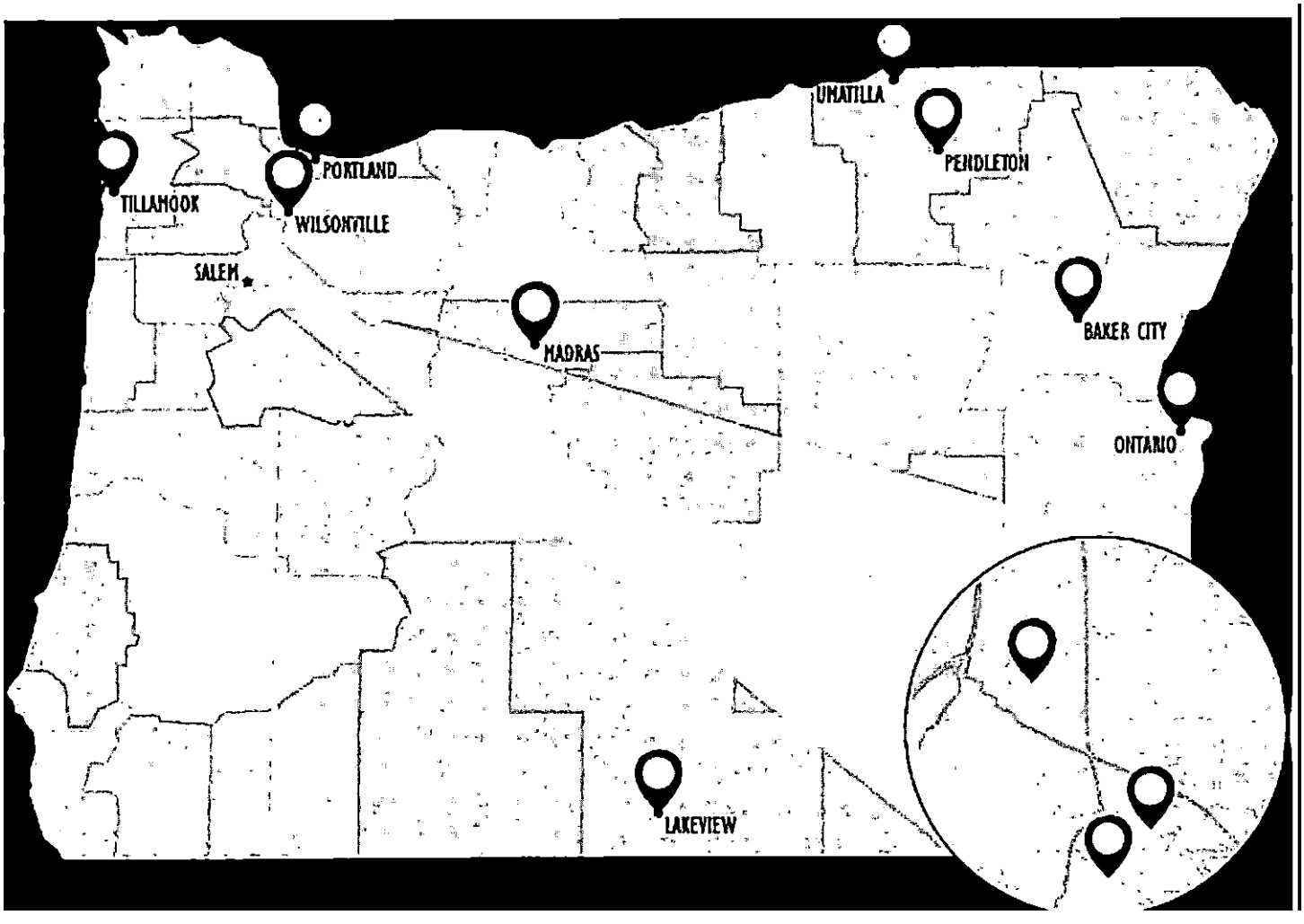
Oregon Department of Corrections
COVID-19 Response and Recovery Plan

January 2, 2023
Second Edition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OREGON DEPARTMENT OF CORRECTIONS COVID-19 Response and Recovery Plan

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Section I.

