WA State DOC COVID-19 Screening, Testing, and Infection Control Guideline
Version 34

The purpose of this updated guidance document is to allow the Washington State Department of Corrections (DOC) to implement strategies that manage COVID-19 as a "new normal", balancing the wellbeing of our patients and staff with the appropriate need to mitigate risk of severe disease. This document covers screening, assessment, testing and infection control of patients housed in Washington DOC facilities.

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Changes in Version *34*

Based on the decrease in clinical severity of COVID-19 due to an increase in the number of fully vaccinated individuals, the number of individuals with a personal history of recent COVID-19 infection, and less virulent circulating COVID-19 variants, the recommended clinical strategy for COVID-19 management and prevention has changed. Following updated WA Department of Health (DOH) Guidelines and the updated CDC Guidelines for Correctional Facilities, Clinical Leadership has transitioned from a transmission mitigation strategy to a risk mitigation strategy. This model will prioritize decreasing COVID-19 hospitalizations and deaths while de-escalating several of the main transmission mitigation strategies, such as the widespread use of quarantine, intake separation and mass testing. This guidance will continue to use community and facility-level indicators to assess COVID-19 risk in a facility. Depending on the community and facility-level risk for COVID-19, some strategies will be used at all times (strategies for everyday operations) versus only at times of increased risk (enhanced prevention strategies). This guidance also emphasizes the importance of maximizing access to in-person visitation, health services, programming and recreational activities in order to promote the wellbeing of our patients as we transition to a "new normal". Nevertheless, if there is an increase in community deaths and hospitalizations due to COVID-19, DOC may need to revert back to prior more restrictive strategies in order to maximize the safety of our patients and staff.

This new guidance has several new changes, please see summary below:

- When COVID-19 local county levels are low (green) **and** COVID-19 activity is minimal in the facility (no Limited Area Outbreak, Facility Wide Outbreak or Facility Wide Cluster status), masking may not be required, refer to Routine Masking Guidance.
- If COVID-19 community levels in the facility's county increases to medium (yellow) to high (red) or facility status changes to any outbreak status or Facility Wide Cluster, facilities are expected to re-implement masking per Routine Masking Guidance.
- Moving patients with COVID-19 to a separate isolation area should be done at all facilities when operationally feasible. For facilities that do not have the resources to operationalize isolation of patients in separate areas, a number or alternative strategies are possible. See page 8.
- COVID-19 testing of symptomatic patients will largely depend on using rapid antigen tests (RATs). COVID-19 PCR testing will continue to have a role in certain situations. Special testing considerations will be observed during the seasonal influenza period. See page 9.
- Immunocompetent patients with COVID-19 will remain in medical isolation for 7 days from test date. Patients can be removed from isolation if there is clinical improvement and after <u>two</u> negative COVID-19 rapid antigen tests prior to clearance on days 6 and 7. See page 10.
- Immunocompromised patients with COVID-19 will remain in medical isolation for 20 days from test date. Patients can be removed from isolation if there is clinical improvement and have <u>two</u> negative COVID-19 rapid antigen tests prior to clearance on days 20 and 21. See page 10.
- Quarantine status as a strategy will now be implemented only in high-risk units: all inpatient units (IPUs), MCC-WSR A and CRCC-Sage East. The rest of DOC areas and facilities, including Reentry Centers, will no longer implement quarantine status as a COVID-19 strategy. See page 11.
- Patients who previously tested positive for COVID-19 within the past 30 days regardless of COVID-19 vaccine status do not need to quarantine. For these patients, rapid antigen testing replaces PCR testing from day 30 until day 90. See page 11.
- Testing for COVID-19 with RATs upon arrival will replace intake separation at reception centers. Intake separation as a strategy will no longer be implemented at most areas and facilities, except some high-risk areas like IPUs. See page 13.

- All patients scheduled for intra-system transfer will be offered testing with COVID-19 RAT 24-48hrs prior to transfer. Pre-transfer RAT is not mandatory, but strongly encouraged. If test is declined, patient may transfer without restrictions, unless patient is symptomatic or has fever. See page 14.
- High-risk areas are units with a high concentration of individuals at high risk for severe COVID-19. These areas will be placed on protective separation status, which includes stricter strategies and a the previous, more conservative outbreak definition. The high-risk areas currently are CRCC-Sage East, MCC-WSR A, and all facility inpatient units (IPUs). See page 14.
- All IPUs will continue to implement intake separation and rapid antigen testing upon admission as risk mitigation strategies. See page 14.
- The Local Area Cluster definition for all areas will now be four staff members occurring within 10 days. See page 17.
- For low-risk areas, the Limited Area Outbreak definition will be four or more confirmed cases of COVID-19 in incarcerated individuals occurring within 14 days who reside in the same living area. See page 17. For high-risk areas, see page 14.
- Outbreak status will no longer trigger quarantine or mass testing for the incarcerated population in the affected unit, except for high-risk areas. Outbreak status is to inform of higher risk of COVID-19 transmission to the unit population and staff, so that individuals can take appropriate measures to decrease risk of infection. Outbreak status will no longer affect or prevent work, transfers, programming, recreation, religious services, visitation, access to dental, medical and mental health. See page 19.
- During a COVID-19 cluster, no mass serial testing of the incarcerated population in the affected area is required, except in high-risk areas (IPUs, MCC-WSR A, CRCC-Sage East). See page 19.
- In low-risk areas, testing the patient population for COVID19 will only occur if patients are symptomatic, upon patient request, or if patient is identified as exposed to a positive individual. This applies to all prison facilities and Reentry Centers. Testing will not be mandatory. Patients that decline testing will return to housing unit and will be encouraged to remain in their cell. See page 20.
- If an outbreak is identified in any high-risk area, strategies such as periodic mass testing and quarantine will be implemented. The testing schedule and duration of outbreak status will be similar to prior protocol versions.
- Outbreak status duration at any low-risk area will be maintained to 20 days from the time that the last known positive patient was removed from the area or completed recovery. See page 20.
- Bebtelovimab (monoclonal antibody) is no longer approved by the FDA as a COVID-19 treatment option.

Screening

1) **Patients presenting with symptoms in a Reentry Center (RC) or prior to Health Services contact in a prison**: Direct the patient to immediately don a surgical mask if not already wearing one, place them in an isolated area within the facility and contact the RC COVID19 Officer/designee (RC Duty Officer if after hours or on weekends) or Health Services respectively.
2) **Intakes arriving from a non-DOC facility**: These inter-system intakes arriving at DOC facilities from county jails, the community, and/or reentry centers will have a temperature taken and will be screened for COVID-19 symptoms immediately upon arrival. If any of the screening items are positive, the patient should immediately don a surgical mask if not already wearing one and be placed in an isolated area.
3) **Patients presenting with symptoms to Health Services:** Patients who arrive to health services areas, presenting with symptoms concerning for COVID-19 should immediately don a surgical mas*k* if not already wearing one and be placed in a holding area or in a room with no other patients while awaiting evaluation.
4) **Intra-system intakes (Patients transferring between DOC facilities):** All intra-system transfers should have a temperature taken prior to boarding and upon exiting the transport bus. If the patient has a temperature

greater than 100.4F (fever) and/or symptoms concerning for Influenza-Like Illness (ILI), per Influenza Protocol patient should immediately don a surgical mask if not already wearing one, be placed in an isolated area, and Health Services or IPN should be contacted for evaluation and testing. Only patients with a fever and/or symptoms for ILI cannot continue with transfer. Patients that are asymptomatic and decline testing can continue with transfer.

5) **Active screening of patients prior to entering Prison Health Services**: All patients entering Health Services areas for scheduled or unscheduled care will be screened for signs and symptoms of COVID-19 with questions and a temperature check. Patients screening positive will immediately don a surgical mask if not already wearing one and be placed in an isolated area for evaluation, according to the Health Services Evaluation section below.

