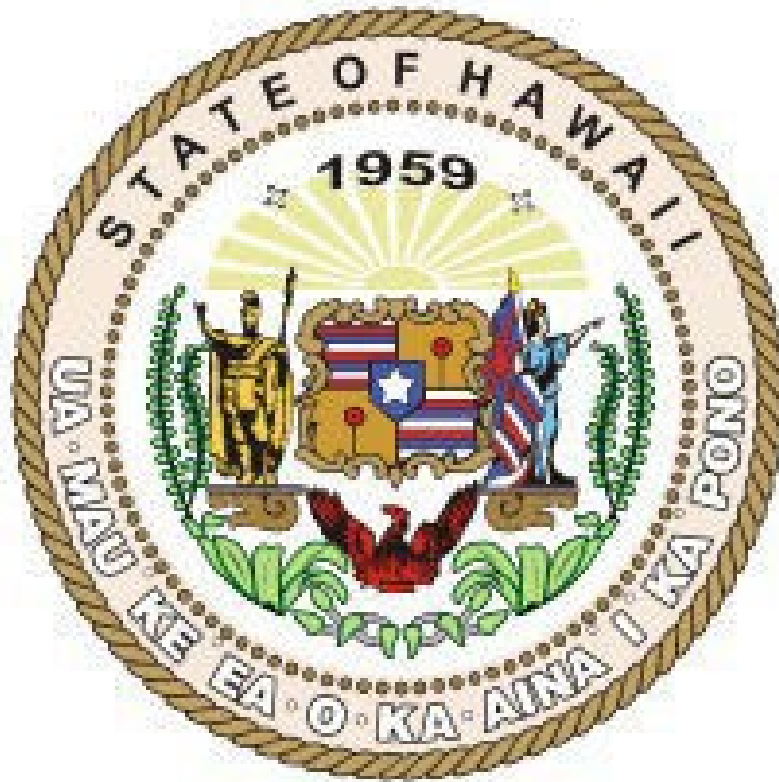


State of Hawaii

Department of Public Safety



PANDEMIC RESPONSE PLAN

COVID-19

(December 22, 2022 Revision)

Table of Contents

Pandemic Response Plan Overview.....	3
COVID-19 Overview.....	4
COVID-19 Pandemic Response Plan Elements.....	6
1. Framework to Assess COVID-19 Risk and Select Prevention Strategies.....	6
2. Communication	12
3. General Prevention Measures.....	13
4. Visitors / Vendors / Volunteers	30
5. Employee Screening and Testing.....	32
6. Intake Screening and Routine Intake Observation	33
7. Initial Management and Testing of SARS-CoV-2	34
8. Personal Protective Equipment (PPE).....	39
9. Transport	43
10. Medical Isolation / Cohorting	44
11. Care for the Sick.....	53
12. Quarantine (<i>Asymptomatic Exposed Inmates</i>).....	55
13. Data Collection, Analysis, and Reporting.....	63
14. Continuous Quality Improvement.....	64
COVID-19 Pandemic Response Plan Implementation Worksheet.....	65
Attachment 1. COVID-19 Visitor/Vendor/Volunteer Screening Tool	81
Attachment 2. COVID-19 Employee Screening Tool	82
Attachment 3. CDC Contact Precautions Sign.....	83
Attachment 4. CDC Droplet Precautions Sign	84
Attachment 5. Isolation Room Precautions Sign.....	85
Attachment 6. Quarantine Room Precautions Sign.....	86
Attachment 7. COVID-19 Re-entry Information Handout.....	87
Attachment 8. Control Strategies for Aerosol Generating Procedures.....	88
Appendix 1. CDC Definitions of Commonly Used Terms	89



Pandemic Response Plan Overview

The COVID-19 Pandemic Response Plan was initially developed by VitalCore Health Strategies and approved by Lannette Linthicum, M.D., and the Office of Correctional Health of the American Correctional Association (ACA). The Department of Public Safety reviewed the plan, which was based upon current guidance from the CDC, and adapted the plan for Hawaii's correctional system. The CDC [Guidance on Management of COVID-19 in Homeless Service Sites and in Correctional and Detention Facilities](#) and [Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 \(COVID-19\) Pandemic](#) provide additional detailed guidance. It is anticipated that the CDC guidance will continue to change so the plan will require revision accordingly.

COVID-19 presents unique challenges for prevention and containment in the correctional environment. Knowledge about COVID-19 and public health guidance for responding to the Pandemic is rapidly changing. Adaptable and updatable practical tools are needed to develop infection prevention and control plans for COVID-19 across a diverse array of U.S. jails and prisons.

The COVID-19 Pandemic Response Plan provides an outline of infection prevention and control information that should be considered for correctional facilities related to a COVID-19 response. The plan provides supplemental guidance to the previously distributed Infectious Disease Clinical Care Guide and existing policies. The plan outline is paired with a fillable MS WORD® Implementation Worksheet that can be customized to address facility-specific issues of concern.

The 1918-19 influenza pandemic provides important lessons for responding to COVID-19. During the 1918-19 influenza ("flu") pandemic, certain cities fared better than others. Those U.S. cities that both acted promptly to control the flu and implemented multiple layers of protective measures had fewer flu cases and lower overall mortality. The COVID-19 Pandemic Response Plan includes multiple layers of protective measures to minimize the impact of the virus in the correctional environment.

The Pandemic Response Plan includes 14 response elements. Each element is outlined in the plan with a corresponding section of the Implementation Worksheet. When completing the Worksheet, it is recommended to reference the corresponding text in the Pandemic Response Plan. The Worksheet can be readily adapted to meet the unique challenges of a specific facility. The Pandemic Response Plan and Worksheet may also be used to facilitate communication between the Department of Health and correctional facilities of the Department of Public Safety in preparation for introduction, transmission, and mitigation of COVID-19 in correctional facilities.

The Pandemic Response Plan may need to be adapted based on an individual facility's physical space, staffing, population, operations, history of SARS-CoV-2 outbreaks, community factors, and other resources and conditions. Facilities should contact HCD, DOH, or CDC if assistance is needed in applying the guidance or addressing topics that are not specifically covered in the Pandemic Response Plan.



COVID-19 Overview

The Department of Public Safety is closely monitoring the spread of the novel coronavirus 2019 (COVID-19). Current information provided by the Center for Disease Control and Prevention (CDC) is included below.

What is Coronavirus Disease 2019 (COVID-19)?

Coronavirus Disease 2019 (COVID-19) is a respiratory illness that can spread from person-to-person. The virus that causes COVID-19 is a Novel Coronavirus that was first identified during an investigation into an outbreak in Wuhan, China and is now causing an International pandemic.

How is the virus causing COVID-19 transmitted?

The virus is thought to spread mainly between people who are in close contact with one another (within approximately 6 feet) through respiratory droplets or small particles produced when an infected person coughs, sneezes, breathes, sings, or talks. Under certain circumstances (e.g., when people are in enclosed spaces with poor ventilation), COVID-19 can sometimes spread by airborne transmission. COVID-19 spreads less commonly through contact with contaminated surfaces (i.e., by touching a surface or object that has the virus, and then touching the mouth, nose, or eyes). The virus is spreading very easily and sustainably between people. In general, the more closely a person interacts with others and the longer that interaction, the higher the risk of COVID-19 spread.

What are the symptoms of COVID-19?

People with COVID-19 have had a wide range of symptoms reported – ranging from mild symptoms to severe illness. People with the following [symptoms](#) may have COVID-19 (not all possible symptoms are listed):

- Fever or Chills
- Cough
- Shortness of Breath or Difficulty Breathing
- Fatigue
- Myalgia, Muscle or Body Aches
- Headache
- New Loss of Taste (ageusia) or Smell (anosmia)
- Sore throat
- Congestion or Runny Nose (Rhinorrhea)
- Nausea or Vomiting
- Diarrhea or Loose Stool

Emergency warning signs for COVID-19 include:

- Trouble Breathing
- Persistent Pain or Pressure in the Chest
- New Confusion
- Inability to Wake or Stay Awake
- Pale, gray, or blue-colored skin, lips, or nail beds, depending on skin tone

Seek emergency medical care immediately if someone is showing emergency warning signs. The list of emergency warning signs is not exhaustive. Contact medical if any other symptoms are severe or concerning. Complications of COVID-19 can include pneumonia, multi-organ failure, and in some cases death.



How can I help protect myself?

People can help protect themselves from respiratory illness with everyday preventive actions. The CDC recommends creating your personal [COVID-19 Plan](#), as well as the following:

- Get vaccinated and stay up to date on your COVID-19 vaccines.
- Improving ventilation and filtration to help prevent virus particles from accumulating indoors.
- Move indoor activities outdoors.
- Get tested for COVID-19, if needed.
- Follow recommendations for [What to Do If You Were Exposed to COVID-19](#).
- Stay home when you have suspected or confirmed COVID-19.
- Seek treatment if you have COVID-19 and are at high risk of getting very sick.
- Avoid contact with people who have suspected or confirmed COVID-19.
- At Medium or High COVID-19 Community Levels, wear masks or respirators and increase space and distance.

How long does it take for symptoms to develop?

The estimated *incubation period* (the time between being exposed and symptom onset) averages 4-5 days (median) and 5-6 days (mean) after exposure with a range of 2-14 days.

Is there a vaccine?

The U.S. Food and Drug Administration (FDA) has approved and authorized (under [Emergency Use Authorization](#)) vaccines to protect people against severe illness, hospitalization, and death, which may be caused by COVID-19. The FDA provides regularly updated information on [COVID-19 Vaccines](#). The CDC provides COVID-19 vaccine information and guidance (see [About COVID-19 Vaccines](#), [Your COVID-19 Vaccination](#), [Stay Up to Date with COVID-19 Vaccines Including Boosters](#), [Possible Side Effects](#), [Safety and Monitoring](#), and [Effectiveness](#)).

Is there a treatment?

The Food and Drug Administration (FDA) has expanded [emergency use authorization](#) (EUA) to allow healthcare providers to conditionally use certain investigational monoclonal antibody medications to prevent SARS-CoV-2 infection. Antiviral medications have also been found to be effective in preventing severe outcomes from COVID-19. Any treatments that are used for COVID-19 should be taken under the care of a healthcare provider. People have been [seriously harmed and even died](#) after taking unapproved products to self-treat. Note: medications are not a substitute for vaccination. The National Institutes of Health (NIH) has developed and regularly updates [COVID-19 Treatment Guidelines](#) to help guide healthcare providers caring for patients with COVID-19.

What are variants?

Viruses constantly change through mutation. New [variants](#) of a virus are expected to occur. Multiple [variants of the virus](#) that cause COVID-19 have been identified in the United States and globally during the pandemic. Scientists are working to learn more about how easily they spread, whether they could cause more severe illness, and whether vaccines will protect people against them.



COVID-19 Pandemic Response Plan Elements

1. Framework to Assess COVID-19 Risk and Select Prevention Strategies

Previous CDC [Guidance on Prevention and Management of Coronavirus Disease 2019 \(COVID-19\) in Correctional and Detention Facilities](#) initiated a shift in the CDC approach “from limiting the spread of COVID-19 to minimizing severe disease.” The CDC recommends the development of a flexible, long-term facility-specific Pandemic Response Plan that assesses risk based on fluid facility factors in the context of COVID-19 community levels when determining the need to enhance everyday prevention strategies due to variation across facilities (e.g., differences in layout, infrastructure, security level, mission, population health needs, on-site healthcare, and staffing levels), shifting epidemiologic trends involving new SARS-CoV-2 variants, and other considerations.

ASSESSING COVID-19 RISK

The CDC identifies three levels of risk: low, medium, and high. The assessment of COVID-19 risk should be based on a combination of CDC COVID-19 Community Levels and Facility-Specific Risks.

COVID-19 Community Levels

COVID-19 Community Levels are categorized as low, medium, and high based on the number of COVID-19 cases in a given community and the impact of severe disease on community-based healthcare systems. The CDC COVID-19 Community Levels are available at:

CDC COVID-19 COMMUNITY LEVELS

When correctional facilities assess the COVID-19 Community Level, they should consider the community where the facility is located as well as the communities from which inmates originate and where staff members live. Facilities receiving inmates from other counties or locations should make reasonable efforts to determine the risk level in originating counties or locations.

Note: correctional facilities providing healthcare services should consult the [CDC’s Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 \(COVID-19\) Pandemic](#) (which uses [COVID-19 Community Transmission Levels](#) rather than COVID-19 Community Levels to guide application of certain COVID-19 prevention strategies in healthcare settings within facilities) for guidance on recommended infection prevention and control strategies for patient care (See also: [Core Infection Prevention and Control Practices for Safe Healthcare Delivery in All Settings – Recommendations of the HICPAC](#)).



Facility-Specific Risks

COVID-19 Community Levels will not always reflect the COVID-19 risk in correctional facilities. Each facility should also assess facility-specific risks to account for unique facility characteristics, operations, and populations, which will guide decisions about when to add or remove enhanced prevention strategies. Examples of relevant facility-specific risks are detailed below. Note: the CDC guidance does not set specific thresholds for facility-specific risks or specify how many specific risk factors to consider before shifting to enhanced prevention measures.

- **Transmission in the facility:** Evaluate the current level of SARS-CoV-2 transmission within the facility. If transmission of the virus within the facility has been identified, facilities should implement [enhanced prevention strategies](#), even if the COVID-19 Community Level is low. Note that enhanced prevention strategies that are implemented due to transmission in the facility can be targeted to certain portions of a facility (rather than a whole building or complex) as long as movement and staff assignments are restricted between areas with and without known transmission.
- **Risk of severe health outcomes:** Determine whether the facility's inmates or staff are [more likely to get very sick from COVID-19](#). Additionally, evaluate whether the facility's capacity to assess infected inmates' eligibility for COVID-19 therapeutics and, for eligible inmates, to ensure timely access to treatment to prevent severe health outcomes. See the NIH [General Management of Nonhospitalized Adults With Acute COVID-19](#) and [Therapeutic Management of Nonhospitalized Adults With COVID-19](#). Facilities should consider applying [enhanced prevention strategies](#) even when the COVID-19 Community Level is low if they are unable to do one of the following: a) access and administer COVID-19 therapeutics on-site to prevent severe health outcomes among inmates more likely to get very sick from COVID-19, OR b) assess inmates' risk for severe outcomes and ensure timely access to care outside the facility.
- **Facility structural and operational characteristics:** Assess whether facility characteristics and operational protocols [contribute to SARS-CoV-2 spread](#) within the facility. Facilities with dense housing arrangements (e.g., dorm/open barracks), frequent population turnover, a high volume of outside visitors, or poor [ventilation](#) systems may consider applying some [enhanced prevention strategies](#), even when the COVID-19 Community Level is low.



SELECTION OF PREVENTION STRATEGIES

Table 1 provides a summary of the CDC COVID-19 Prevention Strategies recommended as: COVID-19 prevention strategies for everyday operations (in place at all times) and enhanced COVID-19 prevention strategies (added or removed based on risk assessment).

Table 1. COVID-19 Prevention Strategies		
COVID-19 Prevention Strategy	COVID-19 Prevention Strategies for Everyday Operations	Enhanced COVID-19 Prevention Strategies
Prepare for Outbreaks	X	
Standard Infection Control	X	
Improve Ventilation*		X
Physical Distancing		X
Well-Fitting Masks/Respirators		
Offer to Inmates and Staff	X	
Indoors for 10 Days if Close Contact	X	
Universal Indoor Masking		X
Up to Date COVID-19 Vaccination	X	
SARS-CoV-2 Testing		
Symptomatic	X	
Close Contact	X	
All Inmates at Intake (or Routine Observation Period)	X	
Before Transfer		X
Before/After Community Visits		X
Before Release		X
Routine Screening Testing		X
Routine Observation Periods During Transfer/Release Protocols		X
Medical Isolation	X	
Quarantine		X
Reduce Movement and Contact Across Housing Units and with the Community		X
Access to COVID-19 Therapeutics	X	
Re-entry Considerations	X	
<p>* As a COVID-19 Prevention Strategy for everyday operations, enhanced ventilation options should be identified, obtained, and tested in advance of higher risk periods to be ready to deploy when needed.</p> <p>Adapted from: CDC Guidance on Management of COVID-19 in Homeless Service Sites and in Correctional and Detention Facilities; 11/29/22. Available at: https://www.cdc.gov/coronavirus/2019-ncov/community/homeless-correctional-settings.html</p>		



COVID-19 Prevention Strategies for Everyday Operations

The CDC recommends maintaining the following COVID-19 prevention strategies at all times, irrespective of the level of COVID-19 risk:

- **Prepare for outbreaks:** Monitor [CDC COVID-19 Community Levels](#) and Facility-Specific Risk Factors to prepare for periods of increased SARS-CoV-2 transmission. Refine the facility's long-term COVID-19 Pandemic Response Plan as needed based on new information. Ensure staff are trained on the current plan. Maintain communication with staff and inmates about what to expect if an outbreak occurs. Continue to work collaboratively with DOH, local hospitals and Providers, community partners, and other correctional facilities.
- **Maintain standard infection control strategies:** Promote good health habits (e.g., hand hygiene), and maintain recommended cleaning and disinfection for standard prevention of infectious diseases, including COVID-19. Ensure that ventilation systems operate properly and provide acceptable indoor air quality for the current occupancy level for each space. Improve and/or repair ventilation systems as necessary. Prepare in advance for periods of higher risk by identifying, obtaining, and testing enhanced ventilation interventions that will be deployed as enhanced prevention strategies when needed. Ensure that recommended personal protective equipment (PPE) is available for staff and inmates based on their level of risk.
- **Masks/Respirators:** Offer masks/respirators to all inmates and staff who want them. Facilities should make well-fitting [masks or respirators](#) available to inmates and staff who would like to use them based on their personal preference. If staff and/or inmates have been exposed to or identified as a close contact of someone with COVID-19, regardless of vaccination and booster status, staff and/or inmates should be required to wear a mask or respirator while indoors for ten (10) full days after exposure.
- **Prevent COVID-19 introduction from staff:** Regardless of vaccination and booster status, exclude staff from work if they have [symptoms of COVID-19](#) or test positive for SARS-CoV-2. If staff have been exposed to or identified as a close contact of someone with COVID-19, regardless of vaccination and booster status, staff should be encouraged to get tested at least five (5) full days after exposure (or sooner, if they develop symptoms).
- **Provide up to date COVID-19 vaccination, including boosters:** Continue to provide and encourage [up to date COVID-19 vaccination](#) for staff and inmates (including boosters, as well as additional doses for people with weakened immune systems and for others who are eligible for additional doses).
- **Maintain diagnostic testing and intake testing strategies:** To the extent possible based on facility resources and supplies, maintain a robust COVID-19 testing program to help prevent transmission in congregate settings and provide critical data for ongoing assessment of the facility's long-term prevention plan.



- **Diagnostic testing** should be performed for any inmate who shows signs or [symptoms of COVID-19](#) and for any inmate who has been exposed to or identified as a close contact of someone with COVID-19 (either through traditional contact tracing or through location-based contact tracing), regardless of COVID-19 vaccination and booster status.
- **Routine COVID-19 screening testing OR a routine observation period should be implemented for all inmates at intake**, regardless of COVID-19 vaccination and booster status. The routine observation period option should only be used in the following scenarios:
 - a) Inmates under intake observation are housed individually, OR b) Inmates under intake observation are housed in small cohorts due to mental health concerns associated with individual housing, and all cohort members begin the observation period on the same day and will be tested at the end of the observation period.
- **Maintain medical isolation procedures for inmates:** Regardless of vaccination and booster status, medically isolate inmates with suspected or confirmed SARS-CoV-2. Ensure that the conditions in medical isolation housing are not punitive and support mental health. Prepare and plan to quickly scale up medical isolation during an outbreak.
- **Assess inmates' risk for severe health outcomes from COVID-19 and ensure timely treatment after infection for those who are eligible for [COVID-19 therapeutics](#).** For facilities without onsite healthcare capacity, plan to ensure timely access to care offsite. See the NIH [General Management of Nonhospitalized Adults With Acute COVID-19](#) and [Therapeutic Management of Nonhospitalized Adults With COVID-19](#).
- **Re-entry Considerations:** Provide releasing inmates with COVID-19 Re-entry Care Packs, which include a mask, the COVID-19 Re-entry Information Handout with COVID-19 prevention information (see [Attachment 7](#)), and county-specific community resources handouts for information on accessing available community services.

Enhanced COVID-19 Prevention Strategies

When the [COVID-19 Community Level](#) is high, or when facility-specific risk factors indicate increased risk, facilities should consider adding enhanced COVID-19 prevention strategies, to the extent possible. Facilities with low risk tolerance can apply any enhanced prevention strategies at any time, even when the CDC COVID-19 Community Level is low or medium. Depending on the risk in different areas of the facility, enhanced prevention strategies can be applied across an entire facility OR can be targeted to a single housing area.