A. Definitions

COVID-19 Prevention Strategies-Strategies for everyday operations: COVID-19 prevention strategies that correctional and detention 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 consider using when the COVID-19 Community Level is high, or when facility-level factors indicate increased risk.

Close contact of a COVID-19 case- In the context of novel coronavirus (COVID-19), an individual is considered a close contact if that person (a) has been less than six feet of a confirmed or suspected COVID-19 case, and has been in the presence of that person for a cumulative total of 15 minutes or more over a 24-hour period (as determined by ODOC's Infectious Diseases Control Provider), or (b) has had direct contact with infectious secretions from a COVID-19 case (e.g., has been coughed on). Close contact can occur while caring for, living with, visiting, or sharing a common space with a confirmed or suspected COVID-19 case.

Cohorting- Cohorting refers to the practice of isolating multiple laboratory-confirmed COVID-19 cases together as a group or quarantining close contacts of a case together as a group. Ideally, cases should be isolated individually, and close contacts should be quarantined individually. However, some correctional facilities do not have enough individual cells to do so and must consider cohorting as an alternative.

Confirmed vs. Suspected COVID-19 case - A confirmed case has received a positive result from a COVID-19 laboratory test, with or without symptoms. A suspected case shows symptoms of COVID-19 but either has not been tested or is awaiting test results. If test results are positive, a suspected case becomes a confirmed case.

Medical Isolation - Medical isolation refers to the physical separation of an individual with confirmed or s_uspected COVID-19 infection to prevent their contact with others and reduce the risk of transmission. In this context, isolation does NOT refer to punitive isolation for behavioral infractions within the custodial setting. Staff are encouraged to use the term "medical isolation" to avoid confusion, and should ensure that the conditions in medical isolation spaces are distinct from those in punitive isolation. Adults in Custody (AlCs) in medical isolation should receive regular visits from medical staff and should have access to mental health services. To the extent possible, provide amenities of regular housing, consistent within the purpose of quarantine and the resources of the institution.

Quarantine -Quarantine refers to the physical separation of an individual who has had close contact with someone with confirmed or suspected COVID-19 to determine whether they develop symptoms or test positive for ttie disease. Quarantine reduces the risk of transmission to others if the individual is later found to have COVID-19., Quarantine is not punitive and AICs in quarantine should not lose privileges.

Physical Distancing - Physical distancing is the practice of increasing the space between individuals and decreasing the frequericy of contact to reduce the risk of spreading COVID-19 (ideally to maintain at least six feet between all individuals, even those who are asymptomatic). Physical distancing strategies can be applied on an individual level (e.g., avoiding physical contact), a group level (e.g., canceling group activities where individuals will be in close contact), and an operational level (e.g., rearranging chairs in the dining hall to increase distance between them).

Symptoms - Symptoms of COVID-19 include fever, cough, shortness of breath, repeated shaking with chills, muscle pain, headache, sore throat, congestion or runny nose, nausea or vomiting, diarrhea, and new loss of taste or smell. Like other respiratory infections, COVlD-19 can vary in severity from mild to severe. When severe, pneumonia, respiratory failure, and death are possible. COVlD-19 is a novel disease, therefore the full range of signs and symptoms, the clinical course of the disease, and the individuals and populations most at risk for disease and complications are not yet fully understood. Monitor the Center for Disease Control and Prevention (CDC) website for updates on these topics. Symptoms of COVID-19 | CDC

B. Introduction to General COVID-19

The Oregon Department of Corrections (ODOC) operates 12 prisons across the state, employees 4,500 people and incarcerates approximately 12,500 adults. ODOC has been planning and preparing for COVlD-19 since February 2020, before the first confirmed cases in the United States. The agency has a Continuity of Operations Plan (COOP) to ensure critical services will continue if emergency occurs. ODOC has a specific COOP for each institution and division, which identifies essential functions and how to maintain continuity should an incident affect staff, those in ODOC's care and custody, buildings, or equipment.