Initial Evaluation

1) For instructions on proper donning and doffing of PPE see the following video and/or document (Spotter guide). For detailed guidance regarding appropriate PPE for each clinical situation, see the PPE matrix or the Infection Control and Prevention section of this document.
    a. If a health care provider is unable to be fit tested *but is medically cleared for a respirator*, they can use a PAPR *after proper training* instead of an N95 respirator (if there is not an established procedure for disinfecting PAPR hoods at facility, the used hood should be discarded after use).
2) Reentry Center staff escorting an individual who is symptomatic but is not yet tested should ask the individual to wait outside or 6 feet away until they put on appropriate PPE.
    a. If possible, escort the patient while maintaining 6 feet of distance to a room to be by themselves for medical isolation.
    b. Any surfaces touched during the escort should be disinfected, including doors.
    c. Once the resident is in medical isolation, RC staff should assess temperature, offer RAT, and then immediately notify the RC COVID19 Officer or Facility Lead and RC Duty Officer if after hours or on weekends. The RC COVID19 Officer/Facility Lead or RC Duty Officer will contact the RC Medical Consultant or if not available or after hours, the COVID19 Medical Duty Officer.
3) In prison, any health care provider making close contact with symptomatic patients referred from the screening section above should don personal protective equipment before the evaluation, including a fit-tested N95 mask, gloves, face shield, and gown. Given the COVID-19 status of a patient is unknown when responding to a medical emergency, PPE should be worn that assumes the patient may have COVID19 until the situation is further evaluated.
    a. Nurse performs a clinical assessment, including temperature check, and asks the following screening questions:
        i. Do you have a fever, new cough, shortness of breath, sore throat, diarrhea, or muscle aches that cannot be attributed to another cause (e.g. muscle aches if COVID-19 vaccination within the past 48 hours), or loss of taste/smell?
        ii. Did you have contact with someone with possible COVID-19 in the previous 10 days?
    b. If the answer to either screening questions is yes, or temperature is greater than 100.4F, notify a healthcare practitioner for further assessment:
        i. After RN assessment, the patient's medical record should be reviewed to identify any CDC designated high risk conditions. If a practitioner is available onsite, patients that have high-risk conditions or have concerning clinical symptoms should be assessed by the provider as soon as possible. Provider will decide whether presentation is compatible with COVID-19 disease or other influenza-like illness.
        ii. If no practitioner is onsite, the nurse will discuss the patient's case with the practitioner via telephone.

4) Medical record should be reviewed to identify if the patient has any CDC designated high risk conditions or uses any aerosol generating equipment (e.g. CPAP, BiPAP, nebulizer).

5) The practitioner will determine the following:

    a. Level of care based on acuity

        i. To emergency department for severely ill patients.

        ii. To a negative pressure room, if one is available, under airborne medical isolation precautions for any non-severely ill patient that requires IPU level care.

        iii. To a facility or community medical isolation unit for those with mild or moderate symptoms of influenza-like illness while awaiting test results.

6) All patients screening positive for symptoms or fever who are placed in medical isolation should be offered rapid antigen tested for COVID-19 and other respiratory viruses as described in the Testing Procedure section below.

7) For further guidance on clinical care of patients with COVID-19 see National Institutes of Health COVID-19 Treatment Guidelines, Choosing COVID-19 Specific Therapy, the DOC Use of Remdesivir protocol, Paxlovid (nirmatrelvir/ritonavir) Use in COVID-19, and Molnupiravir Use for COVID-19 which are available on the DOC Health Services Protocols and Guidelines webpage.

8) Any patients presenting to Health Services for evaluation of influenza-like illness will not be charged a co-pay per the Washington DOC Health Plan.

9) For questions or consultation regarding evaluation or management of patients with suspected or confirmed COVID-19 call the DOC COVID19 medical duty officer phone.

Case Reporting

1) Notification of isolated patients with known COVID-19 in prisons or RC should be sent by email to doccovid19cases@doc1.wa.gov and for RC also send to the RC Medical Consultant at docdlworkrelmedcons@DOC1.WA.GOV.

2) All positive COVID-19 test results for DOC residents in RC should be phoned to the Reentry Center's Medical Consultant and/or the DOC COVID19 medical duty officer phone after hours as needed.

3) Other notifications should occur as per the mapping guidelines.

4) The IPN or RC Medical Consultant or designee will report positive COVID19 cases to their local public health jurisdiction. If the patient was transferred to a second facility for medical isolation or care, the case should be reported to the local public health jurisdiction of the patient's original location. Do not use regular email to communicate health protected information with outside agencies. Personal identifying information may only be reported via an encrypted email (encrypt by putting [SECURE] at the beginning of the email subject line), fax or by phone.

5) The Facility COVID-19 Liaison and RC Medical Consultant will enter the information about the case of suspected/confirmed COVID-19 and the information about the exposed patients on the facility specific COVID-19 Isolation Workbook or similar document.

6) The COVID-19 Prison Facility Data Manager will assist the IPN in tracking facility COVID-19 data and reporting to the COVID-19 EOC.

    Patient rapid antigen test results will be reported to DOH per the section Testing Procedures #4 below. RC staff is responsible for reporting positive patients to ONC staff and DOH.

Infection Control and Prevention

Infection control and prevention principles:

1) Definitions:
   a) **Medical isolation**: Separating a symptomatic patient with a concern for a communicable disease from other patients. Medical isolation status also applies to asymptomatic patients testing positive for COVID-19.
   b) **Quarantine**: Separating asymptomatic patients who have been exposed to a communicable disease from other patients through close contact. Of note, quarantine status is only applicable to high-risk areas.

c) **Cohort**: Grouping patients infected with or exposed to the same agent. Isolated and quarantined patients should NOT cohort together. Cohorting helps minimize transmission outside the defined group, but it may not eliminate the need to quarantine individuals outside the group. Cohorting also does not eliminate the need for individuals within a cohort to socially distance if possible. Cohorting is not currently in use for any DOC area but is a tool that could be implemented if necessary.

2) The following recommendations should be made for prevention of COVID-19:
   a) When COVID-19 local county levels are low (green) **and** COVID-19 activity is minimal in the facility (no cluster or outbreak status), masking may not be required, refer to Routine Masking Guidance.
   b) If COVID19 community levels in the facility's county increase to medium (yellow) to high (red) or facility status changes to any outbreak status or Facility Wide Cluster, masking would be re-implemented per Routine Masking Guidance for patients and staff.
   c) Surgical masks and N95 respirators should be made available to patients at all times for voluntary use.
   d) Perform and encourage frequent hand hygiene.
   e) Cleaning supplies should be made available at all times for voluntary cell/high touch area cleaning.
      (1) Highly discourage the use of bleach as this can exacerbate conditions for those patients with underlying lung disease
   f) Maximize airflow and air filtration as possible.

3) Moderately to severely immunosuppressed individuals based on CDC criteria for a 3-dose COVID-19 vaccine series will be offered tixagevimab/cligavimab (Evusheld) per protocol, if available. Whenever possible, these individuals should not be housed in an open bay unit.
   a) Management of patients receiving outpatient hemodialysis on-site at Monroe Correctional Complex will be managed as follows:
      (1) Universal source control measures:
         (a) While in the MCC dialysis unit with patients not on quarantine or isolation, staff should wear a surgical mask, face shield, gown and gloves.
         (b) ALL patients should wear a surgical mask at all times while they are in the dialysis unit.
         (c) Patients who are not on isolation or quarantine status should never cohort with quarantine or isolation patients in the dialysis unit.
         (d) Clean and disinfect dialysis unit and machines after patient use per current protocols.
         (e) Screen patients at entry to the dialysis unit per current Washington DOC COVID-19 protocol, if positive at screening refer to sections 2 below as clinically appropriate.
         (f) Adequate supplies for hand sanitizing should be placed within reach of dialysis chairs for patient use.
         (g) Maintain 6 feet of distance between all patients regardless of COVID status at all times while in the dialysis unit.

(h) Patients should move to the dialysis unit in a manner that avoids all possible close contacts with each other and with other patients and staff in the MCC WSR Health Services and IPU area.

(2) COVID19 quarantine and isolation patients requiring dialysis:

(a) While in the dialysis unit with patients on quarantine or isolation status, staff should wear the following PPE at all times, and this PPE should be changed between patients after any close contact: Fit-tested N95 respirator, face shield, gown, and gloves.