When selecting enhanced prevention strategies, facilities should balance the need for COVID-19 prevention with the impact of reducing access to services and programming. Facilities may not be able to apply all enhanced prevention strategies due to resources constraints, facility and population characteristics, and other factors, but facilities should add as many as feasible, as a multi-layered approach to increase the level of protection against COVID-19. Facilities with lower risk tolerance can apply enhanced prevention strategies at any time, even when the COVID-19 Community Level is low or medium. Enhanced prevention strategies include the following:

- **Improve ventilation in the facility:** Increase and improve ventilation as much as possible. For options to improve ventilation in buildings, such as increasing the introduction of outdoor air, using portable HEPA filters, and using upper room or in-duct ultraviolet germicidal irradiation systems (UVGI), see [COVID-19 Ventilation in Buildings](#). Where possible, consider holding group activities outdoors.
- **Increase Distance:** Create physical distance where possible. Reduce movement and contact between different parts of the facility and between the facility and community (as applicable).
- **Require [masks/respirators](#) indoors:** Require all inmates, staff, visitors, vendors, volunteers, and any other persons in the facility to wear a well-fitting mask or respirator while indoors.
- **Strengthen SARS-CoV-2 testing strategies:** In addition to providing diagnostic testing at all times and universal screening testing or a routine observation period for inmates at intake (strategies for everyday operations), add other screening testing strategies to identify cases early and to prevent transmission during movement. Examples include:
 - **Routine screening testing for inmates and staff**
 - **Additional movement-based screening testing:**
 - Before transfer to another facility
 - Before/after community visits
 - Before release
- **Add routine observation periods during movement:** Implement routine observation periods as part of intake, transfer and/or release processes to minimize transmission to/from other facilities and the community during movement.
- **Quarantine according to risk tolerance:** Quarantine for COVID-19 is no longer recommended for the general public. According to the CDC, quarantine can be very disruptive to the daily lives of inmates because of the limitations it places on access to programming, recreation, in-person visitation, in-person learning, and other services. However, because of the potential for rapid, widespread transmission of SARS-CoV-2 in correctional settings, some facilities may prefer to continue implementing quarantine protocols for inmates, staff, and/or volunteers who have been exposed to someone with COVID-19. Facilities can base their quarantine policy on their risk tolerance, including factors such as the health of their staff and inmate populations and the impact of quarantine on mental health and staffing coverage. Refer to Element 12 below for guidance on standard and modified quarantine approaches that can be flexibly adapted to changing circumstances.



2. Communication

- It is important that correctional and health care facility leadership meet or consult regularly to review the current status of COVID-19, review updated guidance from the Centers for Disease Control and Prevention (CDC) and the Hawaii Department of Health (HDOH), and flexibly respond to changes in current conditions.
- Responsibility should be assigned for tracking National and Local COVID-19 updates.
- Communicate regularly with staff and the incarcerated population. Specific methods for communicating up to date COVID-19 information and changes to facility policies should be established and provided on a regular basis. Test communication plans to disseminate critical information to inmates, staff, contractors, vendors, visitors, and volunteers.
- Communication should be understandable for non-English speaking and low literacy persons. Provide accommodations for those with cognitive or intellectual disabilities and those who are deaf, blind, or have low vision. Staff should be assigned to be responsible for crafting and disseminating regular updates.
- Post signage throughout the facility to communicate the [Symptoms of COVID-19](#) and measures of prevention such as [Hand Hygiene](#). Post signage to remind staff to stay at home when sick. [Communication Resources](#) are available on the CDC website.
- Train staff on the facility's COVID-19 Pandemic Response Plan. Ensure that all persons in the facility know the [symptoms of COVID-19](#) and the importance of reporting COVID-19 symptoms.
- As much as possible, provide COVID-19 information in person and allow opportunities for inmates and employees to ask questions.
- Examples of key communication messages for employees:
 - Provide updates on the status of COVID-19 within the facility.
 - The importance of staying home if signs or symptoms of COVID-19 are present.
 - The importance of wearing a mask while indoors at work if there is known exposure to COVID-19.
 - Reminders about good health habits to protect themselves, emphasizing cough/sneeze etiquette and hand hygiene.
 - Elements of the facility COVID-19 Pandemic Response Plan to keep employees safe, including the importance of staying up to date on COVID-19 vaccines and boosters.
- Examples of key communication messages for inmates:
 - The importance of immediately reporting COVID-19 symptoms (and reporting if another inmate is experiencing COVID-19 symptoms in order to protect themselves). Establish procedures on how to report symptom observations.
 - Reminders about good health habits to protect themselves, emphasizing cough/sneeze etiquette and hand hygiene.



- Plans to keep inmates safe including the importance of staying up to date on COVID-19 vaccines and boosters.
 - The purpose of medical isolation and quarantine (if used). Address concerns related to reporting symptoms (e.g., being placed on medical isolation) and SARS-CoV-2 testing. Explain that medical isolation and quarantine are not the same as disciplinary segregation (Note: ensure that medical isolation and quarantine are truly operationally distinct from disciplinary segregation).
- Continue to communicate with DOH and community partners.
 - Communication should also be established with local community hospitals to discuss referral mechanisms for seriously ill inmates.
 - Maintain communications with other correctional facilities to share information and collaborate on protocols to prevent transmission between facilities during inmate transfers.

3. General Prevention Measures

General prevention measures include COVID-19 prevention strategies for everyday operations that should be in place at all times and enhanced COVID-19 prevention strategies that may be added or removed based on ongoing risk assessment (see *Table 2* below).

Table 2. General Prevention Measures

- a. Promote good health habits** among employees and inmates:
 - 1) Avoid touching your eyes, nose, or mouth without cleaning your hands first.
 - 2) Wash your hands often with soap and water for at least 20 seconds.
 - 3) Cover your sneeze or cough with a tissue (or into a sleeve), then throw the tissue in the trash.
 - 4) Avoid sharing eating utensils, dishes, and cups.
- b. Adhere to CDC recommendations for [cleaning and disinfection](#).**
- c. Implement CDC recommendations for Ventilation.**
- d. Consider physical distancing measures as an enhanced prevention strategy**, when indicated and as feasible.
- e. Apply CDC recommendations on the use of masks or respirators for different levels of risk.**
- f. Sick employees remain home.**
- g. Maintain SARS-CoV-2 testing strategies.**
- h. Provide and encourage up to date COVID-19 vaccination, including boosters.**
- i. Influenza (flu) vaccine is recommended for persons not previously vaccinated.**
- j. Follow infection prevention and control guidance when conducting screening.**
- k. Utilize control strategies for aerosol generating procedures.**



Note: that correctional facilities providing healthcare services should consult [CDC's Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 \(COVID-19\) Pandemic](#) (which uses COVID-19 Community Transmission Levels rather than COVID-19 Community Levels to guide application of certain COVID-19 prevention strategies in healthcare facilities) for guidance on recommended infection prevention and control strategies for patient care (See also: [Core Infection Prevention and Control Practices for Safe Healthcare Delivery in All Settings –Recommendations of the HICPAC](#)).

a. Good Health Habits

- Good health habits should be promoted in various ways (e.g., educational videos/posters, assessing adherence to cough etiquette and hand hygiene).
- All employees and inmates should view the COVID-19 educational video, which includes measures of prevention and detailed handwashing procedures (see also [Handwashing](#)).
- Each facility should ensure that adequate supplies and facilities are available for handwashing for inmates and employees, as well as visitors, vendors and volunteers.
- Provisions should be made for employees, visitors, vendors, volunteers, and new intakes to wash their hands when they enter the facility. If hand washing stations are not available, provide alcohol-based hand sanitizer with at least 60% alcohol in entrances, exits, and waiting areas. With approval of the Warden, employees should have access to alcohol-based hand rub.
- To the extent possible, provide and continually restock hygiene supplies throughout the facility, including in bathrooms, food preparation and dining areas, intake areas, visitor entries and exits, visitation rooms and waiting rooms, common areas, medical and staff-restricted areas (e.g., break rooms).

b. Cleaning and Disinfection

- The virus that causes COVID-19 can land on surfaces. It is possible for people to become infected if they touch those surfaces and then touch their nose, mouth, or eyes. In most situations, the [risk of infection from touching a surface is low](#). The most reliable way to prevent infection from surfaces is to [regularly wash hands or use hand sanitizer](#). Cleaning and disinfecting (using [U.S. Environmental Protection Agency \(EPA\)'s List N](#)) surfaces can also reduce the risk of infection.
- Implement routine and intensified cleaning and disinfecting procedures in accordance with the CDC guidance on [Cleaning and Disinfecting Your Facility](#), [NIOSH Workplace Solutions: Safe and proper use of disinfectants to reduce viral surface contamination in correctional facilities](#), and OSHA standards.
- Facilities should prepare and plan to restock cleaning and disinfection supplies quickly during a COVID-19 outbreak.



- Cleaning with products containing soap or detergent reduces germs on surfaces by removing contaminants and may also weaken or damage some of the virus particles, which decreases risk of infection from surfaces. When no people with confirmed or suspected COVID-19 are known to have been in a space, [cleaning once a day is usually enough](#) to sufficiently remove virus that may be on surfaces. Clean more frequently or disinfect (in addition to cleaning) in shared spaces if certain conditions apply that can increase the risk of infection from touching surfaces:
 - High touch surfaces
 - Food service, Intake, Medical Unit
 - High transmission of COVID-19 in the community
 - Low number of people wearing masks or respirators
 - Infrequent hand hygiene
 - The space is occupied by people at [increased risk for severe illness from COVID-19](#)
- If there has been a sick person or someone who tested positive for COVID-19 in the facility within the last 24 hours, then clean and disinfect the space. If more than 24 hours have passed since someone who was sick or diagnosed with COVID-19 was in the facility, then clean the space and determine if disinfection is required (review [Cleaning and Disinfecting Your Facility](#)). If more than 3 days have passed, then regular cleaning practices are indicated.
- Routinely clean and disinfect surfaces and objects that are frequently touched, especially in common areas. These may include doorknobs, light switches, sink handles, countertops, toilets, toilet handles, recreation equipment, kiosks, telephones, computer equipment, handrails, elevator buttons, cell bars, etc.
- One strategy is to increase the number of workline inmates who are assigned to conduct continual cleaning of common areas throughout the day.
- Staff should clean shared equipment (e.g., radios, service weapons, keys, handcuffs, computer equipment, telephones), after shared use and when the use of equipment has concluded.
- Hard (non-porous) Surfaces:
 - If surfaces are dirty, clean using a detergent or soap and water prior to disinfection.
 - Consult the [EPA List N: Disinfectants for Coronavirus \(COVID-19\)](#). Follow the manufacturer's instruction for all cleaning and disinfection products (e.g., concentration, application method and contact time, etc.).
 - If EPA-approved disinfectants are not available, diluted, unexpired household bleach can be used if appropriate for the surface. Never mix household bleach with ammonia or any other cleanser.
 - Refer to CDC guidance on [How to Make 0.1% Chlorine Solution to Disinfect Surfaces in Healthcare Settings](#) (see also [illustration](#)).



- Alcohol solutions with at least 70% alcohol may also be used.
- One supplemental strategy for disinfection of hard, non-porous surfaces in large and difficult to reach areas is the timely and routine use of fogging devices, which dispense products with emerging viral pathogens and human coronavirus claims for use against SARS-CoV-2 (consult the [EPA Product List of Disinfectants for Use Against SARS-CoV-2](#) and review [Safety Precautions When Using Electrostatic Sprayers, Foggers, Misters, or Vaporizers for Surface Disinfection During the COVID-19 Pandemic](#)).
- Soft (porous) Surfaces (e.g., carpeted floor, rugs, drapes):
 - Remove visible contamination and clean with appropriate cleaner for soft surfaces.
 - If washable, launder in hottest water setting for the item and dry completely.
 - Use products with [EPA-approved viral pathogen claims](#).
- Electronics:
 - Remove visible contamination, if present.
 - Follow the manufacturer's instructions for all cleaning and disinfection of 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 and other surfaces. Dry surfaces thoroughly to avoid pooling of liquids.

c. Ventilation

- As a strategy for everyday operations, facilities should ensure that ventilation systems operate properly and provide acceptable indoor air quality for the current occupancy level for each space. Improvements and repairs should be made as necessary.
- CDC provides guidance on heating, ventilating, and air-conditioning (HVAC) systems to help reduce the airborne concentration of the virus that causes COVID-19 (see [Guidelines for Environmental Infection Control in Health-Care Facilities](#) and [Ventilation in Buildings](#)).
- As an enhanced prevention strategy, facilities should use enhancements to code-minimum ventilation requirements to improve overall ventilation in the facility. For more information about ventilation considerations and strategies to improve ventilation, such as increasing the introduction of outdoor air, using portable HEPA filters, and using upper room or in-duct ultraviolet germicidal irradiation systems (UVGI), see [COVID-19 Ventilation in Buildings](#). Enhanced ventilation strategies should be identified, obtained, and tested in advance of higher risk periods to be ready to deploy when needed.



d. Physical Distancing Measures

Physical distancing is the practice of increasing the space between individuals and decreasing the frequency of contact between individuals to reduce the risk of spreading a disease. Physical distancing strategies can be applied on an individual level (e.g., avoiding close contact), a group level (e.g., temporarily holding group activities outdoors), and an operational level (e.g., rearranging chairs in the dining hall to increase distance between inmates or using protective barriers if space is limited).

Physical distancing is an enhanced prevention strategy that can be considered when the COVID-19 Community Level is high or when Facility-Specific Risk Factors indicate increased risk. Due to differences among correctional facilities, enhanced physical distancing strategies, if indicated by risk assessment, will need to be tailored to the individual space in the facility and the needs of the inmates and staff, as allowable by physical plant limitations, security restrictions, and operational resources.

CDC recommends facilities list possible physical distancing strategies that could be implemented as needed at different stages of transmission intensity. Some examples of possible enhanced physical distancing strategies to consider when the COVID-19 Community Level is high or when Facility-Level Factors indicate increased risk include:

- Common Areas
 - Provide educational reminders to stay at least 6 feet from others.
 - Provide visual reminders (e.g., tape, paint), on floor surfaces every six feet in walking areas.
 - Enforce increased space between inmates in holding cells, lines, and waiting areas.
 - Remove every other chair in a waiting area.
- Recreation
 - Utilize recreation areas where inmates can spread out, if available.
 - Stagger time in recreation spaces.
 - Restrict recreation space usage to a single housing unit, where feasible.
 - Encourage individual exercises (e.g., walking).
 - Clean and disinfect equipment after individual use and between group use.
- Meals
 - Stagger meals in the dining hall, if possible (one housing unit at a time; clean and disinfect between groups).
 - Rearrange seating in dining hall to increase space between inmates (e.g., remove every other chair or use only one side of table).
 - Increase meals to cell opportunities.
- Group Activities
 - Increase space between individuals during group activities.
 - Reduce the number of group participants to ensure physical separation of at least 6 feet between participants.



- If available, consider the use of alternative settings to usual group activities (e.g., outdoor recreation areas, module dayroom areas, or other areas where inmates can spread out).
- **Education and Program Services**
 - Temporarily convert the educational or program curriculum to self-study, if possible.
 - Consider the use of video modalities for education and other programs, if available.
 - Use no-contact barriers when meeting with inmates, if possible.
 - Limit the size of program participants to ensure physical separation of at least 6 feet between participants in the classroom.
- **Housing**
 - Arrange bunks so that inmates sleep head to foot.
 - If space allows, reassign bunks to provide more space between inmates (ideally 6 feet or more in all directions).
 - Minimize the number of inmates housed in the same room as much as possible.
- **Health Care**
 - Use no-contact barriers when meeting with inmates, if possible.
 - Identify duties that can be performed remotely. Use telehealth for virtual clinic visits with Providers, forensic examiners, community-based case managers, and other professional service providers, if available.
 - If available, designate a room near the intake area to evaluate new intakes with COVID-19 symptoms or exposure risk before the inmate moves to other parts of the facility.
 - If possible, designate a room near each housing unit to evaluate inmates with COVID-19 symptoms, rather than having inmates with COVID-19 symptoms walk through the facility to be evaluated in the medical unit. If designating a room near each housing unit is not feasible, consider staggering inmate sick call visits.
 - Stagger pill-lines or administer medication at modules.
 - Consider increased use of keep on person (KOP) medication orders.
 - Depending on the degree of local community transmission and potential for patient harm, adhere to the CDC guidance on [Managing Healthcare Operations During COVID-19](#). Prioritize services that, if deferred, are most likely to result in patient harm. Prioritize at-risk populations who would benefit most from services (e.g., inmates with serious underlying health conditions, inmates most at-risk for complications from delayed care, or inmates without access to telehealth).
- **Minimize Inmate Movement**
 - Avoid transferring inmates between living areas, when possible.
 - Modify work detail assignments so that each detail includes only individuals from a single housing unit. If a workline provides goods or services (e.g., food service or laundry), for other housing units under medical isolation, ensure that deliveries are made with extreme caution (e.g., workline delivers prepared food to a set location, leaves, and then staff or workline from the housing unit pick up the delivery. Clean and disinfect all coolers, carts, and other objects involved in the delivery).



- Re-entry
 - To the extent possible, ensure the facility re-entry programs include information on accessing housing, social services, and [healthcare resources](#) within the context of social distancing restrictions and modified community business operations related to COVID-19.
 - When the COVID-19 Community Level is high and when possible, encourage releasing inmates to seek housing options among their family or friends in the community to prevent crowding in other congregate settings such as homeless shelters.
 - When linking inmates to shared housing, link preferentially to accommodations with the greatest capacity for physical distancing.

e. Masks or Respirators and No-Contact Barriers

- Transmission of SARS-CoV-2 occurs from individuals who are symptomatic, asymptomatic (i.e., absence of symptoms), and pre-symptomatic (i.e., prior to the development of symptoms). This means COVID-19 could spread between people interacting in close proximity, even if those people are not exhibiting symptoms. Correct and consistent mask or respirator use is key to preventing the spread of droplets and very small particles that contain the virus (i.e., source control).
- As a COVID-19 prevention strategy for everyday operations in place at all times, provide a well-fitting mask or respirator to any inmate and staff member who would like to use them based on their personal preference. Require universal indoor mask/respirator use (unless contraindicated), as an enhanced COVID-19 prevention strategy when the COVID-19 Community Level is high, or when Facility-Specific Risk Factors indicate increased risk.
- Provide masks or respirators at no cost to staff and inmates. Anyone who has trouble breathing, is unconscious, incapacitated or otherwise unable to remove the mask without assistance should not use masks (refer to additional CDC [Considerations for Wearing Masks](#) for conditions and situations that may require adaptation).
- Clearly explain the purpose of masks or respirators to inmates and staff, as well as when the use of masks or respirators may be contraindicated. Masks are designed to contain droplets and particles you breath, cough, or sneeze out. If masks fit closely to the face, masks can also provide you some protection from particles spread by others, including the virus that causes COVID-19. Respirators are designed to protect you by filtering the air and fitting closely on the face to filter out particles, including the virus that causes COVID-19. Respirators can also contain droplets and particles you breath, cough, or sneeze out so you do not spread them to others.



- Choose the most protective mask or respirator that fits well (i.e., fitting closely on the face without any gaps along the edges or around the nose), and can be worn comfortably and consistently. Masks and respirators can provide different levels of protection depending on the type of product and how they are used. When worn properly: layered finely woven masks offer more protection than loosely woven cloth masks; well-fitting disposable procedure masks and KN95s offer even more protection; and well-fitting National Institute for Occupational Safety and Health (NIOSH) approved respirators (e.g., N95s), offer the highest level of protection.
- When possible, based on facility resources and supply, safety and security considerations, risk and indications for use, and contraindications, offer different types of masks and respirators to employees and inmates. Note: the options that are offered in correctional facilities may be limited by safety and security considerations (e.g., concerns about metal nose wires).
- Choose a mask that fits snugly over your nose, mouth, and chin. Gaps can let air with respiratory droplets leak in and out around the edges of the mask. Gaps can be caused by choosing the wrong size or type of mask and when a mask is worn with facial hair.
 - Check for gaps by cupping your hands around the outside edges of the mask.
 - Make sure no air is flowing from the area near your eyes or from the sides of the mask.
 - If the mask has a good fit, you will feel warm air come through the front of the mask and may be able to see the mask material move in and out with each breath.
- Cloth masks can be made from a variety of fabrics (e.g., cotton and cotton blends). Wear cloth masks with a proper fit over your nose, mouth, and chin to prevent leaks; multiple layers of tightly woven, breathable fabric; nose wire (as allowed); and fabric that blocks light when held up to a bright light source. Do NOT wear cloth masks with gaps around the sides of the face or nose; exhalation valves, vents, or other openings; single-layer fabric or those made of thin fabric that do not block light; hard to breath fabric (e.g., vinyl, plastic, leather); and wet or dirty material.
- Disposable procedure masks are sometimes referred to as surgical masks or medical procedure masks. Wear procedure masks with a proper fit over your nose, mouth, and chin to prevent leaks; multiple layers of non-woven material; and a nose wire. Do NOT wear procedure masks with gaps around the sides of the face or nose and wet or dirty material.
- The following methods may be used to improve fit and provide extra protection with cloth and procedure masks:
 - Wear two masks (disposable mask underneath **AND** cloth mask on top)
 - Combine either a cloth mask or disposable mask with a fitter or brace
 - [Knot and Tuck](#) procedure masks
 - Use masks that attach behind the neck and head with either elastic bands or ties (instead of ear loops)



- Educate inmates, employees, and others at correctional facilities on the [Use and Care of Masks](#).
- International respirators are respirators that are designed to meet international standards. KN95 respirators are the most widely available. Other examples include 1st, DL2, DL3, DS2, DS3, FFP2, FFP3, KN100, KP95, KP100, P2, P3, PFF2, PFF3, R95, and Special. International respirators seal tightly to your face when fitted properly.

