassware and dishes.

(Continued directions for use)

CLEANING AND DISINFECTING HARD NONPOROUS SURFACES ON PERSONAL PROTECTIVE EQUIPMENT RESPIRATORS:
Preclean equipment if heavily soiled to ensure proper surface contact. Add 2 oz. of this product to one gallon of water. Use 8 oz per gallon of water to kill Adenovirus Type 7. Gently mix for a uniform solution. Apply solution to hard, nonporous surfaces of the respirator with a brush, coarse spray device, sponge, or by immersion. Thoroughly wet all surfaces to be disinfected. Treated surfaces must remain wet for 10 minutes. Remove excess solution from equipment prior to storage. Comply with all OSHA regulations for cleaning respiratory protection equipment (29 CFR §1910.134).

From the Sani-Guard 24-7 Label:

Sani-Guard 24-7 is a hospital Disinfectant, Bactericidal according to the current AOAC Disinfectants Use-Dilution Method. Fungicidal according to the AOAC Fungicidal Test, and Virucidal* according to the virucidal qualification, modified in the presence of 5% organic serum against:

Bacteria:
Burkholderia cepacia
Campylobacter jejuni [Campylobacter]
Corynebacterium ammoniagenes
Escherichia coli [E. coli]
Escherichia coli pathogenic strain O157:H7 [pathogenic E. coli]
Klebsiella pneumoniae [Klebsiella]
Listeria monocytogenes [Listeria]
Pseudomonas aeruginosa [Pseudomonas]
Salmonella enterica [Salmonella]
Salmonella typhi [Salmonella]
Shigella dysenteriae [Shigella]
Staphylococcus aureus [Staph]
Staphylococcus aureus - Community Associated Methicillin-Resistant [CA-MRSA] [NRS123] [USA400]
Staphylococcus aureus - Methicillin-Resistant [MRSA]
Yersinia enterocolitica

Viruses:
*Adenovirus Type 5
*Adenovirus Type 7
*Hepatitis B Virus [HBV]
*Hepatitis C Virus [HCV]
*Herpes Simplex Virus Type 1 [Herpes]
*Herpes Simplex Virus Type 2 [Herpes]
*Human Coronavirus
*Human Immunodeficiency Virus Type 1 [HIV-1] [AIDS Virus]
*Influenza A2 / Hong Kong Influenza Flu Virus
*Norovirus - Feline Calicivirus
*SARS Associated Human Coronavirus
*Vaccinia Virus [Pox Virus]

Fungi:
Aspergillus niger
Trichophyton mentagrophytes

DILUTION:

Disinfection (1:213)	3 oz. per 5 gallons of water [450 ppm active quat]
Sanitizer (1:256)	1/2 oz. per gallon of water [2 1/2 oz. per 5 gallons of water] [400 ppm active quat]
Sanitizer (1:512)	1/4 oz. per gallon of water [1 oz. per 4 gallons of water] [1 1/4 oz. per 5 gallons of water] [200 ppm active quat]
Sanitizer (1:640)	1.5 oz. per gallon of water [1 oz. per 5 gallons of water] [150 ppm active quat]

DIRECTIONS FOR USE

It is a violation of Federal law to use this product in a manner inconsistent with its labeling.

DISINFECTION / VIRUCIDAL*/ FUNGICIDAL / MOLD AND MILDEW CONTROL DIRECTIONS:
Add 3 oz. of Sani-Guard 24-7 per 5 gallons of water (or equivalent dilution) to disinfect hard, nonporous surfaces.
Before use in federally inspected meat and poultry food processing plants and dairies, food products and packaging materials must be removed from the room or carefully protected. When used on surfaces in areas such as locker rooms, dressing rooms, shower and bath areas and exercise facilities, this product is an effective fungicide against Trichophyton mentagrophytes (the athlete's foot fungus). Apply use-solution with a cloth, mop, sponge, sprayer or by immersion, thoroughly wetting surfaces. For sprayer applications, use a coarse spray device. Spray 6 - 8 inches from surface, rub with brush, sponge or cloth. Do not breathe spray.
Note: For spray applications, cover or remove all food products.
Treated surfaces must remain wet for 10 minutes. Wipe dry with a clean cloth, sponge or mop or allow to air dry. Rinse food contact surfaces such as counter tops, tables, picnic tables, exteriors of appliances and/or stove tops with potable water prior to reuse. Do not use on glasses, dishes or utensils as a disinfectant. For heavily soiled areas, preclean first.

CALPIA
Quality Products ★ Changed Lives ★ A Safer California

Memorandum

Date: March 25, 2020

To: CALPIA Healthcare Customers

From: California Prison Industry Authority • 560 East Natoma Street • Folsom, California 95630-2200

Subject: **SARS-CoV-2 Supplemental Communication**

CALPIA was notified by Lonza, LLC, manufacturer of components used in the production of Cell Block 64 and Sani-Guard 24-7, of the following:

On March 13, 2020 (updated March 19), EPA published an updated list N (https://www.epa.gov/pesticide-registration/list-n-disinfectants-use-against-sars-cov-2) for disinfectant products with emerging viral pathogen and Human Coronavirus claims for use against SARS-CoV-2, the cause of COVID disease.

"Inclusion on this list does not constitute an endorsement by EPA. There may be additional disinfectants that meet the criteria for use against SARS-CoV-2. EPA will update this list with additional products as needed."

Lonza, LLC offers many registrations that were evaluated and accepted by EPA under the Emerging Viral Pathogen program (EVP) listed in Annex 1, and Human Coronavirus listed in Annex 2.

Key clarification:
Annex 1 listed products can make efficacy claims against SARS-CoV-2 in accordance with EPA's Emerging Viral Program.

Annex 2 listed products can be used against SARS-CoV-2 by people only when Annex 1 products are not available. Lonza has submitted Annex 2 products to the EPA to make efficacy claims against SARS-CoV-2 in accordance with EPA's Emerging Viral program. This communication will be updated when Annex 2 product reviews are completed and accepted by the EPA to make claims.

For any supplemental registration based upon any of these listed EPA registered products, customers may make off-label* communications in the following formats:

Cell Block 64 (HWS-64)
COVID-19 is caused by SARS-CoV-2, a novel coronavirus. Cell Block 64 kills similar viruses and therefore can be used against SARS-CoV-2 when used in accordance with the directions for use against Adenovirus type 7 on hard, non-porous surfaces. Refer to the CDC website at https://www.cdc.gov/coronavirus/2019-ncov/index.html for additional information.

Sani-Guard 24-7 (BARDAC 205M-10)
COVID-19 is caused by SARS-CoV-2, a novel coronavirus. Sani-Guard 24-7 (BARDAC 205M-10) kills similar viruses and therefore can be used against SARS-CoV-2 when used in accordance with the directions for use against Norovirus on hard, non-porous surfaces. Refer to the CDC website at https://www.cdc.gov/coronavirus/2019-ncov/index.html for additional information.

If you have any questions, please contact CALPIA at chemicals@calpia.ca.gov.

*Label: The written, printed, or graphic matter on, or attached to, the pesticide or device or any of its containers or wrappers. (https://www.epa.gov/sites/production/files/2018-04/documents/chap-03-mar-2018_1.pdf)

Specialty Ingredients

Lonza

ANNEX 1

NUGEN® MB⁵A Family	EPA Reg. #	Supporting Viral Claim
NUGEN® MB⁵A-256	6836-361	Norovirus (Norwalk Virus) or Rotavirus
NUGEN® MB⁵A -128	6836-362	Norovirus (Norwalk Virus) or Rotavirus
NUGEN® MB⁵A -64	6836-363	Norovirus (Norwalk Virus) or Rotavirus

NUGEN® MB⁵N Family	EPA Reg. #	Supporting Viral Claim
NUGEN® MB⁵N-256	6836-364	Norovirus (Norwalk Virus)
NUGEN® MB⁵N-128	6836-365	Norovirus (Norwalk Virus)
NUGEN® MB⁵N-64	6836-366	Norovirus (Norwalk Virus)

Lonzagard® RCS™ Family	EPA Reg. #	Supporting Viral Claim
Lonzagard® RCS-256 Plus	6836-349	Enterovirus D68 or Norovirus
Lonzagard® RCS-256	6836-346	Enterovirus D68 or Norovirus
Lonzagard® RCS-128 Plus	6836-348	Enterovirus D68 or Norovirus
Lonzagard® RCS-128	6836-347	Enterovirus D68 or Norovirus

Lonzagard® R-82 Family	EPA Reg. #	Supporting Viral Claim
Lonzagard® R-82	6836-78	Norovirus (Norwalk Virus)
Lonzagard® S-18	6836-77	Norovirus (Norwalk Virus)
Lonzagard® S-21	6836-75	Norovirus (Norwalk Virus)
Lonzagard® DC-103	6836-152	Norovirus (Norwalk Virus)
Lonzagard® R-82F	6836-139	Norovirus (Norwalk Virus)
Lonzagard® S-18F	6836-136	Norovirus (Norwalk Virus)
Lonzagard® S-21F	6836-140	Norovirus (Norwalk Virus)

Lonzagard® HWS Family	EPA Reg. #	Supporting Viral Claim
Lonzagard® HWS-256	47371-129	Adenovirus type 7
Lonzagard® HWS-128	47371-130	Adenovirus type 7
Lonzagard® HWS-64	47371-131	Adenovirus type 7
Lonzagard® HWS-32	47371-192	Adenovirus type 7

Lonzagard® Bardac® 205M Family	EPA Reg. #	Supporting Viral Claim
Bardac® 205M 1.3%	6836-277	Norovirus (Norwalk Virus)
Bardac® 205M 2.6%	6836-302	Norovirus (Norwalk Virus)
Bardac® 205M 5.2%	6836-303	Norovirus (Norwalk Virus)
Bardac® 205M 7.5%	6836-070	Norovirus (Norwalk Virus)
Bardac® 205M 10%	6836-266	Norovirus (Norwalk Virus)
Bardac® 205M 14.08%	6836-278	Norovirus (Norwalk Virus)
Bardac® 205M 23%	6836-305	Norovirus (Norwalk Virus)
Bardac® 205M RTU	6836-289	Norovirus (Norwalk Virus)

Disinfecting Wipes Family	EPA Reg. #	Supporting Viral Claim
Lonzagard® Disinfectant Wipes	6836-313	Rotavirus
Lonzagard® Disinfectant Wipes Plus 2	6836-340	Norovirus (Norwalk Virus)

NUGEN® EHP Family	EPA Reg. #	Supporting Viral Claim
NUGEN® EHP RTU	6836-385	Norovirus (Norwalk Virus)
NUGEN® EHP Wipe	6836-388	Norovirus (Norwalk Virus)

Specialty Ingredients

Lonza

ANNEX 2

Bardac® 205M Family	EPA Reg. #	Coronavirus Claim
Bardac® 205M 50%	6836-233	Human Coronavirus SARS Associated Coronavirus

Disinfectant wipes Family	EPA Reg. #	Coronavirus Claim
NUGEN® 2M Disinfectant wipes	6836-372	Human Coronavirus SARS Associated Coronavirus
Lonzagard® Disinfectant Wipes Plus	6836-336	Human Coronavirus SARS Associated Coronavirus

