COVID-19 Pandemic Response Plan

Federal Bureau of Prisons

About This Document

This document contains an Index and Overview followed by 11 separate Modules and an Appendix. For details on what a particular module covers, see the short Table of Contents at the beginning of that module.

Printing: Most likely, you are viewing this document in PDF format. Note that each module starts on its own page 1. To print an individual topic without printing the entire document, use the page numbers listed below.

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RESPONSE PLAN OVERVIEW

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THE CHALLENGE OF COVID-19

Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2), a novel coronavirus, is responsible for the clinical presentation of coronavirus disease 2019 (COVID-19). This is a respiratory illness—first described in Wuhan, China, in December 2019—that spread rapidly and is currently a global pandemic. The COVID-19 pandemic arrived at the Federal Bureau of Prisons' (BOP) institutions in mid-March 2020; today, every facility has identified confirmed cases.

A PANDEMIC refers to the international occurrence or spread of a particular disease, most commonly an infectious disease. More localized spread of disease is usually referred to as an EPIDEMIC or an OUTBREAK.

- Pandemics may occur for a variety of reasons, including MUTATION of existing pathogens (as is usually the case for the influenza virus) or development of NEW PATHOGENS like the severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2), which is causing the current coronavirus disease 2019 (COVID-19) pandemic.
- An important characteristic of a pandemic caused by an infectious disease is the ABILITY OF THE DISEASE TO BE TRANSMITTED from one human to another. With Sars-CoV-2, human-to-human transmission first occurred in China in late 2019 and then spread globally in early 2020.
- Other important aspects that determine the disease's impact are its mode of TRANSMISSION, INFECTIVITY, and VIRULENCE.
  - TRANSMISSION: SARS-CoV-2 is spread primarily when an infected person coughs, sneezes, or speaks, thereby dispersing respiratory droplets that land on the mucous membranes of another person's nose, mouth, or eyes. The dispersal range for these droplets is about six feet. It may also be transmitted when a person touches a surface contaminated by infectious respiratory droplets and then touches their face, or when respiratory aerosols are generated during certain procedures.
  - INFECTIVITY: At first, it was thought that the virus was spread primarily by people who had developed symptoms of the disease—and that focusing efforts on these cases would be sufficient to contain the disease. It has since been determined that a significant number of people may be

transmitting the disease during asymptomatic, presymptomatic, or minimally symptomatic phases of the illness, which has contributed to the infectivity and communicability of the disease.

- **VIRULENCE AND SYMPTOMS:** Lastly, there is a wide range in **SEVERITY OF ILLNESS** (virulence), with current data indicating that the vast majority of cases are in the spectrum of asymptomatic to mild/moderate symptoms.
  - The **MOST COMMON SYMPTOMS** are cough and fever. Shortness of breath has been considered one of the three primary symptoms, but occurs less commonly than the other two.
  - Other **LESS COMMON SYMPTOMS** include body aches, headaches, sore throat, diarrhea, nausea, vomiting, abdominal pain, loss of smell or taste, and runny nose.
  - **Approximately 20 percent of cases will have severe or life-threatening illness and up to two to three percent of patients will die.** Some experts in the field estimate the mortality rate may be 10 times higher than that of seasonal influenza.

- **POST- COVID CONDITIONS:** Post-COVID conditions is an umbrella term for the wide range of physical and mental health consequences present four or more weeks after acute-COVID illness. A patient's immune response appears to dictate long-term consequences to SARS-CoV-2. This immune response is dependent on multiple variables including viral virulence, exposure intensity and duration to the virus, and the host's comorbid medical conditions. Cellular damage from SARS-CoV-2 may cause long-term health consequences, including multiple organ injury. Patients who recover from COVID-19 may not be contagious, but these patients may complain of new, recurrent, or persistent symptoms.
  - Individuals who suffered mild or moderate illness presenting with persistent post-COVID-19 symptoms are called **LONG-HAULERS**. The most common persistent symptoms are fatigue, dyspnea/cough, headache, and joint aches.
  - As patients begin to recover from COVID-19, some individuals who suffered severe COVID illness may develop complications such as blood clotting, myocardial injury, liver injury, renal injury requiring long-term dialysis, and neurological injuries such as strokes, confusion, and anxiety. An estimated 20–50% of COVID-19 patients will continue to have health challenges post-hospitalization.
  - Recovered patients with complaint of new, recurrent, or persistent symptoms after acute COVID-19 should be monitored for long-term sequelae.

In addition to being highly contagious and potentially fatal, COVID-19 presents a number of other challenges including knowledge gaps about the disease, rapidly changing clinical guidance vaccine hesitancy, difficulty preventing its spread in residential settings like correctional and detention facilities, and severe impacts on institutional and organizational operations created by staffing and supply shortages or large numbers of sick patients.

- **Knowledge about COVID-19 and public health guidance for responding to this pandemic is evolving quickly.** Practical tools, together with infection prevention and control plans for COVID-19, are being developed and edited frequently to correspond to current guidance from the Centers of Disease Control (CDC) and the World Health Organization (WHO).
- **COVID-19 presents unique challenges for management in the confined correctional environment.** Cases of COVID-19 have been documented in all 50 U.S. states. Because many individuals infected with COVID-19 do not display symptoms, the virus could be present in facilities before infections are

identified. Good hygiene practices, vigilant symptom screening, wearing of cloth face coverings, and social distancing are critical in preventing further transmission.

The COVID-19 pandemic is the most severe pandemic to affect this country in over 100 years, and must be approached with a sense of urgency. An effective response is possible, but requires rethinking of routine processes, procedures, policies, and priorities, in addition to the application of established infection prevention practices.

This document is designed to provide specific guidance on responding effectively to these challenges—and limiting the spread of COVID-19, its impact on people's lives, and the BOP's missional and operational effectiveness. Effective response to the challenge of COVID-19 requires that all disciplines in a correctional facility come together to develop, implement, and modify plans as information and conditions change.

Swift, decisive, yet evidenced-based planning is paramount.

RESPONSE PLAN MODULES

The **BOP COVID-19 Pandemic Response Plan** is divided into the following MODULES, each providing a detailed outline for correctional facilities. The modules will be updated as needed, based on guidance from key stakeholders including the CDC, WHO, and DOJ; recommendations are revised as new information becomes available.

→ *It is important that the user check back periodically for updates to this plan.*

- MODULE 1. Infection Prevention and Control Measures
- MODULE 2. Personal Protective Equipment
- MODULE 3. Screening and Testing
- MODULE 4. Inmate Isolation and Quarantine
- MODULE 5. Surveillance
- MODULE 6. Inmate Movement
- MODULE 7. Non-COVID Routing Medical and Dental Services
- MODULE 8. Inmate Programming & Services
- MODULE 9. Inmate Visitation
- MODULE 10. Volunteer and Contract Staff Management
- MODULE 11. BOP Employee Management

DEFINITIONS

BOP INSTITUTION STAFF: BOP employees who work within the correctional setting.

BOP NON-INSTITUTION STAFF: BOP employees who work outside the correctional setting, i.e., Regional Office, Central Office, Grand Prairie, Staff Training Academy, Management and Specialty Training Center.

CLOSE CONTACT: In the context of COVID-19, an individual is considered a close contact if they have not been wearing appropriate PPE **and**:

- Have been within 6 feet of an infected person for a cumulative total of 15 minutes or more over a 24-hour period starting from 2 days before illness onset (or, for asymptomatic patients, 2 days prior to test specimen collection) **OR**
- Had direct contact with infectious secretions of a COVID-19 case.

Considerations when assessing close contacts include the proximity to the infected person, duration of exposure, and the clinical symptoms of the person with COVID-19 (i.e., coughing likely increases exposure risk as does an exposure to severely ill persons).

COHORTING: The practice of grouping patients infected or colonized with or potentially exposed to the same infectious agent together to confine their care to one area and prevent contact with susceptible patients. In the BOP, this may refer to housing inmates of similar infection status together rather than in single cells.

CONTACT TRACING: Identifying people infected with COVID-19 (CASES) and the people with whom they came into contact (CONTACTS); and then working with them to interrupt disease spread. Contact tracing for COVID-19 typically involves:

- Interviewing people with COVID-19 (CASE INVESTIGATION) to identify everyone they had close contact with during the time they may have been infectious.
- Notifying contacts of their potential exposure.
- Referring contacts for testing and quarantine/isolation, as indicated
- Monitoring contacts for signs and symptoms of COVID-19

FULLY VACCINATED: Having completed a vaccination series: 2 weeks after their second dose in a 2-dose series (Pfizer or Moderna), or 2 weeks after a single-dose vaccine (Janssen) as authorized by the U.S. Food and Drug Administration of the United States. Proper documentation, including the name of the vaccine and dose administration dates from an official / reliable source, is required for a person to be considered fully vaccinated.

INCUBATION PERIOD: The stage of subclinical disease that extends from the time of exposure to the onset of disease symptoms.

MEDICAL ISOLATION: Confining individuals with suspected (displaying symptoms) or confirmed (based on a positive point of care (POC) or commercial laboratory test) COVID-19 infection, either to single rooms or by COHORTING them with other viral infection patients.

MINIMAL TOLERABLE RISK: The principle of choosing the option that presents the lowest possible risk when ideal conditions cannot be upheld.

NOT FULLY VACCINATED: No documentation of vaccination, partial vaccination (one out of two doses), or less than 14 days have passed following completion of the vaccine series as authorized by the U.S. Food and Drug Administration.

QUARANTINE: In the context of COVID-19, refers to separating (in an individual room or cohorting in a unit) asymptomatic not fully vaccinated persons to **(1)** observe them for symptoms and signs of the illness during the **INCUBATION PERIOD** and **(2)** keep them apart from other incarcerated individuals.

- The BOP utilizes **THREE CATEGORIES OF QUARANTINE** – exposure, intake, and release/transfer
- The need to quarantine during inmate movement is affected by vaccination status, type of inmate movement, the inmate's destination and point of origin, and operational level of the sending institution.

SYMPTOMATIC: People with confirmed COVID-19 have reported a wide range of symptoms that typically appear 2–14 days after exposure to the virus. People with confirmed or suspected COVID-19 infection presenting with any of the following symptoms are considered symptomatic:

- Fever or chills
- Cough
- Shortness of breath or difficulty breathing
- Fatigue
- Muscle or body aches
- Headache
- New loss of taste or smell
- Sore throat
- Congestion or runny nose
- Nausea or vomiting
- Diarrhea

SOCIAL DISTANCING (a.k.a. PHYSICAL DISTANCING): Maintaining a distance of approximately six feet or more between each individual.

SURVEILLANCE: The ongoing systematic collection, analysis, and interpretation of **HEALTH-RELATED DATA**, closely integrated with the **TIMELY DISSEMINATION** of this data to those responsible for preventing and controlling disease and injury. Health data is defined and standardized by the Health Services Division and collected in a uniform and systematic manner. The authoritative and primary source of medical information is the electronic health record.

UP-TO-DATE VACCINATION STATUS: Proper documentation of having completed a vaccination series, and having received a booster according to current recommendations.

GENERAL PRINCIPLES OF A PANDEMIC RESPONSE

A. THREE PHASES OF RESPONSE: PREPARATION, RESPONSE, AND RECOVERY

The pandemic response is divided into three distinct, but overlapping, stages based on the time course of the pandemic: **PREPARATION**, **RESPONSE**, and **RECOVERY**. Individual institutions may be in different stages depending on whether they have had COVID-19 cases at their facility.

- **PREPARATION:** The importance for institutions to develop a response plan **PRIOR** to a local outbreak cannot be overstated. The plan should clearly define a systematic process for all of the elements outlined in the modules.
- **RESPONSE:** Upon identification of the first case, institution executive and medical staff should immediately:
  - Implement the local response plan.
  - Initiate and maintain communication with the regional medical director, health services administrator, and the QI/IP&C consultant.
- **RECOVERY:** This period will involve recovering from the effects of the pandemic emergency, evaluating the BOP response to it, and using this evaluation to prepare for subsequent waves of pandemic.

B. CONTAINMENT AND MITIGATION

Two major goals of a pandemic response are containment and mitigation:

- **CONTAINMENT:** To **LIMIT OR PREVENT SPREAD OF THE DISEASE**. For example, symptom screening, quarantine, and isolation are all containment efforts intended to limit the spread of disease.
- **MITIGATION:** To **LIMIT THE IMPACT OF THE DISEASE ON OPERATIONS** and to address operational challenges and disruptions created by the pandemic. Examples of such strategies include developing modified policies and procedures for routine operations, using alternative PPE strategies due to supply shortages, or setting up alternate care facilities to meet an increased demand for COVID-19-related health care.

CONTAINMENT STRATEGIES

There are a number of important containment strategies to be implemented.

- Environmental cleaning/disinfection/sanitation
- Health and hygiene practices:
  - Face covering (all inmates and staff in public places, with exceptions)
  - Covering the mouth and nose when coughing or sneezing
  - Hand hygiene – wash hands regularly with soap and water for at least 20 seconds or use hand sanitizer
  - Reporting illness early (staff and inmates) and staying home when sick (staff)
- Physical (social) distancing
- Screening for COVID-19 symptoms and signs (elevated temperature)
- Isolation, quarantine, PPE, and testing are essential aspects of limiting transmission and will be considered elsewhere in the document.

MITIGATION SCENARIOS AND STRATEGIES: CONVENTIONAL, CONTINGENCY, AND CRISIS

A framework for understanding mitigation strategies identifies three levels of operational disruption:

- **CONVENTIONAL** scenarios and strategies refer to minimal or no disruptions in normal operations.
- **CONTINGENCY** scenarios and strategies refer to mild to moderate disruption or impact on operations.
- **CRISIS** scenarios and strategies refer to severe disruption or impact on operations.

This framework recognizes that pandemics can make ordinary or well-established standards difficult or impossible to achieve and proposes reasonable alternative standards that provide an acceptable balance of risk and benefit, in light of the limitations created by the pandemic.

  - Examples include the CDC's Strategies to Optimize the Supply of PPE and Equipment during Shortages, the American Dental Association's recommendation to cancel non-urgent dental care, and the decision of many health systems to postpone routine or non-urgent health care interventions.

Mitigation strategies also need to address potential shortages in staffing, supplies, and the ability to provide certain services. Every aspect of the organization needs to have plans to address limitations and disruptions in in these areas, including alternative means of providing essential services.

C. COORDINATION

- It is critically important that correctional and health care leadership, and leadership from all divisions and departments meet regularly to review the current status of COVID-19, review updated guidance from the CDC, and flexibly respond to changes in current conditions.
- Regular meetings should be held, roles and responsibilities for various aspects of the local, regional, and central office response determined, and evidence-based plans developed and rapidly implemented. Consideration should be given to activating the **INCIDENT COMMAND SYSTEM** within the agency and each individual facility to coordinate response to the crisis.
- Responsibility should be assigned for tracking updates to national and local COVID-19 guidance.

Questions from institutions regarding any of the guidance in this Response Plan should be referred to your Regional Medical Director (RMD), Regional Health Care team, and Regional Director / Regional Emergency Operations Centers. The RMDs are aware of the most relevant and recommended approaches.

The medical management of COVID-19—including testing, housing, and treatment strategies—are clinical decisions and deference should be given to the RMD regarding these decisions within the clinical context of each situation and scenario that presents at the respective institution.

D. COMMUNICATION

- **The importance of regular communication with staff, incarcerated persons, and their families cannot be over-emphasized.** Specific methods of communication for all groups should be established. Staff should be assigned responsibility for crafting and disseminating regular updates.
  - *This CDC website offers printable educational posters at: https://www.cdc.gov/coronavirus/2019-ncov/communication/factsheets.html. At the site, type "COVID-19" into the search window.*
- Identify points of contact with local public health authorities, and initiate and maintain ongoing communication regarding changes to testing procedures, guidelines, and reporting.

- As part of plan preparation, communicate with community hospitals to discuss referral mechanisms for transferring severely ill patients to the hospital.

➔ *Questions or concerns from staff should be directed to the following email address: COVID-19Questions@bop.gov*

E. QUALITY IMPROVEMENT (QI)

Periodically throughout the outbreak and at the conclusion of it, review the implementation of your agency's or institution's COVID-19 Pandemic Response Plan to identify what has worked well (best practices), what has not, and deviations from established guidance (opportunities for improvement). Total numbers of cases and contacts treated/evaluated should also be reviewed. Engage the QI committee in evaluating the facility's pandemic response, and identify areas for improvement that should be reported to the leadership team.

F. EDUCATION AND TRAINING

STAFF EDUCATION AND TRAINING

Agency leadership must have clearly-defined mechanisms and well-developed strategies for communicating information and updates broadly and regularly to the field.

Throughout all BOP locations, post signage (available at the CDC site listed above under ***COMMUNICATION***) communicating the following:

- Symptoms of COVID-19 and hand hygiene instructions.
- Advice: Stay at home when sick; if COVID-19 symptoms develop while on duty, leave the facility as soon as possible and follow the CDC recommendations for *"What to Do If You are Sick"*.
- Elements of the facility's COVID-19 Response Plan for keeping employees safe, including social distancing.

➔ *To encourage social distancing and limit the chances of viral transmission, large staff meetings and recalls should be discouraged.*

INMATE EDUCATION AND TRAINING

Throughout the facility, post **SIGNAGE** (available at the CDC site listed above under ***COMMUNICATION***) communicating the following:

- Hand hygiene instructions and good health habits such as covering your cough and sneezes.
- Report symptoms of fever and/or cough or shortness of breath (and if another incarcerated person is coughing) to staff.
- Ensure that signage is understandable for non-English speaking persons and those with low literacy.
- Co-pays for respiratory illness symptoms or fever may be waived.
- Sharing drugs and drug preparation equipment can spread COVID-19.
- Plans to support communication with family members including visitation alternatives, if in-person visits are temporarily halted.
- What the institution is doing to keep incarcerated persons safe, including social distancing.

➔ *Weekly updates should be provided to the inmates via TRULINCS. To encourage social distancing and limit the chances of viral transmission, town halls should be discouraged.*

Module 1. Infection Prevention and Control Measures

WHAT'S NEW

- Updates to *Section D. Face Coverings* to include:
  - All staff and inmates, are to continue wearing a well-fitting mask to protect themselves and others from the spread of COVID-19. All staff and inmates are expected to be able to wear their chosen face covering throughout the day and tolerate wearing it in public indoor settings.
  - In areas where N-95s are considered PPE (*i.e.* quarantine and isolation setting), all individuals are required to be enrolled in a respiratory protection program and follow OSHA regulations regarding its wear. In all other locations, surgical, KN-95, or KF-94 masks may be dispensed and worn. They must properly cover the nose and mouth, and be in accordance with CDC guidance
    - Refer to MODULE 2 for guidance on when the use of N-95 respirators may be required.

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A. HAND HYGIENE AND HEALTH HABITS

GOOD HEALTH HABITS—including those listed below—should be promoted to both employees and inmates, using a variety of means (e.g., educational programs, campaigns including posters, assessing adherence to hand hygiene practices, etc.):

- Avoid close contact with persons who are sick. (See SOCIAL DISTANCING below.)
- Avoid touching your eyes, nose, or mouth.
- Wash your hands often (after contact with high-touch surfaces, before eating, after using the restroom, after removing gloves, etc.) with soap and water for at least 20 seconds. If soap and water are not readily available, use an alcohol-based hand rub (ABHR).
  - ➔ ***The CDC has determined that either washing hands with soap and water (for 20 seconds) or using an alcohol-based hand rub (ABHR) (with at least 60% alcohol) will inactivate SARS-CoV-2,*** *the pathogen that causes COVID-19. Handwashing is also more effective than ABHR at removing certain other kinds of germs and chemicals. (See* ***HAND WASHING*** *and* ***HAND SANITIZER*** *below.)*
- Cover your sneeze or cough with a tissue, then throw the tissue in the trash. If a tissue is not available, cough or sneeze into your sleeve.
- Avoid non-essential physical contact. Avoid handshakes and "high-fives."

HANDWASHING

- Provisions should be made for all staff and visitors to wash their hands when they enter the facility.
- Supplies for handwashing (soap, running water, hand dryers or paper towels) should be readily available for all staff and inmates and continually restocked as needed.
- Provide a no-cost supply of soap to inmates, sufficient to allow frequent hand washing. To reduce the risk of cross-contamination, avoid bar soap and provide liquid or foam soap and a means to dry hands in shared inmate bathrooms where possible. If bar soap is distributed, ensure individuals are not sharing bars.

HAND SANITIZER

- Increase availability and access to alcohol-based hand rub in monitored inmate common areas and staff common areas and housing units where a sink is not readily available.
- ABHR should be at least 60% alcohol.

Alcohol-based hand rub is flammable and must be used and stored correctly:

- STORAGE: Unopened containers must be stored in accordance with institution policy on the storage of hazardous products (secured, bin cards, etc.).

- **IN-USE:**
  - **Wall-mounted dispensers in corridors and common areas** may contain up to 1.2 liters (0.32 gallons) of hand sanitizer for use by staff and inmates.
  - **Wall-mounted dispensers in staff offices and work rooms** may contain up to 2.0 liters (0.53 gallons) of hand sanitizer for use by staff.
  - **Wall-mounted dispensers must be installed away from ignition sources** (outlets, thermostats, appliances, etc.).
  - **Individual bottles** of hand sanitizer may be issued to staff to keep on their person.
  - **Inmates may NOT store alcohol-based hand sanitizer in their cells.**
  - *Contact the Occupational Safety & Health Branch or consult NFC Life Safety Code (NFPA 101) for additional information on the placement of wall-mounted dispensers.*

B. SOCIAL DISTANCING (A.K.A. PHYSICAL DISTANCING)

Institutions should implement social distancing according to the *COVID-19 Modified Operations Matrix*. Institutions with high infection rates and community transmission, and/or low vaccination acceptance will be following Level 3 Operations, which are the most intense modifications from pre-COVID era. These facilities will:

- Minimize inmate movement by separating operations and programming by units (meals, recreation, medical, callouts, education, etc.), with disinfection between groups (e.g., after using phones, seating areas, computers, showers)
- Minimize inmate/staff movement:
  - Minimize transfer of inmates between units.
  - Have inmate housing units move together in restricted moves; avoid contact with other units.
  - Limit staff movement and assignments to single facilities and units, whenever possible
  - Stop or limit movement in/out of institution, as able.
  - Suspend work-release programs based on community and facility situation.
- Enforce increased space between individuals in holding cells, as well as in lines (consider marking the floors at six-foot intervals to help inmates visualize and maintain social distancing), in waiting areas such as intake (e.g., remove or tape-off every other chair in a waiting area), in dining halls (when main line resumes), in programming areas such as education, and during inmate movement / transfers.
- Entrance screening and key line:
  - Maintain social distance among all individuals in the area.
  - Consider marking the floors at six-foot intervals to help employees visualize and maintain social distancing.
- Gatherings of staff (meetings, recalls, lunch and learns, etc.)
  - Cancel such meetings when social distancing cannot be maintained by attendees.
  - WebEx Executive Conferencing Line: Each institution is being provided with lines to utilize for meeting where social distancing cannot be maintained.

GUIDANCE ON CONGREGATE ACTIVITIES

Institutions at Level 3 Operations, will modify their congregate activities (include all staff conferences and training and all applicable inmate programming).

- Virtual methods of congregation are preferred
- All individuals participating in congregate activities *should not* be in quarantine or isolation status due to COVID-19.
- All individuals participating in congregate activities *should not* be exhibiting any symptoms associated with COVID-19.
- The more people an individual interacts with and the longer that interaction lasts, the higher the potential risk of becoming infected with COVID-19. Guidance from the CDC on considerations for events and gathers can be found here: *https://www.cdc.gov/coronavirus/2019-ncov/community/large-events/considerations-for-events-gatherings.html*

The following requirements need to be adopted when planning congregate activities:

- **ADMINISTRATIVE CONTROLS**
  - Encourage the use of outdoor seating areas and social distancing for any small-group activities
  - Perform enhanced cleaning of frequently touched surfaces between every gather.
  - Stagger start and break times
  - Remind participants to avoid any physical contact to include handshaking, hugs, and fist bumps.
- **ENGINEERING CONTROLS**
  - Provide a meeting space that allows ≥60 sq. ft. per person (*e.g.* Divide the sq. ft. space by 60 which will provide the maximum occupancy allowed in that space)
    - Methods for calculating social distancing occupant loads can be found here: *https://www.usfa.fema.gov/coronavirus/planning_response/occupancy_social_distancing.html*
  - Modify the seating layout to allow 6 feet of separation between participants
  - Install shields/barriers between people where 6 feet is not able to be achieved while in compliance with fire and safety codes
    - CDC COVID-19 Employer Information for Office Buildings can be found here: *https://www.cdc.gov/coronavirus/2019-ncov/community/office-buildings.html*
  - Mark off or remove extra seats
  - Remove high-touch communal items (e.g. pens, coffee pots, etc)
  - Encourage people to bring their own pens, water bottles or other personal items to avoid cross contamination (e.g. there should be no communal writing utensils provided for sign-in to decrease contamination)
  - Increase fresh air flow through the area by:
    - Increase the percentage of outdoor air circulated by the HVAC system
    - Open windows when possible
    - Use HEPA filters where possible

- **PROTECTIVE EQUIPMENT**
  - Refer to **MODULE 2** for PPE guidance including facility-wide use of double layer, non-vented, cloth covering, surgical or N95 mask as indicated.

C. ENVIRONMENTAL CLEANING AND DISINFECTION

TERMS

- **CLEANING** refers to the removal of dirt and impurities, including bacteria and viruses from surfaces. Cleaning alone does not kill germs, but helps to remove them and reduce the risk of spreading infection.
  - *Cleaning a surface, before disinfecting it, allows the disinfectant to "reach" the surface more effectively.*
- **DISINFECTING** works by using chemicals to kill bacteria and viruses on surfaces, including those that remain on a surface after cleaning, to reduce the risk of spreading infection.

PLANNING AND PREPARATION

- Develop a local daily cleaning schedule utilizing your housekeeping plan to clean and disinfect, when indicated, all areas of the institution.
  - *Refer to the **APPENDICES** for a Recommended Cleaning Schedule.*
- Identify inmates who are already trained to clean and disinfect all areas of the institution daily.
  - Consider cross-training multiple work crews that are housed separately for performing environmental cleaning.
  - Training should include basic cleaning and disinfection methods, cross-contamination prevention, cleaning product safety, PPE use, and hand washing.
  - Assign the same inmate(s) to the same locations to clean and disinfect daily.
  - Consider cross-training additional workers housed in separate areas to provide backup in the event one group becomes ill.
- Ensure adequate supplies to support intensified cleaning and disinfection, including PPE as indicated.
  - *See **MODULE 2** for information on PPE.*
- Initiate a plan to restock rapidly when needed.

HIGH-TOUCH SURFACES AND HIGH-TRAFFIC AREAS

- Institute a continuous cleaning/disinfection schedule for all high traffic/touch areas.
- Routine cleaning of "**HIGH-TOUCH**" (frequently touched) surfaces should be **increased to no less than several times per day during Level 3 Operations, and may be relaxed to no less than daily during Level 1 Operations.**
- High-touch surfaces include items such as light switches, doorknobs, door handles, desk tops, drawer handles, keys, shared pens, handrails, telephones, computer keyboards and mice, elevator buttons, cell bars, bathroom faucets, etc.

ROUTINE CLEANING AND DISINFECTION

- ***Neither the CDC nor the EPA support the use of thermal or electrostatic foggers for disinfection procedures.***

- If surfaces are dirty, they should be manually cleaned prior to disinfection.
- Once the cleaning process is complete, inmates equipped with PPE should spray disinfectant on all hard surface areas with chemical backpack sprayers, if available.
  - If backpack sprayers are not available, have additional inmates with hand-held spray bottles complete this task.
  - Remember to adhere to the wetting time indicated by the disinfectant manufacturer.
  - This process should be completed as scheduled and more often if needed.
- **Clean and disinfect according to label instructions**, including pre-cleaning steps, product dilution, contact time, and potable water rinse directions.
  - Follow manufacturer's directions including pre-cleaning steps, product dilution, contact time, and rinse directions. The contact time is the amount of time the surface needs to be treated for the product to work. Many product labels recommend keeping the surface wet for a specific amount of time.
  - Follow label instructions for safe and effective use of the product, including precautions that should be taken when applying the product, such as required **PPE** and making sure there is good ventilation during use, and around people.
  - Refer to the manufacturer's documentation for product hazards, as well as shelf life for the concentrated and diluted solutions.
    - *For example, in the case of Virex II/256, the concentrated form has a three-year shelf life, but once diluted it has only a one-year shelf life.*
- The CDC recommends using an EPA-registered, hospital-grade disinfectant from **LIST N** for disinfecting surfaces.
  - **LIST N**, the list of EPA-approved products for **COVID-19 disinfection**, is available at: *https://www.epa.gov/pesticide-registration/list-n-disinfectants-use-against-sars-cov-2-covid-19*
  - Institutions should check with health services to find out if the product currently in use is included on **LIST N**. If the health services product is on **LIST N**, leadership can decide to expand its use for the facility or choose another product from the list.
- Instructions for the use of a bleach solution, Virex II, HDQC2, and HALT are available in the **APPENDICES**.

HARD SURFACES

- If surfaces are dirty, they should be cleaned using soap and water prior to disinfection.
- For disinfection after cleaning, use products approved by EPA for COVID-19 (**LIST N**, see *Useful Links* below).
- If an EPA N-list disinfectant is unavailable, diluted household bleach solutions or alcohol solutions with at least 70% alcohol should be effective.
  - Diluted, unexpired household bleach can be used under direct supervision if appropriate for the surface.
  - Gloves and eye protection should be worn when using bleach products.
    - *Never mix household bleach with ammonia or any other cleanser.*

- Prepare bleach solution by mixing:
  - 5 tablespoons (1/3 cup) bleach per gallon of water OR
  - 4 teaspoons of bleach per quart of water.

SOFT (POROUS) SURFACES (CARPETED FLOORS, RUGS, DRAPES)

- Remove visible contamination, and clean with appropriate cleaners for these surfaces.
- If washable, launder in hottest water setting for the item and dry completely. Otherwise, use products approved by EPA for COVID-19 disinfection (**LIST N**, see *Useful Links* below).

ELECTRONICS

- For electronics such as tablets, touch screens, keyboards, and remote controls: Remove visible contamination if present.
- Follow the manufacturer's instructions for all cleaning and disinfection products.
- Consider use of wipeable covers for electronics.

USEFUL LINKS FOR ADDITIONAL DISINFECTION GUIDANCE

- EPA listing (**LIST N**) of approved disinfectants used to eradicate COVID-19: *https://www.epa.gov/pesticide-registration/list-n-disinfectants-use-against-sars-cov-2*
- EPA frequently asked questions regarding disinfectants and COVID-19: *https://www.epa.gov/coronavirus/frequent-questions-about-disinfectants-and-coronavirus-covid-19*
- CDC recommendations for cleaning and disinfection: *https://www.cdc.gov/coronavirus/2019-ncov/community/organizations/cleaning-disinfection.html*
- CDC IP&C recommendations for healthcare workers during the COVID-19 pandemic: *https://www.cdc.gov/coronavirus/2019-ncov/infection-control/control-recommendations.html*

D. FACE COVERINGS

- All staff and inmates, are to continue wearing a well-fitting mask to protect themselves and others from the spread of COVID-19. All staff and inmates are expected to be able to wear their chosen face covering throughout the day and tolerate wearing it in public indoor settings.
- **Cloth face coverings are worn to protect others, but are not considered to offer protection for the wearer and are not considered to be PPE.** "My mask protects you. Your mask protects me." Cloth face coverings are worn as a measure to prevent spread of respiratory droplets and mitigate against transmission.
  - Individuals should avoid cloth masks that are single layer or *any* masks with vents.
- In areas where N-95s are considered PPE (*i.e.* quarantine and isolation setting), all individuals are required to be enrolled in a respiratory protection program and follow OSHA regulations regarding its wear. In all other locations, surgical, KN-95, or KF-94 masks may be dispensed and worn. They must properly cover the nose and mouth, and be in accordance with CDC guidance
  - → *Refer to MODULE 2 for guidance on when the use of N-95 respirators may be required.*
- It is important to reinforce correct wearing of face coverings by both staff and inmates.
  - Wash hands before putting on a face covering
  - Always use the same side for contact with nose and mouth

- Avoid touching the side of the covering that touches the face, handle face coverings only by the ear loops or ties.
- Place completely over nose and mouth and secure it under the chin while fitting it snugly against the side of the face
- Do not pull the face covering down to talk
- When removing the face covering:
  - Fold outside corners together to prevent contamination of the surface
  - Be careful not to touch eyes, nose and mouth when removing and wash hands immediately after removing.

- Individuals may remove a face covering when working in a private office, cubicle, or workspace.
- A staff member may have an inmate remove their face covering to perform safety and security checks. Once the check is complete, the inmate should place the covering back on their face.
  - To reduce the risk to staff, inmates should remove the face covering themselves.
  - If an inmate cannot remove a face covering, staff should put on gloves prior to removing the inmate's face covering. The staff should stand to the side or behind the inmate so they are not in direct line with the inmate's nose and mouth. The face covering should be removed so that the inside of the covering stays on the inside.
  - If staff assist with placing the face covering back on the inmate, staff should place the face covering back on the inmate in the same orientation it was worn before taken off (inside of the covering stays on the inside).

GUIDANCE ON CLOTH FACE COVERINGS

- Two-layer cloth face coverings are recommended.
  - *Single-layer face coverings (including balaclava or neck gaiters) are NOT recommended.*
- Face coverings with exhalation valves or vents are NOT recommended. While the vents make it easier to exhale, they allow the escape of respiratory droplets into the environment and potentially to another person.

LAUNDERING CLOTH FACE COVERINGS

- All cloth face coverings should be laundered before first use.
- Cloth face coverings may be washed with other clothing.
- It is recommended that staff wash their cloth face coverings at home after each shift.
  - Launder items using the warmest water setting and dry completely.
  - Clean and disinfect clothes hampers, or use a liner that can be washed or thrown away.
- Inmates should send cloth face coverings through the institution wash cycles with other clothing.

- *According to the BOP Facilities Operations Manual (P4200.12), the wash cycle temperature is to be a minimum of 160 degrees Fahrenheit.*
- *Guidance for staff and inmates on how to wear a cloth face covering may be found in the APPENDICES.*

E. SUPPLY MANAGEMENT

A sufficient stock of hygiene supplies, cleaning supplies, PPE, and medical supplies (consistent with the healthcare capabilities of the facility) should be on hand and available, and a plan should be in place to restock as needed if COVID-19 transmission occurs within the facility.