Note: international respirators are designed to standards that do not often have a quality requirement (e.g., about 60% of KN95 respirators NIOSH evaluated during the COVID-19 pandemic in 2020 and 2021 [did not meet the requirements that they intended to meet](#)), and filter varying levels of particles in the air depending on the standard they are designed to meet. Do NOT wear international respirators: if they have exhalation valves, vents, or other openings; if it is hard to breathe while wearing them; if they are wet or dirty; with other masks or respirators; or as a replacement for NIOSH-approved [respiratory protection when required by your job](#).

- NIOSH approves many types of filtering facepiece respirators (see [NIOSH-Approved Particulate Filtering Facepiece Respirators](#) for lists of NIOSH-approved respirators). [Respirators approved by NIOSH](#) are evaluated against a specific U.S. standard that includes a quality requirement. NIOSH-approved respirators filter at least 95% of particles in the air when you have a proper fit. The most widely available are N95 respirators, but other types (N99, N100, P95, P99, P100, R95, R99, and R100) offer the same or better protection as an N95 respirator. Note: CDC recommends that specially labeled “surgical” N95 respirators (i.e., a special subtype of N95 respirators that provide additional protection against hazards present during medical procedures, such as blood splatter), should be reserved for use by healthcare personnel.
 - NIOSH-approved respirators seal tightly to your face when fitted properly (see [Occupational Safety and Health \(OSHA\) respiratory protection program](#)). When worn consistently and properly, they provide the highest level of protection from particles, including the virus that causes COVID-19 (see [How to Use Your N95 Respirator](#) and [Free N95 Respirator Manufacturers](#)). Additionally, they contain your respiratory droplets and particles so you do not expose others to the virus. If you have COVID-19, an N95 or other filtering facepiece respirator with a valve may not protect others as well as one without a valve. To make a filtering facepiece respirator with a valve as protective as one without a valve, follow the manufacturer’s instructions for covering the valve. Do NOT wear NIOSH-approved respirators: if it is hard to breathe while wearing them, if they are wet or dirty, or with other masks or respirators.



- In situations where the use of a respirator is not required either by the employer or by an Occupational Safety and Health Administration (OSHA) standard, the employer may still offer filtering facepiece respirators or permit employees to use their own respirators as long as the employer determines that such respirator use will not in itself create a hazard. This is considered voluntary use under the Respiratory Protection Standard. CDC encourages employers to permit workers to voluntarily use filtering facepiece respirators like N95s. If an employer allows voluntary use of [filtering facepiece respirators](#), the employer must provide users with [29 CFR 1910.134 Appendix D – Information for Employees Using Respirators When Not Required Under the Standard](#).
- Utilize no-contact barriers for inmate encounters as a supplement to the use of masks or respirators, when indicated and feasible.

f. Sick/Exposed Employees

- COVID-19 could gain entrance to a facility via infected employees. As a measure to prevent COVID-19 introduction to a facility from the community, regardless of vaccination and booster status, exclude staff from work if they have symptoms of COVID-19 or test positive for SARS-CoV-2. Staff should be educated to stay home if they have COVID-19 symptoms.
- If employees develop fever, cough, shortness of breath, or other COVID-19 symptoms at work, they should be advised to immediately put on a mask, promptly inform their supervisor, leave the facility, seek testing, and follow [CDC recommended steps for What to Do If You Are Sick](#).
- Review the most recent version of the Department of Human Resources Development instructions for “2019 Novel Coronavirus (COVID-19): Questions and Answers for Supervisors and Managers,” (see also [Interim Guidance for Managing Healthcare Personnel with SARS-CoV-2 Infection or Exposure to SARS-CoV-2](#), and the Equal Employment Opportunity Commission’s ["Pandemic Preparedness in the Workplace and the Americans with Disabilities Act"](#)).
- Review contingency plans for reduced staffing (e.g., [Strategies to Mitigate Healthcare Personnel Staffing Shortages](#)). Plan for absences. Identify critical job functions and plan for alternative coverage. Make plans in advance for how to change staff duty assignments to prevent unnecessary movement between housing units and other areas of the facility, to the extent possible (e.g., ensure the same staff are assigned to the same housing unit across shifts to prevent cross-contamination from units where infected individuals have been identified to units with no infections).
- To the extent possible, ensure sick leave policies are flexible, non-punitive, and actively encourage staff not to report to work when sick to reduce SARS-CoV-2 introduction and transmission in the facility.



- CDC and HDOH recommend the following strategies for determining [return to work](#) at correctional facilities.
 - Staff, who experienced *symptoms*, may return to work after:
 - At least 10 days have passed since symptoms first appeared (with day 0 being the first day of symptoms); **OR**
 - Using a test-based strategy, at least 7 days have passed since symptoms first appeared (with day 0 being the first day of symptoms) **AND** all of the following conditions are met:
 - If using a NAAT, a single negative test must be obtained within 48 hours prior to returning to work; **OR** if using an antigen test, two negative tests must be obtained, one no sooner than day 5 and the second 48 hours later; **AND**
 - At least 24 hours have passed since last fever without the use of fever-reducing medications; **AND**
 - Symptoms (e.g., cough, shortness of breath), have improved*; **AND**
 - The individual was not hospitalized; **AND**
 - The individual does not have a weakened immune system.
 - * Loss of taste and sense of smell may persist for weeks or months after recovery and need not delay the end of medical isolation.
 - Staff, who were *asymptomatic* throughout the infection, may return to work after:
 - At least 10 days have passed since the date of collection of the first positive viral test (with day 0 being the date the specimen was collected for the positive test); **OR**
 - Using a test-based strategy, at least 7 days have passed since the date of collection of the first positive viral test (with day 0 being the date the specimen was collected for the positive test). If using a NAAT, a single negative test must be obtained within 48 hours prior to returning to work; **OR** if using an antigen test, two negative tests must be obtained, one no sooner than day 5 and the second 48 hours later.
- If a staff member has a confirmed COVID-19 infection:
 - [When testing on own] The staff member should adhere to the CDC guidance [What to Do If You Are Sick](#).
 - [When testing at the facility] Immediately notify the individual of the positive result and advise the employee to adhere to the CDC guidance [What to Do If You Are Sick](#).
 - Inform other staff about possible exposure to COVID-19 in the workplace (maintaining confidentiality in accordance with State and Federal laws, and as required by the [Americans with Disabilities Act](#)).
- Staff may use the [guidance for the general public](#) for duration of medical isolation when they are not at work.
- Refer to Modifying Medical Isolation Protocols During Crisis-Level Operations below for additional return to work guidance.



- Employees with known or suspected exposure to someone with COVID-19, regardless of COVID-19 vaccination and booster status, should receive a diagnostic test at least 5 days after the exposure/close contact. Employees should consult their healthcare provider, self-monitor for symptoms, seek testing, and wear a mask or respirator for 10 days while indoors at work, regardless of their vaccination and booster status.
- The following risk mitigation precautions should be implemented to protect the exposed critical infrastructure worker and others prior to and during the work shift:
 - Pre-Screen: The employee should self-screen at home prior to arriving onsite. The employee should not attempt to enter the workplace if any of the following are present: [symptoms of COVID-19](#); temperature equal to or higher than 100.0 °F.
 - Regular Monitoring: The employee should self-monitor and report to the supervisor the development of a temperature or other symptoms. Close contacts who develop symptoms within 10 days of the last exposure should be tested for COVID-19 and immediately self-isolate while awaiting results.
 - Wear a Mask or Respirator: The employee should correctly and consistently wear a mask or respirator (unless contraindicated) while indoors at the workplace for 10 days after the last exposure.
 - Hand Hygiene: The employee should adhere to all recommended prevention strategies for people who have been exposed to someone with COVID-19, including maintaining good hand hygiene.
 - Physical Distance: The employee should avoid crowds and maintain 6 feet of physical distance from others and practice physical distancing as work duties permit in the workplace.
 - Disinfect and Clean Workspaces: Continue enhanced cleaning and disinfecting practices in all areas, especially frequently touched surfaces and objects, including offices, bathrooms, common areas, and shared equipment (refer to CDC [Cleaning and Disinfecting Your Facility](#) and [NIOSH Workplace Solutions: Safe and proper use of disinfectants to reduce viral surface contamination in correctional facilities](#)).
- In addition to physical and medical considerations, the CDC provides information for employees [About Mental Health](#) (see also [Coping with Stress](#), [Support for Employees](#), and specific information for [Public Health Workers and Health Professionals](#)). Employees seeking mental health assistance are encouraged to contact their Primary Care Provider or the Employee Assistance Program (WorkLifeHawaii.org): Oahu at (808) 543-8445 or Neighbor Islands and After Hours at (800) 994-3571. Additional sources of help include:
 - [National Suicide Prevention Lifeline](#) call or text **988**
 - [National Domestic Violence Hotline](#) call 800-799-7233 or TTY 800-787-3224
 - [Disaster Distress Helpline](#) call 800-985-5990 or text TalkWithUs to 66746
 - [Hawaii CARES Crisis Helpline](#) call 808-832-3100 or 800-753-6879



g. Maintain SARS-CoV-2 Testing Strategies

Maintain a robust SARS-CoV-2 testing program, including [diagnostic and screening testing](#), to help prevent or reduce transmission of the virus in correctional facilities and provide critical data for ongoing assessment. Maintain the testing strategies below as COVID-19 prevention strategies for everyday operations.

- **Diagnostic testing** should be performed for anyone who shows signs or [symptoms of COVID-19](#) and for anyone who has been potentially exposed or identified as a [close contact](#) of someone with COVID-19 (either through traditional contact tracing or location-based contact tracing), regardless of COVID-19 vaccination and booster status.
- **Screening testing** should be performed for all inmates at intake, regardless of COVID-19 vaccination and booster status.

Implement enhanced testing strategies (i.e., additional movement-based screening testing and routine screening testing), based on COVID-19 Community-Level and Facility-Specific Risk Factors, as indicated and feasible.

h. COVID-19 Vaccination, including Boosters

The U.S. Food and Drug Administration (FDA) has approved and authorized (under [Emergency Use Authorization](#)) vaccines to protect people against severe illness, hospitalization, and death, which may be caused by COVID-19. The FDA provides regularly updated information on [COVID-19 Vaccines](#). According to the CDC, COVID-19 vaccination is a strategy for everyday operations in correctional facilities and is the most important tool available to prevent severe COVID-19. The CDC reports COVID-19 vaccines are [safe](#) and [effective](#).

- Ensure COVID-19 vaccines and boosters (including additional doses for people who are immunocompromised) are available for all inmates (existing population and new intakes), in order to stay up to date.
- Provide education about COVID-19 vaccines and boosters (see [CDC COVID-19 vaccine communication resources for correctional facilities](#)). Provide inmates with opportunities to ask questions and receive responses. Promote COVID-19 vaccination by educating staff and inmates on the effectiveness, safety, and importance of vaccines. Consider recruiting inmates who received the vaccine to be peer supporters to encourage other inmates to get the vaccine and recruiting staff peers to encourage staff vaccination.
- Work with the Hawaii Department of Health, healthcare providers, and community organizations on effective ways to increase vaccination uptake, informed by input from inmates and staff about why they may not wish to receive the vaccine.



- The CDC provides the following COVID-19 vaccine information:
 - [About COVID-19 Vaccines](#) - [Benefits of Getting a COVID-19 Vaccine](#), [Frequently Asked Questions](#), and [Vaccine Data](#).
 - [Your COVID-19 Vaccination](#) - [Find a COVID-19 Vaccine or Booster](#), [Getting a COVID-19 Vaccine](#), and [COVID-19 Vaccine Information for Specific Groups](#) (including [Moderately or Severely Immunocompromised People](#)).
 - [Stay Up to Date with Your COVID-19 Vaccines Including Boosters](#) - [Understanding How COVID-19 Vaccines Work](#) with specific information on [mRNA COVID-19 Vaccines](#), [Viral Vector COVID-19 Vaccines](#), and [Protein Subunit COVID-19 Vaccines](#); and COVID-19 vaccine overview and safety for [Pfizer-BioNTech](#) (COMIRNATY), [Moderna](#) (Spikevax), [Johnson & Johnson's Janssen](#), and [Novavax](#).
 - [Possible Side Effects](#) – common side effects include pain, redness and swelling on the arm the vaccine was administered; tiredness, headache, muscle pain, chills, fever, nausea (see also [What to Expect after Getting a COVID-19 Vaccine](#)).
 - [The Possibility of COVID-19 after Vaccination: Breakthrough Infections](#).
 - [Myths and Facts about COVID-19 Vaccines](#).

The CDC provides COVID-19 vaccine clinical resources for [healthcare workers](#):

- [Clinical Care Considerations for COVID-19 Vaccination](#)
- [Interim Clinical Considerations for Use of COVID-19 Vaccines in the United States](#)
 - [Interim Considerations: Preparing for the Potential Management of Anaphylaxis after COVID-19 Vaccination](#)
 - [Clinical Consideration: Myocarditis and Pericarditis after Receipt of mRNA COVID-19 Vaccines Among Adolescents and Young Adults](#)
 - [Lab Tests to Collect Shortly After Severe Allergic Reaction/Anaphylaxis Following COVID-19 Vaccination](#)
 - The [Advisory Committee on Immunization Practices](#) (ACIP) provides advice and guidance to the Director of the CDC regarding use of vaccines and related agents for control of vaccine-preventable diseases in the civilian population of the United States. Recommendations made by the ACIP are reviewed by the CDC Director and, if adopted, are published as official CDC/HHS recommendations in the Morbidity and Mortality Weekly Report (MMWR).



- [U.S. COVID-19 Vaccine Product Information](#), including changes and updates; general vaccine information (i.e., dosage, age indication, schedule, and route of administration); administration overview with contraindications/precautions and directions to thaw, prepare and administer; [Prevaccination Screening Checklist](#); standing orders (i.e., [Pfizer-BioNTech](#), [Moderna](#), [Janssen](#), [Novavax](#)); and Preparation and Administration Summary (i.e., [Pfizer-BioNTech](#), [Moderna](#), [Janssen](#), [Novavax](#)).
 - [Pfizer-BioNTech](#)
 - [Moderna](#)
 - [Janssen](#)
 - [Novavax](#)
- [CDC COVID-19 Vaccination Program Provider Requirements and Support](#), which includes requirements for vaccine administration reporting and documentation, directions for reporting adverse events to the [Vaccine Adverse Event Reporting System \(VAERS\)](#), instructions on [How to Enroll as a COVID-19 Vaccination Provider](#), and [FAQs for Private and Public Healthcare Providers About Implementing the CDC COVID-19 Vaccination Program in Provider Practices](#) (see also [COVID-19 Vaccination Data Systems and Data Sources](#)).
- [Training and Education](#) modules with core competencies required by professional qualification, as well as specific information on [Safe and Proper Sharps Disposal During the COVID-19 Mass Vaccination Campaign](#).
- [Vaccine Recipient Education](#), including various educational handouts, instructions on [How to talk to patients about COVID-19 vaccination](#), and an [Interactive COVID-19 Vaccine Conversations Module for Healthcare Professionals](#) (see also [COCA webinar on how to address patient questions and concerns about vaccines](#)).
- [COVID-19 Vaccine Breakthrough Case Investigation and Reporting](#). Vaccine breakthrough infection is defined as the detection of SARS-CoV-2 RNA or antigen in a respiratory specimen collected from a person ≥ 14 days after they have completed all recommended doses of a U.S. Food and Drug Administration (FDA)-authorized COVID-19 vaccine. [Vaccine breakthrough cases](#) are expected. No vaccine is 100% effective at preventing illness in vaccinated people. If COVID-19 infection is suspected in a person who received a complete primary series and it has been at least 14 days since the last dose:
 - Collect a respiratory specimen for SARS-CoV-2 diagnostic testing
 - For patients with positive respiratory specimen results:
 - Forward positive specimen to the State Laboratories Division (SLD) for whole genome sequencing analysis
 - Report the case to HDOH
 - Submit a Vaccine Adverse Event Reporting System (VAERS) report at: <https://vaers.hhs.gov/reportevent.html>
- [Vaccine Effectiveness Research](#).



i. **Influenza Vaccination**

- During influenza season, flu vaccination remains an important measure to prevent an illness that presents similarly to COVID-19. The CDC provides [Interim Guidance for Routine and Influenza Immunization Services During the COVID-19 Pandemic](#) (see also MMWR [Prevention and Control of Seasonal Influenza with Vaccines: Recommendations of the Advisory Committee on Immunization Practices, United States, 2021–22 Influenza Season](#)).
- Encourage correctional employees to obtain flu vaccination.
- Offer the seasonal influenza vaccine to all inmates (existing population and new intakes).

j. **Infection Prevention and Control Guidance for Screening**

Protocol when conducting temperature checks:

- Perform hand hygiene, (i.e., Wash hands with soap and water for at least 20 seconds. If soap and water are not available, use hand sanitizer with at least 60% alcohol).
- Put on a mask or respirator, eye protection (goggles or disposable face shield that fully covers the front and sides of the face) and disposable gloves.
- Check the individual's temperature. Refer to [Non-contact Infrared Thermometers](#) for information on proper thermometer usage and factors that could impact thermometer readings.
 - If performing temperature checks on multiple individuals, put on new gloves for each individual screen and thoroughly clean the thermometer between each screen.
 - If disposable or non-contact thermometers are used and the screener did not have physical contact with an individual, gloves do not need to be changed before the next screen. If non-contact thermometers are used, they should be cleaned with an alcohol wipe (or isopropyl alcohol on a cotton swab) between each individual.
- Remove and discard PPE.
- Perform hand hygiene.

Protocol when conducting temperature checks if a physical barrier or partition is used to protect the screener rather than a PPE-based approach (During screening, the screener stands behind a physical barrier, such as a plexiglass partition, which protects the screener's face and mucous membranes from respiratory droplets that may be produced when the person being screened sneezes, coughs, or talks):

- Perform hand hygiene.
- Put on a mask or respirator and disposable gloves.



- Check the individual's temperature by reaching around the partition or through the window. The screener's face must remain behind the barrier at all times during the screening.
 - If performing temperature checks on multiple individuals, put on new gloves for each individual screen and thoroughly clean the thermometer between each screen.
 - If disposable or non-contact thermometers are used and the screener did not have physical contact with an individual, gloves do not need to be changed before the next screen. If non-contact thermometers are used, they should be cleaned with an alcohol wipe (or isopropyl alcohol on a cotton swab) between each individual.
- Remove and discard gloves.
- Perform hand hygiene.

k. Control Strategies for Aerosol Generating Procedures

- Refer to [Attachment 8](#) for recommended control strategies during aerosol generating procedures, including SARS-CoV-2 specimen collection, emergency dental procedures, CPAP/BiPAP, pulmonary function tests/peak flow tests, nebulizer treatment, and CPR.
- Dental healthcare staff should adhere to the CDC [Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 \(COVID-19\) Pandemic](#) and guidance from the [Hawaii Board of Dentistry](#) (see [Dental COVID-19 FAQ](#)).
- Dental healthcare staff should regularly consult the Hawaii Board of Dentistry and HDOH for current information and recommendations and requirements, which might change based on [level of community transmission](#).
- Postpone all non-urgent dental treatment for inmates with suspected or confirmed SARS-CoV-2 infection until released from medical isolation.
 - Dental care for inmates on medical isolation should only be provided if medically necessary.
 - If an inmate has a fever strongly associated with a dental diagnosis (e.g., pulp and periapical dental pain and intraoral swelling are present), but no other symptoms consistent with COVID-19 are present, dental care can be provided following the practices recommended for routine health care during the pandemic.
- When performing aerosol generating procedures on inmates who are not suspected or confirmed to have SARS-CoV-2 infection, ensure that dental staff correctly wear the recommended PPE (including a NIOSH-approved N95 or equivalent or higher-level respirator in counties with substantial or high levels of transmission) and use mitigation methods such as four-handed dentistry, high evacuation suction, and dental dams to minimize droplet spatter and aerosols. Commonly used dental equipment known to create aerosols and airborne contamination include ultrasonic scaler, high-speed dental handpiece, air/water syringe, air polishing, and air abrasion.



- Dental treatment should be provided in individual rooms whenever possible.
- For dental facilities with open floor plans, to prevent the spread of pathogens there should be:
 - At least 6 feet of space between patient chairs
 - Physical barriers between patient chairs. Easy-to-clean floor-to-ceiling barriers will enhance effectiveness of portable HEPA air filtration systems (check to make sure that extending barriers to the ceiling will not interfere with fire sprinkler systems).
 - Operatories should be oriented parallel to the direction of airflow if possible.
 - Where feasible, consider patient orientation carefully, placing the patient's head near the return air vents, away from pedestrian corridors, and toward the rear wall when using vestibule-type office layouts.
 - Ensure to account for the time required to clean and disinfect operatories between patients when calculating your daily patient volume.