(b) Quarantine and isolation patients should wear an N95 respirator while in the dialysis unit (fit testing is not required).

(c) Quarantine patients will be tested for COVID-19 using a rapid antigen test prior to each dialysis session before arriving to the dialysis unit.

(d) Quarantine patients can be cohorted together during dialysis sessions with strict physical distancing maintained and barrier dividers.

(e) Quarantine patients should not be cohorted with medical isolation patients in the dialysis unit.

(f) Isolation patients who have confirmed COVID-19 can be cohorted together during dialysis sessions with strict physical distancing maintained.

(g) If multiple groups of patients, based on their COVID status, require dialysis on the same day the groups should be scheduled in the following order from earliest to latest in the day:

(i) Patients not on COVID19 quarantine or isolation status.

(ii) Patients on quarantine status.

(iii) Patients on isolation status.

(3) Disinfection of the hemodialysis unit [SEE section on Environmental Cleaning below].

Infection Prevention and Control Categories:

Medical isolation:

1) Medical isolation status is indicated for patients in the following clinical situations:
   a) Patients identified as having an influenza-like illness (ILI) or other symptoms potentially caused by COVID-19, even if they have previously been diagnosed with COVID-19. See page 9 for details related to ILI and the influenza season.
   b) Asymptomatic patients who have tested positive for COVID-19.
2) As soon as staff become aware that a symptomatic patient is suspected or confirmed as a COVID-19 case, staff should direct the patient to put on a surgical mask if not already wearing one until the patient can be isolated in a cell/room.
3) Staff will don PPE per the PPE Matrix, then escort the patient/resident to area of isolation in a cell/room by themselves. Once the resident is in medical isolation, notify medical if they are identified outside the prison clinic.
4) Droplet precautions will be initiated and droplet precaution medical isolation signs will be hung outside the room at cell/room front.
5) All patients requiring medical isolation under this protocol who require ongoing use of aerosol generating medical treatments such as continuous positive airway pressure (CPAP), BiPAP, or nebulized bronchodilator treatment) should be housed in negative pressure isolation rooms, if available, until release criteria have been met as described in Clinical Management of Medical Isolation Patients #3b below. If a negative pressure isolation room is not available at the facility, consult the COVID19 Medical Duty Officer to discuss placement.

PPE for medical isolation:

1) Wear PPE in medical isolation as per the PPE Matrix.
2) All staff must wash hands with soap and water or with alcohol sanitizer after leaving a patient’s cell and removing gloves.

3) PPE <u>must</u> be changed between EVERY patient in medical isolation any time there is close contact except in the following situations:
    a) Units, tiers, or pods that have been identified as medical isolation where ALL patients have a confirmed positive result for COVID-19:
        i) It is not necessary to change eye protection, mask/respirator, and gown between each patient.
        ii) All PPE should be changed if visibly soiled.

Facility Management of Patients on Medical Isolation Status:

1) Custody will work with medical staff to determine the best location to house patients on medical isolation status.
    a) Separating patients with COVID-19 should be done at all facilities when operationally possible.
        i) For facilities that do not have the infrastructure or resources to operationalize isolation of patients in separate areas following CDC guidelines (stand-alone camps), the following mitigation strategies should be followed:
            (1) Move positive patients to a separate area within the available units that maximizes distance from the general population. If possible, house the patient with COVID-19 in a single room behind closed doors.
            (2) Deploy HEPA filters in the areas surrounding isolated patients.
            (3) Notify the general population of increased risk of COVID-19 transmission.
            (4) Promote surgical mask and N95 use.
            (5) Encourage all individuals to self-report any COVID-19 like illness.
            (6) Notify the general population of available testing and COVID-19 treatment options.
            (7) Encourage facilities to discuss with HQ Clinical Leadership for strategizing potential separate isolation space.
2) Patients with COVID-19 may be housed together so long as they do not have other communicable diseases concurrently (i.e. influenza or another viral respiratory disease).
3) If possible, avoid isolating patients with suspected or confirmed COVID-19 in cells with open bars.
4) If an isolated patient needs to be out of their cell, they will don a surgical mask during the necessary movement.
5) Staff will ensure that the patient goes where directed by communication between the sending and receiving area staff.
6) Any pill line medications will be delivered by medical or RC staff unless medical staff determines the need for a different protocol.
7) Meals will be provided by Food Services and delivered to the cell/room.
8) Phone use will be made available to isolated patients, separate from individuals who are not on isolation, per normal unit operations.
    a) Phones should be disinfected after use by those who are on isolation.
9) Basic hygiene, clean clothing, and showers will be made available to isolated patients, separate from individuals who are not on isolation, per normal unit operations.
    a) Showers should be disinfected between isolation patients, and those who are not on isolation, if using the same shower area.
10) Patients in medical isolation should have access to their personal property, regardless of the type of unit being used.
11) Television, playing cards, and/or other recreational activities will be provided.

12) Patients in RC will be issued a cell phone so that they can contact staff as needed without leaving their room. The phone number of the phone given to the resident should be sent to the RC COVID19 Medical Consultant so that staff can also contact the resident as needed.

Clinical management of medical isolation patients:

1) **Symptomatic** patients will have the following diagnostic workup:
   a) For Reentry Centers, patients will be offered a COVID-19 rapid antigen test (RAT) and/or be referred to their community healthcare provider.
   b) For all other prison facilities, all patients will be tested for COVID-19 initially by RAT.
      i) A confirmatory COVID-19 nasal PCR will be collected if RAT is positive outside of an outbreak situation, unless the patient previously had COVID-19 within the past 90 days.
      ii) When **not** during influenza season, if initial RAT is negative, patient is to return to living unit, and advised to self-isolate in the patient's cell. Masking, social distancing and hand washing should be encouraged.
         (1) If this scenario occurs during the influenza season, see below bullet item b).
      iii) If initial RAT is negative, a follow up clinical evaluation and COVID-19 RAT will be offered 48-72 hours from initial testing.
      iv) Reentry Centers will use Rapid Antigen Tests and not PCR testing unless indicated otherwise.
   c) **During influenza season** (October through the end of March):
      i) All **symptomatic** patients should have a COVID-19 RAT and rapid influenza testing done when first assessed. For RC patients, this should be discussed with community provider.
         (1) Clinical staff can use local community influenza levels (Washington State Surveillance Data) to assess whether influenza testing should be outside of specified months. See **Seasonal Influenza Protocol** for details.
      ii) If the initial COVID-19 test and rapid influenza test are negative, send a Respiratory Viral Panel (Interpath # 2910) that same day during the initial evaluation.
         (1) Rapid flu tests and RVPs should be offered to the first 3-4 symptomatic cases in a unit to confirm there is no additional virus besides COVID-19. After this, the RVP can be used less frequently.
      iii) **Only during influenza season**, symptomatic patients with Influenza Like Illness (ILI) that initially test negative to COVID-19 RAT and rapid influenza testing should isolate in their living cells until RVP result is negative (usually 48hrs). Refer to **Seasonal Influenza Protocol** for details.
         (1) If a symptomatic patient declines to test, consult with FMD and Clinical Leadership.
      iv) Influenza positive patients should isolate in a separate area (if possible), and exposed should isolated in their living cells/spaces. Refer to **Seasonal Influenza Protocol** for details.
   d) Depending on the clinical presentation of symptomatic patients and their risk factors, consider other diagnostic testing, i.e. Chest X-ray, CBC with differential, complete metabolic panel, D-dimer, etc. Consider blood cultures for cases concerning for community acquired pneumonia and/or sepsis.
2) COVID-19 positive patients in prisons who are asymptomatic, or experience mild-moderate symptoms will be evaluated once daily by nursing.
   a) Prison nursing will:
      i) Conduct assessment, including complete vital signs at the initial assessment.
      ii) Screen for COVID-19 symptoms, check temperature, and pulse oximetry daily thereafter.

iii) Assessment with vital signs, and consultation with available practitioner should occur if clinical concern develops.

