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IN THE UNITED STATES DISTRICT COURT

FOR THE NORTHERN DISTRICT OF CALIFORNIA

OAKLAND DIVISION

MARCIANO PLATA, et al., Plaintiffs, **v.** **GAVIN NEWSOM, et al.,** Defendants.	01-cv-01351-JST **DECLARATION OF RALPH DIAZ IN SUPPORT OF DEFENDANTS' OPPOSITION TO PLAINTIFFS' EMERGENCY MOTION REGARDING PREVENTION AND MANAGEMENT OF COVID-19**

I, Ralph Diaz, declare:

1. I am the Secretary of the California Department of Corrections and Rehabilitation (CDCR). I was appointed by Governor Gavin Newsom as CDCR's Secretary on March 27, 2019.

Before my appointment as Secretary, I served in several positions at CDCR's headquarters, including Undersecretary of Operations, Deputy Director of Facility Operations, and Associate Director of High Security Institutions. And before I worked at CDCR's headquarters, I served as a prison Warden, Correctional Counselor Supervisor, and Correctional Counselor, after starting my career as a Correctional Officer in 1991. I submit this declaration to support Defendants' opposition to Plaintiffs' emergency motion regarding prevention and management of COVID-19.

2. I have reviewed Plaintiffs' emergency motion seeking relief from the Court related to the COVID-19 crisis. (ECF 3266.) I understand that Plaintiffs' request for relief is based on their claim that CDCR and State Officials have been deliberately indifferent to Plaintiffs' health and safety during this pandemic. Contrary to Plaintiffs' assertion, the Receiver, other State officials, and I have taken numerous bold, decisive, and effective actions to protect inmates and staff in California's prisons. Many of those actions are described below, and many more are described in the exhibits attached to this declaration.

3. Attached as Exhibit A is a table that the Receiver prepared that compares CDCR and CCHCS's response to the COVID-19 pandemic with the recommendations set forth in the Center for Disease Control and Prevention's (CDC) "Interim Guidance on Management of Coronavirus Disease 2019 (COVID-19) in Correctional and Detention Facilities," dated March 23, 2020. The Receiver's table shows that CDCR and CCHCS's response to the pandemic comports with virtually every applicable CDC guideline for correctional facilities. Members of my executive staff and I have reviewed this table and we agree that it accurately reflects all measures that CDCR and CCHCS have taken to date in response to COVID-19, and demonstrates that CDCR and CCHCS have complied with almost all of the CDC's numerous suggested guidelines for correctional facilities.

4. I have worked collaboratively with the Receiver and CCHCS since the beginning of the pandemic and frequently consult with the Receiver and CCHCS staff about best practices and responses to COVID-19. In fact, Dr. Steven Tharratt—the Statewide Medical Executive at CCHCS—cochairs the Department Operations Center, along with Director Gipson, that was activated by CDCR to respond to the COVID-19 pandemic. Most recently, I have been working

with the Receiver to determine how to implement social distancing cohorts in dorm settings. I am grateful for the help and guidance the Receiver and CCHCS have provided throughout this crisis.

5. On March 24, 2020, the Governor issued an executive order (N-36-20) providing that individuals would not be admitted to state custody for 30 days, with the opportunity for CDCR to extend the policy for another 30 days if suspension continues to be necessary to protect the health, safety, and welfare of inmates and staff. In a typical month, CDCR accepts approximately 3,000 new inmates from county jails or other jurisdictions. With the Governor's order suspending admissions into the system, CDCR's prison population will drop significantly through CDCR's normal rate of attrition, which is approximately 3,000 inmates per month. This will help protect inmates during this pandemic in at least two ways. First, the decrease in population should better enable the practice of social distancing within the prisons. Second, the suspension of new inmates coming into the system eliminates one of the paths for the introduction of the virus.

6. Under the authority granted by the Governor's executive order, I intend to extend the suspension of intake for another 30 days. The suspension of intake for a total of 60 days should result in a substantial reduction in the prison population, particularly in conjunction with the measures described below.

7. On March 30, 2020, I exercised my independent authority under California Government Code § 8658 to direct the expedited release of about 3,496 inmates from CDCR's custody. This extraordinary and unprecedented step should further enable social distancing in the prisons. The expedited-release group is comprised of nonviolent inmates who had 60 days or less remaining on their sentences (as of March 30, 2020). As of April 12, 2020, a total of 3,418 inmates had been released under my March 30 directive. These releases will be complete as of today, April 13.

8. Attached as Exhibit B is a timeline that accurately outlines CDCR's responses to COVID-19, and which shows how responsive and dynamic CDCR's actions have been. This timeline is regularly updated on CDCR's website. The timeline shows that CDCR has addressed the COVID-19 crisis by adding new measures almost every day since March 11, 2020. But it does not include the fact that, in addition to the many actions reflected in the timeline, numerous

high-level CDCR staff have also collectively dedicated hundreds of hours of time in eleven COVID task force meetings, to date, that have been convened by the Coleman Special Master and have included Plaintiffs. And additional sub-group meetings have occurred on this topic as well, with the involvement of high-level CDCR staff.

9. Attached as Exhibit C is a printout of CDCR's COVID-19 Preparedness webpage. This webpage is frequently updated and includes an accurate overview of the steps CDCR has taken to address the pandemic.

10. Attached as Exhibit D is a March 11, 2020 memorandum issued by CCHCS to advise CCHCS's healthcare providers of the guidance released by the CDC, California Department of Public Health, and California Occupational Safety and Health Administration, and to share resources for future updates that come available.

11. Attached as Exhibit E is a March 13, 2020 joint message from the Receiver and myself to CDCR employees about the COVID-19 pandemic and CDCR's efforts to develop an appropriate response. The message also included sources of information regarding how to prevent the spread of COVID-19.

12. Attached as Exhibit F is the second version of a comprehensive set of guidelines titled "COVID-19: Interim Guidance for Health Care and Public Health Providers" that was compiled and originally published by CCHCS on March 19, 2020. The guidelines provide important information about COVID-19, including information about symptoms, testing, diagnosis, treatment, and safety.

13. Attached as Exhibit G is a March 23, 2020 memorandum issued by CCHCS and endorsed by CDCR's Division of Adult Institutions to provide guidance on how COVID-19 may impact the Integrated Substance Use Disorder Treatment program and patients receiving treatment under the program.

14. Attached as Exhibit H is a March 26, 2020 memorandum issued by CCHCS and endorsed by CDCR's Division of Adult Institutions requiring the immediate implementation of screening protocols for all staff and visitors entering the prisons. This action was taken to help prevent the introduction of COVID-19 into the prisons.

15. Attached as Exhibit I are guidelines for California's prisons issued by the California Department of Public Health concerning COVID-19. CDCR and CCHCS have considered and implemented recommendations contained in these guidelines.

16. Attached as Exhibit J is an April 1, 2020 joint message from the Receiver and myself advising CDCR's employees that CDCR would be transitioning a cohort of inmates to early parole or Post Release Community Supervision to mitigate the risks of COVID-19.

17. Attached as Exhibit K is an April 6, 2020 memorandum issued by CCHCS and endorsed by CDCR's Division of Adult Institutions to provide guidance to staff regarding the appropriate use and conservation of personal protective equipment. It also accurately describes CDCR and CCHCS's rigorous and ongoing efforts to obtain more protective equipment.

18. Attached as Exhibit L is an April 6, 2020 memorandum issued by CCHCS to CDCR and CCHCS staff regarding the appropriate use and conservation of personal protective equipment. It also discusses (a) the COVID-19 Quick Guide Poster, which follows CDC guidelines for COVID-19 management, (b) the COVID-19 Protective Equipment Guide Poster, which also comports with CDC guidelines for optimizing protective equipment, and (c) a COVID-19 Quick Reference Pocket Guide that staff can keep on person as a resource for guidance on responding to COVID-19 related situations.

19. On April 7, 2020, CDCR's Division of Adult Institutions issued a memorandum requiring a 14-day system-wide modified program to restrict movement in the prisons and to implement additional steps to ensure social distancing. The purpose of this modified program is to prevent opportunities for the spread of COVID-19 and to protect the health and safety of inmates and staff. A copy of this memorandum is attached as Exhibit B to Connie Gipson's declaration in support of Defendants' Opposition to Plaintiffs' Emergency Motion.

20. Attached as Exhibit M is an April 10, 2020 memorandum from the Receiver to me directing that no inmate transfers between institutions should be authorized or undertaken without approval from Health Care Placement Oversight Program (HCPOP) in consultation with the CCHCS public health team. I intend to comply with that directive. The Receiver's memorandum

also set forth a plan for achieving better social distancing in dorms, and I have already been collaborating with the Receiver on how to implement this plan.

21. Attached as Exhibit N is an April 12, 2020 memorandum from the Receiver to me supplementing the Receiver's April 10, 2020 memorandum to clarify that he "had not intended for [his] April 10, 2020 memorandum to affect any inter-institution transfers that 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."

22. I have reviewed Plaintiffs' Emergency Motion Regarding Prevention and Management of COVID-19. (ECF 3266.) In their motion Plaintiffs argue that CDCR will be unable to transfer inmate-patients who are housed in rural and semi-rural prisons when or if they require transfer to hospitals for care. I disagree with Plaintiffs' assertion and believe that CDCR will be able to access higher levels of care in hospital settings when or if such services are necessary. And I believe that CDCR will be able to transfer inmates-patients in need of hospital care even if those inmate-patients are housed in institutions located in rural or semi-rural areas. CDCR and CCHCS have access to hospitals around the State and can transport inmate-patients to those hospitals by various modes including by ambulance and, when necessary, air ambulance or helicopter. CDCR would employ all necessary means to ensure inmate-patient health.

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23. In light of all of the measures that CDCR has already taken in response to COVID-19, and the additional measure that are planned, I am not currently considering transferring inmates to private prisons.

I declare under penalty of perjury that I have read this document, and its contents are true and correct to the best of my knowledge.

Executed on April 13, 2020, in Sacramento, California.

/s/ Ralph Diaz

RALPH DIAZ
(Original signature retained by counsel)

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Exhibit A

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

Data Current as of April 11, 2020

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.
☐ 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.
☐ 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 necessary for medical evaluation, medical isolation/quarantine, clinical care, extenuating security concerns, or to prevent overcrowding.	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.
☐ Stay informed about updates to CDC guidance via the CDC COVID-19 website as more information becomes known.	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.	Completed.
☐ 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.	Not applicable to CDCR.
☐ Make a list of possible social distancing strategies that could be implemented as needed at different stages of transmission intensity.	Completed. CDCR/CCHCS leadership have been considering, and continue to review and consider, all options to improve social distancing.
☐ 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.
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.	Most out-to-court transfers were stopped on March 26, 2020. California's courts have reduced all unnecessary hearings.
☐ Explore strategies to prevent over-crowding of correctional and detention facilities during a community outbreak.	Being done on an ongoing basis.
Post signage throughout the facility communicating the following:	
☐ **For all:** symptoms of COVID-19 and hand hygiene instructions	Done.
☐ **For incarcerated/detained persons**: report symptoms to staff	Done.
☐ **For staff**: stay at home when sick; if symptoms develop while on duty, leave the facility as soon as possible and follow CDC-	Done. Also placed on system-wide website dedicated to the outbreak.

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 with cognitive or intellectual disabilities and those who are deaf, blind, or low-vision.	Posted in multiple languages and available to those with disabilities.
Personnel Practices	
Review the sick leave policies of each employer that operates in the facility.	Done.
☐ Review policies to ensure that they actively encourage staff to stay home when sick.	In place.
☐ If these policies do not encourage staff to stay home when sick, discuss with the contract company.	Not applicable.
☐ Determine which officials will have the authority to send symptomatic staff home.	Done and disseminated.
Identify staff whose duties would allow them to work from home. Where possible, allowing staff to work from home can be an effective social distancing strategy to reduce the risk of COVID-19 transmission.	Done pursuant to Governor's Executive Order.
☐ Discuss work from home options with these staff and determine whether they have the supplies and technological equipment required to do so.	Done. IT departments have made sure adequate equipment is available for work-from-home.
☐ Put systems in place to implement work from home programs (e.g., time tracking, etc.).	Done.
Plan for staff absences. Staff should stay home when they are sick, or they may need to stay home to care for a sick household member or care for children in the event of school and childcare dismissals.	
☐ Allow staff to work from home when possible, within the scope of their duties.	Done pursuant to Governor's Executive Order.
☐ Identify critical job functions and plan for alternative coverage by cross-training staff where possible.	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.	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.
☐ Consider increasing keep on person (KOP) medication orders to cover 30 days in case of healthcare staff shortages.	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. Persons at higher risk may include older adults and persons of any age with serious underlying medical conditions including 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 pursuant to Governor's Executive Order and Cal HR guidance.
• 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.
☐ **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 websiteexternal icon for recommendations regarding worker health.**	Done.
• **Review CDC's guidance for businesses and employers** to identify	Done.

any additional strategies the facility can use within its role as an employer.	
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.	CDCR/CCHCS procurement offices are constantly securing and monitoring supply contracts. The DOC communicates any additional needs to the State Operations Center.
☐ Standard medical supplies for daily clinic needs	No shortages identified.
☐ Tissue	Available.
☐ Liquid soap when possible. If bar soap must be used, ensure that it does not irritate the skin and thereby discourage frequent hand washing.	Additional soap available in institutions.
☐ Hand drying supplies	Available.
☐ Alcohol-based hand sanitizer containing at least 60% alcohol (where permissible based on security restrictions)	California Prison Industry Authority (PIA) is manufacturing sanitizer and dispensers placed throughout the facilities where water is not readily available.
☐ Cleaning supplies, including EPA-registered disinfectants effective against the virus that causes COVID-19external icon	Available and in use. More frequent disinfection schedules in place.
☐ 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.
☐ 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.	Done and in place.
☐ **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.
• 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 Table 1 for recommended PPE for incarcerated/detained persons and staff with varying levels of contact with COVID-19 cases or their close contacts.	Done for both healthcare and custody prior to outbreak as part of annual training.

PREVENTION

Operations	
Stay in communication with partners about your facility's current situation.	Department operations center in continuous communication with all state and federal partners.
☐ State, local, territorial, and/or tribal health departments	Done.
☐ Other correctional facilities	Done.

☐ **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.
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 issue of transfers to the Department of State Hospitals remains unresolved and is being discussed in the *Coleman* task force.
☐ 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 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.	Done.
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 the number of operational entrances and exits to the facility.**	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**	Done.

may prevent spread of COVID-19 if introduced.	
Adhere to CDC recommendations for cleaning and disinfection during the COVID-19 response. Monitor these recommendations for updates.	Done.
☐ 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).	Done. Enhanced cleaning schedules are operational at all facilities.
☐ Staff should clean shared equipment several times per day and on a conclusion of use basis (e.g., radios, service weapons, keys, handcuffs).	Done.
☐ 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.	EPA registered disinfectants are in use.
☐ 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.	Done.
☐ **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.
☐ **Ensure adequate supplies to support intensified cleaning and disinfection practices, and have a plan in place to restock rapidly if needed.**	Stock is available and resupply plans are in place.
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**	Done.

entries and exits, visitation rooms and waiting rooms, common areas, medical, and staff-restricted areas (e.g., break rooms).	
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.	Done Both signage and informational videos play on inmate TV. Instructions for staff available on website and through links to public health messaging.
☐ **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.	Done.
☐ **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.	Done.
☐ **Avoid touching your eyes, nose, or mouth without cleaning your hands first.**	Done.
☐ **Avoid sharing eating utensils, dishes, and cups.**	Done.
☐ **Avoid non-essential physical contact.**	Done
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.	Done.
☐ **Running water, and hand drying machines or disposable paper towels** for hand washing	Done.
☐ **Tissues** and no-touch trash receptacles for disposal	Done. No touch receptacles not in use statewide.

☐ **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.	Done.
☐ **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.
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 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).	Intake screening procedures are in place for all new entrants, transfers, and returnees from outside medical visits.
If an individual has symptoms of COVID-19 (fever, cough, shortness of breath)**:**	
☐ Require the individual to wear a face mask.	Done. See Screening guidance.
☐ Ensure that staff who have direct contact with the symptomatic individual wear recommended PPE.	Done. See Screening guidance.
☐ 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.)	Done. See Screening guidance.
☐ 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.	Not applicable.

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.)	In place. See current COVID19 medical guidelines.
☐ Facilities without onsite healthcare staff should contact their state, local, tribal, and/or territorial health department to coordinate effective quarantine and necessary medical care.	Not applicable.
Implement social distancing strategies to increase the physical space between incarcerated/detained persons (ideally 6 feet 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:	Currently underway. We have defined housing cohorts of 8 in dorm settings to increase social distancing in sleeping areas. Yard release is done with smaller groups and social distancing is encouraged.
☐ **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.
☐ **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)	Done.
☐ **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)	Done with a mixture of in cell feeding and cohorted chow halls.

• Provide meals inside housing units or cells	
☐ **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 group programming has been suspended. Except for mental health groups, which continue based on the mental health tier plan.
☐ **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 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	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 gymnasium.
☐ **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	Done. Most health encounters are being performed cell front where appropriate to minimize clinic entrance. All clinics have designated space to evaluate suspected respiratory cases.

case contact, before they move to other parts of the facility.	
☐ **Communicate clearly and frequently with incarcerated/detained persons about changes to their daily routine and how they can contribute to risk reduction.**	Done. Both written and video messages. Inmate councils are involved in information dissemination.
• **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.
☐ **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.
☐ **Provide up-to-date information about 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	Communications has detailed inmate communication plan.
☐ **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 medical monitoring guidelines.
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.
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	Done for all persons entering a facility.

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).	Not applicable.
☐ 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.
☐ **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 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.	Done See communications detailed plan and COVID-19 webpages. Accessible at https://www.cdcr.ca.gov/covid19/memos-guidelines-messaging/ Done. See employee return to work guidance plan. We are following CDC guidance of return to work for critical healthcare workers for those with close contact with cases at this phase of the outbreak.

☐ **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).	Done by 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	Currently no visitors or volunteers are permitted to enter facilities.

MANAGEMENT

Operations	
☐ **Implement alternate work arrangements deemed feasible in the Operational Preparedness**	Done via Governor's Executive Order.
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.	Done March 24, 2020.
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	Done. See medical guidance plan.

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.	
☐ **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).** Subsequently in this document, this practice is referred to as **routine intake quarantine**.	This was in place until the closure of intake.
☐ **When possible, arrange lawful alternatives to in-person court appearances.**	Done.
Incorporate screening for COVID-19 symptoms and a temperature check into release planning.	In place in our release documents.
Screen all releasing individuals for COVID-19 symptoms and perform a temperature check. (See Screening section below.)	Done.
☐ 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.	Done.
☐ 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	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

linkages to community resources to ensure proper medical isolation and access to medical care.	probation depending on which entity will be responsible for post-release supervision.
☐ 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.	Done. See above.
☐ Coordinate with state, local, tribal, and/or territorial health departments .external icon • 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 our public health team in conjunction with the local public health departments. See current medical guidance plan (currently version 2). https://www.cdcr.ca.gov/covid19/wp-content/uploads/sites/197/2020/03/R_CCHCS-COVID-19-Interim-Guidance-3.19.2020.pdf?label=COVID-19:%20Interim%20Guidance%20for%20Health%20Care%20and%20Public%20Health%20Providers&from=https://www.cdcr.ca.gov/covid19/memos-guidelines-messaging/&label=COVID-19:%20Interim%20Guidance%20for%20Health%20Care%20and%20Public%20Health%20Providers&from=https://www.cdcr.ca.gov/covid19/memos-guidelines-messaging/
Hygiene	
☐ **Continue to ensure that hand hygiene supplies are well-stocked in all areas of the facility.** (See above.)	Done.
☐ **Continue to emphasize practicing good hand hygiene and cough etiquette.** (See above.)	Done.
Cleaning and Disinfecting Practices	

☐ **Continue adhering to recommended cleaning and disinfection procedures for the facility at large.** (See above.)	Done.
☐ **Reference specific cleaning and disinfection procedures for areas where a COVID-19 case has spent time (below).**	Done.
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.
☐ **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. • 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.	Done. See medical guidance document above.
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.	Done.
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	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. https://www.cdcr.ca.gov/covid19/wp-content/uploads/sites/197/2020/03/R_CCHCS

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 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.)	-COVID-19-Interim-Guidance-3.19.2020.pdf?label=COVID-19:%20Interim%20Guidance%20for%20Health%20Care%20and%20Public%20Health%20Providers&from=https://www.cdcr.ca.gov/covid19/memos-guidelines-messaging/&label=COVID-19:%20Interim%20Guidance%20for%20Health%20Care%20and%20Public%20Health%20Providers&from=https://www.cdcr.ca.gov/covid19/memos-guidelines-messaging/

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 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.	This situation has not yet developed. Our medical guidance document envisions this situation and outlines priorities to follow. https://www.cdcr.ca.gov/covid19/wp-content/uploads/sites/197/2020/03/R_CCHCS-COVID-19-Interim-Guidance-3.19.2020.pdf?label=COVID-19:%20Interim%20Guidance%20for%20Health%20Care%20and%20Public%20Health%20Providers&from=https://www.cdcr.ca.gov/covid19/memos-guidelines-messaging/&label=COVID-19:%20Interim%20Guidance%20for%20Health%20Care%20and%20Public%20Health%20Providers&from=https://www.cdcr.ca.gov/covid19/memos-guidelines-messaging/
☐ **Custody staff should be designated to monitor these individuals exclusively where**	Not currently in place due to staffing capabilities.