ODOC is collaborating with local public health officials, coordinating with the Oregon Health Authority (OHAl, and following the CDC https://www.cdc.gov/coronavirus/2019-ncov/community/correction-detention/guidance-correctional-detention.html recommendations to prevent the spread of COVID-19 in Oregon.

Due to Covid-19 being a novel virus, COVID-19 policies have required rapid revision and adaptability. With that being noted, this plan is subject to change based on additional guidance from CDC, OHA or OSHA. DOC is committed to adhering to CDC, OHA and OSHA guidance and requirements.

SECTION 2

Agency Centralized Plan

Systematically, as time has progressed, and the country experienced different variants of the COVlD-19 virus, overall plans, policies, and designs with respect to housing of AICs have been necessarily modified and

adapted. One such change involves where an AIC will be housed after testing positive for COVID-19. Each facility statewide has produced an isolation plan specific to their institution. Each facility will typically house their own positive and suspected positive AICs; unless the level of care needed has escalated beyond the capability of the facility or local hospital. These plans will allow each facility/division to operate independently at the direction of the Functional Unit Manger or their designee to dictate the statuses of their facility/division and what enhanced measures will be implemented in response to the spread of COVID-19.

Oregon Department of Corrections has been operating under the guidance of CDC, OHA and the AOC. Effective the date of this plan, oversight by the AOC will end. The DOC COVID Resource Team will continue to be available to help assist institutions/divisions as they make operational decisions related to COVID-19. Facilities maintain guidance through this document and revised facility specific plans. For information from current CDC Guidance please see the following link. Guidance on Management of Coronavirus Disease 2019 (COVID-19) in Correctional and Detention Facilities | CDC

The Facility-level Factors to be considered listed below and are not all inclusive, but all areas of operations should be reviewed and included in the prevention of spreading and stopping the virus. Each positive case will be evaluated and investigated as a potential outbreak which will inform COVID-19 management and risk mitigation through putting into place appropriate enhanced measures. For ea.ch case, the facility's COVID-19 coordinator will document what measures were taken on the **COVID Case Documentation Form.** The completed form will be saved to a central ODOC folder for documentation purposes.

During periods of escalation or de-escalation of COVID-19 cases, the DL COVID-19 Resource Team may be consulted to assist in determining appropriate changes to enhanced preventions measures.

1. Assessing a Facility's Risk

CDC recommends that correctional facilities use a combination of COVID-19 Community Levels and facility-specific risks to guide decisions about when to apply specific COVID-19 prevention actions. Assessing the following factors can help decide if additional layers of protection are needed because of facility-specific risks:

- **Facility structural and operational characteristics:** Assess w ether facility characteristics or operations contribute to COVID-19 si;iread. For example, facilities may have a higher risk of transmission if they have frequent resident or staff turnover, a high volume of outside visitors, poor ventilation, or areas where many people sleep close together.

- **Risk of severe health outcomes:** Assess what portion of people in the facility are more likely to get very sick from COVID-19, for example, due to underlying health conditions, older age, pregnancy, or poor access to medical care.

- **COVID-19 transmission in the facility:** Assess the extent to which transmission is occurring within the facility. Transmission can be assessed through diagnostic testing of people with COVID-19 symptoms and their close contacts, and through routine screening testing. Per CDC guidelines routine

testing is not recommended, but may be implemented due to a significant outbreak, in consultation with the COVID-19 Resource Team. Results of testing at intake.are not recommended as an indicator of transmission inside the facility, since infections identified at intake most likely occurred elsewhere.