3) COVID-19 positive patients who are clinically concerning or have severe COVID-19 in prisons will be evaluated once daily by a practitioner and receive a nursing assessment at least once per shift.
4) COVID-19 positive patients in Reentry Centers will be contacted by ONC staff instructed to notify staff and seek off-site care if necessary.
   i) Patients that test positive might be transferred to a DOH facility if available.
   ii) If RC staff notice patient is not doing well, consider calling 911 and notifying ONC staff or COVID19 medical duty officer as soon as possible.
5) Unless transfer to a setting for a higher level of medical care is required, all medical care should be delivered in the patient's medical isolation cell or room.
6) For patients testing negative for COVID-19 once and positive for influenza refer to the Seasonal Influenza Protocol for continued management.
7) For patients testing positive for both COVID-19 and influenza:
   a) The case should be discussed with the Facility Medical Director as well as the COVID19 medical duty officer/Infectious Disease consultant immediately for discussion on how to manage.
   b) For RCs, the patient was likely tested for influenza by the community provider and provider indications should be followed. RC Medical Consultant should be notified and the case should be discussed with the COVID19 medical duty officer/Infectious Disease consultant.
   c) The patient should remain in medical isolation according to COVID-19 isolation criteria.
   d) Antivirals for influenza should be used if clinically appropriate.
8) For further guidance on clinical care of patients with COVID-19 see National Institutes of Health COVID-19 Treatment Guidelines, Choosing COVID-19 Specific Therapy, the DOC Use of Remdesivir protocol, Paxlovid (nirmatrelvir/ritonavir) Use in COVID-19, and Molnupiravir Use for COVID-19 which are available on the DOC Health Services Protocols and Guidelines webpage. For questions or consultation regarding evaluation or management of patients with suspected or confirmed COVID-19 call the DOC COVID19 medical duty officer phone.
9) Refer to the Dental COVID19 protocol for instructions on available dental care during isolation.
10) Refer to the COVID-19 Mental Health/Psychiatry Response Guideline for guidance about mental health visits for patients on medical isolation.

Clearing patients from medical isolation:

a) **Asymptomatic or symptomatic immunocompetent** patients with COVID-19 will remain in medical isolation for 7 days from the COVID-19 test date and can be removed from isolation if they are clinically improving, have been afebrile, without fever reducing medication, for 72 hours and have **two** negative COVID-19 rapid antigen tests prior to clearance on days 6 and 7.
b) **Immunocompromised** patients with COVID-19 will remain in medical isolation for 20 days from the COVID-19 test date as long as they are clinically improving, have been afebrile, without fever reducing medication, for 72 hours and have **two** negative COVID-19 rapid antigen tests prior to clearance on days 20 and 21.
   i) If a patient who is considered clinically immunocompromised and has been asymptomatic since their COVID-19 positive test date, testing to discontinue isolation may begin at day 10.
      (1) If day 10 RAT is negative, may repeat RAT on day 11.
      (2) If day 11 RAT is negative, isolation may be discontinued.
      (3) If either the day 10, or day 11 RAT is positive, consult with COVID-19 Clinical Leadership for further direction.

Quarantine:

Quarantine status will now be implemented **only** in high-risk units: all IPUs, MCC-WSR and CRCC-SAGE. The rest of DOC areas and facilities, including Reentry Centers, will no longer implement quarantine status as a COVID-19 strategy. Patients in these high-risk areas who are asymptomatic but have been exposed to confirmed or suspected COVID-19 patients should be placed on quarantine status. If a unit goes on outbreak status, follow the section Outbreak Testing and Management below regarding who and how to quarantine.

PPE for staff interacting with quarantined patients:

1) Whenever possible, staff should avoid close contact with patients in quarantine and maintain social distance.
2) Wear proper PPE based on quarantine status according to the PPE Matrix.

Facility Management of Patients on Quarantine Status:

3) When a COVID-19 positive patient is identified inside these high-risk units, close contacts within the high-risk areas will be placed on quarantine.
    a) For SAGE, exposed patients that are on quarantine should be separated from the rest of the population as operationally possible. Housing challenges and any additional mitigation strategies should be discussed in consultation with COVID19 Clinical Leadership.
    b) IPU exposed patients should remain in an individual IPU room with appropriate signage and testing per protocol. Additional mitigation strategies should be discussed with COVID19 Clinical Leadership , such as HEPA filters, etc.
4) If possible, avoid quarantining patients in areas with open bar cells.
5) If the patient develops symptoms or fever while on quarantine:
    a) Nursing will perform a full assessment upon entering the cell in appropriate PPE for symptomatic patients with suspected COVID-19.
    b) The patient should be offered testing and moved to an individual cell in medical isolation as appropriate.
6) Patients in quarantine should don a surgical mask anytime they leave their cell.
7) Any pill line medications will be delivered to the quarantined patient by medical staff.
8) If staffing or other operations interferes with cell front delivery of medications, alternative measures may be discussed in consultation with COVID19 Clinical Leadership
9) A trash bin and bag, hand sanitizer, and gloves should be available immediately outside the cell/room or unit/house to assist staff in proper doffing of PPE.
10) Unless transfer to a setting for a higher level of medical care is required, all medical care should be delivered in the patient's quarantine cell in prison or at the appropriate Medical or Dental clinic in the facility.
11) Patients in quarantine:
    a) Should have access to the medical clinic during a dedicated time after which the waiting room is empty for a 30 minute period and then disinfected.
    b) See the updated Dental COVID19 protocol for details regarding dental care options for quarantined patients.
12) Signage indicating that the quarantine areas are under airborne precautions will be hung at the cell/room, unit, or tier level.

Clinical Management of Patients on Quarantine Status for High-Risk Areas*:*

1) Asymptomatic patients are placed on quarantine status after being identified as exposed to a confirmed COVID-19 case.
2) Patients who previously tested positive for COVID-19 within the past 30 days regardless of COVID-19 vaccine status do not need to quarantine. For these patients, rapid antigen testing replaces PCR testing day 30 until day 90.
3) All patients placed into quarantine status who are close contacts of a COVID-19 positive patient will be offered a RAT and PCR test for COVID-19 within one business day of the known exposure or knowledge of exposure unless the patient declines.
   a) Patients testing negative for COVID-19 will remain on quarantine status. They will be retested for COVID-19 by PCR (or RAT if applicable) on day 7 from initial exposure date.
      i) Patients testing negative for COVID-19 will remain on quarantine status until 10 days from the time of last contact with the index case has elapsed and will be tested by rapid antigen prior to clearance from quarantine on day 10.
   b) Patients who test positive for COVID-19 or become symptomatic will be transferred to medical isolation.
   c) If a quarantined patient is unable to be tested (for example if testing is declined), the patient should be quarantined for 20 days from date of contact with index case (this is based on the maximum period of time during which an individual remains at risk for developing COVID-19 infection.)
4) Close contacts of symptomatic isolated patients who test negative for COVID-19 may only be released from quarantine if the associated symptomatic patient tests negative for COVID-19 on two tests at least 48 hours apart.
5) Patients in quarantine will be checked on once daily.
   a) Prison nursing will:
      i) Conduct assessment, including a temperature check, oxygen saturation, and monitoring for development of any symptoms at a minimum. Disinfect all equipment, including oxygen saturation monitor, between patients.
      ii) If the symptomatic patient lived in dormitory-style housing (like SAGE), consider quarantining an entire dorm or wing of a housing unit.
      iii) Quarantine checks should be documented on 13-583 Influenza-Like Illness Assessment Flow Sheet.
6) Refer to the COVID-19 Mental Health/Psychiatry Response Guideline for guidance about mental health visits for patients on quarantine.
7) When a quarantined patient develops symptoms or tests positive for COVID-19 and is placed into medical isolation, the quarantine period for the rest of their cohort and other cohorts that share common spaces will be reset to day 0.
8) All patients in quarantine who require ongoing use of aerosol generating medical treatments such as continuous positive airway pressure (CPAP or BiPAP) or nebulized bronchodilator treatment should be housed in negative pressure isolation rooms, if available, until the quarantine period is completed. If a negative pressure isolation room is not available, notify the Facility Medical Director, CMO, deputy CMO, COVID19 Medical Duty Officer or the RC Medical Consultant to discuss placement.
9) Removal from quarantine status requires review by Infection Prevention Nurse or designee or Reentry Center Medical Consultant or designee in prisons and work RC respectively.