4. Visitors / Vendors / Volunteers

At all times (including periods when COVID-19 Community-Level is low or medium):

- Provide alcohol-based hand sanitizer with at least 60% alcohol in visitor entrances, exits, and waiting areas.
- Instruct visitors, vendors, and volunteers to postpone their visit if they have symptoms of COVID-19.
- Visitors, vendors, and volunteers with COVID-19 symptoms should be denied entry into the facility, regardless of COVID-19 vaccination and booster status, and encouraged to seek testing.
- Visitors, vendors, and volunteers with a positive SARS-CoV-2 test (with or without symptoms) should be denied entry into the facility for 10 days from the date when symptoms started, or from the date of the positive test if they do not have symptoms (with Day 0 being the date of specimen collection). Alternatively, visitors, vendors, and volunteers may shorten the duration to 7 days with a negative NAAT obtained within 48 hours prior to facility entrance, **AND** as long as symptoms are improving, the individual has been fever-free for 24 hours, the individual was not hospitalized, and the individual does not have a weakened immune system.
- Visitors, vendors, and volunteers who have been potentially exposed or identified as a close contact to someone with COVID-19 should be encouraged to get tested at least five (5) full days after exposure (or sooner, if they develop symptoms), and required to wear a mask while indoors at the facility for 10 full days after exposure, regardless of vaccination and booster status.



Visitation is essential for the mental health and well-being of inmates. When possible, maximize access to opportunities for in-person visitation, even when [COVID-19 Community Levels](#) are high.

- When facilities maintain in-person visitation or volunteer services during periods of higher risk:
 - Require visitors, vendors, and volunteers to wear a well-fitting cloth mask, procedure mask, or respirator while indoors.
 - Consider using protective barriers in visitation rooms and encouraging physical distancing.
 - Consider requiring visitors to provide documentation of a negative SARS-CoV-2 test result within the last 72 hours before entry.
- If testing for SARS-CoV-2 is unavailable, facilities can consider screening for COVID-19 symptoms (including temperature checks) and asking about recent close contact with someone with COVID-19. Facilities may also consider adding symptom screening as an added layer of protection in addition to testing. Symptom screening can help identify visitors, vendors, or volunteers who should be excluded from a facility before entry. *Symptom screening and temperature checks alone will not prevent all transmission, because it will not identify people with asymptomatic or pre-symptomatic infection.*
 - If facilities use symptom screening as an enhanced prevention strategy, provide visitors, vendors, and volunteers with information to prepare them for screening. Display signage outside visiting areas explaining the COVID-19 screening process. Ensure that materials are understandable for non-English speakers and those with low literacy. Provide accommodations for those with cognitive or intellectual disabilities and those who are deaf, blind, or have low vision.
 - Facilities may use [Attachment 1](#) to implement COVID-19 screening of visitors, vendors, and volunteers. When symptom screening is required by the facility, visitors, vendors, and volunteers who do not clear the screening process or who decline screening should be denied entrance to the facility.



5. Employee Screening and Testing

- As an enhanced COVID-19 prevention strategy, facilities may arrange to offer employees routine screening testing for SARS-CoV-2, increasing or reducing the frequency of available testing according to the level of risk identified by COVID-19 Community-Levels or Facility-Specific Risk Factors.
 - Staff members with a positive test result (with or without symptoms) should be excluded from work for 10 days from the date when symptoms started, or from the date of the positive test if they do not have symptoms (with Day 0 being the date the specimen was collected). See Sick/Exposed Employees above for additional return to work guidance.
 - To avoid unnecessary exclusion from work due to the possibility of a false positive test result, encourage staff who receive a positive antigen test result for SARS-CoV-2 to seek confirmatory PCR testing if asymptomatic.
- If testing for SARS-CoV-2 is unavailable, facilities can consider screening for COVID-19 symptoms (including temperature checks) and asking about recent close contact with someone with COVID-19. Facilities may also consider adding symptom screening as an added layer of protection in addition to testing. Symptom screening can help identify staff who should be excluded from a facility before entry. *Symptom screening and temperature checks alone will not prevent all transmission, because it will not identify people with asymptomatic or pre-symptomatic infection.*
 - If facilities use symptom screening as an enhanced prevention strategy, employees should be screened upon arrival using the COVID-19 Employee Screening form, which asks questions about COVID-19 symptoms, COVID-19 positive results, travel, contact with a known or suspected COVID-19 individual, and temperature check ([Attachment 2](#)).
 - Facilities might choose to laminate the employee screening form and have employees review the screening questions and verbally respond to them. Employees can then sign a log book that includes date, employee name, and position. The temperature should be taken and recorded by the screener in a fourth column in the logbook. Employee screenings would not require documentation on an employee screening form, unless the employee responds “YES” to any question in section 1 or 2, responds “NO” to section 3, or has a temperature of 100.0°F or above. Only positive screens that would deny clearance into the facility require completion of the employee screening form. All cleared employees would only complete the logbook (see example spreadsheet below).

DATE	EMPLOYEE NAME	POSITION	TEMPERATURE



- A temperature should also be taken ideally with a no-touch infrared thermometer. Refer to [Non-contact Infrared Thermometers](#) for information on proper thermometer usage and factors that could impact thermometer readings.
- Employee screening is generally performed by non-health care personnel.
- Positive screens require notification of the Watch Commander or the employee's immediate supervisor for civilian staff.
- All actions should adhere to the most recent version of the Department of Human Resources Development instructions for "2019 Novel Coronavirus (COVID-19): Questions and Answers for Supervisors and Managers."
- When symptom screening is required as an enhanced prevention strategy by the facility, employees who screen positive for symptoms should be sent home and advised to consult their healthcare provider (see [What to Do If You Are Sick](#)). Employees, who screen positive for exposure to someone with COVID-19, regardless of vaccination and booster status, should be required to wear a mask or respirator while indoors for ten (10) full days after exposure while at work.

6. Intake Screening and Routine Intake Observation

- New intakes should be offered masks or respirators (unless contraindicated) and screened for symptoms in accordance with established nursing protocols.
- If new intakes are identified with symptoms then ***immediately place a mask or respirator (unless contraindicated) on the inmate***, have the inmate perform hand hygiene, and place the inmate in a separate room, preferably with a toilet, while determining next steps. Staff entering the room shall wear personal protective equipment (PPE) in accordance with guidance in Element 8.
- Identify inmates who were transported with the symptomatic new intake for the possible need to cohort the identified inmates separately in Routine Intake Observation.
- If new intakes report history of recent exposure to COVID-19, then they should be assessed for possible placement considerations in Routine Intake Observation.
- Routine observation periods can be used as part of intake, transfer, and/or release processes to minimize potential transmission to/from other facilities or the community during movement. Routine observation periods are sometimes referred to as "routine intake/transfer/release quarantine." During routine observation periods, inmates are housed separately from the rest of the facility's population (ideally individually, or as small cohorts if individual housing is not possible or is not advisable due to mental health concerns).



- As a [strategy for everyday operations](#), the CDC recommends facilities implement screening testing OR a routine observation period for all inmates at intake. The routine observation period option should only be used under the following scenarios: a) Inmates under observation are housed individually, OR b) Inmates under observation are housed in small cohorts due to mental health concerns associated with individual housing, and all cohort members begin the observation period on the same day and will be tested at the end of the observation period.
- Observation periods should be 10 days if the inmates under observation are housed individually and are not tested at the end of the observation period.
- Inmates, who have recovered from confirmed COVID-19 illness within the previous 30 days and remain without COVID-19 symptoms, do NOT require routine intake observation.
- If Routine Intake Observation is combined with testing at the end of the observation period, a shorter observation period (minimum of 5 days) could be used. Facilities may consider adding symptom screening as an added layer of protection in addition to testing. Symptom screening can help identify inmates (at intake or in the existing population) who should be evaluated for potential medical isolation. *Symptom screening and temperature checks alone will not prevent all transmission, because it will not identify people with asymptomatic or pre-symptomatic infection.*

7. Initial Management and Testing of SARS-CoV-2

Initial Management of Suspected SARS-CoV-2

- **Source control (placing a mask or respirator on a potentially infectious person) is critically important.** If an inmate is identified with COVID-19 symptoms, then *immediately place a mask or respirator on the inmate (unless contraindicated)* and have the inmate perform hand hygiene.
- Place the inmate in a separate room, preferably with a toilet and sink, while determining next steps. Contact should be minimized to the extent possible until the symptomatic inmate is wearing a mask or respirator (unless contraindicated) and staff are wearing personal protective equipment (PPE) as outlined in Element 8.
- An inmate with COVID-19 symptoms should be moved to medical isolation in a separate environment from other people (ideally individually), medically evaluated (including eligibility for COVID-19 therapeutics), and tested for SARS-CoV-2. Facilities without onsite healthcare capacity to medically evaluate and/or treat inmates with suspected COVID-19 should contact the on-call medical provider to ensure that timely evaluation and treatment take place through telehealth, an offsite medical facility, additional healthcare providers, or other means.



- A single new case of SARS-CoV-2 infection in a staff member or inmate should be evaluated as a potential outbreak, prompting a case investigation (i.e., traditional case investigation and contact tracing or location-based contact tracing), and testing of close contacts. If an inmate tests positive at intake but has not had close contact with other members of the facility's population and is immediately placed in medical isolation, the inmate's positive test result could be considered an isolated case, rather than a part of a larger outbreak, and may not trigger enhanced prevention strategies. However, it may be necessary to test other people who were exposed during intake or transport.

Testing for SARS-CoV-2

- The CDC provides an [Overview of Testing for SARS-CoV-2](#), [Testing Strategies for SARS-CoV-2](#), [Guidance for Healthcare Workers about COVID-19 \(SARS-CoV-2\) Testing](#), and testing consideration for correctional and detention facilities within the [Guidance on Management of COVID-19 in Homeless Service Sites and in Correctional and Detention Facilities](#). Decisions about how to manage and test inmates for SARS-CoV-2 should be made in collaboration with the facility Provider, Physician Manager, or Medical Director and the Hawaii Department of Health.
- Nasopharyngeal swabbing should only be performed by qualified staff with demonstrated competency. See instructional video at: <https://www.youtube.com/watch?v=DVJNWefmHjE>. For additional testing information, see the CDC [Interim Guidelines for Collecting and Handling of Clinical Specimens for COVID-19 Testing](#), [Interim Laboratory Biosafety Guidelines for Handling and Processing Specimens Associated with Coronavirus Disease 2019 \(COVID-19\)](#), [Guidance for SARS-CoV-2 Rapid Testing Performed in Point-of-Care Settings](#), and [How to Report COVID-19 Laboratory Data](#).
- People undergoing testing should receive clear information on what the results mean, recommended actions associated with negative or positive results, the difference between testing for screening versus for medical diagnosis, who will be able to access the results, how the results may be used, and any consequences for declining to be tested. Individuals tested are required to receive patient fact sheets as part of the test's [emergency use authorization](#). If offering testing to staff, follow the guidance from the [Equal Employment Opportunity Commission](#). Refer to the [Occupational Safety and Health Administration](#) for compliance with [29 CFR Part 1904](#) with respect to COVID-19 occupational illness recording requirements.
- There are several types of SARS-CoV-2 and COVID-19 related *in vitro* diagnostic (IVD) devices. Viral tests authorized by the [Food and Drug Administration \(FDA\)](#), including [Nucleic Acid Amplification Tests \(NAATs\)](#), antigen tests, and [other tests](#) (e.g., breath tests), are used to diagnose [current infection](#) with SARS-CoV-2, the virus that causes COVID-19. Tests can differ based on sensitivity (i.e., number of false-negative results/missed detections of SARS-CoV-2) and/or specificity (i.e., number of false-positive results/tests incorrectly identifying SARS-CoV-2 when the virus is not present).



The “gold standard” for diagnostic detection of SARS-CoV-2 remains the real-time reverse transcription-polymerase chain reaction (RT-PCR), which are high sensitivity, high specificity NAATs for diagnosing SARS-CoV-2 infection.

- Antigen tests are immunoassays that detect the presence of a specific protein on the surface of the virus. Different antigen tests generally have similar specificity, but are less sensitive than most NAATs. Because of the performance characteristics of antigen tests, use of an [Antigen Testing Algorithm](#) is recommended to determine when confirmatory NAAT testing is needed. See also [Guidance for SARS-CoV-2 Rapid Testing Performed in Point-of-Care Settings](#).
- [Antibody \(or serology\) tests](#) are used to detect past infection with SARS-CoV-2 and can aid in the diagnosis of Multisystem Inflammatory Syndrome. It is not currently known whether a positive antibody test result indicates immunity against SARS-CoV-2; therefore, at this time, antibody tests should not be used to determine if an inmate is immune against infection. The CDC does not recommend using antibody testing for diagnosing current infection (see the CDC [Interim Guidelines for COVID-19 Antibody Testing](#)).

Diagnostic Testing

- [Diagnostic testing](#) is intended to identify current infection and is performed when a person has signs or symptoms consistent with COVID-19, or when a person is asymptomatic (without symptoms) but has recent known or suspected exposure to someone with COVID-19. Diagnostic testing is a COVID-19 prevention strategy for everyday operations in correctional facilities and should be implemented at all times, even when COVID-19 Community Level is low or medium. Diagnostic testing is recommended for staff and inmates with signs or symptoms consistent with COVID-19 and all close contacts of persons with SARS-CoV-2 infection, regardless of symptoms or COVID-19 vaccination or booster status.
- The CDC recommends facilities consider suspending co-pays for inmates seeking medical evaluation for possible COVID-19 symptoms, especially during outbreaks, to remove possible barriers to symptom reporting. Ensuring the availability of low-barrier diagnostic testing can help identify cases early and limit the size of outbreaks.
- Inmates infected with SARS-CoV-2 can have another viral (e.g., [influenza](#), [Respiratory Syncytial Virus \(RSV\)](#)), bacterial, or fungal infection at the same time. During widespread cocirculation of SARS-CoV-2 and influenza, including during the off season, the CDC recommends clinicians consider multipathogen testing.

Screening Testing

- [Screening testing](#) is used to identify people infected with SARS-CoV-2 who are asymptomatic or pre-symptomatic and do not have known or suspected exposure to someone with COVID-19. Screening testing can be a valuable tool in correctional facilities for detecting infections early to help stop transmission quickly. [NAATs](#) or [antigen tests](#) can be used for screening testing.
- Some forms of screening testing (i.e., testing at intake) are [strategies for everyday operations](#) in correctional facilities, and other forms of screening testing are [enhanced prevention strategies](#).



Movement-Based Screening Testing

- Movement-based screening testing is the routine screening testing of inmates, regardless of vaccination and booster status, at intake, before transfer to another facility, and before community visits or release.
 - At Intake (strategy for everyday operations). Test all incoming inmates at intake and house new arrivals separately from the existing facility population (individually if feasible) in the 5-day Routine Intake Observation. If the test result is negative, retest inmates on day 5 of the Routine Intake Observation period before they are assigned housing with the existing inmate population. The routine observation period option should only be used under the following scenarios: a) Inmates under routine intake observation are housed individually, or b) Inmates are housed in small cohorts due to mental health concerns associated with individual housing, and all cohort members begin the observation period on the same day and will be tested at the end of the observation period. As an alternative to testing at intake and when an inmate refuses testing, complete Routine Intake Observation for 10-days without testing.
 - Before Transfer to Another Facility (enhanced prevention strategy). When COVID-19 Community Levels or Facility-Specific Risk Factors indicate increased risk, consider testing all inmates before transfer to another correctional facility. Wait for a negative test result before transfer, and do not transfer inmates with a positive test unless necessary for medical care, infection control, lack of medical isolation space, or extenuating correctional, judicial, or security concerns. As an alternative to testing and when an inmate refuses testing, complete Routine Transfer Observation (RTO) at the sending facility for 10 days prior to the transfer.
 - Before Release (enhanced prevention strategy). When COVID-19 Community Levels or Facility-Specific Risk Factors indicate increased risk, consider testing inmates before release from the facility. For planned releases of inmates who will be housed in other congregate settings (e.g., homeless shelters, group homes, halfway houses, residential substance abuse programs), or households with persons who are at high risk of severe illness from COVID-19, test inmates as close as possible to the day of release. In the event of an unexpected release to another congregate setting or a high-risk household, conduct release testing to the extent possible when indicated. Notify DOH for assistance arranging medical isolation upon release for people who have a positive test result.
 - Before/After Community Visits (enhanced prevention strategy). When COVID-19 Community Levels or Facility-Specific Risk Factors indicate increased risk, consider testing inmates before community visits (e.g., medical appointments, court appearances, community programs). If performing testing before community visits, test inmates leaving the facility as close as possible to the day of the visit. If COVID-19 Community Levels or Facility-Specific Risk Factors indicate increased risk, consider testing 5 days after return to the facility from community visits.



Routine Screening Testing

- Routine screening testing (a.k.a., surveillance testing), is an enhanced prevention strategy. Routine screening testing is the regular testing of asymptomatic inmates and staff with no known or suspected exposure to SARS-CoV-2, with the goal of identifying COVID-19 cases early to prevent widespread transmission.
- Ideally, a routine screening testing program includes both inmates and staff regardless of vaccination status. It can include all inmates and staff in a facility, or a targeted or random subset chosen according to criteria the facility designates (see examples below). If staff are tested during routine screening testing, consider [testing staff on the first day of their work week](#) (defined as four or more consecutive work days), rather than randomly or regularly on another day of the work week, if feasible.
- If routine screening testing is conducted only among a subset of individuals in a facility or facilities within a correctional system, CDC recommends the following factors to guide prioritization and selection of the subset:

Facility/Housing Factors

- Facilities that house inmate populations more likely to get very sick from COVID-19
- Facilities with low rates of up to date vaccination (including inmates and staff)
- Facilities that have experienced recent cases or outbreaks
- Facilities or Housing units where preventive measures such as physical distancing or [adequate ventilation](#) are difficult to implement (e.g., dormitory-based housing or older facilities)
- Facilities with higher levels of interaction with the community (e.g., through in-person visitation or frequent turnover, off-site medical visits, work release, or court appearances)

Individual-Level Factors

- Inmates and staff members who are more likely to get very sick from COVID-19 (e.g., staff who have self-identified to the employer that they are more likely to get very sick from COVID-19 due to an individual medical condition)
- Inmates assigned to critical on-site work details within the facility that require them to leave their housing unit or mix with persons in other housing units (e.g., food service, laundry)
- Inmates who participate in programming with inmates from other housing units
- Inmates participating in work furlough programs, frequent off-site medical visits, and frequent court appearances
- Staff working in a facility designated for medical care
- Staff working in multiple areas of the facility or multiple congregate facilities (e.g., more than one correctional facility)
- Staff who live or spend time with other staff who work in other areas of the facility (e.g., family or household members, carpools)



8. Personal Protective Equipment (PPE)

Table 3. Definitions of “Masks” and “Respirators”

Masks: Include disposable procedure masks (a.k.a., surgical masks or medical procedure masks), which are available in various shapes and types (e.g., flat with nose bridge and ties, duck billed, flat and pleated, pre-molded with elastic bands); and cloth masks, which can be made from a variety of fabrics.

Respirators: Include international respirators (e.g., KN95), and N-95 or higher filtering, face-piece respirators that are NIOSH-approved.

- Criteria for using various types of PPE based on the type of contact is outlined in Table 4.
- The CDC recommends the following Personal Protective Equipment (PPE) when an individual has close contact with or provides medical care to a person with suspected or confirmed COVID-19 (see Element 3d above for additional details about masks and respirators).
 - **Respirators.**
 - Include international respirators (e.g., KN95) and NIOSH-approved N-95 or higher filtering, face-piece respirators.
 - N95 respirators should be prioritized when contact is anticipated with infectious aerosols or droplets from someone with COVID-19.
 - Through the established [respiratory protection program](#), ensure that staff and inmates who require respiratory protection for work responsibilities have been medically cleared, trained, and fit-tested as appropriate.
 - N95 respirators should not be worn with facial hair that interferes with the respirator seal.
 - If N95 respirators are to be used, they must be used in the context of a fit-testing program. Fit testing is specific to the brand/size of respirator to be used.
 - Perform [User Seal Check](#) prior to every use to ensure an adequate seal is achieved (see also [Respirator On/Respirator Off](#)).
 - **Masks.**
 - Include disposable procedure masks and cloth masks.
 - A procedure mask can be layered underneath a cloth mask for improved fit and filtration. However, a procedure mask should not be layered underneath a second procedure mask. Use of a [mask fitter or brace](#) may help to improve fit. See also [Knot and Tuck](#) for procedure masks.
 - **Eye Protection** (goggles or disposable face shield that fully covers the front and sides of the face).
 - This does not include personal eyeglasses.
 - If reusable eye protection is used, it should be cleaned and disinfected in accordance with the manufacturer’s instructions.