Cleaning Schedule Week of:_____

	1st Watch	2nd Watch	3rd Watch
Monday	Area:_____ Date:_____ Areas / Time / Time / Time Restroom Showers Sinks Dayroom Inmate Name:_____ Staff Signature:_____	Area:_____ Areas / Time / Time / Time Restroom Showers Sinks Dayroom Inmate Name:_____ Staff Signature:_____	Area:_____ Areas / Time / Time / Time Restroom Showers Sinks Dayroom Inmate Name:_____ Staff Signature:_____
Tuesday	Area:_____ Date:_____ Areas / Time / Time / Time Restroom Showers Sinks Dayroom Inmate Name:_____ Staff Signature:_____	Area:_____ Areas / Time / Time / Time Restroom Showers Sinks Dayroom Inmate Name:_____ Staff Signature:_____	Area:_____ Areas / Time / Time / Time Restroom Showers Sinks Dayroom Inmate Name:_____ Staff Signature:_____
Wednesday	Area:_____ Date:_____ Areas / Time / Time / Time Restroom Showers Sinks Dayroom Inmate Name:_____ Staff Signature:_____	Area:_____ Areas / Time / Time / Time Restroom Showers Sinks Dayroom Inmate Name:_____ Staff Signature:_____	Area:_____ Areas / Time / Time / Time Restroom Showers Sinks Dayroom Inmate Name:_____ Staff Signature:_____
Thursday	Area:_____ Date:_____ Areas / Time / Time / Time Restroom Showers Sinks Dayroom Inmate Name:_____ Staff Signature:_____	Area:_____ Areas / Time / Time / Time Restroom Showers Sinks Dayroom Inmate Name:_____ Staff Signature:_____	Area:_____ Areas / Time / Time / Time Restroom Showers Sinks Dayroom Inmate Name:_____ Staff Signature:_____
Friday	Area:_____ Date:_____ Areas / Time / Time / Time Restroom Showers Sinks Dayroom Inmate Name:_____ Staff Signature:_____	Area:_____ Areas / Time / Time / Time Restroom Showers Sinks Dayroom Inmate Name:_____ Staff Signature:_____	Area:_____ Areas / Time / Time / Time Restroom Showers Sinks Dayroom Inmate Name:_____ Staff Signature:_____
Saturday	Area:_____ Date:_____ Areas / Time / Time / Time Restroom Showers Sinks Dayroom Inmate Name:_____ Staff Signature:_____	Area:_____ Areas / Time / Time / Time Restroom Showers Sinks Dayroom Inmate Name:_____ Staff Signature:_____	Area:_____ Areas / Time / Time / Time Restroom Showers Sinks Dayroom Inmate Name:_____ Staff Signature:_____
Sunday	Area:_____ Date:_____ Areas / Time / Time / Time Restroom Showers Sinks Dayroom Inmate Name:_____ Staff Signature:_____	Area:_____ Areas / Time / Time / Time Restroom Showers Sinks Dayroom Inmate Name:_____ Staff Signature:_____	Area:_____ Areas / Time / Time / Time Restroom Showers Sinks Dayroom Inmate Name:_____ Staff Signature:_____

*Please ensure there are disinfectant and paper towels near ALL telephones
*Cleaning at a minimum of every 3 hours

ATTACHMENT S

Memorandum

Date: APR 10 2020

To: Associate Directors, Division of Adult Institutions
Wardens
Chief Executive Officers

Subject: **SCREENING OF CRITICAL INMATE WORKERS**

In response to current the Coronavirus Disease 2019 (COVID-19) pandemic the California Department of Corrections (CDCR) and California Correctional Health Care Services (CCHCS) are implementing the following precautions to reduce exposure to both inmates and staff.

Screening Process
Prior to releasing a critical inmate worker, the housing unit floor officer shall ask three screening questions to determine if the inmate has symptoms of influenza-like illness (ILI) including COVID-19. The screening shall include asking an inmate the following questions: Do you have a cough? Do you have a fever? Do you have difficulty breathing? If the critical inmate worker answers no to all the questions, they shall be allowed to report to work. If the critical inmate worker answers yes to any of the questions, the housing unit floor officer shall notify their immediate supervisor, and the inmate's work supervisor that the inmate will not be reporting to work.

The custody supervisor who was notified by the housing unit floor officer shall contact the nursing staff on the affected facility of the initial screening outcome. Custody escorting staff and the affected inmate shall don appropriate personal protective equipment and the inmate shall be escorted to the triage screening area for medical evaluation. If a positive screen for ILI/COVID-19 is a result of the medical evaluation, the inmate shall be housed as appropriate based upon custody and clinical protocols. If a negative screen for ILI/COVID-19 is a result of the medical evaluation, the inmate shall be escorted back to his assigned housing unit.

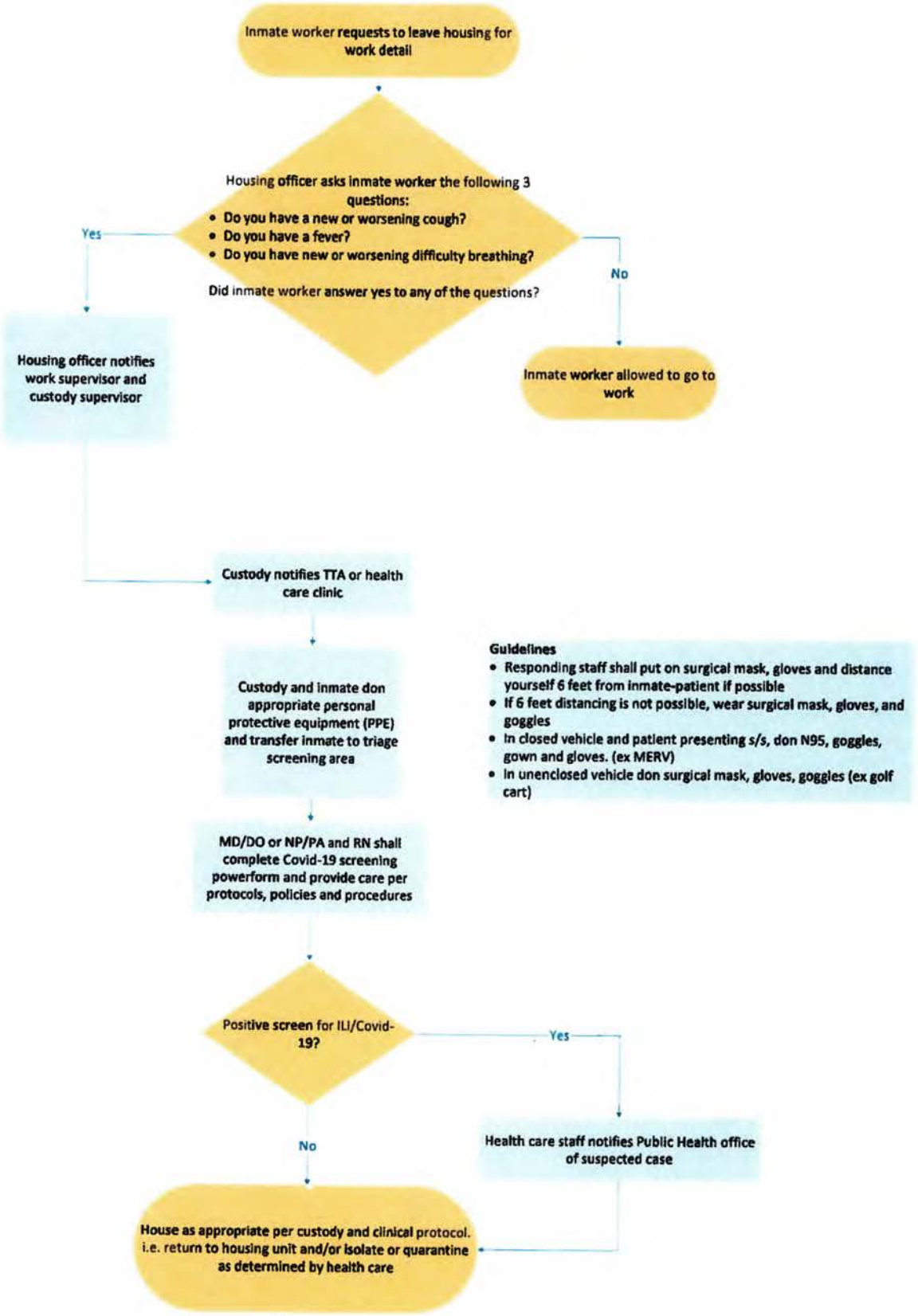
The health and safety of all individuals within the institution is our top priority. Please work together at the institution to operationalize the process provided above.

CONNIE GIPSON
Director
Division of Adult Institutions

Electronically Signed
STEVEN THARRATT, MD, MPVM, FACP
Director, Health Care Operations
Statewide Chief Medical Executive

Attachments

Covid-19: Inmate Worker



CALIFORNIA CORRECTIONAL HEALTH CARE SERVICES

Covid-19: Housing

Type of Housing Unit Location for Influenza (Flu) and Covid-19

Quarantine/ Contact Housing

Confirmed Influenza or Covid-19 exposure
Without signs and symptoms

High Risk Patients should be isolated in single cell status.
(Example: High Risk 1&2, over 65, comorbidities, pregnant)

Quarantine housing
Quarantine Period: 14 days

Develops signs and symptoms

No → Return to regular housing once quarantine completed

Yes → **Suspect Housing**

Suspect with signs and symptoms of ILI

Individually Isolated

Quarantine/ Contact without signs and symptoms

Guidelines

- If any signs and symptoms of ILI develops move that inmate-patient to suspect housing
- If housing location is in a cell setting and signs and symptoms develop for any inmate-patient: cellmate restarts quarantine time of 14 days
- If housing location is in a dorm setting and signs and symptoms develop for any inmate-patient: entire cohort restarts quarantine time 14 days.