It is recommended that facilities maintain a 90-DAY SUPPLY of the following items:

- Standard medical supplies for daily clinic needs
- Tissues
- Liquid or foam soap for hand washing, when possible, to avoid cross-contamination. If bar soap is distributed, each person should be given (cost-free) their own bar of soap, and bars should not be shared.
- Hand drying supplies
- Alcohol-based hand sanitizer containing at least 60% alcohol
- Cleaning supplies, including EPA-registered disinfectants from the EPA list N.
- Recommended PPE (surgical masks, N95 respirators, eye protection, disposable medical gloves, and disposable gowns/one-piece coveralls).

  → *See MODULE 2 for more detailed information on supply chain management, including recommendations for extending the life (optimization) of all PPE categories in the event of shortages, and when surgical masks are acceptable alternatives to N95s.*
- Sterile viral transport media and sterile swabs to collect specimens if COVID-19 testing is indicated. Institutions should work with locally established commercial laboratory contacts to ensure adequate supply chains for collection items. If adequate supply of collection items cannot be secured locally, notification should be provided to the Central Office HSD.

  → *See Module 7 for information regarding obtaining supplies for the collection of specimens if influenza testing is completed using the Abbott ID Now point-of-care machines.*

To ensure that appropriate 90-day supplies are on hand at all times throughout the deployment of this pandemic plan, the institution should ensure that the following PROCESS is in place:

1. **STAFFING:** A primary staff member or group of staff members should have delegated responsibility for all institution supplies, including PPE, cleaning and disinfection items, and other items listed above. Consider assigning several staff members to support the supplies mission.
2. **TRACKING:** One staff member should be assigned to enter the applicable data into the SUPPLIES DASHBOARD, to ensure accurate tracking of supplies and monitoring their use. This person should be either the primary staff member mentioned above, or one of the members of the supplies group.
3. **FORECASTING:** Submitting supply chain inventory according to Central Office direction is important to determine "BURN RATES" and to forecast usage needs across all institutions. Institutions may choose to calculate their own "burn rates" to assist with accurate forecasting of all required supplies.
4. **PROCUREMENT:** Institutions should track and keep historical information related to local attempts to procure all supplies. This information is helpful when pursuing national-level vendors, as those with supply sites close to institutions may expedite the delivery of required supplies.

→ *The Incident Command System (ICS) Logistics Branch actively seeks to find necessary PPE through government, commercial, and other sources to maintain PPE for staff during the pandemic. Institutions should continue local efforts to procure all levels of PPE that meet applicable standards, working with local vendors to establish supply chains. If an institution is unable to secure necessary supplies, they should contact their regional EOC for guidance. Refer to MODULE 2 Personal Protective Equipment for additional information on PPE supply chain management.*

F. TEMPORARY ENCLOSURES

The construction of INDIVIDUAL ISOLATION AREAS as a supplement or replacement for social distancing, face coverings, and standard precautions is NOT RECOMMENDED. Temporary enclosures do not serve a medical or infectious disease purpose.

Temporary enclosures can pose fire and safety concerns. The LIFE SAFETY CODE **(NFPA 101)** allows privacy curtains and plastic sheeting to be used in detention and correctional facilities with a number of restrictions.

- Temporary enclosures must comply with the requirements for new detention and correctional occupancies (NFPA 101, chapter 22).
- Material used in privacy curtains must be tested in accordance with NFPA 701 (Standard Method of Fire Tests for Flame Propagation of Textiles and Films, 2015 edition).
- Special emphasis must be placed on means of egress components (number, width, distance and arrangement) (NFPA 101, chapter 22 section 2.2, Means of Egress Requirements).
- Construction of temporary enclosures necessitates a review and possible modification of the facility fire plan.

Temporary enclosures may also impact compliance with other codes and standards.

- Without proper clearance, operation of the sprinkler and fire alarm systems may be impaired.
- Temporary structures may also affect the operation of the building heating, ventilation, and air conditioning system.

Before an institution determines some type of physical barriers are medically necessary, Regional Infection Prevention and Control Officers, as well as the Regional Safety Administrator, Regional Medical Director and Regional Health Services Administrator, should be consulted.

- If the decision is made to install TEMPORARY BARRIERS, the use of partial height dividers constructed of a non-combustible material such as gypsum board is recommended.
- If a decision is made to use PRIVACY CURTAINS OR PLASTIC SHEETING, review the fire test documentation and verify that the installation will not interfere with area egress or the operation of any building fire protection systems.
  - ➔ *Documentation of the fire tests, egress, and fire system reviews should be maintained by the institution.*

MODULE 2. PERSONAL PROTECTIVE EQUIPMENT (PPE)

WHAT'S NEW

- Addition of definition: **SURGICAL MASK EQUIVALENTS** are disposable facemasks that are expected to provide equivalent protection as an FDA-approved surgical mask. Examples include KN-95 or KF-94 facemasks.
- Updates to *Table 1. Recommended Use of PPE*

MODULE 2 TABLE OF CONTENTS

TERMINOLOGY/DEFINITIONS

***CDC** = Centers for Disease Control and Prevention*
***FDA** = Food and Drug Administration*
***NIOSH** = National Institute for Occupational Safety and Health*

COHORTING: The practice of grouping patients infected or colonized with or potentially exposed to the same infectious agent together to confine their care to one area and prevent contact with susceptible patients. In the BOP, this may refer to housing inmates of similar infection status together rather than in single cells.

INCUBATION PERIOD: The stage of subclinical disease that extends from the time of exposure to the onset of disease symptoms.

MEDICAL ISOLATION: Confining individuals with suspected (displaying symptoms) or confirmed (based on a positive point-of-care (POC) or commercial laboratory test) COVID-19 infection, either to single rooms or by COHORTING them with other viral infection patients.

QUARANTINE: In the context of COVID-19, refers to separating (in an individual room or cohorting in a unit) asymptomatic not fully vaccinated persons to (1) observe them for symptoms and signs of the illness during the INCUBATION PERIOD and (2) keep them apart from other incarcerated individuals.

- The BOP utilizes THREE CATEGORIES OF QUARANTINE – exposure, intake, and transfer
- The need to quarantine during inmate movement is affected by vaccination status, type of inmate movement, the inmate's destination and point of origin, and operational level of the sending institution.

CLOTH FACE COVERINGS, SURGICAL MASKS, AND RESPIRATORS

- **CLOTH FACE COVERINGS:** Cloth face coverings serve as "source control" for the persons wearing them. They primarily protect others rather than the wearer by limiting dispersion of infectious respiratory droplets into the environment. "My mask protects you. Your mask protects me." Although they may offer some protection to the wearer, unlike FDA-approved surgical masks or N-95 respirators, they are **NOT considered to be PPE.** Refer to **MODULE 1** for guidance on cloth face coverings.
- **SURGICAL MASKS: This term refers to disposable facemasks that are FDA-APPROVED LEVEL III MEDICAL MASKS.** Surgical masks come in various shapes and types (e.g., flat with nose bridge and ties, duck billed, flat and pleated, and pre-molded with elastic bands).
  - **SURGICAL MASK EQUIVALENTS** are disposable facemasks that are expected to provide equivalent protection as an FDA-approved surgical mask. Examples include KN-95 or KF-94 facemasks.
- **RESPIRATORS:** This term refers to N-95 or higher filtering, face-piece respirators that are certified by CDC/NIOSH as PPE.

→ *Face masks that are not FDA-approved for medical use are not to be considered PPE. Individuals working under conditions that require PPE should not use a cloth face covering or a facemask that is not FDA-approved.*

STRATEGIES TO OPTIMIZE THE SUPPLY OF PPE

OPTIMIZATION STRATEGIES offer a continuum of options when PPE supplies are stressed, running low, or absent. The terms **EXTENDED USE** and **REUSE** apply to PPE that are normally "one-time use" items (i.e., N-95 respirators, surgical masks, and gowns).

- **EXTENDED USE OF PPE may be utilized during periods when shortages are anticipated.** Extended use of PPE is the practice of wearing the same PPE for repeated close contact encounters with several different patients, **WITHOUT removing the PPE between patient encounters.**
- **REUSE OF PPE may be utilized when supply cannot meet demand.** Reuse of PPE is the practice of using the same PPE by one healthcare provider (**HCP**) for multiple encounters with different patients, but **removing it after each encounter.** The respirator is stored in between encounters to be put on again prior to the next encounter with a patient. As it is unknown what the potential contribution of contact transmission is for COVID-19, care should be taken to ensure that HCPs do not touch outer surfaces of the PPE during care, and that PPE removal and replacement be done in a careful and deliberate manner. (See *Donning and Doffing* below.). Once PPE availability returns to normal, promptly resume conventional practices.

→ *A quick reference summary for CDC strategies to optimize personal protective equipment supplies is available at: https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/strategies-optimize-ppe-shortages.html*

RECOMMENDED LEVELS OF PPE

- Regardless of the indoor setting, unless otherwise specified (i.e., where N-95s are PPE), all staff and inmates are to continue wearing a well-fitting face covering to protect themselves and others from the spread of COVID-19. All staff and inmates are expected to be able to wear the chosen face covering throughout the day and tolerate wearing it in public indoor settings.
  - Note, a cloth face covering does **not** constitute personal protective equipment (PPE).

- Quality of face covering and other recommended PPE for inmates and staff will vary based on the type of contact with inmates, the type of procedure being performed, the type of separation (QUARANTINE vs. MEDICAL ISOLATION), the type of room utilized (single cell with solid doors and walls, open cells with bars, room without anteroom, or barracks-style space), and PPE availability.
- In areas where N-95s are considered required PPE (i.e. quarantine and isolation setting), all individuals are required to be enrolled in a respiratory protection program and follow OSHA regulations regarding its wear. This includes use of the OSHA Respirator Medical Evaluation Questionnaire, medical evaluation (if indicated), and fit testing.
- In all other locations, surgical, KN-95, or KF-94 masks may be dispensed and worn for use as PPE. They must properly cover the nose and mouth, and be in accordance with CDC guidance.

This MODULE covers each type of recommended PPE, including appropriate use, supply optimization, and guidance in the event of a shortage.

➔ *Table 1 summarizes the appropriate use of each type of PPE.*

➔ *Table 2 summarizes length of use, re-use, disposal, and storage of PPE.*

TABLE 1. RECOMMENDED USE OF PPE

INDIVIDUAL WEARING PPE[1]	N-95 RESPIRATOR	SURGICAL MASK	EYE PROTECTION	GLOVES	GOWN/ COVERALLS
INMATES					
Inmates housed in **QUARANTINE**	Wear surgical mask or equivalent for source control, including if housed as a cohort, when staff enter, when moving around unit to phones, computer, etc.				
Inmates housed in **MEDICAL ISOLATION**	Wear surgical mask or equivalent for source control, including if housed as a cohort, when staff enter, when moving around unit to phones, computer, etc.				
Orderlies housed within and performing cleaning in **MEDICAL ISOLATION** and quarantine areas	Additional PPE may be needed based on disinfectant Safety Data Sheet (SDS)			X	X
Orderlies NOT housed within and performing cleaning in **MEDICAL ISOLATION** and quarantine areas	PPE requirements are the same as they are for staff working in these areas. The SDS and local hazard assessment should be reviewed for any additional PPE requirements based upon the chemical hazard.			X	X
Laundry and food service workers handling items from **MEDICAL ISOLATION** or **QUARANTINE**				X	X
STAFF	**N-95 RESPIRATOR**	**SURGICAL MASK**	**EYE PROTECTION**	**GLOVES**	**GOWN/ COVERALLS**
Staff providing **ROUTINE HEALTH SERVICES** to inmates (COVID not suspected)		X	X[2]	X[2]	X[2]
Staff performing **STAFF SCREENING** and temperature checks		X	X	X	
Staff performing non-contact **TEMPERATURE CHECKS** in **QUARANTINE**		X	X	X	
Staff having **DIRECT CONTACT** (including medical care, opening food trap door, entering room, escort or transport) with inmates in **QUARANTINE**		X	X	X	X

Table continues on next page

STAFF	N-95 RESPIRATOR	SURGICAL MASK	EYE PROTECTION	GLOVES	GOWN/ COVERALLS
Staff working in a **QUARANTINE** unit that is an open dorm, barracks, or unit with barred cells	X[3]		X	X	X
Medical staff providing care to inmates in **MEDICAL ISOLATION,** or other correctional staff entering their rooms or opening food trap doors	X[3]		X	X	X
Staff in contact with medical isolation inmates during transport or within same compartment space.	X[3]		X	X	X
Staff present during **AEROSOL-GENERATING PROCEDURES** or **NASAL SWABBING**, regardless of whether or not COVID-19 is suspected	X		X	X	X
Staff handling laundry or food service items from **MEDICAL ISOLATION** or **QUARANTINE**				X	X
Staff cleaning a **COVID** case area	N-95 if cleaning or disinfecting an isolation room. Additional PPE may be needed based on product SDS.			X	X

[1] All staff and inmates are expected to wear a face covering in indoor environments unless greater respiratory protection is recommended with the use of surgical masks, surgical mask equivalents, or N-95 respirators as indicated in this table.
[2] Wear gloves for patient care (with gloves changed and hand hygiene performed between patients). Gowns and eye protection (face shields or goggles) should be worn if direct or very close contact with ill inmates (e.g., temperature checks) or splashes or spray is anticipated.
[3] A NIOSH-approved N-95 is preferred. N-95 respirator use requires users be enrolled in the OSHA Respiratory Protection Program. This program includes use of the OSHA Respirator Medical Evaluation Questionnaire, medical evaluation (if indicated), and fit testing. Based on local and regional situational analysis of PPE supplies, FDA-approved surgical masks may be an acceptable alternative when the supply chain of respirators cannot meet the demand. Consult with your regional EOC prior to the use of facemasks in lieu of N-95 respirators.

TABLE 2 summarizes recommendations on PPE, including length of use, re-use, disinfection, disposal, and storage. More detailed information follows in the sections below.

➔ *See previous discussion of optimization strategies (EXTENDED USE and RE-USE).*

TABLE 2. LENGTH OF USE, RE-USE, DISPOSAL, AND STORAGE OF PPE

PPE	LENGTH OF USE	RE-USE/ DISINFECTION	DISPOSAL	STORAGE FOR PPE TO BE REUSED
FACE SHIELD	Multiple times	YES/YES	Regular trash	Specified place for re-used PPE or paper bag with ID
GLOVES	One-time use only	NO	Regular trash	—
GOGGLES	Multiple times	YES/YES	Regular trash	Specified place for PPE after cleaning and disinfection
GOWN	One-time use only	NO	Regular trash	—
GOWN ***SHORTAGE – CRISIS STRATEGY****	Multiple times	YES/NO	Regular trash	Hang in designated spot outside of doffing area with ID

Table continues on next page

PPE	LENGTH OF USE	RE-USE/ DISINFECTION	DISPOSAL	STORAGE FOR PPE TO BE REUSED
SURGICAL MASK OR EQUIVALENT for general use	EXTENDED USE for shift; discard if soiled or damaged	No	Regular trash	—
SURGICAL MASK for staff screening	EXTENDED USE for shift	No	Regular trash	—
SURGICAL MASK for quarantine	EXTENDED USE for shift, doff upon exit	No	Regular trash	—
N-95 RESPIRATOR for Isolation	One-time use only, doff upon exit	No	Regular trash	—
N-95 RESPIRATOR for Isolation ***SHORTAGE – CRISIS STRATEGY****	Doff upon exit; store for use up to 5x or until soiled or difficult to breathe through	YES/NO	Regular trash	Paper bag with ID
* *See CDC strategies for optimizing PPE during shortages: https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/index.html*				

DONNING AND DOFFING

Staff who are wearing PPE—including masks and gloves—should be trained on its use.

- *CDC instructions, including posters and video training on donning and doffing (removing) PPE, are available at: https://www.cdc.gov/coronavirus/2019-ncov/hcp/using-ppe.html*
- *See PPE donning and doffing skill tests in the Appendices that can be used for verification of the above training.*

- It is strongly emphasized that HAND HYGIENE (using soap and water or an alcohol-based hand sanitizer) be performed BEFORE AND AFTER **donning and doffing any PPE item.** This includes touching or adjusting the respirator if needed for comfort or to maintain fit.
- GLOVES: If a task requires gloves, hand hygiene should be performed prior to donning gloves and again immediately after removing the gloves. In any instance where gloves are not used, hand hygiene should be performed before touching any patient or patient environment and after touching any patient or patient environment.
- EYE PROTECTION: HCP should leave patient care area if they need to remove their eye protection. See protocol for removing and reprocessing *eye protection* below.
- UTILITY BELTS: If utility belts are worn over PPE, they are removed and belt and items on belt cleaned and disinfected as appropriate.
- There should be an area for donning and doffing PPE at the entrance and exit from QUARANTINE and MEDICAL ISOLATION areas. It can be a designated taped area to stand in, or a makeshift anteroom created with barrier materials.
  - Refer to MODULE 1 concerning risks associated with creating barriers with regard to fire mitigation strategies and emergency egress routes.
  - Under no circumstances should PPE worn in the medical isolation or quarantine areas be worn to other areas of the institution. **PPE must be removed in doffing area at exit.**

- Donning and doffing areas should include **POSTERS** demonstrating correct PPE donning and doffing procedures
- **The donning and doffing areas should NOT include:**
  - Microwaves
  - Food
  - Utensils used for drinking or eating
  - Coffee/water dispensers
- **The doffing area should include:**
  - An alcohol-based hand hygiene product or a sink with soap and water
  - A receptacle for reusable items (face shields or goggles)
  - A large waste bin with a clear trash bag
  - Cleaner/disinfectant
  - An area to hang or bag recycled items for reuse *if there is a critical shortage only* (i.e., a command strip hanger for reuse of gowns, with ID written on gown, or paper bags with IDs for N-95s)
    - Create a system to clean and disinfect the equipment to be re-used (i.e., the person that used the equipment sprays and wipes it off—per manufacturer's wet time—and then places it in donning area for reuse).

N-95 RESPIRATORS

- *When the use of an N-95 respirator is required, only **NIOSH-approved N-95 respirators** should be utilized, whenever possible, to lessen the chance of counterfeit N-95 respirator use. Verification of NIOSH approval can be found at: https://wwwn.cdc.gov/niosh-cel/*
- *More information regarding identification of counterfeit N-95 respirators can be found at: https://www.cdc.gov/niosh/npptl/usernotices/counterfeitResp.html*

APPROPRIATE USE OF N-95 RESPIRATORS

- N-95 respirators should be used:
  - For all **AEROSOL-GENERATING PROCEDURES** (whether or not COVID-19 is suspected), e.g., nebulizer, high flow oxygen, CPR, nasopharyngeal swabbing for flu or COVID-19, etc.
  - When entering **MEDICAL ISOLATION ROOMS OR AREAS WITH SYMPTOMATIC CONFIRMED OR SUSPECT COVID-19 INMATES**.
  - Consider use of N-95 respirators in **QUARANTINE** open dorm, barrack, and open-bar units if any positive cases have occurred (i.e., in exposed quarantine unit)
- To be considered compliant with OSHA, when N-95 respirators are recommended PPE, users of N-95 respirators must be enrolled in the **OSHA RESPIRATORY PROTECTION PROGRAM**. This program includes use of the **OSHA RESPIRATOR MEDICAL EVALUATION QUESTIONNAIRE**, **MEDICAL EVALUATION** (if indicated), and a **FIT-TESTING** program. Fit testing is specific to the brand/size of respirator to be used.
  - N-95 respirators should NOT be worn with facial hair that interferes with the respirator seal. Images of appropriate facial hairstyles can be found at: https://www.cdc.gov/niosh/npptl/pdfs/FacialHairWmask11282017-508.pdf

- Refer to the local institution Occupational Safety and Health Department for any/all items related to N-95 fit testing

SUPPLY OPTIMIZATION FOR N-95 RESPIRATORS

The CDC and NIOSH recommend the following strategies for optimizing supplies of disposable N-95 respirators.

→ *See the CDC and NIOSH recommendations at:*
https://www.cdc.gov/coronavirus/2019-ncov/hcp/respirators-strategy/index.html
https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/decontamination-reuse-respirators.html

- Use alternatives to N-95s (other classes of filtering facepiece respirators)
- Use of N-95 respirators beyond stated expiration date.
- Extended use of N-95 for repeated close contact encounters.
- Limited re-use of N-95 for multiple contact encounters
- Use of a cleanable face shield (preferred) or a surgical mask over an N-95 respirator and/or other steps (e.g., masking patients, use of engineering controls), when feasible, to reduce surface contamination of the respirator.
- Hanging of used respirators in a designated storage area or keeping them in a clean, breathable container such as a paper bag between uses.
  - To minimize potential cross-contamination, store respirators so that they do not touch each other and the person using the respirator is clearly identified.
  - Storage containers should be disposed of or cleaned regularly.
- Discarding respirators in any of the following conditions:
  - After it has been used five separate times.
  - When visibly soiled.
  - When difficult to breathe through.
  - Following use during aerosol-generating procedures such as bronchoscopy or sputum collection.
  - Contaminated with blood, respiratory or nasal secretions, or other bodily fluids from patients, or if damaged.
- **Donning procedures for previously used N-95 respirators:** Use a new pair of clean (non-sterile) gloves when donning a used N-95 respirator and performing a user seal check. Discard gloves after the N-95 respirator is donned and any adjustments are made to ensure the respirator is sitting comfortably on your face with a good seal.

GUIDANCE IN THE EVENT OF AN N-95 SHORTAGE

In the event of a shortage, N-95 respirators should be reserved for **CONFIRMED COVID-19** inmates and for use when an inmate is undergoing an **AEROSOL-GENERATING PROCEDURE**, including testing for COVID-19.

→ *Surgical masks are an acceptable alternative when the supply chain of N-95 respirators cannot meet the demand.*

SURGICAL MASKS OR EQUIVALENT

APPROPRIATE USE OF SURGICAL MASKS

- Surgical masks must be worn by **ALL HEALTH CARE WORKERS** to include staff, contractors, and inmate workers in all patient care areas, whether or not there are patients in the clinic area as both PPE and source control (protection of patients and co-workers).
- Surgical masks should be worn by **ALL OTHER STAFF** when performing enhanced screenings, screening inmates coming into the institution, during R&D encounters, when escorting asymptomatic persons to quarantine, when entering the **QUARANTINE** environment for temperatures or care, and when less than 6 feet from inmates in **QUARANTINE.***

★ ***Wearing of surgical masks applies to ALL TYPES OF QUARANTINE:*** *Intake, exposed, and pre-release/ transfer.*

- Surgical masks should be worn if an **INMATE WORKER FROM GENERAL POPULATION** is utilized as an orderly in quarantine. Alternatively, a fit-tested N-95 may be worn.

SUPPLY OPTIMIZATION FOR SURGICAL MASKS

Prioritize surgical masks for selected activities such as:

- **ESSENTIAL PROCEDURES** when splashes and sprays are anticipated with suspected or confirmed COVID-19 case or when bloodborne pathogen exposure is anticipated.
- During **CARE ACTIVITIES** where splashes and sprays are anticipated.
- During activities where **PROLONGED FACE-TO-FACE OR CLOSE CONTACT** with a potentially infectious patient is unavoidable.
- For performing **AEROSOL-GENERATING PROCEDURES**, if respirators are no longer available.

The CDC recommends the following strategies for optimizing the supply of surgical masks.

→ *See the CDC's recommendations at: https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/strategies-optimize-ppe-shortages.html*

- Use surgical masks beyond stated expiration date. If there is no expiration date on the facemask label or packaging, facilities should contact the manufacturer to determine if the facemask can be used. The user should visually inspect the product prior to use and, if there are concerns (such as degraded materials or visible tears), discard the product.
- Implement limited re-use of surgical masks.
  - Surgical masks with elastic ear hooks may be more suitable for re-use. Facemasks that fasten via ties may not be able to be undone without tearing and should be considered only for extended use, rather than re-use.
  - When removed, surgical masks should be carefully folded so that the outer surface is held inward and against itself to reduce the user's contact with the outer surface during storage. Store the folded mask between uses in a clean, paper bag, or breathable container.
  - The surgical mask should be removed and discarded if soiled, damaged, or hard to breathe through.

GUIDANCE IN THE EVENT OF A SHORTAGE OF SURGICAL MASKS

- Exclude staff and inmate workers at increased risk for severe illness from COVID-19 from contact with known or suspected COVID-19 patients.
- Instead of a surgical mask, use a face shield that covers the entire front (extending to the chin or below) and sides of the face.
- Use of cloth face coverings are not considered PPE, since their capability to protect HCP is unknown. CAUTION should be exercised when considering this option. Cloth face coverings should ideally be used in combination with a face shield that covers the entire front (extending to the chin or below) and sides of the face
- Once PPE availability returns to normal, promptly resume conventional practices.

GOWNS

APPROPRIATE USE OF GOWNS AND COVERALLS

- Gowns are used when in direct contact with inmates in QUARANTINE and MEDICAL ISOLATION, for performing care or activities where splashes and sprays are anticipated, and during use of aerosol-generating procedures, including swabbing inmates for COVID testing.
- If custody staff need to wear a duty belt over their protective gown or coverall (for access to equipment), ensure that the duty belt and gear are disinfected after close contact with the individual. Clean and disinfect duty belt and gear prior to re-use, using an EPA list N cleaning spray or wipe, according to the product label.
- Current CDC guidelines do not require use of gowns that conform to any particular standards. Gowns and coveralls that conform to international standards, including EN 13795 and EN14126, could be reserved for activities that may involve moderate to high amounts of body fluids.

SUPPLY OPTIMIZATION OF GOWNS

➔ *CDC contingency strategies for optimizing supplies of gowns may be found at: https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/isolation-gowns.html*

- **Gowns should be prioritized for the following:** Aerosol-generating procedures; patient care activities where splashes and sprays are anticipated; and high-contact patient care activities that provide opportunities for transfer of pathogens to the hands and clothing of staff (i.e., dressing, bathing/showering, transferring, provision of hygiene, changing linens, assistance with toileting, device care or use, and wound care).
- **Cloth gowns that can be rewashed are preferred over reusing disposable gowns.** Disposable gowns are not typically amendable to being doffed and re-used because the ties and fasteners typically break during doffing.
- **If a disposable gown must be used more than once during a shift:**
  - Wipe off any obvious contamination on the front of the gown while wearing new gloves.
  - Remove gloves, perform hand hygiene, and don new gloves. Then, remove gown:
    - Release the ties at neck and waist, then grasp the gown at the inside shoulder area, and pull the gown down and away from your body.
    - Once the gown is off your shoulders, pull one arm at a time from the sleeves of the gown so that the gown arms are bunched at your wrists. Pull gown away from body and off.

- Hang gown up on designated hanger with inside facing out.

➢ Re-don the gown with clean gloves on, only touching the inside of gown. Remove gloves, perform hand hygiene, and apply new gloves. Have someone secure back of gown with ties or tape.

➢ Dispose of gown at the end of the shift.

GUIDANCE IN THE EVENT OF A SHORTAGE OF GOWNS AND COVERALLS

In situations where gowns are severely limited or not available, the following pieces of clothing can be considered as a last resort for care of COVID-19 patients, as **SINGLE USE**:

- Disposable laboratory coats
- Reusable (washable) patient gowns
- Reusable (washable) laboratory coats
- Disposable aprons
- Combinations of clothing can be considered for activities that may involve body fluids when there are no gowns available, for example:
  - ➢ Long-sleeve aprons in combination with long-sleeve patient gowns or laboratory coats
  - ➢ Open back gowns with long-sleeve patient gowns or laboratory coats
  - ➢ Sleeve covers in combination with aprons and long-sleeve patient gowns or laboratory coats

GLOVES

- Wear gloves when in direct contact with inmates, when transporting inmates, during food delivery or tray removal, upon entry to quarantine or medical isolation of COVID-19 suspected or confirmed cases—and when providing medical care of inmates, in general.
- **Gloves are not a substitute for hand hygiene.** Change gloves and perform hand hygiene during patient care if gloves become damaged or become visibly soiled with blood or body fluids following a task; when moving from work on a soiled body site to a clean body site on the same patient; or if another clinical indication for hand hygiene occurs.

➔ *Never wear the same pair of gloves in the care of more than one patient.*

GUIDANCE IN THE EVENT OF A SHORTAGE OF DISPOSABLE MEDICAL GLOVES

- The CDC does not recommend disinfection of disposable medical gloves however, in times of extreme shortages, alcohol-based hand sanitizer (ABHS) is the preferred method for performing hand hygiene of gloved hands when gloves are not visibly soiled.
- Disposable medical gloves can be disinfected or up to six (6) applications of ABHS.
- If ABHS is not available, soap and water may be used although washing may be impractical for short-cuffed gloves where water may enter inside the worn gloves.
- Disposable medical gloves can be cleaned with soap and water up to 10 times.

EYE PROTECTION

- Eye protection is defined as goggles or a disposable face shield that fully covers the front and sides of the face to protect the membranes of the eyes.
- Eye protection does **NOT** include personal eyeglasses.

APPROPRIATE USES OF EYE PROTECTION

Eye protection is used in a range of situations:

- If direct or very close contact with ill inmates (e.g. temperature checks) or if splashes or spray is anticipated.
- When performing temperature checks
- When screening inmates coming into the institution
- During R&D encounters
- While in QUARANTINE and MEDICAL ISOLATION units that are open, barracks-style, or cells with bars*
- When entering the room or opening the trap door of QUARANTINED or MEDICAL ISOLATION rooms*
- When escorting asymptomatic persons to QUARANTINE*

★ ***Wearing of eye protection applies to ALL TYPES OF QUARANTINE (intake, exposed, and pre-release/ transfer), as well as MEDICAL ISOLATION.***

SUPPLY OPTIMIZATION OF EYE PROTECTION

- EXTENDED USE of eye protection is the practice of wearing the same eye protection for repeated close contact encounters with multiple patients, without removing eye protection between patient encounters. **Extended use of eye protection can be applied to disposable and reusable devices.**
- If a disposable face shield is cleaned and disinfected ("reprocessed"), it should be dedicated to one staff member and reprocessed whenever it is visibly soiled or removed (e.g., when leaving the isolation area) prior to putting it back on. Refer to *Donning and Doffing* section for protocol for removing and reprocessing eye protection.
  - Eye protection should be discarded if damaged (e.g., face shield can no longer fasten securely to the provider, or if visibility is obscured and reprocessing does not restore visibility).
  - Staff should take care not to touch their eye protection. If they touch or adjust their eye protection, they must immediately perform hand hygiene.

GUIDANCE IN THE EVENT OF A SHORTAGE OF EYE PROTECTION

Shift eye protection supplies from disposable to re-usable devices (i.e., goggles and reusable face shields). Ensure cleaning and disinfection between users if goggles or reusable face shields are used.

SUPPLY CHAIN MANAGEMENT

- At least once weekly, inventory current supplies of PPE and enter levels into the inventory capture dashboard as directed by the Health Services Division.
- Refer to MODULE 1 for additional supply chain management guidance.

Facilities should implement the following to preserve PPE supplies including:

- Exclude non-essential staff from entering isolation or quarantine areas.
- Minimize the number of individuals who need to use respiratory protection by limiting persons in direct contact with suspected or confirmed COVID-19 cases.
- Reduce face-to-face encounters with inmates being screened at entry points, at R&D encounters, and at sick calls and triage.

MODULE 3. SCREENING AND TESTING

WHAT'S NEW

- Movement quarantine is now referred to as movement observation.
- Quarantine is clarified to specifically describe exposure quarantine.

MODULE 3 TABLE OF CONTENTS

A. SCREENING INMATES FOR COVID-19

1. INDICATIONS FOR SCREENING

- **INTAKE SCREENING:** All new inmate arrivals at any BOP facility.
  - Includes all new intakes (detainees and commitments, writ returns, parole violators, bureau intra-system transfers, etc.), regardless of their mode of arrival (voluntary surrender, USMS/JPATS, ICE, BOP, etc.).
  - Includes hospital returns, and court appearances (same-day trips)
  - COVID-19 screening is recommended early in the intake screening process, preferably before entering the building.
  - Documentation of the COVID-19 symptom screen and temperature check for new intakes will be recorded in the BEMR Intake note, along with disposition to general population, movement observation, quarantine or isolation.
- **EXIT SCREENING:** All inmates exiting/leaving the premises (i.e. hospital trips, court appearances, transferring to other BOP institutions, going to RRC, releasing, etc.).
- **SCREENING AS PART OF CONTACT INVESTIGATION:** Close contacts of a COVID-19 case.
- **SCREENING AS PART OF ENTRY/EXIT TO QUARANTINE OR MEDICAL ISOLATION.** Refer to **MODULE 4** -Inmate Isolation and Quarantine.

2. SCREENING PROCESS

- **SYMPTOM SCREENING**
  - Chills, cough, shortness of breath
  - Fatigue, muscle or body aches, headache
  - New loss of taste or smell
  - Sore throat, congestion, or runny nose
  - Nausea, vomiting, or diarrhea
- Inmates who are symptomatic or have a temperature (see below) need to be isolated promptly. (Refer to **MODULE 4** and the **Medical Isolation Checklist** in the **APPENDICES**.)
- **TEMPERATURE CHECK** (see *Temperature Check Protocol* below): A "temperature" depends on the kind of thermometer used:
  - Oral: ≥ 100.4˚F
  - Ear: ≥101˚F
  - Forehead: ≥ 100˚F
- **PPE FOR INMATE SCREENINGS:** Staff who are conducting inmate screenings will wear PPE including gown, disposable gloves, surgical mask and face shield/eye protection (goggles or face shield that fully covers the front and sides of face), in accordance with CDC guidance.
- **USE OF NON-HEALTH CARE STAFF:** To assist health care staff in completing screenings, non-health care staff can be trained to obtain temperatures, record yes/no answers to a symptom screen, and document on a roster.
  - *Any positive screening is reported promptly to health care staff for further assessment, planning, and intervention.*
  - Training videos for non-health care providers to check temperatures can be found on the BOP Sallyport COVID-19 guidance page.

- Upon completion of a temperature video, staff should complete the Opinio Survey also found on the BOP Sallyport COVID-19 guidance page, so that the training can be added to the staff person's training record.

3. TEMPERATURE CHECK PROTOCOL

- Perform **HAND HYGIENE** (see **MODULE 1**)
- Don PPE (see **MODULE 2**)
- **CHECK INDIVIDUAL'S TEMPERATURE:**
  - Non-contact or disposable thermometers are preferred over reusable oral thermometers.
  - If **DISPOSABLE OR NON-CONTACT THERMOMETERS** are used and the screener did not have physical contact with the individual, the screener's gloves do not need to be changed before the next individual is temperature-checked.
    - *Non-contact thermometers should be cleaned routinely for infection control.*
  - If performing **ORAL TEMPERATURE CHECKS** on multiple individuals, ensure that a clean pair of gloves is used for each individual being checked and that the thermometer is used with disposable probe tips.
- Remove and discard **PPE**.
- Perform **HAND HYGIENE**.