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.	
☐ **Minimize transfer of COVID-19 cases between spaces within the healthcare unit.**	Done.
☐ **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.
☐ **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**	We 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.

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 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.	Done. We are 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 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).	Currently disinfection occurs; we do not currently wait to disinfect.
☐ **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	EPA registered disinfectants are used.

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 (1/3rd 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.	Done.
☐ **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.	Done. Alcohol based disinfectants are not currently in use.

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.
☐ **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.	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. 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	Done.
☐ **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. ☐ **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 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).	Done. Our quarantine guidelines follow CDC and CDPH current guidance.
☐ **Keep a quarantined individual's movement outside the quarantine space to an absolute minimum.**	Done, although some cohorted quarantined individuals have group feeding and share bathrooms.

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.	
☐ **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. 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.	Currently the majority of quarantines are cohorted. All are monitored twice a day.

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 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	Done. Our quarantine guidance follows this prioritization schema.

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** (see PPE section and Table 1)**:** 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.

☐ **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.
☐ **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.) See Screening section for a procedure to perform temperature checks safely on asymptomatic close contacts of COVID-19 cases.	Done. See current medical guideline document.
☐ **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.	Consistent with our medical guideline document. https://www.cdcr.ca.gov/covid19/wp-content/uploads/sites/197/2020/03/R_CCHCS-COVID-19-Interim-Guidance-3.19.2020.pdf?label=COVID-19:%20Interim%20Guidance%20for%20Health%20Care%20and%20Public%20Health%20Providers&from=https://www.cdcr.ca.gov/covid19/memos-guidelines-messaging/&label=COVID-19:%20Interim%20Guidance%20for%20Health%20Care%20and%20Public%20Health%20Providers&from=https://www.cdcr.ca.gov/covid19/memos-guidelines-messaging/
☐ **Restrict quarantined individuals from leaving the facility (including transfers to other facilities) during the 14-day**	Done.

quarantine period, unless released from custody or a transfer is necessary for medical care, infection control, lack of quarantine space, or extenuating security concerns.	
☐ **Quarantined individuals can be released from quarantine restrictions if they have not developed symptoms during the 14-day quarantine period.**	Done.
☐ **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 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.	Not done. Quarantined individuals either receive cell feeding or eat as a quarantined cohort based on facility design.
☐ **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.	Done.
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.	Done.
☐ **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.	Done. See medical guidance document. https://www.cdcr.ca.gov/covid19/wp-content/uploads/sites/197/2020/03/R_CCHCS-COVID-19-Interim-Guidance-3.19.2020.pdf?label=COVID-19:%20Interim%20Guidance%20for%20Health%20Care%20and%20Public%20Health%20Providers&from=https://www.cdcr.ca.gov/covid19/memos-guidelines-messaging/&label=COVID-19:%20Interim%20Guidance%20for%20Health%20Care%20and%20Public%20Health%20Providers&from=https://www.cdcr.ca.gov/covid19/memos-guidelines-messaging/
☐ **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 disabilities and those who are deaf, blind, or low-vision.	Done. See communications plan.
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.
☐ **Consider additional options to intensify social distancing** within the facility.	In progress.
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.	Done. See communications plan.
☐ **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.**	Currently following CDPH guidance regarding return to work for critical healthcare workers for all facility staff.

See above for definition of a close contact. Refer to CDC guidelines for further recommendations regarding home quarantine for 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.
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.

☐ **Refer to PPE section to determine recommended PPE for individuals persons in contact with confirmed COVID-19 cases, contacts, and potentially contaminated items.**	Done via PPE policy memo distributed April 6, 2020, with link to CDC guidelines.
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 current medical guidelines (currently version 2). https://www.cdcr.ca.gov/covid19/wp-content/uploads/sites/197/2020/03/R_CCHCS-COVID-19-Interim-Guidance-3.19.2020.pdf?label=COVID-19:%20Interim%20Guidance%20for%20Health%20Care%20and%20Public%20Health%20Providers&from=https://www.cdcr.ca.gov/covid19/memos-guidelines-messaging/&label=COVID-19:%20Interim%20Guidance%20for%20Health%20Care%20and%20Public%20Health%20Providers&from=https://www.cdcr.ca.gov/covid19/memos-guidelines-messaging/
☐ **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) and monitor the guidance website regularly for updates to these recommendations.**	Done. See current medical guidance, version 2. https://www.cdcr.ca.gov/covid19/wp-content/uploads/sites/197/2020/03/R_CCHCS-COVID-19-Interim-Guidance-3.19.2020.pdf?label=COVID-19:%20Interim%20Guidance%20for%20Health%20Care%20and%20Public%20Health%20Providers&from=https://www.cdcr.ca.gov/covid19/memos-guidelines-messaging/&label=COVID-19:%20Interim%20Guidance%20for%20Health%20Care%20and%20Public%20Health%20Providers&from=https://www.cdcr.ca.gov/covid19/memos-guidelines-messaging/
☐ **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**	Done.

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.	
☐ **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.**	In place.
☐ **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., 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.	Done.
☐ **Ensure that all staff are trained to perform hand hygiene after removing PPE.**	Done.

☐ **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.**	Done. Communications has provided extensive education regarding this topic to both patients and staff.
☐ **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 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	Current PPE procedures are consistent with this guidance.

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** 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**	Done. At present, we do not have a shortage of N95 masks.

Exhibit B

Updates

For the latest CDCR COVID-19 information and updates, visit the CDCR COVID-19 Preparedness webpage (https://www.cdcr.ca.gov/covid19/).

4/10/20: All institutions increase laundry services

4/9/20: Secretary Diaz releases video messages to staff (https://vimeo.com/cchcs/covid19-cdcrsec-staff-04072020), stakeholders (https://vimeo.com/cchcs/covid19-cdcrsec-sh-04072020), and population (https://vimeo.com/cchcs/covid19-cdcrsec-pop-0472020)

4/9/20: University of California, San Francisco AMEND webinar (https://vimeo.com/403558684) on COVID-19 in jails and prisons released to staff

4/8/20: CDCR partners with JPay to provide inbound email print services to all institutions at a reduced rate

4/8/20: Mandatory 14-day modified program (https://www.cdcr.ca.gov/covid19/wp-content/uploads/sites/197/2020/04/COVID19-Modified-Program.pdf?label=Mandatory%2014-day%20Modified%20Program&from=https://www.cdcr.ca.gov/covid19/memos-guidelines-messaging/) implemented

4/8/20: CALPIA to continue only critical operations

4/7/20: Transfers from Reception Centers suspended through April 22

4/7/20: DJJ education to be provided via distance learning

4/6/20: Staff use of PPE memo (https://www.cdcr.ca.gov/covid19/wp-content/uploads/sites/197/2020/04/R_STAFF-USE-PPE.pdf) issued

4/6/20: PPE guidance and information (https://www.cdcr.ca.gov/covid19/wp-content/uploads/sites/197/2020/04/R_PH-PPE-GUIDANCE.pdf) issued

4/3/20: Tiffany Haddish (https://www.facebook.com/cacorrections/posts/10157393591397061?__cft__%5b0%5d=AZVJAbgnas0wYDju9W2H2-F2BIfQ_ZOI9p_HfmOMuXIRCWNACXCkQTj9k0aF76OrBwn-zQ4ngkwcLK9irqhdz5esnhy0f40zGtsDeOkI4eOzmy2Aj0R4rc1bzJUm-zupxBHF4HVRSR1WBAWwINQ3Gf61_MxAAivjxd7hDpT4AACdBQ&__tn__=%2CO%2CP-R) speaks to incarcerated youth via Skype

4/1/20: Internal patient registry launched to assist in monitoring patients with suspected or confirmed COVID-19

3/31/20: Federal Receiver J. Clark Kelso releases video message (https://www.cdcr.ca.gov/insidecdcr/2020/03/31/message-to-all-cdcr-cchcs-staff-from-receiver-j-clark-kelso/) to all staff

3/31/20: CDCR announces plan to expedite transition to parole (https://www.cdcr.ca.gov/news/2020/03/31/cdcr-announces-plan-to-further-protect-staff-and-

inmates-from-the-spread-of-covid-19-in-state-prisons/) for certain eligible inmates with 60 days or less to serve

3/31/20: FAQs (https://www.cdcr.ca.gov/covid19/frequently-asked-questions-for-plan-on-expedited-release-and-increased-physical-space-within-state-prisons/) for expedited release and increased physical space published

3/30/20: Free phone call days, reduced-price emails announced (https://www.cdcr.ca.gov/covid19/cdcr-gtl-jpay-expand-communication-access/)

3/29/20: CALPIA announces hand sanitizer production

3/29/20: Inmates allowed alcohol-based hand sanitizer in approved areas under supervision

3/29/20: Inmate cases reported at CIM (1) and LAC (2)

3/27/20: Temperature screenings (https://www.cdcr.ca.gov/covid19/wp-content/uploads/sites/197/2020/03/R_COVID-19-Facility-Entrance-Final-v6.pdf) implemented for all entering prisons and community correctional facilities

3/26/20: Population tracking press release (https://www.cdcr.ca.gov/news/2020/03/26/cdcr-and-cchcs-unveil-covid-19-tracking-tool-for-incarcerated-population-testing-cases-and-results/) issued

3/26/20: Large-scale construction projects suspended inside secure perimeters

3/26/20: DJJ provides free Skype visits (https://www.cdcr.ca.gov/juvenile-justice/visiting-your-loved-one-with-skype-for-business/) at Pine Grove Youth Conservation Camp

3/25/20: Population COVID-19 Tracking (https://www.cdcr.ca.gov/covid19/population-status-tracking/) released

3/25/20: Secretary Diaz releases video message to staff (https://www.cdcr.ca.gov/insidecdcr/2020/03/26/secretary-diaz-addresses-cdcr-staff/)

3/25/20: Secretary Diaz releases video message to population (https://vimeo.com/400758862/824c4cf567)

3/25/20: All in-service training postponed until July

3/24/20: Governor issues Executive Order (https://www.gov.ca.gov/2020/03/24/governor-newsom-issues-executive-order-on-state-prisons-and-juvenile-facilities-in-response-to-the-covid-19-outbreak/) with directives to CDCR

- Adult, DJJ intake from counties suspended for 30 days
- BPH to develop process for videoconferencing parole hearings
- In-person parole hearings suspended for 60 days

3/24/20: Transfers into MCRP, CCTRP, ACP suspended through April 6

3/24/20: Transfers to Conservation Camps suspended until further notice

3/23/20: Social distancing posters (1 (https://www.cdcr.ca.gov/covid19/wp-content/uploads/sites/197/2020/03/COVID-19-SD-Poster-Germ-cloud-PORTRAIT.pdf) and 2 (https://www.cdcr.ca.gov/covid19/wp-content/uploads/sites/197/2020/03/COVID-19-SD-Poster-SIX-FEET-PORTRAIT.pdf)) provided to institutions

3/23/20: All staff TB testing delayed

3/23/20: CDCR/CCHCS-created educational video (https://vimeo.com/399285302/3f5516409d) released for population

3/22/20: First inmate tests positive (https://www.cdcr.ca.gov/news/2020/03/22/cdcr-and-cchcs-confirm-first-inmate-tests-positive-for-covid-19/)

3/21/20: Basic Correctional Officer Academy scheduled for March 24 postponed

3/21/20: Current Basic Correctional Officer Academy accelerated

3/21/20: Reception Center inmates to be quarantined for 14 days

3/20/20: Interim Guidance for Health Care and Public Health Providers (https://www.cdcr.ca.gov/covid19/wp-content/uploads/sites/197/2020/03/R_CCHCS-COVID-19-Interim-Guidance-3.19.2020.pdf) issued

3/20/20: Two confirmed staff cases (https://www.cdcr.ca.gov/covid19/cdcr-cchcs-covid-19-status/)

3/19/20: Standardized academic testing postponed

3/19/20: Ramadan, Passover, Easter services to be provided in-cell

3/19/20: Inmate transfers limited to only essential movement

3/19/20: Parole suitability hearings postponed through April 6

3/19/20: Written peace officer exams postponed through April 6

3/18/20: Temporary travel and meeting restrictions (https://www.cdcr.ca.gov/covid19/wp-content/uploads/sites/197/2020/03/2020-03-18-R-Temporary-Travel-and-Meeting-Restrictions.pdf)

3/18/20: All CDCR/CCHCS staff given verbal screenings before entering any work locations

3/17/20: COVID19@cdcr.ca.gov (mailto:COVID19@cdcr.ca.gov) email address goes live

3/17/20: JPay offers two free stamps per week to registered electronic messaging users

3/17/20: Global Tel Link to offer free phone calls March 19 and 26

3/17/20: No volunteers or rehabilitative program providers allowed to enter prisons

3/17/20: Parole suitability hearings postponed through March 20

3/17/20: All transfers of out-of-state parolee1s or inmates to California stopped for 30 days

3/17/20: Message from the Secretary and Receiver (https://www.cdcr.ca.gov/covid19/message-of-appreciation-and-direction-to-all-cdcr-cchcs-staff/) sent to all staff

3/17/20: Updated guidelines for staff who live in the Bay Area (https://www.cdcr.ca.gov/covid19/employees-65-employees-with-chronic-health-conditions-and-school-closures/)

3/16/20: Reentry facility, parole guidelines (https://www.cdcr.ca.gov/covid19/division-of-adult-parole-operations/) issued

3/16/20: Advanced Learning Institute trainings canceled (https://www.cdcr.ca.gov/covid19/staff-training-and-development/)

3/16/20: Updated guidelines for employees age 65+ or with chronic health conditions (https://www.cdcr.ca.gov/covid19/employees-65-employees-with-chronic-health-conditions-and-school-closures/)

3/15/20: Department Operations Center activated (https://www.cdcr.ca.gov/covid19/department-operation-center-activation/)

3/15/20: In-person observers not permitted at parole suitability hearings (https://www.cdcr.ca.gov/covid19/board-of-parole-hearings-information/)

3/14/20: Family visits postponed statewide, effective 3/16/20

3/14/20: Updated school closure impact guidelines (https://www.cdcr.ca.gov/covid19/school-closures-due-to-the-coronavirus/)

3/14/20: Expanded precautions at institutions – mandatory verbal screening for all entering state prisons

3/13/20: Secretary and Receiver issue memo: Message to employees regarding COVID-19 (new coronavirus) (https://www.cdcr.ca.gov/covid19/wp-content/uploads/sites/197/2020/03/2020-03-13-R_Message-to-Employees-Regarding-COVID-19-New-Coronavirus-1.pdf)

3/13/20: Correctional Sergeant written examination scheduled for 3/21/20 postponed until further notice

3/12/20: Tours canceled statewide

3/11/2020: 2019 Novel Coronavirus (COVID-19) (https://www.cdcr.ca.gov/covid19/wp-content/uploads/sites/197/2020/03/Memorandum-2019-Novel-Coronavirus-COVID-19.pdf) memo issued

3/11/20: Facts sheets, posters and additional information about COVID-19 distributed to the population (https://www.cdcr.ca.gov/covid19/population-communications/)

3/11/20: Events of 250 attendees or more canceled

3/11/20: Normal visiting canceled statewide

Exhibit C

COVID-19 Preparedness

April 11, 2020 update:

Please see today's update on CDCR and CCHCS COVID-19 preparedness and response.

April 11 updates

- *As of April 11, 2020, there are 42 incarcerated persons who have tested positive for COVID-19. See the CDCR and CCHCS Patient Testing Tracker* (https://www.cdcr.ca.gov/covid19/population-status-tracking/) *for the latest testing and case information for the incarcerated population.*
- *There are currently 77 CDCR/CCHCS employees who have tested positive for COVID-19. See the CDCR/CCHCS COVID-19 Employee Status webpage* (https://www.cdcr.ca.gov/covid19/cdcr-cchcs-covid-19-status/) *for a breakdown by location.*
- *The California Board of Parole Hearings (BPH) has held 116 parole suitability hearings by video and telephone conference between April 1-10. BPH anticipates moving forward with all scheduled hearings through video conference beginning Monday, April 13, consistent with Governor Gavin Newsom's March 24 Executive Order (https://www.gov.ca.gov/2020/03/24/governor-newsom-issues-executive-order-on-state-prisons-and-juvenile-facilities-in-response-to-the-covid-19-outbreak/)*

A breakdown of the hearing outcomes is below:

- *32 grants*
- *42 denials*
- *8 stipulations*
- *8 waived*
- *25 postponed*
- *1 continued*

Below is comparison of grants as a percentage of hearings held by videoconference versus hearings held in 2019:

- *Grants as a percentage of hearings held by video: 43%*
- *Grants as a percentage of hearings held in 2019: 34%*
- *Denials as a percentage of hearings held by video: 57%*
- *Denials as a percentage of hearings held in 2019: 66%*

(para español, haga clic aquí (https://www.cdcr.ca.gov/covid19/preparacion-covid-19/)*. Las traducciones al español se proporcionan dentro de las 24 horas de una actualización)*

Executives and staff at CDCR and CCHCS are working closely with infectious disease control experts to minimize the impact of COVID-19 on our operations. To ensure we are ready to immediately respond to any COVID-19 related incident, CDCR and CCHCS activated the Department Operations Center (DOC) in order to be fully prepared to respond to any departmental impacts resulting from COVID-19.

CDCR and CCHCS are dedicated to the safety of everyone who lives in, works in, and visits our state prisons. We have longstanding outbreak management plans in place to address communicable disease outbreaks such as influenza, measles, mumps, norovirus, and varicella,

as well as preparedness procedures to address a variety of medical emergencies and natural disasters.

Public safety is a top priority for CDCR, as is the health of our community. The department has been diligent in implementing proactive efforts to ensure health and safety, including recent actions to limit the risks and spread of COVID-19. Examples include limiting all non-essential or emergency transportations between CDCR facilities; screening all who enter the prisons; and suspending visits by the public. As a further protective measure, Governor Newsom issued an executive order (https://www.gov.ca.gov/2020/03/24/governor-newsom-issues-executive-order-on-state-prisons-and-juvenile-facilities-in-response-to-the-covid-19-outbreak/) recently directing CDCR to temporarily halt the intake of inmates and youth into the state's 35 prisons and four youth correctional facilities. We are continuously evaluating and implementing proactive measures to help prevent the spread of COVID-19 and keep our CDCR population and the community-at-large safe.