Routine Pre-procedure COVID-19 Testing:

1) Health care providers may require routine COVID-19 testing of asymptomatic patients prior to surgical, dental, or other aerosolizing procedures.
   a) Patients may be housed in their usual housing units without special quarantine or medical isolation procedures while awaiting test results.
   b) Staff interacting with these patients may do so without additional PPE other than a **routine surgical mask.**
   c) Test the patient with a COVID-19 rapid antigen test within 24 hours of the planned procedure as described in the Testing Procedure section below, including test result documentation and reporting.
   d) Refer to the COVID-19 Dental Services Protocol for details around on-site dental procedures.
   e) For patients testing positive with the rapid antigen test, refer to isolation section.
      i) Notify the onsite or offsite consultant or their office staff that the patient tested positive and reschedule procedure after isolation is completed.
   f) For patients testing negative with rapid antigen test:
      i) The patient is considered COVID-19 negative and can proceed with the planned procedure.
   g) For on-site pulmonary function testing (PFTs) or nebulizer treatments in the outpatient clinic:
      i) Conduct pre-procedure rapid antigen testing as above.
      ii) Staff should don proper PPE for an aerosolizing procedure if remaining in the room with the patient, including an N95 respirator, eye protection, gown, and gloves.
      iii) Perform testing/treatment in a room with a free-standing HEPA filter adequate for the room size.
2) Patients in RC can be tested on site or can arrange COVID-19 rapid antigen testing in the community on their own at any of the available testing sites with the help of their community provider.
3) If rapid antigen testing is not available or unacceptable to the community provider, standard COVID-19 PCR testing can be done on-site 48-72 hours prior to the procedure in order to get the results back in time.

Inter-system and Intra-system Testing:

Inter-system transfer testing includes individuals admitted to DOC from County Jails, returning from Reentry Centers, or the community that require COVID-19 testing to reduce the potential risk of COVID-19 spread.

Intake Testing for Prisons:

1) Within 24 hours of arrival, all individuals admitted to prisons will be offered testing for COVID-19 by RAT.
   a) If initial RAT testing at intake is positive, please refer to isolation section.
   b) If initial RAT testing at intake is negative, patient may be housed where appropriate for custody level/needs as determined by Prisons.
   c) If initial RAT testing at intake is declined, patient may be housed where appropriate for custody level/needs as determined by Prisons.
2) If the patient is already on isolation at intake, the individual should immediately be housed in medical isolation area and complete duration from date of positive test per outside test result communication.
3) If a patient arriving to prisons from county jails, reentry centers, or the community must be housed in a unit identified as high risk (IPUs, CRCC-Sage East, MCC-WSR A), intake separation strategy should be implemented, unless the patient has had COVID-19 in the past 30 days, in accordance with the Protective Separation Section bullet #4 below.

Transfer Testing for Prisons and Reentry Centers:

1) Intra-system transfers apply to all transfers in between DOC facilities, including prisons, stand-alone camps, and admissions to Reentry Centers:
   a) All patients scheduled for transfer will be offered testing with RAT only 24-48hrs prior to transfer.
      i) If pre-transfer RAT test is positive, please refer to isolation section.
      ii) If pre-transfer RAT test is negative, patient may transfer without restrictions.
      iii) If pre-transfer RAT test is declined, patient may transfer without restrictions.
         (1) Pre-transfer testing is not mandatory but should be strongly encouraged.
         (2) If patient is symptomatic or has a fever (>100.4F), transfer should be re-scheduled.
   b) For patients transferring to areas identified as high-risk (IPUs and CRCC-SAGE East only), refer to Protective Separation Section below.

High-Risk Areas

1) **High-Risk Areas:** Housing units with a high concentration of individuals at high risk for severe COVID-19 may be placed on protective separation status in order to reduce the risk of introduction and transmission of COVID-19. This includes stricter strategies and a separate outbreak definition for these areas.
   a) At the current time, the following units are on protective separation status:
      i) CRCC-Sage East.
      ii) MCC-WSR A.
      iii) All DOC facility inpatient units (IPUs).
   b) **Limited Area Outbreak**
      i) Two or more confirmed cases of COVID-19 in incarcerated individuals occurring within 14 days who reside in the same living area OR
      ii) One or more confirmed cases of COVID-19 in incarcerated individuals AND one or more confirmed cases of COVID-19 in staff or volunteers working in proximity to the incarcerated individual case/cases occurring within 14 days.

2) **Special direction to staff working on protective separation units:**
   a) Only necessary and assigned staff should have access to this unit.
   b) Staff must wash hands before entering and exiting the unit.
   c) Staff will wear surgical masks at all times while working in IPUs (healthcare building) and CRCC-Sage East despite community and facility COVID-19 levels.
   d) No staff interacting with quarantined and isolated individuals should be entering these units during their assigned shift.
   e) When not interacting with patients, staff will maintain 6 feet of distance from other staff as possible.
   f) Staff working in SAGE will be rapid tested every shift, prior to entering the unit/tier. Staff who have previously tested positive for COVID-19 within the past 30 days do not need to test daily.

3) **Special direction to incarcerated individuals living on protective separation units:**
   a) Individuals are restricted to interacting with others only from within their living unit if possible.
   b) Patients are encouraged to wear a surgical mask at all times when outside of their cell/room.
   c) Patients are encouraged to eat meals in their rooms if safe to do so.
   d) Individuals shall be given pill line at their cells or at a unique time away from others in the facility.
   e) Individuals should be allowed to go outside with just their living unit.
   f) Porters should be from the unit in protective isolation when possible and may not be from a unit with known active cases.

i) If porters are not from the protective living unit they are working in, they will undergo daily COVID-19 RAT testing prior to attending work.

4) **Testing of incarcerated individuals transferring into protective separation units:**
   a) Patients transferring into protective separation units will be offered the COVID-19 vaccine prior to transfer, if possible, or upon arrival in the unit, if the vaccine series, including booster dose, was not already completed.
   b) **For Sage East only**, prior to transfer into the unit, patients will have:
      i) Two negative COVID-19 test results and a negative viral respiratory panel (no rapid influenza test is necessary). The second COVID test should be collected with the viral respiratory panel 7 days after the first COVID test.
      ii) The transfer should occur as soon as possible after the second test results are received and within 1 week of testing.
      iii) Incarcerated individuals should be screened the day of transfer utilizing the screening questions and temperature checks per protocol for intra-system transfers.
   c) Patients transferring into facility **inpatient units (IPUs)** from another or elsewhere in the same facility:
      i) Do not require testing PRIOR to transfer to the IPU. If a patient is requiring IPU transfer, care should not be delayed by obtaining a COVID19 RAT prior to transfer.
      ii) Patients should be screened the day of transfer utilizing the screening questions and temperature checks per protocol for intra-system transfers.
      iii) Upon arrival in the IPU, place transferring inpatients into single rooms, whenever possible.
      iv) After arrival, collect COVID-19 RAT twice, on day 0 and day 5 of admission to IPU.
      v) Patients should not intermix, have access to inpatient unit day rooms, or be roomed together until they have had two negative COVID test results and a negative viral respiratory panel.
      vi) Patients on isolation or quarantine for COVID-19 should be placed in a negative pressure room when housed in an IPU. If no negative pressure room is available, consult with COVID-19 Clinical Leadership.
      vii) Patients returning to the IPU from a community hospital after **at least** an overnight stay, will be placed into intake separation upon return. **Intake separation is not necessary if they return directly to general population or if it is an emergency room visit that does not include an overnight stay.**

PPE Requirements for Prison and Reentry Center Staff:

Contact with asymptomatic individuals who are not on medical isolation or quarantine:

1. Follow standard universal precautions
2. Wear PPE when in contact with individuals on medical isolation, and quarantine as per the PPE Matrix
3. A PAPR may be substituted for an N95 mask and eye protection according to the PAPR protocol and PAPR Training PowerPoint.
   i) Refer to the PAPR Spotter Guide on how to properly don & doff
   ii) PAPR use is not amenable to dental procedures
4. If a breathalyzer screening is necessary on a person without COVID-19 symptoms, in addition to a protective barrier, don proper PPE per the PPE matrix, and have the person face away from any staff when performing the test. Disinfect the breathalyzer machine after use.
5. Prior to working or entering an area that requires an N95 respirator per the PPE matrix, staff must be medically cleared and fit tested for the brand of N95 being used.