Suspect with signs and symptoms of ILI

Guidelines

- Flu and Covid-19 diagnosed via laboratory testing
- If confirmed Covid-19, transfer to confirmed Covid-19 housing
- If confirmed flu, transfer to confirmed flu housing
- May house all sick patients in one building as long as each individual is isolated

Guidelines for Housing

Institutional leadership shall identify housing locations as follows:

Quarantine:
May be dorm setting
High risk patients (High Risk 1&2, over 65, comorbidities, pregnant) move to isolation

Suspect:
Individually celled, solid door preferred
May house all sick patients in one building as long as each individual is isolated

Confirmed:
Flu patients can cohort with other flu patients
Covid-19 patients can cohort with other Covid-19 patients

- Influenza-like illness has signs and symptoms such as chills, sore throat, fever, cough can be seen in both Covid-19 and flu. However, diagnosis will be determined by laboratory testing

Confirmed diagnosed via lab results

Flu Housing

Covid-19 Housing

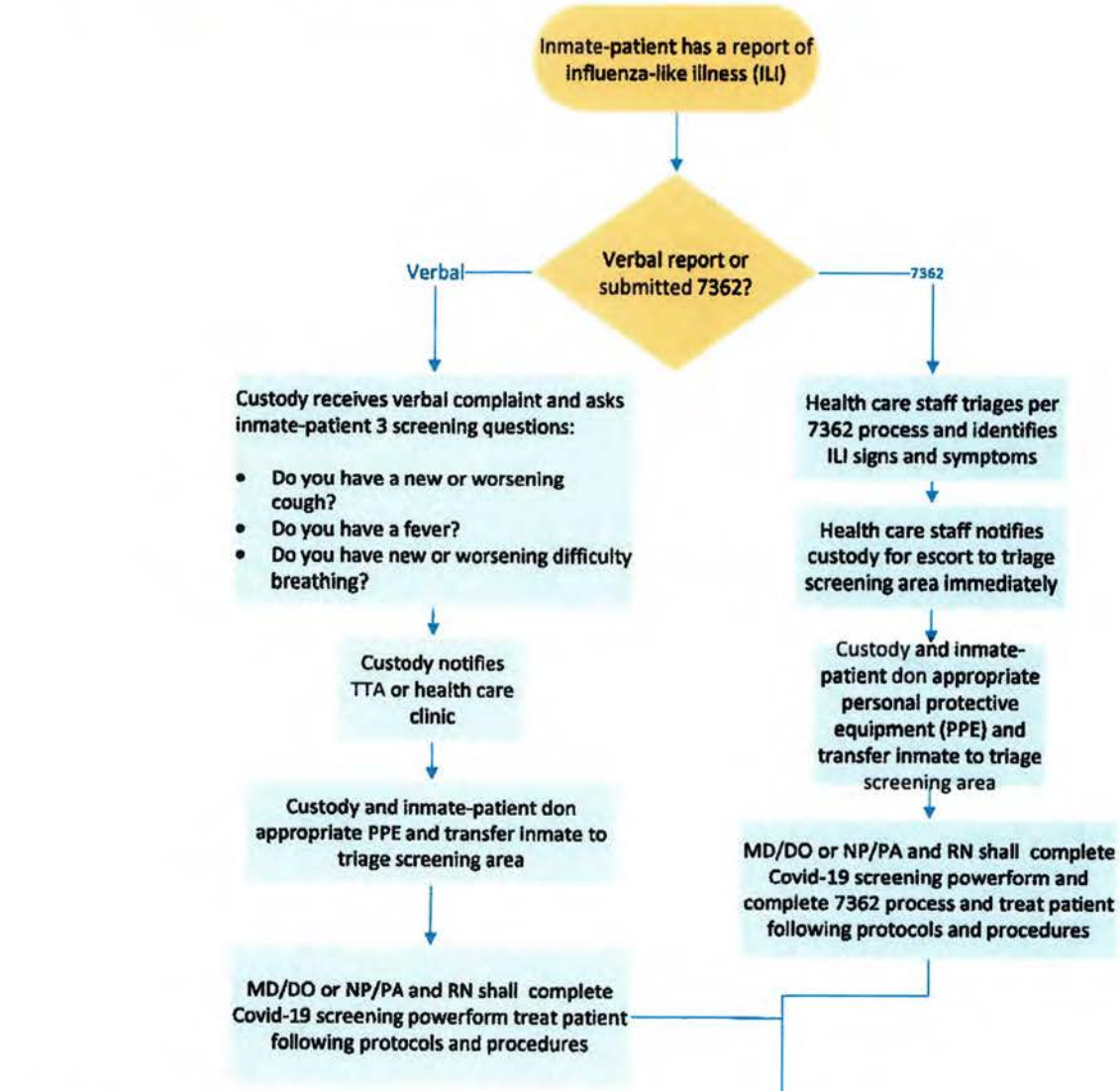
Confirmed diagnosed via lab results
Guidelines

- Single cell, can cohort with same diagnosis

Guidelines for discharge

- 7 days after onset of symptoms and 3 days without fever (100.4 degrees Fahrenheit) without use of antipyretics or resolution of symptoms, whichever is longer

Covid-19: Self-Declaration

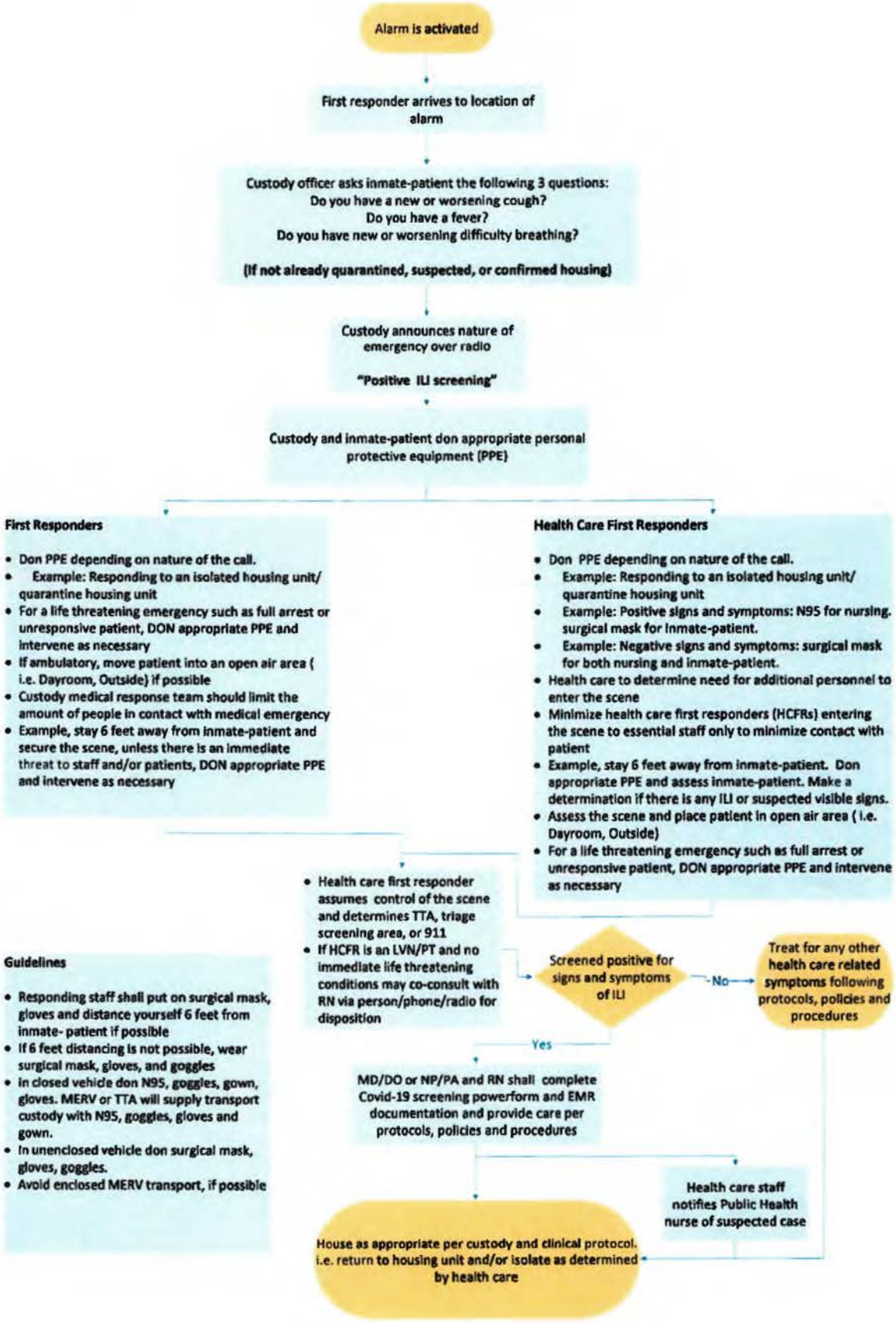


Guidelines

- Institutional leadership shall identify:
- Health care staff assigned to triage screening area, including MD/DO or PA/NP and RN
- Screen patients in designated triage screening area:
- Existing building/space (preferred choice)
- Temporary covered location (secondary choice)
- Responding staff shall put on surgical mask, gloves and distance yourself 6 feet from inmate-patient if possible
- If 6 feet distancing is not possible, wear surgical mask, gloves, and goggles
- In closed vehicle with patient presenting with s/s don N95, goggles, gown, gloves. (ex MERV)
- In unenclosed vehicle don surgical mask, gloves, goggles. (ex golf cart)
- Avoid enclosed MERV transport, if possible

CALIFORNIA CORRECTIONAL HEALTH CARE SERVICES

Covid-19: Emergency Medical Response Process



CALIFORNIA CORRECTIONAL HEALTH CARE SERVICES

ATTACHMENT T

Division of Adult Institutions Pandemic Operation Guidelines

Operational Condition Normal (OPCON) Core Functions	Category	Operation	Triggering Event
Operations	Safety Security	Normal	• Able to sustain normal operations and perform all Non-essential and Essential Functions
	Feeding	Normal	
	Medication	Normal	
	Health Care Access	Normal	
	Mental Health Care	Normal	
	Showers	Normal	
	Committee's	Normal	
Program Activities	Mail	Normal	
	Visiting	Normal	
	Education	Normal	
	Vocation	Normal	
	Religious Services	Normal	
	Self-Help	Normal	
	Yard Activity	Normal	
	Dayroom Activity	Normal	
	Volunteers/Contractors	Normal	
Privileges	Phone calls	Normal	
	Canteen	Normal	
	Packages	Normal	
	In-cell Activities	Normal	
Population/Transportation	Intra-facility Transfers	Normal	
	RC Processing	Normal	
	Out to Court	Normal	
	Medical Guarding Transportation	Normal	

Division of Adult Institutions Pandemic Operation Guidelines

Operational Condition – Alpha (OPCON) Core Functions	Category	Operation	Triggering Event:
Operations	Safety Security	Normal	• Some modifications to Program Activities Modification to Program Activities/Transportation and population to minimize exposure or to address staff limitations which may occur in any discipline (custody, non custody, health care, mental health, etc) impacting daily operation. • Custody Staffing levels between 80-89% of authorized posts filled. As workload is shed, use custody resources as overtime avoidance.
	Feeding	Normal	
	Medication	Normal	
	Health Care Access	Normal	
	Mental Health	Normal	
	Showers	Normal	
	Committee's	Normal increasing social distancing	
Program Activities	Mail	Normal	
	Visiting	May be cancelled or reduced	
	Education	May be cancelled or reduced	
	Vocation	May be cancelled or reduced	
	Religious Services	May be cancelled or reduced. May become in unit roving support	
	Self-Help	May be cancelled or reduced. May become in unit roving support	
	Yard Activity	Normal	
	Dayroom Activity	Normal	
	Volunteers/Contractors	May be cancelled or reduced	
Privileges	Phone calls	Normal	
	Canteen	Normal	
	Packages	Normal	
	In-cell Activities	Normal	
	Intra-facility Transfers	Select Transfer jurisdictions identified for closure	
Population/Transportation	RC Processing	Cluster incoming from County. Possible reduced intake or closure of intake as directed by health care.	
	Out to Court	Normal	
	Medical Guarding Transportation	Emergent/Urgent Continues some routine appointments may be cancelled.	