BELOW IS AN OVERVIEW OF STEPS WE ARE TAKING REGARDING COVID-19

Modified Program

Effective April 8, 2020, all CDCR adult institutions will implement a mandatory 14-day modified program (https://www.cdcr.ca.gov/covid19/wp-content/uploads/sites/197/2020/04/COVID19-Modified-Program.pdf?label=Mandatory%2014-day%20Modified%20Program&from=https://www.cdcr.ca.gov/covid19/memos-guidelines-messaging/). While movement has been limited throughout institutions already, CDCR has implemented these mandatory restrictions statewide for two weeks in order to further reduce staff and inmate exposure to COVID-19.

"This is a time where we are all truly in this together, we are all experiencing changes in our daily lives in an effort to do what's for the greater good of us all," CDCR Secretary Ralph Diaz said. "For the next 14 days there are going to be a lot of changes within our institutions, but we do it with the overall health and safety of all those who live and work in them, and the health and safety of the public, at the forefront. We will continue to seek ways for the incarcerated population to stay in touch with their support systems, retrieve items from canteen services, and have out-of-cell time that we know is important for overall physical and mental health. We ask for patience and an understanding that we are doing everything we can to create better physical distancing within our institutions, staff and inmates—we are all Californians in this effort."

While these restrictive measures are mandatory, the incarcerated population will still have access to medication, health care services, yard time, canteen, packages, and cell-front religious programming while allowing for physical distancing and proper cleaning/disinfecting. Showers and telephones will be disinfected between each use.

Meals will be served in cells or housing units. Recreation/yard time will be allowed; however, schedules will be staggered by housing unit to increase physical distancing. If canteen cannot be accommodated during yard time, staff will facilitate delivery to housing units. Only inmates classified as critical workers will be permitted to report to work.

Community Resource Managers and education staff will provide program materials, games, books, etc., to housing units. Staff will conduct additional rounds to ensure the safety and well-being of those on modified program.

Expedited release and plan to increase space within institutions

On March 31, CDCR announced its plan to further protect staff and inmates (https://www.cdcr.ca.gov/news/2020/03/31/cdcr-announces-plan-to-further-protect-staff-and-inmates-from-the-spread-of-covid-19-in-state-prisons/) from the spread of COVID-19 in state prisons.

CDCR has expedited the transition to parole for eligible inmates who have 60 days or less to serve on their sentences and are not currently serving time for a violent crime as defined by law, a person required to register under Penal Code 290, or domestic violence.

The plan will create increased capacity and space to help with inmate movement, physical distancing, and quarantine and isolation efforts for positive COVID-19 cases.

The plan also includes making more use of the state's private and public Community Correctional Facilities, as well as maximizing open spaces in prisons, such as gymnasiums, to increase capacity and inmate movement options.

All of the approximately 3,500 inmates eligible for this expedited release will be released by Monday, April 13.

For frequently asked questions on this plan, visit our FAQ page here (https://www.cdcr.ca.gov/covid19/frequently-asked-questions-for-plan-on-expedited-release-and-increased-physical-space-within-state-prisons/).

Expanded precautions at institutions and office locations

All staff and visitors entering CDCR correctional institutions will undergo a touchless temperature screening prior to entering the facility. This is in addition to the ongoing verbal symptom screening. This applies to CDCR state prisons and community correctional facilities. For guidance on this implementation, see the COVID-19 Facility Entrance Screening.

CDCR and CCHCS have implemented mandatory verbal screening for every person entering **any** work location, in line with screenings in place at prisons since March 14.

Those attempting to enter a state prison or office building at any time are required to verbally respond if they currently have new or worsening symptoms of a respiratory illness. If the individual's response is that they are experiencing symptoms, they will be restricted from entering the site that day.

All CDCR institutions have been instructed to conduct additional deep-cleaning efforts in high-traffic, high-volume areas, including visiting and health care facilities. Those in the incarcerated population identified as assisting with cleaning areas of the institution have received direct instruction on proper cleaning and disinfecting procedures in order to eliminate coronavirus.

Communal areas such as dayrooms, showers, restrooms and offices are cleaned at a minimum of twice per shift during second and third watch, and more if needed. Disinfecting frequency has been increased, including regular disinfecting of touchpoints (telephones, door knobs, desk areas, etc.). All cleaning practices will allow for physical distancing of staff and porters.

On March 11, all CDCR institutions were instructed to order 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. These dispensers will 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.

Staff have been granted permission to carry up to two ounces of personal-use hand sanitizer. The incarcerated population is being provided extra soap when requested and hospital-grade disinfectant that meets CDC guidance for COVID-19.

CDCR and CCHCS have been actively monitoring and assessing institutions to ensure staff have an adequate supply of personal protective equipment to immediately address any potential COVID-19 exposures, and to protect staff and incarcerated people. The workgroup will continue to collaborate and maintain open lines of communication with the Governor's Office of Emergency Services to identify any deficiencies and ensure adequate supplies are available at each institution on an ongoing basis.

California Prison Industry Authority production

In an effort to help prevent the spread of COVID-19, the California Prison Industry Authority (CALPIA) has begun producing hand sanitizer for use by both staff and the incarcerated population.

CALPIA is producing two types of hand sanitizer: *Cleanse,* which contains alcohol, and *Cleanse – AF* (Alcohol Free) which contains the active ingredient Benzalkonium Chloride. The alcohol-based hand sanitizer will be used in the sanitizer dispenser stations being directed into housing units, dining halls, work change areas, and other areas where sinks and soap are not immediately available. The non-alcohol based product is being produced for future needs.

The hand sanitizer is being made available to CDCR and CCHCS facilities and locations. If CALPIA's inventory exceeds the needs of those two departments, CALPIA will make the product available to other state agencies.

CALPIA worked with the California Department of Public Health and within two weeks was able to acquire the necessary licensing for relabeling, repackaging, and mixing.

CALPIA has already started delivering the bottles to CDCR facilities.

The production of the materials will occur at CALPIA's Chemical Enterprise located at the California State Prison, Los Angeles County.

To help prevent the spread of COVID-19 within the California Department of Corrections and Rehabilitation (CDCR) prisons, the California Prison Industry Authority (CALPIA) has started producing reusable cloth barrier masks to meet some of the supply needs of staff and inmates. The masks are being produced at CALPIA's Fabric enterprises at the California Institution for Women, Mule Creek State Prison, California Men's Colony, Sierra Conservation Center, Correctional Training Facility, California Correctional Institution, and Centinela State Prison. CALPIA has made approximately 17,000 barrier masks, with plans to produce 10,000 per day, and has begun distributing the masks to the institutions for both staff and inmate use. All institutions will increase laundry services in order to accommodate proper washing and drying of barrier masks.

CALPIA will continue only critical operations necessary to support the effort to address COVID-19. These operations include the Healthcare Facilities Maintenance program, which will be increasing work hours and days to seven days a week in order to provide increased frequency of cleaning and sanitation, as well as Laundry services, which will be increased to seven days a

week. Other critical operations include food and beverage packaging and the production of hand sanitizer at California State Prison, Los Angeles County.

Screening incarcerated population on entry into prisons

All incarcerated persons received into a Reception Center institution are placed into an automatic 14-day quarantine for monitoring. For more on CDCR and CCHCS quarantine protocols, visit our COVID-19 Status (https://gcc01.safelinks.protection.outlook.com/?url=https%3A%2F%2Fwww.cdcr.ca.gov%2Fcovid19%2Fcdcr-cchcs-covid-19-status%2F&data=02%7C01%7CDana.Simas%40cdcr.ca.gov%7Cb289a7c86e924c100f6708d7d127c0c3%7C0662477dfa0c4556a8f5c3bc62aa0d9c%7C0%7C0%7C637207840984514096&sdata=%2Fr1fOjVQFht%2FiygQmZjeoRWHN0cakc2DcSvPyp9mCFQ%3D&reserved=0) webpage.

Immediately upon entry, all inmates are screened for symptoms of influenza-like illness (ILI) including COVID-l9. The inmate populations that must be screened include, but are not limited to, those entering via reception centers, receiving and release locations and fire camps, and returning from court, a higher level of care, or an offsite specialty appointment.

The screening shall include asking an individual if they have a cough, fever and/or difficulty breathing, and taking their temperature. Based on the screening questions, temperature reading, and health care staff's clinical judgement, the individual will either be placed in isolation, quarantine or other housing.

Social distancing

CDCR has implemented several practices to encourage "social distancing," which is a strategy recommended by public health officials to stop the spread of contagious diseases. Social distancing requires the creation of physical space between individuals, minimizing gatherings, and ensuring space between individuals when events or activities cannot be modified, postponed, or canceled. Achieving space between individuals of approximately six feet is advisable.

The incarcerated population has received information about social distancing, and staff and inmates are practicing social distancing strategies where possible, including limiting groups to no more than 10, assigning bunks to provide more space between individuals, rearranging scheduled movements to minimize mixing of people from different housing areas, encouraging social distancing during yard time, and adjusting dining schedules where possible to allow for social distancing and additional cleaning and disinfecting of dining halls between groups.

Transportation/Receiving and Release protocols

Effective March 24, CDCR will suspend intake of all incarcerated persons into both adult state prison and Division of Juvenile Justice facilities for a minimum of 30 days. California Governor Gavin Newsom issued an Executive Order (https://gcc01.safelinks.protection.outlook.com/?url=https%3A%2F%2Fwww.gov.ca.gov%2F2020%2F03%2F24%2Fgovernor-newsom-issues-executive-order-on-state-prisons-and-juvenile-facilities-in-response-to-the-covid-19-outbreak%2F&data=02%7C01%7CDana.Simas%40cdcr.ca.gov%7Cb289a7c86e924c100f6708d7d127c0c3%7C0662477dfa0c4556a8f5c3bc62aa0d9c%7C0%7C1%7C637207840984524088&sdata=K1qcU0GPI8DnmF8fTLT5pNk2ZV9TlhVf4cMYAeZ6qss%3D&reserved=0) directing CDCR to suspend intake into state correctional facilities for 30 days. All persons convicted of felonies shall be received, detained, or housed in a jail or other facility currently detaining or housing them for that period. The order allows Secretary Diaz to grant one or more 30-day extensions 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.

CDCR has suspended transfers of inmates into the Male Community Reentry Program (https://gcc01.safelinks.protection.outlook.com/?url=https%3A%2F%2Fwww.cdcr.ca.gov%2Frehabilitation%2Fmcrp%2F&data=02%7C01%7CDana.Simas%40cdcr.ca.gov%7Cb289a7c86e924c100f6708d7d127c0c3%7C0662477dfa0c4556a8f5c3bc62aa0d9c%7C0%7C0%7C637207840984524088&sdata=TUbKWRsQ%2BUUOazKP%2FWwNSQ62HNe3jYqPcdoLYGg2pHM%3D&reserved=0) (MCRP), the Custody to Community Transitional Reentry Program (https://gcc01.safelinks.protection.outlook.com/?url=https%3A%2F%2Fwww.cdcr.ca.gov%2Fadult-operations%2Fcustody-to-community-transitional-reentry-program%2F&data=02%7C01%7CDana.Simas%40cdcr.ca.gov%7Cb289a7c86e924c100f6708d7d127c0c3%7C0662477dfa0c4556a8f5c3bc62aa0d9c%7C0%7C0%7C637207840984534085&sdata=6QxnVgYRFZEpkzr53XrFQKlPGrN7izJffrZIs1l9aTA%3D&reserved=0) (CCTRP), and the Alternative Custody Program (https://gcc01.safelinks.protection.outlook.com/?url=https%3A%2F%2Fwww.cdcr.ca.gov%2Fadult-operations%2Facp%2F&data=02%7C01%7CDana.Simas%40cdcr.ca.gov%7Cb289a7c86e924c100f6708d7d127c0c3%7C0662477dfa0c4556a8f5c3bc62aa0d9c%7C0%7C0%7C637207840984534085&sdata=LOmec3UwbZNH6nLMVKBDJ6SBGycVBA7lMvLxdddfPkE%3D&reserved=0) (ACP) until further notice. CDCR has taken this step to limit potential exposure of staff to COVID-19 during inmate transfers to the community. Additionally, as part of this program, incarcerated persons remain under the jurisdiction and responsibility of CDCR, to include providing any required medical attention. Releasing incarcerated persons to these programs could potentially expose them to COVID-19 in the community which would require their transfer back to an institution for medical care for non-emergent health care needs, increasing risk for potential exposure within our institutions.

CDCR has also suspended transfers of inmates to the Conservation Camp program until further notice. Inmate transfers previously initiated under the approved guidelines, who are currently on layover, will be moved to their final destination.

All transfers out of Reception Centers are suspended through April 22, 2020.

Moves to Department of State Hospital beds at Atascadero State Hospital, Coalinga State Hospital, and Patton State Hospital are allowed only for mentally disordered offender (MDO) referrals.

All Interstate Compact Agreement transfers of out-of-state parolees and inmates to California will cease for 30 days.

To mitigate workload when non-essential movement resumes, this cancellation of all non-essential inmate movement impacts movement only; classification committees and review processes will move ahead as normal.

While it's required to have three staff members to make a quorum, it is only required, during this unique time, to have two staffers physically present in the committee room with the remaining committee member joining by call. All present in the room should practice social distancing.

California statute permits the Director to authorize temporary community leave for inmates from prison. To reduce risks of COVID-19 to all who work and live in the state prison system

and our surrounding communities, there will be no temporary community leave approvals at this time. We will work to make communications available to individuals in these situations.

Visiting

As part of CDCR's COVID-19 prevention efforts, normal visiting at adult and juvenile facilities is canceled statewide until further notice based on California Department of Public Health guidance for mass gatherings. This includes overnight family visits and Division of Juvenile Justice visiting.

Institutions have been instructed to find opportunities to allow increased phone access for the incarcerated population so they may keep in touch with their support system, while also practicing social distancing and other infectious disease safety protocols.

At this time, legal/attorney visits are being held for urgent needs only. Hospice visits will no longer be held until further notice. Marriages will be postponed; those affected are encouraged to work with the institution's Community Resource Manager regarding rescheduling for a later date.

Expanded telephone use

In recognition of the need for incarcerated people to have contact with their loved ones, the Division of Adult Institutions has expanded phone access for certain privilege groups. Access will be via current inmate phone equipment, with extra precautions taken to clean phones and allow physical distancing to limit possible exposure and transmittal of illness. Inmates on C Status (lost privileges due to disciplinary reasons) will remain on phone restrictions until C Status until that status has been completed or removed.

The following populations will be allowed to make calls above their privilege group until further notice:

- Inmates in Administrative Segregation for non-disciplinary reasons, designated Privilege Group B, will be allowed one phone call per week (previously one per month; Privilege Group A are normally allowed one call per week)
- All other inmates in restricted housing will be allowed to make one phone call once every two weeks (currently no phone calls permitted)
- Reception Center inmates will be provided one phone call per week (currently one call within first seven days and one per month after)
- Inmates in Psychiatric Inpatient Program settings will be allowed one call per week unless they are prohibited by the Interdisciplinary Treatment Team (with documented clinical justification).

CDCR's inmate telephone network provider Global Tel Link (GTL) has offered the adult incarcerated population three days of free phone calls each week through the end of April. There is no limit on the number of calls; however, each institution may limit time to accommodate need. The following days are designated for free calling:

Week 1: March 31, April 1, April 2

Week 2: April 7, 8, 9

Week 3: April 14, 15, 16

Week 4: April 21, 22, 23

Week 5: April 28, 29, 30

CDCR's electronic messaging provider for the incarcerated population, JPay, is providing reduced-priced emails to those incarcerated at the pilot institutions and free emails for those inmates who cannot afford it. The five pilot sites that currently have the technology include: High Desert State Prison, Kern Valley State Prison, California Institution for Women, Central California Women's Facility, and Substance Abuse Treatment Facility. At some of these institutions, only certain yards currently have this technology. Details will be provided to the incarcerated population at the institutions.

JPay has also extended inbound email print services to all institutions at a reduced rate. This service enables incarcerated people's family and friends to use the JPay app to send e-correspondence, which mailroom staff then print and deliver with regular mail. Family and friends purchase stamps for this service. While this will not eliminate physical mail, this process reduces COVID-19 transmission risk. This service is also a cost-effective way for incarcerated people to maintain contact with family and friends, which is especially important while visiting is closed. This service is expected to go live on April 10.

More information about JPay services is available in English (https://www.cdcr.ca.gov/covid19/wp-content/uploads/sites/197/2020/04/R_CDCR-Take-Ones-English-Sample.pdf)and Spanish (https://www.cdcr.ca.gov/covid19/wp-content/uploads/sites/197/2020/04/R_CDCR-Take-Ones-Spanish-Sample.pdf).

The youth within the Division of Juvenile Justice already receive free phone calls and have begun using free Skype video calls for visiting.

Rehabilitative programs and volunteers

Non-CDCR/CCHCS/CALPIA staff will not be permitted to enter state prison until further notice. This includes people who enter state prison as volunteers, or to facilitate rehabilitative programs. Paid union representatives, and Inmate Ward Labor (IWL) staff will be permitted. CalVet representatives and contractors who work with institution staff to conduct interviews and provide forensic evaluations for incarcerated veterans to receive federal disability benefits for themselves and their families pursuant to Senate Bill 776 will also be permitted.

No rehabilitative programs, group events, or in-person educational classes will take place until further notice. At this time, all tours and events have been postponed, and no new tours are being scheduled.

Education

The Office of Correctional Education is working with institution principals, library staff, and teachers to provide in-cell assignments where possible in order for students to continue their studies, legal library access and educational credit-earning opportunities.

For those in our incarcerated population who need supplementary academic support, CDCR has encouraged Disability Placement Program, Developmental Disability Program, and Every Student Succeeds Act staff to coordinate with the institution instructor to provide additional assistance to enrolled students where possible.

Standardized testing has stopped until further notice, although we are encouraging education staff to continue to engage their students as much as possible to stay focused on their rehabilitation and positive programming during this time.

Recreation and Law Library Services will continue to be available to the incarcerated population even if physical access is restricted due to safety and security measures.

Religious programs

CDCR recognizes the importance of religion in the daily life and spiritual growth of incarcerated people. Unfortunately, the department has limited group religious programming for upcoming holidays such as Ramadan, Passover, and Easter. These services will be provided as in-cell services as an alternative. CDCR will provide the appropriate Ramadan and Passover daily meals to allow incarcerated people to observe their religious meal traditions, including appropriately beginning and breaking their Ramadan fast.

Chaplains will conduct individual religious counseling as appropriate while maintaining social distancing, and CDCR is working to provide televised religious services to the population.

Health care services

The health and safety of our population is of critical importance to CDCR and CCHCS. While our agency is working together to prepare for and respond to COVID-19, we will continue to provide urgent health care services. To reduce risks to both patients and staff, inmate movement will be minimized. In addition, some specialty and routine care may be delayed as a result of both internal redirections and external closures. All cancelled appointments will be rescheduled as soon as safely possible. Health care staff will continue to see and treat patients through the 7362 process and those with flu-like symptoms will be tested for COVID-19 as appropriate.

On March 20, CCHCS issued COVID-19: Interim Guidance for Health Care and Public Health Providers. This document provides clinical guidelines to health care providers in response to COVID-19 cases in the California prison system. View guidelines distributed to institution staff on March 20, 2020. (https://www.cdcr.ca.gov/covid19/wp-content/uploads/sites/197/2020/03/R_CCHCS-COVID-19-Interim-Guidance-3.19.2020.pdf?label=COVID-19:%20Interim%20Guidance%20for%20Health%20Care%20and%20Public%20Health%20Providers%20&from=https://www.cdcr.ca.gov/covid19/memos/)

CDCR and CCHCS have launched an internal patient registry to assist institutions in monitoring patients with suspected or confirmed COVID-19. The COVID-19 Registry also tracks all individuals by risk. 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 to compile risk factor data. This registry also includes release date information for each individual, in the event that individuals are to be considered for early release during the pandemic. This tool is not publically available as it contains personal health care information protected by medical privacy laws.