SOURCE CONTROL IS CRITICALLY IMPORTANT.

- If inmates are identified with symptoms of COVID-19, immediately have them put on a **FACE COVERING** and perform **HAND HYGIENE**.
- Escort staff will don appropriate PPE (refer to **MODULE 2**) and escort the inmate to the designated **RESPIRATORY MEDICAL ISOLATION** area.

B. COVID-19 TESTING

1. DIAGNOSTIC TESTS

The most accurate test for the **SARS-COV-2 VIRUS** that causes COVID-19 is a molecular test performed on respiratory secretions, using nucleic acid amplification technology (**NAAT**), usually a reverse transcriptase-polymerase chain reaction (**RT-PCR OR PCR**). COVID-19 viral antigen tests are also available for testing of respiratory secretions.

- Based on the available evidence and published recommendations, the **BOP-PREFERRED SAMPLE** for symptomatic and asymptomatic cases is a swab from the **nasopharynx, mid-turbinate, or anterior nares.**
  - A lower respiratory tract specimen is usually reserved for testing in a hospital setting or for patients whose upper respiratory tract specimen has tested negative despite a high degree of clinical suspicion.
  - Sputum induction is not recommended in the outpatient setting due to increased risk for exposure to respiratory droplets or aerosols.
  - In general, the BOP does not recommend the use of antibody testing unless it is required by civilian health care entities for a patient to be evaluated.

- **COVID-19 COMMERCIAL PCR TESTS** are sent out to a lab for processing after institution staff collect the swab sample, and then appropriately label and package it. These "send-out" PCR tests are processed using an FDA-approved test.
  - ➔ *Utilization of the BOP national laboratory contract for COVID-19 testing is required for commercial testing.*
- **RAPID, POINT-OF-CARE (POC) TESTS** are FDA-approved tests available for detection of viral nucleic acid or antigen and performed by BOP staff, after appropriate training.
  - ➔ *Negative results from patients with symptoms should be treated as preliminary and confirmed with a molecular assay, if necessary, for patient management.*

2. INDICATIONS FOR TESTING

Depending on the status of testing supplies and the increased understanding of the epidemiology of transmission, expanded **TESTING STRATEGIES** have become an important tool in the prevention and management of COVID-19 infections. This is especially true in congregate living and residential settings such as correctional facilities where social distancing may be difficult to achieve or maintain.

➔ *The indications for testing for the SARS-CoV-2 virus in a correctional environment include both **ASYMPTOMATIC** and **SYMPTOMATIC** inmates with compelling reasons or priorities for testing.*

Specific INDICATIONS FOR TESTING in the BOP are listed below in FOUR (A–D) CATEGORIES. If there are limitations on the number of tests that can be performed at a given location, prioritization of testing indications may be needed and should be done in consultation with the Regional Medical Director, the Regional Health Services Administrator, and the Regional Infection, Prevention, and Control Consultant.

➔ *Refer to **MODULE 4. MEDICAL ISOLATION AND QUARANTINE**, for further guidance regarding (1) testing inmates into medical isolation (2) testing in and out of quarantine and (2) other criteria for releasing inmates from medical isolation and quarantine.*

SYMPTOMATIC INMATES

➔ *Testing **SYMPTOMATIC INMATES** is the primary reason for use of the POC COVID-19 tests in the BOP. However, a negative test result from a POC system should **NOT** be used as the sole basis for patient management decisions, due to concerns about **FALSE NEGATIVE RESULTS**.*

- Symptomatic inmates whose POC test is **POSITIVE** should be placed in **MEDICAL ISOLATION**.
  - ➔ *A **POSITIVE** POC test result does **NOT** require confirmation with a commercial PCR test.*
- Ideally, symptomatic inmates whose POC test is **NEGATIVE** should undergo **CONFIRMATION TESTING** - another specimen is collected and sent out for commercial **PCR** lab testing.
  - ➔ *Until the confirmation commercial PCR test results are known, the symptomatic patient is placed into **MEDICAL ISOLATION**—but separate from symptomatic patients whose POC test was positive. If the commercial PCR test result is positive, the inmate may be cohorted in medical isolation with other positive cases. Clinical judgment will be needed if the commercial lab test result is negative and consultation with Regional Health Services staff is recommended.*
  - ➔ *During critical testing supply availability or severe staff shortages, it may not be possible to repeat testing with a commercial PCR test on symptomatic inmates; in these cases, the inmates should be presumed infected and placed into **MEDICAL ISOLATION**.*
- **Testing for release from COVID-19 medical isolation is NOT recommended.**
  - ➔ *Refer to **MODULE 4** for criteria used for releasing inmates from medical isolation.*

ASYMPTOMATIC INMATES WITH KNOWN OR SUSPECTED CONTACT WITH A COVID-19 CASE

- When a staff or inmate case of COVID-19 is identified at an institution, **CONTACT TRACING** of both inmates and staff should be performed expeditiously.
- All inmates identified as **CLOSE CONTACTS** of the index case should be assessed for symptoms and tested using either a POC or commercial PCR test based on how quickly the results are needed and the supply availability at the institution.
- **TESTING IN HOUSING UNITS:** Because COVID-19 is very contagious and is spread by asymptomatic as well as symptomatic individuals, expanded testing of all inmates in an entire housing unit should be considered—especially if the unit has open sleeping areas (rather than cells with solid walls and doors), common areas where inmates have close contact, or houses inmates with high-risk conditions.
- **INSTITUTION-WIDE TESTING** of inmates may be considered where one or more inmate or staff cases of COVID-19 have been identified in different housing units.
  - This is recommended especially if substantial transmission is confirmed beyond the index case, or if staff or inmates have moved about the institution.
  - Institutions should consult with their regional infection prevention and control (IPC) officer prior to initiating expanded testing strategies.
- **RETESTING DURING WIDESPREAD TRANSMISSION:** Retesting of close contacts who previously tested negative—or retesting more broadly—is recommended when there is widespread institution transmission. A testing frequency of every 3 to 7 days is recommended, whenever feasible, in consultation with the Regional IPC and the Regional Medical Director.

ASYMPTOMATIC INMATES WITH NO KNOWN OR SUSPECTED CONTACT WITH A COVID-19 CASE

- **A TEST-IN/TEST-OUT STRATEGY** is used, when indicated, for inmates being admitted to and discharged from any type of routine observation period or quarantine.
- **ALL INMATE INTAKES, RELEASES, AND TRANSFERS** (including to BOP Medical Referral Centers) should be tested.
  - *Refer to **MODULE 6** for specific guidance regarding testing procedures for **INMATE MOVEMENT**.*
  - While a commercial PCR test may be used for routine observation periods (formerly known as movement quarantine) instead of a POC test, outside processing has the disadvantage of a longer turnaround time.
  - A POC test may be used instead of the commercial PCR test, depending on how quickly the results are needed, and the supply availability at the institution
- **INMATES RETURNING FROM THE COMMUNITY** should be tested. Examples include an extended time in an emergency department or crowded waiting area; residing overnight in the community or alternative setting including hospitalization or furlough; work release; and court appearances.
  - *Inmates with frequent or regular trips to the community (e.g., court hearings, work release), may need to be housed in a separate housing group and tested periodically (e.g., once every three to seven days).*
- **HEALTH-CARE RELATED TESTING:**
  - Inmates may be required to be tested in order to be seen at a **CIVILIAN HEALTH CARE SYSTEM.**
  - For **RESIDENTIAL HEALTH CARE UNITS AT MRCs** (e.g., Nursing Care Center units) without any known or suspected cases of COVID-19, **BASELINE TESTING** of inmate residents is recommended by the

CDC in conjunction with **PERIODIC RETESTING**. Institutions should consult with their regional IPC to determine frequency of testing.

- **INSTITUTION-WIDE SURVEILLANCE TESTING** involves testing all inmates at an institution without any known COVID-19 cases.
  - The effectiveness, feasibility, and role of this type of testing in a correctional setting is not clearly defined and requires considerable resources. Low participation rates are likely to limit its effectiveness, and institution health care staffing levels are likely to be insufficient to accomplish it.
  - **ALTERNATIVE STRATEGIES:** When institution-wide surveillance testing of inmates is not feasible, alternative strategies may be considered such as **PERIODIC TESTING OF CERTAIN GROUPS** such as inmates with risk factors for severe COVID-19 illness, CPAP users, inmates who work in groups or who may interact with large numbers of staff or inmates as part of their duties (e.g., food service, orderlies), inmates housed in a residential health care unit, etc.
  - Institutions should consult with their regional IPC to determine frequency of testing.

RELEASE FROM MOVEMENT OBSERVATION OR QUARANTINE

- Every inmate undergoing a routine observation period (formerly known as movement quarantine) or quarantine will require a PCR or POC test out on the last day.

3. SPECIMEN COLLECTION

The following information applies to specimen collection for either a POC or PCR test. Training videos, fact sheets and manufacturer website links for these tests are available on the Sallyport COVID-19 guidance page.

→ *Handle **LABORATORY WASTE** from testing suspected or confirmed COVID-19 patients the same as all other biohazardous waste in the laboratory. Currently, there is no evidence to suggest that this laboratory waste needs any additional packaging or disinfection procedures.*

USE OF THE POC TESTS

- All staff performing testing must demonstrate competency.
  - → *Refer to the **APPENDICES** for the **Competency and Performance Assessment** and **Training Log** forms.*
- Staff using the Abbott ID NOW machines must perform quality control (QC) tests as specified by the CLIA waiver and the manufacturer.
  - → *Refer to the **QUICK REFERENCE INSTRUCTIONS** for using the Abbott ID NOW machine and running QC tests, available at: https://dam.abbott.com/en-us/homepage/coronavirus/38993-ID-NOW-QRG-r4-HD.pdf*
- Staff using the Abbott BinaxNOW COVID-19 Ag Card should refer to **PROCEDURE CARD** and **QUICK REFERENCE SHEET** available at: *https://www.globalpointofcare.abbott/en/product-details/navica-binaxnow-covid-19-us.html*

LOCATION FOR SPECIMEN COLLECTION

When collecting diagnostic respiratory specimens (e.g., nasopharyngeal (NP) swabs) from a patient with possible COVID-19, the following should occur:

- Specimen collection should be performed outdoors if possible.
- If testing is performed in an examination room and is repeatedly used for consecutive testing of inmates, a method of purifying the air is recommended—such as an airborne infection isolation room (AIIR) or a room with a portable high-efficiency particulate air (HEPA) air purifier:
  - Use a HEPA filter that is sufficient for the size of the room (consult with HVAC), and base the wait time between individuals on the clean air delivery rate (CADR) for the filters.
  - In rooms without HEPA filtering, coordinate with the facilities department to determine if the air flow in the room(s) can be adjusted to vent to the outside or to increase the rate of air exchange.

PPE FOR STAFF

Staff performing the testing and/or handling of specimens should wear an N95 respirator, eye protection (face shield or goggles), gloves, and a gown.

- If the supply of N95 respirators is limited, they should be prioritized for procedures at higher risk for producing infectious aerosols (e.g., intubation). In this case, staff should use surgical masks.
- Staff should remove PPE when leaving the testing area.
- Gloves should be changed after each patient, and hand hygiene should be performed prior to donning new gloves.
- Avoid contact of the gown with inmates during swabbing, to minimize contamination of the gown. If a gown becomes soiled (e.g., inmate sneezes on the gown during specimen collection):
  - Doff the gown in the collection room and perform hand hygiene.
  - Doff the gloves (both pairs if double gloved) and perform hand hygiene.
  - Proceed directly to exit and perform hand hygiene upon exiting.
  - Don a new gown and gloves outside the testing area.
- If eye protection is also soiled:
  - Doff gloves and perform hand hygiene.
  - Don clean gloves.
  - Doff eye protection using strap from the back.
  - Eye protection can either be disposed of in trash or cleaned with an EPA disinfectant wipe.
  - Doff gloves and dispose of in trash and perform hand hygiene
  - Don new gloves and face shield or goggles outside the testing area.

→ *If a staff member needs to take a break and leave the testing area, the procedure will be the same as above, with all PPE doffed and hand hygiene performed inside the room before leaving.*

→ *Refer to MODULE 2 for additional information on PPE, including donning and doffing procedures.*

PREPARATION FOR SPECIMEN COLLECTION

- **INMATES** should wear their BOP-approved face covering in the testing area and pull it down below their nose, leaving their mouth covered during the collection of the specimen.
- **ESSENTIAL STAFF ONLY:** The number of staff present during the procedure should be limited to only those essential for patient care and procedure support. Place a notice on the door that COVID testing is being conducted. Only authorized personnel can enter.
- **WAITING AREA:** Inmates will stand on marked areas, which will be ≥6 ft apart in front of the screening table, and maintain social distancing while waiting.
- **ROOM PREPARATION:**
  - 30 minutes prior to specimen collection, testing rooms will be disinfected.
  - Place a countertop splash guard (if available) in front of the machine, if collecting and running tests in same room.
  - Place a chux on the floor in front of the machine (if available), and dispose of it at the end of each day.
- **EXPIRATION DATES:** All testing supplies should be checked for expiration date prior to use. If expired, supplies should be returned to the BOP Central Fill and Distribution (CFAD).

SPECIMEN COLLECTION PROCEDURE:

- Orient the inmate being swabbed toward a wall so that, if they cough or sneeze, the respiratory droplets will not be directed toward another person or a space where others will walk.
- Before the NP swabbing, ask the inmate to blow their nose and provide them with tissues, as well as hand sanitizer to use afterwards.
- Proceed to the screening questions and explain the procedure, allowing time to answer the inmate's questions.
- Collect the NP swab (allow 3–5 minutes, including packaging of sample).
- Discard the used swabs as biohazardous waste.
- Work surfaces such as the chair and table within a 6-foot radius of the swabbing location should be cleaned and decontaminated after each inmate.
- If excessive coughing or sneezing occurs during the collection process, in addition to wiping down surfaces, there will be a 10-minute wait before the next individual enters the testing room.

  → *Abbott ID NOW and BinaxNOW Ag Card respiratory samples must be processed within* **ONE HOUR** *of collection and* **MAY NOT** *be refrigerated for later processing.*

DECONTAMINATION OF THE TESTING AREA

- Follow the manufacturer's guidelines for cleaning POC testing machines.
- At the end of the swab testing, the room will be cleaned and wiped down and mopped with appropriate EPA-approved disinfectant per manufacturers' directions for dilution, contact time, and safe handling.

→ *Refer to* **MODULE 1** *for additional cleaning and decontamination guidance.*

4. LABORATORY ORDERING AND DOCUMENTATION

POINT OF CARE TESTS

- COVID-19 RNA results (e.g. Abbott ID NOW test) are documented in the EMR Flow Sheets under COVID-19 RNA.
- COVID-19 antigen results (e.g. Abbott BinaxNOW) are documented in the EMR Flow Sheets under COVID-19 AG.
- POC testing does not require an NMOS order.

→ *Refer to the BEMR user document "COVID-19 Flow Sheet" for step-by-step instructions, available on BOP Sallyport.*

SEND-OUT TESTING

- There is only one SEND-OUT commercial COVID-19 Lab Test available under the Laboratory Information System (LIS) Tests tab in BEMR:
  - COVID-19 Novel Coronavirus
- Type **COVID** in the Lab Test Search box.
  - → *If lab orders were incorrectly ordered using a different test and typing "COVID" in the comments, those must be D/C and reordered using one of the two tests listed above.*

PUBLIC HEALTH NOTIFICATION OF POSITIVE TESTS

- COVID-19 is a **REPORTABLE DISEASE** and must be reported to civilian health authorities in accordance with individual state reporting requirements.
- Contact the local health department to ascertain reporting requirements and methods for sharing data.

5. SCREENING AND TESTING PROCEDURES SUMMARY

All movement-specific screening and testing procedures can be found in **MODULE 6. INMATE MOVEMENT.**

All screening and testing procedures for quarantine or symptomatic and/or positive confirmed testing can be found in **MODULE 4. INMATE ISOLATION & QUARANTINE**

6. MANAGING INMATES WHO REFUSE TESTING

Inmate refusal of testing may be a concern that requires management, not just for the sake of the inmate's individual healthcare, but also to aid in management decisions that could involve the healthcare of others. **As such, it is considered not just a refusal for medical treatment, but also an act that affects the safe and orderly running of the institution.**

→ ***Program Statement 6190.04, Infectious Disease Management,*** *states, "The Bureau tests an inmate for an infectious or communicable disease when the test is necessary to verify transmission following exposure to bloodborne pathogens or to infectious body fluid. An inmate who refuses diagnostic testing is subject to an incident report for refusing to obey an order."*

ADMINISTRATIVE MANAGEMENT OF INMATES WHO REFUSE TESTING

Although not every potential scenario can be anticipated, the information below provides some guidance and principles for the management of inmates who refuse COVID-19 testing.

- A distinction should be made between those who simply refuse testing and those who are willing to be tested, but are unable to tolerate testing via nasopharyngeal, oropharyngeal, nasal mid-turbinate or anterior nares swabbing. Follow CDC instructions on proper sample collection and handling: *https://www.cdc.gov/coronavirus/2019-ncov/lab/guidelines-clinical-specimens.html#specimen*
- If an inmate refuses testing, the first action is to **EDUCATE** the inmate on the importance of testing, why it is being conducted, and the potential risks and benefits of testing vs. refusal.
- Except where noted under "B. Clinical Management" below, if an inmate continues to refuse COVID testing, they should be given a **DIRECT ORDER** to submit to testing.
  - If an inmate refuses the direct order, an **INCIDENT REPORT** should be generated. A sample Incident Report is provided in **APPENDICES**.
  - A **MEDICAL TREATMENT REFUSAL FORM** should also be completed.
  - Due to the risk of exposure for staff, a use of force to involuntarily obtain a sample is generally not recommended.

CLINICAL MANAGEMENT OF INMATES WHO REFUSE TESTING

Clinical management of inmates refusing COVID-19 testing will vary depending on a variety of factors:

- **SYMPTOMATIC PATIENTS (REGARDLESS OF VACCINATION STATUS):** Place in single-cell **MEDICAL ISOLATION** until they clear CDC symptom-based criteria for release from isolation. Ideally, this isolation should be separated from both suspected and known positive COVID-19 isolation cases.
  - → *Refer to MODULE 4 for information regarding medical isolation.*
- **ASYMPTOMATIC CLOSE CONTACTS:** Inmates who refuse testing will complete quarantine and will be screened for symptoms.
  - If the inmate becomes **SYMPTOMATIC** at any time during the quarantine, follow guidance for symptomatic patients in the bullet above.
  - If the inmate remains **ASYMPTOMATIC**, testing should continue to be made available throughout the quarantine period.
    - If the inmate **submits to testing and tests negative**, they will complete quarantine and test-out on the last day of quarantine in order to be released.
    - If the inmate **submits to testing and tests positive**, they should be placed in **MEDICAL ISOLATION** and follow time-based criteria for release from isolation.
    - If the inmate **continues to refuse testing**, they should be placed in continued quarantine for another 10 days. They may be released at the end of the additional 10 days if they remain asymptomatic.
- **ASYMPTOMATIC NEW BOP INTAKES:** Follow guidance for **ASYMPTOMATIC CLOSE CONTACTS** above.
- **ASYMPTOMATIC INMATES REFUSING TO "TEST-OUT" PRIOR TO RELEASE FROM MOVEMENT OBSERVATION (FORMERLY KNOWN AS INTAKE QUARANTINE):** Follow guidance above for **ASYMPTOMATIC CLOSE CONTACTS** who refuse testing to release from quarantine.

- **ASYMPTOMATIC INMATES REQUIRED TO BE TESTED IN ORDER TO BE SEEN AT A CIVILIAN HEALTH CARE SYSTEM:** Educate the inmate on the need for testing in order to be seen at civilian health care system.
  - If inmate continues to refuse, have inmate sign refusal for testing and for the medical trip. Document in BEMR that inmate was educated on the testing requirements of the outside facility and that inmate refused.
  - Educate the inmate to notify Health Services if they change their mind about testing so that they can go on the medical trip. In this instance, since testing would not otherwise be indicated, **NO** direct order or Incident Report should be given for refusal.
  - It is also important to note that even if an inmate has previously refused COVID-19 testing, if experiencing a **MEDICAL EMERGENCY**, they should still be taken to a community hospital.
- **ASYMPTOMATIC INMATES TRANSFERRING TO/ARRIVING AT A BOP MEDICAL REFERRAL CENTER (MRC):**
  - When feasible, follow the above guidance for **ASYMPTOMATIC CLOSE CONTACTS**.
  - In some instances, the medical condition may have precluded completion of transfer observation (formerly known as transfer quarantine) at the sending facility. In these instances, it is especially important for MRCs to implement intake observation procedures. With these cases, it is imperative that the sending and receiving institutions are in direct communication to ensure a smooth, timely and appropriate transfer.
- **ASYMPTOMATIC INMATES DEPARTING A BOP FACILITY FOR HOME CONFINEMENT, REGIONAL REENTRY CENTER, OR FULL TERM/GOOD CONDUCT TIME RELEASE,** especially if there are any cases of COVID at the institution:
  - Follow the above guidance for **ASYMPTOMATIC CLOSE CONTACTS** prior to release. Note that this may delay an inmate's release, and inmate should be educated as such.
  - If circumstances require **IMMEDIATE RELEASE** or it is mandated without enough time to fulfill a routine observation period or quarantine requirements, the receiving facility, home and/or local health department must be notified of the patient's COVID-19 status. Direct order and Incident Report for refusal of testing in this situation does **NOT** apply.
- **ASYMPTOMATIC INMATES DEPARTING A BOP FACILITY AS A TRANSFER TO ANOTHER BOP FACILITY OR OTHER CORRECTIONAL JURISDICTION:** Follow above guidance for **ASYMPTOMATIC CLOSE CONTACTS**.
- **TESTING INMATES AS PART OF AN INSTITUTION-WIDE SURVEILLANCE PROGRAM:** Follow above guidance for **ASYMPTOMATIC CLOSE CONTACTS**.

C. INFLUENZA TESTING

- For patients with acute respiratory symptoms, it may be difficult to distinguish between symptoms of influenza and COVID-19. This is an especially important consideration when high seasonal influenza activity overlaps with the COVID-19 pandemic. During such times, the BOP recommends testing for both COVID-19 and influenza A/B.
- Facilities may test for influenza via commercial (Quest) testing, department of health flu testing, or the POC testing.
  - Several POC influenza tests have been CLIA waived for institutions with a current, valid CLIA certificate of Waiver.
  - Information regarding the Abbott ID NOW Influenza test can be found here: *https://www.globalpointofcare.abbott/en/product-details/id-now-influenza-ab-2.html*
  - Training for POC test processing must be completed prior to use. Institutions should contact the National Laboratory Administrator for training guidance.

MODULE 4. MEDICAL ISOLATION AND QUARANTINE

WHAT'S NEW

- MOVEMENT QUARANTINE is now referred to as MOVEMENT OBSERVATION. Refer to the *BOP Pandemic Plan* Module 6. Inmate Movement for details on routine observation requirements during inmate movement.
- "Quarantine" is now only used in the context of COVID-19 as it refers to separating an individual or a group of individuals (cohort) with a known or suspected exposure to the SARS-CoV-2 virus.

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A. DEFINITIONS

CASE refers to an individual who has a positive test for COVID-19 **OR** who has symptoms consistent with COVID-19, but has not yet been tested or whose test results are pending.

CLOSE CONTACT: In the context of COVID-19, an individual is considered a close contact if they have not been wearing appropriate PPE **and**:

- Have been within 6 feet of an infected person for a cumulative total of 15 minutes or more over a 24-hour period starting from 2 days before illness onset (or, for asymptomatic patients, 2 days prior to test specimen collection) **OR**
- Had direct contact with infectious secretions of a COVID-19 case.

Considerations when assessing close contacts include the proximity to the infected person, duration of exposure, and the clinical symptoms of the person with COVID-19 (i.e., coughing likely increases exposure risk as does an exposure to severely ill persons).

COHORTING: The practice of grouping patients infected or colonized with or potentially exposed to the same infectious agent together to confine their care to one area and prevent contact with susceptible patients. In the BOP, this may refer to housing inmates of similar infection status together rather than in single cells.

FULLY VACCINATED: Hx. Of having completed a vaccination series: 2 weeks after their second dose in a 2-dose series (Pfizer or Moderna), or 2 weeks after a single-dose vaccine (Janssen) as authorized by the U.S. Food and Drug Administration of the United States.

MEDICAL ISOLATION: Confining individuals with suspected (displaying symptoms) or confirmed (based on a positive point of care [POC] or commercial laboratory test) COVID-19 infection, either to single rooms or by **COHORTING** them with other infected patients.

MOVEMENT OBSERVATION: periods (formerly known as movement quarantine) implemented during movement as part of intake, transfer and/or release processes. Movement observation is not indicated after potential exposure to someone with COVID-19 and inmates in movement observation should **not** be housed with post-exposure quarantine or medical isolation cohorts.

> ➔ *Refer to* the *BOP Pandemic Plan Module 6. Inmate Movement for details on routine observation requirements and procedures during inmate movement.*

NOT FULLY VACCINATED: No documentation of vaccination, partial vaccination (one out of two doses), or less than 14 days following completion of the vaccine series as authorized by the U.S. Food and Drug Administration.

QUARANTINE: In the context of COVID-19, refers to separating an individual or a group of individuals (cohort) with a known or suspected exposure to an infected person to **(1)** observe them for symptoms and signs of the illness during the **INCUBATION PERIOD** and **(2)** keep them apart from other incarcerated individuals.

UP-TO-DATE VACCINATION STATUS: Proper documentation of having completed a vaccination series, and having received a booster according to current recommendations.

SYMPTOMATIC: People with confirmed COVID-19 have reported a wide range of symptoms that typically appear 2–14 days after exposure to the virus. People with confirmed or suspected COVID-19 infection presenting with any of the following symptoms are considered symptomatic:

- Fever or chills
- Cough
- Shortness of breath or difficulty breathing
- Fatigue
- Muscle or body aches
- Headache
- New loss of taste or smell
- Sore throat
- Congestion or runny nose
- Nausea or vomiting
- Diarrhea

B. GENERAL GUIDANCE

1. GENERAL HOUSING CONSIDERATIONS FOR QUARANTINE AND MEDICAL ISOLATION

- Each institution will identify and designate specific quarantine and medical isolation areas within the institution—prior to need.
- Plan for separate physical locations (dedicated housing areas and bathrooms) to:
  - **ISOLATE** individuals with confirmed COVID-19 (individually or cohorted).
  - **ISOLATE** individuals with suspected COVID-19, separate from confirmed cases.
  - **QUARANTINE**, when indicated, close contacts (see definition above) of those with confirmed or suspected COVID-19 (ideally individually; cohorted if necessary).
- The plan should include contingencies for identifying multiple locations if numerous infected individuals and/or close contacts are identified and require medical isolation or quarantine simultaneously. See **MEDICAL ISOLATION** and **QUARANTINE** sections below for more detailed cohorting considerations.
- When identifying spaces for isolation and quarantine, consider spaces not being utilized such as those used for education, religious services, visiting, recreation, or facilities. Tents, shower stations, and mobile hand hygiene stations may need to be obtained to create separate spaces at some facilities.
- When possible, it is recommended that a room be designated near each housing unit and intake area to evaluate and test individuals with COVID-19 symptoms.
- **RESTRICTIONS ON MOVEMENT:** To the extent possible, quarantined and medically isolated inmates should be restricted from being transferred, having visits, or mixing with the general population.
- **SIGNAGE:** The doors to both quarantined and medical isolation units should remain closed.
  - Print out color medical isolation and quarantine signs to be placed on the door of the room or unit, indicating isolation or quarantine, and the recommended personal protective equipment (**PPE**). Printable signs are available in the **APPENDICES**.

- Cohorted groups should not be in contact with other cohorts. To prevent co-mingling of cohorts and to help correctional staff when moving inmates for showers, phone, computer time and recreation, consider quarantine signs in different colors for each separate cohorted group.

- Provide individuals under medical isolation or quarantine with tissues and, if permissible, a lined no-touch trash receptacle (the liner allows for easier, no-touch emptying). Instruct them to:
  - Cover their mouth and nose with a tissue when they cough or sneeze.
  - Dispose of used tissues immediately in the lined trash receptacle.
  - Wash hands immediately with soap and water for at least 20 seconds.

2. STAFF ASSIGNMENTS AND TRAINING

- **STAFF ASSIGNMENTS:**
  - Staff assignments to quarantine and medical isolation spaces should remain as consistent as possible. These staff should limit their movements to other parts of the facility as much as possible.
  - If staff must serve multiple areas of the facility, ensure that they change **PPE** when leaving the isolation or quarantine space.
  - If a shortage of **PPE** supplies necessitates reuse, ensure that staff always move from areas of low exposure to areas of high exposure risk while wearing the same PPE, to prevent **CROSS-CONTAMINATION**.
  - → *For example, start in a housing unit where no one is known to be infected, then move to a space used as quarantine for close contacts, and end in an isolation unit.*

- **STAFF TRAINING:**
  - Train staff and inmate workers on appropriate **PPE** use in quarantine and medical isolation. (Refer to **MODULE 2** for information on PPE.)
  - Train staff and inmate workers on how to appropriately **CLEAN AND DISINFECT** high-touch hard and soft surfaces in quarantine and medical isolation areas. (Refer to **MODULE 1** for more information on cleaning and disinfection.)
  - Train and remind staff and inmates on proper hand hygiene.

3. PERSONAL PROTECTIVE EQUIPMENT (PPE)

MEDICAL ISOLATION and QUARANTINE have different requirements for the use of PPE. Refer to **MODULE 2** for the specific PPE to be used in each situation, as well as supply chain management.

- **LOCATIONS:** A **PPE DONNING OR DOFFING AREA** should be designated at the entry and exit to both quarantine and isolation. The **PPE DONNING AND DOFFING AREAS** can be created with assistance from the facilities department, or an area can be taped off for a visual indication of where to don and doff PPE. Refer to **MODULE 2** for an inventory of items that should be present in these locations.
- **INSTRUCTIONAL POSTERS:** PPE **DONNING** and **DOFFING** areas should have signage designating the use of each space as well as instructions for donning or doffing PPE. CDC posters and fact sheets for donning and doffing PPE can be found here: *https://www.cdc.gov/coronavirus/2019-ncov/downloads/A_FS_HCP_COVID19_PPE.pdf*

4. LAUNDRY

- Laundry from individuals in COVID-19 medical isolation or quarantine can be washed with another individuals' laundry.
- Persons handling laundry from either quarantine or medical isolation should wear a gown or coveralls (to protect clothing) and disposable gloves. Perform hand hygiene after removing gloves.
- Do not shake dirty laundry—to minimize the potential of dispersing virus through the air.
- Clean and disinfect dirty clothes bins after use.

5. FOOD SERVICE ITEMS AND MEALS

- Meals should be provided to medically isolated or quarantined individuals in their in their respective units, if possible.
- In some facilities, cohorted quarantined inmates may be allowed to go together to meals when they can eat as a separate group and maintain social distancing (i.e., provide more space between individuals in the dining hall by removing every other chair and using only one side of the table).
  - Cohorted inmates should wear facial coverings (except when they are eating) and maintain social distancing any time they are out of their personal area.
  - The food service area must be cleaned and disinfected between groups.
- Disposable food service items can be disposed of in regular trash.
- Non-disposable food service items should be handled with gloves and washed as normal.
- Persons handling used food items from either quarantine or medical isolation should wear a gown or coveralls (to protect clothing from spills) and disposable gloves. Perform hand hygiene after removing gloves.

6. CLEANING AND DISINFECTION

Spaces where quarantined or medically isolated inmates have spent time must be cleaned and disinfected while in use and after discharge (see MODULE 1 for more detailed information):

- If possible, the inmate(s) should assist in cleaning and disinfecting their areas prior to their discharge from quarantine or medical isolation.
- Ensure that persons performing cleaning and disinfection of medical isolation or quarantine areas are wearing the recommended PPE for the product and the space being cleaned. Refer to MODULE 2 for required PPE.

7. RECREATION

- MEDICAL ISOLATION: Inmate recreation will be suspended while in medical isolation. The institution should provide other means for inmates to occupy their time such as reading materials, educational materials, etc.
- QUARANTINE: If recreation is allowed for quarantine and occurs as a group, it should be limited to established cohorts, whenever possible, and the recreation area cleaned and disinfected between and after use (see MODULE 1). If recreation is suspended, the institution should provide other means for inmates to occupy their time such as reading materials, educational materials, etc.

C. MEDICAL ISOLATION

MEDICAL ISOLATION is a critical infection control measure for COVID-19. It separates inmates who are symptomatic and/or who test positive for COVID-19 (symptomatic or asymptomatic) from the general population and other staff.

- As soon as an individual develops symptoms of COVID-19 or tests positive for SARS-CoV-2, ensure they are wearing their required face covering (surgical mask preferred if it can be worn safely). Inmate should be immediately placed under medical isolation in a separate environment from other individuals, and medically evaluated.
  - ➔ *Anyone who has trouble breathing, or is unconscious, incapacitated, or otherwise unable to remove the mask without assistance should not wear a cloth face covering.*
- Refer to the MEDICAL ISOLATION CHECKLIST in the APPENDICES for a summary of all medical isolation requirements.

MEDICAL ISOLATION for COVID-19 should be distinct in name and practice from the use of restrictive housing for disciplinary or administrative reasons—even though limited housing availability may require the use of cells normally used for restrictive housing. To avoid being placed in these conditions, inmates may hesitate to report their COVID-19 symptoms. This can lead to continued transmission within shared housing spaces and, potentially adverse health outcomes for infected individuals.

Ensure that MEDICAL ISOLATION is operationally distinct—with different conditions of confinement compared to restrictive housing, even if the same cells are used for both. For example:

- Ensure that individuals under medical isolation receive daily (at a minimum) visits from medical staff.
- Ensure that individuals under medical isolation or quarantine have access to mental health services.
- Make efforts to provide similar access to radio, TV, a clock/watch, reading materials, personal property, and commissary as would be available in the individuals' regular housing units.
- Consider allowing increased telephone privileges without a cost barrier to maintain mental health and connection with others while isolated.