- **Gloves.**
 - Disposable examination gloves should be changed if torn or heavily contaminated.
- **Gown/One-Piece Coverall.**
 - If security staff are unable to wear a disposable gown or coverall due to limitations in access to the duty belt and gear, then the duty belt and gear should be disinfected after close contact with an inmate with confirmed or suspected COVID-19. Clothing should be changed as soon as possible. Clean and disinfect duty belt and gear prior to reuse.
 - If gowns/one-piece coveralls are in short supply, prioritize for aerosol-generating procedures and high contact activities that provide opportunities for transfer of pathogens to the hands and clothing of the wearer.
- Train staff and inmates, who are required to wear PPE, to correctly don, doff, and dispose of PPE. See CDC instructions on [donning](#) (putting on) and [doffing](#) (removing) PPE: [Comprehensive PPE Training Videos](#), [PPE Sequence Poster](#), [Use Personal Protective Equipment \(PPE\) When Caring for Patients with Confirmed or Suspected COVID-19](#), [Infection Control Guidance for Healthcare Professionals about Coronavirus \(COVID-19\)](#), and [Protecting Healthcare Personnel](#).
- It is strongly emphasized that hand hygiene be performed before donning and after doffing PPE.
- Designate PPE donning/doffing stations outside all spaces where PPE will be used. PPE stations should include a dedicated trash can for disposal of used PPE (one for laundry and one for trash or biohazard), a hand washing station or access to alcohol-based hand sanitizer with at least 60% alcohol, and a [PPE Sequence Poster](#) illustrating correct donning and doffing procedures.
- Ensure PPE is readily available where and when needed. When possible, based on facility resources and supply, safety and security considerations, risk and indications for use, and contraindications, offer inmates masks or respirators providing the same level of protection as those provided to employees when inmates are in a similar environment.
- If not already in place, the facility should establish a [respiratory protection](#) program, as appropriate, to ensure that employees are fit-tested, medically cleared, and trained for any respiratory protection they will need within the scope of their responsibilities. Inmates may also be considered for enrollment in a respiratory protection program depending on their work-related exposure risk (e.g., inmates working in an environment where they may be exposed to COVID-19 – such as in a medical isolation unit – would be considered for enrollment due to occupational risk).
- If employees must serve multiple areas of the facility, ensure that employees change PPE when leaving the medical isolation space. If a shortage of PPE supplies necessitates reuse, ensure that employees move only from low to high exposure risk areas while wearing the same PPE to prevent cross-contamination (e.g., start in a housing unit where no one is known to be infected or exposed and end in a medical isolation unit).



- Inventory current supplies of PPE and implement plans for restocking PPE as needed (see [Personal Protective Equipment \(PPE\) Burn Rate Calculator \(Version 2\)](#)).
- Develop contingency plans for PPE shortages during the COVID-19 pandemic. Refer to the CDC [Strategies to Optimize the Supply of PPE and Equipment](#) and [Summary for Healthcare Facilities: Strategies for Optimizing the Supply of PPE during Shortages](#) (see also [Strategies for Optimizing the Supply of Eye Protection](#), [Strategies for Optimizing the Supply of Isolation Gowns](#), [Strategies for Optimizing the Supply of Disposable Medical Gloves](#), [N95 and Other Respirators](#), [Summary for Healthcare Facilities: Strategies for Optimizing the Supply of N95 Respirators during Shortages](#), [Implementing Filtering Facepiece Respirator \(FFR\) Reuse, Including Reuse after Decontamination](#), [When There Are Known Shortages of N95 Respirators](#), [Elastomeric Respirators: Strategies During Conventional and Surge Demand Situations: Conventional, Contingency, and Crisis Strategies](#), and [Considerations for Optimizing the Supply of Powered Air-Purifying Respirators \(PAPRs\): For Healthcare Practitioners \(HCP\)](#)).
- The CDC identifies PPE as one of many examples of risk factors for heat-related illness. Heat stroke, the most severe form of heat-related illness, is a life-threatening medical emergency.

Early signs of heat stroke may include:

- Confusion
- Difficulty performing routine tasks or answering simple questions, like “What is today’s date?” or “Where are we?”
- Slurred speech

Late signs of heat stroke may include:

- Seizures
- Loss of consciousness
- Organ failure resulting in death

The CDC provides guidance on how to reduce the risk for heat-related illness during the COVID-19 pandemic (see [What Workers Need to Know about Heat Stress Prevention during the COVID-19 Pandemic](#)).



Table 4. COVID-19 Personal Protective Equipment Recommendations

Situation	N95 Respirator ¹	International Respirator ¹ or Procedure Mask	Cloth Mask	Eye Protection ⁴	Gloves ⁴	Gown/ Coveralls ⁴
STAFF						
Temperature Checks: Staff performing temperature checks for any persons who are NOT under medical isolation or quarantine precautions	X ²			X	X ⁵	5
Medical Isolation and Quarantine: Staff working in designated medical isolation or quarantine areas <u>without</u> close contact with persons under medical isolation or quarantine precautions	X					
Medical Isolation and Quarantine: Staff having close contact with (including transport) or providing medical care to persons under medical isolation or quarantine precautions	X			X	X	X
Routine Operations: Staff working in areas of the facility NOT designated for medical isolation or quarantine	X ^{2,3}					
INCARCERATED/DETAINED PERSONS						
Confirmed or suspected COVID-19 cases, or showing symptoms of COVID-19	X ²					
Quarantine: (individually or in a cohort) as a close contact of someone with COVID-19	X ²					
Medical Isolation and Quarantine: Working in designated medical isolation or quarantine areas <u>without</u> close contact with persons under medical isolation or quarantine precautions	X ²					
Medical Isolation and Quarantine: Working in designated medical isolation or quarantine areas <u>with</u> close contact with persons under medical isolation or quarantine precautions	X ²			X	X	X
Routine Operations: Living or working in areas of the facility NOT designated for medical isolation or quarantine	X ^{2,3}					
<p>¹ NIOSH-approved respirators include N95s. International respirators include KN95s and KF94s. See Types of Masks and Respirators for a full list of NIOSH-approved and international respirators.</p> <p>² Masks and respirators can provide different levels of protection depending on the type and how they are used. Choose the most protective mask or respirator that fits well and can be worn comfortably and consistently. Refer to Elements 3d and 8 for additional details on masks and respirators.</p> <p>³ When the COVID-19 Community Level is low or medium, a well-fitting mask or respirator should be offered and provided to all inmates and staff who want them. When the COVID-19 Community Level is high or Facility-Specific Risk Factors indicated higher risk, facilities should require all persons in the facility to wear a well-fitting mask or respirator indoors.</p> <p>⁴ If using cleaning products, additional PPE may be needed based on the cleaning product label. See Cleaning and Disinfecting Your Facility for details.</p> <p>⁵ Sanitize or change gloves between each temperature check. A gown could be considered if extensive contact with the person being screened is anticipated. Adapted from: CDC. Guidance on Management of COVID-19 in Homeless Service Sites and in Correctional and Detention Facilities; 11/29/22. Available at: https://www.cdc.gov/coronavirus/2019-ncov/community/homeless-correctional-settings.html</p>						



9. Transport

Minimizing Movement

For short-term periods, as an enhanced COVID-19 prevention strategy, when COVID-19 Community-Levels or Facility-Specific Risk Factors indicate increased risk, consider minimizing non-essential inmate transports to reduce contact between the facility and the community and to prevent transmission. Examples include:

- Postponing non-essential community visits
- Restricting movement between facilities

The CDC identifies programming as essential for the mental health and well-being of inmates. When possible, maximize access to opportunities for programming, even when [COVID-19 Community Levels](#) are high.

Routine Transport Observation

Routine observation periods during transfer and/or release can be added as [enhanced prevention strategies](#), when COVID-19 Community-Levels are high or Facility-Specific Risk Factors indicate increased risk. The routine observation period option should only be used under the following scenarios: a) Inmates under observation are housed individually, OR b) Inmates under observation are housed in small cohorts due to mental health concerns associated with individual housing, and all cohort members begin the observation period on the same day and will be tested at the end of the observation period.

- Inmates in Routine Transport Observation (i.e., observation of inmates, who enter the facility by outside transport, including inmates who attend court hearings outside the facility, regardless of vaccination and booster status, before housed in the general population), should be housed separately from the existing inmate population.
- Observation periods should be 10 days if the inmates under observation are not tested at the end of the observation period.
- If Routine Transport Observation is combined with testing at the end of the observation period, a shorter observation period (minimum of 5 days) could be used.
- Inmates, who are transported to outside medical appointments and do not have symptoms consistent with COVID-19, do NOT require routine transport observation upon return to the facility due to low risk.
- Inmates, who have recovered from confirmed COVID-19 illness within the previous 30 days and remain without COVID-19 symptoms, do NOT require routine transport observation.



Transportation of Inmates on Medical Isolation Status

Refer to the CDC guidance for Emergency Medical Services in the [Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 \(COVID-19\) Pandemic](#) for information on safely transporting inmates with confirmed or suspected COVID-19. If a decision is made to transport a patient with confirmed or suspected COVID-19 to a health care facility or another correctional facility and the transport vehicle is not equipped with the features described in the EMS guidance, the following transport considerations should be followed at a minimum.

- Notify the receiving health care facility or correctional facility of the pending transport of a potentially infectious patient. Prior to a transfer to another correctional facility, ensure that the receiving facility has capacity to properly medically isolate the inmate upon arrival.
- Patient wears a mask or respirator (unless contraindicated) and performs hand hygiene.
- Transporting officer wears recommended PPE: preferably N-95 respirator, gloves, gown, and eye protection. Note: when accompanying EMS in ambulance, transporting officer should use recommended PPE for aerosolizing procedures.
- Prior to transporting, all PPE (except for mask or respirator) is removed and hand hygiene is performed. This is to prevent contaminating the driving compartment.
- Ventilation system should bring in as much outdoor air as possible. Set fan to high. If the vehicle has a ceiling hatch, keep it open, if feasible.
- Do NOT place air on recirculation mode.
- Weather permitting, drive with the windows down.
- Following the transport, if close contact with the patient is anticipated, put on a new set of PPE. Perform hand hygiene after PPE is removed.
- After transporting a patient, air out the vehicle for one hour before using it without a mask or respirator.
- When cleaning the vehicle, wear a disposable gown and gloves. A mask or respirator and a face shield or goggles should be worn if splashes or sprays during cleaning are anticipated.
- Clean and disinfect the vehicle after the transport utilizing instructions in Element 3b.

10. Medical Isolation / Cohorting (*Symptomatic Persons*)

Table 5. Definitions of “Medical Isolation” and “Quarantine”

Medical Isolation: refers to the procedure of separating someone with confirmed or suspected COVID-19 infection (i.e., those who are sick with COVID-19 symptoms and those with no symptoms), from others who are not infected.

Quarantine: refers to the procedure of separating people who might have been exposed to COVID-19 from others.

*Medical Isolation is a strategy for everyday operations in correctional facilities.



Medical Isolation During Routine Operations

A critical infection control measure for COVID-19 is to promptly separate inmates with confirmed or suspected COVID-19 infection (i.e., those who are sick with COVID-19 symptoms and those with no symptoms), from other inmates who are not infected. Medical isolation is a non-punitive medical intervention. To avoid confusion, staff are encouraged to use the term, “medical isolation,” as opposed to “isolation” for behavioral infractions (i.e., disciplinary segregation). To encourage prompt reporting of COVID-19 symptoms and support mental health, ensure that the conditions in medical isolation are operationally distinct from those in disciplinary segregation. While cohorting inmates with laboratory confirmed COVID-19 is acceptable, cohorting inmates with suspected COVID-19 is not recommended due to the high risk of transmission from infected to uninfected inmates. Inmates with laboratory confirmed COVID-19 should be housed separately from those with undiagnosed respiratory illness.

- The CDC provides guidance for housing individuals under medical isolation. Facilities should have a plan in place to ensure that separate physical locations (dedicated housing areas and bathrooms) have been identified to:
 - Medically isolate inmates with suspected COVID-19 (ideally individually for short periods while awaiting test results)
 - Medically isolate inmates with confirmed COVID-19 (individually or as a cohort)

The facility medical isolation plan should include expansion contingencies to prepare for surges in cases (e.g., if testing reveals 10%, 25%, 50% or more of the facility population is infected with SARS-CoV-2). Facilities without sufficient space to implement effective medical isolation should coordinate with the Hawaii Department of Health to ensure that COVID-19 cases will be appropriately managed.

- To minimize the likelihood of disease transmission, inmates who are medically isolated or cohorted should wear a well-fitting mask or respirator (unless contraindicated), upon identification of symptoms or a positive test, whenever another individual enters the medical isolation space (unless the person entering the medical isolation space for confirmed COVID-19 also has confirmed COVID-19), and if the inmate leaves the medical isolation space for any reason. Masks or respirators should be replaced as needed.
- Facilities should ensure that medical isolation is operationally distinct from disciplinary segregation to the extent possible, even if the same housing spaces are used for both. To avoid being placed in punitive housing conditions, inmates may be hesitant to report COVID-19 symptoms, leading to continued transmission within shared housing spaces and, potentially, lack of timely health care and greater risk of adverse health outcomes for infected inmates who delay reporting symptoms.
 - Ensure that inmates under medical isolation receive regular visits from medical staff and have access to mental health services.



- Provide similar access to radio, television, reading materials, personal property, commissary, showers, and other resources as would be available in regular housing units, as possible.
 - Allow increased telephone privileges or other opportunities to communicate with others outside the facility to support mental health while medically isolated, where possible.
 - Communicate regularly with medically isolated inmates about the duration and purpose of the medical isolation period.
 - Ensure staff understand that the same restrictions placed on inmates in segregated housing when used for disciplinary reasons should not be applied to inmates housed in the same spaces for COVID-19 related reasons.
- Medical isolation cells or rooms should be identified with the Respiratory Infection Isolation Room Precautions sign (see [Attachment 5](#)) and relevant CDC [Transmission-Based Precautions](#) sign(s) (e.g., [Contact Precautions](#) and [Droplet Precautions](#)). See [Attachment 3](#) and [Attachment 4](#).
 - The door to the designated Medical Isolation area should always remain closed, except when staff must enter and exit the designated area, or when the medically isolated inmate must enter and exit the designated area for treatment or bathroom use.
 - Keep the inmate's movement outside the medical isolation space to a minimum.
 - Provide medical care to medically isolated inmates inside the medical isolation space, unless it is not physically possible to do so or unless the inmate needs to be transferred to a healthcare facility.
 - Dedicated medical equipment (e.g., blood pressure cuffs), should be decontaminated in accordance with manufacturer's instructions.
 - Serve meals inside the medical isolation space. Inmates in medical isolation should throw disposable food service items in regular trash in the medical isolation room. Non-disposable food service items should be handled with gloves and washed with hot water or in a dishwasher. Individuals handling food service items should clean their hands after removing gloves.
 - Provide inmates in medical isolation with tissues, and if permissible and available, a lined no-touch trash receptacle. Instruct inmates 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.
 - Laundry should be transported from the medical isolation area to the laundering location in a bag liner that is either disposable or can be laundered. Individuals handling laundry from COVID-19 cases should wear disposable gloves and gown, discard after each use, and perform hand hygiene. Do not shake dirty laundry (to minimize the possibility of dispersing virus through the air). Laundry from COVID-19 cases may be washed with other inmate laundry. Use the hottest appropriate water setting and dry items completely. Clean and disinfect clothes hampers in accordance with Element 3b.



- Ideally, the Medical Isolation unit should have a dedicated bathroom attached. If not, inmates must wear a mask or respirator (unless contraindicated) to go to the bathroom outside the room. When a dedicated bathroom is not feasible, do not reduce access to restroom or shower use as a result. Clean and disinfect areas used by infected inmates frequently on an ongoing basis during medical isolation.
- Minimize shared air between medical isolation spaces and other spaces within a building. Ventilation to/from the medical isolation space should be separate from ventilation to other spaces within the same building. Air should flow from clean to less clean areas.
- Where possible, restrict medically isolated inmates from leaving the facility (including transfers to other facilities) during the medical isolation period, unless released from custody or a transfer is necessary for medical care, infection control, lack of medical isolation space, or extenuating correctional, judicial, or security concerns.
- If inmates with suspected or confirmed COVID-19 must be taken out of the medical isolation room, they should wear a well-fitting mask or respirator (unless contraindicated) and perform hand hygiene before leaving the room.
- If an inmate who is in medical isolation must undergo a procedure that is likely to generate aerosols (e.g., suctioning, administering nebulized medication, testing for COVID-19), they should be placed in a separate room. An N95 respirator (not a surgical mask), gloves, gown, and face protection should be used by staff.
- If the facility is housing inmates with confirmed COVID-19 as a cohort:
 - Only inmates with laboratory-confirmed COVID-19 should be placed under medical isolation as a cohort. Multiple inmates with laboratory-confirmed COVID-19 can be housed as a cohort (in a dorm or cell environments) regardless of the date of their positive test result. According to the CDC, “Cohorting inmates during medical isolation can mitigate some mental health concerns associated with individual medical isolation and can increase capacity for medical isolation during case surges.” Do not cohort inmates who have confirmed COVID-19 with other inmates who have suspected COVID-19, with other inmates who have other illnesses, or with other non-infected inmates.
 - Use a single, large, well-ventilated room with solid walls and a solid door that closes fully, where possible.
 - To conserve PPE and reduce the risk of cross-contamination across different parts of the facility, consider using one large space for cohorted inmates with confirmed COVID-19 on medical isolation status. Depending on the degree and severity of illness among inmates, bunk beds may or may not be suitable.
- If feasible, designated security staff should be assigned to monitor medically isolated inmates in order to minimize exposures. If an inmate has laboratory-confirmed COVID-19, staff should maintain a consistent duty assignment in the same area of the facility across shifts to prevent transmission across different facility areas, where possible. Staff assigned to medical isolation



posts should limit their movement to other parts of the facility as much as possible. If staff must serve multiple areas of the facility, ensure staff change PPE when leaving the medical isolation space. If PPE supplies necessitate reuse, staff should move from areas of low to high exposure risk (e.g., start in a housing unit where no one is known to be infected and end in a medical isolation unit).

- When feasible and consistent with security priorities, encourage staff to maintain a distance of 6 feet or more from an inmate with COVID-19 symptoms while interviewing, escorting, or interacting in other ways. Keep interactions with inmates with COVID-19 symptoms as brief as possible.
- Admission to and Discharge from Medical Isolation must be ordered by a Provider.
 - If an inmate with suspected COVID-19 receives a positive SARS-CoV-2 test, the inmate can be moved to cohorted medical isolation with other inmates with confirmed COVID-19 to continue medical isolation until discharged by the Provider.
 - If an inmate with suspected COVID-19 receives a negative SARS-CoV-2 test and the inmate is discharged from Medical Isolation by the Provider, the inmate may be returned to general population housing unless the inmate requires completion of routine observation (e.g., Routine Intake Observation, Routine Transport Observation).

Table 6. CDC Levels of Illness Severity

Mild Illness: Individuals who have any of the various signs and symptoms of COVID-19 (e.g., fever, cough, sore throat, malaise, headache, muscle pain) without shortness of breath, dyspnea, or abnormal chest imaging).

Moderate Illness: Individuals who have evidence of lower respiratory disease by clinical assessment or imaging, and a saturation of oxygen (SpO_2) $\geq 94\%$ on room air at sea level.

Severe Illness: Individuals who have $\text{SpO}_2 < 94\%$ on room air at sea level (or, for individuals with chronic hypoxemia, a decrease from baseline of $> 3\%$), ratio of arterial partial pressure of oxygen to fraction of inspired oxygen ($\text{PaO}_2/\text{FiO}_2$) < 300 mmHg, a respiratory rate > 30 breaths/min, or lung infiltrates $> 50\%$.

Critical Illness: Individuals who have respiratory failure, septic shock, and/or multiple organ dysfunction.

Note: The highest level of illness severity experienced at any point in the clinical course should be used when determining the duration of transmission-based precautions (see also [NIH Clinical Spectrum of SARS-CoV-2 Infection](#)).

- The CDC recommended strategy for [discontinuing medical isolation](#) and [transmission-based precautions](#) are expected to change as additional data on [Ending Isolation and Precautions for People with COVID-19: Interim Guidance](#) become available. Providers should review the CDC guidance cited above and HDOH [Medical Advisories](#) for rapidly changing updates. At this time, CDC recommends the following for discontinuation of transmission-based precautions for laboratory-confirmed COVID-19.



- Inmates, who experienced *mild to moderate illness* and are not [moderately to severely immunocompromised](#):
 - At least 10 days have passed since symptoms first appeared (with day 0 being the first day of symptoms); **OR** at least 7 days have passed since symptoms first appeared **and** the use of a test-based strategy (i.e., a negative NAAT test within 48 hours prior to discontinuing medical isolation **or** 2 negative antigen tests, one no sooner than day 5 and the second 48 hours later); **AND**
 - At least 24 hours have passed since last fever without the use of fever-reducing medications; **AND**
 - Symptoms (e.g., cough, shortness of breath), have improved*

* Loss of taste and sense of smell may persist for weeks or months after recovery and need not delay the end of medical isolation.
- Inmates, who were *asymptomatic* throughout the infection and are not [moderately to severely immunocompromised](#):
 - At least 10 days have passed since the date of collection of the first positive viral test (with day 0 being the date the specimen was collected for the positive test) **OR**
 - At least 7 days have passed since the date of collection of the first positive viral test **and** the use of a test-based strategy (i.e., a negative NAAT test within 48 hours prior to discontinuing medical isolation **or** 2 negative antigen tests, one no sooner than day 5 and the second 48 hours later)
- Inmates, who experienced *severe to critical illness* and are not [moderately to severely immunocompromised](#):
 - At least 10 days and up to 20 days have passed since symptoms first appeared (with day 0 being the first day of symptoms); **AND**
 - At least 24 hours have passed since last fever without the use of fever-reducing medications; **AND**
 - Symptoms (e.g., cough, shortness of breath), have improved

* A test-based strategy can be considered in consultation with infectious disease experts.