Division of Adult Institutions Pandemic Operation Guidelines

Operational Condition – Bravo (OPCON) Core Functions	Category	Operation	Triggering Event:
Operations	Safety Security	Normal	• Increased Modification to Program Activities/Transportation and Population to minimize exposure and/or to address isolation /quarantines and/or to address some staff limitations in any discipline (custody, non custody health care, mental health, etc) impacting daily operations. • Custody staffing level between 70-79% of authorized posts filled. As Workload is shed, use custody resources as overtime avoidance.
	Feeding	Increase Social Distancing /May cell feed.	
	Medication	Evaluate staffing availability and needs of health care. Some instances of cell front or podium distribution as directed by local health care.	
	Health Care Access	Appointments completed as directed by Health Care (Refer to Clinical Operations Plan)	
	Mental Health Care	Mental Health Groups and one on ones completed as directed by Mental Health (Refer to Mental Health Emergency Plan)	
	Showers	Normal	
	Committee's	Normal increasing social distancing	
Program Activities	Mail	Normal	
	Visiting	Cancelled	
	Education	Cancelled	
	Vocation	Cancelled	
	Religious Services	Cancelled. Provide roving support	
	Self-Help	Cancelled	
	Yard Activity	Reduce by 50%	
	Dayroom Activity	Reduced by 50%	
	Volunteers/Contractors	Cancelled	
Privileges	Phone calls	Normal	
	Canteen	Normal	
	Packages	Normal	
	In-cell Activities	Normal	
Population/Transportation	Intra-facility Transfers	Select Transfer types may be stopped	
	RC Processing	Cluster incoming from County. Possible reduced intake or closure of intake as directed by health care	
	Out to Court	Check local jurisdictions for closure	
	Medical Guarding Transportation	Emergent/Urgent Continues some routine appointments may be cancelled.	

Division of Adult Institutions Pandemic Operation Guidelines

Operational Condition – Charlie (OPCON) Core Functions	Category	Operation	Triggering Event:
Operations	Safety Security	Normal	• Significant Modifications to Program Activities/ Transportation and Population/Core Functions due to increased mitigation measures to minimize exposures and/or isolations/ quarantines and/or to address increased staff limitations in any discipline (custody, non custody, health care, mental health, etc) impacting daily operation. • Staffing level between 60-69% of authorized posts filled. • Custody resources focused on core essential operations in priority. • Use Peace Officer resources in the institution to perform essential duties such as counselors assisting with CO duties. • Use custody resources from Statewide Transportation Unit to assist with vacancies as available. • Identify additional strike team resources for custody and shift schedule changes needed to maximize resources.
	Feeding	Cell feeding only due to limited custody staff resources	
	Medication	Continue best method based on staff resource availability as directed by Health Care. May increase instances of cell front or podium distribution by local health care	
	Health Care Access	Urgent (Refer to Clinical Operations Plan)	
	Mental Health Care	Mental Health Groups and one on ones completed as directed by Mental Health (Refer to Mental Health Emergency Plan)	
	Showers	Normal	
	Committee's	Normal increasing social distancing	
Program Activities	Mail	Normal	
	Visiting	Cancelled	
	Education	Cancelled	
	Vocation	Cancelled	
	Religious Services	Cancelled. Provide roving support	
	Self-Help	Cancelled	
	Yard Activity	Reduce by 50%	
	Dayroom Activity	Reduced by 50%	
	Volunteers/ Contractors	Cancelled	
Privileges	Phone calls	Normal	
	Canteen	Normal	
	Packages	Normal	
	In-cell Activities	Consider increases to include: 1) reading material 2) activities 3) TV, Radio, Tablet Access (if possible)	
Population/Transportation	Intra-facility Transfers	Select Transfer types may be stopped	
	RC Processing	Cluster incoming from County. Possible reduced intake or closure of intake as directed by health care	
	Out to Court	Check local jurisdictions for closure	
	Medical Guarding Transportation	Emergent/Urgent Continues some routine appointments may be cancelled as directed by health care.	

Division of Adult Institutions Pandemic Operation Guidelines

Operational Condition-Delta (OPCON) Core Functions	Category	Operation	Triggering Event
Operations	Safety Security	Normal	• Extensive Modifications to Program Activities/ Transportation and Population/Core Functions due to mitigation efforts to minimize exposure and/or increased isolation/quarantine and/or increased staff limitations in any discipline (custody, non custody, health care, mental health, etc) impacting daily operation. • Extensive custody vacancies resulting in minimal custody staffing levels. Staffing level between 59-50% or below of authorized post filled. • Custody resources focused only on the most critical functions in priority order. • Possible shift modifications to maximize resources available. • All available Peace Officers performing core most critical essential duties (Counselors, Management, etc.). • All available non-custody perform any identified essential functions as appropriate such as feeding, delivering mail, etc. • Use strike team resources identified to include neighboring institutions, other identified institution staff, Statewide
	Feeding	Cell feeding only due to limited custody staff resources	
	Medication	Best method of efficiency as determined by health care (may include cell front or podium pass)	
	Health Care Access	Only Urgent/Emergent as determined by health care (Refer to Clinical Operations Plan)	
	Mental Health Care	Cancelled groups/one on ones due to lack of custody staff. MH cell front only unless urgent/emergent (Refer to Mental Health Emergency Plan)	
	Showers	In the event of extreme staff shortages, may be reduced/cancelled only for the duration required due to extreme custody staff shortages	
	Committee's	Cancelled except for extreme urgency	
Program Activities	Mail	May be delayed due to staff shortages	
	Visiting	Cancelled	
	Education	Cancelled	
	Vocation	Cancelled	
	Religious Services	Cancelled	
	Self-Help	Cancelled	
	Yard Activity	Cancelled	
	Dayroom Activity	Cancelled	
	Volunteers/ Contractors	Cancelled	
Privileges	Phone calls	May be reduced/cancelled due to staff shortages	
	Canteen	Only essential items and delivery may be delayed due to staff or inventory shortages. May be cancelled in extreme circumstances.	
	Packages	May be reduced based on availability of staff to process	
	In-cell Activities	Provide increased 1) reading material 2) activities 3) TV, Radio, Tablet Access (if possible)	

	Packages	May be reduced based on staff to process	Transportation, HQ staff, Parole as available for essential core functions
Population/Transportation	Intra-facility Transfers	Increased number of Select Transfer Types Stopped	
	RC Processing	If intake continues, cluster county intake. Increased reductions of intake. Possible complete intake closure.	
	Out to Court	Check local jurisdiction for closures. Continue only as per court orders	
	Medical Guarding Transportation	Emergent/Urgent. Only critical appointments as directed by medical due to severe custody staff shortages.	

Key Components to DAI Pandemic Operation Guidelines:

- Applicability and effectiveness of the individual Mitigation Controls may vary from site to site.
- As part of the ongoing assessment of OPCON levels, the CDCR determines whether a certain Mitigation Control is applied locally, regionally, or statewide.
- Any CDCR communication regarding OPCON levels will include indication of the applicable sites and notification of the applicable departmental personnel and stakeholders.
- The higher the OPCON level, the greater the hardship and strain on CDCR staff and offenders. It is therefore the goal of CDCR to remain in an elevated OPCON level for only the duration required. If it is no longer necessary to remain in an increased OPCON level, the review process for return to the next lower level will be initiated.
- Institutional Executive team will triage and prioritize essential programs. All decisions regarding elevating and lowering OPCON levels will be made by the institutional Warden (assisted by the recommendation of the executive leadership).
- Individual sites may operate in different OPCON levels at the same time.
- Reference the Clinical Operations Plan for details related to health care pandemic operations.
- Reference the Mental Health Emergency Plan for details related to mental health pandemic operations.

ATTACHMENT U

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 a primary clinician and a psychiatrist.

- 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 Troche, 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*

ATTACHMENT V

CALIFORNIA CORRECTIONAL HEALTH CARE SERVICES

MEMORANDUM

Date:	April 5, 2020
To:	Chief Executive Officers Chief Psychiatrists Chiefs of Mental Health Senior Psychiatrist, Supervisors
From:	Joseph Bick, MD (signature on file) Director (A), Division of Health Care Services
Subject:	**COVID-19 SCREENING PRIOR TO MENTAL HEALTH TRANSFERS**

Referrals to Mental Health Inpatient care shall continue when a patient requires such placement to prevent serious harm to self or others or to address serious mental health decompensation. Transfers must take place in a manner that minimizes the risk for transmission of COVID-19. Therefore, all Mental Health patients shall be screened for COVID-19 within 12 hours of transfer from one facility to another.

Screening shall be performed by a medical or psychiatric physician in consultation with the institution public health or infection control nurse prior to the patient leaving a facility. The clearance shall be clearly documented in a transfer note in the chart. Prior to patient transfer, the content of the note shall also be verbally communicated from the sending psychiatrist or other medical physician to the Chief or Senior psychiatrist at the receiving institution.

The following information shall be included in the transfer note:

1. Title Note: Medical screening transfer note
2. Referring Institution
3. Receiving Institution
4. Does the patient have a new or worsening cough? [Y/N]
5. Does the patient have a fever (>100 F)? [Y/N]
6. Is the patient experiencing new or worsening shortness of breath? [Y/N]
7. Is the patient currently on isolation? [Y/N]
8. Is the patient currently on quarantine? [Y/N]
9. Is the patient known to be a contact of a confirmed COVID -19 case? [Y/N]
10. Include the patient's vitals for the last 14 days as available
11. Rationale for recommending transfer.

cc: Diana Toche, DDS, Undersecretary of Healthcare
Steve Tharratt, MD, Director Healthcare Operations
Connie Gibson, Director, Division of Adult Institutions
Eureka C. Daye, Deputy Director (A), Statewide Mental Health
Renee Kanan, MD, MPH, Chief Quality Officer, Deputy Director of Medical Services
Barbara Barney-Knox, Deputy Director of Nursing (A), Statewide Chief Nurse Executive
Jay Powell, Associate Warden, HCPOP
Regional Health Care Executives
Regional Chief Nurse Executives
Regional Deputy Medical Executives
Deputy Directors

ATTACHMENT W

CALIFORNIA CORRECTIONAL
HEALTH CARE SERVICES

MEMORANDUM

Date: April 10, 2020

To: Associate Directors, Division of Adult Institutions
Wardens
Chief Executive Officers
Chiefs of Mental Health
Chief/Senior Psychiatrists
Chief Medical Executives
Chief Nurse Executives
Psychiatric Inpatient Program Executive Directors

From:

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

CONNIE GIPSON
Director
Division of Adult Institutions

BARBARA BARNEY-KNOX
Deputy Director (A), Nursing
California Correctional Health Care Services

Subject: **COVID EMERGENCY MENTAL HEALTH TREATMENT GUIDANCE AND COVID TEMPORARY TRANSFER GUIDELINES AND WORKFLOW**

This memorandum announces the release of the COVID Emergency Mental Health Treatment Guidance and COVID Temporary Transfer Guidelines and Workflow (attached). These documents provide guidance to the field regarding temporary treatment-in-place and the activation of temporary housing for patients referred to an inpatient level of care but may not be able to transfer to another institution due to restrictions on transportation related to COVID-19.

When a patient requires emergency inpatient care to prevent serious harm to self or others or to address serious mental health decompensation, referrals to mental health inpatient level of care shall continue per the COVID Temporary Transfer Guidelines and Workflow, and following procedures detailed in the previously released COVID-19 Screening Prior to Mental Health Transfers.

A Temporary Mental Health Unit (TMHU) is a consolidation of high acuity patients in adjacent cells where treatment can be provided to a group of individuals who require similar inpatient

MEMORANDUM

treatment. Institutions shall identify clusters of cells for a TMHU per the COVID Emergency Mental Health Treatment Guidance. Local custody and healthcare leadership shall work together to identify the TMHU locations.