1. HOUSING AND GENERAL CONSIDERATIONS

- Ideally, MEDICAL ISOLATION will be in a single, well-ventilated room with a solid door and an attached bathroom.
- When housing inmates in medical isolation as a COHORT:
  - ➢ **ONLY** persons with LABORATORY-CONFIRMED COVID-19 should be placed under medical isolation together as a cohort.
  - ➢ Do **NOT** cohort CONFIRMED COVID-19 cases with inmates who are SUSPECTED of having COVID-19.
  - ➢ Ensure that cohorted groups of people with confirmed COVID-19 wear RECOMMENDED FACE COVERINGS (surgical mask preferred) whenever anyone (including staff) enters the isolation space.
    - ➔ *Anyone who has trouble breathing, or is unconscious, incapacitated, or otherwise unable to remove the mask without assistance should not wear a cloth face covering.*

- When possible, use **ONE LARGE SPACE** for cohorted medical isolation, rather than several smaller spaces. This practice will conserve PPE and reduce the chance of cross-contamination across different parts of the facility.

- **TRANSFERS:** If possible, avoid transferring infected individuals to another facility, unless necessary for medical care, court order, or critical housing limitations. Refer to **MODULE 6** for additional guidance.
- **AEROSOL-GENERATING PROCEDURES:** If a patient who is in medical isolation must undergo a procedure that is likely to generate aerosols (e.g., suctioning, administering nebulized medications, testing for COVID-19), they should be placed in a separate room. An N-95 respirator (not a surgical mask), gloves, gown, and face protection should be used by staff. (For more information, see **MODULE 7**.)
- **DEDICATED MEDICAL EQUIPMENT:** If possible, use disposable or dedicated medical equipment in medical isolation areas (i.e., blood pressure cuffs). Equipment should be left in the medical isolation area and decontaminated in accordance with manufacturer's instructions between cohorts.
- **IN-PERSON COURT APPEARANCES:** Inmates in COVID **MEDICAL ISOLATION** should not have in-person court appearances unless absolutely necessary. Having the inmate appear via telephone hearing should be strongly considered. A video teleconference (VTC), if accessible, can also be used as an alternative.
- **MEDICAL ISOLATION IN SINGLE CELLS:** If medical isolation in single cells is necessary (inmates are not cohorted), Psychology Services staff should be consulted to ensure inmates proposed for single celling are not particularly vulnerable individuals and/or to make recommendations.

2. MONITORING AND DOCUMENTATION

→ *Only medical staff can screen and assess patients in **MEDICAL ISOLATION**.*

→ *Refer to **MODULE 3** for additional information on screening and testing.*

SYMPTOMATIC PERSONS IN MEDICAL ISOLATION

- Assess, **AT LEAST DAILY**, for temperature and symptoms of illness and decompensation, including asking about shortness of breath and cough. Other objective data may include respiratory rate, as well as pulse and oxygen saturation by pulse oximetry.

  → *Symptomatic patients with high-risk co-morbid conditions may require more frequent assessments.*
- Assessments for symptomatic inmates in medical isolation should be **DOCUMENTED** in the medical record.
- Date of entry into and out of isolation and daily assessments should be noted in the medical record.
- A physician or advanced practice provider (APP) will be notified for any of the following: pulse oximetry < 94%, pulse > 100, temp > than 101°F, or respiratory rate > 22 per minute.

- **EMERGENCY WARNING SIGNS:** A low threshold should be used for deciding to transport an inmate to an **OUTSIDE HOSPITAL** if any of the following emergency warning signs for COVID-19 are noted:
  - Trouble breathing
  - Acute onset of hypoxia/oxygen desaturation (pulse oximetry less than 90%)
  - Persistent pain or pressure in the chest
  - New confusion
  - Inability to wake or stay awake
  - Bluish lips or face
- **TREATMENT:** Several monoclonal antibody products have received Emergency Use Authorization (EUA) for prophylaxis and treatment of persons who are at risk for severe disease. Providers should consult with their Regional Medical Director and monitor updates from the CDC on the latest treatment guidelines.

  → *Refer to the* BOP COVID-19 Outpatient Therapeutics Clinical Guidance
- **ISOLATION INFIRMARY:** Under certain circumstances, establishment of an onsite infirmary at an institution may be necessary. Considerations include the number of symptomatic patients, institution resources and local healthcare resources. The decision to stand up an infirmary should be made in consultation between the institution with regional and central office leadership. Refer to **APPENDICES** for COVID-19 Medical Isolation Infirmary Guidance.

ASYMPTOMATIC, COVID-19 PATIENTS IN MEDICAL ISOLATION

- Asymptomatic inmates in medical isolation should be **ASSESSED DAILY** by health services staff for signs and symptoms of COVID-19.
- The assessments for asymptomatic inmates in medical isolation should be **DOCUMENTED** in the medical record under the screenings tab.

RELEASE FROM MEDICAL ISOLATION

- Release from medical isolation should be noted in the medical record and the Health problem code updated to note "**RESOLVED.**" Sentry coding is noted as "**RECOVERED.**"
- Refer to the **COVID-19 Coding Clinical Reference Guide** located in the **APPENDICES** for the correct diagnosis codes.

3. RELEASE FROM MEDICAL ISOLATION

Testing for release from COVID-19 medical isolation is not routinely recommended. The BOP follows the CDC guidance to determine when to discontinue medical isolation as discussed below:

→ *See Discontinuation of Isolation for Persons with COVID-19 Not in Healthcare Settings, available at:* https://www.cdc.gov/coronavirus/2019-ncov/hcp/disposition-in-home-patients.html .

TABLE 1. CDC DEFINITIONS OF COVID-19 ILLNESS SEVERITY

- **MILD ILLNESS:** Individuals who have any of the various signs and symptoms of COVID-19 (i.e., fever, cough, sore throat, malaise, headache, muscle pain) without shortness of breath, dyspnea, or abnormal chest imaging.
- **MODERATE ILLNESS:** Individuals who have evidence of lower respiratory disease by clinical assessment or imaging, and an oxygen saturation (SpO2) > 94% on room air.
- **SEVERE ILLNESS:** Individuals who have a respiratory frequency 30 breaths per minute, SpO2 <94% on room air (or for patients with chronic hypoxemia, a decrease from baseline of >3%), and lung infiltrates >50%
- **CRITICAL ILLNESS:** Persons with respiratory failure, septic shock, and/or multiple organ dysfunction.
- **SEVERELY IMMUNOCOMPROMISED:** Includes conditions such as being on chemotherapy for cancer, untreated HIV infection with CD4 lymphocyte count <200, combined primary immunodeficiency disorder, and receipt of prednisone > 20mg/day for more than 14 days.

SOURCE: *https://www.cdc.gov/coronavirus/2019-ncov/hcp/disposition-hospitalized-patients.html#definitions*

- **ASYMPTOMATIC INMATES** who test positive and never develop symptoms **can be released from medical isolation** when at least 10 days have passed since the date of symptom onset or COVID-19 positive test, whichever happened first.
- **INMATES WITH MILD OR MODERATE SYMPTOMS**, who tested positive or negative, **can be released from medical isolation** at least 10 days after symptom onset, resolution of fever for at least 24 hours without the use of fever reducing medications, **and** if symptoms (e.g., cough, shortness of breath) have improved.
- **INMATES WITH SEVERE SYMPTOMS REQUIRING HOSPITALIZATION, OR SEVERELY IMMUNOCOMPROMISED INMATES, can be released from medical isolation** 20 days after symptom onset, resolution of fever for at least 24 hours without the use of fever reducing medications, and if symptoms have improved

  → *Although the above strategies are appropriate for COVID-19 patients who are severely immunocompromised, the CDC indicates a test-based approach may also be considered in these cases. Consultation with the Regional Medical Director is recommended prior to using a test-based strategy in this scenario.*

D. QUARANTINE

→ *Refer to the **Quarantine Checklist** in the APPENDICES for a summary of all quarantine requirements.*

- **All Inmates entering COVID-19 quarantine** utilize a test-in/test-out strategy, with a quarantine duration of at least 10 days (the incubation period of the SARS-CoV2 virus).
- **Exceptions to quarantine requirements:**
  - Inmates previously diagnosed with COVID-19 do not need to be quarantined within 90 days of their initial symptom onset (for symptomatic cases) or their initial COVID-19 positive test (for asymptomatic cases) if they have met the current CDC release from isolation criteria.

1. ADMISSION TO QUARANTINE

- **PPE:** An inmate being moved to quarantine should wear a facial covering or surgical mask. Escorting staff in contact with the person should wear gloves, surgical mask, face shield or goggles, and a gown or coveralls.
- **DURATION OF QUARANTINE** is a minimum of 10 days.

2. HOUSING CONSIDERATIONS FOR QUARANTINE

- *To reduce the risk of transmission while in quarantine, facilities should make every effort to quarantine inmates in cells with solid walls and doors. **COHORTING** of individuals who arrive in the same bus/air travel, or who had equivalent exposures is an acceptable practice, especially in inmates/patients with mental health disorders.*
- *Different categories of quarantine (Intake, Exposure, and Release/Transfer) should be housed separately.*

- **COHORTING:**
  - Inmates housed in a single or double cell who co-mingle (e.g. shower in a community bathroom, recreate as a group, etc.) are considered to be cohorted. To the extent possible, these groups should be limited in number (e.g., 10) and kept consistent with the same inmates throughout the duration of quarantine.
  - There will be times when an housing unit will quarantine in place, because there's been an exposure with a case from the same housing unit.
  - If a cohort co-mingles with any other cohort the 10-day quarantine period must be reset for all groups.
  - If quarantined as a cohort, the 10-day quarantine period must be reset to zero if an inmate in the cohort becomes symptomatic or new inmates are added to the quarantine.
- **PLACEMENT OF BEDS IN COHORTED QUARANTINE:** As feasible, the beds/cots of inmates quarantined as a cohort should be placed at least 6 feet apart. Consider alternating head-to-foot sleeping positions, if feasible.
- **QUARANTINING IN SINGLE CELLS:** If quarantining in single cells is necessary (inmates are not cohorted), Psychology Services staff should be consulted to ensure inmates proposed for single celling are not particularly vulnerable individuals and/or to make recommendations.

HOUSING OPTIONS IN ORDER OF PREFERENCE

The CDC lists the following options for housing inmates in QUARANTINE, in order of preference from top to bottom:

- Separately, in single cells with solid walls and solid doors that close fully.
- Separately, in single cells with solid walls, but without solid doors.
- As a cohort, in a large, well-ventilated cell with solid walls, a solid door that closes fully, and at least 6 feet of personal space assigned to each individual in all directions.
- As a cohort, in a large, well-ventilated cell with solid walls and at least 6 feet of personal space assigned to each individual in all directions, but without a solid door.
- As a cohort, in single cells without solid walls or solid doors, preferably with an empty cell between occupied cells creating at least 6 feet of space between individuals.

- As a cohort, in multi-person cells without solid walls or solid doors, preferably with an empty cell between occupied cells. Employ social distancing strategies.
- As a cohort, in the individuals' regularly assigned housing unit, but with no movement outside the unit. Employ social distancing strategies related to housing in the Prevention section above to maintain at least 6 feet of space between individuals. Place beds head-to-foot instead of head-to-head to create more space.
- Safely transfer to another facility with capacity to quarantine.

→ *Transfer should be avoided due to the potential to introduce infection to another facility; proceed ONLY if no other options are available.*

- **HIGHER-RISK INMATES:** Ideally, do **NOT** cohort individuals who are at higher risk of severe illness and mortality from COVID--19, including persons 65 and older or with certain co-occurring conditions.

  → *See the CDC's guidance Underlying Medical Conditions Associated with Higher Risk for Severe COVID-19: Information for Healthcare Providers (cdc.gov)*

- **MEDICAL REFERRAL CENTERS:** At MRCs, the facility's exposure quarantine area for COVID-19 should be in a separate area from the medical units (Nursing Care Center [NCC] units, ambulatory care units, etc.), whenever possible. MRC intake transfers that need to be quarantined on a medical unit due to care level for other medical conditions should be quarantined in a single room with solid walls and door, placed on droplet and standard transmission precautions, with full COVID-19 PPE worn by staff when entering the room. Donning and doffing PPE appropriately and practicing hand hygiene is critical. To the extent possible, staff interventions with the inmate in quarantine should be limited.

3. MONITORING AND DOCUMENTATION DURING QUARANTINE

- Inmates in quarantine should be screened at least once daily for COVID-19 symptoms. Twice-daily screening may be considered for patients with high-risk conditions.
- Inmates in Quarantine will use a test-in/test-out strategy.
  - On admission to and discharge from quarantine, inmates should have their COVID-19 symptoms and testing results documented in the medical record.
  - Either POC testing (Abbott ID Now, BinaxNOW) or a commercial PCR lab may be used for testing into or out of quarantine.
  - Refer to **MODULE 3** for additional guidance regarding testing of inmates.
- It may be helpful to maintain a **ROSTER** of inmates who are in quarantine, including cell assignment, date of placement in quarantine, projected end date of quarantine, date of placement in that specific cell, cell mate or members of the cohort, and designated facility.
- Non-healthcare staff—trained to obtain temperatures and record yes or no answers to a symptom screen and documenting on a roster—can assist health services staff to complete daily screenings. Any positive screening is reported promptly to healthcare staff for further assessment, planning and intervention.
- A physician or Advanced Practice Provider (APP) will be notified for any of the following: Inmates who become symptomatic or have a temperature (mouth) ≥ 100.4˚F, (ear) ≥ 101˚F, or (forehead) ≥ 100˚F need to be isolated promptly. Upon assessment, the physician or APP should document assessment in the medical record.

- Any inmate who becomes symptomatic or tests positive during quarantine, should be moved to a designated medical isolation area, as described above.
- Refer to the **COVID-19 Coding Clinical Reference Guide** in the **APPENDICES** for correct diagnosis codes.

5. OTHER QUARANTINE AND MEDICAL ISOLATION CONSIDERATIONS

QUARANTINE OF INMATES PREVIOUSLY DIAGNOSED WITH COVID-19

- Current evidence indicates that people who have recovered from COVID-19 can continue to shed detectable levels of virus for up to 90 days after illness onset. However, the virus levels are considerably lower than during illness and are in ranges that are unlikely to be contagious. Information in this continues to evolve. Patients that have met release from isolation criteria are no longer considered infectious, even though they may continue to test positive for up to 90 days.

ISOLATION OF RE-INFECTED INMATES

- If at least 90 days has passed from the onset of their initial illness or positive test, and a patient presents with new onset of COVID-like symptoms, consider the possibility of re-infection. After appropriate symptom screening, temperature check, and testing the inmate should be provided with appropriate face covering (surgical mask preferred), and moved to a designated medical isolation area for 10 days.
- Refer to **MODULE 6** for guidance regarding intake/release/transfer observation for inmates previously diagnosed with COVID-19.

MODULE 5. SURVEILLANCE

WHAT'S NEW

- Updated email for reporting staff positive cases. The correct email is BOP-HSD-StaffcovidNotification-S@bop.gov
- Removal of references for notification of exposed staff.

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The purpose of COVID-19 surveillance is to monitor the current state of the pandemic. It involves **measuring** epidemiological (disease-related) aspects of the pandemic in order to **manage** it appropriately. Public health surveillance is the ongoing systematic collection, analysis, and interpretation of data, closely integrated with the timely dissemination of these data to those responsible for preventing and controlling disease and injury.

- Surveillance is essential during a pandemic to assist in reducing SARS-COV-2 transmission. It should involve a combination of facility and community monitoring.
- Institutions should develop a SURVEILLANCE PLAN addressing SYNDROMIC SURVEILLANCE, CONTACT TRACING, and SURVEILLANCE TESTING, which are described below.

A. SYNDROMIC SURVEILLANCE

Syndromic surveillance includes the following:

- Clinician reporting on inmates presenting to sick call with acute respiratory complaints, fevers, and pneumonias. The BOP's electronic surveillance dashboard can assist with monitoring of respiratory complaints.
- Self-reporting of staff who develop COVID-19 like symptoms
- Reporting of staff not permitted entry to the institution upon COVID-19 screening (institutions following Level 3 operations)
- Reporting on staff calling in sick related to COVID-19 symptoms.
- Clinician and laboratory reporting on the number of inmate and staff COVID-19 positive and negative cases.
- Reporting on inmate hospitalization and discharges
- Reporting on COVID-19 related deaths (inmates or staff)
- Community COVID-19 positive cases, hospitalizations, and death—including communities where staff members are known to live, visit, and commute

B. Contact Tracing

Contact tracing can be a useful tool to help contain disease outbreaks. When deciding whether to perform contact tracing, consider the following:

- Have a plan in place for how close contacts of individuals with COVID-19 will be managed, including quarantine or isolation, as appropriate. (Refer to Module 3 - *Screening and Testing*, and Module 4 - *Inmate Isolation and Exposure Quarantine*.)
- Contact tracing may be more feasible and effective in settings where incarcerated/detained individuals have limited contact with others (e.g., celled housing units)—compared to settings where close contact is frequent and relatively uncontrolled (e.g., open dormitory housing units).
- **Contact tracing can be especially impactful in the following situations:**
  - When there is a small number of infected individuals (staff or inmate)—such as in a particular work unit or housing unit—aggressively tracing close contacts and separating them from the general population can help curb transmission before many others are exposed.
  - When the infected individual (staff or inmate) has had close contact with individuals from other housing or work units, identifying close contacts can help prevent the infection from spreading throughout the entire facility.
  - When the infected individual (staff or inmate) has recently been in a community setting, identifying close contacts can help reduce transmission from the facility into the community.
- If there is a large number of individuals with COVID-19 in the facility, contact tracing may become difficult to manage:
  - When there is identified ongoing transmission in a specific area, formal contact tracing may not be indicated when new cases are identified.
  - Under such conditions, consider broad-based testing in order to identify infections and prevent further transmission. Decisions for expanded testing should be made in consultation with the Regional Infection Prevention and Control Officer (IPC) and Medical Director.

Contact Investigation & Tracing Guidance

Promptly complete a contact investigation with SARS-CoV-2 positive inmates and staff to identify close contacts and complete contact tracings to stop transmission or decrease the number of cases within the institution. Utilize information from the contact investigation to identify and trace all close contacts of the source case(s) 48 hours prior to the source case's symptom onset or testing (if asymptomatic).

- Close contact is defined as a cumulative exposure time > 15 minutes in 24 hours and within < 6 feet of distance.
- Refer to the Appendices for a useful tool to help guide contact investigation and tracing.

- Staff Contact Tracing:
  - The HR department may need to be involved with the contact tracing to include assistance with obtaining staff member's phone number(s) for source contact investigation and extending to contact tracing of staff.
  - Report all staff positive cases through your EOC and local HR department as soon as possible utilizing the Staff Positive Case Form in the Appendices.
    - Include a copy/screen shot of laboratory results.

- Email BOP-HSD-StaffcovidNotification-S@bop.gov for confirmation and assimilation into the Bureau's database.
- The subject line for the email is to include: COVID-19 Staff + Results - Name of institution.

➢ Once staff contacts are determined:

- Check with the local DOH – they may want a list of staff tracing contacts to conduct their own investigation.
- Staff identified as close contacts should be notified that they are a contact to an identified COVID-19 case.
  - Refer to MODULE 11 for staff guidance with potential exposure to SARS-CoV-2.

- INMATE CONTACT TRACING:
  - ➢ Run a Sentry roster of the inmate quarters to identify roommates and close contacts.
  - ➢ Determine work contacts and recreation/activity contacts.
  - ➢ Determine test results; last day of work, activities or visits.
  - ➢ Attempt to determine contacts within the last 48 hours since the development of symptoms or two days prior to the SARS-CoV-2 test, if asymptomatic. Have a plan in place for how close contacts of individuals with COVID-19 will be managed, including quarantine or isolation, whichever is appropriate. (Refer to MODULE 3 - *Screening and Testing*, and MODULE 4 - *Inmate Isolation and Exposure Quarantine*.)
  - ➢ If an entire work crew is identified or an open unit bay, it may be necessary to quarantine the entire unit for exposure quarantine.

EDUCATE STAFF AND INMATES

- Provide training regarding signs and symptoms of infection, hand hygiene, social distancing, and proper wear and removal of facial coverings and PPE to prevent infection with SARS-CoV-2.
- Ensure education signage is posted at the facility via email, TRULINK and educational fliers.

C. SURVEILLANCE TESTING

Congregate settings such as prisons are at high risk for SARS-CoV-2 transmission. SURVEILLANCE TESTING assists in identifying asymptomatic or mildly symptomatic spread that may elude symptom-based surveillance. The Centers for Disease Control and Prevention (CDC) refers to this type of testing as routing screening testing, which it recommends performing weekly even when there is no known transmission occurring. This may be done on a facility-wide basis or in specific subsets of the population based on staffing resources, and available testing supplies.

It is recommended that facilities develop a COVID-19 surveillance/routing screening testing plan using viral tests (PCR or antigen) for inmates who are at risk for increased exposure to SARS-CoV-2, which may include:

- Recent COVID-19 cases or transmission at the facility
- Housing units where there is close contact among inmates and where physical distancing is difficult to achieve.
- Following in-person visitation
- Return from off-site trips into the community (e.g. hospitalization, writ returns, court appearances, furloughs, etc.)
- Institutions with frequent inmate movement

- Individual inmates or units housing inmates at higher risk of severe COVID-19 illness (e.g. long term care or medical housing units)
- Inmates on work details at high risk for contracting COVID-19 or transmitting it to others such as orderlies, sanitation workers, food service workers, town drivers, trash details, or UNICOR.

D. Data Sharing to Assist in Surveillance

- The COVID-19 pandemic has magnified the significance of a MULTIDISCIPLINARY APPROACH to managing the spread of SARS-CoV-2—requiring communication, collaboration, and data sharing within the facility and with the local health department.
- Utilize data sharing to disseminate information, assist in evidence-based clinical decisions, and expedite the deployment of resources needed to mitigate widespread transmission of SARS-CoV-2.
- Contact your local health department to ascertain reporting requirements and methods for sharing data. COVID-19 is a reportable disease and must be reported to civilian health authorities in accordance with individual state reporting requirements. The data systems listed below can assist in monitoring the current state of the COVID-19 pandemic.
  - BOP respiratory surveillance dashboard
  - BOP COVID-19 dashboard
  - BOP public website
  - Community, local, and state COVID-19 dashboards.

➔ *If there are any questions related to what data may be shared with the local health department, contact your Regional IPC.*

MODULE 6. INMATE MOVEMENT

NOTE: This Module reviews considerations for inmate movement only. For guidance on inmates exposed to COVID-19, refer to the *BOP Pandemic Plan*, Module 4. Inmate Isolation & Quarantine

WHAT'S NEW

- Updates to *Section M. In-Person Court Appearances* and *Appendix A. Inmate Movement Table*:
  - **Upon return to the institution/detention center,** inmates without known exposure to SARS-CoV-2 do not require immediate testing or routine observation periods. The following procedures are recommended:
    - All inmates who return the same day (less than 24-hour) from a court appearance will undergo SSTC in addition to the usual return procedures
    - Inmates who return from a court appearance after more than 24 hours have elapsed will undergo a routine observation period (5-7-day test in/test out) prior to release into general population if not fully vaccinated.
  - All inmates who have daily trips to court, should be housed separately from general population inmates and/or in a cohort, and in addition to daily SSTC, undergo weekly POC/PCR testing. If the inmate is not fully vaccinated, a routine observation period (5-day test in/test out) is needed prior to release into general population.

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A. DEFINITIONS

FULLY VACCINATED: Having completed a vaccination series: 2 weeks after their second dose in a 2-dose series (Pfizer or Moderna), or 2 weeks after a single-dose vaccine (Janssen) as authorized by the U.S. Food and Drug Administration.

HIGH-RISK UNIT: any unit with an inmate population that is deemed *high risk for severe COVID related illness* due to their age, medical diagnosis, physical layout of the dormitory, or other contributing factor.

MOVEMENT OBSERVATION: periods (formerly known as movement quarantine) implemented during movement as part of intake, transfer and/or release processes. Movement observation is not indicated after potential exposure to someone with COVID-19 and inmates in movement observation should **not** be housed with post-exposure quarantine or medical isolation cohorts. Inmates are housed separately from the rest of the facility's population to minimize transmission to or from other facilities and the community during movement.

- There are three types of routine movement observation periods at transfer, intake, and release. These are formerly known as transfer quarantine, intake quarantine and release quarantine respectively.
- These observation periods are not to be confused with "medical observation", which can only be authorized by a physician in rare circumstances in accordance with Patient Care Policy PS6031.04.
- Routine observation periods during inmate movement is affected by vaccination status, type of inmate movement, the inmate's destination and point of origin, and the operational level of the sending institution.

MEDICAL ISOLATION: Confining individuals with suspected (displaying symptoms) or confirmed (based on a positive POC or commercial laboratory test) COVID-19 infection, either to single rooms or by **COHORTING** them with other similarly infected patients.

→ *Refer to the BOP Pandemic Plan Module 4. Inmate Isolation & Quarantine for additional guidance on COVID-19*

MINIMAL TOLERABLE RISK: The principle of choosing the option that presents the lowest possible risk when ideal conditions cannot be upheld.

NEW INTAKES: Includes new commitments, voluntary surrenders, writ returns, and any inmate brought to a BOP facility by the U.S. Marshals Service including the Justice Prisoner and Alien Transportation System, U.S. Customs and Border Protection, or Immigration and Customs Enforcement. Inmates returning from day trips (e.g., hospital or court returns) *are not* new intakes.

NON-BOP LOCATION (OR NON-BOP INSTITUTION): Any institution outside of the 121 recognized BOP facilities; this includes all contract facilities.

NOT FULLY VACCINATED: No documentation of vaccination, partial vaccination (one out of two doses), or less than 14 days have passed following completion of the vaccine series as authorized by the U.S. Food and Drug Administration.

POC TEST: A SARS-CoV-2 rapid point of care viral test (e.g., Abbott ID NOW™ COVID-19 PCR test, Abbott BinaxNOW™ COVID-19 Ag card, or Quidel Quickvue COVID-19 Ag test).

QUARANTINE: The separation (in an individual room or cohorting in a unit) and monitoring of asymptomatic individuals following exposure or close contact with someone with suspected or confirmed COVID-19.

UP-TO-DATE VACCINATION STATUS: Proper documentation of having completed a vaccination series and having received a booster according to current recommendations.

SS: COVID-19 symptom screen.

TC: COVID-19 temperature check.

B. PLANNING FOR INMATE MOVEMENT

Advanced and coordinated planning is required when transferring inmates to other BOP locations or other correctional jurisdictions, or when releasing inmates from BOP custody. Collaboration and coordination among departments, institutions, and regions is necessary to reduce the risk of SARS-CoV-2 exposure and transmission during inmate movement. Planning for inmate movement should be coordinated from the beginning with local Executive Staff, Case Management Coordinators (CMC), Unit Team, and Health Services staff—from all the institutions involved—in setting transfer dates and ensuring that all aspects of the transfer process are carried out efficiently. Coordination with other agencies (e.g., U.S. Marshals Service, Immigration and Customs Enforcement), as well as local or state health authorities, may also be necessary.

- Whenever possible, inmate move planning should occur enough in advance to accomplish the movement observation period, testing and/or screening procedures appropriate to the specific type of inmate movement.
- A **ROUTINE TRANSFER OBSERVATION PERIOD** may require approximately 5-10 days of advanced planning (sometimes more depending on lab results turn-around) and a **BOP INTRASYSTEM TRANSFER** requires up to 72 hours.
- PPE appropriate for each setting (testing, transportation, etc.) should be worn by staff in accordance with established procedures. (See **MODULE 2**.)

C. GENERAL TRANSPORTATION CONSIDERATIONS

Movement of inmates can be a simple, short-distance transfer—or a complex, multi-day, multi-institution process. The risk of SARS-CoV-2 exposure and transmission increases as the complexity of the move increases.

Normal transport routes and schedules need to be reviewed and reconsidered during a pandemic, taking into consideration the current epidemiological context (e.g., infection and transmission rates). Inmate movement should be coordinated in a manner that considers the following:

- Even a BOP intrasystem transfer direct from one BOP facility to another is not without some degree of risk due to the characteristics and communicability of SARS-CoV-2.
- **MOVEMENT VARIABLES** that increase the risk of SARS-CoV-2 exposure and transmission should be avoided whenever possible, including: multiple stops, introduction of multiple staff, and mixing together of inmates from other BOP facilities or other correctional jurisdictions.
- (b)(7)(E); (b)(7)(F)
- **Minimize the amount of time inmates are held in HOLDOVER**; the longer an inmate spends in transit, the greater the risk for exposure to the virus. The frequency of certain drop offs or pick-ups may need to be increased to minimize holdovers.

- **To minimize risk of exposure and transmission, avoid mixing the following inmate groups at the institution and during movement as much as possible:**
  - Inmates are considered to be at lower risk for exposure and transmission if they are 1) coming from a BOP facility regardless of vaccination status and have completed the recommended transfer procedures or 2) up-to-date on their vaccines regardless of point of origin, or 3) not up-to-date on their vaccines but completed the recommended intake procedures.
  - Inmates considered to be at higher risk for exposure and transmission are those who are not fully vaccinated and coming from a non-BOP location, with unknown movement procedures. Inmates from non-BOP locations may not have completed a transfer observation, undergone testing, or symptom screening.
- An inmate who is currently in or meets the criteria for COVID-19 medical isolation (a current positive SARS-CoV-2 test or who has fever or symptoms of COVID-19) should **NOT** be transferred or released from BOP custody unless absolutely necessary (e.g., immediate release, completion of a sentence) and with coordination of appropriate medical precautions and care. During critical housing limitations, transfer of infected inmates may be necessary to assure the safety and wellness of staff and inmates; this should only be done in consultation with the Regional Medical Director and approval of the Medical Director.
- An inmate who is currently in or meets the criteria for placement in quarantine after an exposure, should **NOT** be transferred or released from BOP custody unless absolutely necessary (e.g., immediate release, court order, completion of a sentence).

D. MONITORING AND DOCUMENTATION DURING MOVEMENT OBSERVATION

- Daily COVID-19 symptom screens and temperature checks are NOT required routinely for inmates completing intake/release/transfer observation. Symptoms screen and temperature checks are only required upon entry and exit from the observation period.
- Inmates completing movement observation periods will use a test-in/test-out strategy
  - Either POC testing (Abbott ID Now, BinaxNOW) or a commercial PCR lab may be used for testing into or out of quarantine.
  - On admission to and discharge from an observation period, inmates should have their symptoms and testing results documented in the medical record.
- It may be helpful to maintain a **ROSTER** of inmates who are completing movement observation periods, including cell assignment, date of placement in observation, projected end date of observation, date of placement in that specific cell, cell mate or members of the cohort, and designated facility.
- **The BEMR Exit Summary/transfer paperwork should be provided to the bus LT/USMS** to verify that required screening and testing have been completed.
- **Documentation on the BEMR exit summary/transfer paperwork (e.g., In-Transit Form) needs to include:**
  - For **TRANSFERS OR RELEASES** – document the start and end dates of routine observation periods, SARS-CoV-2 test type, dates and results for both admission and discharge tests, and results of the symptom screen within 24 hours of transfer.

- For **BOP INTRASYSTEM TRANSFERS** – document the SARS-CoV-2 test type, date and result within 72 hours of a BOP intrasystem transfer and results of the symptom screen within 24 hours of transfer.
- **For inmates who have a history of COVID-19 illness and are recovered and ready to transfer:** Exit summary and clinical notes should include the inmate's most recent COVID-19 history (e.g., date of symptom onset, date of initial positive SARS-CoV-2 test, date and criteria used for release from isolation, and any complications or sequelae from the illness).
- **VACCINATION STATUS** to include the manufacturer and date(s) of COVID-19 vaccine (if vaccinated) should be noted on all exit summaries.

E. STRATEGIES TO LIMIT SARS-COV-2 TRANSMISSION DURING INMATE MOVEMENT

The BOP uses multiple strategies for limiting transmission of SARS-CoV-2 during inmate movement, depending on the type of movement and the epidemiology of SARS-CoV-2 at the institution. Procedures for movement are designed to address the risk for transmission to the most vulnerable and in a variety of situations including new inmates arriving at a facility, outgoing inmates from a facility to different destinations, detainees and holdovers, as well as different origination sources of inmates (within the BOP and external to the BOP). The two **primary** movement procedures utilize either a 5-7-day test-in/test-out routine observation period or a combination of a POC test with symptom screen prior to departure as described below in more detail with each movement type.

→ *Refer to the Appendices at the end of this Module for a table and algorithms describing movement of fully vaccinated and not fully vaccinated inmates and movement procedures at detention centers, holdover sites, and the Federal Transfer Center.*

- **NOT FULLY VACCINATED INMATES** undergo a routine observation period as a new intake to the BOP, when arriving at their designated facility, and when transferring or releasing to a community location (e.g., home confinement, residential reentry center, or community release). A COVID-19 BOP intrasystem transfer procedure may be performed instead of a routine observation period when transferring from an institution at operational level 1 to another BOP facility or correctional jurisdiction or when they are in holdover status en route to another BOP facility.
- **FULLY-VACCINATED INMATES** ordinarily do not need a routine observation period as new intakes, prior to transfer to another BOP facility or correctional jurisdiction, or when transferring or releasing to a community location (e.g., home confinement, residential reentry center, or community release). There may be other situations in which it is appropriate for fully vaccinated inmates to undergo a routine observation period, especially in the context of active transmission and exposures during movement. The decision for a fully-vaccinated inmate to undergo a routine observation period is recommended in consultation with Regional Health Services staff.

F. INTAKE PROCEDURES

PRIOR TO ENTERING THE INSTITUTION, OR IN R&D: **All** new intakes to an institution, including voluntary surrenders, BOP intrasystem transfers, or arrivals from outside the BOP system, will be screened by medical staff for SARS-CoV-2—including a COVID-19 symptom screen, a temperature check, and an approved viral test (either a POC or a commercial lab PCR test).

- **Inmates who arrive symptomatic AND/OR test positive will be placed in MEDICAL ISOLATION regardless of COVID-19 vaccination status.**

- **Not fully vaccinated inmates who arrive asymptomatic AND test negative will undergo a routine intake observation period.**
  - If inmates become symptomatic during this period, they should be re-tested (POC or commercial test) and placed in **MEDICAL ISOLATION** immediately.
  - If inmates remain asymptomatic, they will complete the **INTAKE OBSERVATION PERIOD** for at least 5 days. They are then tested out of the routine observation period with a POC test or commercial PCR test at 5 days or later. If the test is negative, the inmate can be released to the general population. If the test is positive, they will be placed in **MEDICAL ISOLATION** immediately.

→ *An exception to a routine 5-day observation period is recommended for inmates who are not fully vaccinated and are entering a high-risk unit (dorm style, dialysis, dementia units, etc); these inmates should continue to complete a 10-day routine observation period if feasible.*

- **Fully vaccinated inmates** will be screened by medical staff for SARS-CoV-2—including a COVID-19 SSTC and an approved viral test for SARS-CoV-2 as new intakes, but do not require a routine intake observation period.