Inmates who are [moderately to severely immunocompromised](#) (regardless of COVID-19 symptoms or severity) may produce replication-competent virus beyond 20 days after symptom onset or, for those who were asymptomatic throughout their infection, the date of their first positive viral test. CDC recommends use of a test-based strategy and (if available) consultation with an infectious disease specialist to determine the appropriate duration of medical isolation and transmission-based precautions. The following includes the criteria for the test-based strategy:

- Inmates, who were *symptomatic* and are [moderately to severely immunocompromised](#):
 - Resolution of fever without the use of fever-reducing medications; **AND**
 - Symptoms (e.g., cough, shortness of breath), have improved; **AND**
 - Results are negative from at least two consecutive respiratory specimens collected 48 hours apart (total of two negative specimens) tested using an antigen test or NAAT



- Inmates, who were *asymptomatic* and are [moderately to severely immunocompromised](#):

- Results are negative from at least two consecutive respiratory specimens collected 48 hours apart (total of two negative specimens) tested using an antigen test or NAAT

Re-testing for SARS-CoV-2 infection is suggested if symptoms worsen or return after ending medical isolation and transmission-based precautions. If a patient has persistently positive nucleic acid amplification tests beyond 30 days, additional testing could include molecular studies (e.g., [genomic sequencing](#)) or viral culture, in consultation with an infectious disease specialist.

Moderate to severely immunocompromising conditions include, but might not be limited to, those defined in the [Interim Clinical Considerations: Use of COVID-19 Vaccines in the United States](#). Other factors, such as end-stage renal disease, likely pose a lower degree of immunocompromise, and there might not be a need to follow the recommendations for those with moderate to severe immunocompromise. Ultimately, the degree of immunocompromise for the patient is determined by the treating provider, and preventive actions should be tailored to each patient and situation.

- According to the CDC, the guidance on medical isolation [does not imply immunity to COVID-19](#).
 - People who have recovered from COVID-19 may have low levels of virus detectable for up to 3 months after diagnosis. This means that if the person, who has recovered from COVID-19, is retested within 3 months of initial infection, the person may continue to have a positive test result, even though the person may not be spreading COVID-19.
 - Studies suggest that [reinfection](#) with SARS-CoV-2 with the same virus variant as the initial infection or reinfection with a different variant are both possible; early reinfection within 90 days of the initial infection can occur (see [Reinfection with COVID-19](#)).
 - If an inmate has a new exposure to someone with suspected or confirmed COVID-19 and:
 - Has recovered from illness due to laboratory-confirmed SARS-CoV-2 infection and has already met criteria to end medical isolation, and
 - Is within the first 30 days following the onset of symptoms of their initial laboratory-confirmed SARS-CoV-2 infection or within 30 days of their positive SARS-CoV-2 test result if they were asymptomatic during initial infection, and
 - Has remained [asymptomatic](#) since the new exposure, then the inmate generally does not require repeat testing for SARS-CoV-2 in the context of the new exposure.
 - If an inmate has a new exposure to someone with suspected or confirmed COVID-19 and:
 - Has recovered from illness due to laboratory-confirmed SARS-CoV-2 infection and has already met criteria to end medical isolation, and
 - Is within the first 30 days following the onset of symptoms of their initial laboratory-confirmed SARS-CoV-2 infection or within 30 days of their positive SARS-CoV-2 test result if they were asymptomatic during initial infection, and
 - Has become [symptomatic](#) since the new exposure, then the inmate should be tested using antigen tests to identify a new infection. If the inmate tests negative, the antigen test should be repeated according to [FDA guidance](#).



- If an inmate has a new exposure to someone with suspected or confirmed COVID-19 and:
 - Has recovered from illness due to laboratory-confirmed SARS-CoV-2 infection and has already met criteria to end medical isolation, and
 - Is within the first 31-90 days following the onset of symptoms of their initial laboratory-confirmed SARS-CoV-2 infection or within 31-90 days of their positive SARS-CoV-2 test result if they were asymptomatic during initial infection, and
 - Has remained asymptomatic or has become symptomatic since the new exposure, then the inmate should be tested using antigen tests (rather than an NAAT, such as a PCR test) to identify a new infection. The inmate should not test until at least 5 days after the exposure. If the inmate tests negative, the antigen test should be repeated according to [FDA guidance](#).
- If more than 90 days have passed since a prior SARS-CoV-2 infection, testing and management, including medical isolation if indicated, should proceed as it would for someone who had not previously been diagnosed with SARS-CoV-2 infection.
- If an inmate with suspected or confirmed COVID-19 is to be released from the facility before discharge from medical isolation, notify the Hawaii Department of Health to provide direct linkage to community resources and release planning (e.g., transport, shelter, and medical care).
- If an inmate on medical isolation status is scheduled to transfer to the Hawaii State Hospital or another correctional facility, hold the transfer until the inmate is cleared for transfer by the Medical Director or Physician Manager.
- After an inmate with COVID-19 is discharged from medical isolation, close off the area. If possible, open outside doors and windows and use fans or HVAC 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. Ensure that persons cleaning the area wear recommended PPE for medical isolation (see Table 4). Thoroughly clean and disinfect utilizing instructions in Element 3b with an emphasis on frequently touched surfaces.

Vacuum the space, if needed, using high-efficiency particulate air (HEPA) filter and bags. While vacuuming, temporarily turn off in-room, window-mounted, or on-wall recirculation heating, ventilation, and air conditioning systems to avoid contamination of HVAC units. Do not deactivate central HVAC systems, which provide better filtration capabilities and introduce outdoor air into the areas serviced.

Modifying Medical Isolation Protocols During Crisis-Level Operations

- Because of the potential for rapid, widespread transmission of SARS-CoV-2 in congregate environments and [evidence](#) that infected people who are up to date on their COVID-19 vaccines can transmit the virus to others, CDC recommends maintaining 10-day or 7-day with test-based strategy medical isolation periods as much as possible for all infected inmates and staff in correctional facilities, regardless of vaccination and booster status. (Note: staff may use CDC [guidance for the general public](#) for duration of medical isolation when they are not at work).



- As a last resort and only in limited circumstances during short-term crisis-level operations (e.g., when staffing shortages threaten to compromise the safety and security of the facility or the continuity of essential operations; or there is insufficient space to medically isolate all inmates who have been infected for the full 7- to 10-day period and other options to increase space have been exhausted), the facility Warden or Administrator should consult HCD and HDOH to discuss approaches that would meet the facility needs while maximizing infection control during these short-term periods. During crisis-level operations, facilities may need to consider short-term alternatives to the recommended 7- to 10-day medical isolation periods for staff and/or inmates.
- The following are the CDC guiding principles for reducing medical isolation periods during crisis-level operations:
 - Reductions in the duration of medical isolation should be as minimal as possible to mitigate the crisis scenario.
 - Decisions to shorten the duration of medical isolation should be made independently for staff and for inmates, based on the specific resources that are constrained at the time (e.g., shortening medical isolation for staff due to staffing shortages would not automatically trigger shortened duration for inmates as well).
 - Before reducing medical isolation duration, consider alternatives (e.g., shifting from individual to cohorted medical isolation units for inmates or reducing the inmate population).
 - Consider the risk of transmission within the facility (e.g., layout, history of previous transmission), and the risk profile of the population within the facility and access to COVID-19 therapeutics to prevent severe illness.
 - If crisis-level protocols allow infected staff to return to work before 7 to 10 days of medical isolation, the risk of transmission can be reduced by assigning the infected staff to work exclusively in medical isolation units or in assignments where the infected staff have minimal contact with others until day 10.
 - If a facility shortens the duration of medical isolation, consider incorporating negative test results into protocols (i.e., “test-out” strategies). The following factors are necessary for facilities to incorporate test-out strategies without compromising essential functions.
 - Sufficient testing supplies and staff capacity to maintain recommended diagnostic testing and screening testing at intake.
 - Results of testing obtained in a timely manner to inform decision-making.
 - Sufficient staff capacity to continue to prioritize care and treatment for inmates at high risk for severe illness from COVID-19.
- Once the period of crisis-level operations has passed, facilities should return to the CDC recommended 7- to 10-day duration for medical isolation. Ensure staff and inmates understand that reduced medical isolation protocols are short-term crisis-management tools and the facility will return to the full 7- to 10-day medical isolation recommendations.
- In facilities with severe resource constraints during crisis-level operations, it may be necessary to modify other COVID-19 prevention measures. In order to prioritize the prevention of severe outcomes from COVID-19, facilities should consult the HCD and HDOH if considering short-term modifications.



11. Care for the Sick

- Staff evaluating and providing care for COVID-19 cases should review the CDC [Clinical Care Considerations](#) and the National Institutes of Health [Coronavirus Disease 2019 \(COVID-19\) Treatment Guidelines](#). Monitor the guidance regularly for updates to the recommendations (see also [Clinical Care Quick Reference for COVID-19](#), [Core Infection Prevention and Control Practices for Safe Healthcare Delivery in All Settings](#), [Interim Clinical Considerations for COVID-19 Treatment in Outpatients](#), and [Clinical Questions about COVID-19: Questions and Answers](#)).
- As a [strategy for everyday operations](#), correctional facilities should maintain awareness of how to access [COVID-19 Treatments and Medications](#) to prevent severe COVID-19 in the inmate population. Facilities without onsite healthcare capacity should maintain a plan to assess inmates' risk for severe health outcomes and to ensure timely access to treatment outside the facility. The U.S. Food and Drug Administration (FDA) expanded [emergency use authorization](#) (EUA) to allow healthcare providers to use certain investigational [monoclonal antibody medications](#) to prevent SARS-CoV-2 infection and severe health outcomes under certain conditions.
- [Antiviral medications](#) have also been found to be effective in preventing severe outcomes from COVID-19. Note: medications are not a substitute for vaccination; vaccination remains the best tool to prevent severe illness and death from COVID-19. The National Institutes of Health (NIH) has developed and regularly updates [Coronavirus Disease 2019 \(COVID-19\) Treatment Guidelines](#) to help guide healthcare providers caring for patients with COVID-19.
- The recipe for oral rehydration solution is shown in Table 7 below.

Table 7. Oral Rehydration Solution Recipe

1-gallon clean water

10-tablespoons of sugar

4-teaspoons salt

Directions: Stir up. Do not boil. Can add sugar-free drink mix to flavor. Use within 24 hours.

- Facilities should maintain a system for the identification of inmates, with COVID-19, who are at [increased risk for severe illness from COVID-19](#). The [Veterans Health Administration COVID-19 \(VACO\) Index](#), which was developed in collaboration with the US Department of Health and Human Services (including the CDC, NIH, VA, and the ASPR), estimates risk of 30-day mortality after COVID-19 infection using pre-COVID-19 health status. Inmates on medical isolation status should be assessed as clinically indicated for signs and symptoms of shortness of breath or decompensation; high-risk inmates (i.e., by VACO Index or clinical determination), should be assessed at least daily. Prioritize assessment for identified high-risk inmates (i.e., by VACO Index or clinical determination), during crisis-level operations.



- Clinicians should be aware of the potential for some patients to rapidly deteriorate after illness onset. Clinicians caring for patients with dyspnea should consider close monitoring due to the risk for progression to acute respiratory distress syndrome (ARDS). See [Clinical Care Considerations](#).
- The facility should have a plan in place to safely transfer inmates with severe illness from COVID-19 to a local hospital if they require care beyond what the facility is able to provide.
- A low threshold should be used for making the decision to transport an inmate to the hospital if the inmate develops shortness of breath.
- Inmates diagnosed with COVID-19 should be evaluated and managed, as directed by the Provider. Inmates should be instructed to immediately notify the Medical Unit if experiencing any relapse of COVID-19 symptoms.
- The CDC is actively working to learn about the short- and long-term health effects associated with COVID-19. Although most people with COVID-19 get better within a few days or weeks of illness, some people experience [Post-COVID Conditions](#), which include a wide range of ongoing health problems people can experience four or more weeks after initial infection with SARS-CoV-2 (see also [Post-COVID Conditions: Information for Healthcare Providers](#)). The most commonly reported persistent symptoms include:
 - Dyspnea or increased respiratory effort
 - Fatigue
 - Post-exertional malaise (i.e., the worsening of symptoms following even minor physical or mental exertion, with symptoms typically worsening 12-48 hours after activity and lasting for days or weeks), and/or poor endurance
 - “Brain fog” or cognitive impairment
 - Cough
 - Chest pain
 - Headache
 - Palpitations or tachycardia
 - Arthralgia
 - Myalgia
 - Paresthesia
 - Abdominal pain
 - Diarrhea
 - Insomnia and other sleep difficulties
 - Fever
 - Lightheadedness
 - Impaired daily function and mobility
 - Pain
 - Rash (i.e., urticaria)
 - Mood changes
 - Anosmia or dysgeusia
 - Menstrual cycle irregularities
 - Erectile dysfunction



- Identify inmates with [post-COVID-19 conditions](#), as recommended by CDC's National Center for Health Statistics. Provide follow-up health care services in accordance with the CDC [Post-COVID Conditions: Information for Healthcare Providers](#) (see also UpToDate® [COVID-19: Evaluation and management of adults with persistent symptoms following acute illness \("Long COVID"\)](#) by Mikkelsen and Abramoff (updated November 18, 2022)).
- Inmates who are released while being treated for COVID-19 should be provided education about:
 - [Steps to Take When Sick with COVID-19](#)
 - [Symptoms of Coronavirus \(COVID-19\)](#) and emergency warning signs (e.g., trouble breathing; persistent pain or pressure in the chest; new confusion; inability to wake or stay awake; and pale, gray, or blue-colored skin, lips, or bed nails, depending on skin tone), requiring immediate medical care.

12. Quarantine (*Asymptomatic Exposed Persons*)

The purpose of quarantine is to help prevent the spread of disease that can occur before a person knows they are sick or if they are infected with the virus without feeling symptoms. Quarantine is an enhanced prevention strategy that separates inmates who might have been exposed to COVID-19 from others. Facilities that choose to implement quarantine can consider a range of approaches to balance their infection control and operational needs and the mental health needs of their inmates and staff. Facilities may shift between quarantine approaches to adapt to changes in disease severity and transmissibility of different SARS-CoV-2 variants, or to respond to staffing and space shortages during case surges. When implementing quarantine, ensure that the conditions in quarantine are operationally distinct from those in disciplinary segregation (see Element 10, medical isolation).

Standard Quarantine Approach

- In the context of COVID-19, a person is considered a Close Contact if the person has been within 6 feet of a confirmed or suspected COVID-19 case for a cumulative total of 15 minutes or more over a 24-hour period, starting from 48 hours before illness onset (or starting from 48 hours before the first positive test if asymptomatic) until the time the infected person meets criteria to end medical isolation.
- Refer to the [Interim Guidance on Developing a COVID-19 Case Investigation and Contact Tracing Plan](#), [Contact Tracing for COVID-19](#), [Case Investigation and Contact Tracing: Part of a Multipronged Approach to Fight the COVID-19 Pandemic](#), and [Managing Investigations During an Outbreak](#) for additional information on the use of Contact Tracing for the identification of Close Contacts in order to help contain disease outbreaks.
 - Persons with recent exposure to SARS-CoV-2 can be identified in two ways:
 - **Traditional case investigation and contact tracing.** Case investigations can [prioritize](#) identification of close contacts who are [more likely to get very sick from COVID-19](#) so they can be referred to a healthcare provider to determine eligibility for [treatment](#) if they test positive for SARS-CoV-2.



- **Location-based contact tracing.** When traditional case investigation and contact tracing are not feasible, facilities may identify persons with recent known or potential exposure to SARS-CoV-2 based on whether they spent time in the same locations as an infected person during the time the infected person was considered infectious (e.g., all residents and staff members assigned to a housing unit where a case has been identified).
- Traditional case investigation and contact tracing can be especially impactful when there is a small number of infected individuals in the facility or in a particular housing unit, when the infected individual had close contact with individuals from other housing units, and when the infected individual recently visited a community setting.
- Traditional case investigation and contact tracing may be more feasible and effective in settings where inmates have limited contact with others (e.g., celled housing units), compared to settings where close contact is frequent and relatively uncontrolled (e.g., open dormitory housing units).
- According to the CDC, “In correctional and detention facilities, contact tracing to identify each individual’s close contacts, including visitors, can be difficult,” especially when there are large numbers of individuals with COVID-19 in the facility. People considered to be close contacts may include all persons defined by a particular setting/location (e.g., all inmates and staff assigned to a dormitory or unit where a case has been identified). Under such conditions, using location-based contact tracing, consider [broad-based testing](#), which involves testing everyone in the affected area(s) of the facility, regardless of COVID-19 vaccination and booster status, in order to identify infections and prevent further transmission. The scope of broad-based testing should be based on the extent of inmate and staff movement between parts of the facility with and without cases. Examples of broad-based testing strategies include:
 - Testing all persons in a single housing unit where someone tested positive, if there has not been movement to or contact with other areas of the facility through the staff or inmates (i.e., inmates have not left the housing unit and the staff work exclusively in that housing unit).
 - Testing all persons in an entire module or facility when cases have been identified in multiple parts of the module or facility, or if there has been movement between parts of the module or facility with and without cases.

Consider including staff in [broad-based testing](#) efforts, *regardless of vaccination and booster status*, in order to identify COVID-19 cases quickly and slow transmission. If it is not feasible to test staff at the facility, facilities should work with community partners to implement staff testing.



- Viral testing is recommended for all close contacts of persons with SARS-CoV-2 infection, regardless of symptoms or COVID-19 vaccination and booster status.
 - Administer an initial diagnostic test as soon as possible.
 - Medically isolate those who test positive to prevent further transmission.
 - Asymptomatic close contacts testing negative should be placed under quarantine precautions for 10 days from their last exposure.
 - If the initial test is negative, re-test inmates in a quarantine cohort every 3-7 days to identify and medically isolate infected inmates early and minimize continued transmission within the cohort. To the extent possible, the testing interval should be based on the stage of an ongoing outbreak (e.g., testing every 3 days when transmission is escalating; testing every 5-7 days when transmission has slowed).

Note: When the transmissibility of circulating SARS-CoV-2 variant(s) is high, serial testing may be challenging to implement because of reduced staffing levels and/or large numbers of inmates in cohorted quarantine. In such situations, facilities may choose to prioritize serial testing primarily when the circulating SARS-CoV-2 variant(s) also causes high rates of severe illness, with a focus on identifying infections early to prevent severe health outcomes.

- Re-test inmates in a quarantine cohort on day 10 of the quarantine period. If all cohorted inmates test negative, quarantine precautions may be discontinued. If cohorted asymptomatic close contacts refuse SARS-CoV-2 testing on day 10, quarantine precautions may be discontinued.
- Regardless of vaccination and booster status, inmates who are close contacts of a suspected or confirmed COVID-19 case (i.e., other inmates, staff, visitors, vendors, volunteers), should be placed under quarantine for 10 days.
 - If an inmate is quarantined due to close contact with an individual who has laboratory confirmed COVID-19, but the quarantined inmate tests negative, the inmate should continue to quarantine for the full 10 days after last exposure and follow all recommendations of public health authorities. A negative COVID-19 test result could mean that the individual tested was likely not infected at the time the sample was collected or the specimen was inadequate. Persons with a negative COVID-19 test can develop infection at a later time.
 - If an inmate is quarantined due to close contact with a suspected COVID-19 individual who subsequently tests negative, the inmate may be considered for medical discharge from quarantine by the Provider. Due to the possibility of false negative results and other medical considerations involving the medically isolated inmate, only a Provider may order the discontinuation of quarantine.
 - Inmates, who have recovered from confirmed COVID-19 illness within the previous 30 days and remain without COVID-19 symptoms, do NOT require quarantine or testing for SARS-CoV-2 in the context of the new exposure (unless the inmate develops new symptoms). If more than 30 days have passed since a prior SARS-CoV-2 infection, testing and management, including quarantine and medical isolation if indicated, should proceed as it would for someone who had not previously been diagnosed with SARS-CoV-2 infection.