Dental care

The California Dental Association recommends that all non-urgent dental care be suspended for the next 14 days. Effective immediately and until further notice, dental treatment shall be limited to Dental Priority Classification (DPC) 1 conditions (urgent care). For more information on what qualifies as urgent care, view HCDOM 3.3.5.4 (https://gcc01.safelinks.protection.outlook.com/?url=https%3A%2F%2Fcchcs.ca.gov%2Fwp-content%2Fuploads%2Fsites%2F60%2FHC%2FHCDOM-ch03-art3.5.4.pdf&data=02%7C01%7CDana.Simas%40cdcr.ca.gov%7Cb289a7c86e924c100f6708d7

d127c0c3%7C0662477dfa0c4556a8f5c3bc62aa0d9c%7C0%7C1%7C637207840984544076&sdata=32JMHUCxD1BMpHxflLgoCWd9lkcCakt9D9QfSGWqPFg%3D&reserved=0).

Specialty care appointments

In order to reduce risks to patients and staff, all non-urgent offsite specialty appointments will be re-scheduled to a later time. Telemedicine appointments will continue at this time.

Board of Parole Hearings/Parole suitability hearings

All in-person Board of Parole Hearings (BPH) adult parole suitability hearings are postponed for a minimum of 60 days. BPH is working to develop a process for conducting parole hearings by videoconference for all participants to attend, including incarcerated persons, attorneys, commissioners, and victims/victims next-of-kin. That process is expected to be in place by mid-April, per the Governor's Executive Order (https://gcc01.safelinks.protection.outlook.com/?url=https%3A%2F%2Fwww.gov.ca.gov%2F2020%2F03%2F24%2Fgovernor-newsom-issues-executive-order-on-state-prisons-and-juvenile-facilities-in-response-to-the-covid-19-outbreak%2F&data=02%7C01%7CDana.Simas%40cdcr.ca.gov%7Cb289a7c86e924c100f6708d7d127c0c3%7C0662477dfa0c4556a8f5c3bc62aa0d9c%7C0%7C1%7C637207840984544076&sdata=bKbYLUqwNc3%2FP9%2Fw%2FuK04kBuOYlR6LjFP%2F6H6uBRQrc%3D&reserved=0).

Board of Juvenile Hearings proceedings will take place as scheduled via video conference only. Go to the Board website for more information. https://www.cdcr.ca.gov/juvenile-justice/juvenile-parole-board/ (https://gcc01.safelinks.protection.outlook.com/?url=https%3A%2F%2Fwww.cdcr.ca.gov%2Fjuvenile-justice%2Fjuvenile-parole-board%2F&data=02%7C01%7CDana.Simas%40cdcr.ca.gov%7Cb289a7c86e924c100f6708d7d127c0c3%7C0662477dfa0c4556a8f5c3bc62aa0d9c%7C0%7C0%7C637207840984554073&sdata=i%2FP%2F76ZpNHbLKipVcF4iFzbJi7mkldzbFlkQsk3rP3k%3D&reserved=0)

Division of Adult Parole Operations

The Division of Adult Parole Operations (DAPO) is committed to the safety of the community, staff, and those in its care. Given the increased risk associated with the use of mass/public transportation and those under parole supervision deemed a high-risk population (older adults and those with known serious chronic medical conditions), DAPO will make some operational changes to support both staff and the individuals under their care and supervision, including suspending lobby traffic except for initial parole interviews and emergencies, and suspending office visits for those age 65 and older and/or with chronic medical conditions.

All parolees' conditions of parole remain in place, with the exception of the items listed above. DAPO administrators and supervisors will assess all measures being implemented and adjust, modify, or waive required specifications as appropriate. Any questions parolees may have related to COVID-19 prevention efforts should be directed to their Parole Agent. Learn more here (https://gcc01.safelinks.protection.outlook.com/?url=https%3A%2F%2Fwww.cdcr.ca.gov%2Fcovid19%2Fdivision-of-adult-parole-operations%2F&data=02%7C01%7CDana.Simas%40cdcr.ca.gov%7Cb289a7c86e924c100f6708d7d127c0c3%7C0662477dfa0c4556a8f5c3bc62aa0d9c%7C0%7C0%7C637207840984554073&sdata=oKcA3WPjx9T3e8uMvYuzuiXyJEiAi%2BW7VevmFtxaCPQ%3D&reserved=0).

Modified Community Correctional Facilities and Community Reentry Programs

CDCR's in-state contract facilities are conducting verbal screenings of staff and participants who enter the facilities. Those attempting to enter one of these facilities are required to verbally

respond if they currently have symptoms of a respiratory illness.

Visiting has also been halted at these facilities until further notice.

CDCR is committed to continuing education programs and limiting the impact our COVID-19 response has on positive rehabilitative programming for our Community Reentry Programs. Rehabilitative programs at the reentry facilities will continue with modifications made to class sizes to encourage social distancing, with some potential program closures.

At this time, participants are generally restricted from leaving the facilities outside of mandated legal reasons, urgent medical needs, if they are employed in the community, or for critical reentry services related to those within 30-45 days of release.

Participants age 65 or older are only eligible for passes to go out in the community for emergency situations only.

Visiting has been canceled at the Community Prisoner Mother Program (CPMP) in line with recommendations from public health officials and the cessation of visiting at CDCR locations statewide. This includes scheduled off-site visits for children residing at CPMP with their mothers. Family members may continue to drop approved items such as diapers, wipes, baby food and baby snacks (for children under 1), during normal visiting hours even during closure. CPMP staff are diligently working to ensure the mothers' and children's needs are met and supplies are readily available with a surplus where needed. They are working closely with community healthcare providers and medical staff at nearby California Institution for Women to keep all required appointments for mothers and children.

Division of Juvenile Justice

CDCR's Division of Juvenile Justice (DJJ) will begin virtual visitation at all four of its facilities effective April 11. Video visiting appointments are requested by approved visitors for DJJ youth via a dedicated email address and scheduled in 30-minute blocks during regular weekend visitation hours. The visitation takes place on laptop computers placed on tables in standard visiting areas to give youth privacy and assure social distancing is taking place. Appointment requests (https://www.cdcr.ca.gov/juvenile-justice/visiting-your-loved-one-with-skype-for-business/) are screened by staff to make sure that only approved visitors are utilizing the service. A successful trial of the program was implemented on March 27 at Pine Grove Youth Conservation Camp in Amador County. A press release announcing the launch of the new program is available here (https://www.cdcr.ca.gov/news/2020/04/07/california-division-of-juvenile-justice-implements-virtual-visiting/).

Directions will be posted around the DJJ facilities so that youth can share the information with their support system.

Effective March 18, no volunteers are allowed to enter DJJ until further notice. All volunteer programs are postponed. When entering, all staff, volunteers and visitors will be given the same health screenings in place at other state institutions, including temperature checks.

The California Education Authority is continuing high school classes for youth in DJJ. As of April 7, all education provided will be via distance learning.

We also encourage letter writing as a way to stay in touch and are increasing the number of postage stamps available to youth.

Board of Juvenile Hearings proceedings will take place as scheduled via videoconference only. Go to the Board website for more information: https://www.cdcr.ca.gov/juvenile-justice/juvenile-parole-board/ (https://www.cdcr.ca.gov/juvenile-justice/juvenile-parole-board/)

For the latest on steps DJJ is taking to protect youth from COVID-19, visit the DJJ webpage here (https://www.cdcr.ca.gov/juvenile-justice/).

Construction projects

On March 20, 2020, CDCR suspended large-scale construction projects located within the secure perimeter of CDCR facilities. Limited construction activities are continuing as necessary to make work areas safe and protect construction areas from deterioration during the suspension. While the construction industry overall has been identified as an essential business/service under Executive Order E-33-20, the interest of CDCR as a construction owner is unique. Construction occurring at facilities under CDCR jurisdiction impacts the health and safety of thousands of employees and persons incarcerated in youth and adult institutions. The action to suspend large-scale construction projects was consistent with earlier preventive actions, such as the cancellation of visiting and volunteer entries statewide, and seeks to reduce and minimize the number of non-CDCR employees that enter CDCR institutions on a daily basis. These decisions are not made lightly, and are taken with the safety of all who work in, live in, and visit our facilities in mind.

Peace officer hiring and academies

Written peace officer exams are suspended until April 6, 2020. The health and safety of our staff, cadets, and candidates is a top priority. CDCR is taking all the available precautions to ensure a safe and healthy environment. These precautions include regular office cleanings, hand sanitizer/gloves when applicable, reduced testing and physical fitness group sizes, and social distancing.

The Basic Correctional Officer Academy (BCOA) that is currently underway has been accelerated to allow graduation to move from May 1, 2020, to April 7, 2020. The BCOA scheduled to start Tuesday, March 24, will be postponed for at least 30 days.

Population communication

CDCR Secretary Ralph Diaz will be releasing regular video message updates directly to the incarcerated population. You can see the latest message from March 25 here (https://gcc01.safelinks.protection.outlook.com/?url=https%3A%2F%2Fvimeo.com%2F400758862%2F824c4cf567&data=02%7C01%7CDana.Simas%40cdcr.ca.gov%7Cb289a7c86e924c100f6708d7d127c0c3%7C0662477dfa0c4556a8f5c3bc62aa0d9c%7C0%7C1%7C637207840984564065&sdata=rGtZkMRcnQN1Y5CBJdpiW27scQ3MLaG3NKEzNHib0PA%3D&reserved=0).

Wardens, captains, public information officers, and other institution executives have been instructed to meet with their respective Inmate Advisory Councils either individually or in small groups where social distancing can be maintained. This is to encourage an open line of communication between the incarcerated population and the institution leaders in charge of their care in order to quickly and efficiently meet their needs.

To keep members of our population informed, we have created and distributed fact sheets and posters in both English and Spanish that provide education on COVID-19 and precautions recommended by CDC, which expand upon those advised during cold and flu season. We have

also begun streaming CDC educational videos on the CDCR Division of Rehabilitative Programs inmate television network and the CCHCS inmate health care television network. Learn more here (https://gcc01.safelinks.protection.outlook.com/?url=https%3A%2F%2Fwww.cdcr.ca.gov%2Fcovid19%2Fpopulation-communications%2F&data=02%7C01%7CDana.Simas%40cdcr.ca.gov%7Cb289a7c86e924c100f6708d7d127c0c3%7C0662477dfa0c4556a8f5c3bc62aa0d9c%7C0%7C0%7C637207840984564065&sdata=LQUKzZExIzF0YcnEHrTdezSZLSUkAA%2FulwfKSVIIDYI%3D&reserved=0).

Additionally, we are providing regular department updates regarding COVID-19 response to the Statewide Inmate Family Council and all institutional Inmate Family Councils who serve the family and friends of the incarcerated population to ensure they are aware of the steps the department is taking to protect their loved ones housed in our institutions.

Communication and guidance to staff

CDCR Secretary Ralph Diaz will be releasing regular video message updates directly to CDCR staff. You can see the latest message from March 25 here (https://gcc01.safelinks.protection.outlook.com/?url=https%3A%2F%2Fvimeo.com%2F400756098%2F8d895b053b&data=02%7C01%7CDana.Simas%40cdcr.ca.gov%7Cb289a7c86e924c100f6708d7d127c0c3%7C0662477dfa0c4556a8f5c3bc62aa0d9c%7C0%7C1%7C637207840984574058&sdata=YiKdJAZUjC0D8l8k8dzGDVtRisPci%2B8QocgA8OCfLKs%3D&reserved=0).

Federal Receiver J. Clark Kelso released a video message (https://www.cdcr.ca.gov/insidecdcr/2020/03/31/message-to-all-cdcr-cchcs-staff-from-receiver-j-clark-kelso/) to all CCHCS and CCHCS staff.

Only in-service training (IST) for range, weapons, and chemical agents qualifications and training shall continue as long as social distancing can be achieved. All other IST has been postponed until July.

We have worked continuously to keep staff informed of the evolving situation, including creating internal and external webpages with health-related information from CDC and California Department of Public Health on how they can protect themselves against COVID-19. We have also provided staff with California Department of Human Resources (CalHR) updates on personnel and work-related questions specific to the COVID-19 issue.

CDCR and CCHCS care for the health and wellness of its workforce and have been working to accommodate those who have been impacted by this evolving situation. We will continue to work diligently with CalHR and labor organizations on how we can best keep our workforce protected and provide for the safety and security of our institutions.

For more employee resources related to COVID-19, see our webpage here: https://www.cdcr.ca.gov/covid19/information/ (https://gcc01.safelinks.protection.outlook.com/?url=https%3A%2F%2Fwww.cdcr.ca.gov%2Fcovid19%2Finformation%2F&data=02%7C01%7CDana.Simas%40cdcr.ca.gov%7Cb289a7c86e924c100f6708d7d127c0c3%7C0662477dfa0c4556a8f5c3bc62aa0d9c%7C0%7C0%7C637207840984574058&sdata=CtPoh6zi3sKjB5BJ8ZhWCIZZRWfvC8B9zqL%2Ffr6ZmMQ%3D&reserved=0).

Exhibit D

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

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

Exhibit E

State of California Department of Corrections and Rehabilitation

Memorandum

Date: March 13, 2020

To: CDCR Employees Statewide
CCHCS Employees

Subject: **MESSAGE TO EMPLOYEES REGARDING COVID-19 (NEW CORONAVIRUS)**

This message is being written to all California Department of Corrections and Rehabilitation (CDCR) and California Correctional Health Care Services (CCHCS) staff regarding COVID-19 (new coronavirus). We know this is a challenging time for all of you, both professionally and personally, as we work through this ongoing pandemic. Over the upcoming weeks and months, CDCR and CCHCS may operate differently than what you are used to in order to protect and support both staff and the individuals in our custody. We are committed to keeping you informed with the most accurate and current information as we receive it or when decisions are made that impact the Department. We want to assure you that CDCR and CCHCS are working closely with infectious disease control experts to prepare for scenarios wherein COVID-19 could significantly affect department operations. In order to better coordinate the Department's strategies across all disciplines, CDCR has designated Douglas Eckenrod, Assistant Deputy Director, as the COVID-19 coordinator for the Department. Mr. Eckenrod will serve as a liaison between CDCR and CCHCS to coordinate efforts and track ongoing activities relating to COVID-19.

To help keep you informed, the Department has sent out communications and created two internal pages with health-related information from the Centers from Disease Control and Prevention (CDC) and the California Department of Public Health (CDPH) on how staff can protect themselves against the COVID-19, as well as personnel information provided from the California Department of Human Resources. The links have been provided below:

CDC Link
https://www.cdc.gov/coronavirus/2019-ncov/index.html

CDPH Link
https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/Immunization/nCOV2019.aspx

We will continue to follow CDC and CDPH guidelines for responding to the coronavirus and will maintain cooperation and communication with local and state health departments. We

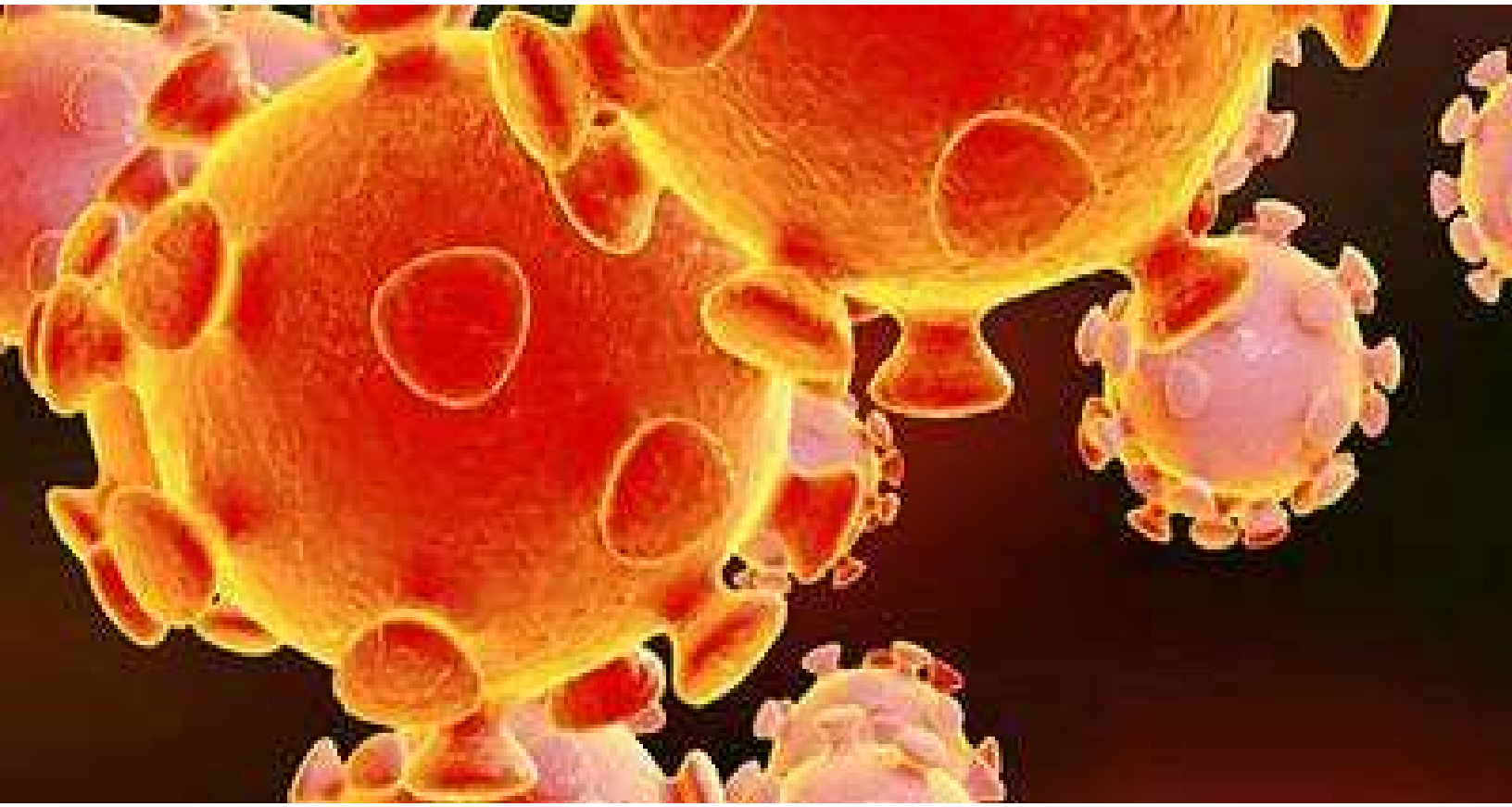
encourage you to continue to communicate through your chain of command so any questions or concerns can be addressed directly. Specific questions related to the Department's strategies regarding COVID-19 can be sent via email to M_CDCRCOVID19prevention@cdcr.ca.gov.

RALPH M. DIAZ
Secretary

J. CLARK KELSO
Receiver

Exhibit F

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



Public Health Nursing Program

Version 2.0

CALIFORNIA CORRECTIONAL
HEALTH CARE SERVICES

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

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

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

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.

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

INTRODUCTION

Coronaviruses are a large family of viruses that are common in many different species of animals; some coronaviruses cause respiratory illness in humans. 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 >100°F, 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.