→ *Refer to Section I for Holdover Sites, Bus hubs and Detention Centers movement procedures*

→ *Refer to Section J for OKL movement procedures.*

G. BOP INTRASYSTEM TRANSFERS (INMATE MOVEMENT FROM ONE BOP FACILITY TO ANOTHER BOP FACILITY) OR TRANSFER TO ANOTHER CORRECTIONAL JURISDICTION

When inmates move from one BOP facility to another BOP facility, procedures are dependent on inmate vaccination status and institution operational level. Institutions should refer to the *COVID-19 Modified Operations Matrix* and the appendices at the end of this document for transfer procedures of fully vaccinated and not fully vaccinated inmates.

- **Fully vaccinated inmates**

  Fully vaccinated inmates ordinarily do not need to undergo a routine transfer observation prior to BOP intrasystem transfer or transfer to another correctional jurisdiction.
  - Operational Level 1 at sending institution: SS within 24 hours prior to transfer
  - Operational Level 2 or 3 at sending institution: POC test within 72 hours and a SS within 24 hours prior to transfer.

  → *Refer to Section I for Holdover Sites, Bus hubs and Detention Centers movement procedures*

  → *Refer to Section J for OKL movement procedures.*

- **Not fully vaccinated inmates:**
  - Operational Level 1 at sending institution: POC test within 72 hours and a SS within 24 hours prior to transfer.
  - Operational Level 2 or 3 at sending institution: Require transfer observation period.
  - **DO NOT TRANSFER ANY** inmate who has been exposed to COVID-19; instead, place in **QUARANTINE.**
- Inmates with a history of COVID-19 diagnosed within the past 90 days do not routinely need a SARS-CoV-2 test or routine transfer observation period prior to transfer.

- **DO NOT TRANSFER** inmates who are symptomatic and/or test positive; instead, place in **MEDICAL ISOLATION.**
- **All not fully vaccinated** BOP intrasystem transfers should undergo a routine intake observation period when they arrive at their designated facility (refer to *Section H*).
- A symptom screen, temperature check, and a viral test is performed on **all inmates** when they arrive at their designated facility regardless of vaccination status.

→ *For this procedure to be effective, institutions will ensure that other aspects of the BOP COVID-19 Pandemic Plan are implemented, including but not limited to broad-based inmate testing strategies, exposure quarantine, and medical isolation.*

H. TRANSFER OBSERVATION PERIOD

- Whenever possible, several days of advance planning is recommended to allow sufficient time to complete the **ROUTINE TRANSFER OBSERVATION PERIOD.**
- **TRANSFER OBSERVATION** will be used for 1) not fully vaccinated inmates transferring out of the BOP to community locations (e.g., full term release, residential reentry center, or home confinement); or 2) not fully vaccinated inmates transferring to another BOP facility or to other correctional jurisdictions, dependent on COVID-19 operational level of the sending institution.
- **TRANSFER OBSERVATION** is not routinely required for fully vaccinated inmates moving to other BOP facilities, correctional jurisdictions, or community locations (e.g., full term release, residential reentry center, or home confinement).
- Routine observation periods, quarantine or medical isolation, should NOT be interrupted for transfers unless absolutely necessary (e.g. court order, immediate release).
- Situations in which an inmate becomes symptomatic or tests positive for COVID-19 just prior to immediate release or completion of their sentence will be referred to the Regional Medical Director for guidance on plans for release.

→ *Refer to **MODULES 3 AND 4** for additional information regarding medical isolation and quarantine procedures.*

All inmates meeting criteria for ROUTINE TRANSFER OBSERVATION PERIODS will be managed in one of the following three categories, which are discussed below:

1. Inmates with no prior history of COVID-19 who are not fully vaccinated.
2. Inmates previously diagnosed with COVID-19 who have since recovered and have met the current criteria for release from medical isolation (see **MODULE 4**).
3. Immediate releases.

→ *Consultation with the Regional Medical Director, Regional Health Services Administrator, and Regional Infection Prevention Consultant is recommended for management of inmates who are not in one of these three categories.*

1. TRANSFER OR RELEASE OF INMATES WITH NO PRIOR HISTORY OF COVID-19 WHO ARE NOT FULLY VACCINATED

Prior to transfer, these inmates will undergo a POC or commercial lab PCR test and enter **TRANSFER OBSERVATION**. These inmates should be housed separately from inmates in **QUARANTINE OR IN INTAKE OBSERVATION**. See **MODULES 3 AND 4** for additional information regarding medical isolation and quarantine procedures

- Inmates will remain in transfer observation for a minimum of 5 days. They may be tested out of observation on day 5 with a POC test or commercial PCR lab test
  - If any inmate completing a transfer observation tests positive, the routine transfer observation period must be restarted for all other inmates in that cohort.
- Movement is preferred within five days of receiving the negative SARS-CoV-2 test result, regardless of the mode of travel (by ground or air). When this 5-day window for movement cannot be achieved, the time frame for movement may be expanded to within 14 days of receiving the negative SARS-CoV-2 test result, as long as the observation conditions are maintained for the entire time.
  - A symptom screen and temperature check need to be performed within 24 hours prior to departure from the facility, if transferring to an RRC, home confinement, or for a full term or immediate release. For all other BOP to BOP transfers, or BOP to other correction jurisdiction transfers, only a symptom screening needs to be performed within 24 hours prior to departure.
  - Documentation of the symptom screen, temperature, and entry and exit date test results must be included in the exit summary/transfer paperwork. (See *Documentation* above.)
  - Inmate movement that needs to occur more than 14 days after receipt of a negative test result should be discussed with regional health services staff.

2. TRANSFER OR RELEASE OF INMATES WITH A HISTORY OF COVID-19 INFECTION

- **WITHIN 90 DAYS OF INITIAL SYMPTOM-ONSET OR POSITIVE TEST:** Inmates with a history of SARS-CoV-2 infection within the last 90 days who have met criteria for release from medical isolation do not need to be placed in a **TRANSFER OBSERVATION** and should not be tested.
- **MORE THAN 90 DAYS SINCE INITIAL SYMPTOM-ONSET OR POSITIVE TEST:** Inmates who have met criteria for release from medical isolation and are more than 90 days from their initial symptom onset or initial positive SARS-CoV-2 test are managed as inmates who have not had COVID-19 (see #1 above).

- **INMATES NOT CLEARED FROM MEDICAL ISOLATION:** Inmates with COVID-19 currently in medical isolation should not be released or transferred unless absolutely necessary (e.g., immediate release, completion of sentence). Special precautions and coordination with the Regional Medical Director are necessary for such cases, including use of appropriate PPE, source control, and notification of appropriate civilian health authorities or the receiving correctional jurisdictions.

➔ *For the above scenarios, institutions will complete the Documentation requirements outlined above. Notification should be made to the receiving facility, jurisdiction, or local health authorities of the transfer.*

3. IMMEDIATE RELEASES

The following actions should be taken when an inmate being released cannot be managed as described above under #1 or #2 because of statutory or judicial requirements.

- A symptom screen, temperature check, and rapid POC test should be performed on the day of departure and documented in the electronic health record, exit summary, and/or transfer paperwork. (See *Documentation* above.)
- The local health authorities in the receiving locality should be notified, and the travel arrangements coordinated with them, if necessary (e.g., if exposure quarantine or isolation conditions are required during transportation or upon their arrival).
- The inmate should wear a face covering when departing the facility and while en route to their destination.

→ *Due to the ongoing changes to guidelines for home confinement, readers are referred to the most recent guidance from Reentry Services Division regarding transfer to home confinement.*

I. HOLDOVER SITES, BUS HUBS AND DETENTION CENTERS

Holdover sites, bus hubs, and detention centers are critical to continuing expeditious movement throughout the BOP system; however, due to their nature of frequent intakes and transfers, they require special consideration to prevent the spread of COVID-19. This guidance is based on an analysis of exposure risk for the inmate's point of origin (coming from a BOP facility or a non-BOP location) and the inmate's vaccination status (fully vaccinated vs. not fully vaccinated).

- Characteristics of each institution (e.g. types and amount of available housing) and the amount of infection occurring at the facility or during the movement require some flexibility in how new detainees, pre-trial, pre-sentence, and holdover inmates are managed. Critical staffing shortages and housing limitations might affect how cohorts are separated. Institutions, in consultation with Regional Health Services, should be making decisions to uphold the MINIMAL TOLERABLE RISK standard. Refer to *Section M* for infection control guidance for transportation of Holdover site, Bus Hub or Detention Center inmates.
  - → *Refer to the Appendices at the end of this Module for the Holdover and Detention Center Movement Procedures Algorithm*
  - → *Inmates **designated** to holdover sites, bus hubs and detention centers are managed using the procedures described in* Section F. Intake Procedures.
- Inmates are considered to be at lower risk for exposure and transmission if they are 1) coming from a BOP facility regardless of vaccination status and have completed the recommended transfer procedure, or 2) fully vaccinated regardless of point of origin, or 3) not fully vaccinated from a non-BOP location after completing intake observation.
- Inmates considered to be at higher risk for exposure and transmission are those who are not fully vaccinated and coming from a non-BOP location who have not completed transfer observation, testing, or symptom screening.
- To minimize risk of exposure and transmission, keeping the above two groups separated at the institution and during movement is recommended to the extent possible.

- **HOLDOVER AREAS:** Holdover sites and bus hubs should designate specific holdover areas for cohorting of inmates in advance, in numbers commensurate with anticipated levels and frequency of incoming inmates. Smaller cohorts may be housed together within these holdover areas (e.g., 10 inmates in five 2-person cells) and moved to recreation, food services, showers, etc. without mixing with other cohorts.
- **ON ARRIVAL TO THE HOLDOVER SITE**, **all** inmates being placed in holdover status will have a symptom screen and temperature check.
  - Not fully vaccinated inmates coming from a non-BOP location will undergo **INTAKE OBSERVATION** prior to transfer or release into the general population.

HOLDOVERS FROM BOP INSTITUTIONS, FULLY-VACCINATED INMATES FROM NON-BOP LOCATIONS, INMATES WHO HAVE COMPLETED INTAKE OBSERVATION

Inmates from BOP facilities who are fully vaccinated, have completed intake observation at the holdover site, or are fully vaccinated inmates from non-BOP facilities ordinarily do **NOT** need to complete **TRANSFER OBSERVATION**) prior to moving on to their next destination. Routine observation periods may be appropriate for fully vaccinated inmates in the context of active viral transmission during inmate movement. Such decisions should be made in consultation with Regional Health Services staff.

- **OVERNIGHT REBOARDS (< 24 HOURS):** POC tests, symptom screen and temperature check are **NOT** required for movement.
- **INMATES IN HOLDOVER STATUS 24 TO < 72 HOURS:** perform a symptom screen within 24 hours of transfer. POC testing is not required.
- **INMATES IN HOLDOVER STATUS 72 HOURS OR MORE:** perform a POC test within 72 hours and a SS within 24 hours of transfer.
- **PROLONGED HOLDOVERS BEING CONSIDERED FOR GENERAL POPULATION HOUSING:** Not fully vaccinated inmates who are expected to be housed at a holdover site, bus hub, or detention center for a prolonged period of time (> 5 days) may complete **INTAKE OBSERVATION** and be moved to the general population, when appropriate and in accordance with established institution procedures upon meeting criteria for release from routine observation.
  - After relocation to the general population and, prior to transferring to another BOP facility, inmates should undergo the transfer procedure appropriate for their vaccination status, type of transfer and operational level.
- Different procedures are utilized by OKL for management of BOP intrasystem transfers (refer to Section J).
- On arrival to their designated facility, all not fully vaccinated inmates must complete **INTAKE OBSERVATION.**

HOLDOVERS FOR NOT FULLY-VACCINATED INMATES FROM NON-BOP INSTITUTIONS

Holdover inmates from non-BOP facilities, and who are not fully vaccinated will undergo the following procedures:

- Undergo symptom screening, temperature check, and POC test on arrival to the institution
- Complete a 7-day stay minimum at the institution
- Undergo POC/PCR testing within 48 hours of expected departure, and symptom screen within 24 hours of departure.
- Holdover inmates who stay at the institution beyond the 7-day minimum, may transfer anytime by undergoing a POC/PCR test within 72 hours of departure and a symptom screen within 24 hours of departure.

→ *Not fully vaccinated inmates from a non-BOP institution should* ***NOT*** *be mixed with other holdover groups until after completing intake observation.*

- If a **NOT FULLY VACCINATED INMATE FROM A NON-BOP INSTITUTION** completes a 7-day test-in/test-out **INTAKE OBSERVATION** at the holdover site or detention facility, they are eligible to release to general population or transfer using the BOP holdover or intrasystem transfer procedure, as applicable.
  - ➢ If the holdover site or detention facility is at Operational Level 1 (Green), observation periods can be decreased to 5 days.
- On arrival to their designated facility, all not fully vaccinated inmates must complete **INTAKE OBSERVATION.**

MIXED GROUPS

If a holdover site, bus hub, or detention center receives a **mixed group of not fully vaccinated** inmates from both BOP and non-BOP institutions, they must **ALL** be managed as a **NOT FULLY VACCINATED INMATES FROM A NON-BOP LOCATION** at the holdover site—with SSTC and POC testing on arrival, 7-day stay minimum at the institution, and POC/PCR test out within 48 hours of transfer and SS within 24 hours of departure as described above.

J. FEDERAL TRANSFER CENTER, OKLAHOMA CITY (FTC)

The Federal Transfer Center is the nexus of BOP movement operations, and thus requires special consideration of transfer procedures to ensure that vital movement occurs as safely as possible. This guidance is based on an analysis of exposure risk for the inmate's point of origin (coming from a BOP facility or a non-BOP location) and the inmate's vaccination status (fully vaccinated vs not fully vaccinated).

→ *Refer to the Appendices at the end of this document for the OKL Federal Transfer Center Movement Procedures Algorithm*

→ *Refer to Section M for infection control guidance for transportation of FTC inmates.*

- Inmates are considered to be at lower risk for exposure and transmission if they are 1) coming from a BOP facility regardless of vaccination status and have completed the recommended transfer procedure, or 2) fully vaccinated regardless of point of origin, or 3) not fully vaccinated from a non-BOP location after completing intake observation.

- Inmates considered to be at higher risk for exposure and transmission are those who are not fully vaccinated and coming from a non-BOP location who have not completed transfer observation, testing, or symptom screening.
- To minimize risk of exposure and transmission, keeping the above groups separated at the institution and during movement is recommended to the extent possible.
- **BOP inmates** are symptom screened, temperature checked, and POC tested on arrival. Once cleared (i.e., all findings are negative), they are placed in "move-ready" units organized into smaller cohorts within the housing units and do not mix with other cohorts.
- **Inmates arriving from non-BOP locations who are fully vaccinated** are symptom screened, temperature checked, and POC tested. If all findings are negative, they may be housed in "move-ready" units. When deemed necessary and appropriate, the FTC may also house these holdovers with the not fully vaccinated inmates from non-BOP locations described below if there are housing limitations.
- **Inmates arriving from non-BOP locations who are not fully vaccinated** are transported from various non-BOP correctional facilities to the FTC. They are housed separately from the "move-ready" groups and organized into smaller cohorts within the housing units. Ideally, they do not mix with other cohorts in the same housing unit.
  - Holdover inmates who have completed a 7-day intake observation at the FTC or have become fully vaccinated while at the FTC may be moved to "move-ready" units.
  - If the FTC is at Operational Level 1 (Green), observation periods can be decreased to 5 days.
- On a case-by-case basis in consultation with Regional Health Services staff, alternative housing strategies may be utilized to adapt to the changing demands of inmate movement.
- Inmates who arrive designated to the FTC will follow procedures in *Section F.*

INTAKE PROCEDURES FOR HOLDOVERS ARRIVING FROM NON-BOP LOCATIONS

- All inmate holdovers arriving from non-BOP locations are symptom screened, temperature checked and POC tested upon arrival.
- Fully vaccinated inmates who screen and test negative may be housed in a "move-ready" unit or in a "non-BOP" unit depending on housing capacity and the level of COVID-19 transmission.
- Not fully vaccinated inmates who screen and test negative are housed in a "non-BOP" unit. These holdovers may be moved to "move-ready" units if they become fully vaccinated while at OKL or have completed **INTAKE OBSERVATION.**
- All inmate holdovers arriving from non-BOP locations who are not fully vaccinated will be kept at OKL for a minimum of 7 days.
  - If OKL is at Operational Level 1 (Green), observation periods can be decreased to 5 days.
- Unvaccinated inmates will be offered vaccination with the COVID-19 vaccine.

OUTGOING MOVEMENT PROCEDURES

- **BOP inmates or inmates who are fully vaccinated** will be symptom screened within 24 hours prior to departure.
- **Inmates who arrived from non-BOP locations, are not fully vaccinated, and have not completed a INTAKE OBSERVATION** will have a POC viral test within 48 hours prior to departure (as close to the time of departure as is feasible) and symptom screening within 24 hours prior to departure.

K. MEDICAL TRANSFERS TO MRCS

A longer Intake Observation is recommended for inmates entering high-risk units to limit SARS-CoV-2 transmission to vulnerable populations.

- **Fully vaccinated inmates** should follow the intrasystem transfer procedures at the sending institution as appropriate for their vaccination status and the institution operational level.
- **Not fully vaccinated** inmates should undergo the transfer procedure appropriate for their type of transfer, vaccination status, and the operational level of the institution. Note that an exception to a routine 5-day observation period is recommended for inmates who are not fully vaccinated and are entering a high-risk unit (dorm style, dialysis, dementia units, etc); these inmates should continue to complete a test-in/test-out 10-day intake observation period if feasible.

Emergency Designations

Upon receipt of an emergency designation approval by the Office of Medical Designations and Transport (**OMDT**) at the sending facility, the inmate must complete the transfer procedure appropriate for their vaccination status and the operational level of the institution.

- **IF TEST-IN IS POSITIVE:** The patient should be placed in **MEDICAL ISOLATION**. The sending institution and the receiving MRC should discuss the specifics of the case and determine the most appropriate course of action regarding transfer, including acuity of the patient's medical condition and appropriateness of transfer in light of the patient's COVID-19 status. However, there may be rare instances where the nature and acuity of the patient's medical condition necessitates a more expeditious transfer. These cases should be discussed among the sending institution, the receiving MRC, and the Chief of Health Programs.
- **IF TEST-IN IS NEGATIVE:** The patient will complete **TRANSFER OBSERVATION** as specified above under *Transfer or Release of Inmates with No Prior History of COVID-19*. See also *Other Considerations for Medical Transfers* below.

Routine Urgent Designations

Since **ROUTINE URGENT** designations may take a longer period from the date of designation approval to the actual transfer date, designated patients may generally await transfer in their current housing unit.

- When the date of transfer has been provided by the MRC, the patient should undergo the transfer procedure appropriate for their type of transfer, vaccination status and the operational level at the institution.

Other Considerations for Medical Transfers

- **HOSPITALIZED PATIENTS AND THOSE IN LTC:** There are times when the patient awaiting transfer is being managed at an outside hospital or long-term care facility (LTC) and transfer observation within the BOP institution prior to transfer is not possible. In these circumstances, the patient may be transferred without **TRANSFER OBSERVATION**. If the patient is actively infected with COVID-19, proper PPE will be needed during transfer.

- **SPECIALIZED NEEDS:** In some instances, due to the medical condition and/or needs of the patient, placement completing transfer observation may pose a challenge (e.g., need for assistance with ADLs, wound care). Unique solutions may need to be developed to appropriately accommodate the patient's needs. Considerations may include: temporary placement at an LTC facility, housing patient in transfer observation with other transfer observation group inmate(s) that may assist with minor needs, or a designated inmate companion who is healthy and whose vaccines are up-to-date.
- In the case of a **DESIGNATED INMATE COMPANION**, the companion will need to test negative immediately prior to the start of **TRANSFER OBSERVATION** with either a POC or a commercial lab test. The companion will house with the patient for the duration of the observation period until the patient leaves the institution. Since the companion is not expected to be transferred, they will not need to undergo the symptom screening process or a SARS-CoV-2 test at the end of the observation period to return to general population.
  - ➔ *However, if the patient whom the companion is assisting or housing with becomes symptomatic or tests positive, the companion is considered a **CLOSE CONTACT** and must test-in/test-out of **QUARANTINE**.*

L. MEDICAL APPOINTMENTS & HOSPITAL TRIPS

An important area of consideration is the risk of exposure to COVID-19, as well as other concerns, posed by medical trips to the community. Institutions with high facility or community transmission rates, and/or low vaccination acceptance levels (Operational Level 2 and 3 operations), should consider postponing or rescheduling non-urgent consultations or procedures according to guidance in **MODULE 7. NON-COVID-19 ROUTINE & DENTAL SERVICES**.

- Regardless of vaccination status, all patients should undergo SSTC and POC testing prior to scheduled appointments
- If time allows, a SSTC and POC testing should be completed immediately prior to emergency trips while awaiting the arrival of EMS staff.
- When medical appointments and/or hospitalizations are medically necessary despite the risk of exposure to COVID-19, SSTC and POC testing should fall into the following categories (Refer to *Appendix A. Inmate Movement Table*)
  - ➢ **Patient is FULLY VACCINATED and has a medical appointment or trip to the emergency room but returns to the institution in less than 24-hours:** the patient will undergo standard intake procedures upon return to the institution.
  - ➢ **Patient is FULLY VACCINATED and returns to the institution after 24 hours:** the patient should undergo SSTC and POC testing upon arrival in addition to following usual standard intake procedures.
  - ➢ **Patient is NOT FULLY VACCINATED and has an appointment or trip to the emergency room but returns to the institution in less than 24-hours:** the patient will undergo SSTC in addition to following usual standard procedures upon return to the institution. Patient should be offered the COVID-19 vaccine.
  - ➢ **Patient is NOT FULLY VACCINATED and returns to the institution after 24 hours:** the patient should undergo SSTC and a full test-in/test-out 5-day intake observation period. Patient should be offered the COVID-19 vaccine.

M. IN-PERSON COURT APPEARANCES

Court appearances are important aspects of the U.S. criminal justice system but create potential risks for SARS-CoV-2 transmission from close interactions that may occur. A number of variables affect the risk of COVID-19 transmission during in-person court appearances and will determine some of the specific management strategies that are needed at each location.

- The U.S. Marshals Service (USMS) takes responsibility for the inmate from the time they leave the BOP institution until their return. Each USMS district may have their own procedures. Individual courts may also have different COVID-19 prevention/mitigation procedures and requirements. Knowing the risk or likelihood of mixing with non-BOP inmates and other court personnel with unknown exposure and vaccination status while BOP inmates are with the USMS and the courts is essential to determining their risk of COVID-19 exposure.
- The frequency of an inmate's court appearances and the number of inmates going to a court at any one time are also important factors to consider.
- **It is recommended that each BOP facility contact the USMS and the court** to ascertain their COVID-19 mitigation procedures and consult with Regional Health Services staff on developing an individualized strategy. The following are general principles to follow:
  - **BOP officials will request that BOP inmates be cohorted only with their own housing or routine observation period cohort** and not be mixed or transported with inmates from other housing units or institutions. Regardless of vaccination status, SSTC is required within 24 hours prior to each court appearance.
- **Prior to each court appearance,** a POC test is also required within 72 hours for fully vaccinated inmates at operational level 2 or 3 institutions and for all not fully vaccinated inmates.
- **Upon return to the institution or detention center,** inmates without known exposure to SARS-CoV-2 do not require immediate testing or routine observation periods. The following procedures are recommended:
  - All inmates who return the same day (less than 24-hour) from a court appearance will undergo SSTC in addition to the usual return procedures.
  - Inmates who return from a court appearance after more than 24 hours have elapsed will undergo a routine observation period prior to release into general population if not fully vaccinated.
- All inmates who have daily trips to court, should be housed separately from general population inmates and/or in a cohort, and in addition to daily SSTC, undergo weekly POC/PCR testing. If the inmate is not fully vaccinated, a routine observation period is needed prior to release into general population.
- Inmates in "holdover" status may be going to court on a weekly, monthly basis or unpredictable frequency; they should be housed separately from inmates who have completed an intake observation period.
- Inmates in "holdover" status, who are expected to remain at the institution for a prolonged period and are done with their court case will need to complete an intake observation prior to being released to general population.
- Do not mix not fully vaccinated inmates with General Population inmates, unless they have undergone intake observation.

- **Testing an inmate immediately after a one-day court appearance** would have little utility and is not recommended. However, a POC test can be used before a court appearance on a case-by-case basis, especially if the test is required by the court.
- Inmates in COVID MEDICAL ISOLATION OR QUARANTINE should not have in-person court appearances unless absolutely necessary. Having the inmate appear via telephone hearing should be strongly considered. A video teleconference (VTC), if accessible, can also be used as an alternative.
- Inmates should wear face coverings (surgical mask preferred) and perform hand hygiene just before departure and upon return to the institution.

N. INFECTION CONTROL GUIDANCE FOR TRANSPORTATION OF INMATES

➔ *See MODULE 2 for more details on the use of PPE. See MODULE 1 for more information about hand hygiene, social distancing, and cleaning and disinfection.*

The following PPE is required for inmates who are fully vaccinated or have completed TRANSFER OBSERVATION:

- INMATES: Face coverings
- STAFF: Face coverings and gloves

The following PPE is required for movement of not fully vaccinated BOP or non-BOP groups who have not completed TRANSFER OBSERVATION but have been POC tested and symptom screened (i.e. a BOP INTRASYSTEM TRANSFER PROCEDURE).

- INMATES: Surgical mask
- STAFF: Surgical mask, face shield or goggles, and gloves

The below guidance should be implemented for the safe transportation of the following groups:

- Inmates with signs and symptoms of respiratory illness or a positive SARS-CoV-2 test where movement is necessary prior to clearance from medical isolation.
- Not fully vaccinated groups of inmates, where infection has not been ruled out (i.e. has not completed TRANSFER OBSERVATION OR BOP INTRASYSTEM TRANSFER PROCEDURE)

- VEHICLE SET-UP PRIOR TO TRANSPORT
  - Place vehicle indoor fan on FRESH AIR ONLY, and NOT re-circulation mode.
  - Set fan to HIGH.
  - Driver side-window should be rolled down to the lowest position possible
  - Rear and side windows on both sides of the vehicle should be propped opened (weather permitting).
  - When the vehicle being used is a bus: Open the hatch on the ceiling of the vehicle.

- INMATE ACTIVITY PRIOR TO BOARDING THE VEHICLE:
  - The inmate is given a direct order to:
    - Place surgical mask on their face and then,
    - Perform hand hygiene by washing hands or sanitizing with an institution-approved hand sanitize solution

- **PPE for Driver and Officer**
  - All staff must wear an N95 or equivalent
  - When performing any action within close proximity to the inmate (e.g., putting on or removing restraints), eye protection, gloves, and gown, along with N95 or its equivalent, must be worn.
    - Once the inmate is placed into the vehicle, gloves and gown should be removed outside of the vehicle and discarded into a trash bag and hand hygiene performed.
    - Officer in contact with inmate(s) puts on new gown and gloves before helping inmates disembark from vehicle.

- **Inmates Boarding the Vehicle**
  - Fill bus starting from the back to maximize distance of the nearest inmate from the driver.

- **After the End of Transport**
  - Introduce fresh air into the vehicle for one hour by opening all doors and windows on the vehicle
  - While wearing all required PPE mentioned above, the vehicle should be cleaned and sanitized using the institution's approved hospital grade disinfectant (EPA Schedule N)

Infection Control Guidance for Transportation of FTC, Holdover and Detention Center Inmates

This guidance is based on an analysis of exposure risk for the inmate's point of origin (coming from a BOP facility or a non-BOP location) and the inmate's vaccination status (fully vaccinated vs not fully vaccinated).

- Inmates are considered to be at lower risk for exposure and transmission if they are 1) coming from a BOP facility regardless of vaccination status and have completed the recommended transfer procedure, or 2) fully vaccinated regardless of point of origin, or 3) not fully vaccinated from a non-BOP location after completing intake observation.
- Inmates considered to be at higher risk for exposure and transmission are those who are not fully vaccinated and coming from a non-BOP location who have not completed transfer observation, testing, or symptom screening.
- To minimize risk of exposure and transmission, keeping the above two groups separated at the institution and during movement is recommended to the extent possible.

- While being processed for outgoing movement, the two groups will be kept separate to the extent possible. Any instances in which BOP and fully vaccinated inmates are in close proximity to non-BOP not fully vaccinated inmates should be minimal based on the limitations of holding cells in the R&D area and the specialized needs of the inmates (e.g., max custody, designated to FLM ADX, SMU, residential units).
- Inmates moving from the FTC will be issued surgical masks without metal nose pieces (donned in R&D) to wear underneath a cloth face cover (double masking) and worn until their intake at the gaining facility, at which time they would resume wearing their preferred approved face cover.
- Outgoing flights and buses may include BOP and fully vaccinated inmates and non-BOP not fully vaccinated inmates as required by the movement. To the extent possible, these groups will be kept separate or physically distanced from each other. Inmates will board the JPATS flight or bus by group, with the non-BOP not fully vaccinated inmate section of the bus toward the rear part of the bus. Each

group will be seated in separate sections of the plane or bus and each section will be separated by enough empty rows to account for 6 feet.

- The following PPE is required for movement of inmates who are not fully vaccinated and have not completed **TRANSFER OBSERVATION** but have been POC tested and symptom screened.
  - **INMATES:** Surgical masks
  - **STAFF:** Surgical mask, face shield or goggles, and gloves

APPENDIX A. INMATE MOVEMENT TABLE

Movement Type	Fully Vaccinated	Not Fully Vaccinated
Intake from non-BOP facility	• SSTC and POC testing at intake • No intake observation period required • If screening and testing are negative, follow standard intake / R&D procedures; may be housed in General Population.	• Complete intake observation (5-day test- in/test-out) • Offer COVID-19 vaccine
BOP to BOP Transfer or Transfer to Other Correctional Jurisdiction - Sending Institution	• Standard R&D procedures • **Transferring from Level 1 Institution:** ▪ SS within 24 hours of transfer • **Transferring from Level 2 or 3 Institution:** ▪ POC test within 72 hours and SS within 24 hours of transfer • No transfer observation period required • Send vaccination documentation as appropriate	• **Transferring from Level 1 Institution:** ▪ POC test within 72 hours of transfer, and SS within 24 hours of transfer • **Transferring from Level 2 or 3 Institution:** ▪ Complete transfer observation (5-day test-in/test-out) • Offer COVID-19 vaccine
BOP to BOP Transfer – Receiving Institution	• SSTC and POC test at intake • No intake observation required • If screening and testing are negative, follow standard intake / R&D procedures; may be housed in General Population.	• Complete intake observation (5-day test-in/test-out) • Offer COVID-19 vaccine
Transfers to home confinement or halfway houses (RRCs) – Sending Institution	• Standard R&D procedures • No transfer observation required • SSTC within 24 hours of transfer • POC test within 72 hours of transfer • Send vaccination documentation as appropriate	• Complete transfer observation (5-day test-in/test-out) • Offer COVID-19 vaccine
Full Term Release	• Standard R&D procedures • No release observation required • SSTC within 24 hours of release • POC test within 72 hours of release • Send vaccination documentation as appropriate	• Complete release observation (5-day test- in/test-out) • Offer COVID-19 vaccine
Immediate Release	• POC+SSTC prior to release; send vaccination documentation as appropriate	
Inmate Movement Table Page 1 of 4		

Movement Type	Fully Vaccinated	Not Fully Vaccinated

Detention Centers and Holdover Facilities
It is important to distinguish between the following:
• Inmates from BOP facilities or fully vaccinated inmates from non-BOP facilities
  ▪ Inmates in this category should follow the guidance in the **fully vaccinated** column.
• Inmates from other agencies, correctional jurisdictions, contract and private correctional facilities, or voluntary surrenders and who are not fully vaccinated.
  ▪ Inmates in this category should follow the guidance in the **not fully vaccinated** column.
• Ordinarily, these two groups are not mixed at the institution; follow the Infection Control Guidance for Transportation in *Section M* for outgoing bus/JPATS flights.
• Institutions with limited housing availability may opt to manage their cohorts based on the minimal tolerable risk.[1]
• Inmates arriving as designated to these facilities are managed as new intakes not holdovers.
	Arriving from a BOP institution
	• SSTC and POC test on arrival
	• House in holdover unit
	
	Arriving from a non-BOP institution
	• SSTC and POC test on arrival
	• May house in holdover unit or complete intake observation with not fully vaccinated from a non-BOP facility.
	
	When transferring out:
	• OVERNIGHT REBOARDS (< 24 HOURS): POC tests and SS are NOT required for movement.
	• INMATES IN HOLDOVER STATUS 24 TO < 72 HOURS: perform a SS within 24 hours of transfer.
	• INMATES IN HOLDOVER STATUS 72 HOURS OR MORE: perform a POC test within 72 hours and a SS within 24 hours prior to transfer.
	
	→ *Refer to Section I and Appendix D for Holdover Sites, Bus hubs and Detention Centers movement procedures*
		Arriving from a BOP institution
		• SSTC and POC test on arrival
		• House in holdover unit
		
		Arriving from a non-BOP facility
		• SSTC and POC testing on arrival.
		• 7-day intake observation at the institution
		• Offer COVID-19 vaccine
		• POC/PCR test out w/in 48 hrs of departure
		• If all negative, may transfer out of institution after SSTC w/in 24 hrs of departure.
		• Holdover inmates who end-up staying beyond the 7-day observation period, may transfer with a POC test within 72 hours and a SS within 24 hours prior to departure.
		