2. COVID-19 Prevention Strategies

The actions facilities can take to help keep their populations safe from COVID-19 can be categorized as prevention strategies for **everyday operations** and **enhanced prevention strategies.**

Prevention strategies for everyday operations should be in place at all times, even if COVID-19 Community Levels are low or medium. These include all of the strategies listed below except those marked *enhanced strategy.*

Enhanced prevention strategies should be added to supplement the prevention strategies for everyday operations when COVID-19 Community Levels are high, any time there has been transmission within the facility itself, or based on the assessment of other facility-specific factors that increase risk. These include the strategies listed below that are marked *enhanced strategy.*

When adding enhanced prevention strategies, facility operators should balance the need for COVID-19 prevention with the impact from reducing access to services and programming. Facilities may not be able to apply all enhanced COVID-19 prevention strategies due to local resource constraints, facility and population characteristics, or other factors. However, they should add as many as feasible, as a multi-layered approach to increase the level of protection against COVID-19. 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, wing, or building. Facilities with lower risk tolerance can apply enhanced prevention strategies at any time, even when the COVID-19 Community Level is low or medium.

Support Staff and A/Cs to Stay Up to *Date with COVID-79 Vaccines*

Encourage and enable staff, volunteers, and AICs to stay up to date on COVID-19 vaccination. Where possible, offer the vaccine onsite and support peer outreach to promote vaccination.

Improve Ventilation

Ensure HVAC systems operate properly and provide acceptable indoor air quality.

Enhanced strategy: Where possible, consider holding group activities outdoors.

Enhanced strategy: Increase and improve ventilation as much as possible. Identify, obtain, and test enhanced ventilation options in advance of higher risk periods to be ready to deploy when needed. Short-term and long-term tools to improve ventilation in buildings can be found on the CDC website.

Provide Testing for COV/D-19, as Needed

Test AICs and staff who have been exposed or who are symptomatic, in accordance with CDC testing guidance and OHA Investigative Guidelines. Advise staff who have been exposed or who are symptomatic to seek testing offsite.

Enhanced strategy: Consult with the state health department about whether to implement routine screening testing of AICs and/or staff if there are concerns about the population being at especially high risk for severe illness from COVID-19. Routine testing can help identify infections early, which is especially important for people who are eligible for treatment.

For more information on testing large numbers of people, review CDC guidance on Performing Broad-Based Testing for SARS-CoV-2 in Congregate Settings.

Wear Masks, Respirators, and/or PPE, as Appropriate

Mask policies: Staff, AICs and any other persons entering facilities or DOC properties may choose to continue wearing masks, if not required. All masks will be provided by the Agency at no cost to the staff or AIC.

Maintain a stock of personal protective equipment (PPE).

Offer high-quality masks/respirators to all AICs and staff and all persons entering the facility and provide other PPE for staff and AICs based on risk (see below for more information on PPE).

Masking requirements in the following areas are required based upon OHA (OR333-018-1010), OHSA (OAR 437-001-0744) rules and the CDC Interim Infectious Prevention and Control Recommendations for Healthcare Personnel and will not be subject to modification until further notification from ODOC Administration

- Health Services Clinic areas
- Areas in which aerosol generating activities occur
- CCCF Intake Center-CCCF will develop plan for Intake Center and masking, to be approved by COVID-19 Resource Team

Enhanced strategy: Require universal indoor masking, regardless of vaccination status.

Promote Infection Control and Facility Cleaning

Conduct standard infection control, cleaning, and disinfection at all times.

Maintain supplies for hand hygiene, cleaning, and disinfection, at no cost to AICs.

Enhanced strategy: Add enhanced cleaning and disinfection protocols.

Implement Post-Exposure Guidance

Test AICs and staff who have been exposed at least five full days after exposure (or sooner, if they develop symptoms) and require them to wear a mask while indoors for 10 full days after exposure, regardless of vaccination status.