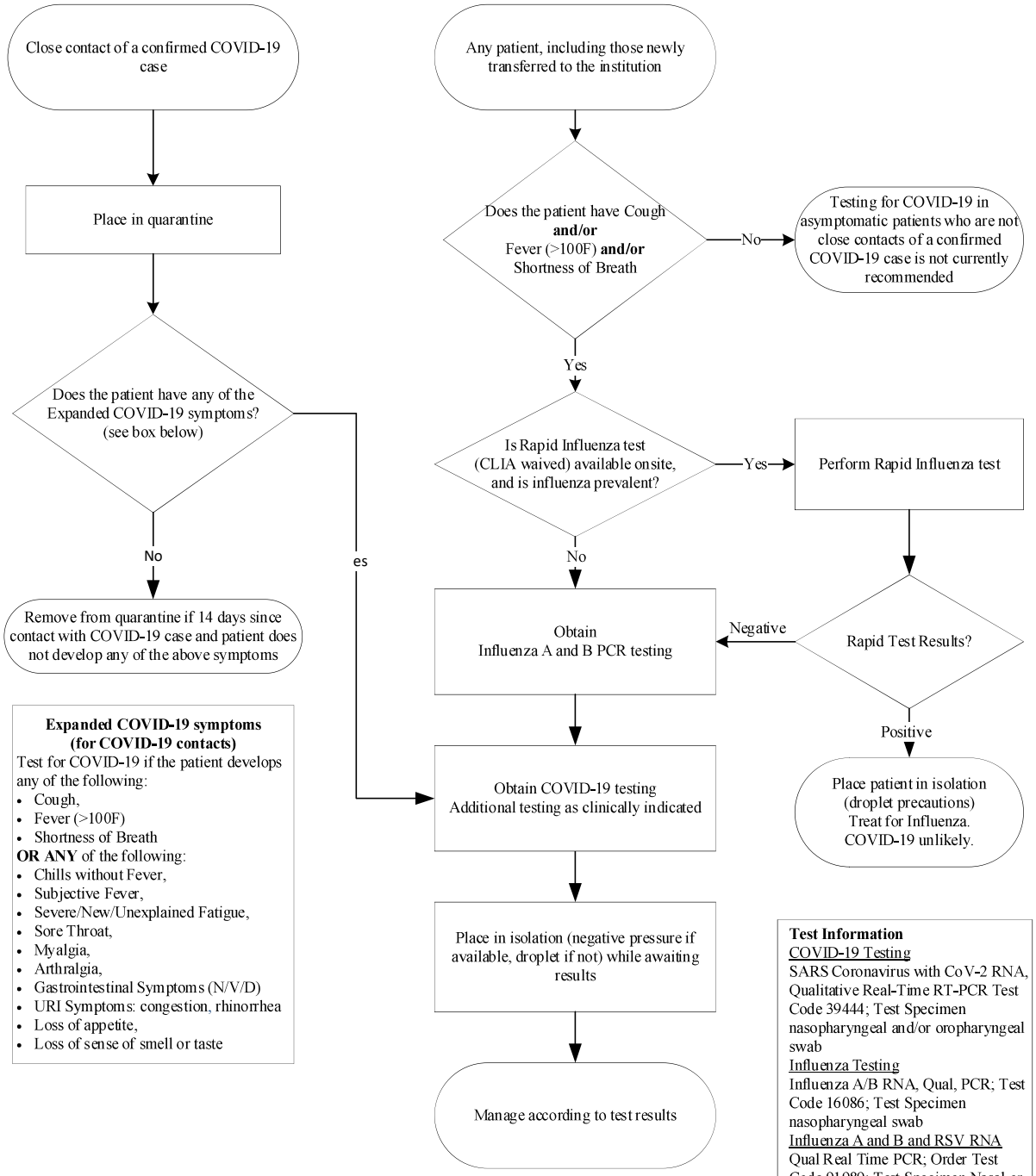
The following patients should be tested immediately for COVID-19:

- 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.

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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

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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.

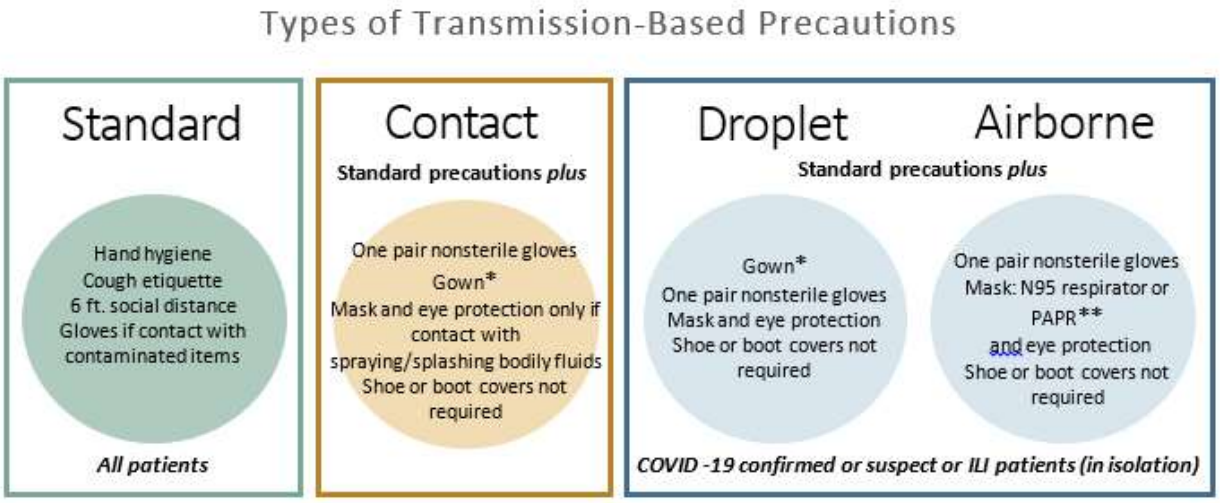
- For previously reported contacts of cases: new exposures, transfers between institutions, discharges/paroles, and releases from quarantine.

- 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



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.

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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

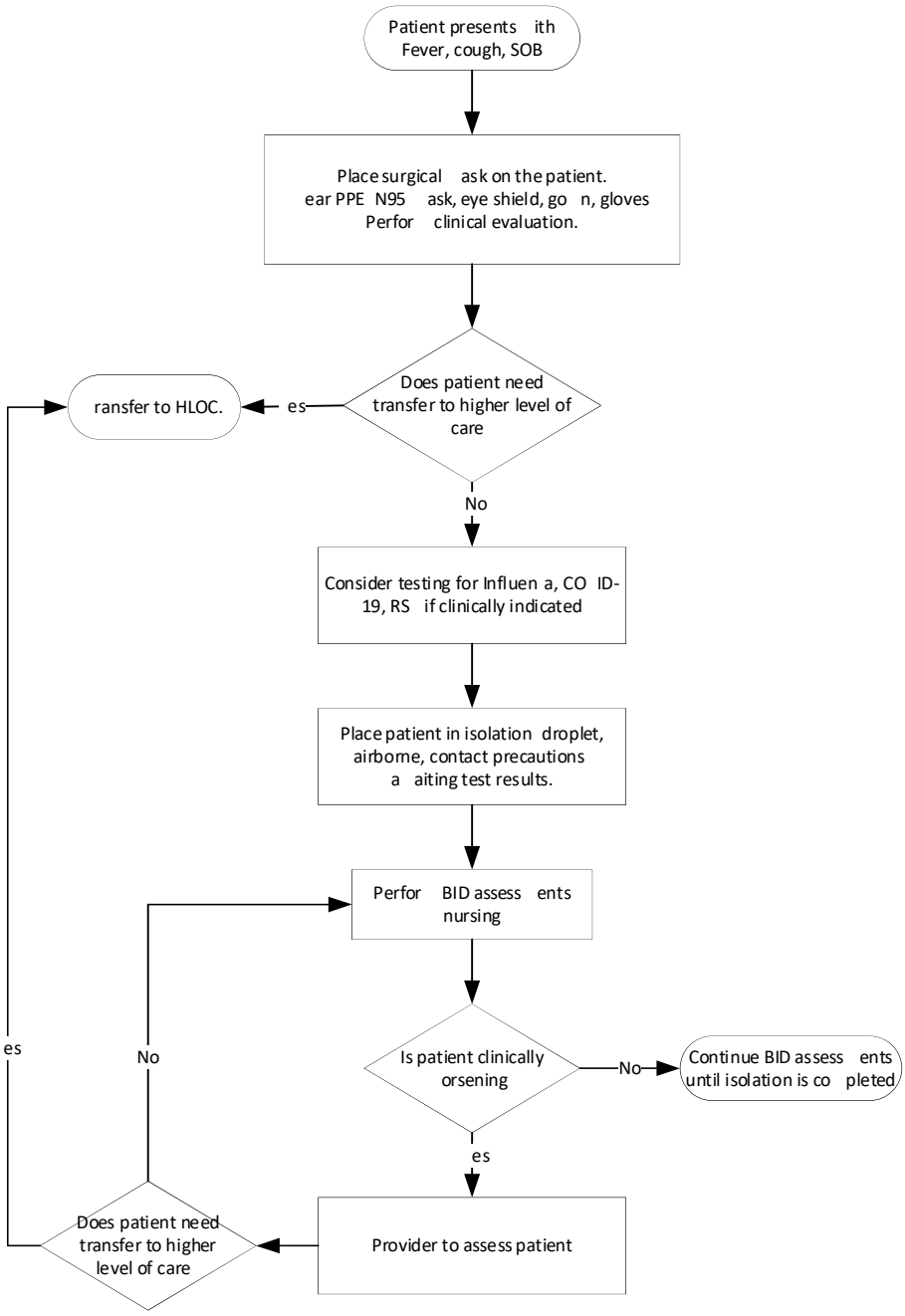
- Patients with suspected COVID-19 require a minimum of twice daily nursing assessment, including, but not limited to:
  - Temperature monitoring
  - Pulse oximeter monitoring
  - Blood pressure checks
  - Respiratory rate and heart rate
- Monitor patients for complications of COVID-19 infection, including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

E a at o o COVID-19 S e t at e t



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.

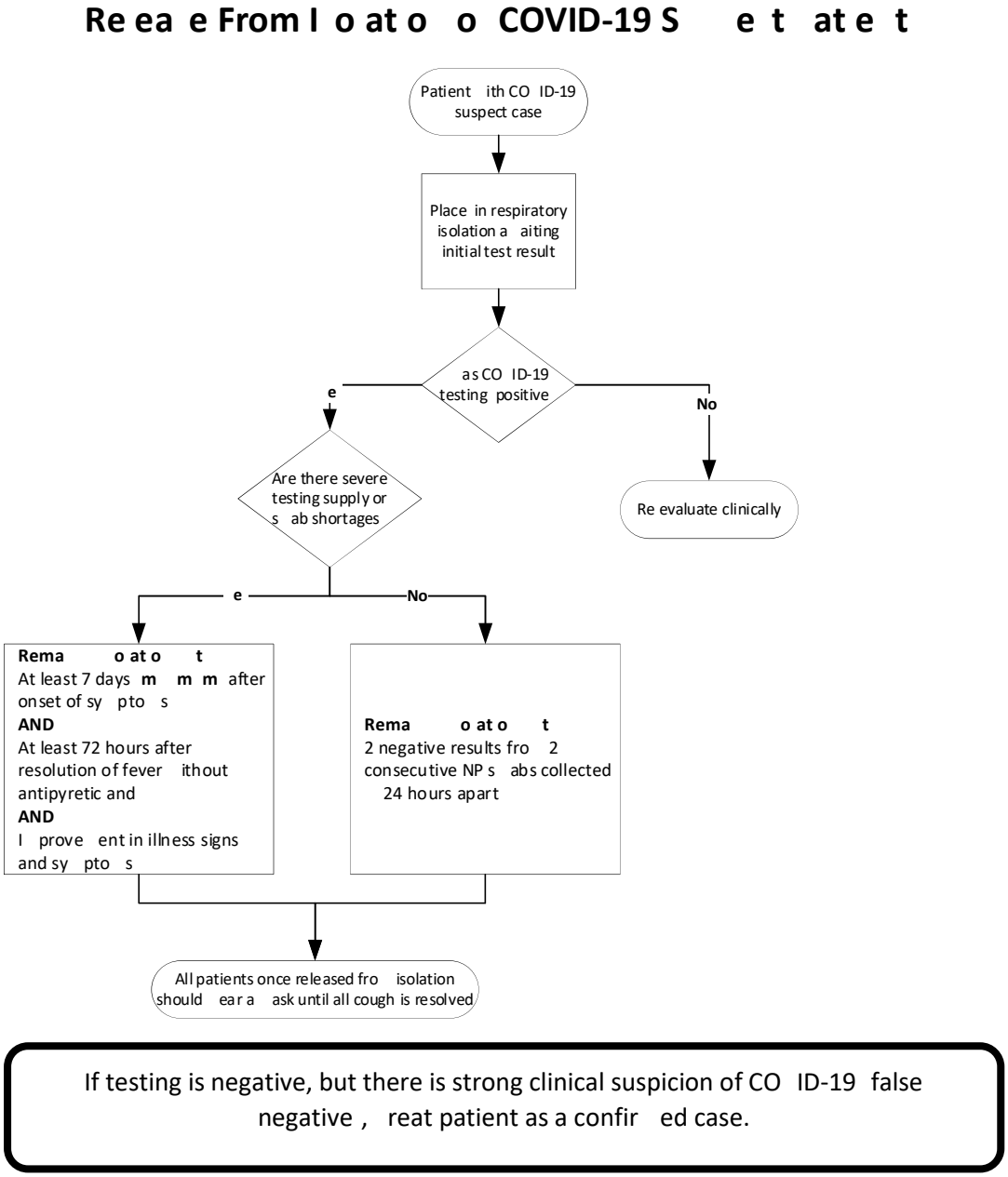
Resolution of cough, is not necessary, however people with residual cough should always wear a mask once released, until completely without cough.

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



If testing is negative, but there is strong clinical suspicion of CO ID-19 false negative , reat patient as a confir ed 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

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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
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7. United States Department of Labor, Occupational Safety and Health Administration https://www.osha.gov/laws-regs/regulations/standardnumber/1910/1910.134
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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. Interi Guidance on Manage ent of Coronavirus Disease 2019 CO ID-19 in Correctional and Detention Facilities https:// .cdc.gov/coronavirus/2019-ncov/co unity/correction-detention/guidance-correctional-detention.ht l
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APPENDIX 1: CORONAVIRUS DISEASE 2019 (COVID-19) CHECKLIST

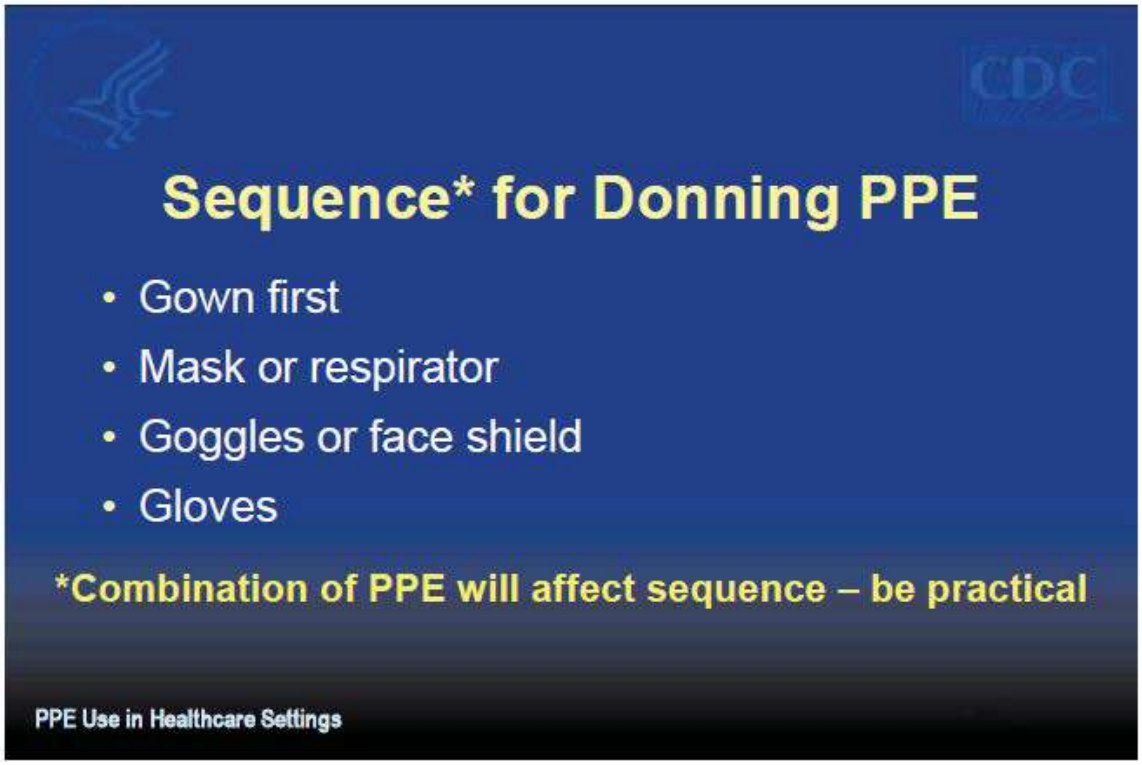
1. RECOGNITION, REPORTING, AND DATA COLLECTION	
	a. Be on alert for patients presenting with fever or symptoms of respiratory illness.
	b. Report suspect cases to institutional leadership, local health department, and the Public Health Branch.
2. INFECTION PREVENTION AND CONTROL MEASURES	
	a. Isolate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

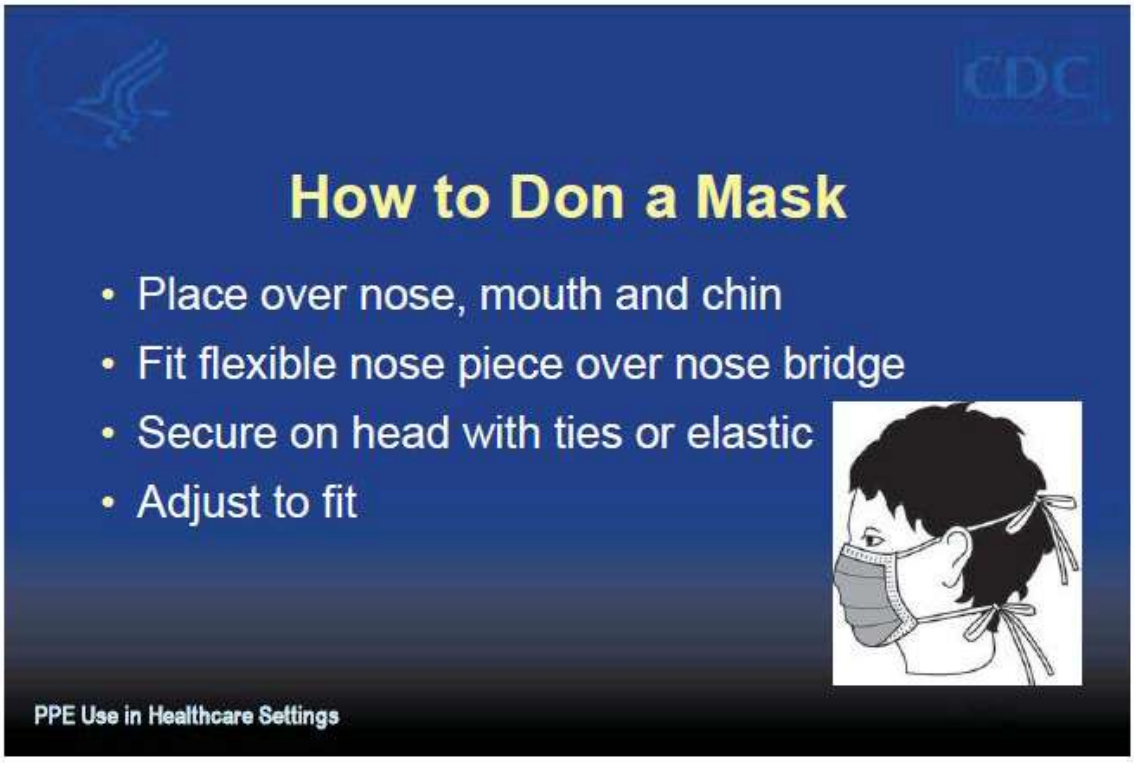
APPENDIX 2: DROPLET PRECAUTIONS CHECKLIST