		*** If the Holdover/Detention Center is at Operational Level 1 (Green), routine observation periods can be decreased to 5 days.*
		
		→ *Refer to Section I and Appendix D for Holdover Sites, Bus hubs and Detention Centers movement procedures*

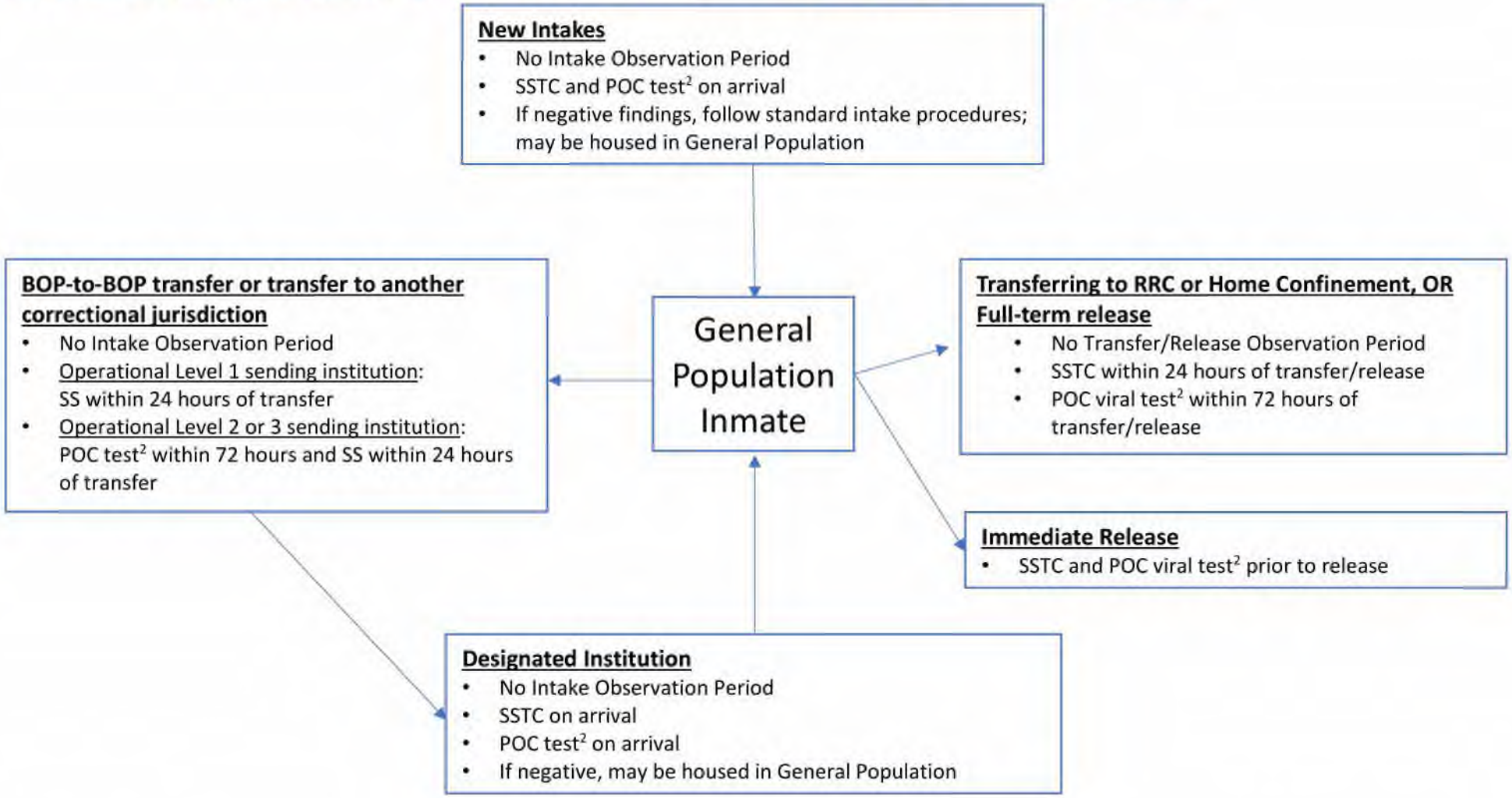
[1] When ideal standards cannot be upheld, act on the option that represents the lowest possible risk

Inmate Movement Table Page 2 of 4

Movement Type	Fully Vaccinated	Not Fully Vaccinated
Federal Transfer Center (FTC / OKL) The FTC houses inmates based on their point of origin (BOP vs. non-BOP institution) and on their vaccination status. **When transferring out:** • Only a SS is required for inmates in a "move-ready" unit. For those in a "non-BOP" unit, a POC test is required within 48 hours and a SS within 24 hours prior to departure. • Inmates from "move-ready" and "non-BOP" housing units may travel "together but separated" (i.e., they may travel on the same bus or plane but are seated in different areas with each group separated from the other by six feet)	From a BOP institution • SSTC and POC test on arrival • House in "move-ready" unit From a non-BOP institution • SSTC and POC test on arrival • May house in "move-ready" or "non-BOP" unit depending on housing capacity and COVID-19 transmission	From a BOP institution • SSTC and POC test on arrival • House in "move-ready" unit From a non-BOP institution • SSTC and POC test on arrival • House in "non-BOP" unit a minimum of 7 days ** (If the Federal Transfer Center is at Operational Level 1 (Green), routine observation periods can be decreased to 5 days).
	→ *Refer to Section J and Appendix E for OKL movement procedures.*	
Medical Appointments & Hospital Trips	• Prior to appointment: SSTC and POC test • Returns after same day/ less than 24-hour trips ▪ Follow usual return procedures • Returns after trips > 24 hours ▪ SSTC and POC test in addition to following usual return procedures	• Prior to appointment: ▪ SSTC and POC test • Returns after same day/ less than 24-hours ▪ SSTC in addition to following usual return procedures • Returns after trips > 24 hours ▪ Routine observation period (5-day test in/test out) • Offer COVID-19 vaccine
Court Appearances (continued on next page) • CDC Guidance states the following in relation to court appearances: Test incarcerated/detained persons leaving the facility as close to the day of visit as possible (no more than 3 days prior). • Each court may have additional or different procedural requirements.	• **Level 1 Institution:** ▪ SSTC within 24 hours prior to each court appearance • **Level 2 or 3 Institution:** ▪ POC test w/in 72 hours and SSTC w/in 24 hours prior to each court appearance • Follow usual return / R&D procedures	• Prior to court appearance: ▪ SSTC and POC test • Returns after same day/ less than 24-hours ▪ SSTC in addition to following usual return procedures
Inmate Movement Table Page 3 of 4		

Movement Type	Fully Vaccinated	Not Fully Vaccinated
Court Appearances (continued)	• Follow-up SSTC and POC testing once a week for two weeks after the most recent court appearance	• <u>Returns after trips > 24 hours</u> ▪ Routine observation period (5-day test in/test out) • Inmates who have daily trips to court, should be housed separately from general population inmates, and undergo weekly POC/PCR testing • Routine observation period (5-day test in/test out) is needed prior to release into general population • Offer COVID-19 vaccine
Inmate Movement Table Page 4 of 4		

APPENDIX B. ROUTINE OBSERVATION PERIODS DURING MOVEMENT FOR FULLY VACCINATED[1] INMATES

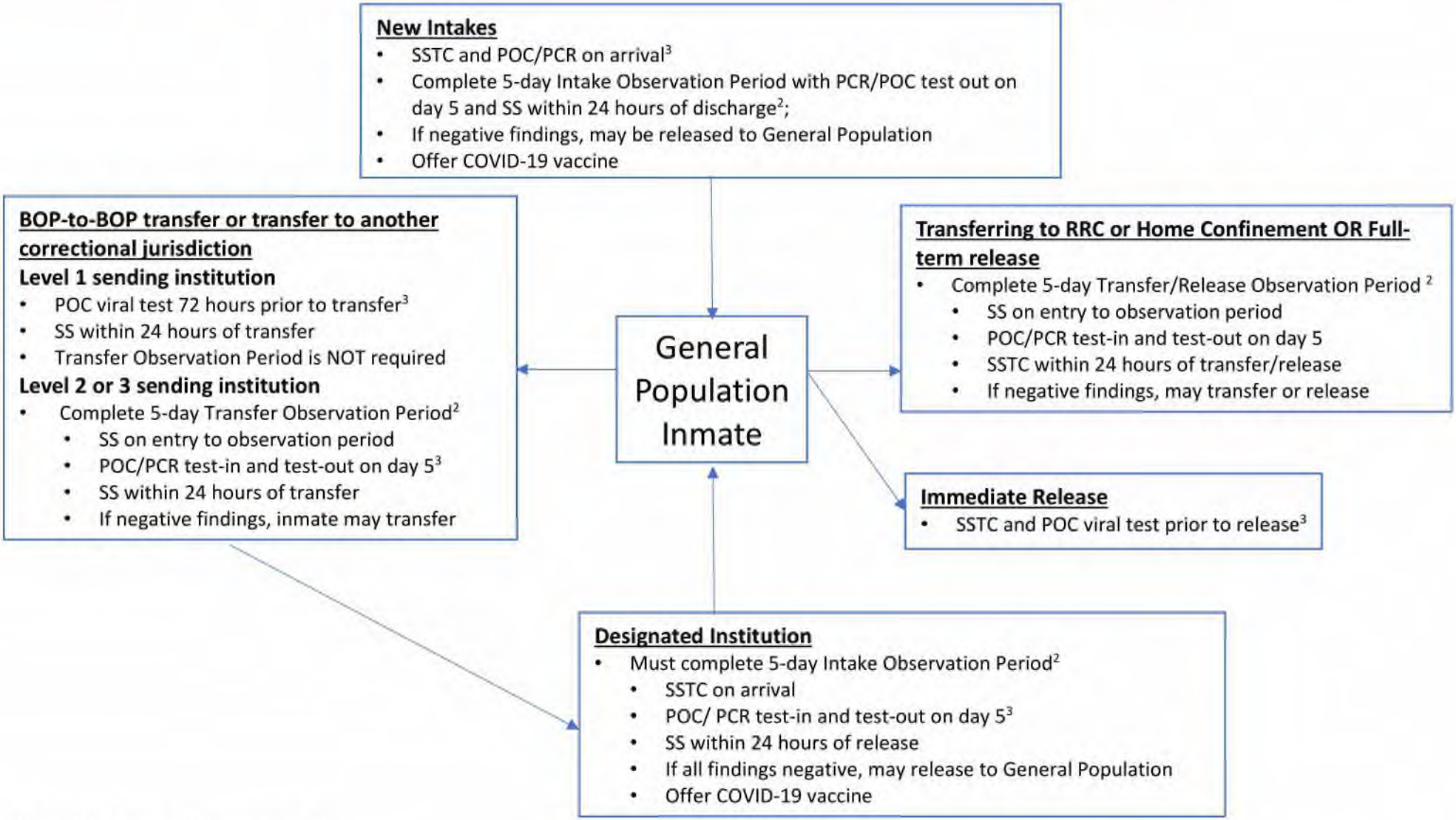


SS: Symptom screen; TC: Temperature check

[1] *Fully Vaccinated* means a person 2 weeks after either their second dose in a 2-dose series (Pfizer or Moderna) or after a single dose series (Janssen). To be managed as a Fully Vaccinated inmate, there must be BEMR documentation of vaccine series completion.

[2] Inmates with a positive COVID-19 test in the last 90 days (who completed their medical isolation) do not typically need a viral test.

APPENDIX C. ROUTINE OBSERVATION PERIODS DURING MOVEMENT FOR NOT FULLY VACCINATED[1] INMATES



SS: Symptom screen; TC: Temperature check

[1] *Fully Vaccinated* means a person 2 weeks after either their second dose in a 2-dose series (Pfizer or Moderna) or after a single dose series (Janssen). To be managed as a Fully Vaccinated inmate, there must be BEMR documentation of vaccine series completion.

[2] Inmates who are not fully vaccinated entering a high-risk unit are recommended to continue to complete a 10-day intake observation period.

[3] Inmates with a positive COVID-19 test in the last 90 days (who completed their medical isolation) do not typically need a viral test.

APPENDIX D. HOLDOVER AND DETENTION CENTER PROCEDURES

Inmates arriving from **BOP Institutions** (regardless of vaccination status) and inmates arriving from **non-BOP[2] locations who are fully vaccinated**

- SSTC and POC testing on arrival (all inmates)

(these two groups do not mix at the institution)

Not fully vaccinated holdover inmates from **non-BOP[2] facilities**

- SSTC and POC testing on arrival
- Complete 7-day Intake Observation Period
- POC/PCR test-out w/in 48 hours of departure
- SS w/in 24 hours of departure
- If all negative, may transfer out of institution
- Offer COVID-19 Vaccine
- Holdover inmates who stay beyond the 7-day Intake Observation Period, may transfer after:
  - SS within 24 hours of departure
  - POC test within 72 hours of departure

***If the Holdover/Detention Center is at Operational Level 1 (Green), Observation Period can be decreased to 5 days*

If leaving in less than 24 hrs

- No SS
- No POC testing

If leaving 24-72 hrs

- SS within 24 hrs of transfer
- No POC testing

If leaving ≥ 72 hrs

- SS within 24 hrs of transfer
- POC viral test within 72 hours prior to transfer

If expected to change from "holdover status" (designated to institution or released to General Population):

- Complete 7-day Intake Observation Period if not fully vaccinated[1]
  - SS on entry to observation period/arrival
  - POC/PCR test-in and test-out on day 7
  - SS within 24 hours of release from Intake Observation Period
  - If negative findings, may release to General Population.

***If the Holdover/Detention Center is at Operational Level 1 (Green), Observation Period can be decreased to 5 days*

SS: Symptom screen; TC: Temperature check

[1] *Fully Vaccinated* means a person 2 weeks after either their second dose in a 2-dose series (Pfizer or Moderna) or after a single dose series (Janssen). To be managed as a Fully Vaccinated inmate, there must be BEMR documentation of vaccine series completion.

[2] Non-BOP location or institution applies to any institution outside of the 122 recognized BOP facilities; this includes all contract facilities.

APPENDIX E. OKL – FEDERAL TRANSFER CENTER MOVEMENT PROCEDURES

Holdover inmates arriving from a **BOP Institution** (regardless of vaccination status) *or* who are arriving from **a non-BOP location[2] and are fully vaccinated[1]**
- SSTC and POC testing on arrival
- Placed in "move-ready" unit

ON ARRIVAL

(these two groups do not mix at the institution)

Not fully vaccinated holdover inmates from **non-BOP[2] facilities**
- SSTC and POC testing on arrival
- Must complete 7-day Observation Period
- POC/PCR test-out w/in 24 hours of departure
- If all negative, may transfer out of institution after SS w/in 24 hours of departure
- Offer COVID-19 Vaccine

*** If FTC OKL is at Operational Level 1 (Green), observation periods can be decreased to 5 days*

- SS within 24 hours of departure

UPON DEPARTURE

Inmates who stay beyond the 7-day Intake Observation Period, may transfer after:
- SS within 24 hours of departure
- POC test within 72 hours of departure

Together BUT SEPARATED Outgoing Bus/JPATS FLIGHT Procedures
- *To the extent possible, these two groups will not mix in R&D or "waiting areas"*
- *All inmates will be provided surgical masks without metal nose piece to be donned in R&D and worn under a cloth mask*
- *Not fully vaccinated holdover inmates from non-BOP facilities will board the bus/airplane first towards the rear (preferred)*
- *The BOP and fully-vaccinated inmate group will board the bus/airplane last, and towards the front allowing empty seat rows to achieve >6 ft of distance between the groups.*

Upon Arrival to designated BOP institution:
- SSTC and POC testing on arrival
- **Complete 5-day Intake Observation Period if not fully vaccinated**
  - POC/PCR test-out on day 5
  - SS within 24 hours of release from Intake Observation Period
  - If negative findings, may release to General Population
  - Offer COVID-19 Vaccine

Inmates who arrive as designated to OKL:
- SSTC and POC viral test on arrival
- **Complete 7-day Intake Observation Period if not fully vaccinated**
  - POC/PCR test-out on day 7
  - SS within 24 hours of release from Intake Observation Period
  - If negative findings, may release to General Population
  - Offer COVID-19 Vaccine

*** If FTC OKL is at Operational Level 1 (Green), observation periods can be decreased to 5 days*

SS: Symptom screen; TC: Temperature check

[1] *Fully Vaccinated* means a person 2 weeks after either their second dose in a 2-dose series (Pfizer or Moderna) or after a single dose series (Janssen). To be managed as a Fully Vaccinated inmate, there must be BEMR documentation of vaccine series completion.

[2] Non-BOP location or institution applies to any institution outside of the 122 recognized BOP facilities; this includes all contract facilities.

MODULE 7. NON-COVID ROUTINE MEDICAL & DENTAL SERVICES

WHAT'S NEW

- The performance of PFTs and peak flow testing for a patient with symptoms or confirmed COVID-19 should only be considered if clinically necessary to monitor the course of the disease or adjust the treatment.
- Inmates assigned to work duties or training activities that are exclusive to the dental clinic should be vaccinated for COVID-19 according to current CDC guidance.

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A. ROUTINE HEALTH CARE DELIVERY DURING THE COVID-19 PANDEMIC

Many aspects of routine health care delivery may become disrupted during the COVID-19 pandemic. Institutions should adjust their operations based on the *COVID-19 Modified Operations Matrix* and develop a plan of action that addresses health care delivery according to the operational level of the institution.

➔ *See MODULE 1. INFECTION PREVENTION AND CONTROL MEASURES, for more information on hand hygiene, social distancing, cleaning and disinfection, cloth face coverings, and supply management.*

➔ *See MODULE 2. PERSONAL PROTECTIVE EQUIPMENT for more information on PPE.*

- **When there is known COVID-19 transmission within a facility and/or surrounding community or low vaccine acceptance rates,** moderate to intense disruptions of normal operations will be necessary to mitigate spread of disease. When an institution is functioning at Level 3 operations, health care services may be limited to urgent health care needs and routine services may be postponed as clinically appropriate.
  - ➔ *Refer to the APPENDICES for "Prioritization of Health Care Services Based on Degree of Disruption to Normal Operations."*
- Refer to **MODULE 2** for PPE use when delivering health care to an inmate NOT suspected of COVID-19.
- **Cloth face coverings for inmates:** All inmate patients in the HSU should wear a cloth face covering at all times except when physical examination requires access to the mouth/nose.
- **Waiting area:** Chairs should be at least 6 feet apart during Level 2 and Level 3 operations. Hand hygiene stations should be available at all facilities.
- **Staggered appointments:** It may be necessary to limit the number of persons in the HSU to promote social distancing according to the Operational Level of the institution. Consider grouping persons to be evaluated by housing unit.
- **Signage:** Post signage within the HSU to emphasize important behavior (distancing, respiratory etiquette, wearing of face coverings, hand hygiene).
- Increase frequency of cleaning and disinfection on the health services unit: See the section on *Environmental Cleaning and Disinfection* in **MODULE 1**, and post a schedule in the HSU.

B. CHRONIC CARE

Prioritize CHRONIC CARE evaluations during the COVID-19 pandemic to focus on the identification and monitoring of inmates with poorly controlled conditions, who are pregnant, who are not fully vaccinated, or who are at risk for more severe COVID-19 illness such as the following:

- People age 50 years and older
- People admitted to a nursing care unit or long-term care facility
- Other high-risk individuals, including:
  - People with chronic lung disease or moderate to severe asthma
  - People who have heart disease with complications
  - People who are immunocompromised, including those receiving cancer treatment
  - People of any age with underlying medical conditions such as obesity (BMI ≥ 30), diabetes, sickle cell disease, renal failure, or liver disease, particularly if not well-controlled

C. SICK CALL

- **Inmates should have continued access to health care during a pandemic.** Triage inmates based on medical acuity, as outlined in the PATIENT CARE PROGRAM STATEMENT 6031.04, with a focus on evaluating the acutely ill and scheduling appointments for those requesting routine medical care.
- **Priority should be given to those with COVID-like symptoms or urgent medical conditions.** Inmates who come to sick call with respiratory symptoms should immediately be placed in a separate room and directed to wear a mask, if not already doing so, and perform hand hygiene.
  - ➔ *Refer to the APPENDICES for "Triage of Certain Medical and Mental Health Conditions During COVID-19 Disruptions."*
- Institutions at Operational levels 2 or 3, may need alternate methods of running sick call so that the waiting room is not crowded with inmates waiting to be triaged:
  - ➢ It may be necessary to organize sick call by housing unit; refer to the *COVID-19 Modified Operations Matrix* for requirements for social distancing and cohorting dependent upon operational level of the institution.
  - ➢ Consider transitioning to an electronic sick call process only.
  - ➢ Scheduling "routine" sick call for issues other than acute illness (requests for medication renewal, medical idle, issuing of supplies, etc.) at a different time.

D. AEROSOL-GENERATING PROCEDURES (AGPS)

Institutions should minimize, to the greatest medical extent, the use of AGPs to mitigate the risk of COVID-19 transmission. Among the AGPs that may be utilized within a BOP institution are nebulizer treatments, continuous positive airway pressure (CPAP), bi-level positive airway pressure (BiPAP), and pulmonary function testing (PFT). Institutions should retrieve a report from BEMR identifying inmates who have been issued a nebulizer or CPAP machine and follow the recommendations below.

1. NEBULIZER TREATMENTS

- **To the greatest extent possible, the use of a metered dose inhaler (MDI) should be used instead of a nebulizer.** Even in the acute setting, the use of an MDI with a spacer has been shown to be at least as effective as a nebulizer when used correctly.
  - ➔ *It may be necessary to use more doses per event, or more frequent dosing than the baseline prescription for the medication.*
- **If a nebulizer MUST be used:**
  - ➢ Administer the treatment in an airborne infection isolation (AII) room when possible. If an AII room is not available, use a single room with solid walls and a solid door.
  - ➢ Attach an in-line viral filter (e.g., Airlife 001851) at the end of the 6-inch flex tube that extends from the nebulizer kit.
  - ➢ Minimize the number of staff involved in administering the nebulizer, and the amount of time the staff spends in the room.
  - ➢ When in the room, staff should use appropriate PPE (refer to MODULE 2).
  - ➢ The room and equipment must be disinfected when finished (refer to the section on *Environmental Cleaning and Disinfection* in MODULE 1).

2. CPAP/BIPAP

➔ *As of the writing of this guidance, there are no special or increased cleaning recommendations for CPAP/BiPAP equipment or machines. Patients should be reminded to perform their usual regularly scheduled daily and weekly cleaning regimens as recommended by the equipment manufacturers.*

Most patients who use a CPAP machine do so for sleep apnea. In many of these cases, it may be reasonable to consider that the RISKS OF AEROSOLIZATION of the SARS CoV-2 virus (leading to transmission) outweigh the risks of the short-term discontinuation of CPAP use during the pandemic; this is a clinical decision, and as such at the discretion of the attending physician.

MILD TO MODERATE SLEEP APNEA

In cases where CPAP is used for mild to moderate sleep apnea with no significant co-morbidities, the CPAP machines may be retrieved from the patient until the risks of COVID-19 transmission at the institution have abated.

SEVERE SLEEP APNEA WITH CO-MORBIDITIES

In patients with severe sleep apnea with co-morbidities—such as morbid obesity, pulmonary hypertension, cardiomyopathy, etc.—even the temporary discontinuation of BiPAP or CPAP may constitute a higher risk. When the decision is made to allow the patient to continue using CPAP/BiPAP, the following procedures should be considered to mitigate the spread of COVID-19:

➔ ***It is highly recommended that these patients should be tested for COVID-19.***

- Patients that TEST POSITIVE should be placed in ISOLATION and a contact investigation should be performed. Any identified close contacts, as well as inmates bunking nearby, should be tested for COVID-19, have a symptom screen and temperature check, and be placed in quarantine or isolation as indicated.
- For patients that TEST NEGATIVE, the following HOUSING ADJUSTMENTS (*listed in order of preference*) should be made as feasible:
  - ➢ It is preferable that CPAP wearers be single-celled in a room with solid walls and a solid door that closes. Psychology Services staff should be consulted any time a patient is being considered for placement in a single cell, to ascertain whether the patient is considered high risk, or has any mental health condition to preclude him/her from single-cell placement.
    - The door should be closed when BiPAP or CPAP is in use.
    - When in the room, and CPAP/BiPAP are in use, staff should use appropriate PPE. (See MODULE 2 for proper use of PPE.)
    - A CPAP/BiPAP sign should be posted on the door to alert staff to the PPE required for entering the room. (Refer to the APPENDICES for the sign.)
    - Minimize the number of staff and the amount of time spent in rooms when CPAP/BiPAP are in use.
    - Room and equipment must be disinfected prior to a new patient occupying a room previously used by a CPAP/BiPAP user.
    - If single cells are limited, prioritize use of these rooms to patients under quarantine.
  - ➢ Cohort CPAP/BiPAP wearers to one area of a unit in a lower bunk.
  - ➢ House CPAP/BiPAP wearers maximally distanced from others.

SET-UP AND USE OF CPAP/BIPAP

- If at all possible, CPAP/BiPAP should be set up and used with a full-face, non-vented CPAP mask with an in-line viral filter attached to the intake and exhalation ports. The viral filters should be changed daily. (See the APPENDICES for a set-up diagram.)
- If the recommended setup is not readily obtainable, the humidifier chamber should be removed from the device, when possible, or the device be used without humidification
- There will be cases when the above set up is not tolerated by the patient, and when this occurs the attending physician will decide what is in the best interest of the patient and utilize their clinical judgement in mitigating the aerosolization according to the above described controls.

3. SUPPLEMENTAL OXYGEN

- Within BOP institutions, the use of supplemental oxygen is typically LOW FLOW via the use of nasal cannula. This is NOT considered to be an AGP and should NOT require specific precautions.
- Use of HIGH FLOW OXYGEN, HUMIDIFIED TRACH MASKS, or NON-REBREATHERS do involve AGPs and their use should be performed with the same precautions and measures described above for CPAP/ BiPAP use.

4. PULMONARY FUNCTION TESTING (PFT)/PEAK FLOWS

The performance of PFTs and peak flow testing for a patient with symptoms or confirmed COVID-19 should only be considered if clinically necessary to monitor the course of the disease or adjust the treatment.

E. DIRECTLY OBSERVED THERAPY

- It may be necessary to administer medications by unit or cell depending on the Operational Level of the institution. Refer to the COVID-19 Modified Operations Matrix for requirements for social distancing and cohorting dependent upon operational level of the institution.
- **Reduce staff exposure at insulin line** by encouraging inmate self-injection of insulin when feasible. When inmates cannot inject themselves, advise employees to change gloves between each patient and wear appropriate PPE (see MODULE 2).

F. RESPONSE TO EMERGENCIES

- ADDITIONAL PPE: In addition to the PPE normally required for emergency response, staff should prepare to respond to emergencies in quarantine or medical isolation units with appropriate PPE (see MODULE 2)
- FOR CPR: Staff performing CPR on a suspected or confirmed COVID-19 case should wear a tight fitting respirator and eye protection and use a bag-valve-mask (e.g. an AMBU®-BAG) for breaths.
  - ➔ *It is reasonable for staff to start with compressions-only CPR until health services staff arrive with an Ambu®-bag.*
- Place PPE in areas where staff can easily access it for emergencies:
  - ➢ Add "PPE to-go" bags (4 pairs of gloves, masks, gowns, N-95s, eye wear, 1 Ambu® bag) to emergency bags and response kits and carts.
  - ➢ When feasible add PPE to areas where an AED is housed.

G. INFLUENZA VACCINATIONS

All staff and inmates should be encouraged to accept the influenza vaccine.

- Influenza vaccine is recommended for all persons who do not have contraindications during the influenza season
- Please contact your Regional Chief Pharmacist for any questions regarding supplies of vaccine.
- Please see the CDC *Vaccination Guidance During a Pandemic* for additional information vaccinating those with COVID-19, available at: *https://www.cdc.gov/vaccines/pandemic-guidance/index.html*.
- During the flu season it may be difficult to discern between symptoms of influenza and COVID-19 necessitating testing for both. The BOP has approved rapid testing for influenza. Facilities can utilize commercial send-out testing, public department of health assistance for flu testing, or rapid POC tests.

H. OUTSIDE MEDICAL AND DENTAL CONSULTATIONS

An important area of consideration is the risk of exposure to COVID-19, as well as other concerns, posed by the medical and dental trips that are typically required on a daily basis at BOP institutions nationwide. These trips present a potential point of exposure for staff and inmates at local hospitals and health centers. They may also require significant staffing resources, particularly for escorts, at a time when staffing levels may be low as a result of COVID-19. In addition, local hospitals and clinics may be limiting their own operating hours and procedures, making these community health resources difficult to access.

- Staff responsible for scheduling and coordinating outside consultations should maintain regular COMMUNICATION with outside providers to ensure health services and escort staff are complying with guidance from provider offices and hospitals.
- Leveraging TELEHEALTH modalities, when possible, is an important way to reduce the need for outside medical trips. Institutions should explore ways to increase telehealth options.
- Consider POSTPONING OR RESCHEDULING non-urgent consultations (see discussion of CONSIDERATIONS below).

1. CONSIDERATIONS IN DECIDING TO POSTPONE OR RESCHEDULE CONSULTATIONS

The decision to POSTPONE OR RESCHEDULE medical care in the community is considered an important and necessary **response to this national emergency and is NOT made lightly**. This decision is affected by several variables, including the category and urgency of the care, the safety and health of inmates and staff, and good clinical judgment.

- Care for ACUTE, EMERGENT, OR URGENT CONDITIONS is medically necessary and should NOT be postponed or rescheduled.
  - MEDICAL examples include, but are not limited to, myocardial infarction, hemorrhage, stroke, severe trauma, etc.
  - DENTAL examples include, but are not limited to, uncontrolled bleeding, cellulitis/swelling that potentially compromises the airway, trauma involving major facial bones, complications after oral surgery, significant pathology, etc.
- NON-EMERGENT BUT MEDICALLY NECESSARY CARE is prioritized in part by the risk of deterioration, the likelihood of successful repair at a later time, and significant pain that impairs activities of daily living.

- ROUTINE, ELECTIVE, OR MEDICALLY ACCEPTABLE MEDICAL CARE may be postponed on a case-by-case basis, or re-scheduled as reasonably available during active facility/community transmission and according to community resources

2. UTILIZATION REVIEW COMMITTEE

The Clinical Director or designee should convene the UTILIZATION REVIEW COMMITTEE as outlined in PATIENT CARE PROGRAM STATEMENT 6031.04. Certain institutions may require involvement of Regional resources. In the context of the current COVID-19 pandemic, the purpose of the group is to:

- Review the AVAILABLE RESOURCES of the institution for trips (scheduled and unscheduled).
- Review HISTORICAL TRENDS to estimate and plan for the number of unscheduled, and emergent trips.
- Perform REVIEWS OF SCHEDULED MEDICAL TRIPS ON A REGULAR BASIS, as needs and available resources are likely to continue to change.
- RE-SCHEDULE PLANNED MEDICAL TRIPS as much as reasonably possible to minimize staff and patient exposure to community healthcare settings, to accommodate potential staff resource limitations, and to avoid over-burdening local resources with elective visits.
- EVALUATE NEW MEDICAL CONSULTATION REQUESTS in light of institution and community resources.

  ➔ *If further guidance is needed, please contact your respective Regional Medical Director. Their contact information is available on the Health Services Division Sallyport page.*

I. DENTAL SERVICES DELIVERY CONSIDERATIONS

The following restrictions for dental services are intended to minimize the production of aerosols and the possible spread of infection to patients and health services staff. The limitation of procedures at this time also aims to assure that adequate PPE is available for use during urgent and emergent dental treatment.

➔ *The BOP Clinical Guidance on Infection Control and Environment of Care in Dental Health-Care Settings, https://www.bop.gov/resources/pdfs/infection_control_in_dental_healthcare_guidance.pdf should be followed at all times.*

➔ *Institutions should also follow the CDC's Summary of Infection Prevention Practices in Dental Settings, available at: https://www.cdc.gov/oralhealth/infectioncontrol/pdf/safe-care2.pdf*

- EMERGENCY/URGENT dental care will continue to be provided.

  ➔ *See Examples of Urgent/Acute Dental Care below.*
- NON-URGENT / ROUTINE dental treatment and preventive dental services: All institutions are to continue non-urgent / routine dental services. COVID-19 transmission rates at the institution and surrounding communities as well as the patient's SARS-CoV-2 infection status are important factors to consider. The following recommendations are intended to guide dental programs in safely providing non-urgent / routine dental care.
  - INMATE POPULATION TRANSMISSION STATUS. The institution's epidemiologic status of SARS-CoV-2 infection and transmission is an important consideration for making decisions about the provision of dental services during the COVID-19 pandemic. Deferral of non-urgent dental care is prudent when there is widespread transmission occurring throughout a facility. As a general rule, non- urgent / routine dental services will be provided when institution SARS-CoV-2 transmission rates are lower or when transmission occurs only in limited areas. Regular consultation with institution Health Services leadership is recommended to determine whether the transmission

status at the institution has changed. Altering the strategy for non-urgent / routine dental services may be necessary if there is an increase of COVID-19 cases in the inmate population.

- **COMMUNITY TRANSMISSION.** The level of community transmission may be indicative of the risk for staff introducing SARS-CoV-2 into the inmate population. Rates of known or suspected infection in staff may also be a good indicator of this risk. When SARS-CoV-2 infection is widespread among institution staff, consider deferring non-urgent / routine dental care. Decisions to provide routine dental care based on community and staff transmission rates are made in conjunction with institution Health Services leadership.
- **PATIENT INFECTION STATUS.** After considering local institution and community transmission rates, the individual patient infection status should be considered. Non-urgent / routine patient care will be provided to those who are not known or suspected to have active SARS-CoV-2 infection or who are not a close contact of a SARS-CoV-2 infection. Non-urgent / routine dental care should be deferred for those who are currently known or suspected to be infected with SARS-CoV-2 or who are in medical isolation or quarantine.

- Dental Admissions and Orientation (A&O) examinations should be scheduled in coordination with medical staff to limit the number of inmates in medical waiting areas.
  - Inmates who have been waiting the longest for their A&O examinations shall be prioritized as much as possible.
  - Cohorted scheduling of Dental A&O inmates who are receiving History and Physical examinations should be implemented in order to reduce visits to the HSU, as applicable. Physical / social distancing needs to be ensured when inmates are cohorted for such evaluations.

1. SUPPLEMENTARY RECOMMENDATIONS FOR DENTAL CARE

- When SARS-CoV-2 transmission is occurring at an institution, dental staff should work with medical staff to establish triage procedures.
- The patient's temperature will be measured and symptoms reviewed for every patient encounter. Follow medical staff guidance if COVID-19 symptoms are present or temperatures are elevated.
- Patients should wear a face covering for source control (immediately prior to and following any intraoral procedure).
- Some procedures performed on patients with suspected or confirmed SARS-CoV-2 infection could *generate infectious aerosols*. Procedures that pose such risk should be avoided when possible and, if required to be performed, additional control measures may be necessary (See *Dental Management of COVID-19 Symptomatic/Diagnosed Patients* below).
- To help minimize aerosols or spatter, use four-handed dentistry with high-volume evacuation suction and rubber dams when applicable.
- COVID-19 is spread primarily via respiratory droplets through close contact from person-to-person and less commonly through contact with contaminated surfaces. It is paramount during this time that all dental staff follow CDC transmission-based precautions for droplet and contact precautions—in addition to BOP guidance for infection control as it pertains to sterilization, hand washing, and disinfecting surfaces (see MODULE 1).