The determination for the TMHU location shall be based upon space availability and the following considerations:

1. **Suicide Resistant**
2. **Line of sight from the officers' station**
3. **Contiguous grouping of cells**
4. **Proximity to treatment space**
5. **Available space in the unit for out-of-cell activities**
6. **Functional loud-speaker system**
7. **Reasonable access to an exercise yard**

To ensure staff awareness of this guidance, Wardens and Chief Executive Officers (CEOs) shall ensure training on this memorandum is completed and submit a proof of practice memorandum identifying the housing location of each TMHU. Wardens shall ensure all chief deputy wardens, associate wardens, captains, and lieutenants receive On-the-Job training and submit a proof of practice memorandum to their respective mission's Associate Director. CEOs shall ensure applicable healthcare staff receive On-the-Job training and submit a proof of practice memorandum to the respective Regional Mental Health Administrators. Proof of practice memorandums shall be submitted within 30 days from the date of this memorandum.

If you have questions or require additional information related to this memorandum, you may contact the Mental Health Policy Unit by email: CDCR MHPolicyUnit@cdcr.

Attachment

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CDCR COVID Temporary Transfer Guidelines & Workflow

In an attempt to limit the transmission of COVID-19, all non-emergency movement shall be immediately curtailed. When a patient requires emergency inpatient care to prevent serious harm to self or others or to address serious mental health decompensation, referrals to Mental Health Inpatient care shall continue, including place-in orders to Intermediate Care Program (ICF), Acute Psychiatric Program (APP), or Mental Health Crisis Bed (MHCB). The best option is to place the patient in an available bed in an ICF, APP, or MHCB within the same institution. The next best option is for the patient to be housed and treated in the same institution within a Temporary Mental Health Unit, as described in a separate document regarding treatment to be rendered in these units, titled COVID Emergency Mental Health Treatment Guidance. The third option is for Enhanced Level of Care Treatment modalities in cells designated for this, which may include the patient's own cell, as described in a separate document regarding treatment to be rendered in these units, titled COVID Emergency Mental Health Treatment Guidance. The fourth option, when patients are not psychiatrically safe in their current environment and for whom none of the prior options are available or protective, is to transfer the patient to another institution that has safer options, while also balancing the substantial risks of COVID in this pandemic. All transfer requests to other facilities will be reviewed as described below, and HCPOP will not act on the place-in order without approval from the Regional Mental Health Administrator or the IRU.

Inpatient Referrals to a Different Facility:

I. Institution Review: Transfer out of the patient's current facility shall not proceed unless meeting the criteria below, as assessed by the treatment team:
   1. an imminent, life-threatening emergency necessitates transfer, or
   2. serious mental health decompensation necessitates transfer, and
   3. the life-threatening condition or serious decompensation cannot be reasonably treated at the institution.

II. When a transfer is not clinically necessary, alternate strategies for managing the patient within the institution must be implemented. A medical hold shall be placed by the primary care physician or psychiatric physician to prevent movement.

III. If transfer to an MHCB is pursued, Regional Review is required: If the referral meets the criteria above, the primary clinician shall email and call the Regional Mental Health Administrator or designee. They shall include an explanation of why the criteria above have been met. The Regional Mental Health Administrator must then consult with the Regional Deputy Medical Executive. HCPOP will not transfer patients to a new facility without receiving approval from the Mental Health Administrator.

IV. If transfer to an ICF or APP program is pursued, IRU Review is required: When a local treatment team requests an inpatient transfer to another facility at an Acute or Intermediate level of care, the request, describing the criteria in Section I above that have been met, shall be sent by email to the IRU inbox at CDCR DHCS DSH Referral Updates@CDCR (m_cdcrdchcsdmhreferupdate@cdcr.ca.gov).
   1. IRU shall hold referrals not meeting the above criteria as incomplete, and shall not move these referrals forward for endorsement by HCPOP.

2. When the IRU approves an inpatient transfer to another facility, the approval shall be communicated by the IRU to HCPOP.

V. For transfer to ICF, APP, or MHCB: The treatment team and reviewers shall also consider if the patient currently has symptoms consistent with COVID-19, has possible exposure to a COVID-19 case and is therefore in quarantine, is symptomatic in isolation (suspect case), or is a confirmed case in isolation. There must be medical clearance by a local medical physician or psychiatric physician in consultation with the institution public health or infection control nurse prior to the patient leaving a facility.
   1. The clearance shall be clearly documented by the primary care physician or psychiatrist in a transfer note, to be included in the chart, addressing the factors included in Attachment A.
   2. The content of the note should also be orally communicated from the sending psychiatrist or other medical physician to the Chief or Senior psychiatrist at the receiving institution so appropriate measures can be taken prior to patient arrival.

VI. Acceptance Procedure: Prior to acceptance of an inter-facility patient transfer into an ICF, APP, or MHCB, a psychiatrist shall review all inpatient referrals including the medical transfer note information and the risk factors noted above.
   1. If there are substantial concerns regarding the patient's medical risk, or risk to other patients and staff at the facility given the referring information, a discussion must occur with the referring clinician and psychiatrist, to weigh the risks and determine a final outcome. If there is a disagreement between the referring and accepting institutions, Mental Health leadership at headquarters will assist in resolving the issue.
      a. Any decision not to accept MHCB referrals shall be immediately communicated to HCPOP.
      b. Any decision not to accept ICF or APP referrals made by the medical director due to infection control concerns shall be entered in the "MH Acute/ICF Disposition" order by selecting "More information needed" and notifying the IRU of the need for the patient to remain at the referring institution due to COVID-19 concerns.

VII. Transfer Procedure: Prior to transfer, emergency medical services, custody transportation, and the receiving facility should all be informed of any precautions to be taken as per CDCR CCHCS HC DOM 3.1.9 Health Care Transfer. A facemask shall be maintained on the patient throughout transfer. If a patient refuses to wear a facemask, the patient shall be placed in an area of the van that relatively isolates the patient and officers should wear protective equipment when transporting the patient to and from the van in accordance with CDCR's Covid-19 Staff PPE Guide: https://www.cdcr.ca.gov/covid19/wp-content/uploads/sites/197/2020/03/PPE-GUIDE-POSTER4.pdf
Consideration may also be given to having the patient wear a spit mask for the escort to and from the van.
   1. If a patient is already on isolation or quarantine, the isolation or quarantine should be maintained and completed at the new facility.

VIII. HCPOP and the IRU will track all inpatient referrals and any exceptions to transfer timelines.

If an inpatient bed becomes available, the institutional staff may determine which patient should be placed into that bed based upon clinical acuity, place that patient in the bed, and notify HCPOP and/or IRU via email as follows:

1. MHCB Placements: email MHCB.HCPOP@cdcr.ca.gov indicating the patient's name, CDCR number, bed number the patient is or will be placed into, and the date and time of placement.
2. ICF and ACUTE Placements: email cdcrdmhreferralupdate@cdcr.ca.gov and ripaupdates@hcpop.ca.gov indicating the patient's name, CDCR number, bed number the patient is or will be placed into, and the date and time of placement.

Discharges

ICF, APP, and MHCB discharges are to stay at their current facility whenever possible. If a patient must transfer to a different facility due to irreconcilable custodial issues (e.g. enemy concerns, staff separation alerts), clinical staff will complete COVID-19 clinical screening and document this screening utilizing the guidelines in Attachment A. Clinical staff will inform the Classification and Parole Representative if any personal protective equipment is needed during transfer and will inform the receiving Chief or Senior Psychiatrist regarding the patient's transfer and any treatment needs including those related to COVID 19 risks.

Attachment A

Medical Transfer Note

The following information shall be included in the transfer note in EHRS, and orally communicated to the receiving institution's Chief or Senior psychiatrist; if they are unavailable, it should be communicated to the Chief of Mental Health:

1. Title Note: Medical transfer note
2. Referring Institution
3. Receiving Institution
4. Does the patient have a new or worsening cough? [Y/N]
5. Does the patient have a fever (>100 F)? [Y/N]
6. Is the patient experiencing new or worsening shortness of breath? [Y/N]
7. Is the patient currently on isolation? [Y/N]
8. Is the patient currently on quarantine? [Y/N]
9. Is the patient known to be a contact of a confirmed COVID-19 case? [Y/N]
10. Include the patient's vitals for the last 14 days as available
11. Rationale for recommending transfer.

ATTACHMENT X

COVID Emergency Mental Health Treatment Guidance

Introduction

The purpose of this document is to provide guidance to the field regarding management of patients requiring inpatient treatment.

For all patients requiring inpatient mental health treatment (PIP or MHCB), the first choice for admission will be determined by HCPOP and located within an ICF, APP, or MHCB, as available at the same institution. However, it is recognized that not all facilities have these levels of care, or local units may be at full capacity. As such, institutions must endeavor to develop treatment commensurate with the patient's needed level of care.

Institutions shall follow the MHCB referral policy and patients shall be placed in alternative housing for no longer than 24 hours or until HCPOP assigns a bed at the local MHCB (whichever occurs first) and if one is not available, the patient will be placed in a temporary mental health unit (TMHU), if available.

Definitions

2:1 Suicide Watch: This type of suicide watch allows for one staff member to conduct suicide watch duties for two patients simultaneously. Clear, direct, and full visibility into both cells must be made by the observer at the same time.

Collaborative Team Treatment: Where there are severe shortages of PPE and/or tele-presenters, every available member of the treatment team could separately call into a single laptop (or other device) and a single tele-presenter could host 10 to 15 minute joint sessions with each patient at the open cell door. If the patient can be safely be brought to a confidential space or room, this is preferable, but not required in the collaborative team treatment model.

Enhanced Level of Care Treatment: When a patient is referred to an inpatient level of care and is unable to transfer to an inpatient bed, the inmate will receive an enhanced level of care treatment which is summarized later in this document. In this instance, the maximum possible out-of-cell time and other resources should be made available for patients.

Inpatient Treatment: Mental Health Crisis Bed (MHCB), Acute Psychiatric Program (APP), and Intermediate Care Facility (ICF) levels of care.

Temporary Mental Health Unit (TMHU): A Temporary Mental Health Unit (TMHU) is a consolidation of high acuity patients in adjacent cells where treatment can be provided to a group of individuals who require inpatient treatment. The treatment is an enhanced level of treatment which is summarized later in this document. Institutions shall identify a location where there are preferably 10-15 contiguous available cells that can be utilized for mental health treatment. The treatment offered should be as close as possible to treatment offered in an unlicensed mental health crisis bed units (MHCBUs). This is not alternative housing.

Treat in Place: An appropriate cell where enhanced level of care treatment can be provided.

Overview

Current Level of Care/Housing	Level of Care Referral	Placement Preference
GP, CCCMS, EOP	MHCB	1st Local MHCB 2nd Temporary Mental Health Unit 3rd Treat in Place 4th Transfer to an external MHCB
MHCB	APP	1st Transfer to local PIP 2nd Treat-in-place within MHCB 3rd Transfer to an external PIP
GP, CCCMS	ICF	1st Transfer to local PIP 2nd Temporary Mental Health Unit 3rd Treat in place 4th Transfer to an external PIP
MHCB	ICF	1st Transfer to local PIP 2nd Treat-in-place within MHCB or EOP 3rd Transfer to an external PIP
EOP	ICF	Treat in place or TMHU or EOP. This is determined based upon clinical judgment

The Temporary Mental Health Unit (TMHU) should be considered when an institution is able to designate a cluster of cells for patients in outpatient settings who require similar inpatient mental health treatment.