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

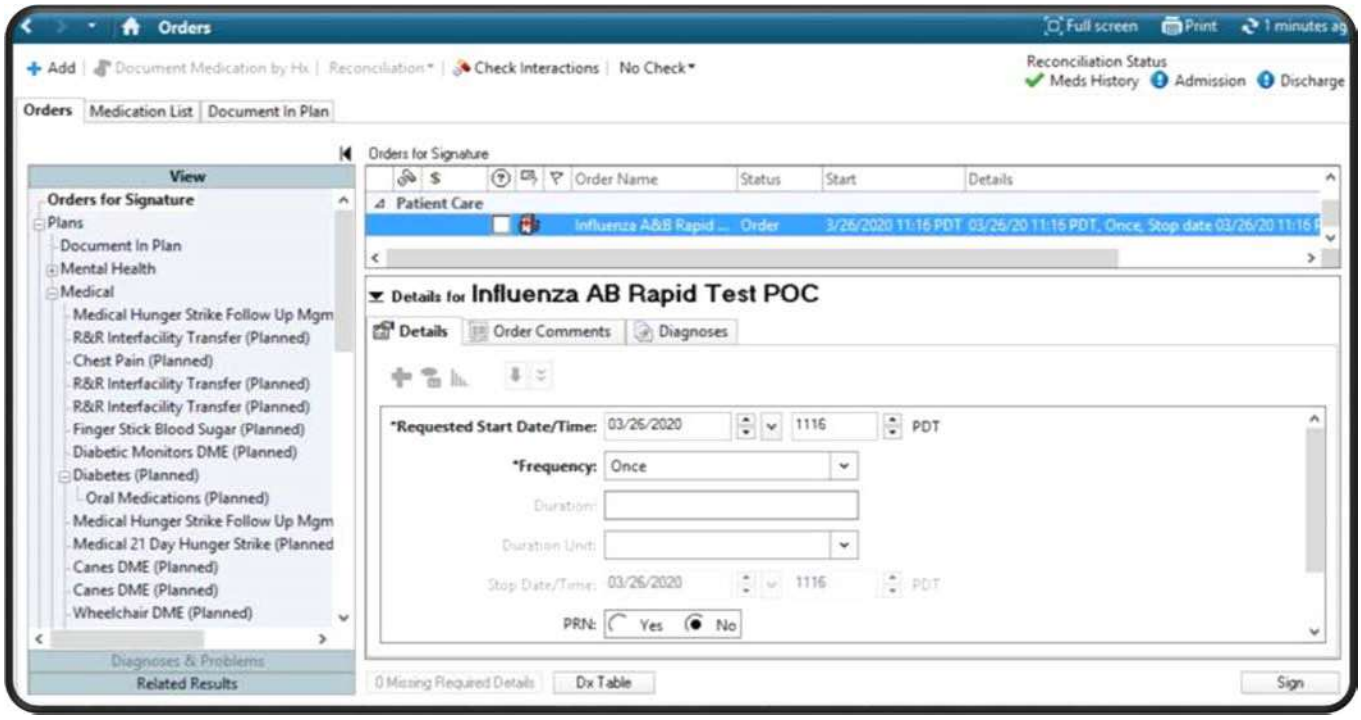
PPE Use in Healthcare Settings

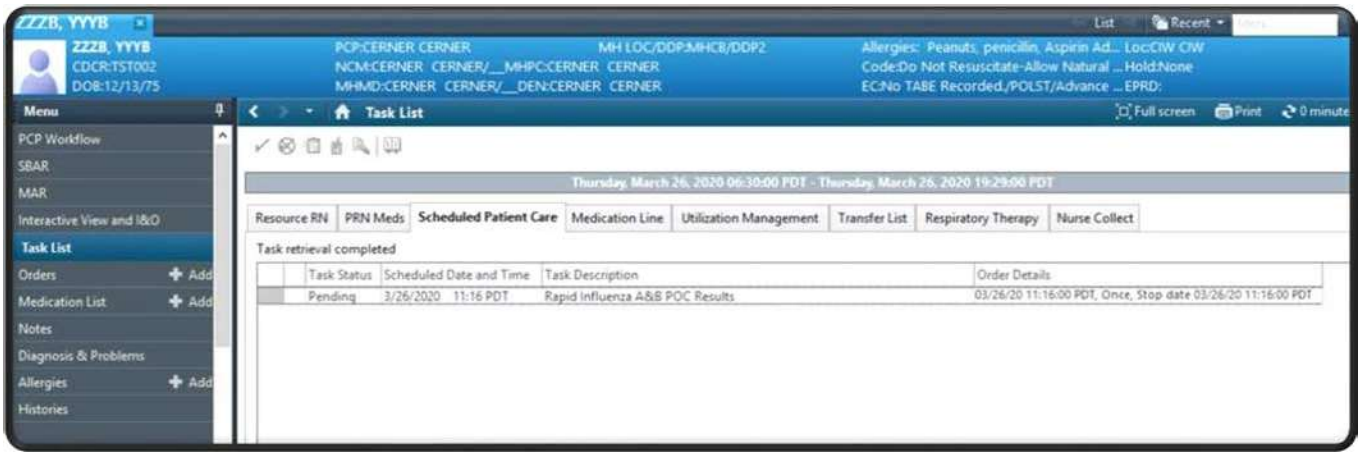
APPENDIX 4: HOW TO ORDER RAPID INFLUENZA DIAGNOSTIC TESTING IN THE EHR

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:

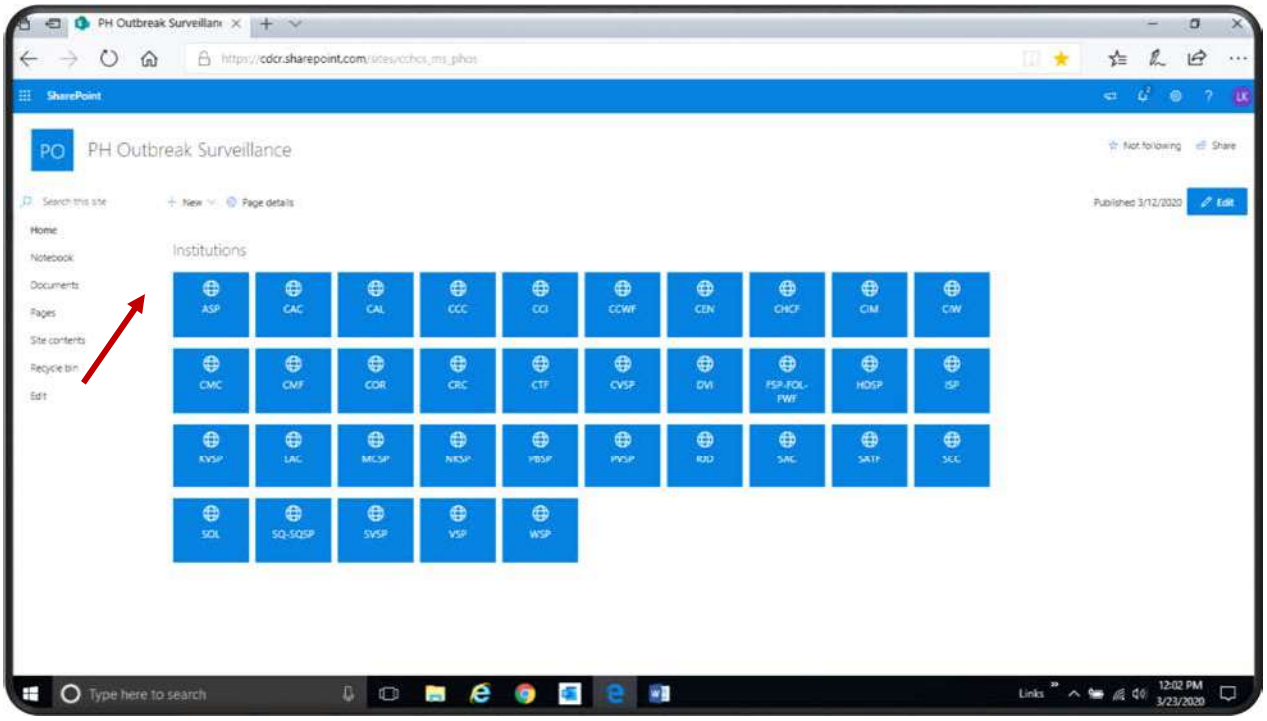
https://cdcr.sharepoint.com/sites/cchcs_ms_phos

- **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.

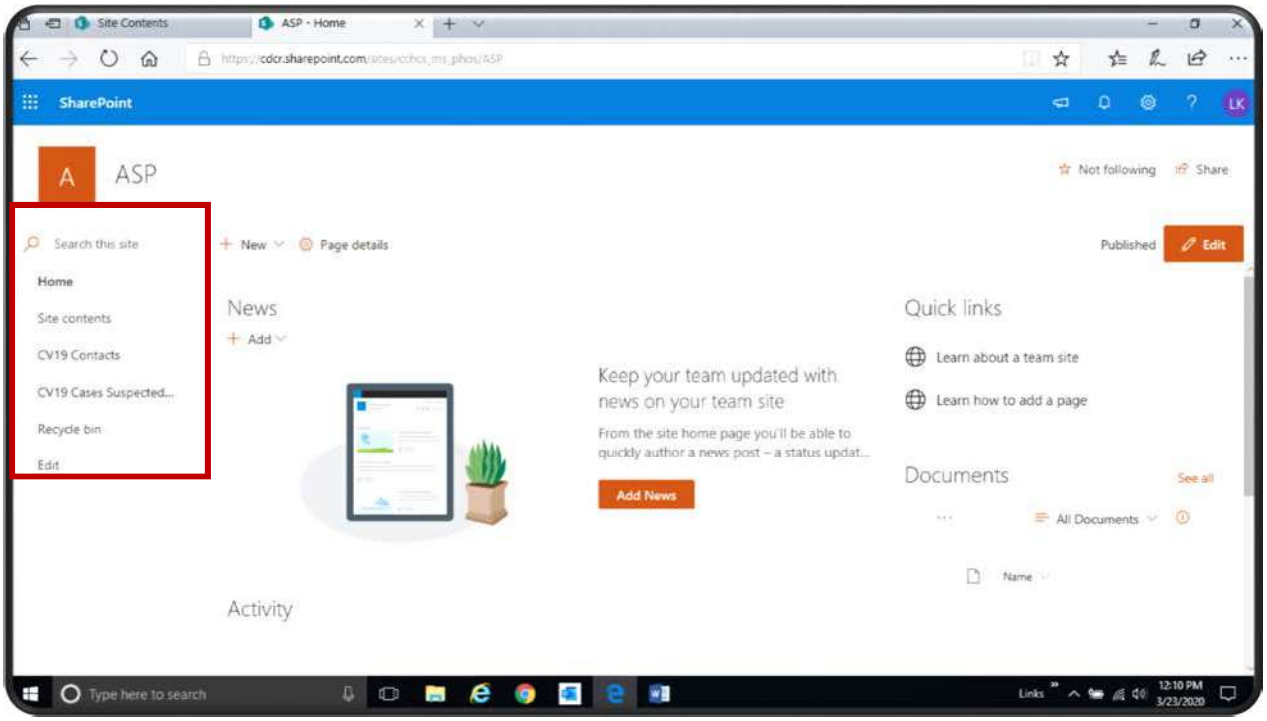
No report is needed if there are no new cases/contacts and no significant updates to existing cases/contacts.

REPORTING IN SHAREPOINT

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

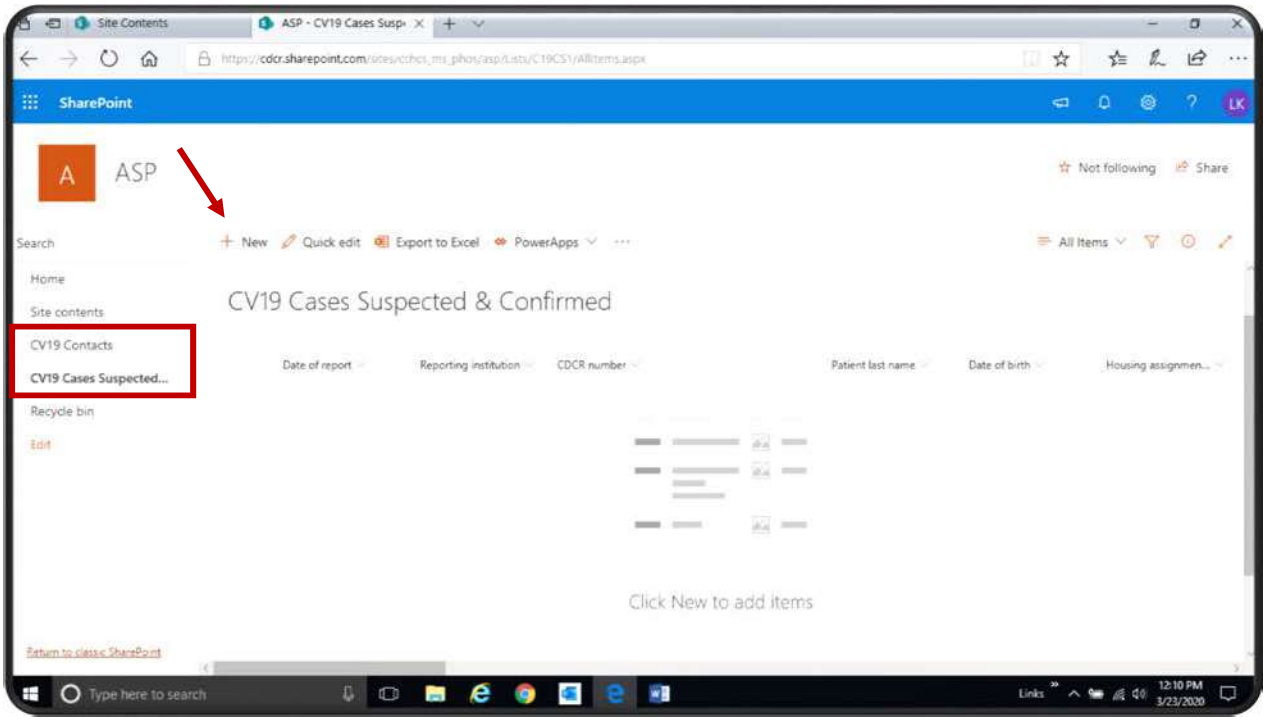


Each institution has a home page with a navigation panel on the left.

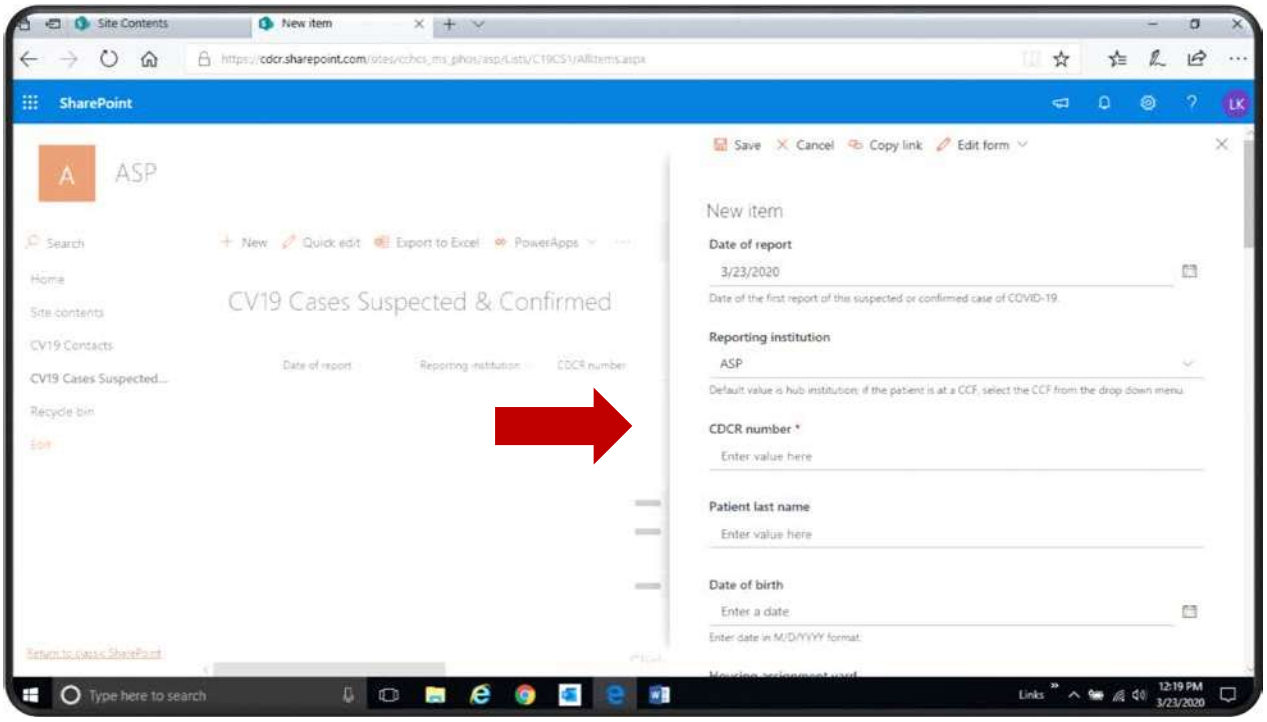


To access the CASES line list, click on **CV19 Cases Suspected & Confirmed**. To access the CONTACTS line list, click on **CV19 Contacts**. This guide applies to both the CASES and CONTACTS line lists.

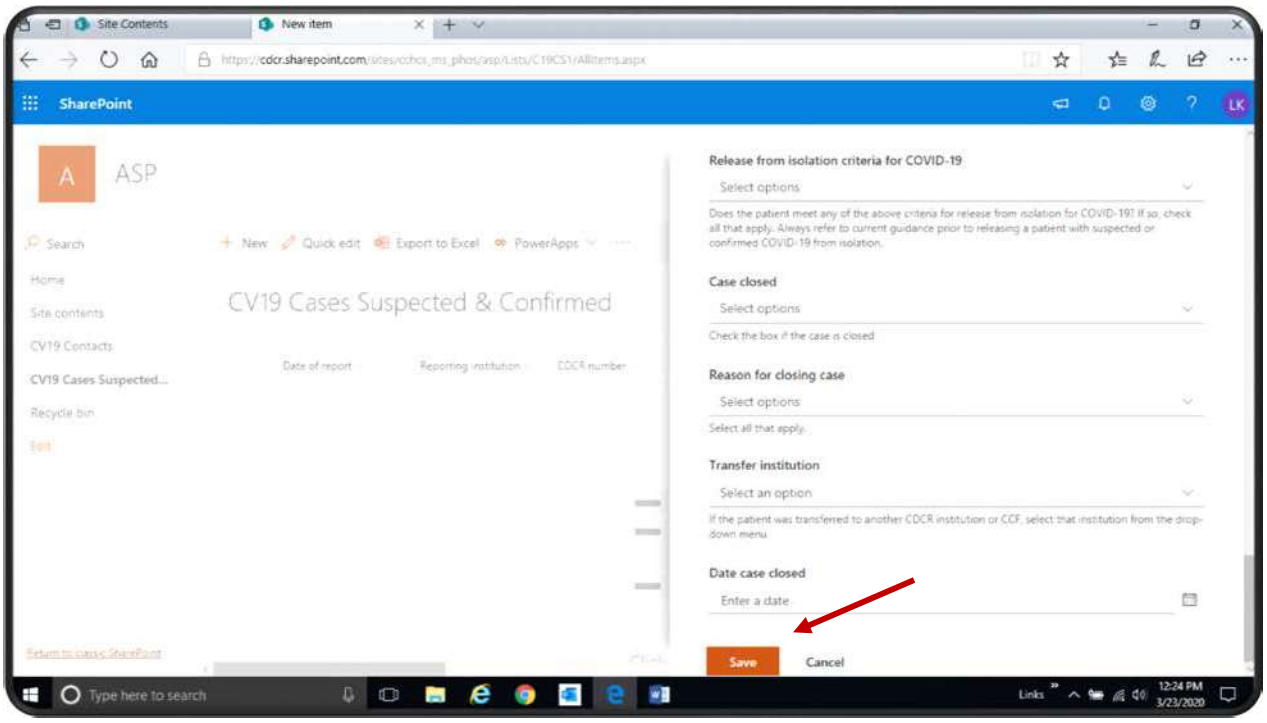
To add a new patient to a line list, click on **New**



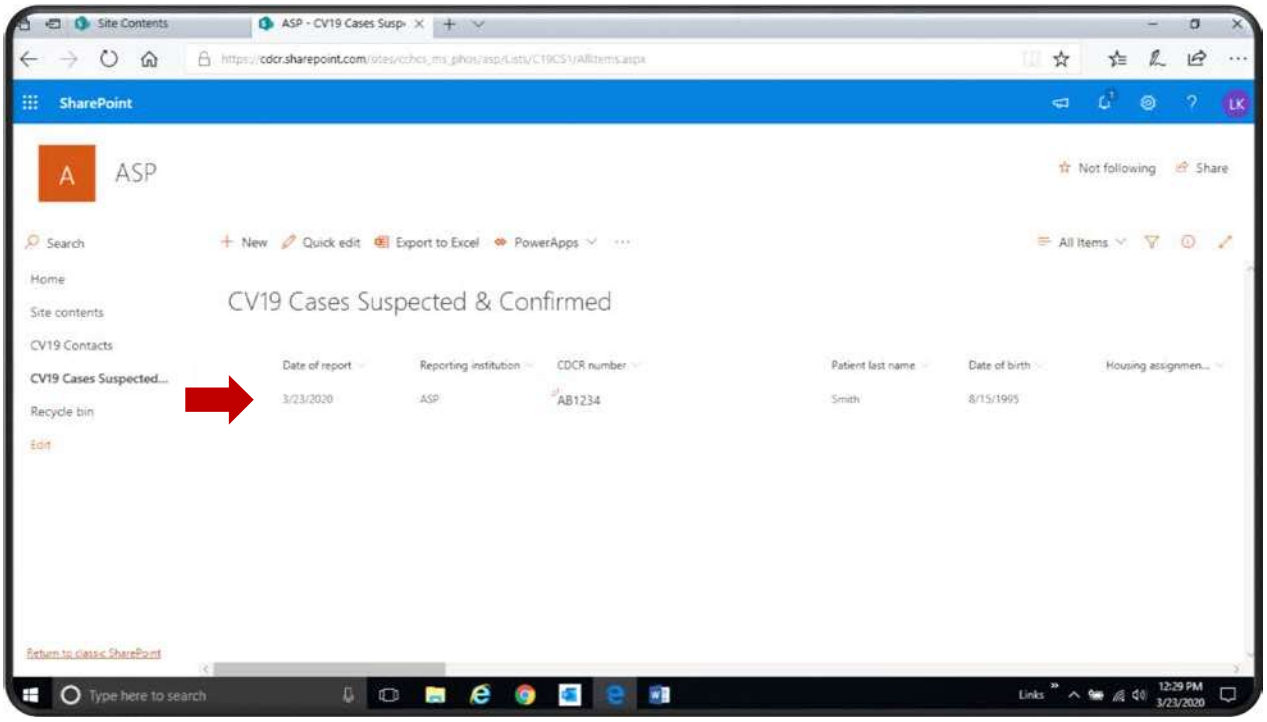
A new record (data entry form) will open on the right.