EXAMPLES OF URGENT/ACUTE DENTAL CARE

- Extraction of symptomatic non-restorable teeth
- Management of active infections/swelling/cellulitis
- Pulpectomy of symptomatic teeth that otherwise meet policy criteria for endodontic therapy (root canal therapy should be completed when the patient is asymptomatic)

- Caries removal and temporization of symptomatic cavitated lesions
- Acute trauma/lesion/pathology that requires immediate evaluation/treatment
- Dental treatment required prior to life-saving medical treatment such as radiotherapy/chemotherapy

2. DENTAL MANAGEMENT OF COVID-19 SYMPTOMATIC/DIAGNOSED PATIENTS

- If a dental patient is suspected or confirmed to have COVID-19, defer dental treatment when possible.
- If emergency dental care is medically necessary, airborne precautions should be followed, with care provided in a hospital or other facility with an isolation room with negative pressure.
- If a symptomatic/diagnosed patient requires immediate evaluation/treatment by an outside provider, work closely with your Clinical Director to ensure that all parties (custody, transportation, receiving facility, etc.) are aware of the patient's symptoms/diagnosis.

→ *See MODULE 2. PERSONAL PROTECTIVE EQUIPMENT for more information on PPE.*

3. DENTAL MANAGEMENT OF ASYMPTOMATIC PATIENTS/NON-INFECTED PATIENTS

Due to the close proximity of providers to dental patients, treatment should be conducted using PPE as recommended in the section *Dental Engineering Controls* below. In addition, keep in mind the following considerations.

- Ensure the appropriate amount of PPE and supplies are stocked to support your patient volume. If PPE and supplies are limited, prioritize dental care for the highest need, most vulnerable patients.
- Extended use of N-95 respirators can be considered if there is a PPE shortage.
- Dentist, dental hygienist, dental assistants and inmate dental orderlies must wear a surgical mask in all patient care areas, whether or not there are patients in the clinic/area. All dental inmate workers may wear their cloth face covering outside of patient care areas.
- Dental student rotations may resume when SARS-CoV-2 infection risks are lower at the institution and respective community.
- Inmates assigned to work duties or training activities that are exclusive to the dental clinic should be vaccinated for COVID-19 according to current CDC guidance. This includes inmates enrolled in the dental assistant apprenticeship program and inmates functioning solely within sterilization areas.

4. DENTAL ENGINEERING CONTROLS

In addition to the guidance provided above, ENGINEERING CONTROLS aim to further decrease the potential spread of COVID-19 in a patient treatment setting. In the interest of safely increasing the number of dental patients that can be treated, the BOP Dental Program—in conjunction with the Occupational Safety & Health Branch (OSH) —has put together a list of recommendations for engineering controls in line with CDC recommendations.

- All AGPs will require a N-95 respirators, high-evacuation suction, and dental dam when applicable.
- Standard PPE to be worn by dental health care personnel during aerosol generating procedures includes: gloves, gown, eye protection or face shield, and N-95 respirator.
- The HVAC systems air changes per hour (ACH) in the dental clinics is ideally set at 15 ACH.
  - Consult with HVAC/facilities staff to determine if your clinic's HVAC unit can be programmed to 15 ACH.
  - If the clinic's HVAC system cannot achieve 15 ACH, it is recommended that the clinic supplements with a portable solution (e.g., portable HEPA filtration units).

- Patient chairs should be at least 6 feet apart, and operatories should be separated by a physical barrier. When determining the best patient separation for your clinic, consider implementing the following:
  - Spacing out individuals receiving care to every other chair as necessary to achieve six feet of distance between chairs.
  - Using "Shields on Wheels" described as a piece of Plexiglas wider than the length of the chair and no higher than 7 feet, on wheels that can be moved around so as not to interfere with the sprinkler system.
  - Consult with your safety department regarding egress requirements and building fire protection systems.
  - Consult with Correctional Services regarding the safety and security of the dental clinic with altered sight lines.

➔ *Recommendations may change as additional information becomes available. Additional questions should be referred to the respective Regional Chief Dental Officer. Refer also to the CDC's Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic, available at https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html*

MODULE 8. INMATE PROGRAMING AND SERVICES

WHAT'S NEW

Updates made throughout this document related to the *COVID-19 Modified Operations Matrix* – institutions operating at Level 1 or 2 will follow the guidance in the Matrix, when applicable. Institutions operating at level 3 will follow the mitigation strategies and guidance contained in this module.

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A. INMATE SERVICES

- Develop a local daily cleaning schedule utilizing your housekeeping plan to clean and disinfect, when indicated, equipment used by multiple inmates (kitchen, UNICOR, barber shop tools, etc) and areas where inmates gather (dining hall, recreation, etc.)
  - Refer to **MODULE 1** – *Infection Prevention and Control Measures* for specific guidance regarding cleaning and disinfection.

1. RECREATION

- Recreation services are an important component of both general wellbeing and the development of positive leisure time management skills. Institutions at Operational Levels 1 or 2 per the *COVID-19 Modified Operations Matrix* should follow guidance in the matrix.
- For institutions at Operational Level 3:
  - Stagger time in recreation spaces. Generally, inmates in groups of no more than 100 should access the recreation yard for a minimum of one hour at a time, so long as they maintain social distancing and wear cloth face coverings when indicated.
  - Inmates should have access to the recreation yard at least three times per week, and attend with inmates from their designated housing units.
  - Group sports are prohibited.
  - Use of gym equipment (e.g., weights, basketballs) are prohibited.
  - Small classes that do not involve physical contact may be offered at the discretion of the Warden. If this occurs, all equipment / materials must be thoroughly sanitized after each use.
  - Recreation will continue in Special Housing, consistent with standards outlined in policy.

2. UNICOR

- In consultation with the Safety and Health Services departments, Wardens should continue to monitor institution plans to safely continue UNICOR operations at their institutions.
- Plans should include the use of appropriate face coverings or PPE, as necessary, as well as disinfection and cleaning procedures, etc. Refer to **Module 1**- *Infection Prevention and Control Measures.*

- Institutions at Operational Levels 1 or 2 per the *COVID-19 Modified Operations Matrix* should follow guidance in the matrix.
- For institutions at Operational Level 3:
  - Space inmates six feet apart for work details, with facial coverings in place, and, if possible, provide a physical barrier, such as plexi-glass, between workers
  - Consider a modification of UNICOR detail assignments or shifts with two or more details, each working a separate shift. House each individual detail together and on a separate unit from the other details or shifts so that if one unit/shift is affected by COVID-19, another detail/shift can cover the same assignment.
  - Consider cross-training individuals for increased job coverage within UNICOR. House these individuals separately from the primary work group.

3. Work Details

- Institutions at Operational Levels 1 or 2 per the *COVID-19 Modified Operations Matrix* should follow guidance in the matrix.
- For institutions at Operational Level 3:
  - Consider a modification of work detail assignments so that each detail includes only individuals from a single housing unit.
  - Cross-train individuals for increased job coverage for details such as food service, laundry, and orderlies. House these individuals separately from the primary work group.
  - Screen orderlies assigned to health service units (HSUs) for COVID-19 symptoms and temperature prior to each shift. Orderlies assigned to HSUs must also wear a surgical mask at all times in the HSU.
    - *Consider a weekly testing schedule for inmate workers in long-term care or in-patient units.*
  - In facilities with active COVID-19 cases (staff or inmate), consider screening inmate food service workers and orderlies for COVID-19 symptoms and temperature prior to each shift, as well as periodic testing for COVID-19.
  - Space inmates six feet apart for work details, with facial coverings in place, and, if possible, provide a physical barrier, such as plexi-glass, between workers.

4. Food Service / Dining Hall

- Institutions at Operational Levels 1 or 2 per the *COVID-19 Modified Operations Matrix* should follow guidance in the matrix.
- For institutions at Operational Level 3 the following options may be considered to reduce the interaction between individuals, especially when masks are removed for the purposes of eating.
  - Require that masks not be removed unless the person is actually eating their food.
  - Stagger meals (for instance, one housing unit at a time) to allow for social distancing.
  - In lines, enforce the need to be six-feet apart. Consider marking the floors at six-foot intervals.
  - Rearrange dining hall seating to increase space between individuals, e.g., remove every other chair and use only one side of a table so individuals are not facing each other.
  - Minimize self-serve foods, e.g., eliminate salad bars.
  - Provide meals inside housing units or cells.

5. Laundry

There are no requirements to separate laundry between risk groups. Laundry from a COVID-19 case can be washed with other individuals' laundry.

- Individuals handling laundry from COVID-19 cases should wear disposable gloves, discard the gloves after each use (e.g., after putting laundry into the washing machines), and perform hand hygiene—before performing other duties.
- Do not shake dirty laundry, to minimize the possibility of dispersing virus through the air.
- Launder items using the hottest appropriate water setting, and dry items completely.

6. Electronic Law Library (ELL) and Discovery Materials

- Whenever possible, consistent with social distancing protocols and safe institution operations, inmates should be permitted access to the ELL under conditions determined by the Warden at each facility.
- Similarly, inmates will need access to discovery materials relevant to pending cases, beyond those which are personally maintained by the inmates in their cells. It is recommended that a schedule be established to permit fair and timely access to ELL terminals and discovery materials upon inmate request, and that the schedule be provided to inmates at the facility.

7. Barbershop

Institutions at Operational Levels 1 or 2 per the *COVID-19 Modified Operations Matrix* should follow guidance in the matrix.

For institutions at Operational Level 3:

- **Limited services:** Barbershops will provide limited services to include haircuts only – no shaves.
- **Required PPE:** Barbers will be required to wear facial coverings, gowns, gloves and face shield at all times. Inmates will wear cloth face coverings to the extent possible while receiving haircuts. Inmates receiving services will wear disposable or re-washable capes, smocks, neck strips, etc. These items will be disinfected or disposed of between each haircut.
- **Social Distancing:** Haircuts will be done by housing unit/cohorts. The number of inmates in the barbershop at any given time will vary by facility space and waiting areas. **All stations must be spaced at least six feet apart.** Inmates will wait outside the barbershop, adhering to social distancing and with facial covering in place, until the barber is ready to for them. Inmates will not interact with each other in the barbershop.
- Consider a station barrier between the work stations if it doesn't interfere with egress or fire code standards.
- To prevent cross-contamination, remove all unnecessary items (magazines, newspapers, and any other unnecessary paper products/decor).
- **Hand-washing** – Barbers must wash hands with soap and warm water, for a minimum of 20 seconds between every haircut given. Barbers should wash hands immediately after touching their face, nose, eyes, mask or any non-sanitized surface. Inmate clients should wash hands or hand sanitize as they enter the barber shop.

- **Disinfection and Sanitation:**
  - All shops will be thoroughly cleaned and disinfected prior to reopening each day. Refer to **Module 1** – for guidance on cleaning and disinfection.
  - Disinfect all surfaces, tools, and linens, even if they were cleaned before the shop was closed the day before.
  - Shops will maintain regular disinfection of all tools, shampoo bowls, and workstations.
  - All tools will be disinfected between each use. Disinfectant for immersion of tools must be mixed daily and replaced sooner if it becomes contaminated throughout the work day (e.g., hair or debris floating in solution or cloudy color).
  - Electrical equipment that cannot be immersed in liquid shall be wiped clean and disinfected, per the manufacturer's instructions before and after each use.
  - Use disposable towels when possible and dispose of them after every use. Wash any non-disposable towels, drapes, etc. in hot water setting and dry completely at warmest temperature setting.
  - The barber chair will be disinfected between each client. Floors will be thoroughly cleaned each day. All trash containers will be emptied daily.
- **Signage:** COVID 19 signage will be posted in the shop to include signs and symptoms, handwashing signs and social distance signs.
- **Supplies:** Only the assigned barber will be allowed to handle any supplies. All clean supplies and tools will be kept in a clean dry place when not in use.
- **Work Attire:** Inmate Barbers should arrive at the barbershop showered and wearing clean clothing. Inmates should shower and change clothes as soon as they return from work.
- **Barber Training Programs:** Barber training programs may include training on specific types of cuts and shaves. Before implementing these programs, facilities should evaluate the epidemiological picture of the institution and develop plans in collaboration with the region and facility infection prevention and control leads.

B. Programming Considerations

Programming is an essential function in our facilities; furthermore, delivery of the **First Step Act (FSA)**-approved **Evidence-Based Recidivism Reduction (EBRR)** programs and **Productive Activities (PAs)** is required by law. Institutions at Operational Levels 1 or 2 per the *COVID-19 Modified Operations Matrix* should follow guidance in the matrix. For institutions at Operational Level 3, institutions will offer programming in the following ways:

- **Residential programs** (i.e., RDAP, BRAVE, SOTP, TCU, FIT, Life Connections, etc.) will continue as required by policy. Program targets remain the same. Staff may conduct more groups to accommodate smaller group size or they may conduct groups with more than 10 participants, so long as other social distancing modifications remain in place (e.g., holding groups in larger spaces; suspending community meetings, wearing masks, etc.)
- **Non-residential** EBRR programs and PAs (e.g., GED, Anger Management) will continue. Overall programming targets remain the same. Where programming targets are established (e.g., Resolve, Drug Education) staff may choose to deliver more groups of smaller size to meet the programming target. Staff may conduct groups with more than 10 participants, so long as other social distancing

modifications remain in place (e.g., holding groups in larger spaces; suspending community meetings, wearing masks, etc.)

  - EBRR and PA programming must be delivered in a fashion consistent with the curriculum. However, for purposes of safety/social distancing, staff may offer programs in the housing unit or in outdoor or unused spaces. Programming designed to be provided in person (i.e. a facilitator instructing participants) MAY NOT be locally modified to distance learning without a facilitator present (i.e. participants completing work independently in their cells and turning it into the facilitator).

- **GED TESTING**, in groups of six or less, will resume with priority given to inmates releasing within 120 days. Other inmates may be tested if resources allow.
- **PROGRAMING RESOURCES** will be devoted to FSA services rather than local programs, such as ACE classes. Non-essential programs are only delivered when all FSA mandates are met and when it is safe to do so, with appropriate mitigation strategies in place.
- **CHAPLAINCY SERVICES** must allow for religious observances to occur with appropriate safety modifications in place.

C. HOUSING CONSIDERATIONS

- Arrange bunks so that individuals sleep head-to-foot to increase the distance between their faces.
- Rearrange scheduled movements to minimize mixing of individuals from different housing units.
- Ensure thorough cleaning/disinfection of living space when assigned to a new occupant.
- If space allows, reassign bunks to provide more space between individuals (ideally six feet or more in all directions). Ensure that bunks are cleaned thoroughly if assigned to a new occupant.
- Minimize the number of individuals housed in the same room as much as possible.
- Consider opening vacant housing units to decrease population density, when feasible.

D. PSYCHOLOGY SERVICES

While protecting the health of inmates and staff, institutions must also ensure that:

- Mental health emergencies are prevented.
- Appropriate care is provided to vulnerable inmates.

The following recommendations will support these objectives:

- If inmates are confined to their cells, single cells should be eliminated to the greatest extent possible, to reduce the isolation and privacy that can facilitate suicide. Psychology Services staff should be consulted regarding any inmates proposed for single celling to ensure they are not particularly vulnerable individuals and/or to make recommendations.
- Psychologists must conduct daily rounds in all areas where inmates are housed or confined, to observe and communicate with inmates; psychologists may make recommendations regarding vulnerable inmates to ensure that their needs are met. If psychologist staffing levels necessitate, Treatment Specialists may assist with rounds.
- Psychologists must remove inmates from their cells for private sessions when providing crisis intervention or suicide risk assessments.

- Psychologists must offer to remove inmates with CARE3-MH and CARE4-MH assignments from their cells at least weekly for individual clinical contact, while following social distancing, and masking guidance.
- If suicide watch is recommended by a staff member and the usual suicide watch room is not available, **PS5324.08, SECTION 12, SUICIDE PREVENTION PROGRAM**, states that under emergency conditions a room other than the designated suicide watch room may be used, as long as an inmate on watch is returned to the approved room when it becomes available. Emergency suicide watch rooms may not be in the Special Housing Unit.
- Institutions may elect to continue using suicide watch companions at the discretion of the Warden.

MODULE 9. INMATE VISITATION

WHAT'S NEW

- Updates made throughout this document related to the *COVID-19 Modified Operations Matrix* – institutions operating at Level 1 or 2 will follow the guidance in the Matrix regarding visitation, when applicable. Institutions operating at level 3 will follow additional guidance contained in this module.
- Institutions are encouraged to communicate with the United States Attorney's Office, preferably through their Consolidated Legal Center, if unable to accommodate the preferred method of attorney-client contact.

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A. GENERAL GUIDANCE FOR ALL VISIT TYPES

- Depending upon factors such as local community transmission rates and institution COVID-19 epidemiological status, consider suspending or modifying visitation programs, if legally permissible. This decision is an executive level decision made by the agency's Central Office Executive Staff.
- Post signage at the entrance to the facility and communicate with potential visitors instructing them to postpone visits if they have respiratory illness.
- The status of visitation for the agency and for each institution should be posted on the bop.gov website.
- All visitors should self-monitor for symptoms of COVID-19 and a take a temperature prior to a planned visit to a BOP facility. All visitors with symptoms and or elevated temperature should postpone their visit.
- Screening for COVID-19 symptoms and a temperature check will be performed by BOP staff prior to entry at any institution operating at Level 3 according to the *COVDI-19 Modified Operations Matrix*.
  - *If possible, a Plexiglas barrier should be installed at the location of staff/contract/visitor screening to prevent direct droplet exposure.*
  - *See the Visitor/Volunteer/Contractor COVID-19 Screening Tool in the APPENDICES.*
  - *See MODULE 2 – PPE for guidance for performing COVID-19 screenings.*
- Visitors who are sick or symptomatic should not be allowed to visit.
  - *See the Visitor/Volunteer/Contractor COVID-19 Screening Tool in the APPENDICES.*
- All visitors must wear a non-vented face covering while at the institution (from the time they arrive to the time they depart) and must maintain at least 6 feet of separation with the person they are visiting.
- A handwashing or hand sanitizing station should be established and available for use by all visitors at all visitor points of entry and exit and within the visiting room area. Visitors should be encouraged to wash their hand before and after visitation.

B. SOCIAL VISITS

- Inmate social visits are important to inmate well-being but also create a risk for introducing COVID-19 infection into the work force and incarcerated population by civilian visitors from the community.
  - *An agency-level decision to suspend or resume inmate social visits is made and communicated by the BOP Executive Staff based on agency- and pandemic-specific circumstances.*
  - *The current status of visitation should be reflected both on the Bureau's public website as well as each individual institution's website.*
- **Arrangements should be made to increase options** for incarcerated persons to communicate with their families via telephone or video teleconferences (VTC), especially when in-person visitation is limited or suspended.
- **The following criteria should be considered when making the decision to not allow in-person inmate social visitation.**
  - Visitation should not occur at institutions with a COVID-19 movement moratorium or when active institution transmission is occurring. If an institution develops active COVID-19 transmission after

visitation has been scheduled, the visitation may need to be cancelled and rescheduled at a later date when transmission abates.

- Individual inmates should not be allowed in-person visits when they are in medical isolation or quarantine.
- Visitors who are sick, have symptoms of COVID-19, a non-contact forehead temperature ≥ 100 °F, decline symptom screen and temperature check, or refuse to wear a face covering should not be allowed to visit in-person.

- **In addition to the GENERAL GUIDANCE listed above, the following procedures should be followed to limit the spread of COVID-19 when visitation is allowed.**
  - Institutions will need to prepare in advance and develop procedures prior to starting in-person visitation.
  - Identify a specific location where visitation will occur and determine how many visitors and inmates will be allowed in that space in order to achieve at least six feet of physical / SOCIAL DISTANCING. State and local restrictions on group size may apply.
  - Develop an appropriate flow or staging of visitors to maintain at least six feet of physical / SOCIAL DISTANCING during entry to the facility, screening, and movement to the visitation room. Having a visitation schedule booked in advance is recommended to prevent crowding of visitors at all points in the visitation process.
  - All visitation with inmates should be NON-CONTACT. PLEXIGLAS OR SIMILAR BARRIER will need to be installed to prevent contact during the visit. Consultation with an environmental and safety compliance officer is recommended to ensure life safety and fire code requirements are met.
  - To prevent mixing of different groups of inmates, scheduled visitation by housing unit or cohort is encouraged.
  - Inmate searches before and after visitation are conducted according to policy. PPE for the officer performing the search includes a face covering and gloves.
  - The visiting rooms and barriers should be CLEANED AND DISINFECTED between individual visitors or groups and cleaned / disinfected after visitation is over. Refer to MODULE 1 - *Infection Prevention and Control,* for specific recommendations on cleaning and disinfection procedures.

C. LEGAL VISITS

Legal visits are important aspects of the U.S. criminal justice system, but they create potential risks for COVID-19 transmission from the close interactions that may occur. In addition to the many general infection prevention measures recommended by the CDC, the BOP uses quarantine, medical isolation, and testing for COVID-19 to limit the risk of transmission.

The following recommendations apply these established infection prevention procedures and principles in a way that accommodates legal visits as safely possible.

- *In general, testing an inmate for COVID-19 immediately after a legal visit would have little utility and is not recommended.*

- Inmates and attorneys/legal visitors should wear FACE COVERINGS (cloth or surgical mask) and should perform HAND HYGIENE (washing hands with soap and water or using hand sanitizer) just before and after in-person visits.

- Use of PLEXIGLAS OR SIMILAR BARRIER between inmate and attorney is strongly recommended for in-person visits. In the alternative, if a barrier is not present, SOCIAL DISTANCING (i.e., 6 feet apart) should be used.
- Attorneys/legal visitors should self-monitor for symptoms of COVID-19 and take a temperature prior to a planned legal visit to a BOP facility. Attorneys/legal visitors will be screened for COVID-19 symptoms and a temperature check will be performed by BOP staff prior to entry at any institution operating at Level 3 according to the *COVDI-19 Modified Operations Matrix*. Legal visitors who are sick or symptomatic should not be allowed to visit.

  → *See the Visitor/Volunteer/Contractor COVID-19 Screening Tool in the APPENDICES.*
- If necessary, documents should be passed back and forth in a manner to AVOID CONTACT between individuals.
- When legal attorney rooms are available, they should be utilized to allow for SOCIAL DISTANCING among all present in the room. If there is no legal attorney room available and if there is more than one attorney/inmate pair present, all participants should also be separated by more than six feet to the extent possible, while protecting attorney-client communications.
- Tables, chairs, and other high-touch surfaces should be CLEANED AND DISINFECTED after each use.
- INMATES IN COVID ISOLATION should NOT have in-person legal visits unless absolutely necessary. Inmates in medical isolation have, or are suspected to have, COVID-19 and may transmit the infection through close or direct contact with others. Strongly consider rescheduling until the inmate has met release from medical isolation criteria or utilizing legal telephone calls and, if available, VTC.
- INMATES IN COVID QUARANTINE should NOT have in-person legal visits unless absolutely necessary. Quarantined inmates may have asymptomatic COVID-19 infection or be in the incubation period, and should delay legal visits until they have COVID-tested negative at the end of quarantine. Legal telephone calls or VTC with attorneys, if available, are recommended as alternatives.
- **Institutions are encouraged to communicate with the United States Attorney's Office, preferably through their Consolidated Legal Center, if unable to accommodate the preferred method of attorney-client contact.**

MODULE 10. VOLUNTEER AND CONTRACT STAFF MANAGEMENT

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GENERAL CONSIDERATIONS

- Contractors and volunteers provide important services to the inmate population and to the agency during routine operations. During a pandemic, the importance of on-site services must be balanced with the risk of infection being introduced into an inmate population or office setting by a visitor from the community.
- Pandemics may also create a greater need for such services when contingency or crisis situations arise due to a higher demand for services, increased numbers of sick employees or contractors, a need for alternate care facilities at an institution, etc... Thus, contractors and volunteers need to be considered as viable options for addressing agency and institution needs.
- Central Office Executive Staff will need to make overall agency decisions related to the role of contractors and volunteers during a pandemic. However, within the framework of those general decisions, individual institution needs and contracting decisions will be made locally in consultation with Regional leadership.

ESSENTIAL VOLUNTEERS AND CONTRACTORS

- ESSENTIAL SERVICES MAY INCLUDE: Medical services, mental health services, religious services (if unable to provide remote services), and critical infrastructure repairs.
- Volunteers and contractors performing essential services or maintenance on essential systems may continue entering the institution. All General Guidance for Inmate Visitation applies to contractors and volunteers, including screening for COVID-19 symptoms using the same procedures for staff prior to entry.
  - ➔ *Refer to MODULE 9, Inmate Visitation, for general information and procedures regarding visits.*
  - ➔ *See the Visitor/Volunteer/Contractor COVID-19 Screening Tool in the Appendices.*
- Volunteers and contractors who feel ill should be instructed not to report to the institution, but notify their point of contact at the institution.

BACKGROUND INVESTIGATIONS AND SECURITY CLEARANCE

- When determining clearance requirements for non-BOP individuals, refer to the following **BOP Information Security Programs policy (PS1237.16)**:

  3.3 Non-BOP Individuals (Contractors and Volunteers)

  Certain non-BOP individuals do not require a clearance to perform the following:

  - Low-risk services such as an initial installation of IT systems where no data is resident.

- Low-risk services such as infrequent maintenance or repairs of IT systems where no data is resident.
- Moderate-risk medical non-BOP individuals, working in Health Services, as long as the individual is only accessing information normally used in the course of providing professional medical services (no computer/system access).
- Individuals who enter a BOP facility no more than 52 days in a 12-month period.

- In deployment of this PANDEMIC RESPONSE PLAN, laws and regulations applicable to background investigations and security clearance must be followed. Institutions are encouraged to begin this clearance process upon identification of the volunteer or contractor, so as to avoid delays in allowing access to the institution or performing work.
- Human Resources staff should be available to quickly and efficiently obtain all documentation, including a pre-employment waiver, to initiate and complete the clearance process as quickly and efficiently as possible.
- For Health Services contractors requested or utilized under this plan, computer access and electronic health record (EHR) training should be initiated as soon as permissible so that contractors can perform their work with the appropriate documentation.
- All non-BOP individuals must always be monitored and escorted by staff knowledgeable about the work being performed.
- A signed non-disclosure agreement and an Information Security briefing must be completed prior to work being performed. All pre-employment requirements, as stated in HSPD-12 DOJ regulations, and BOP employment policy apply (an NCIC, fingerprint check, or any other local entrance or visiting procedures).
- All non-BOP individuals not meeting the categories listed in PS 1237.16 Section 3.3 must have a security clearance commensurate with their access. Non-BOP individuals who access a BOP IT system also need a PIV card. Documentation is maintained in the contractor/volunteer security file.
- NATIONAL GUARD ASSISTANCE: In some cases, it may be necessary to utilize National Guard assets authorized by their respective state governors. In this instance, additional clearances may not be required.
- Any questions regarding clearances should be directed to Security and Background Investigation Section of the Human Resources Management Division or to the Chief Information Officer in Information, Policy, and Public Affairs Division.

NON-ESSENTIAL VOLUNTEERS AND CONTRACTORS

Consideration should be given to limit access to the facility by non-essential volunteers and contractors.

→ *Refer to MODULE 9, Inmate Visitation, for information regarding personal and legal visits.*

MODULE 11. BOP EMPLOYEE MANAGEMENT

WHAT'S NEW

- As of March 21, 2022, requests for COVID-19 related temporary job modification (TJM) should be directed through the local Human Resources Departments for assessment and resolution.

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A. DEFINITIONS

BOP INSTITUTION STAFF: BOP employees who work within the correctional setting.

BOP NON-INSTITUTION STAFF: BOP employees who work outside the correctional setting, i.e., Regional Office, Central Office, Grand Prairie, Staff Training Academy, Management and Specialty Training Center.

FULLY VACCINATED: Having completed a vaccination series: 2 weeks after their second dose in a 2-dose series (Pfizer or Moderna), or 2 weeks after a single-dose vaccine (Janssen) as authorized by the U.S. Food and Drug Administration of the United States. Proper documentation, including the name of the vaccine and dose administration dates from an official / reliable source, is required for a person to be considered fully vaccinated.

NOT FULLY VACCINATED: No documentation of vaccination, partial vaccination (one out of two doses), or less than 14 days following completion of the vaccine series as authorized by the U.S. Food and Drug Administration.

POTENTIAL EXPOSURE: Having close contact within 6 feet of an individual with confirmed or suspected COVID-19 for greater than 15 minutes while not wearing recommended PPE within a 24-hour period. The timeframe for potential exposure includes the 48-hour period before the individual became symptomatic.

UP-TO-DATE VACCINATION STATUS: Proper documentation of having completed a vaccination series and having received a booster according to current recommendations.

B. ENHANCED EMPLOYEE SCREENING FOR GAINING ENTRY

- COVID-19 could gain entrance to a facility through infected employees. Staff should be educated to stay home if they have any COVID-19 associated symptoms to include but not limited to fever and/or respiratory symptoms. If employees become sick at work, they should be advised to promptly report this to their supervisor and go home. Institutions should work with executive staff and human resources to develop a local contingency plan for reduced staffing.
- When the *BOP COVID-19 Modified Operations Matrix* indicates, all employees must be screened upon arrival with a temperature check, as well as questions about respiratory and other COVID-related symptoms and whether they have had contact with a known COVID-19 case.
  - ➔ *A **COVID-19 ENHANCED SCREENING TOOL FOR STAFF/CONTRACTORS/VISITORS** is available in the Appendices. This form can be laminated so that the screening staff can read the questions to the employees being screened and accept their responses verbally.*
  - ➢ Given the public health emergency, **staff who REFUSE the enhanced health screening when indicated based on the Matrix,** will be denied entry, charged leave and may be subject to disciplinary action.
  - ➢ Employee screenings do not require written documentation unless the person responds "YES" to any question or has a temperature, as described below.
  - ➢ The temperature check should ideally be taken with a no-touch, infra-red thermometer. If an employee registers a temperature of greater than or equal to 100 degrees (Fahrenheit), they will be considered for denial to the facility after consultation with facility's medical officer on duty. They should be advised to consult with their healthcare provider. (See the *Algorithm for Symptomatic BOP Staff*.)

- If the temperature is out of range, (<93.7°F or >108.1°F or screen reads "HI" or "LOW") the employee should be asked to stand aside for 10 minutes and then the temperature should be remeasured.
- Temperature and symptom screening can be performed by non-health care personnel trained to measure temperature.
  - Training videos for non-healthcare providers to check temperatures can be found on the BOP Sallyport COVID-19 Guidance page.
  - Upon completion of the Temperature Video(s), staff should complete the Opinion Survey also found on the BOP Sallyport COVID-19 guidance page so that the training can be added to the training record.

- Information regarding screening of volunteers and contract staff can be found in MODULE 10.

C. GUIDANCE FOR STAFF TO MITIGATE AND PREVENT SPREAD AND TRANSMISSION OF SARS-COV-2

Under the condition of not compromising the BOP missions, facility leadership should ensure the implementation of **feasible** procedures to mitigate and prevent the spread of SARS-CoV-2 in the facility and between facilities as recommended by CDC and to protect workers at risk in the workplace per OSHA guidance.

- *Please refer to the following link to find the up-to-date interim guidance for mitigating and preventing the spread of COVID-19 in correctional facilities: CDC Interim Guidance on Management of Coronavirus Disease 2019 (COVID-19) in Correctional and Detention Facilities and monitor this guidance website regularly for updates to these recommendations for mitigating and preventing the spread of COVID-19.*

1. TASKS FOR STAFF

- Practice good cough and sneeze etiquette.
- Practice good hand hygiene
- Wear face covering when indicated unless PPE is indicated.
- Avoid touching your eyes, nose, or mouth without cleaning your hands first.
- Avoid non-essential physical contact.
- Practice social distancing among staff to the extent possible. The staff member should maintain 6 feet between themselves and others and practice social distancing as work duties permit.
- Staff interacting with incarcerated/detained individuals with COVID-19 symptoms should wear PPE as recommended in the CDC interim guidance.

2. TASKS FOR FACILITY MANAGEMENT

- Ensure that PPE and donning, doffing, and disposal stations are readily available where and when needed.
- Educate staff that cloth face coverings should not be used as a substitute for surgical masks or N-95 respirators. Surgical masks should be conserved for situations requiring PPE.
- Enforce CDC guidance among the incarcerated/detained persons, such as wearing face covering and temperature checks.

- Routine cleaning and disinfecting – clean high touch surfaces and shared objects once a day with detergents or soap. The facility should continue enhanced cleaning and disinfecting practices in all areas including offices, bathrooms, common areas, and shared equipment.

➔ *Refer to Cleaning and Disinfecting Your Facility | CDC for details about cleaning the facility regularly and deep cleaning when someone is sick.*

- Clean and disinfect the affected spaces (areas used by the person who was sick) in the facility when someone was sick or diagnosed with COVID-19.

TABLE 1. CLEANING AND DISINFECTION OF AREAS USED BY PERSONS DIAGNOSED WITH COVID-19

Time since person was sick with COVID-19	What to do
≤ 24 hours	Clean and disinfect the affected areas
24 hours to 3 days	Clean the affected areas. Optional disinfection
> 3 days	No additional cleaning required beyond regularly scheduled cleaning

➢ **Before cleaning and disinfecting**

- Close off affected areas and do not use until they have been cleaned and disinfected.
- Wait as long as possible (at least several hours) before cleaning and disinfection.

➢ **While cleaning and disinfecting**

- Open doors and windows and use fans or HVAC (heating, ventilation, and air conditioning) settings to increase air circulation in the area.
- Use products from *EPA List* according to the instructions on the product label.
- Wear a mask and gloves while cleaning and disinfecting.
- Focus on the immediate areas occupied by the person.
- Vacuum the space if needed and if available, use a vacuum equipped with high-efficiency particulate air (HEPA) filter and bags.
- While vacuuming, temporarily turn off in-room, window-mounted, or on-wall recirculation heating, ventilation, and air conditioning systems to avoid contamination of HVAC units.
- Do NOT deactivate central HVAC systems. These systems provide better filtration capabilities and introduce outdoor air into the areas that they serve.

D. GUIDANCE FOR STAFF WITH POTENTIAL EXPOSURE TO COVID-19

- The Infection Control person in charge will determine whether the employee has had **POTENTIAL EXPOSURE** (see *definition* above) to a COVID-19 case and requires further assessment.
- Any staff (civil service or PHS) who are subject to or received movement restrictions at the direction of public health authorities should provide this information to their supervisor and institution Human Resources and not return to work until instructed to do so.
- Per **PS6701.01**, all employees are required to report a COVID-19 positive test to their institution human resources department. Reporting should include completion of the **STAFF POSITIVE CASE FORM** located in the Appendices in addition to the lab report or screen shot indicating diagnosis.
- Any questions regarding leave flexibilities should be forwarded to the Staffing and Employee Relations Section (SERS) for further guidance.