Enhanced level of care treatment should be considered when various levels of inpatient care are needed. This enhanced level of care can occur if, for example, a patient is in a crisis bed or a TMHU, but the patient requires a higher level of care, like acute inpatient care (APP). Enhanced level of care treatment should also occur for patients requiring inpatient care, for example MHCB level of care, but who are in various locations throughout an institution, for example if an institution is unable to establish a TMHU due to physical plant, staffing, or COVID-exposure concerns, or if all TMHU beds are filled. Additionally, enhanced level of care treatment-in-place should be considered for patients who have been referred to inpatient treatment but are not in acute distress requiring immediate inpatient treatment. An institution can have both a TMHU and additionally offer enhanced level of care treatment-in-place for patients who may need inpatient care, but be physically located throughout the institution.

For patients who are confirmed positive for COVID-19 or in quarantine for a suspected positive, the preference would be to treat-in-place to limit movement and exposure unless they meet criteria for transfer (see I in CDCR COVID Temporary Transfer Guidelines & Workflow document).

Temporary Mental Health Unit

A Temporary Mental Health Unit (TMHU) is a consolidation of high acuity patients in adjacent cells where treatment can be provided to a group of individuals who require similar inpatient treatment.

Institutions shall identify a location where there are preferably 10-15 available cells that can function as an unlicensed MHCBU-like setting. This is not alternative housing. These units shall:

- Allow for potential 1:1 and 2:1 suicide watch
- Enable ease of tracking patients for the mental health clinicians, custodial personnel, and nurses.
- Whenever possible, make it easier to perform milieu-based therapeutic alternatives such as groups (including educational groups specific to COVID-19), based upon CDCR COVID-19 guidelines.
- Enable staff to coordinate activities for patients.

Location of Temporary Mental Health Unit

Institutions shall identify clusters of cells for the TMHU based upon space availability and taking into account Local Operating Procedure for Alternative Housing. Priority considerations for location:

1. Restricted housing, such as LTRHU, STRHU, GP ASU, EOP Hub, PSU, or SHU, will be managed on a case-by-case basis, with further guidance to come.
2. Suicide Resistant housing units (ligature points, friable items for ingestion, etc.)
3. Line of sight from the officers' station
4. Contiguous grouping of cells
5. Proximity to treatment space
6. Available space in the unit for out-of-cell activities
7. Functional loud-speaker system
8. Reasonable access to an exercise yard

All TMHU cells will be visually marked within the unit so staff are aware of their location.

Multiple TMHUs can be established to accommodate custody level and potential enemy concerns.

Staffing

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.

Interdisciplinary Treatment Teams

The initial IDTT shall occur within 72 hours of patient's placement in the TMHU. Routine IDTTs shall occur every 7 days until the patient can be safely transferred to an inpatient environment. During IDTT, all available team members shall review the patient's treatment needs, progress and goals. Additionally, the treatment team members shall discuss the provision of issue and property from a clinical perspective and assess the presence or absence of serious clinical deterioration. IDTTs may occur via teleconference.

Where staffing allows, the required IDTT members identified in the MHSDS Program Guide, Mental Health Crisis Bed shall be present.

Issuance of Property and Privileges

Property and privileges should be provided in the Mental Health Patient Issue order for each patient. Additionally, these should be reviewed during the initial IDTT. The provision of property and privileges must be considered and communicated to all members of the treatment team. Considerations shall be for:

- Clothing
- Writing implements
- Paper
- Books
- Phone calls
- Yard time
- Mental Health Observation
- Access to the library cart
- In-cell activities, games, puzzles, tablets, physical and other activities with the recreational therapist.
- Dayroom
- Group therapy

Clinical teams shall refer to the memo titled, "Mental Health Crisis Bed Privileges Revision" dated February 14, 2017 when determining issuance of property for patients in the TMHU. All orders for level of observation, issuance and property shall be standing orders and updated as clinically indicated.

Specific Treatment Considerations

The delivery of care to patients in the TMHU will be evaluated daily. The delivery of care will be adjusted based on the total percentage of staff available for patient care and direct activities.

Required Elements of Treatment Options in the TMHU

- All patients placed in the TMHU due to acute suicidality will be on 1:1 suicide watch until the treatment team can assess and determine the appropriate level of observation based upon clinical need and the patient's presentation. If the patient was admitted to the temporary mental health treatment unit for suicidality, the individual sessions should include safety planning development and enhancements to assist the patient in identifying and utilizing modifiable behaviors for ongoing safety from self-harm (see memorandum, "Updated Mental Health Crisis Bed – Referral, Referral Rescission, and Discharge Policy and Procedures" dated October 18, 2018).
    - For patients on 1:1 suicide watch, the psychiatrist will make contact with a designated nursing staff, preferably before and after the clinical contact with the patient, to review pertinent information noted during the suicide watch.
    - Suicide precautions (15-minute checks) are not authorized unless the cell has previously been found to be suicide-resistant.
- Interdisciplinary huddles shall be utilized to disseminate clinical information about patients housed in the TMHU.
    - If in-person huddles cannot be accomplished safely, while adhering to social distancing, huddles shall occur telephonically.

- Individual treatment out-of-cell shall occur daily and will be conducted by either the primary clinician or the psychiatrist, whenever possible. Supplemental treatment options provided in-cell should be reviewed during individual sessions and the clinician should provide feedback on the work the patient has completed with the in-cell activities.
- Rounding
    - Rounding shall occur twice per day, when possible, but no less frequently than at least once per day by a clinical social worker, psychologist, or psychiatrist. At least once per day, results from the rounding must be communicated to the psychiatrist covering the temporary mental health treatment unit if the psychiatrist did not perform the rounding.
- All patients in the TMHU shall have at least equal access to existing resources, out-of-cell time and privileges that other inmates and patients have in the housing unit where the TMHU is located:
    - Yard
    - Showers
    - Phone Calls
- The patient can be afforded other resources, unless clinically contraindicated by the IDTT, such as:
    - JPAY tablets
    - Radios
    - Electronic Appliance Loaner Program
    - Reading materials
    - See section entitled "Supplemental Treatment Options"
- Recreational Therapy
    - Increased Recreational Therapy, developed through collaboration with all members of the treatment team to determine the most effective activities for the patient, given his or her unique treatment teams.
    - If the patient cannot receive recreational therapy outside of his or her cell, due to COVID exposure risk, recreational therapy shall be focused on activities that the patient can engage in while in his or her cell. Examples are mindfulness activities, yoga, guided imagery, meditation, music therapy, community milieu activities, and physical activities to improve both physical and mental health wellbeing.
- Individual treatment
    - Confidential individual treatment by a member of the treatment team shall occur each day, where safe to do so.
    - Primary clinicians shall focus their efforts during individual treatment not just on the primary mental health treatment goals for the patient, but also how to adjust to being in close quarters for extended periods of time due to the COVID crisis.
    - Supplemental treatment options provided in-cell should be reviewed during individual sessions and the clinician should provide feedback on the work the patient has completed with the in-cell activities.

<u>Supplemental Treatment Options in the TMHU</u>

In addition to the required elements of TMHU treatment, other optional treatment modalities can be considered.

- If/when necessary consider utilizing Collaborative Team Treatment, as described below:

- Where necessary due to staffing, a tele-presenter with portable equipment such as a laptop with a camera, microphone, and speakers could connect to the same WebEx meeting with any available members of the treatment team attending by video conference. The team members would be able to participate on their own personal computers. The tele-presenter would then carry the laptop to the patient's cell front, where the entire treatment team would be able to engage in a collaborative session. It is preferable for cell doors to be open when conducting this cell side treatment modality.
- This is a strategy to minimize the amount of ingress and egress required within the entire institution, particularly for quarantined areas. This achieves the of goal minimizing the amount of potential staff and patient exposure, while maintaining an ability for the entire team to gather accurate information about the status of the patient, discuss patient care together, and develop & coordinate plans together.
- If PPE or tele-presenters are not available in sufficient quantities, the tele-presenter could then be the only member of the treatment team required to don and doff scarce protective equipment.
- Tele-presenter selection. The current working emergency COVID plan notes “staff that could be used as tele-presenters is decided by each institution to include:
  - Medical Assistant
  - Any staff unable to perform their assigned duties during the crisis (with training), e.g.
  - Dental
  - Staff on administrative time off
  - Support staff
  - Any healthy state personnel
  - Any Mental Health provider (Group leader, RT, SW, LCSW, PhD/ PsyD)
  - LVN, RN, CNA, Psych Techs
  - Any medical provider (PA, NP, MD)"
  - During the COVID crisis, any of the above staff may serve as tele-presenters in a priority to be determined by the CEO in consultation with the Chief Psychiatrist, Director of Mental Health, Supervising Dentist, Chief Nurse Executive, and other leadership as necessary, based on local availability and necessary duties. Volunteers could be selected first, and if re-direction to tele-presenter duty continues to be necessary, they could be assigned based on inverse seniority. To reinforce, these decisions are at the discretion of the CEO, in consultation with the Chief Psychiatrist and other leadership.

- Group therapy and structured out-of-cell time
  - Group therapy shall occur in small groups (3-4 people) where space allows them to remain at least 6 feet apart and the area can be sanitized between each group member.
  - For individuals on suicide watch, consider having the staff member monitor patient while in group, when feasible and safe.
  - If no groups can be run, then PM yard should be considered.
  - Dayroom
  - All out of cell activity offered within the TMHU will be documented on the 114-A

<u>Discharge Criteria</u>

If a patient no longer requires inpatient mental health treatment, the discharge IDTT shall rescind the referral to the higher level of care. Upon discharge, the primary clinician shall complete a full discharge SRASHE with Safety Planning Intervention. Additionally, orders for five-day follow ups and custody discharge checks shall be made.

Higher Level of Care Triage

When a local inpatient bed becomes available, the treatment team will triage all patients in the TMHU, or in other locations who are waiting for an inpatient bed, and determine which patient is most acutely mentally ill and that individual will be assigned to the available MHCB.

Enhanced Level of Care Treatment

When a patient is referred to an inpatient level of care and is unable to transfer to an inpatient bed, a TMHU, or is already in an inpatient setting, treatment will be provided in the patient's housing unit until transfer can occur. In this instance, the maximum possible out-of-cell time and other resources should be made available for patients.

Patients receiving enhanced treatment-in-place for acute suicidality shall be placed on 1:1 suicide watch.

- For patients on 1:1 suicide watch, the psychiatrist will make contact with a designated nursing staff, preferably before and after the clinical contact with the patient, to review pertinent information noted during the suicide watch.
- Suicide precautions (15-minute checks) are not authorized unless the cell has previously been found to be suicide-resistant.

StaffingClinical 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.

Enhanced Level of Care Treatment Modalities

When possible, all treatment shall be conducted in a confidential space. This includes both individual and group treatment.

- Individual treatment out-of-cell shall occur daily and will be conducted by either the primary clinician or the psychiatrist, whenever possible. Supplemental treatment options provided in-cell should be reviewed during individual sessions and the clinician should provide feedback on the work the patient has completed with the in-cell activities.
- Rounding
    - Rounding shall occur twice per day, when possible, but no less frequently than at least once per day by a clinical social worker, psychologist, or psychiatrist. At least once per day, results from the rounding must be communicated to the psychiatrist covering the temporary mental health treatment unit if the psychiatrist did not perform the rounding.