- Facilities should make every effort to quarantine close contacts of an inmate with suspected or confirmed COVID-19 individually, unless mental health concerns preclude individual housing. Cohorting multiple close contacts in quarantine could result in the transmission of COVID-19 to inmates who are not infected. Cohorting should only be practiced if there are no other available options. Do not add more inmates to an existing quarantine cohort after the 10-day quarantine clock has started, if possible.
- Consider possible co-infection with other respiratory illnesses (e.g., influenza), in quarantine decisions. Individual quarantine is recommended for inmates with co-infection.
- If cohorting close contacts is necessary, be especially mindful of those who are [more likely to get very sick from COVID-19](#). Ideally, they would not be cohorted with other quarantined inmates, to reduce their chance of infection. If cohorting is unavoidable, make all possible accommodations to reduce exposure for inmates who are more likely to get very sick from COVID-19.
- If cohorted quarantine is necessary, to reduce transmission risk, the CDC recommends selecting housing areas that:
 - Are well ventilated
 - Minimize the number of inmates sharing the housing space
 - Maximize the physical distance between inmates sharing the housing space
 - Are physically separated (i.e., solid walls and solid doors) from non-quarantine spaces
- Facilities should plan to modify operations when quarantine housing might be needed at varying proportions of the population (e.g., 10%, 25%, 50% or more of the population are identified as close contacts and require quarantine housing). Facilities without sufficient space to implement effective quarantine should consult with the Hawaii Department of Health (HDOH) to ensure that quarantine cases will be appropriately managed.
- The solid door (if available) to the Quarantine Room should remain closed. A sign should be placed on the door of the room indicating that it is a Quarantine Room, which lists recommended personal protective equipment (PPE) (see [Attachment 6](#)).
- Ideally, the quarantine area should have a dedicated bathroom attached. If not, inmates must wear a mask or respirator (unless contraindicated) to go to the bathroom outside the room. When a dedicated bathroom is not feasible, do not reduce access to restroom or shower use as a result. Clean and disinfect areas used by quarantined inmates frequently on an ongoing basis during the quarantine period.
- If single cells for medical isolation (of those with suspected COVID-19) and quarantine (of close contacts) are limited, CDC recommends prioritizing the available housing in rank order as follows to reduce the risk of further SARS-CoV-2 transmission and adverse health outcomes:
 - Inmates with suspected COVID-19 who are at [increased risk for severe illness from COVID-19](#).
 - Other inmates with suspected COVID-19.
 - Quarantined close contacts of someone with COVID-19 who are themselves at increased risk for severe illness from COVID-19.



- CDC recommends prioritizing symptom checks for inmates who are more likely to get very sick from COVID-19 to identify infections early and assess treatment eligibility, rather than requiring healthcare staff to check all quarantined residents for [COVID-19 symptoms](#). If an inmate develops symptoms for SARS-CoV-2, the inmate should be considered a suspected COVID-19 case, given a well-fitting mask or respirator (if not already wearing one), and moved to medical isolation immediately (individually, and separately from those with confirmed COVID-19 and others with suspected COVID-19) and further evaluated. If the inmate is tested and receives a positive result, the inmate can then be cohorted with other inmates with confirmed COVID-19.
- Facilities should maintain a system for the identification of inmates, with COVID-19, who are at increased risk for severe illness. To assist in the identification of high-risk inmates, along with clinical determinations by Providers, use the [Veterans Health Administration COVID-19 \(VACO\) Index](#), which was developed in collaboration with the US Department of Health and Human Services (including the CDC, NIH, VA, and the ASPR) and estimates risk of 30-day mortality after COVID-19 infection using pre-COVID-19 health status. If feasible, facilities should quarantine inmates in single cells and avoid cohorting in quarantine [People Who Are at Increased Risk for Severe Illness](#) (see also [Underlying Medical Conditions Associated with Higher Risk for Severe COVID-19: Information for Healthcare Professionals](#)). If cohorting is unavoidable, make all possible accommodations (e.g., intensify social distancing strategies), to reduce exposure risk and adverse health outcomes for inmates at increased risk for severe illness.
- When an inmate who is part of a quarantined cohort becomes symptomatic:
 - If the inmate is tested for SARS-CoV-2 and receives a positive result, the 10-day quarantine clock for the remainder of the cohort must be reset to 0.
 - If the inmate is tested for SARS-CoV-2 and receives a negative result: the 10-day quarantine clock for this inmate and the remainder of the cohort does not need to be reset. The inmate can return from medical isolation to the quarantine cohort for the remainder of the quarantine period as the symptoms and diagnosis allow.
 - If the inmate is not tested for SARS-CoV-2, the 10-day quarantine clock for the remainder of the cohort must be reset to 0.
- Inmates who have been exposed to someone with COVID-19 should wear a well-fitting mask or respirator under the following circumstances:
 - Inmates should wear masks or respirators immediately upon identification as a close contact of someone with COVID-19 (if not already in a quarantine space)
 - Quarantined inmates housed as a cohort should wear masks or respirators at all times, except when contraindicated or not practicable.
 - Quarantined inmates housed alone should wear masks or respirators whenever another individual enters the quarantine space, except when contraindicated or not practicable.
 - If a quarantined inmate leaves the quarantine space for any reason, the inmate should wear a well-fitting mask or respirator (unless contraindicated) as source control.



- Staff assignments to quarantine spaces should remain as consistent as possible. Staff assigned to quarantine posts should limit their movement to other parts of the facility as much as possible. If staff must serve multiple areas of the facility, ensure staff change PPE when leaving the quarantine space. If PPE supplies necessitate reuse, staff should move from areas of low to high exposure risk to prevent cross-contamination.
- To maintain access to programming during quarantine, facilities may choose to allow inmates quarantined as a cohort to move outside of their housing space and continue daily activities as a group. Inmates in quarantine should not mix with inmates or staff not assigned to their cohort and should wear a mask indoors.
- Admission to and Discharge from Quarantine must be ordered by a Provider.
 - Inmates quarantined individually may be considered for release from quarantine restrictions if they have not developed COVID-19 symptoms and have not tested positive for SARS-CoV-2 for 10 days since their last exposure to someone who tested positive.
 - Test all inmates who are cohorted on quarantine when identified as close contacts of someone with suspected (not tested) or confirmed COVID-19 at the end of the 10-day quarantine period, before releasing the cohort from quarantine.
- Restrict quarantined inmates from leaving the facility (including transfers to other facilities) during the 10-day quarantine period, unless released from custody or a transfer is necessary for medical care, infection control, lack of quarantine space, or extenuating correctional, judicial, or security concerns.
- If an inmate on quarantine status (not routine observation) due to exposure to suspected or confirmed COVID-19 is to be released from the facility before medically discharged from quarantine, notify the Hawaii Department of Health to provide direct linkage to community resources and release planning (e.g., transport, shelter, and medical care).
- If an inmate on quarantine status is scheduled to transfer to the Hawaii State Hospital or another correctional facility, hold the transfer until the inmate is cleared for transfer by the Physician Manager or Medical Director.



Modified Quarantine Approaches

Due to the potential for rapid, widespread transmission of SARS-CoV-2 in congregate environments and [evidence](#) that infected people who are up to date on their COVID-19 vaccines can transmit the virus to others, a 10-day quarantine period provides the greatest protection from potential COVID-19 transmission to other inmates and staff. However, quarantine protocols for inmates may need to be modified in some facilities to balance the risks of severe disease from COVID-19 and the impact of prolonged quarantine on inmates' mental health, or to adapt to changes in disease severity and transmissibility from different SARS-CoV-2 variants.

According to the CDC, quarantine can be very disruptive to the daily lives of inmates because of the limitations it places on access to programming, recreation, in-person visitation, in-person learning, and other services. These challenges are especially pronounced when inmates must be quarantined as cohorts, because quarantine periods can become prolonged due to continued transmission. In addition, recommended serial testing every 3–7 days during cohorted quarantine has been difficult for facilities to accomplish during large outbreaks when testing and staffing resources have been strained.

Table 8 presents a range of modified quarantine approaches that can be considered for inmates with variations in duration, testing, movement, and monitoring strategies. When choosing among these approaches, facilities should consider the current [COVID-19 Community Level](#) (which incorporates both transmission and disease severity for currently circulating variants) in combination with Facility-Specific Risk Factors and what is known about the incubation period of the variants circulating at the time. During times when risk tolerance is low (e.g., when disease severity is high), facilities should choose lower risk strategies.

In collaboration with HCD and HDOH, facilities considering modified quarantine approaches should complete a risk assessment by carefully weighing the risks of increased transmission and secondary clusters, and consider facility-specific characteristics (e.g., facility vaccination rate for inmates, COVID-19 community levels, compliance with prevention strategies, ability to properly ventilate, proportion of inmates at increased risk for severe illness from COVID-19, and availability of resources for broad-based testing, daily symptom screening, and outbreak response), before implementing a modified quarantine approach.



Table 8. Standard and Modified Quarantine Approaches

Quarantine Characteristic	Standard Approach	Modified Approaches
Who is required to quarantine	All exposed inmates, regardless of vaccination and booster status.	Only exposed inmates not up to date on their COVID-19 vaccines and who have not recovered from a prior SARS-CoV-2 infection in the last 30 days.
Movement outside the quarantine space	Keep movement outside the quarantine space to a minimum.	Allow a quarantine cohort to move outside the quarantine space and continue daily activities as a group, but without mixing with inmates or staff not assigned to their cohort. Maintain consistent staff assignments to support cohort integrity. Maintain use of well-fitting masks or respirators among staff and inmates while indoors, and implement serial testing for inmates.
Duration	Quarantine for 10 days after last exposure/close contact with someone with COVID-19.	<i>Test-out option:</i> Quarantine for no fewer than 5 days, with a negative viral test result after Day 5. <i>Daily testing option:</i> Test daily for no fewer than 5 days, and allow normal activities as long as viral test results are negative.
Testing [during individual quarantine]	After the initial diagnostic test, test inmates again after Day 5.	After the initial diagnostic test, release inmates from quarantine after the full recommended 10-day period with no additional testing. (Test inmates who develop symptoms, make additional testing available on request, and actively offer testing to inmates more likely to get very sick from COVID-19 to identify infections early and assess treatment eligibility.)
Testing [during cohorted quarantine]	Implement serial testing every 3-7 days for the entire cohort.	<i>Reduced cohort size option:</i> After the initial diagnostic test, implement serial testing every 3-7 days for the entire cohort. Use small cohort sizes to reduce the risk of continued transmission and prolonged quarantine periods. <i>Reduced testing option – during crisis-level operations only:</i> After the initial diagnostic test, test inmates who develop symptoms, and make additional testing available on request. Actively offer additional testing to inmates more likely to get very sick from COVID-19 to identify infections early and assess treatment eligibility. Release cohorted inmates from quarantine after 10 days have passed without any new cases.
Monitoring	Conduct daily symptom checks for all quarantined inmates.	Conduct daily symptom checks only for quarantined inmates more likely to get very sick from COVID-19 . Identifying symptomatic infection early can facilitate timely treatment and reduce the risk of severe outcomes.

Adapted from: CDC Guidance on Management of COVID-19 in Correctional and Detention Facilities (Table 3); 05/03/22. Available at: <https://www.cdc.gov/coronavirus/2019-ncov/community/correction-detention/guidance-correctional-detention.html>



13. Data Collection, Analysis, and Reporting

Implement methods for tracking information about inmates and employees with suspected and/or confirmed COVID-19.

- COVID-19 data assists public health professionals and health care providers monitor the spread and intensity of COVID-19 in our correctional system; supports an understanding of the illness, disease severity, and associated social disruptions; and informs the public health response to COVID-19. The following information should be tracked:
 - Facility: the specific correctional facility where the inmate is housed.
 - Tested: the number of inmates who have been administered a COVID-19 viral test and received results while incarcerated.
 - Refused Testing: the number of symptomatic inmates who refused COVID-19 viral testing.
 - Negative: the number of inmates who have been administered a COVID-19 test and have received a negative result from a COVID-19 viral test while incarcerated.
 - Inconclusive: the number of inmates who have been administered a COVID-19 test and have received an inconclusive result from a COVID-19 viral test while incarcerated.
 - Positive: the number of inmates who have been administered a COVID-19 test and have received a positive result from a laboratory confirmed COVID-19 PCR test while incarcerated.
 - Probable: the number of inmates who have been administered a COVID-19 test and have received a positive result from a COVID-19 antigen test or a presumptive positive result from PCR testing, but do not confirm infection by taking a confirmatory PCR test, while incarcerated.
 - Pre-Incarceration Positive: the number of inmates who received a positive result from a COVID-19 viral test prior to incarceration.
 - Number of Persons in Medical Isolation: the number of inmates who received a positive result from a COVID-19 viral test and are currently infectious and the number of inmates who are presenting with symptoms of COVID-19 and have been separated, in a single cell or by cohorting, from others who are not ill in order to prevent the spread of disease.
 - Hospitalization: the number of inmates with laboratory confirmed COVID-19 who are currently hospitalized for a COVID-19 related illness, as determined by HDOH.
 - Recovered: the number of inmates who received a positive COVID-19 viral test, but have been successfully treated and discharged from medical isolation by the Provider in accordance with CDC guidelines.
 - Deaths: the number of inmate deaths that have been identified by the HDOH as COVID-related. This is provisional data that does not reflect the actual cause of death, which is based on the medical examiner report and autopsy.



- To the extent permitted by Federal and State laws, facilities and programs should maintain a database on the number of employees who have tested positive for COVID-19, the number of employees who are recovered from COVID-19, and the number of employee deaths related to COVID-19. Maintain [The COVID-19 Log](#) and [Report COVID-19 Fatalities and In-Patient Hospitalizations to OSHA](#), as required by the [OSHA recording and reporting requirements](#). If a staff member has a confirmed SARS-CoV-2 infection, maintain the infected employee's confidentiality as required by federal and state laws, and the [Americans with Disabilities Act](#).

14. Continuous Quality Improvement

The purpose of Continuous Quality Improvement (CQI) programs is to improve health care by identifying problems, implementing and monitoring corrective action, and studying the effectiveness of the corrective action. Periodically and at the conclusion of an outbreak, the facility should review the implementation of the COVID-19 Pandemic Response Plan in the context of identifying what has worked well and what areas require improvement. Findings from the facility CQI committee should be reported to the Division Administration for appropriate distribution to assist all correctional facilities. Members of the facility CQI committee should include the Warden and relevant Section Administrators.



COVID-19 Pandemic Response Plan Implementation Worksheet

This MS Word® template worksheet is designed for facilities to operationalize the guidance in this COVID-19 Pandemic Response Plan. It should be adapted to the unique needs of your facility.

Date Updated:

Completed by:

1. Assess COVID-19 Risk and Select Prevention Strategies

a. Identify members of the facility leadership team responsible for COVID-19 pandemic response planning and implementation, including roles and responsibilities:

b. Which facility members are responsible for assessing COVID-19 Risk by monitoring COVID-19 Community Levels and reviewing Facility-Specific Risk Factors?

c. What is the current [COVID-19 COMMUNITY LEVEL](#) for your facility?

d. Facility-Specific Risk Factors

Transmission in the Facility. What is the current level of SARS-CoV-2 transmission within the facility?

What area(s) of the facility have seen COVID-19 cases within the last 10 days?

Are the recent COVID-19 cases limited to new intakes?



Risk of Severe Health Outcomes. What proportion of the facility's inmate population and staff are more likely to get very sick from COVID-19?

Is the facility able to access and administer COVID-19 therapeutics on-site to prevent severe health outcomes among inmates who are more likely to get very sick from COVID-19?

Is the facility able to assess inmates' risk for severe outcomes and ensure timely access to care outside the facility?

Facility Structural and Operational Characteristics. Does the facility have dense housing arrangements (e.g., dorm/open barracks)?

Does the facility experience frequent population turnover?

Do ventilation systems meet code-minimum ventilation requirements?

e. Strategies for Everyday Operations

Are the following strategies for everyday operations being maintained?

STRATEGY FOR EVERYDAY OPERATIONS	YES	No
Prepare for Outbreaks		
Standard Infection Control		
Offer Well-Fitting Masks/Respirators to Inmates and Staff		
Wear Masks/Respirators Indoors for 10 Days if Close Contact		
Up to Date COVID-19 Vaccination		
SARS-CoV-2 Testing		
Symptomatic		
Close Contact		
All Inmates at Intake (or Routine Observation Period)		
Medical Isolation		
Access to COVID-19 Therapeutics		



If a strategy (or component of a strategy) for everyday operations is not being maintained, what measures of mitigation are being implemented?

f. Enhanced Prevention Strategies

Which enhanced prevention strategies will be used and when will the enhanced prevention strategies be used (specify the Facility-Specific Risk Factor(s) (i.e., transmission in the facility, risk of severe health outcomes, facility structural and operational characteristics), that would trigger use of enhanced prevention strategies)?

ENHANCED PREVENTION STRATEGIES	COVID-19 Community Levels at High	Facility-Specific Risk Factors Indicate Increased Risk
Improve Ventilation		
Physical Distancing		
Universal Indoor Masking		
SARS-CoV-2 Testing		
Before Transfer		
Before/After Community Visits		
Before Release		
Routine Screening Testing		
Routine Observation Periods During Transfer/Release Protocols		
Quarantine		
Reduce Movement and Contact Across Housing Units and with the Community		



2. Communication

a. Who is responsible for monitoring COVID-19 updates from CDC and Hawaii Department of Health?

CDC Website: <https://www.cdc.gov/coronavirus/2019-ncov/index.html>

Hawaii Department of Health Websites:

<https://health.hawaii.gov/news/covid-19-updates/>

<https://health.hawaii.gov/coronavirusdisease2019/>

<https://health.hawaii.gov/coronavirusdisease2019/for-clinicians/>

b. The mechanisms for regular updates (paper/electronic/telephonic) will be as follows:

- **Staff:**
- **Inmates:**
- **Families of inmates:**

Review recommendations for posting signage in the facility. What signage will be posted in the facility and where will the signage be posted?

c. The following staff are responsible for communicating with stakeholders:

d. Department of Health:

Oahu (**Disease Reporting Line**): (808) 586-4586
Maui District Health Office: (808) 984-8213
Kauai District Health Office: (808) 241-3563
Big Island District Health Office (Hilo): (808) 933-0912
Big Island District Health Office (Kona): (808) 322-4877
After hours on Oahu: (808) 600-3625
After hours on neighbor islands: (800) 360-2575 (toll free)

Fax: (808) 586-4595



e. Who is the Point of Contact at the Hawaii Department of Health?

Name(s):

Phone Number:

Email:

f. Local community referral hospital:

Phone:

3. General Prevention Measures

a. Good Health Habits: How will good health habits be promoted with your staff (e.g., posters, leadership emphasizing hand hygiene, educational video, email messages to staff)?

1) Are there facilities for employees and visitors to wash hands when entering and leaving the facility? YES NO If no, what are the plans to address this issue?

2) Are there facilities for inmates to wash hands at intake? YES NO
If no, what are the plans to address this issue?

3) Are soap dispensers or hand soap available in all employee and inmate restrooms? YES NO
What is the plan to ensure soap dispensers are refilled regularly?

4) What is the plan to ensure inmates have an adequate supply of soap?

5) Are signs for hand hygiene and respiratory etiquette visibly posted at the entry, in modules, and other high traffic areas? YES NO

6) Are tissues available? YES NO If so, where?

7) Are no-touch trash receptacles available? YES NO
If so, where?



b. Environmental Cleaning:

Review CDC recommendations regarding environmental cleaning. Note: common EPA-registered household disinfectants are considered effective. *(If necessary)* purchase EPA hospital-grade disinfectants from Schedule N: <https://www.epa.gov/pesticide-registration/list-n-disinfectants-use-against-sars-cov-2>. (Recommended products are both a surface cleaner and disinfectant with a 3-minute wet time or less.) What disinfectants will the facility use?

Identify “high-touch” surfaces in the facility (e.g., doorknobs, handrails, keys, telephones):

The following plan will be implemented to increase the frequency and the extent of cleaning and disinfection of high-touch surfaces in this facility:

c. Physical Distancing: What physical distancing measures will be implemented as enhanced prevention strategies when the COVID-19 Community Level is high or Facility-Specific Risk Factors indicate increased risk (Review across all Sections in the facility)?

- 1)
- 2)
- 3)
- 4)
- 5)
- 6)
- 7)
- 8)
- 9)



In what areas of the facility do staff interact or come in close contact with one another (e.g., break rooms, locker rooms, shared offices)?

What precautions will be taken, as an enhanced prevention strategy, to prevent transmission between staff members in these spaces?

d. Use of Masks or Respirators and No-Contact Barriers:

Will the facility offer masks or respirators to staff and inmates? YES NO

When COVID-19 Community Levels are high or Facility-Specific Risk Factors indicate increased risk, will the facility require the use of masks or respirators while indoors?

YES NO

What is the facility plan for inmate encounters using no-contact barriers as an enhanced prevention strategy?

e. Employees Stay Home When Sick: Does communication with employees include the message that they should stay home when sick? YES NO

Sick employees should be advised to follow CDC guidance on [What to do if you are Sick](#)

If NO, what corrective action will be implemented?

f. COVID-19 Vaccination and Boosters: Is there a protocol for obtaining and administering COVID-19 vaccines? YES NO

If yes, what is the procedure for obtaining COVID-19 vaccines?



If yes, what plans are there to continue offering COVID-19 vaccines and boosters to inmates (e.g., when are vaccines and boosters offered to new intakes, when and how are vaccines and boosters offered to existing inmates, when and how often are vaccine clinics scheduled)?

Have health care staff received training on how to respond to inmate questions about COVID-19 vaccines?