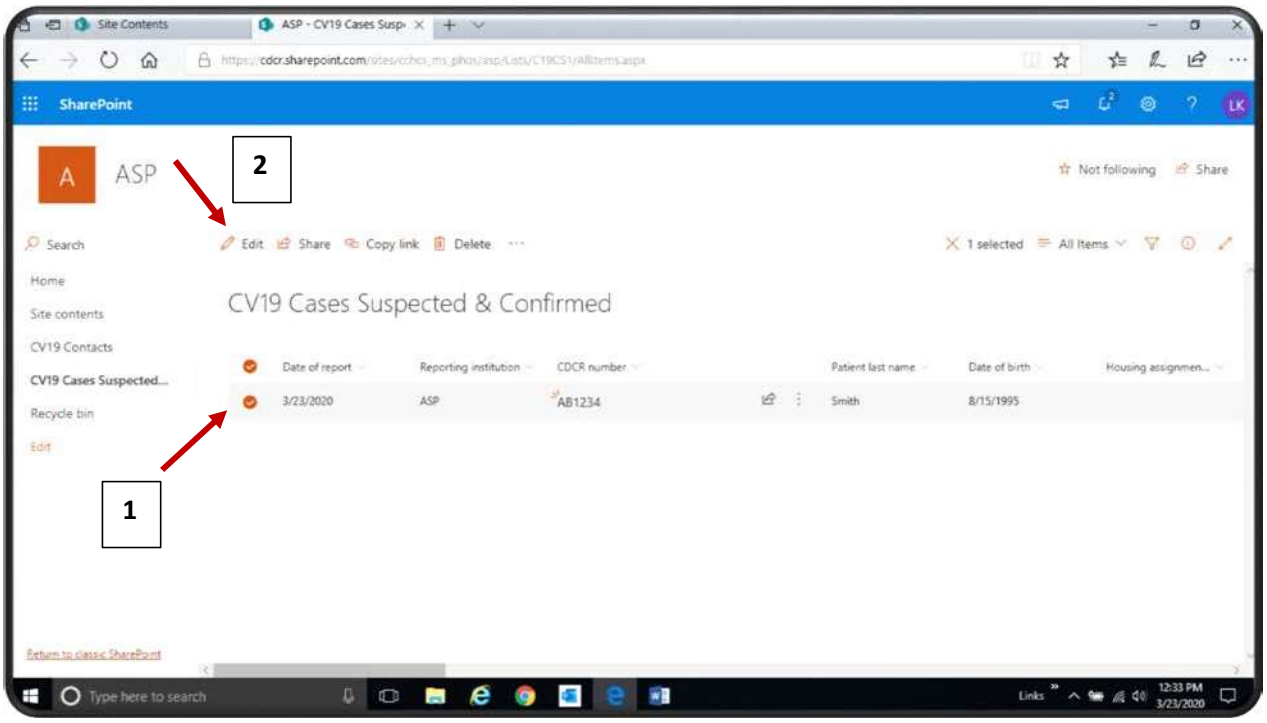
Scroll through the form to enter data. Brief instructions are provided below the form fields. Refer to the **Data Definitions** section on page 9 for detailed instructions for each field in the CASES and CONTACTS line lists. Click on **Save** at the bottom of the form to add the report to the line list.



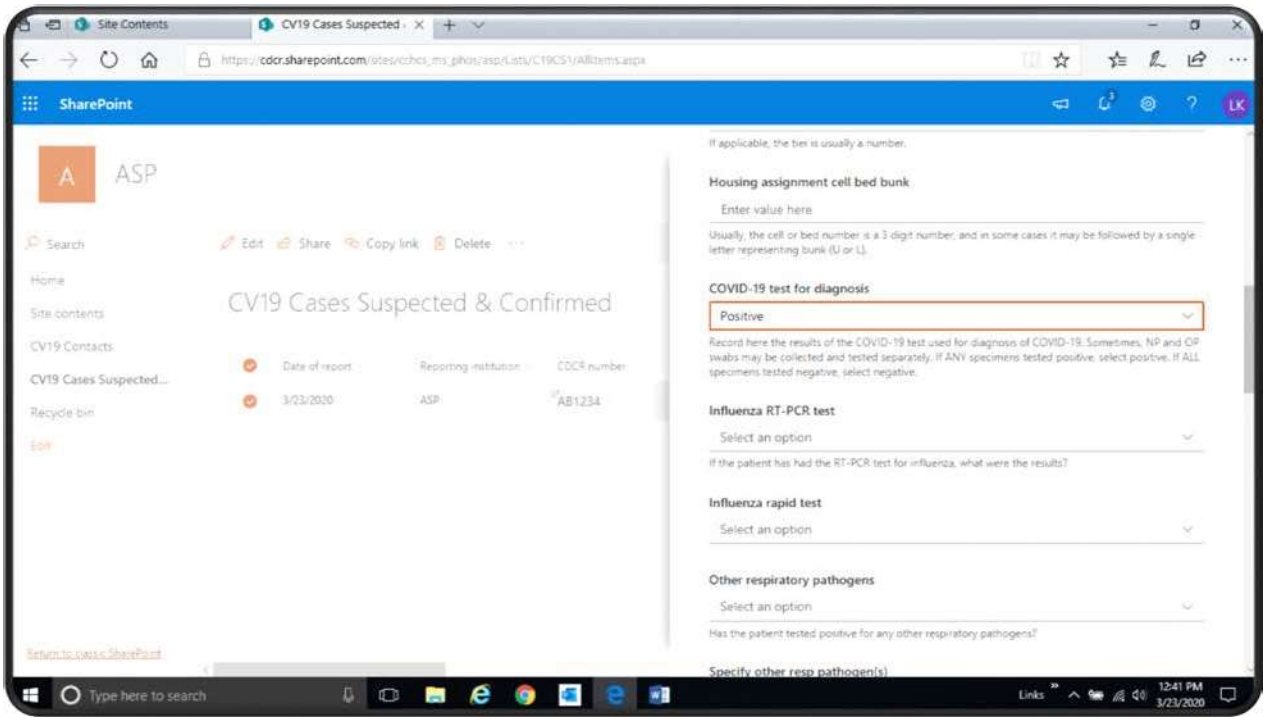
Saving the form adds the report to the line list.



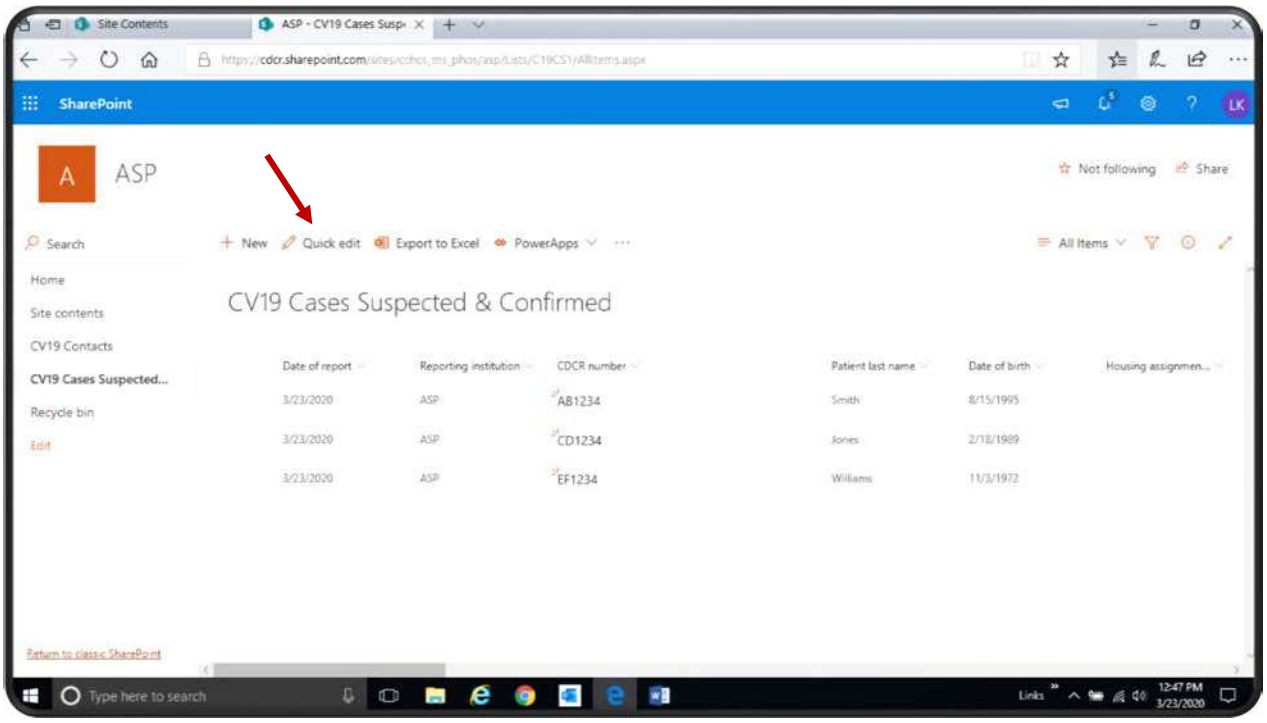
To enter updated information after saving the form, click on the row [1] to select the record in the line list, then click on **Edit** [2] to re-open the form.



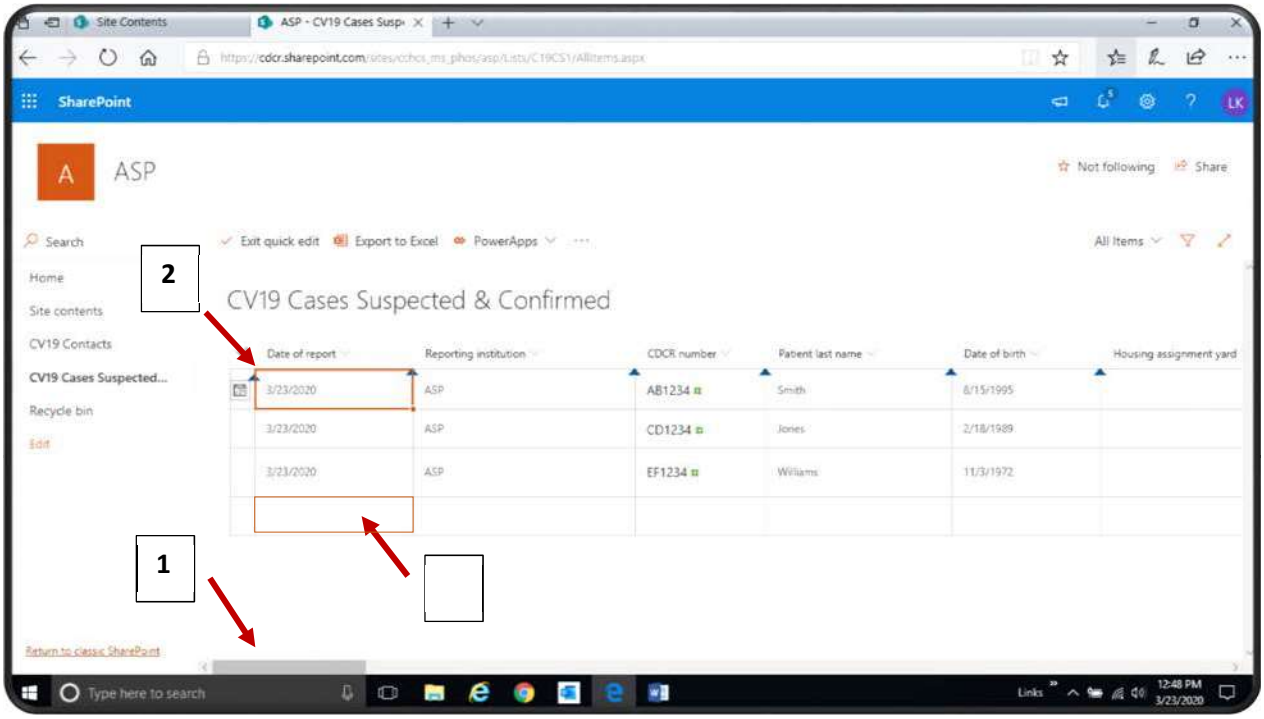
Enter your new information (e.g., diagnostic test, isolation dates) and click on **Save** (as above).



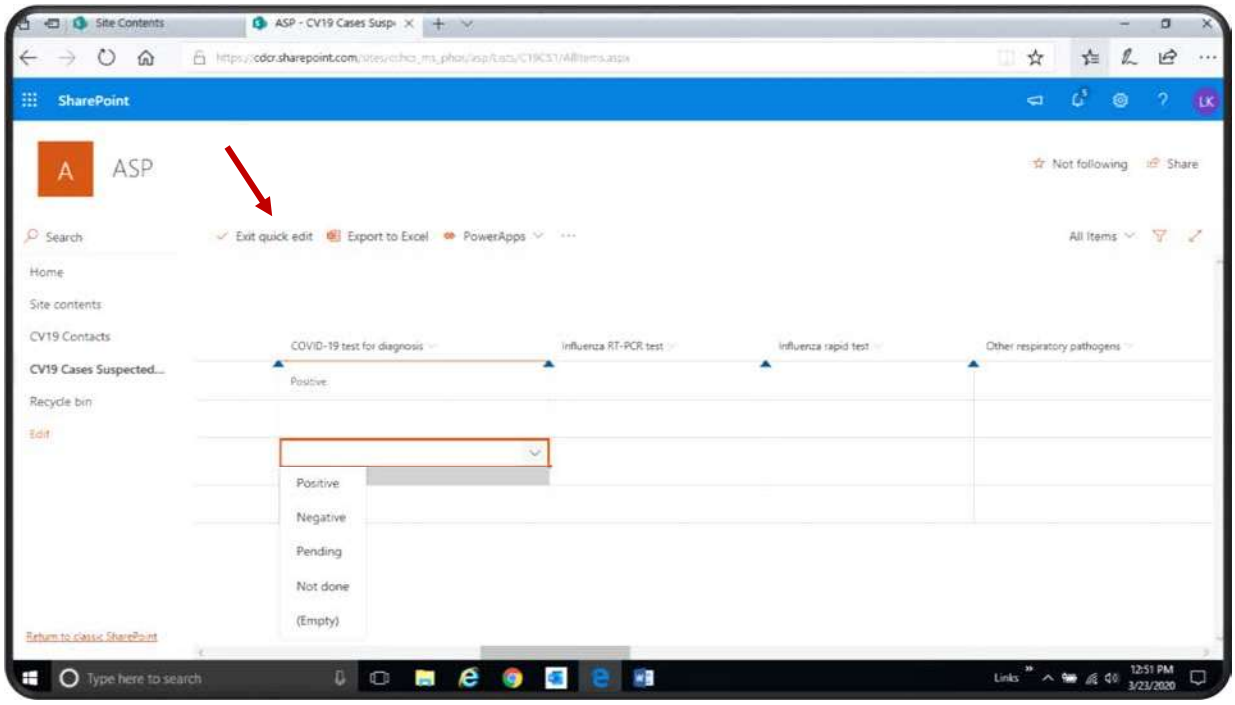
To edit a record directly in the line list, you can also click on **Quick Edit**.



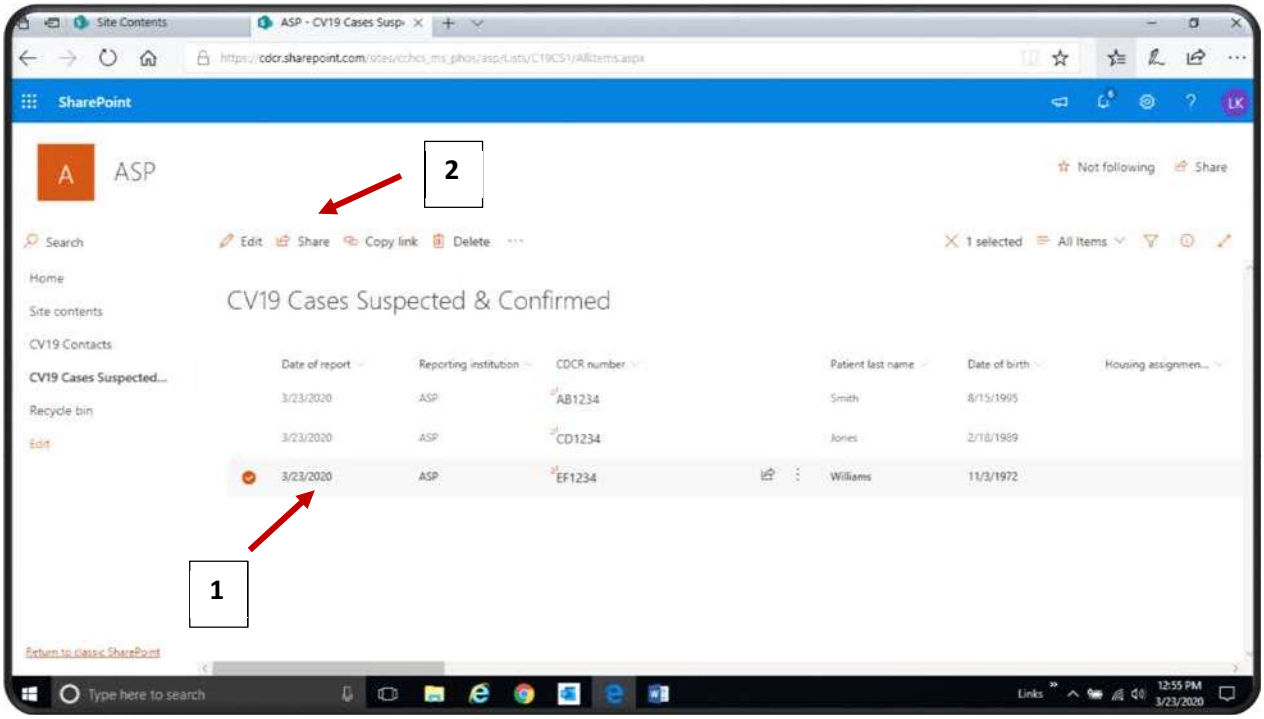
Use the scroll bar [1] to move across the line list. Clicking on any field [2] will highlight it and enable an update to be entered. You can also cut and paste from an Excel spreadsheet into a blank row [3] in SharePoint (e.g., to add a list of CDCR numbers to initiate reports for new patients).