- All patients in the TMHU shall have at least equal access to existing resources, out-of-cell time and privileges that other inmates and patients have in the housing unit where the TMHU is located:
    - Yard
    - Showers
    - Phone Calls
- The patient can be afforded other resources, unless clinically contraindicated by the IDDT, such as:
    - JPAY tablets
    - Radios
    - Electronic Appliance Loaner Program
    - Reading materials
    - See section entitled "Supplemental Treatment Options"
- Recreational Therapy
    - Increased Recreational Therapy, developed through collaboration with all members of the treatment team to determine the most effective activities for the patient, given his or her unique treatment teams.
    - If the patient cannot receive recreational therapy outside of his or her cell, due to COVID exposure risk, recreational therapy shall be focused on activities that the patient can engage in while in his or her cell. Examples are mindfulness activities, yoga, guided imagery, meditation, music therapy, community milieu activities, and physical activities to improve both physical and mental health wellbeing.
- Individual treatment
    - Confidential individual treatment by a member of the treatment team shall occur each day, where safe to do so.
    - Primary clinicians shall focus their efforts during individual treatment not just on the primary mental health treatment goals for the patient, but also how to adjust to being in close quarters for extended periods of time due to the COVID crisis.
    - Supplemental treatment options provided in-cell should be reviewed during individual sessions and the clinician should provide feedback on the work the patient has completed with the in-cell activities.
- Group therapy
    - Group therapy shall occur in small groups (3-4 people) where space allows them to remain at least 6 feet apart and the area can be sanitized between each group member.
    - For individuals on suicide watch, consider having the staff member monitor patient while in group, when feasible and safe.
    - If no groups can be run, then PM yard should be considered.
    - Cell front CNA nursing activities
        - Based upon the patient's acuity and clinical determination, the CNA conducting suicide watch can engage the patient utilizing CNA activities.
- When possible, interdisciplinary huddles should be utilized to disseminate clinical information about patients receiving Enhanced Level of Care Treatment.

<u>Resources for Supplemental In-Cell Treatment</u>

- Primary clinicians to utilize clinical resources to allow patients to complete therapeutic work, determined by their treatment goals listed in the master treatment plan.
- Recreational Therapists will offer patients access to in-cell activities.
  - Institutions should use any stock of ASU Workbooks for outpatient settings, as these workbooks provide many activities for individuals while in-cell.
  - Recreational Therapy resources have been provided to all institutions that cover gratitude journals, mindfulness meditation and yoga, and stress management through art.
- Mindfulness and guided meditation videos have been created by the Mental Health Training Unit for distribution to institutional televisions to be played for all patients to engage in while in-cell.
- Resources have been sent to all Chiefs of Mental Health for in-cell therapeutic work. It is expected that the clinical teams will review these resources and provide clinically relevant activities to patients.
- Meta-sourced free self-help guides
  - https://mindremakeproject.org/2018/11/12/free-printable-pdf-workbooks-manuals-and-self-help-guides/
  - http://www.evworthington-forgiveness.com/diy-workbooks
- Anger Management
  - Evidence-based curriculum using CBT and DBT skills to address behavior change
- Start Now - Forensic Version
  - CBT/DBT based curriculum that covers a broad set of topics that will be useful for all patients.
- Depression/Anxiety/Mood disorders
  - Evidence-based curriculum is being provided to all institutions.

Monitoring

The Regional Mental Health Administrators (RMHA) will monitor all TMHUs and treatment-in-place locations established in their respective region each day. The goal of this daily oversight is to ensure the various components of the TMHU and enhanced treatment-in-place are occurring and are appropriate for the patients.

ATTACHMENT Y

COVID Emergency Mental Health Treatment Guidance For MAX Custody Patients

When a MAX custody patient is referred to an inpatient bed, the patient shall be placed in an available inpatient bed within the institution by HCPOP whenever possible. If no inpatient bed is available, the patient shall be placed under observation as clinically appropriate until the following occurs within 24 hours:

1. The Warden or designee will review the case and determine if a specialized ICC is necessary to consider suspension of MAX custody status.
2. If a specialized ICC is warranted, it will be held with mental health participation as usual to assess the patient's reason for MAX custody designation and to determine if the MAX custody can be suspended to allow housing and mental health treatment as per the COVID-19 Temporary Emergency Transfer Guidelines document.
3. If the specialized ICC suspends the MAX custody designation, then treatment and transfer will follow the COVID-19 Temporary Emergency Transfer Guidelines document.
4. If the committee determines MAX custody cannot be suspended, the MAX custody patient shall be housed in a TMHU for a maximum of 10 days, that can be located in the following locations in the following priority:
    a. EOP ASU Hub/PSU
    b. STRH/LTRH
    c. ASU

MAX Custody TMHU Location

Institutions shall identify a location where there are preferably 5-15 available clustered cells in a segregation setting as specified above. This is not alternative housing. All TMHU cells will be visually marked within the unit so staff are aware of their location. These units shall:

1. Allow for potential 1:1 and 2:1 suicide watch
2. Enable ease of tracking patients for mental health clinicians, custodial personnel, and nurses.
3. Whenever possible, make it easier to perform milieu-based therapeutic alternatives such as groups (including educational groups specific to COVID-19), based upon CDCR COVID-19 guidelines.
4. Enable staff to coordinate activities for patients.
5. Take the following into consideration:
    a. Line of sight from the officers' station.
    b. Proximity to treatment space.
    c. Available space in the unit for out-of-cell activities.
    d. Functional loud-speaker system.
    e. Reasonable access to an exercise yard.
    f. Suicide Resistant housing units (ligature points, friable items for ingestion, etc.). Retrofitted Intake Cells shall be used as first priority for the newly admitted segregation inmates as per policy. In the event the institution has enough retrofitted Intake Cells for their new admits, the institution may consider using a few Intake Cells for their TMHU.

MAX Custody TMHU Treatment and Services

1. The patient will be offered at least 5 hours of structured, out-of-cell treatment during the week (this can include participation in existing ASU groups, or TMHU-patient-specific groups with RTs, nursing staff, or clinicians).
2. The patient will be offered at least 15 hours of unstructured out-of-cell time during the week (including yard in which social distancing is observed).
3. All group therapy should be considered in the context of the potential spread of infection, and should only be performed where it can be done safely.
4. The Sergeant and psychiatrist and/or primary clinician shall have a daily discussion regarding patients' participation in out-of-cell treatment, yard, meals, phone calls, showers and other information related to the patients programming.
5. Interdisciplinary treatment teams (IDTTs) will be held at 72 hours, and again at 7 days from the date of placement.
6. Treatment team members will track whether patients are availing themselves of the opportunity to program out of cell for at least the 5 hours of structured treatment and 15 hours of unstructured out of cell time. If the patient is not participating due to mental health reasons, the subsequent IDTT shall include a discussion of alternate treatment strategies to be considered.
7. If the patient is demonstrating signs of clinical decompensation, they would be moved from the segregation unit in a timely manner.
8. At seven days from the date of placement, an IDTT will be held. If it is determined that the patient is not improving or stabilizing sufficiently to decrease their level of care to the level prior to referral, the patient will be referred to an MHCB and must be transferred to an inpatient unit potentially at another facility within 10 days from the date of placement, following procedures described in the COVID-19 Temporary Emergency Transfer Guidelines.
9. Staffing: 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.
10. All of the following services as per the COVID-19 Emergency Mental Health Treatment Guidance document:
    a. Issuance of Property and Privileges: Property and privileges should be provided in the Mental Health Patient Issue order for each patient. Additionally, these should be reviewed during the initial IDTT. The provision of property and privileges must be considered and communicated to all members of the treatment team. Considerations shall be for:
        - Clothing
        - Writing implements
        - Paper
        - Books
        - Phone calls
        - Yard time
        - Mental Health Observation
        - Access to the library cart

- In-cell activities, games, puzzles, tablets, physical and other activities with the recreational therapist.
- Group therapy

b. Clinical teams shall refer to the memo titled, "Mental Health Crisis Bed Privileges Revision" dated February 14, 2017 when determining issuance of privileges for patients in the TMHU. All orders for level of observation, issuance and privileges shall be standing orders and updated as clinically indicated.

c. The delivery of care to patients in the TMHU will be evaluated daily, and adjusted based on the total percentage of staff available for patient care and direct activities.

d. All patients placed in the TMHU due to acute suicidality will be on 1:1 suicide watch until the treatment team can assess and determine the appropriate level of observation based upon clinical need and the patient's presentation. If the patient was admitted to the temporary mental health treatment unit for suicidality, the individual sessions should include safety planning development and enhancements to assist the patient in identifying and utilizing modifiable behaviors for ongoing safety from self-harm (see memorandum, "Updated Mental Health Crisis Bed – Referral, Referral Rescission, and Discharge Policy and Procedures" dated October 18, 2018).
   - For patients on 1:1 suicide watch, the psychiatrist will make contact with a designated nursing staff, preferably before and after the clinical contact with the patient, to review pertinent information noted during the suicide watch.
   - Suicide precautions (15-minute checks) are not authorized unless the cell has previously been found to be suicide-resistant.

e. Interdisciplinary huddles shall be utilized to disseminate clinical information about patients housed in the TMHU.

f. If in-person huddles cannot be accomplished safely, while adhering to social distancing, huddles shall occur telephonically.

g. Individual treatment out-of-cell shall occur daily and will be conducted by either the primary clinician or the psychiatrist, whenever possible. Supplemental treatment options provided in-cell should be reviewed during individual sessions and the clinician should provide feedback on the work the patient has completed with the in-cell activities.

h. Rounding shall occur twice per day, when possible, but no less frequently than at least once per day by a clinical social worker, psychologist, or psychiatrist. At least once per day, results from the rounding must be communicated to the psychiatrist covering the temporary mental health treatment unit if the psychiatrist did not perform the rounding.

i. All patients in the TMHU shall have at least equal access to existing resources, out-of-cell time and privileges that other inmates and patients have in the housing unit where the TMHU is located:
   - Yard
   - Showers
   - Phone Calls

j. The patient shall be afforded other resources, unless clinically contraindicated by the IDTT, such as:
    - JPAY tablets
    - Radios
    - Electronic Appliance Loaner Program
    - Reading materials
    - See section entitled "Supplemental Treatment Options" below

k. Recreational Therapy
    - Increased Recreational Therapy, developed through collaboration with all members of the treatment team to determine the most effective activities for the patient, given his or her unique treatment teams.
    - If the patient cannot receive recreational therapy outside of his or her cell, due to COVID exposure risk, recreational therapy shall be focused on activities that the patient can engage in while in his or her cell. Examples are mindfulness activities, yoga, guided imagery, meditation, music therapy, community milieu activities, and physical activities to improve both physical and mental health wellbeing.

l. Individual treatment
    - Confidential individual treatment by a member of the treatment team shall occur each day, where safe to do so.
    - Primary clinicians shall focus their efforts during individual treatment not just on the primary mental health treatment goals for the patient, but also how to adjust to being in close quarters for extended periods of time due to the COVID crisis.
    - Supplemental treatment options provided in-cell should be reviewed during individual sessions and the clinician should provide feedback on the work the patient has completed with the in-cell activities.

m. Supplemental Treatment Options in the TMHU: In addition to the required elements of TMHU treatment, other optional treatment modalities can be considered. If/when necessary consider utilizing Collaborative Team Treatment, as described below:
    - Where necessary due to staffing, a tele-presenter with portable equipment such as a laptop with a camera, microphone, and speakers could connect to the same WebEx meeting with any available members of the treatment team attending by video conference. The team members would be able to participate on their own personal computers. The tele-presenter would then carry the laptop to the patient who should be secured within a TTM in a confidential location, where the entire treatment team would be able to engage in a collaborative session.
    - This is a strategy to minimize the amount of ingress and egress required within the entire institution, particularly for quarantined areas. This achieves the of goal minimizing the amount of potential staff and patient exposure, while maintaining an ability for the entire team to gather

accurate information about the status of the patient, discuss patient care together, and develop & coordinate plans together.