Implement Isolation Guidance

- Isolate staff, volunteers, and AICs who test positive for COVID-19 away from other AICs or away from the facility, as applicable, for 10 days since symptoms first appeared or from the date of sample collection for the positive test (if asymptomatic). If the individual has a negative viral test,, isolation can be shortened to be 7 days, as long as symptoms are improving and the individual has been fever-free for 24 hours, the individual was not hospitalized, and the individual does not have a weakened immune system. Note that the isolation period correctional facilities is longer than the duration recommended for the general public because of the risk of widespread transmission in dense housing environments and the high prevalence of underlying medical conditions associated with severe COVID-19.

- If multiple AICs have tested positive, they can isolate together in the same area. However, confirmed and suspected cases should not be housed together.
- Ensure continuation of support services, including behavioral health and medical care, for AICs while they are in isolation.
- During crisis-level operations, such as severe shortages of staffing or space, facilities may need to consider short-term reductions to the recommended isolation period for staff and/or AICs. Facilities should consult their state health department (or equivalent) to discuss approaches that would meet their needs while maximizing infection control.

Support Access to Treatment, as Needed

- Effective treatments are now widely available and must be started within a few days after symptoms develop to be effective. Support timely treatment to those eligible; facilities without onsite healthcare capacity should plan to ensure timely access to care offsite.

Per CDC:

The FDA has expanded EUAs for use of certain investigational monoclonal antibody medications to prevent SARS-CoV-2 infection, including in correctional populations, under the following conditions:

- There is an occurrence of COVI D-19 in other individuals in the same institutional setting, **and;**
- The patient being treated is not fully vaccinated or is not expected to mount an adequate immune response to complete COVID-19 vaccination, **and;**
- The patient being treated is at higher risk for progression to severe COVID-19, including hospitalization or death (e.g., they have certain comorbidities).

In addition, **antiviral medications** are now available that are effective in preventing severe outcomes from COVID-19. These medications can be ordered at no cost either through the office of the Assistant Secretary for Preparedness and Response (ASPR) within the Department of Health and Human SeNices, the manufacturer, or possibly through their usual mechanism for obtaining medications. The National Institute of Health COVID-19 Treatment Guidelines provide information about these drugs and describe what is known about their effectiveness.....**Medications are not a sub_stitute for vaccination.**

Pharmacy has recently obtained Paxlovid for AIC use. Updates will be provided periodically on any other drug procurement when necessary. Paxlovid will be utilized to treat AICs with mild to moderate COVID 19 until further notice. The tier response guidelines published by NIH will utilized dictated by supply when necessary.

If an AIC is diagnosed with mild to moderate COVID-19 disease and antiviral therapy (i.e., Paxlovid) requested, please email DOC Medical Director or Chief of Pharmacy with this request along with the following information/documentation:

- Date of symptom onset
- Current symptoms, including whether or not'AIC has a new supplemental oxygen requirement
- COVID-19 test result
- Age
- Vaccination/booster status
- Immune status
- Relevant medical history

If you are considering monoclonal antibody therapy, please provide the same documentation as for Paxlovid and DOC Medical Director or Chief of Pharmacy.

Per CDC:

Who Is Moderately or Severely Immunocompromised?

Many conditions and treatments can cause a person to be immunocompromised, also known as having a weakened immune system. People are considered to be moderately or severely immunocompromised if they have:

- Been receiving active cancer treatment for tumors or cancers of the blood
- Received an organ transplant and are taking medicine to suppress the immune system
- Received a stem cell transplant within the last 2 years or a_re taking medicine to suppress the immune system
- Moderate or severe primary immunodeficiency (such as DiGeorge syndrome, Wiskott-Aldrich syndrome)
- Advanced or untreated HIV infection
  Active treatment with high-dose corticosteroids or other drugs that may suppress their immune response

Monitor and Communicate Potential Outbreaks or Needs

- Continue partnerships with OHA and LPHAs and plan for outbreak communications, staffing shortages, spaces for quarantine (in facilities that choose to implement it; not routinely recommended) and isolation, and continuity of services.

Increase Space and Distance

- **Enhanced strategy:** Create physical distance in congregate areas where possible.