YES NO

g. Influenza Vaccination: Is there flu vaccine in stock? YES NO

If yes, number of doses?

If yes, what plans are there to continue offering vaccination to inmates who have not been vaccinated?

h. Infection Prevention and Control Guidance When Screening: When implementing screening as an enhanced prevention strategy, have staff who conduct screening of employees, visitors, vendors, volunteers, and new intakes received education on the infection prevention and control guidance? YES NO

If no, what corrective action be taken?

i. Control Strategies for Aerosol Generating Procedures:

Did medical staff implement control strategies for aerosol generating procedures involving diagnostics, CPAP/BiPAP use, pulmonary function/peak flow tests, and nebulizer treatments?

YES NO

If NO, what corrective actions are being implemented?

Did dental staff implement control strategies for aerosol generating procedures in accordance with the CDC [Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 \(COVID-19\) Pandemic](#) and guidance from the [Hawaii Board of Dentistry](#)? YES NO



If NO, what corrective actions are being implemented?

4. Visitors / Vendors / Volunteers

When COVID-19 Community Level is high or when Facility-Specific Risk Factors indicate increased risk, what enhanced prevention measures will be implemented for (e.g., restrict non-essential visitors, vendors, and volunteers from entering sections of the facility where transmission is occurring; require visitors, vendors, and/or volunteers to wear well-fitting masks or respirators while indoors at the facility; use protective barriers in visitation rooms; encourage physical distancing; visitor testing or screening):

a. Visitors:

b. Volunteers:

c. Vendors:

If visitation is suspended, what alternative methods will be offered to inmates to communicate with family, friends, and visitors?

What signage or methods are being used to communicate with visitors?

As an enhanced prevention strategy, is the facility prepared to conduct screening for visitors/vendors/volunteers? YES NO

If yes, who will conduct the screening?



5. Employee Screening and Testing

Does the facility offer employee testing for SARS-CoV-2 on-site? If so, how frequent?

As an enhanced prevention strategy, is the facility prepared to conduct screening for employees?

YES NO

If yes, who will conduct the screening?

Do you have an infrared no-touch thermometer for employee screening? YES NO

If NO, what are your plans for acquiring an infrared no-touch thermometer?

The following system will be utilized for employees to report illness/exposures:

The following system will be used to track employee illness/exposures:

6. New Intake Screening and Routine Intake Observation

Does the facility use Routine Intake Observation? YES NO

Does the facility conduct screening testing at intake? YES NO

If the facility uses Routine Intake Observation in combination with Intake Testing (upon admission and on the last day of Routine Intake Observation), how long will the Routine Intake Observation period be (e.g., 5, 7, 10 days)?



7. Initial Management and Testing of SARS-CoV-2

It is recommended that individuals with symptoms be immediately issued a mask or respirator and be placed in a separate room with a toilet and sink (if available).

What separate room will be used for this purpose?

Do you have capacity in this facility to perform diagnostic testing of SARS-CoV-2? YES NO

If yes, what are the plans to ensure competency in nasopharyngeal swabbing?

What are current recommendations regarding COVID-19 testing?

Review CDC recommendation for collection of clinical specimens. Do you have needed supplies for testing? YES NO

If NO, what are your plans to obtain the supplies?

Planning for how the facility will modify operations when implementing broad-based testing for SARS-CoV-2.

Will specific housing units or areas be designated for inmates who test positive? YES NO

If YES, which housing units or modules will be initially designated for positive cases?

If NO, how will the facility manage positive cases and prevent transmission of the virus in housing areas with both uninfected inmates and positive cases?

How will the facility manage those who decline testing?



If testing reveals that more inmates are positive than negative, will those who test negative be reassigned to different housing (rather than reassigning those who test positive)? YES NO

If yes, how will the facility mitigate further transmission within the facility?

How will housing areas be systematically and thoroughly cleaned and disinfected if large numbers of positive inmates are identified and housing units are rearranged?

How will the facility manage the logistics of moving large numbers of inmates into different housing arrangements (e.g., where will inmates go while the housing units are being cleaned and disinfected, and how will positive and negative inmates be separated during this time)?

8. Personal Protective Equipment

Date: What is the current inventory of the following?

Surgical Masks:

International respirators:

N-95 respirators:

Gowns (disposable):

Gowns (washable):

Eye Protection- Goggles:

Eye Protection—Disposable face shields:



What is your plan for securing and maintaining an adequate supply of PPE?

If respirators are available, but in limited supply, what activities will they be prioritized for?

What is your plan for fit-testing employees?

What is your plan for fit-testing inmates?

How does the facility plan to train adult correctional officers in donning and doffing of PPE?

Who will conduct the training?

Who will organize the training?

When will the training occur?

How does the facility plan to train civilian employees in donning and doffing of PPE?

How does the facility plan to train inmates in donning and doffing of PPE?

Review Table 4 (COVID-19 Personal Protective Equipment Recommendations) and the CDC [Strategies to Optimize the Supply of PPE and Equipment](#). What strategies are being implemented to optimize the supply of PPE and equipment?



9. Transport

What is your plan for training transport staff on procedures for transport?

10. Medical Isolation / Cohorting (*Symptomatic Inmates*)

What is your capacity for medically isolating inmates with suspected COVID-19 in single cells with a toilet?

Where will medical isolation cells for suspected COVID-19 be located?

What is your capacity for cohorting inmates in cells, quads, modules, or dorms, with toilets/sinks?

What areas of the facility have been designated for medical isolation of confirmed COVID-19 in cohorts?

What is your plan for designating and training officers assigned to medical isolation cells, quads, modules, or dorms on medical isolation procedures?

Is it feasible to designate specific security staff to only monitor medically isolated inmates to minimize the potential for exposure among staff? YES NO

If YES, how will staff be selected for this duty?

If NO, how will you mitigate the risk of cross-contamination across different housing areas in the facility?



Review recommendations for laundry and food service. What are your plans for educating staff and inmate workers on the laundry and food service recommendations?

Review recommendations for cleaning areas where COVID-19 cases spent time. What are your plans for training staff and inmate workers on the cleaning recommendations?

11. Care for the Sick

Do you have an adequate supply of Oxygen and medications for supportive care of a respiratory illness?

Do you have an adequate supply of monoclonal antibodies (mAb) or antiviral medications for the prevention of severe outcomes from COVID-19?

What is your facility plan for monitoring ill inmates?

12. Quarantine (*Asymptomatic Exposed Inmates*)

What cells, quads, modules, and dorms could be used for individual quarantine?

What cells, quads, modules, and dorms could be used for cohorted quarantine?

How do you plan to monitor inmates under quarantine?

What is your plan for supplying masks or respirators needed for an entire housing unit of inmates for a period of 10 days?



What is your plan/ability to provide single cells for exposed persons who are at risk for severe illness from COVID-19 (e.g., over age 60 or with underlying medical conditions)?

Which standard or modified quarantine approaches will the facility use as an enhanced prevention strategy?

13. Data Collection, Analysis, and Reporting

Who is responsible for collecting and reporting data on employees with suspected/confirmed COVID-19?

How will the employee information be communicated to the data collector?

Who is responsible for collecting and reporting data on inmates with suspected/confirmed COVID-19?

Tina Agaran, CSBA, and Toni Schwartz, PIO, collect and report on data, respectively.

How will the inmate information be communicated to the data collector?

Facility nursing will report instances of COVID-19 testing, requiring medical isolation as a Priority I Incident. Vendor will provide automated result reporting.

14. Continuous Quality Improvement

Who are the members of the facility CQI committee for COVID-19?

Who will be responsible for communicating the results of the reviews to the Division Administrators for appropriate distribution to other facilities?



Attachment 1. COVID-19 Visitor/Vendor/Volunteer Screening Tool

DEPARTMENT OF PUBLIC SAFETY
CORONAVIRUS DISEASE 2019 (COVID-19)
VISITOR/VENDOR/VOLUNTEER SCREENING TOOL

SECTION A (TO BE COMPLETED BY VISITOR/VENDOR/VOLUNTEER)

Please complete the following:	
Date	
Name	
1. Please answer the following questions:	
<input type="checkbox"/> Yes <input type="checkbox"/> No	In the past 10 days, have you tested positive for COVID-19?
<input type="checkbox"/> Yes <input type="checkbox"/> No	In the past 10 days, have you traveled outside Hawaii?
<input type="checkbox"/> Yes <input type="checkbox"/> No	In the past 10 days, have you had contact with a person suspected or known to be infected with COVID-19?
2. Today or in the past 14 days, have you had any of the following symptoms?	
<input type="checkbox"/> Yes <input type="checkbox"/> No	Fever, Felt Feverish, or Chills
<input type="checkbox"/> Yes <input type="checkbox"/> No	Cough
<input type="checkbox"/> Yes <input type="checkbox"/> No	Shortness of Breath or Difficulty Breathing
<input type="checkbox"/> Yes <input type="checkbox"/> No	Fatigue
<input type="checkbox"/> Yes <input type="checkbox"/> No	Muscle or Body Aches
<input type="checkbox"/> Yes <input type="checkbox"/> No	Headache
<input type="checkbox"/> Yes <input type="checkbox"/> No	New Loss of Taste or Smell
<input type="checkbox"/> Yes <input type="checkbox"/> No	Sore Throat
<input type="checkbox"/> Yes <input type="checkbox"/> No	Congestion or Runny Nose
<input type="checkbox"/> Yes <input type="checkbox"/> No	Nausea or Vomiting
<input type="checkbox"/> Yes <input type="checkbox"/> No	Diarrhea or Loose Stool
<input type="checkbox"/> Yes <input type="checkbox"/> No	I CERTIFY THAT MY RESPONSES ARE TRUE AND CORRECT
3. Temperature	
<input type="checkbox"/> Yes <input type="checkbox"/> No	Can staff take your temperature?

SECTION B (TO BE COMPLETED BY STAFF)

4. Take Temperature	
<input type="checkbox"/> Yes <input type="checkbox"/> No	Is the temperature of the visitor/vendor/volunteer 100.0°F or above?
5. Clearance	
<input type="checkbox"/> Yes <input type="checkbox"/> No	Is the visitor/vendor/volunteer clear for purpose of this screening to enter the facility?

Staff Name: _____

Staff Title: _____



Attachment 2. COVID-19 Employee Screening Tool

DEPARTMENT OF PUBLIC SAFETY CORONAVIRUS DISEASE 2019 (COVID-19) EMPLOYEE SCREENING TOOL

SECTION A (TO BE COMPLETED BY EMPLOYEE)

Please complete the following:	
Date	
Employee Name	
1. Please answer the following questions:	
<input type="checkbox"/> Yes <input type="checkbox"/> No	In the past 10 days, have you tested positive for COVID-19?
<input type="checkbox"/> Yes <input type="checkbox"/> No	In the past 10 days, have you traveled outside Hawaii?
<input type="checkbox"/> Yes <input type="checkbox"/> No	In the past 10 days, have you had contact with a person suspected or known to be infected with COVID-19?
2. Today or in the past 10 days, have you had any of the following symptoms?	
<input type="checkbox"/> Yes <input type="checkbox"/> No	Fever, Felt Feverish, or Chills
<input type="checkbox"/> Yes <input type="checkbox"/> No	Cough
<input type="checkbox"/> Yes <input type="checkbox"/> No	Shortness of Breath or Difficulty Breathing
<input type="checkbox"/> Yes <input type="checkbox"/> No	Fatigue
<input type="checkbox"/> Yes <input type="checkbox"/> No	Muscle or Body Aches
<input type="checkbox"/> Yes <input type="checkbox"/> No	Headache
<input type="checkbox"/> Yes <input type="checkbox"/> No	New Loss of Taste or Smell
<input type="checkbox"/> Yes <input type="checkbox"/> No	Sore Throat
<input type="checkbox"/> Yes <input type="checkbox"/> No	Congestion or Runny Nose
<input type="checkbox"/> Yes <input type="checkbox"/> No	Nausea or Vomiting
<input type="checkbox"/> Yes <input type="checkbox"/> No	Diarrhea or Loose Stool
<input type="checkbox"/> Yes <input type="checkbox"/> No	I CERTIFY THAT MY RESPONSES ARE TRUE AND CORRECT
3. Temperature	
<input type="checkbox"/> Yes <input type="checkbox"/> No	Can the screener take your temperature?

SECTION B (TO BE COMPLETED BY SCREENER)

4. Take Temperature	
<input type="checkbox"/> Yes <input type="checkbox"/> No	Is the temperature of the employee 100.0°F or above?
5. Clearance	
<input type="checkbox"/> Yes <input type="checkbox"/> No	Is the employee clear for purpose of this screening to enter the facility?

Screener Name: _____

Screener Title: _____



Attachment 3. CDC Contact Precautions Sign











Attachment 4. CDC Droplet Precautions Sign





Attachment 5. Isolation Room Precautions Sign

<h2>Respiratory Infection Isolation Room Precautions</h2> <p><i>PRECAUCIONES de sala de aislamiento de infección respiratoria</i></p>	
<p>TO PREVENT THE SPREAD OF INFECTION, ANYONE ENTERING THIS ROOM SHOULD USE: <i>Para prevenir el esparcimiento de infecciones, todas las personas que entren a esta habitación tienen que:</i></p>	
	<p>HAND HYGIENE <i>Hygiene De Las Manos</i></p>
	<p>Face Mask or N-95 Respirator <i>Mascara Facial o Respirador N95</i></p>
	<p>Gloves <i>Guantes</i></p>
	<p>GOWN <i>Bata</i></p>
	<p>Eye Protection <i>Protección para los ojos</i></p>
	<p>Ensure that the door to this room remains closed <u>at all times</u>. <i>Asegurese de mantener la puerta de esta habitación cerrada <u>todo el tiempo</u>.</i></p>








Attachment 6. Quarantine Room Precautions Sign

Quarantine Room Precautions

PRECAUCIONES de sala de Guaratena

TO PREVENT THE SPREAD OF INFECTION,
ANYONE ENTERING THIS ROOM SHOULD USE:

*Para prevenir el esparcimiento de infecciones,
todas las personas que entren a esta habitación tienen que:*

	HAND HYGIENE <i>Hygiene De Las Manos</i>
	Face Mask or N-95 Respirator <i>Mascara Facial o Respirador N95</i>
	Gloves <i>Guantes</i>
	GOWN – only if close contact <i>Bata-solo si hay contacto cercano</i>
	Eye Protection <i>Protección para los ojos</i>
	Ensure that the door to this room remains closed <u>at all times</u>. <i>Asegurese de mantener la puerta de esta habitación cerrada <u>todo el tiempo</u>.</i>



Attachment 7. COVID-19 Re-entry Information Handout



DEPARTMENT OF PUBLIC SAFETY COVID-19 RE-ENTRY INFORMATION



Coronavirus Disease 2019 (COVID-19) is a respiratory illness that can spread from person-to-person.

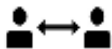
COVID-19 symptoms may include:

- fever or chills
- cough
- shortness of breath or difficulty breathing
- fatigue
- muscle or body aches
- new loss of taste or smell
- headache
- sore throat
- congestion or runny nose
- nausea or vomiting
- diarrhea

Severe cases can result in hospitalization and death. Get emergency medical attention if you have:

- trouble breathing
- persistent pain or pressure in the chest
- pale, gray, or blue colored skin, lips, or nail beds depending on skin tone.
- new confusion
- inability to wake or stay awake

Call 9-1-1 for emergency medical attention



HOW TO PROTECT YOURSELF & OTHERS

Residents of Hawaii are advised to take a few simple precautions to help reduce their risk of exposure:

- Get vaccinated and stay up to date on your COVID-19 vaccine or booster
- Wear a well-fitted mask or respirator
- Social distance or stay 6 feet away from others
- Avoid poorly ventilated spaces and crowds
- Get tested to prevent spread to others
- Wash your hands often; cover coughs and sneezes
- Clean and disinfect
- Monitor your health daily



ISOLATION AND QUARANTINE

Isolation: When you tested positive for COVID-19 or if you have COVID-19 symptoms.

Quarantine: When you have been in close contact with someone with COVID-19.

If you are re-entering the community while on medical isolation or quarantine status, follow the guidance provided by medical or contact the Hawaii Department of Health or your Provider for current guidance on what to do and when to end isolation or quarantine.



RESOURCES AND LINKS

Hawaii Department of Health

- Call 2-1-1
- www.hawaii.covid19.com

COVID-19 Vaccines or Boosters

- Call 800-232-0233
- Text zip code to 438829
- www.vaccines.gov



Attachment 8. Control Strategies for Aerosol Generating Procedures

General Strategies to Reduce Risk with Aerosol Generating Procedures:

1. Examine whether the procedure is medically necessary, identify viable effective alternatives, and consider temporarily discontinuing non-essential use during the COVID-19 pandemic.
2. If aerosol generating procedures are deemed medically necessary, minimize the risk by:
 - a. Limiting staff involved in the procedure
 - b. Recommended PPE: N95 respirator, face shield, gloves and gown.
 - c. Perform in airborne infection isolation (AII) room or single room with solid walls and doors.
 - d. Thoroughly disinfect the room after use.

Procedure	Recommendations
Diagnostics (e.g., COVID-19, Influenza)	Nasopharyngeal and oropharyngeal swabs should be performed in a room with a door that closes. PPE: N95 respirator, gown, gloves, eye protection
Dental	Dental Health Professionals adhere to the CDC Interim Infection Prevention and Control Guidance for Dental Settings During the COVID-19 Response and guidance from the Hawaii Board of Dentistry . PPE: N95 respirator, gown, gloves, eye protection
CPAP/BiPAP	Providers review patients with sleep apnea on CPAP/BiPAP: <ul style="list-style-type: none">▪ For most patients on CPAP the short-term discontinuation of CPAP is less risky than the potential for aerosolized virus spread with CPAP use during pandemic.▪ For patients on BiPAP/CPAP with severe sleep apnea and comorbidities (such as significant cardiomyopathy with history of arrhythmias) for whom short-term discontinuation of BiPAP/CPAP is not considered safe, single cell housing (with solid door) should be sought.▪ COVID-19 can live on surfaces so frequent cleaning of CPAP equipment being used is encouraged during the pandemic
PFTs/Peak Flow Meters	It is recommended that pulmonary function tests and peak flow measurements be postponed due to COVID-19 pandemic.
Nebulizer Treatments	Avoid nebulizer use by converting to metered dose inhaler (MDI) if possible <ul style="list-style-type: none">▪ Use MDI with spacer, if possible▪ Consider increasing puffs per sitting and more frequent use, if clinically indicated▪ Some medications are available as dry powder inhaler▪ National supply issues have been reported for some MDIs; consult with pharmacist as needed If must use nebulizer: <ul style="list-style-type: none">▪ Use in single room with closed door▪ Limit staff and staff present use N95 respirator, gown, gloves, eye protection▪ Disinfect room and equipment after treatment
CPR	CPR is performed in accordance with American Heart Association guidelines. Modifications include: <ul style="list-style-type: none">▪ Limit number of people in room to essential (no more than 3)▪ Put on appropriate PPE before entering the scene: N95 respirator, gown, gloves, eye protection▪ Use of bag-mask ventilation over mouth-mask/face shield preferred

Adapted from: VitalCore Health Strategies and California Department of Corrections Division of Health Care Services Memorandum: Aerosol Generating Procedures, April 8, 2020.



Appendix 1. CDC Definitions of Commonly Used Terms

COVID-19 Prevention Strategies:

- **Strategies for everyday operations**: COVID-19 prevention strategies that correctional facilities should keep in place at all times, even when the COVID-19 Community Level is low.
- **Enhanced COVID-19 prevention strategies**: Additional COVID-19 prevention strategies for facilities to use when the COVID-19 Community Level is medium or high, or when Facility-Level Factors indicate increased risk.

Close contact or exposure to someone with COVID-19 – Someone who was within 6 feet of another person with suspected or confirmed COVID-19 for a cumulative total of 15 minutes or more over a 24-hour period. Consult the CDC website for the current definition for when a person would be considered a close contact of someone with COVID-19. Persons with recent exposure to SARS-CoV-2 can be identified in correctional facilities in two ways:

- **Traditional case investigation and contact tracing**. Involve working with a patient (symptomatic and asymptomatic) who has been diagnosed with an infectious disease to identify and provide support to people (contacts) who may have been infected through exposure to the patient. This process prevents further transmission of disease by separating people who have (or may have) an infectious disease from people who do not.
- **Location-based contact tracing**. When traditional case investigation and contact tracing are not feasible, facilities may identify persons with recent known or potential exposure to SARS-CoV-2 based on whether they spent time in the same locations as an infected person (e.g., all inmates and staff assigned to a housing unit where a case has been identified).

Medical isolation – Physical separation of an individual with confirmed or suspected COVID-19 to prevent contact with others and reduce the risk of transmission.

Quarantine – Physical separation of an individual who has had close contact with someone with confirmed or suspected COVID-19 to reduce the risk of transmission to others if the individual is later found to have COVID-19.

Staff – All public or private sector employees working within a correctional facility. “Staff” does not distinguish between healthcare, custody, and other types of staff members, nor between government and private employers.

Up to date – A person has received all recommended doses in their primary series COVID-19 vaccine, and any booster dose(s) when eligible.