Environmental Cleaning

1) Enhanced frequency of cleaning and disinfection procedures of high touch surfaces is recommended during the COVID-19 pandemic in prisons and work releases.
2) Disinfectant must be EPA approved for COVID-19.
   a) All DOC approved disinfectants are adequate for COVID-19.
   b) Follow manufacturer instructions regarding contact time necessary for the disinfectant to work. Most quaternary ammonium compounds require 10 minutes of contact time, including the Pink Correct Pac solution.
   c) Routine use of bleach for general cleaning is discouraged due to irritating fumes and the potential for toxic gas if combined with other disinfectants.
3) Management of laundry:
   a) Laundry from medical isolation or quarantine patients and cells will be placed in rice bags and transported in yellow bags.
   b) In work release, the resident will notify staff by phone when they place their laundry outside their door. Staff will do the laundry for residents on medical isolation or quarantine at least weekly.
   c) Contents should be treated as infectious laundry and placed into the washing machine set on hot water in the rice bag. Once out of the washing machine, it is no longer considered an infectious risk.
   d) Laundry from patients on isolation and quarantine does not have to be washed separately from others.
4) Food service management:
   a) Meals for isolated and quarantined patients should be served in disposable clamshells. If trays are used, staff should wear **gloves** and wash hands before and after handling. If picking up the food trays requires entering a quarantine or medical isolation area, follow the PPE Matrix.
   b) In work release, the meal should be left on a chair or table outside each resident's room and the resident should be notified that it is there.
5) Whenever possible, for isolation or quarantine settings, porters should only be assigned duties within the area where they live.
   a) Porters working in areas they do not live in, that require N95 respirator per the PPE matrix, should also be medically cleared and fit tested for the brand of N95 being used. This process should be conducted by the IPN team and local provider.
6) Any individuals involved in cleaning rooms occupied by isolated suspected or confirmed COVID-19 cases, including DOC staff and employed incarcerated individuals, should wear PPE as per the PPE Matrix. Cleaning of a room after someone with COVID-19 has been removed should be delayed for as long as possible.
7) Rooms occupied by quarantined patients, who are moved prior to the completion of the 14-day period, should be similarly cleaned only by individuals wearing PPE as per the PPE matrix.
8) Whenever possible, porters should live in the areas they are responsible for cleaning.
9) Disinfection of on-site hemodialysis unit at Monroe Correctional Complex before and after each group dialysis session
   a) Cleaning and disinfecting should be performed with no patients present in the unit.
   b) After each dialysis session no staff or porters should enter the unit for 1 hour, at which time the unit can be entered for disinfecting.
   c) Staff and porters entering the unit for cleaning should wear the following PPE: Gown, gloves, eye protection, and surgical mask.
   d) The dialysis unit should be cleaned and disinfected on the day of the dialysis session. If there are multiple sessions per day the unit should be cleaned and disinfected prior to each session that day.

e) All surfaces, equipment, and supplies within 6 feet of the patient should be disinfected or discarded
   i) This includes walls, floor, cabinets, desks, countertops, and any other items within 6 feet of the dialysis station
   ii) Licensed dialysis unit staff are responsible for cleaning and disinfecting the dialysis station
   iii) Dialysis unit porters are responsible for cleaning and disinfecting the environment around the dialysis station as described in i) above
   iv) Disposable medical supplies near the hemodialysis station should be discarded.

f) All staff and porters should be educated, trained, and have competency assessed for these cleaning and disinfecting procedures

Outbreak and Cluster Testing and Management

This guidance describes management of COVID clusters and outbreaks in DOC facilities, including recommendations for mass testing and safe unit operation. Please refer to the Prison Division Cluster & Outbreak Checklist or Reentry Center Cluster and Outbreak Checklist for additional operational details.

1) **Cluster definition**: A group of confirmed cases of COVID-19 that only involves staff and/or volunteers.
   a. Limited Area Cluster
      i. Four or more confirmed cases of COVID-19 in staff and/or volunteers occurring within 10 days who work in the same living unit or work area without known community exposure to explain their infection.

   b. Facility Wide Cluster
      i. 20 or more confirmed cases of COVID-19 in a main facility, 6 or more confirmed cases of COVID-19 in a camp (free-standing or co-located minimum security unit), or 4 or more confirmed cases of COVID-19 in a reentry center within 10 days among staff and/or volunteers across a facility regardless of their position or post OR
      ii. 12 or more confirmed cases of COVID-19 in a main facility or 4 or more confirmed cases of COVID-19 in a camp (free-standing or co-located minimum security unit) within 10 days among staff and/or volunteers within a facility that have direct contact with the incarcerated population.

   c. ONC team and facility COVID19 liaisons will determine when a facility meets the definition of a cluster.

2) **Outbreak definition**: A group of confirmed cases of COVID-19 that includes incarcerated individuals. The following definitions are for low-risk areas only. **For the outbreak definition used for high-risk areas (IPUs, MCC-WSR A, CRCC-Sage East), refer to High-Risk Areas Section above (page 14).** The outbreak definitions used for all other areas, including RCs, are:
   a. Limited Area Outbreak
      i. Four or more confirmed cases of COVID-19 in incarcerated individuals occurring within 14 days who reside in the same living area, including reentry centers

   b. Facility Wide Outbreak
      i. Two or more Limited Area Outbreaks that are connected, occurring simultaneously in the same facility. In a reentry center, 4 or more confirmed cases of COVID-19 in a reentry center within 14 days

   c. Incarcerated individual COVID-19 cases occurring in intake separation areas (e.g. IPUs) will not be included in (a) above.

   d. Discussion between COVID-19 Prisons liaison, HS liaison and COVID-19 Clinical Leadership may be necessary to determine if cases on transfer separation will be attributed to the sending or receiving facility.

   e. If an outbreak occurs in a prison or reentry center, the respective prison and reentry outbreak checklists should be followed.

3) If two or more symptomatic patients test positive for influenza please refer to the Seasonal Influenza Protocol for ongoing management.
   - **a.** If overlapping COVID-19 and influenza outbreaks occur in the same living area contact COVID-19 medical duty officer or Infectious Diseases Consultant.

4) **Contact tracing, mapping, quarantine:**
   - **a.** Notify the Occupational Health Medical Director or designee if cluster definition has been reached after staff and/or volunteers in a facility tested positive from the same work area or living unit within 10 days of each other.
   - **b.** Once a cluster or outbreak of COVID-19 has been identified, contact tracing of suspected and confirmed COVID cases will be conducted in order to identify ("map") close contacts and determine a next recommendation.
     - i. In a prison, mapping and tracing is done by the Infection Prevention Nurse (IPN), in cooperation with the Occupational Nurse Consultant (ONC) and the facility mapping team, if staff cases are involved.
     - ii. In a Reentry Center, on site mapping and tracing is done by the RC Medical Consultant or COVID-19 Medical Duty Officer, in cooperation with the RC COVID Officer. Local Public Health maps staff and resident contacts in the community.
   - **c.** Patients who require testing to be offered related to close contact will be determined on a case-by-case basis considering environmental, clinical, and operational aspects of the scenario in coordination with the Infection Prevention Nurse, RC Medical Consultant and/or Occupational Health Medical Director.
   - **d.** When contact tracing is complete the identified individuals and living areas will be placed on quarantine as indicated if applicable, such as in high-risk areas.
   - **e.** Patients testing positive for COVID19 will be moved to medical isolation or an IPU based on level of medical care needed. Patients in Reentry Centers may isolate in a single room if available, based on recommendations of the RC Medical Consultant.
   - **f.** Testing of affected DOC staff will occur in accordance with Cluster testing protocol and COVID-19 checklist. Staff will be tested using a rapid antigen test unless stated otherwise.
   - **g.** Testing of the population for COVID-19 during an outbreak will be done in the room/cell of each individual.
   - **h.** Patients in quarantined high-risk areas will have symptom screening and temperature checks at least once daily and will be moved to medical isolation areas if they screen positive or become symptomatic.
   - **i.** When symptomatic or COVID-19 positive patients are moved to medical isolation from a quarantined unit, the remaining cohort or cohorts with shared living areas who were potentially exposed to the individual will have its quarantine period reset to day 0.
   - **j.** Asymptomatic residents in a RC may continue to go to work and other necessary point to point destinations during a COVID-19 facility outbreak as long as they have no reported symptoms.