- **Enhanced strategy:** Reduce movement and contact between different parts of the facility and between the facility and the community (as applicable).

3. Quarantine After Exposure

Quarantine (separating and restricting the movement of people who were exposed to a contagious disease to prevent further transmission in case they become sick) for COVID-19 is no longer recommended for the general public and is no longer mandatory In correctional and detention facilities, quarantine can be very disruptive to the daily lives of AICs because of the limitations it places on access to programming, recreation, in-person visitation, in-person learning, and other services. Facilities should consider these variables when assessing the need to implement this enhanced measure. However, because of the potential for rapid, widespread transmission of SARS-CoV-2 in these settings, some facilities may prefer to continue implementing quarantine protocols for AICs, 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 AIC populations and the impact of quarantine on mental health and staffing coverage.

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 AlCs 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.

Considerations for facilities implementing quarantine include the following:

- **Housing** - AICs who have been exposed can be quarantined individually or cohorted with others who have been exposed (cohorted quarantine). Facilities using cohorted quarantine should be aware that transmission can occur within the cohort if someone is infected. Using smaller cohort sizes can help minimize continued transmission. Once a cohort is established, additional persons exposed at different times should not be added.

- **Testing** - Serial testing may be used during cohorted quarantine. Within quarantine cohorts, serial testing every 3-7 days can identify new cases early. If new cases are identified in the cohort, the quarantine period should restart. Serial testing can be used for all AICs in a cohort, or prioritized for people who are more likely to get very sick from COVID-19 to identify infections early and assess them for treatment promptly.

- **Movement** - To maintain access to programming during quarantine, facilities may choose to allow AICs quarantined as a cohort to move outside of their housing space and continue daily activities as a group. AICs in quarantine should not mix with AICs or staff not assigned to their ohort and should wear a mask indoors.

- **Duration** - For facilities choosing to implement quarantine after a person is exposed to someone with COVID-19, a 10-day quarantine period provides the greatest protection from potential COVID-19 transmission to other AICs and staff, but is disruptive to their lives and to facility operations. One option to balance these needs is to shorten the quarantine period if an exposed person tests negative after 5 days, but to continue masking indoors through day 10.

- **Monitoring** - Rather than requiring healthcare staff to check all quarantined AICs for COVID-19 symptoms, facilities can prioritize symptom checks for AICs more likely to get very sick from COVID-19 to identify infections early and assess treatment eligibility.

4. Personal Protective Equipment and Source Control

The types of personal protective equipment (PPE) and source control recommended in correctional facilities are detailed below.

- **When indoor masking is required (or when individuals choose to wear masks based on their personal preference),** all AICs and staff may use disposable facemasks, barrier face coverings, or NIOSH-approved respirators.

- **AICs with confirmed or suspected COVID-19** may use disposable facemasks, barrier face coverings, or NIOSH-approved respirators.

- **Staff and AICs working in areas of the facility designated for isolation or quarantine** should only use NIOSH-approved respirators.

- **Staff and AICs who will have close contact with AICs who are under quarantine or isolation precautions, including during transport,** should use NIOSH-approved respirators, eye protection, gowns/coveralls, and gloves.

If not already in place, employers should establish a respiratory protection program, as appropriate, to ensure that staff members are fit-tested, medically cleared, and trained for any respiratory protection they

will need within the scope of their responsibilities. AlCs may also be considered for enrollment in a respiratory protection program depending on work-related exposure risk. For example, AICs working in an environment where they may be exposed to COVID-19, such as in a COVID-19 medical isolation unit, would be considered for enrollment due to occupational risk. For more details, see the OSHA Respiratory Protection Standard

5. Identifying Exposures

CDC is not recommending that facilities prioritize individual contact tracing. This guidance document provides information on how to conduct contact tracing in facilities that wish to do so, and it includes options for person-level contact tracing as well as location-based contact tracing, which has been more feasible in some congregate settings in the past. Identifying close contacts of someone with COVID-19 can help people who have been exposed to monitor themselves for symptoms. This is especially important if any of those close contacts are more likely to become very sick from COVID-19, so that they can identify an infection early and receive care to prevent severe outcomes

People who have been exposed can be identified in two ways:

- **Case investigation and person-based contact tracing.** See recommendations for Investigating a COVID-19 Case. Case investigations can prioritize identification of close contacts who are more likely to get very sick from COVID-19, so that they can be referred to a healthcare provider to determine eligibility for treatment if they test positive for COVID-19.