- If PPE or tele-presenters are not available in sufficient quantities, the tele-presenter could then be the only member of the treatment team required to don and doff scarce protective equipment.
- Tele-presenter selection. The current working emergency COVID plan notes "staff that could be used as tele-presenters is decided by each institution to include:
  i. Medical Assistant
  ii. Any staff unable to perform their assigned duties during the crisis (with training), e.g.
    1. Dental
    2. Staff on administrative time off
    3. Support staff
    4. Any healthy state personnel
  iii. Any Mental Health provider (Group leader, RT, SW, LCSW, PhD/ PsyD)
  iv. LVN, RN, CNA, Psych Techs
  v. Any medical provider (PA, NP, MD)"

  During the COVID crisis, any of the above staff may serve as tele-presenters in a priority to be determined by the CEO in consultation with the Chief Psychiatrist, Director of Mental Health, Supervising Dentist, Chief Nurse Executive, and other leadership as necessary, based on local availability and necessary duties. Volunteers could be selected first, and if re-direction to tele-presenter duty continues to be necessary, they could be assigned based on inverse seniority. To reinforce, these decisions are at the discretion of the CEO, in consultation with the Chief Psychiatrist and other leadership.
- Group therapy and structured out-of-cell time
  i. All group therapy should be considered in the context of the potential spread of infection, and should only be performed where it can be done safely.
  ii. When safely possible, it is preferable to have group therapy occur in small groups (3-4 people) where space allows them to remain at least 6 feet apart and the area can be sanitized between each group member.
  iii. When safely possible, group Therapy shall occur in an existing mental health treatment area with TTMs. For individuals on suicide watch, consider having the staff member monitor patient while in group, when feasible and safe.
  iv. If no groups can be run, then PM yard should be considered.
  v. All out of cell activity offered within the TMHU will be documented on the 114-A

n. Discharge Criteria: If a patient no longer requires inpatient mental health treatment, the discharge IDTT shall rescind the referral to the higher level of care. Upon discharge, the primary clinician shall complete a full discharge SRASHE with

Safety Planning Intervention. Additionally, orders for five-day follow ups and custody discharge checks shall be made.

ATTACHMENT Z

CDCR COVID EOP Temporary Transfer Guidelines & Workflow

In an attempt to limit the transmission of COVID-19, all non-emergency movement shall be immediately curtailed, as per constantly evolving circumstances which require flexibility and adaptation as events and requirements change due to COVID-19. All movement within a facility can continue, taking into consideration COVID status. All transfer requests to other facilities will be reviewed as described below, and HCPOP will not act on the place-in order without approval from the Regional Mental Health Administrator or the IRU.

Outpatient Referrals to a Different Facility:

All outpatient external transfers or releases from segregated housing to mainline mental health programs at other institutions, to include transfers from desert institutions, transfers from stand-alone ASUs to STRH, CCCMS to EOP, and EOP to CCCMS will not occur unless the following exists:

I. Institution Review: Transfer out of the patient's current facility shall not proceed unless meeting the criteria below, as assessed by the treatment team:
   1. an imminent, life-threatening emergency necessitates transfer, or
   2. serious mental health decompensation necessitates transfer, and
   3. the life-threatening condition or serious decompensation cannot be reasonably treated at the institution.

II. If transfer is pursued, Regional Review is required: If the referral meets the criteria above, the Chief of Mental Health or Chief Psychiatrist shall email and call the Regional Mental Health Administrator or designee. They shall include an explanation of why the criteria above have been met. The Regional Mental Health Administrator must then consult with the Regional Deputy Medical Executive. The Division of Adult Institutions and/or HCPOP will not transfer patients to a new facility without receiving approval from the Mental Health Administrator.

When a transfer is not clinically necessary, alternate strategies for managing the patient within the institution must be implemented. When full staffing is available, EOP programming should be offered at the standard Program Guide mandated frequency and quality of care (Page 12-3-13: Inmate-patients awaiting EOP transfer shall have updated individualized treatment plans to address patient's current clinical needs [CDCR 7388, *Mental Health Treatment Plan*]. While awaiting EOP transfer, inmate-patients shall be seen on an at least weekly basis by the PC, as clinically indicated, with ongoing assessment of emergency transfer criteria). In institutions that do not have levels of staffing sufficient to provide standard EOP programming, they should be treated in accordance with the Tier Chart. This includes patients released via ICC from an EOP ASU Hub program, but unable to be placed on any EOP yard at the same institution (e.g. due to widespread safety concerns); these patients may be placed on a local CCCMS yard while applying the same criteria for consideration of transfer.

ATTACHMENT AA

State of California Department of Corrections and Rehabilitation

Memorandum

Date: April 1, 2020

To: Associate Directors, Division of Adult Institutions
Wardens
Chief Executive Officer
Chiefs of Mental Health
Chiefs of Psychiatry

Subject: **COVID- 19 ELECTRONIC APPLIANCE PROGRAM FOR RESTRICTED HOUSING INMATES**

The purpose of this memorandum is to announce the implementation of the Electronic Appliance Loaner Program in all restricted housing areas. Restricted housing shall encompass those inmates confined to quarters who are not permitted normal release, therefore require a greater degree of supervision than normal. This program has been developed in order to enhance the Department's in-cell activities in response to the COVID-19 pandemic. This program implementation shall remain in effect during the duration of the pandemic. Upon resolution, the memorandum dated January 22, 2014, titled, *Multi-Powered Radio Loaner Program in Administrative Segregation Units*, and memorandum dated August 4, 2017, titled *Electronic Tablet Loaner Program in Administrative Segregation and Short-term Restricted Housing*, shall reconvene.

The electronic appliance loaner program shall be implemented within all restricted housing units. Upon placement into restricted housing, all offenders shall be offered an electronic appliance as described below. Staff shall also ensure all appliances have been disinfected prior to any issuance or redistribution from one inmate to another. The process will be as follows:

- Initial Intake
  - During the initial 72-hour intake period, a loaner crank radio shall be issued if available.
- After Intake, the following may be provided:
  - Television
    - If the assigned cell has power capabilities and a television service provider, a television may be issued.
      - If the offender has a television in their personal property, it shall be retrieved and provided to the inmate.
      - If the inmate does not have an electronic appliance in their personal property, a loaner television shall be issued first.
      - In the event the cell does not have power capabilities, or there are not sufficient loaner televisions, staff shall issue the inmate a crank radio as outlined below.

- Radios
  - If the assigned cell has power capabilities and the offender has a corded radio in their personal property, it shall be retrieved and provided to the inmate.
  - If the assigned cell does not have power capabilities, a loaner crank radio shall be issued.
  - Should radios not be available, a wait list by date of placement shall be established and issued by arrival date order.

Expectations

- Inmates will be allowed to keep the appliance until they are released from restricted housing, or issued an entertainment appliance from their personal property.
- All property restrictions relative to entertainment appliances within restricted housing shall be suspended during this program.
- Each institution shall ensure each loaner electronic appliance is issued a state property tag for accountability.
- The restricted housing supervisor shall be responsible to ensure the assigned property officer and inmate complete a CDCR 128-B, Electronic Appliance Loaner Program Agreement form upon issuance.
- The assigned property officer will track issuance of the appliance on a distribution log, and will ensure the appliance is in proper working order. Upon release from restricted housing, the inmate shall relinquish the loaner electronic appliance.
- If the electronic appliance has been altered or destroyed, the restricted housing supervisor shall determine if it was intentional or unintentional. In the event it has been determined to be intentional, staff shall utilize progressive discipline per California Code of Regulations Section 3312. In addition, the inmate will be charged the full replacement cost.
- Those institutions authorized to use the Electronic Tablet Loaner Program in their restricted housing units shall continue to offer tablets as a viable electronic appliance.

Wardens are directed to implement these procedures immediately. Provide proof of practice to your respective Mission Associate Director within 1 week of the date of this memoradum. In addition to this directive, Wardens are encouraged to collaborate with Mental Health managers and provide innovative methods to assist in combating boredom and encouraging mental stimulation within their restricted housing settings.

If you have any questions, contact Lourdes White, Captain, Mental Health Compliance Team, at (916) 835-5679 or Lourdes.White@cdcr.ca.gov.

CONNIE GIPSON
Director
Division of Adult Institutions

Original Signed by:
JOSEPH BICK, M.D.
Director
Health Care Services

Attachments

cc: Kimberly Seibel
Jennifer Barretto
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ATTACHMENT AB

State of California Department of Corrections and Rehabilitation

Memorandum

Date: April 1, 2020

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

Subject: **COVID-19 PROGRAMMING OPPORTUNITIES FOR INMATES PARTICIPATING IN THE MENTAL HEALTH SERVICES DELIVERY SYSTEM IN RESTRICTED HOUSING**

The purpose of this memorandum is to announce the implementation of third watch programming opportunities within restricted housing in response to the current Coronavirus (COVID-19) disease. This program implementation shall remain intact during the duration of the pandemic. At the resolution, all programming will reconvene to their original format.

In the event mental health groups and clinical one-to-ones are unable to occur in the restricted housing units, wardens will ensure evening (PM) yard is provided to inmates in the mental health services delivery system. For those units designated to quarantine status, all movement will be in accordance with current departmental expectation. This direction has been developed in order to maximize out-of-cell time and enhance the Department's suicide prevention efforts during this pandemic. The attached listing identifies those institutions and their respective restricted housing units already staffed to provide PM yard. Due to the direction to increase evening programming opportunity within every mental health restricted housing program, the wardens without staffing for PM yard will have the authority to approve overtime on an as needed basis. All overtime detail code for this program will be coded as "MHYD" to accurately capture expenditures and a weekly report of incurred overtime will be reported to the respective Associate Director.

Wardens are encouraged to collaborate with Mental Health managers and provide innovative methods to assist in combating boredom and encouraging mental stimulation within their restricted housing settings. Wardens shall also ensure precautions are taken for both staff and inmate safety to include procedures to limit risk of exposure and transmittal of illness (social distancing) from inmate to inmate.

If you have any questions, contact Lourdes White, Captain, Mental Health Compliance Team, via email at Lourdes.White@cdcr.ca.gov or via phone at (916) 835-5679.

CONNIE GIPSON
Director
Division of Adult Institutions

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

Attachment

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Lourdes White
Mental Health Regional Administrators
Regional Healthcare Executives

Mental Health Restricted Housing
Third Watch Yard

INST	Housing Designation
COR	ASU-STRH
HDSP	ASU-STRH
KVSP	ASU-STRH
PBSP	ASU-STRH
LAC	ASU-STRH
CMC	EOP ASU
PVSP	STRH
SATF	STRH
SVSP	STRH
SAC	STRH