5) **Unit operation and cohorting:**
   - **a.** After a cluster is identified, movement of the population will not be affected.
   - **b.** Outbreak status will no longer trigger quarantine or mass testing in the unit, **except** for high-risk areas.
   - **c.** Outbreak status is to inform of higher risk of COVID-19 transmission to the unit population and staff, so that individuals can take appropriate measures to decrease risk of infection.
   - **d.** Outbreak status signage will be posted at the unit entrance so that staff and patients are aware of higher risk of COVID-19.
   - **e.** Outbreak status will no longer affect or prevent work, transfers, programming, recreation, religious services, visitation, access to dental, mental or medical care.
   - **f.** Incarcerated individuals in high-risk living areas on quarantine during an outbreak situation will be placed into distinct contact cohorts at the beginning of the quarantine period if necessary or recommended by COVID19 liaisons or Clinical Leadership.

g. Essential workers should be able to continue to work in their positions unless they develop symptoms and subsequently test positive, requiring isolation.
    i. If symptomatic essential workers are unable to be tested (or decline testing), they should not attend to work until symptoms are resolved.

h. For high-risk areas, cohorting might still be necessary as a transmission mitigation strategy, and COVID-19 liaisons should discuss with COVID-19 Clinical Leadership if needed.

6) Population testing and Cluster/Outbreak resolution:

a. During a COVID-19 Limited Area Cluster status, no mass serial testing in the affected area is required, **except** in high-risk areas (IPUs, MCC-WSR A, CRCC-Sage East).

b. High-risk areas that have met outbreak definition (see High Risk Areas section for definition) will be transitioned to outbreak operations and placed on quarantine.

c. Testing the patient population for COVID19 will only occur if patients are symptomatic, upon patient request, or if patient is identified as exposed to a positive individual. This applies to all prison facilities and Reentry Centers.
    i. Testing will not be mandatory. Patients that decline testing will return to housing unit and encouraged to remain in their cell.
    ii. In the case of Reentry Centers, patient that decline testing or have been exposed should be encouraged to remain in their room. No mandatory quarantine is recommended.
    iii. The rest of residents should be informed of an increased risk of COVID19 exposure.

d. Once an outbreak is identified in a high-risk area, the following testing will occur:
    i. Test entire unit with both COVID-19 RAT and PCR testing within 24hrs of status change. No need to test recently diagnosed positive patients.
    ii. Second round of testing will occur by RAT and PCR on the 3rd or 4th day since status change.
    iii. Third round of testing will occur by RAT on the 7th day since status change.
    iv. Subsequent testing will occur by RAT and will take place every 4-7 days serially until outbreak is resolved, depending on the clinical situation and in coordination with Clinical Leadership.
    v. Enhanced testing measures may be indicated as determined by Covid-19 Clinical Leadership and Facility COVID-19 Liaisons.
    vi. Once serial testing results show that all patients in the high-risk area have two consecutive negative tests on days 5-7 and 10-14 since last positive test AND they have been on quarantine status at least 10 days since last known positive case was removed, the area can be removed from quarantine.
        - If patients from high-risk areas decline testing, then outbreak status will remain for 20 days after the last positive patient has been removed from the unit.
        - If a patient refuses to move to isolation, next steps should be discussed in consultation with COVID-19 Clinical Leadership and Facility COVID-19 liaisons.

e. For **low-risk areas**, outbreak status will be maintained for 20 days from the time that the last known positive patient was removed from the area.
    i. If a patient who tests positive for COVID-19 refuses to move to isolation, this 20 day count would start once the patient is considered recovered in consultation with Facility COVID-19 Liaisons.

f. Prior to moving patients into a quarantined high-risk area in a prison during an outbreak situation, discuss with COVID-19 Clinical Leadership and Facility COVID-19 liaisons.

Release/Transfer of Patients into the Community or Non-DOC Facilities

a) For any patient who had a positive COVID-19 test in medical isolation who is releasing from a DOC facility and is 5 days or less from symptom onset or COVID-19 test date:

i) If the patient is releasing to a private residence the patient and their family member/sponsor will be educated by the IPN, release nurse or designee, on isolation precautions to use while in their home and informed that these precautions should be maintained until the completion of day 5 from date of positive test.

ii) If the patient is releasing to a congregate housing setting (e.g., on a voucher, transitional housing, half-way house, etc.), the IPN, release nurse or designee, will contact the congregate housing staff, inform them of the status of the patient, and inquire about the house's ability to maintain the patient's isolation until completion of day 5.

(1) If the congregate housing setting can maintain the patient's isolation, prior to release, the patient will be educated by the IPN on isolation precautions to use while in their new residence and informed that these precautions should be maintained until the completion of day 5 from date of positive test.

(2) If the congregate housing setting is unable to maintain the patient's isolation, the IPN should contact DOH, the patient's counselor, and/or records to explore alternative housing options.

(3) A patient requiring isolation housing should not be released until a clear housing plan is in place.

(4) An instructional brochure will be given to every patient releasing from medical isolation in English or Spanish.

b) If the patient had a positive COVID-19 test and remains in medical isolation at the facility after 5 days of isolation, and they had severe illness (e.g. hospitalized or required remdesivir) or are significantly immunosuppressed, the patient should be offered a COVID-19 rapid antigen test within 24 hours of release.

(1) If the COVID-19 rapid antigen test is negative the patient may release as planned without restrictions.

ii) If the COVID-19 rapid antigen test is positive, the patient will be considered a positive and will release in medical isolation as outlined above.

c) If the patient has suspected COVID-19 due to symptoms, the patient should be offered a COVID-19 rapid antigen test within 24 hours of release.

i) If the COVID-19 rapid antigen test is negative the patient may release as planned without restrictions.

(1) The patient should be encouraged to seek out COVID-19 testing in the community 48-72 hours after release.

ii) If the COVID-19 rapid antigen test is positive, the patient will be considered a positive and will release in medical isolation as outlined above.

Transportation of Patients with Suspected or Confirmed COVID-19 Disease

1) This section refers to transportation of patients under Washington DOC jurisdiction to or between DOC facilities who are confirmed or suspected (by a licensed medical provider) to have COVID-19 disease. This includes those with community custody violations, reentry center/GRE returns, and patients currently housed in DOC facilities.

2) Masking for all transportation of incarcerated individuals will be required during the transport for staff and patients, per Routine Masking Guidance.

3) No patient with confirmed COVID-19 disease will be transported between DOC facilities without approval of the Facility Medical Director in consultation with the COVID-19 Medical Duty Officer.

4) For any patients with confirmed or suspected COVID-19 being transported into or between facilities, custody officers, community custody officers, or other DOC staff in close contact with the patient will don PPE per the PPE Matrix.

5) If unable to wear a disposable gown because it limits access to duty belt and gear, duty belt and gear must be disinfected after contact with individual.

6) Transport of more than one patient at a time from medical isolation or quarantine from high-risk areas will be reviewed with the Infection Prevention Nurse at the facility, RC Medical Consultant, or COVID-19 EOC.

7) A symptomatic patient will not be transported with other patients without discussion with the DOC Nurse Desk, COVID Medical Duty Officer, RC Medical Consultant, or the facility Infection Prevention Nurse depending on the scenario and location of the transport.