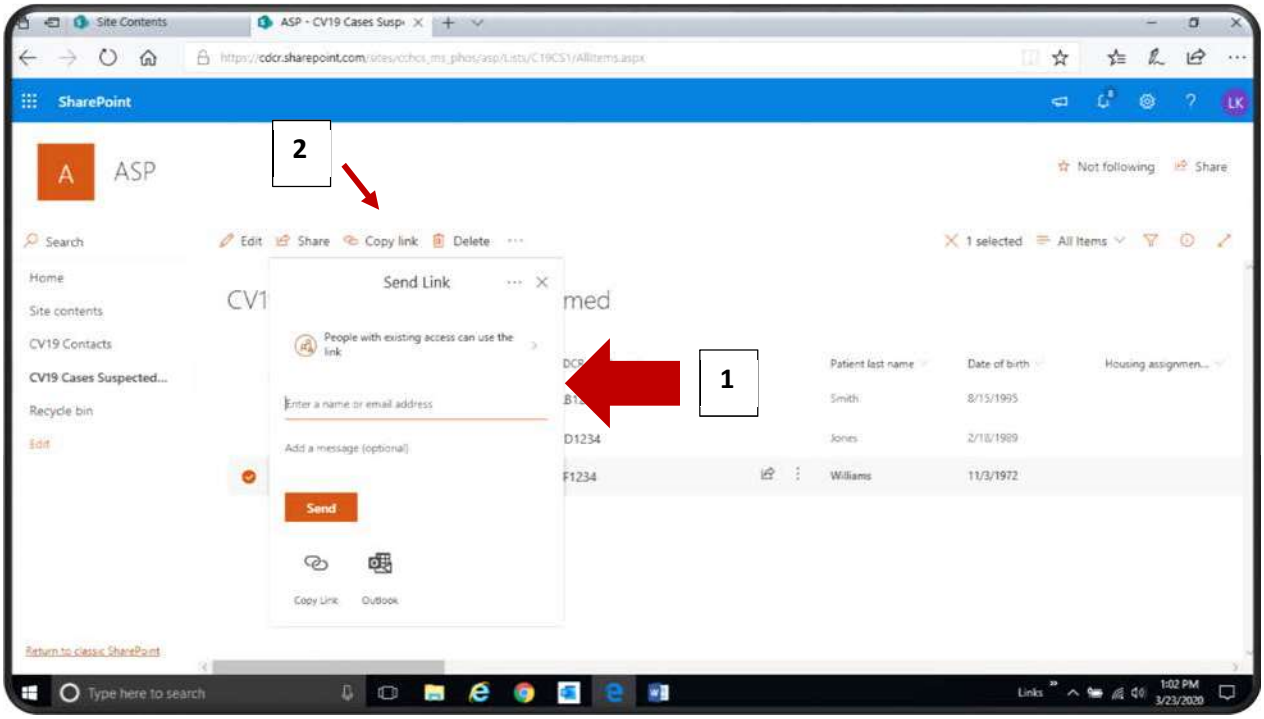
After entering new information into the line list, click on **Exit Quick Edit** to save the update.



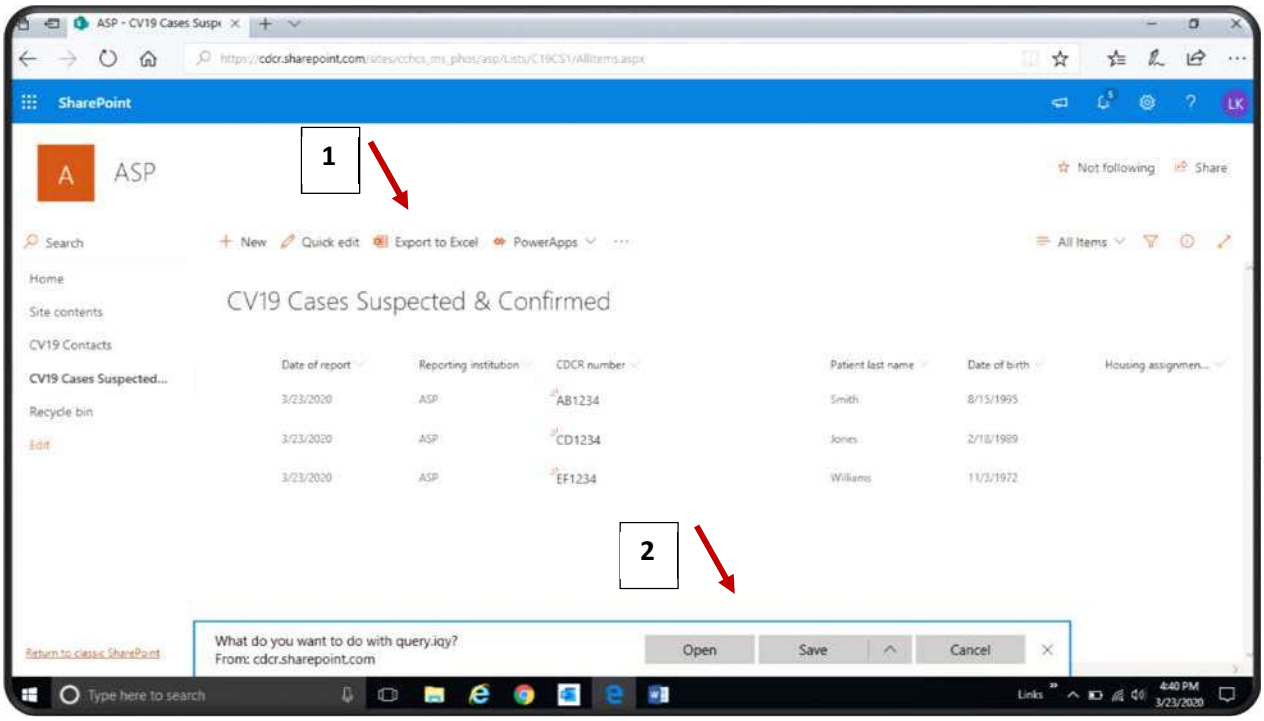
To share a link to an individual case report (e.g., to communicate with other health staff in the institution), select the record by clicking on it [1] and then click on **Share** [2].



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).

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

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:

_____

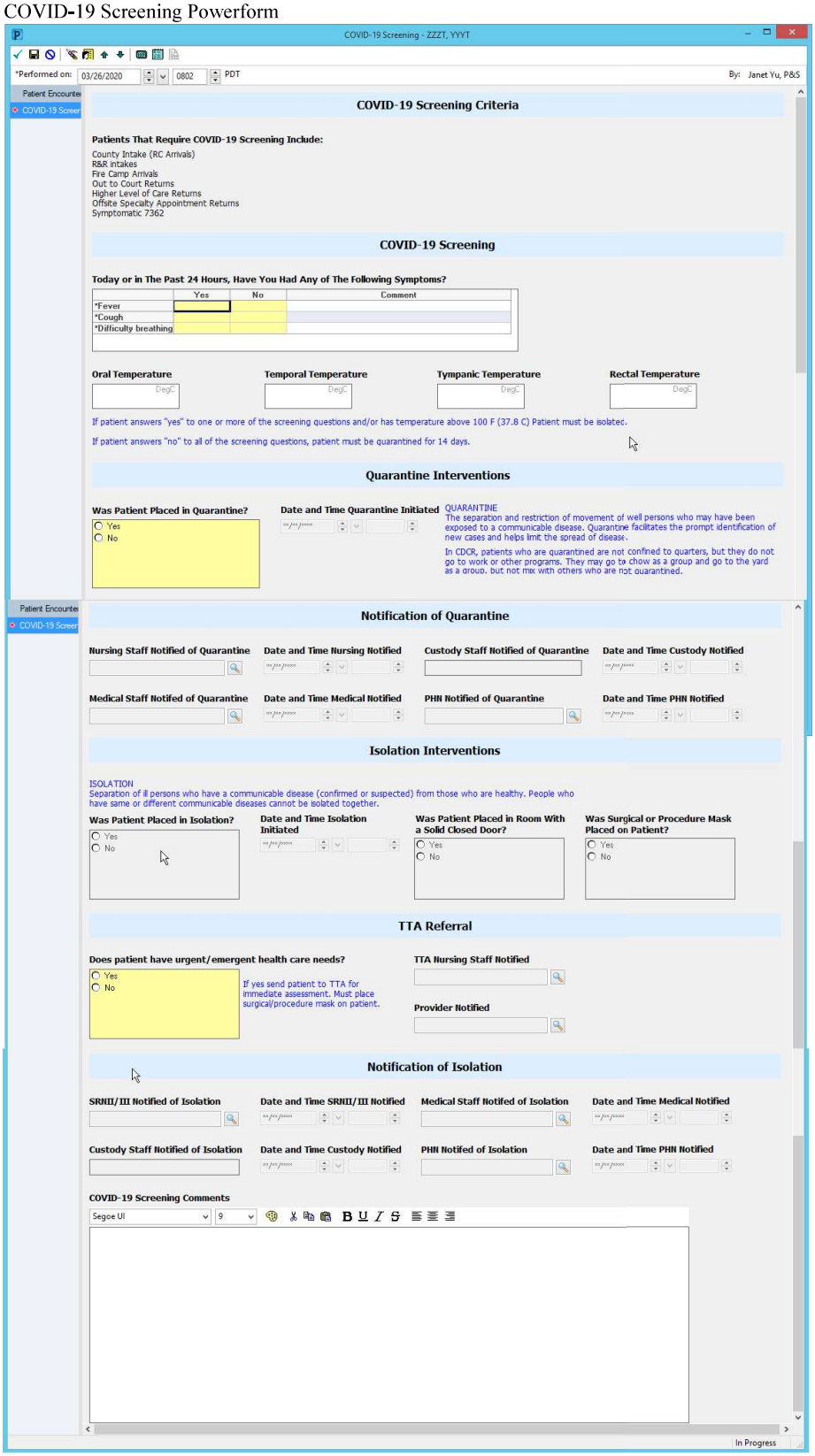
For further information contact:
Institution: _____
Name of Public Health Nurse or Designee: _____
Phone Number: _____ Fax Number: _____

March 2020 *Page 1 of 1*

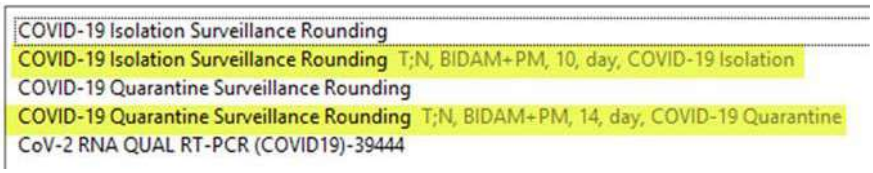
APPENDIX 10: COVID-19 POWERFORM INSTRUCTIONS; SCREENING, ISOLATION, AND QUARANTINE SURVEILLANCE

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

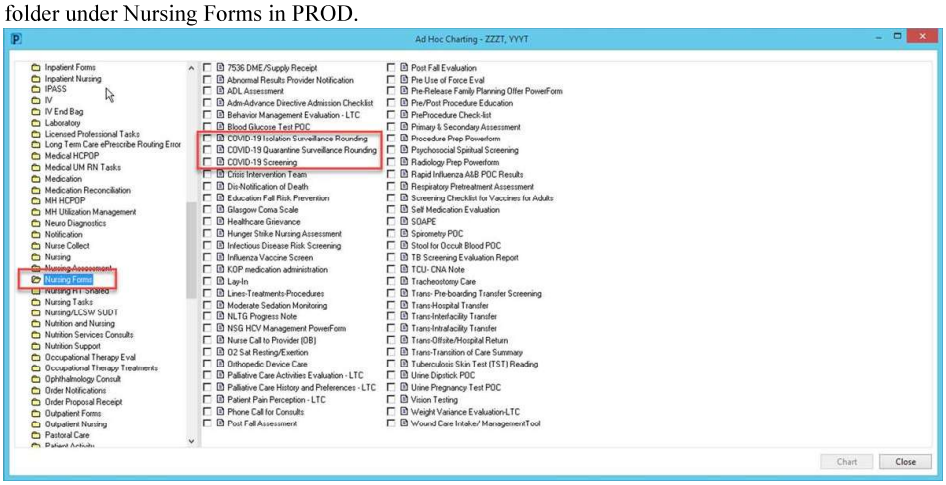
1. COVID-19 Screening Powerform



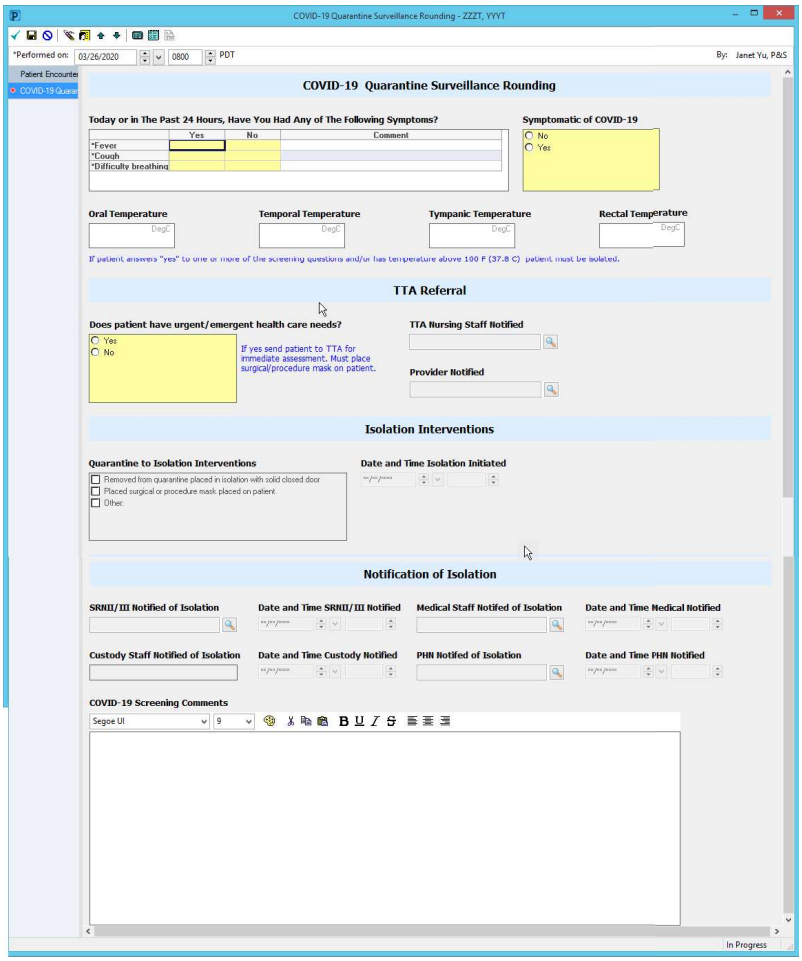
2. COVID-19 Isolation Surveillance Rounding twice a day for 10 days and COVID-19 Quarantine Surveillance Rounding twice a day for 14 days.



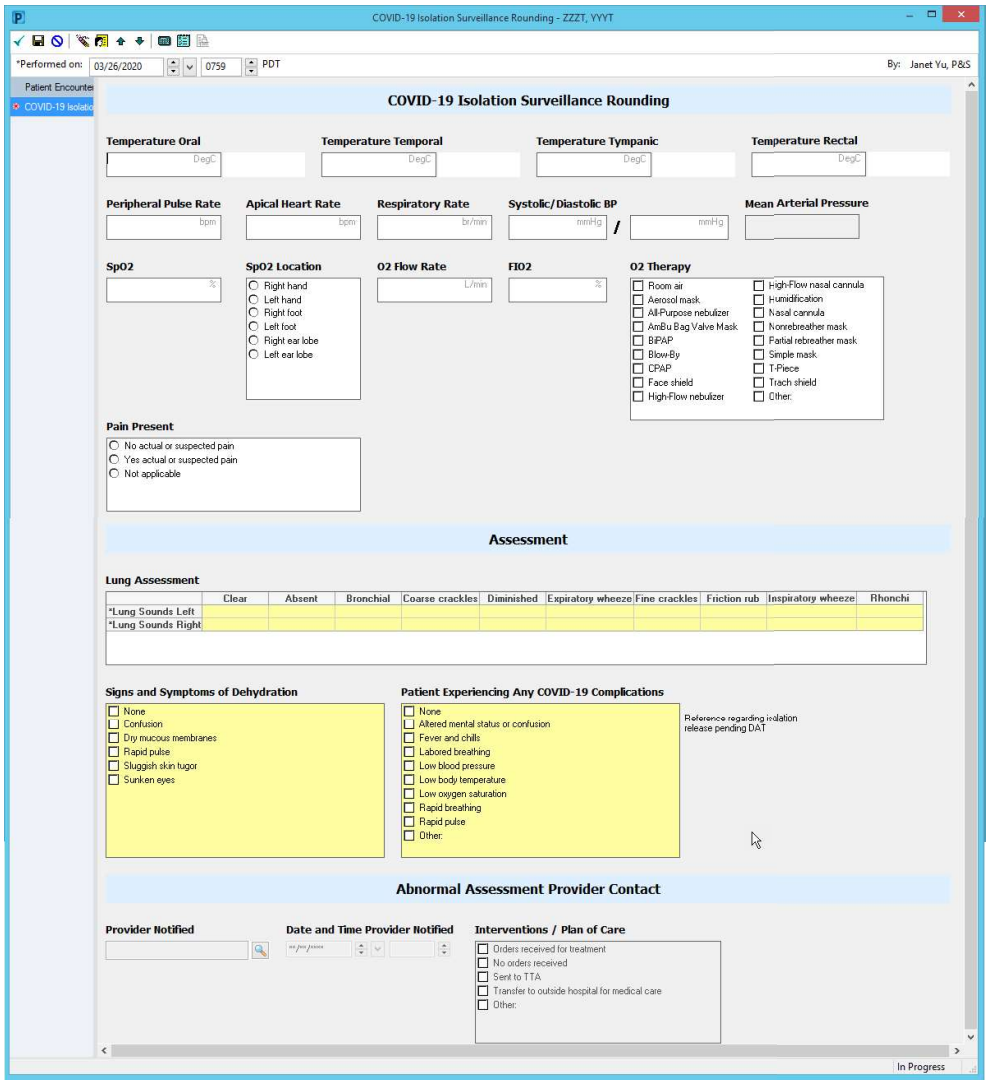
3. Once these orders are placed, it will trigger a task for the nurse to complete the appropriate Surveillance Rounding Powerform. These powerforms are currently viewable in the Adhoc folder under Nursing Forms in PROD.



COVID-19 Quarantine Surveillance Rounding



COVID-19 Isolation Surveillance Rounding



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Attorneys for Defendants

IN THE UNITED STATES DISTRICT COURT

FOR THE NORTHERN DISTRICT OF CALIFORNIA

OAKLAND DIVISION

MARCIANO PLATA, et al., Plaintiffs, **v.** **GAVIN NEWSOM, et al.,** Defendants.	01-cv-01351-JST **E HI ITS G-N TO DECLARATION OF RALPH DIAZ IN SUPPORT OF DEFENDANTS' OPPOSITION TO PLAINTIFFS' EMERGENCY MOTION REGARDING PREVENTION AND MANAGEMENT OF COVID-19**