- **Location-based contact tracing.** Location-based contact tracing may be preferable in correctional facilities where traditional person-based contact tracing is ineffective because of crowding, mixing of AlCs and staff, difficulty ascertaining close contacts, and AlCs' movements in and out of the facility. Location-based contact tracing identifies people with recent known or potential exposure based on whether they spent time in the same areas as a person with COVID-19 during the time the infected person was considered infectious. The infectious period is considered to be two days prior to onset of any symptoms, or from the date of the positive test if they do not have symptoms, through the end of isolation. This process can help identify additional facilities (or portions of facilities) that might need investigation and testing. Examples of how to conduct location-based contact tracing include identifying areas where someone who has tested positive for COVID-19 spent time while they were infectious. For AICs, this could include their housing unit, work detail, transport bus, dining area, and any programmatic activities; for staff and volunteers, this could include their duty station, break room, and carpool.

- For sites/areas of a facility that have been identified in location-based contact tracing, consider conducting location-based testing. For more information on testing large numbers of people, review CDC guidance on Performing Broad-Based Testing for SARS-CoV-2 in Congregate Settings.

6. Considerations for Correctional Facilities

Testing at Intake - *strategy for everyday operations*

As an additional *strategy for everyday operations* in this setting, test all new AICs entering at intake.

AICs will be tested at initial intake. AICs determined to be positive for COVID-19 will be isolated and retested at 7 days for release from isolation. A routine observation period of 5 days will follow. After the observation period, the AIC will be tested and, if negative, may proceed to transfer out of Intake. If an AIC refuses testing, they will complete a 10-day observation period.

Testing during Transfer and Release - *enhanced prevention strategy*

An additional *enhanced prevention strategy* for this setting is to test AICs during transfer and/or release protocols. Routine observation periods can be added during movement protocols as well, as additional *enhanced prevention strategies.*

Masks and Respirators

High-quality masks or respirators should be provided to AICs and all individuals entering facilities at no cost and replaced as needed. When possible, offer different types of masks and respirators to staff and AICs so that they can choose the option that fits them best and that they can wear consistently. The options that are offered in correctional facilities may be limited by safety and security considerations, such as concerns about metal nose wires.

In environments where the risk of SARS-CoV-2 transmission is higher and safety and security considerations allow, AICs should be offered masks or respirators providing the same level of protection as those provided to staff in a similar environment.

Isolation and Quarantine Spaces

Because of limited individual housing spaces within many correctional, infected or exposed people are often placed in the same housing spaces that are used for administrative or disciplinary segregation. To encourage prompt reporting of COVID-19 symptoms and to support mental health, ensure that medical isolation and quarantine are *operationally distinct* from administrative or disciplinary segregation, even if the same housing spaces are used for both. For example, as much as possible, provide similar access to radio, TV, reading materials, personal property, commissary, showers, clean clothing and linens, and other resources as-would be available in individuals' regular housing units.

Visitation and Programming

Visitation and programming are essential for AICs' mental health and well-being.

7. Data Reporting:

Each case will be documented using the Department form and will include identifying information regarding the AIC/Staff testing positive, identified close contacts, method of contact tracing (case investigation and person-based contact tracing or location-based contact tracing), what enhanced prevention strategies were implemented in response to the case, if any, and any relevant comments. This form will be uploaded to a central folder, organized by institutions to document decision, making and actions taken.