8) Transport vehicles will be disinfected after transportation of a patient with confirmed or suspected COVID-19.

Contact Tracing

1) Cases of COVID-19 in Prison will be thoroughly investigated by the IPN with assistance as needed from the facility mapping team to identify additional contacts within the facility for the IPN to further investigate:

    a) Review the patient's cell and living unit location, job, classes, etc. to determine who could have been exposed and should be offered testing or requires quarantine in areas identified as high-risk (IPUs, CRCC-Sage East, MCC-WSR A).

    b) If in the course of the contact tracing it is apparent that DOC staff may have had close contact with a COVID-19 case, identified staff should be directed to report their contact to the facility's testing team and Occupational Health so that the necessary rapid antigen testing can be initiated.

2) Cases of COVID-19 among residents in RC will be thoroughly investigated within the facility by the RC Medical Consultant with assistance as needed from the RC COVID Officer.

    a) Staff close contacts will be reported to Occupational Health, who will determine the necessary testing for staff who were identified as a close contact in a reentry center.

3) In areas identified as high-risk (IPUs, CRCC-Sage East, MCC-WSR A), the decision on what patients to quarantine will be made by the IPN in consultation with COVID-19 Clinical Leadership and facility COVID-19 Liaisons.

4) A close, or high-risk, contact with potential COVID-19 cases will be defined as follows for the purpose of this guideline:

    a) Close contact is defined as being within 6 feet of someone with suspected or confirmed COVID-19 for a cumulative total of *15* minutes within a twenty-four hour period, starting 2 days prior to symptom onset or test date.

    b) Having unprotected direct contact with infectious secretions or excretions of the patient (e.g., being coughed on, touching used tissues with a bare hand).

    c) Contact not considered close or high risk include briefly entering the patient room without having direct contact with the patient or their secretions/excretions, or a brief conversation with a patient who was wearing a facemask.

    d) Mitigating and exacerbating factors should be considered in determination of contact risk. For example, a suspected or confirmed COVID-19 case will be more likely to transmit disease if they are generating respiratory aerosols through actively coughing, singing, or shouting during the contact, and less likely if they are wearing a facemask. Other factors to consider include presence of any symptoms, proximity, duration of exposure, environmental factors (indoor/outdoor, ventilation in the area).

    e) Facility COVID-19 Liaisons should refer to their respective checklists for guidance on where to make notifications for any new cases of COVID-19 and/or new areas that meet Cluster or Outbreak criteria.

        i) Prisons COVID-19 Checklist

        ii) Reentry COVID-19 Checklist

        iii) Clinical COVID-19 Checklist

Testing Procedures

1.) Staff will be tested using Rapid Antigen Tests only, unless specified otherwise.

2.) When COVID-19 local county levels are low (green) and COVID-19 activity is minimal at the individual facility (not on any outbreak status or Facility Wide Cluster status), staff serial testing can be suspended or "warm closed".

3.) When COVID-19 community levels in the facility's county increase to medium/high or facility status changes to any outbreak status or Facility Wide Cluster, facilities are expected to restart the above staff serial testing procedures 24-48 hours from change in status.

   i) Each facility will be responsible for designating "ready staff" and have plans in place to effectively re-instate these measures when indicated.

   ii) Each facility will be responsible for designating the individual(s) in charge of monitoring COVID19 community levels in their county and notifying HQ and COVID19 Clinical Leadership on change in status.

4.) While testing patient population in high-risk areas who are on quarantine with PCR tests, if a PCR test results as inconclusive in a facility that is on any outbreak status, upon receipt of inconclusive test staff will obtain a RAT and a repeat PCR. If RAT is negative, the patient may remain in the current quarantine location while the repeat PCR is being processed. If the facility is not on outbreak status, then patients with inconclusive PCR tests should be placed in isolation if indicated.

5.) For influenza rapid point of care testing, follow test manufacturer testing instructions.

6.) For viral respiratory panel, follow Interpath lab testing instructions for test number 2910.

7.) Please refer to the PPE Matrix for appropriate PPE to wear when collecting COVID-19 test samples.

8.) Polymerase chain reaction (PCR) testing for COVID-19

a. PCR is a molecular test that detects virus genetic material and is used in all cases that testing is required by this protocol unless other testing methods are specifically mentioned.

b. Upper respiratory samples appropriate for COVID-19 PCR testing can include any of the following nasopharyngeal, mid-turbinate, and anterior nasal swabs. Patient collected nasal anterior and mid-turbinate samples are preferred. All sampling techniques require synthetic tipped swabs, such as dacron, nylon, or polyester, without wooden handles:

   i. Nasal mid-turbinate swab:

      1. Nasal mid-turbinate swab can be clinician or patient collected.
      2. Use a flocked tapered swab. Tilt patient's head back 70 degrees. While gently rotating the swab, insert swab less than one inch (about 2 cm) into nostril (until resistance is met at turbinate). Rotate the swab several times against nasal wall and repeat in other nostril using the same swab.

   ii. Anterior nares specimen swab:

      1. Anterior nares specimen swab can be clinician or patient collected.

      (2) Using a flocked or spun polyester swab, insert the swab at least 1 cm (0.5 inch) inside the nares and firmly sample the nasal membrane by rotating the swab and leaving in place for 10 to 15 seconds. Sample both nares with same swab.

c. There are currently three laboratory options for COVID-19 testing:

   i. **Interpath Laboratory**:

      1. Testing through Interpath does not require specialized supplies for packaging and shipping as samples are picked up through the established Interpath lab courier.

2. Collect COVID-19 specimen per Interpath Laboratories test collection guidance.

ii. **Northwest Pathology or Atlas Genomics Lab**:

1. Enter the Northwest Pathology/Atlas Genomics online portal, TestDirectly, to enter a testing order.
   a. Health Services staff must have pre-authorization to access this site. Contact Docdlcovid19testing@doc1.wa.gov to request site access.
   b. Create or locate the patient profile, create an electronic order, and print the barcode label from the portal.
2. Collect COVID-19 specimen per Northwest Pathology test collection guidance.
3. Northwest Pathology specimens are validated for 7 days at room temperature, Atlas Genomics specimens are validated for 5 days at room temperature.
4. Ship test sample via FedEx. Pre-paid labels and shipping containers can be ordered in advance from the Washington Department of Health. COVID-19 viral test kits should be ordered through the facility Logistics Section Chief.
5. Test results are available through the TestDirectly portal.

9.) See the DOC COVID-19 Testing protocol for details on how to conduct the BinaxNOW or BD Veritor Rapid antigen testing for COVID-19:

10.) Guidance on using and reporting of Rapid Antigen Tests for COVID-19 in patients

a. Document test result on DOC 13-415 In-House Lab Results
b. See specific sections of this protocol to determine clinical action to take in response to the COVID-19 rapid antigen test result. In general, patients with just a positive COVID-19 rapid Ag test result:
   i. Are considered preliminary positives until the result is confirmed with a standard PCR test
   ii. Will be single celled and will NOT be housed with other COVID-19 positive patients in a cell or RCF
c. Clinical scenarios in which rapid antigen testing is indicated per protocol include pre-procedure, pre-release to the community, patients who require testing who have had COVID-19 with the past 90 days, clearing patients from isolation, including those who use aerosolizing equipment or are immunocompromised. Rapid testing of individuals in a facility is also approved per the DOC Sweat Lodge protocol, prison funeral trip protocol, and Incarcerated Individual Department of Natural Resources Deployment protocol. Other indications require approval of the CMO, deputy CMO or infectious disease specialist.
d. Reporting positive rapid Ag test results to DOH can occur in one of two ways:
   i. Fax each individual COVID-19 POC DOH Reporting Form completely filled out to DOH at 206-512-2126
      1. Test Name: Abbott BinaxNOW COVID-19 Ag CARD or BD Veritor Plus

   OR

   ii. The facility will completely fill out the DOH POC Reporting Spreadsheet for positive rapid antigen testing and at the end of each day email the spreadsheet of positives via secure email (by putting the following in the subject line: [SECURE] DOC POC COVID-19 testing with date) to Phocis-fax@doh.wa.gov