- The BOP relies on the local Health Department or the individual's healthcare provider to release COVID-19 positive staff from isolation in accordance with *CDC guidance for Quarantine and Isolation in High-Risk Congregate Settings*.
- A negative COVID-19 test is not required for staff to return to work. Follow guidance below for return to work requirements.
- *If the employee becomes symptomatic in any of the below scenarios, see the Algorithm for Symptomatic BOP Staff below.*

1. ASYMPTOMATIC INSTITUTION STAFF REPORTING POTENTIAL EXPOSURE TO COVID-19

BOP employees are considered to be part of the critical infrastructure of the institution. To ensure continuity of operations of essential functions, the CDC advises that **CRITICAL INFRASTRUCTURE WORKERS** are permitted to continue work following potential exposure to COVID-19, provided they remain asymptomatic.

- The exposed employee should report to work.
- The employee should monitor their health status with continual awareness of development of COVID-19 symptoms twice daily to include monitoring their temperature.
- In addition to adopting all feasible measures and precautions, staff should seek testing 3-5 days post exposure incident.
- Asymptomatic staff with a **POSITIVE** COVID-19 exposure should consider breakthrough infection precautions until tested negative 3-5 days post exposure.
  - Asymptomatic staff who test positive for COVID-19 may return to work after 10 days have passed since first positive COVID-19 test.

2. ASYMPTOMATIC NON-INSTITUTION STAFF REPORTING POTENTIAL EXPOSURE TO A COVID-19

- Staff who currently have an approved telework agreement (regular or situational) and have not completed COVID-19 vaccine series are expected to continue telework at their home for the required quarantine time period.
- Staff who currently have an approved telework agreement (regular or situational) and have completed COVID-19 vaccine series are expected to report to work without the need for quarantine at their regular schedule.
- The employee should monitor their health status with continual awareness of development of COVID-19 symptoms twice daily to include monitoring their temperature.

E. GUIDANCE FOR STAFF WITH POSITIVE COVID-19 TEST

1. ASYMPTOMATIC NON-INSTITUTION STAFF

- Staff who currently have an approved telework agreement (regular or situational) are expected to continue telework at their home regardless of their vaccine status.
- The employee should monitor their health status with continual awareness of development of COVID-19 symptoms twice daily to include monitoring their temperature.

2. ASYMPTOMATIC INSTITUTION STAFF

- If positive test was received via PCR test, the staff member is required to stay out of work for a period of 10 days from the date of the positive test.
- If positive test was received via antigen test, follow-up PCR test is required
  - If PCR is positive following positive antigen test, then the date begins from the positive antigen test.

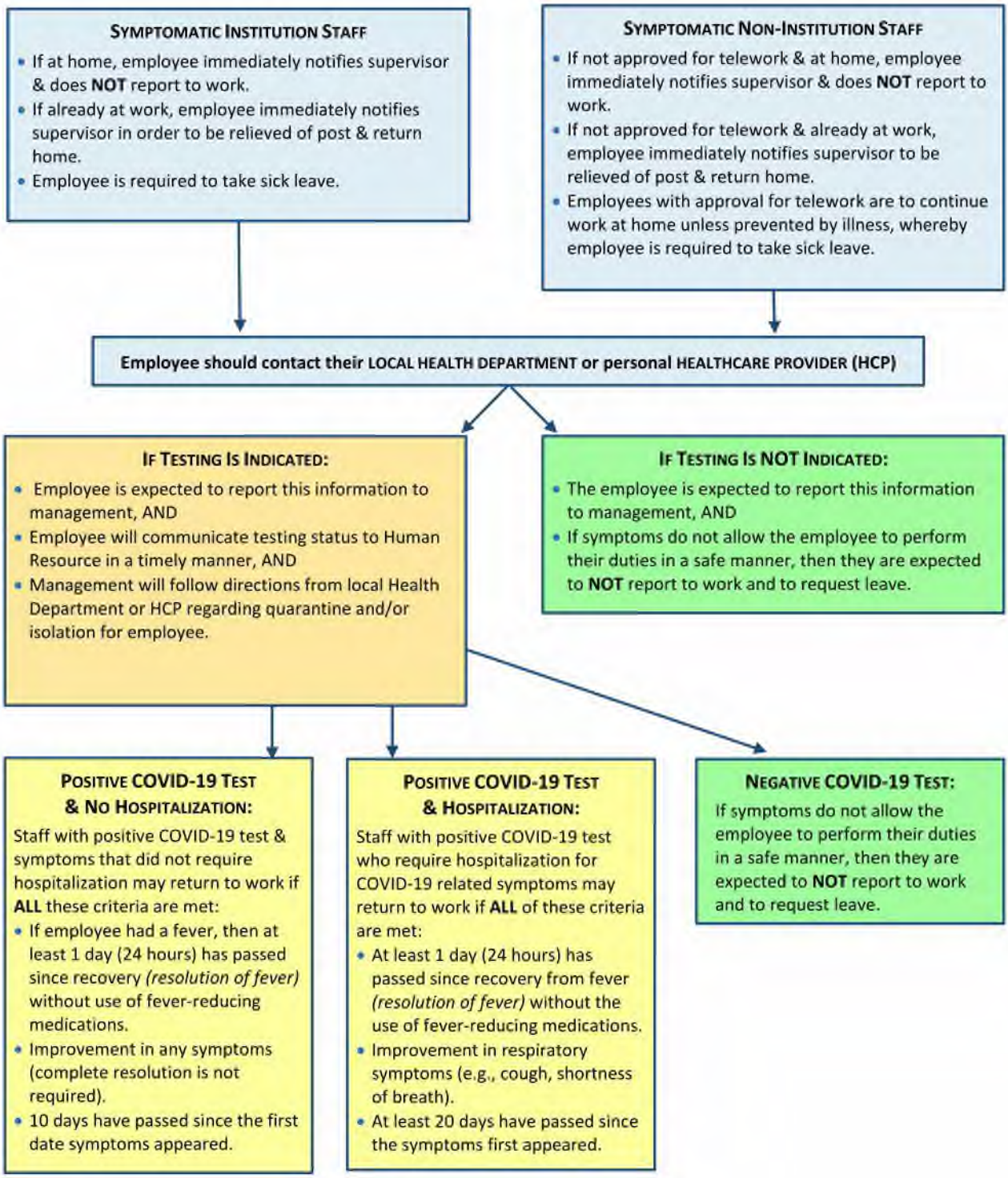
3. SYMPTOMATIC STAFF

Due to the widespread prevalence of COVID-19-infected persons, staff with symptoms suggestive of COVID-19 infection may not be aware if a potential exposure has occurred. The *Algorithm for Symptomatic BOP Staff* on the following page shows the steps that should be taken if a BOP employee has symptoms suggestive of COVID-19.

- The BOP relies on the local Health Department or the individual's healthcare provider to release COVID-19 positive staff from isolation in accordance with *CDC guidance for Quarantine and Isolation in High-Risk Congregate Settings*.
- If the provider has cleared a staff member to return to work and the staff member refuses, the individual should be charged AWOL. The individual can also be issued an 8-point letter after consultation with the Occupational Safety and Health Branch.

(Algorithm begins on next page)

F. ALGORITHM FOR SYMPTOMATIC BOP STAFF



G. GUIDANCE FOR STAFF TESTING

Refer to **MODULE 3 SCREENING & TESTING** for information regarding types of COVID-19 tests available.

All institutions are advised to identify methods for staff to be voluntarily tested for COVID-19.

- Institutions are strongly encouraged to establish relationships with the local health department for testing. Utilization of a staff specific BOP national contract for COVID-19 testing is a secondary option.
  - ➔ *Staff may locate community testing sites through the following link: https://www.hhs.gov/coronavirus/community-based-testing-sites/index.html.*
- Several locales have established procedures to allow first responders to be tested for COVID-19. Institutions are encouraged to become familiar with the procedures and locations of these resources to augment, or in lieu of, testing with DOHs or BOP national contract. Some of these locations may require a memo or letter from the individual's employer verifying their status as someone working in a Critical Infrastructure Industry. Please use the *Critical Infrastructure Memo to Local DOH for Employee Testing* memo template located in the Appendices to satisfy this requirement, as needed.
- Once testing options are identified, staff should be made aware of their options in a direct and prominent fashion.
- **Institutions should post the available testing locations staff can utilize to obtain COVID-19 testing.**
- Per **PS6701.01**, all employees are required to report a COVID-19 positive test to their institution human resources department. Reporting should include completion of the **STAFF POSITIVE CASE FORM** located in the Appendices in addition to the lab report or screen shot indicating diagnosis.
- **Questions related to staff testing**, should be routed the Health Services Branch email box (BOP-HSD-HealthServicesBranch@bop.gov).

1. INDICATIONS AND PRIORITIES FOR TESTING

In addition to the current CDC guidance on testing, specific indications for testing staff in the BOP are listed below. If there are limitations in the number of tests that can be performed at a given location, prioritization of testing indications may be needed and should be done in consultation with the Central Office Occupational Safety & Health Branch and Infectious Disease Prevention & Control Staff.

- **Staff regardless of vaccination status** may be offered routine testing on an at least weekly basis when community transmission is at substantial or high level. Staff testing must be available at all institutions.
  - ➢ Staff with a reported positive COVID-19 test within the past 90 days should not be tested.
- **All staff, regardless of vaccination status, with symptoms consistent and/or suggestive of COVID-19** should be referred to their private physician or health department for evaluation and testing.
  - ➢ Institution-wide testing of staff may be considered by the Warden, in consultation with the local health department, where one or more staff cases of COVID-19 have been identified, where there is substantial transmission confirmed beyond the initial (index) case, or if the individual has moved about the institution.

- **Asymptomatic staff with known or suspected contact with a COVID-19 case regardless of vaccine status.**
  - *As a reminder, the primary testing modality used in this category should be that of the local health department when possible.*
  - When a case of COVID-19 is identified at an institution, a contact tracing of both staff and inmates should be performed expeditiously.
  - All staff identified as close contacts of the initial case will be referred to local Department of Health or contract testing provider (if activated at the local institution).
  - Testing is ideally performed 3-5 days after identified exposure date.
  - **Asymptomatic staff will continue to report to work** (regardless of vaccination status) while monitoring for COVID-19 associated symptoms twice daily to include their temperature while awaiting testing results and complying with all local requirement regarding use of face covering at all times.

2. SCREENING AND DIAGNOSTIC TESTS

Multiple types of tests are currently utilized to screen for and diagnose COVID-19 disease. Screening tests are not considered diagnostic by themselves and should be followed up appropriately with additional testing and/or clinical evaluation, with few exceptions.

Refer to **MODULE 3 SCREENING & TESTING** for additional details on COVID-19 tests. Note that COVID-19 testing procedures may differ for the inmate population.

SCREENING TESTS FOR COVID-19

- Antigen tests, such as BinaxNOW COVID-19 Tests (Abbott) or other similar tests, are considered screening tests when used in asymptomatic individual.
- Antigen screening tests by themselves, including any COVID-19 home tests, without additional medical evaluation or diagnostic testing are not sufficient for confirmation of diagnosis in asymptomatic individual.
- For **SYMPTOMATIC PERSONS** or **PERSONS CONFIRMED AS CLOSE CONTACTS TO A COVID-19 POSITIVE INDIVIDUAL**, a positive antigen test performed at a medical clinic/facility or COVID-19 testing center may be sufficient for diagnosis without a follow-up confirmatory test. Federal Employees' Compensation Act (FECA) requirements for acceptance of these diagnosis as work related may be different than agency requirements.
- For **ASYMPTOMATIC PERSONS WITHOUT KNOWN EXPOSURE**, positive antigen tests should be followed by confirmatory PCR testing.
- Public health measures, including directing sick employees to remain at home, should be implemented if a screening test for COVID-19 is positive regardless of symptoms, or if a screening test for COVID-19 is negative in an individual with symptoms consistent with COVID-19 while waiting for a confirmatory diagnostic test.

DIAGNOSTIC TESTS FOR COVID-19

- Nucleic acid amplification tests (NAAT) are considered diagnostic tests for COVID-19. This includes tests labeled as reverse transcriptase-polymerase chain reaction (RT-PCR or PCR) tests, such as the Abbott ID NOW tests.

- Employees requiring diagnostic PCR testing should attempt to obtain testing through their own primary care provider, public health department clinic, or authorized COVID-19 testing center.
- In communities with community shortages in diagnostic testing, institutions may consider utilizing the Quest Diagnostic contract as a secondary testing option for employees.

3. STAFF TESTING NATIONAL CONTRACT

The BOP has awarded a national contract with Quest Diagnostics to provide COVID-19 molecular diagnostic (PCR). For institutions that utilize/activate the national contract, Quest Diagnostics will provide an initial shipment of self-collection kits to each BOP facility which will be replenished based on availability.

Wardens at each facility will assign an **ADMINISTRATOR** and **BACKUP ADMINISTRATOR** for this contract.

ADMINISTRATOR responsibilities will include:

- Provide contact information to Quest Diagnostics in order to set-up a username and password for administrator online access.
- Receive initial training by Quest.
- Provide self-collection kits to BOP staff meeting indications for testing listed above, utilizing Quest Diagnostic's online pre-registration process, and assisting in the shipment of self-collection kits.
- Review registration information for completion.
- Create testing requisitions and provide to staff, along with the self-collection kit, utilizing Quest Diagnostic's online portal.
- Hold all signed consents at each BOP facility in Human Resources Department.
- Arrange FedEx Overnight pick-up of the packages/samples that have been collected on that day.

BOP STAFF meeting indications for testing listed above will:

- Be provided a link to complete registration by locally assigned Administrator.
- Register via Quest Diagnostic's online portal with their demographic information as prompted.
- Sign the required Consents for testing and release of results to the BOP per Employee Health care Policy (**PS6701**).
- Package the sample/paperwork according to provided instructions once the specimen is self-collected and paperwork is complete.
- Provide the completed package to the **ADMINISTRATOR** to arrange for pick-up by FedEx
- Once the sample has been collected, Quest Diagnostics will manage shipment, processing, testing, and resulting of all samples.

4. REPORTING STAFF TEST RESULTS

- For PCR tests completed through the national contract:
  - Staff can access their results through a secure on-line portal provided by Quest Diagnostics.
  - All staff with a positive test result will be notified via phone immediately by a Quest Diagnostics provider. In the event the staff is not available by phone, he/she will be notified via overnight mailing of results.

- Through a secure electronic method, Quest Diagnostics will provide a nightly aggregate report of staff results to the appropriate BOP representative.
- Report will be provided in Excel format (csv) with de-identified and/or identified information as per consent signed.

- PCR test results obtained from an appropriate medical clinic/facility or COVID-19 testing center are acceptable for Agency reporting purposes.
- In **SYMPTOMATIC PERSONS** or **PERSONS CONFIRMED AS CLOSE CONTACTS TO A COVID-19 POSITIVE INDIVIDUAL**, a positive antigen test obtained from an appropriate medical clinic/facility or COVID-19 testing center AND medical note documenting symptoms or confirmed COVID-19 exposure are acceptable for Agency reporting purposes.

H. TDY AND OFFICIAL TRAVEL

- Guidance for **COVID-19 TIPS FOR OFFICIAL TRAVEL USING COMMERCIAL VENDORS** is available in the Appendices
- **Regardless of duty location, upon returning from travel, staff should self-monitor their health status twice per day** through temperature checks and evaluation for symptoms such as coughing, shortness of breath, chills, muscle pain, or new loss of taste and smell for a period of 14 days.
- Also, regardless of duty location, staff shall notify their supervisor immediately if they believe they had prolonged contact with any COVID-19 positive individual in the workplace while they were not properly supplied and/or protected with PPE.
- **If ASYMPTOMATIC, regardless of vaccination status or location assigned during TDY**, there is no indication for quarantine upon returning from TDY and staff are to report to work on their scheduled work day.
- **If an employee becomes SYMPTOMATIC at any time during travel:** they should continue to use methods to protect others including wearing a mask and physically distancing while seeking a medical evaluation and viral test.
- **For those individuals who test positive for COVID-19 or receive a positive test report while on travel:**
  - **The supervisor should be notified** and provided documentation of the positive COVID-19 diagnosis, such as the results of a COVID-19 test or medical provider note diagnosing the employee with COVID-19.
  - **Arrangement must be made to isolate in the hotel room for at least five (5) days.** Day zero (0) is the first day of COVID-19 symptoms or the date of the first positive test, whichever is first. This may require management to extend lodging accommodations, per diem, and transportation schedule.
  - Interactions with others should be minimized to the maximum extent possible, and level 3 surgical mask or higher must be worn when interactions with others is necessary.
  - **Isolation is terminated** when symptoms have resolved or are improving after five (5) days AND the employee has been afebrile for greater than 24 hours without fever reducing medications
    - They may resume travel back to their home station on day six (6),
    - An appropriate mask should be worn around others for an additional five (5) days,

  - They should not return back to work at the institution until the 10-day isolation period has ended.
- The employee should seek appropriate medical attention (urgent care or emergency department) as needed.

- **If an employee becomes SYMPTOMATIC at any time during the 14 days post-TDY:**
  - They should not report to work.
  - They should give notice to their Supervisor.
  - They should alert the Local Health Department or their personal Healthcare provider.
  - → *See the Algorithm for Symptomatic BOP Staff above.*

I. COVID-19 RELATED TEMPORARY JOB MODIFICATIONS (TJM)

As of March 21, 2022, these requests should be directed through the local Human Resources Departments for assessment and resolution.

J. GUIDANCE FOR LEAVE ASSIGNMENTS

WEATHER & SAFETY LEAVE

- Staff are entitled to Weather & Safety Leave if they are placed in quarantine status by the Agency
- The granting official for Weather and Safety leave is the local Warden.
- It is not appropriate to use Weather and Safety Leave for staff who have tested positive for COVID-19.

CONTINUATION OF PAY (COP)/OFFICE OF WORKERS' COMPENSATION PROGRAM (OWCP) LEAVE

- Once a staff member files for OWCP, they must use COP.
- COP leave is for a maximum of 45 days *when medically indicated*.

SICK LEAVE

As a reminder, supervisors have the authority to approve advanced sick leave for a maximum of 240 hours (30 days) to full-time employees in accordance with DOJ Order 1630.1B, Leave Administration, and P.S. 3630.02, Leave and Benefits.

K. PERSONAL TRAVEL

Personal travel should be delayed until a person is fully vaccinated. If travel is needed prior to full vaccination, precautions should be taken. If staff have a condition or are taking medication that weakens the immune system, even after vaccination, they may need to continue taking all precautions, such as wear a mask, stay 6-feet away from others, avoid crowds and poorly ventilated spaces, wash your hands often, cover coughs and sneezes, and clean and disinfect, etc.

- **Regardless of duty location, upon returning from travel, staff should self-monitor their health status twice per day** through temperature checks and evaluation for symptoms associated with COVID-19.
- **If an employee becomes symptomatic at any time:**
  - They should not report to work.
  - They should give notice to their supervisor.

- They should alert the Local Health Department or their personal Healthcare provider.
- → *See the Algorithm for Symptomatic BOP Staff above.*

- CDC levels of transmission by region can be located here: *https://www.cdc.gov/coronavirus/2019-ncov/travelers/map-and-travel-notices.html*

1. DOMESTIC TRAVEL RECOMMENDATIONS

- **Fully vaccinated staff**
  - Wearing a mask over the nose and mouth is required during travel via public transportation or in the indoor area of a hub, airport, or station.
  - Follow all state and local recommendations and requirements, including mask wearing and social distancing during travel.
  - After domestic travel, staff should self-monitor for COVID-19 symptoms; isolate and get tested if symptoms develop. Follow all state and local recommendations or requirements.
  - After domestic travel, testing or self-quarantine is not required if fully vaccinated or staff have recovered from COVID-19 in the past 3 months. Staff should still follow all other travel recommendations.
- **Not fully vaccinated staff**
  - Wearing a mask over the nose and mouth is required during travel via public transportation or in the indoor area of a hub, airport, or station.
  - Complete a viral test 1-3 days before departure.
  - After travel:
    - Get tested with a viral test 3-5 days after travel and stay home and self-quarantine for a full 7 days after travel, As critical infrastructure workers, staff may return-to-work by using extra precautions in the situation of staffing shortage.
    - If the test is positive, isolate at home.
    - Self-monitor for COVID-19 symptoms for 14 days regardless of test results; and get tested if symptoms develop

2. INTERNATIONAL TRAVEL RECOMMENDATIONS

- Prior to travel: staff may need to test 1-3 days in advance, dependent upon vaccination status and the host country requirement.
- During travel wearing a mask over the nose and mouth is required during travel via public transportation or in the indoor area of a hub, airport, or station.
- After travel:
  - Get tested with a COVID-19 viral test 3-5 days after travel.
  - Self-monitor for COVID-19 symptoms; isolate and get tested if symptoms develop.
  - If not fully vaccinated, in addition to the testing recommendations above, stay home and self-quarantine for a full 7 days after international travel, even if the COVID-19 test is negative at 3-5 days.

- If staff have recovered from a documented COVID-19 infection within the past 90 days (regardless of vaccination status), they do not need to get a test 3-5 days after travel. They also do not need to self-quarantine after travel.
- If staff develop COVID-19 symptoms after travel, isolate and consult with a healthcare provider for testing recommendations.

L. RECOMMENDATIONS FOR FAMILY OR OTHERS IN THE EMPLOYEE'S HOUSEHOLD

Employees in isolation or quarantine should be directed to the CDC guidelines on practicing social distancing and good hand-hygiene for the 14-day period. See also the CDC recommendations for coping with daily life at: *https://www.cdc.gov/coronavirus/2019-ncov/daily-life-coping/index.html*

M. RIDESHARE/VANPOOL GUIDANCE

- **Practice every-day protective measures:**
  - Complete the COVID-19 Vaccine series recognized by FDA
  - Wear a cloth face covering over nose and mouth.
  - Use proper hand hygiene. Wash your hands regularly with soap and water for at least 20 seconds, or use an alcohol-based hand sanitizer containing at least 60% alcohol.
  - Avoid touching your eyes, nose, or mouth.
- **Avoid Ridesharing and Vanpools when possible.**
- **When using vanpools, implement the following measures:**
  - Wear a cloth face covering over nose and mouth at all times during the ride.
  - Maximize physical distancing among passengers when possible.
  - Windows should be cracked open at least one inch.
  - The air conditioning unit should be set on FRESH AIR, and NOT on recirculated air.
  - To the extent possible, avoid contact with surfaces frequently touched by others such as door frame/handles, windows, seat belt buckles, steering wheel, gearshift, signaling levers, and other vehicle parts before they are cleaned and disinfected. These surfaces should be cleaned and disinfected after each use. Avoid touching your face until you have washed or sanitized your own hands.

N. RESOURCES FOR STAFF

As a result of COVID-19, staff have most likely been rebalancing personal, family, school, work, and community demands to protect themselves and loved ones. Staff may have concerns about becoming infected, passing on an infection, being isolated at home, spouses and family members losing jobs, and having children out of school. Times of great change, such as these, can cause fear, worry, moodiness, sleeplessness, and agitation. These are normal reactions to a new and constantly changing situation. Resources to help support efforts at healthy coping maybe located on the Sallyport COVID-19 Guidance page and through the CDC.

1. STAFF SUPPORT LINE

During the current COVID-19 pandemic, the lives of all persons around the globe and, in particular, BOP staff, are being touched directly and indirectly by this deadly disease. Some staff have been infected with COVID-19 already. Many know someone who is, or has been infected. With a pandemic of this magnitude, it is possible that staff will lose loved ones, or even that the Bureau may suffer the loss of staff members to the virus. The stress evoked by COVID-19 weighs on us all.

We recognize that most staff have COVID-related concerns. Some concerns may be related to the workplace. Other concerns may be connected to their family or home life. These concerns can cause stress, worry, or other difficult emotions. As law enforcement professionals, Bureau staff are accustomed to working under stressful conditions. However, the COVID-19 pandemic presents challenges that may, at times, appear overwhelming to many staff members.

To offer a helpful outlet for staff members to openly discuss their concerns, the agency activated a **24-HOUR STAFF SUPPORT LINE** - contact information available on Sallyport. You will not be asked to identify yourself, but you may if you wish. The person you speak to will be a Bureau staff member, with institution experience. You will be given an opportunity to share your concerns, receive support, and engage in problem solving. We believe that talking about your concerns, rather than silently carrying them inside, is a better way to cope with the stress of the COVID-19 pandemic.

The Bureau recognizes its responsibility to the workforce that fulfills its custody mission day after day, no matter how challenging. **WE ENCOURAGE YOU TO USE THE 24-HOUR STAFF SUPPORT LINE**. This is one way we take care of our own.

WHAT'S NEW

- Language updated in *Appendix N. Quarantine Room Sign* and *Appendix P. Quarantine Checklist to change* intake, release, and transfer "quarantine" to intake, release, and transfer "observation periods."
- Updates to ICD-10 coding in *Appendix Q. COVID-19 Coding Clinical Reference Guide*
- Minor edits to ensure consistency with the COVID-19 Pandemic Response Plan Modules
- Removal of *Appendix W. Critical Infrastructure Memo to Local DOH for Employee Testing* and re-lettering of the following appendices.
- Updated email address in *Appendix Z. Staff Positive Case Form:* all employees are required to report a COVID-19 positive test through their institution human resources department to *BOP-HSD-StaffCovidNotifications-S@bop.gov*.

List of Appendices

APPENDIX A. RECOMMENDED CLEANING AND DISINFECTION SCHEDULE

AREA TO BE CLEANED	FREQUENCY OF CLEANING	FREQUENCY OF DISINFECTION
Windows/Window Ledges	Daily	Daily
Toilets/Sinks	Daily	Daily
Trash Receptacles	Empty three times daily, or as needed; clean daily	Daily
Floors, Stairs, and Other Walking Surfaces	Sweep and damp-mop daily	Daily
Telephones	Multiple times daily	After each use
Microwave Ovens	Clean daily and when visibly dirty	Daily
Drinking Fountains	Multiple times daily	Disinfect when cleaning
Door/Door Jams	Multiple times daily	Disinfect when cleaning
Mop Sinks	Rinse and clean after every use	After each use
Mop Buckets	Empty and rinse after every use	After each use
Wet-Mop Heads	Replace with a clean mop head after each use	Launder used mop heads daily
Dust-Mop Heads	Replace with a clean mop head after each use	Launder used mop heads daily
Furnishings	Daily cleaning of multi-use common area furniture (chairs, tables, etc.)	Disinfect when cleaning

APPENDIX B. DISINFECTING WITH HALT™

Consult the manufacturer's recommendations and the safety data sheet for appropriate PPE to be worn during preparation and use of this product.

CONTROL OF HALT CONCENTRATE AND SOLUTION

- **STORAGE OF HALT CONCENTRATE:** Must be stored in accordance with institution policy on the storage of hazardous products (secured, bin cards, etc.). Must be under **DIRECT STAFF SUPERVISION** at all times or in locked dispensers.
- **MIXING HALT DILUTED SOLUTION FOR DISINFECTING:** Mix using dilution dispensers provided by the manufacturer. If a dispenser is not available, mixing must be done under **DIRECT STAFF SUPERVISION**. (See **PREPARATION OF HALT SOLUTION** below.)
- **USE OF DILUTED SOLUTION:** Once the solution is diluted, no special supervision is required for inmate use.

PREPARATION OF HALT SOLUTION USING MANUFACTURER'S GUIDANCE

- **IF A DISPENSER IS AVAILABLE:** Connect the dispenser and distribute the concentrate as needed into spray bottles or mop buckets, following the manufacturer's instructions.
- **IF NO DISPENSER IS AVAILABLE:** A gallon jug may be used. Under **DIRECT STAFF SUPERVISION**, add 2 ounces of HALT concentrate to the jug and fill the rest of it with cold water. Label the jugs as "HALT solution," with the date that the solution was prepared.
- The manufacturer recommends that a fresh solution be mixed daily for greatest efficacy however, they indicate that mixed solutions may be able to last up to a week and maintain efficacy.

HOW TO USE SOLUTION

- If surfaces are dirty, they should first be cleaned with detergent or soap and water—prior to disinfection with HALT solution.
- Apply HALT solution to hard, non-porous surfaces.
- All surfaces must **REMAIN WET FOR 10 MINUTES** for maximum disinfection. After the 10-minute we time, allow to air-dry or wipe surfaces to dry and remove any residue.
  - **FLOORS** do not need to be rinsed unless they are to be coated with finish or restorer.
  - **FOOD CONTACT SURFACES**—such as appliances and kitchen countertops—must be **RINSED WITH POTABLE WATER.**
  - **Do NOT use HALT on glassware, utensils, or dishes!**

APPENDIX C. DISINFECTING WITH HDQC®2

Consult the manufacturer's recommendations and the safety data sheet for appropriate PPE to be worn during preparation and use of this product.

CONTROL OF HDQC 2 CONCENTRATE AND SOLUTIONS

- **STORAGE OF HDQC 2 CONCENTRATE:** Must be stored in accordance with institution policy on the storage of hazardous products (secured, bin cards, etc.). Must be under **DIRECT STAFF SUPERVISION** at all times or in locked dispensers.
- **MIXING HDQC 2 DILUTED SOLUTION FOR DISINFECTING:** Mix using dilution dispensers provided by the manufacturer. If a dispenser is not available, mixing must be done under **DIRECT STAFF SUPERVISION**. (See **PREPARATION OF HDQC 2 SOLUTION** below.)
- **USE OF DILUTED SOLUTION:** Once the solution is diluted, no special supervision is required for inmate use.

PREPARATION OF HDQC 2 SOLUTION USING MANUFACTURER'S GUIDANCE

- **IF A DISPENSER IS AVAILABLE:** Connect the dispenser and distribute the concentrate as needed into spray bottles or mop buckets, following the manufacturer's instructions.
- **IF NO DISPENSER IS AVAILABLE:** A gallon jug may be used. Under **DIRECT STAFF SUPERVISION**, add 2 ounces of hdqC 2 concentrate to the jug and fill the rest of it with cold water. Label the jugs as "hdqC 2 solution," with the date that the solution was prepared.
- The manufacturer recommends that a fresh solution be mixed daily for greatest efficacy; however, they indicate that mixed solutions may be able to last up to a week and maintain efficacy.

HOW TO USE SOLUTION

- If surfaces are dirty, they should first be cleaned with detergent or soap and water—prior to disinfection with hdqC 2 solution.
- Apply hdqC 2 solution to hard, non-porous surfaces.
- All surfaces must **REMAIN WET FOR 10 MINUTES** for maximum disinfection. After the 10-minute we time, allow to air-dry or wipe surfaces to dry and remove any residue.
  - **FLOORS** do not need to be rinsed unless they are to be coated with finish or restorer.
  - **FOOD CONTACT SURFACES**—such as appliances and kitchen countertops—must be **RINSED WITH POTABLE WATER.**
  - **Do NOT use hdqC 2 on glassware, utensils, or dishes!**

APPENDIX D. DISINFECTING WITH VIREX® II/256

Consult the manufacturer's recommendations and the safety data sheet for appropriate PPE to be worn during preparation and use of this product.

CONTROL OF VIREX II/256 CONCENTRATE AND SOLUTIONS

- **STORAGE OF VIREX II/256 CONCENTRATE:** Must be stored in accordance with institution policy on the storage of hazardous products (secured, bin cards, etc.). Must be under **DIRECT STAFF SUPERVISION** at all times or in locked dispensers.
- **MIXING VIREX II/256 DILUTED SOLUTION FOR DISINFECTING:** Mix using dilution dispensers provided by the manufacturer. If a dispenser is not available, mixing must be done under **DIRECT STAFF SUPERVISION**. (See **PREPARATION OF VIREX II/256 SOLUTION** below.)
- **USE OF DILUTED SOLUTION:** Once the solution is diluted, no special supervision is required for inmate use.

PREPARATION OF VIREX II/256 SOLUTION USING MANUFACTURER'S GUIDANCE

- **IF A DISPENSER IS AVAILABLE:** Connect the dispenser and distribute the concentrate as needed into spray bottles or mop buckets, following the manufacturer's instructions.
- **IF NO DISPENSER IS AVAILABLE:** A gallon jug may be used. Under **DIRECT STAFF SUPERVISION**, add ½ ounce of Virex II/256 concentrate to the jug and fill the rest of it with cold water. Label the jugs as "Virex II/256 solution," with the date that the solution was prepared.
- The shelf life of the diluted solution is 1 year.

HOW TO USE SOLUTION

- If surfaces are dirty, they should first be cleaned with detergent or soap and water—prior to disinfection with Virex II/256 solution.
- Apply Virex II/256 solution to hard, non-porous surfaces.
- All surfaces must **REMAIN WET FOR 10 MINUTES** for maximum disinfection. After the 10-minute we time, allow to air-dry or wipe surfaces to dry and remove any residue.
  - **FLOORS** do not need to be rinsed unless they are to be coated with finish or restorer.
  - **FOOD CONTACT SURFACES**—such as appliances and kitchen countertops—must be **RINSED WITH POTABLE WATER.**
  - **DO NOT use Virex II/256 on glassware, utensils, or dishes!**

APPENDIX E. INFORMATION FOR ALL STAFF – CLOTH FACE COVERINGS

Cloth Face Coverings

Help Slow the Spread of COVID-19

- The BOP now requires all staff to wear cloth face coverings whenever indicated.
- All staff will receive a cloth face covering to use at work.
- The covering is re-useable and should not be thrown away.
- It is still important to maintain social distancing of 6 feet, when indicated.

How to Wear a Cloth Face Covering

- Make sure it fits snugly, but comfortably, against the side of the face. Secure with ties or ear loops.
- Use a covering with multiple layers of fabric, but make sure it allows for breathing without restriction.
- It should withstand laundering and machine drying without damage or change to shape.
- Be careful not to touch your eyes, nose, or mouth when removing—and wash hands immediately after.
- Do not put used face coverings where others can touch them.
- Do not touch or use anyone else's face covering. Assume that used masks are contaminated until they are laundered. Keep a bag with you to store your face covering if you will be taking it off in the car or other non-social space.
- If you take off your face covering (e.g., to eat) and then put it back on, be sure that the outside stays on the outside (consider marking the outside or inside).

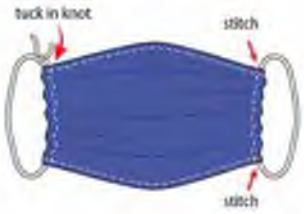
Routinely Wash Cloth Face Coverings

- The covering should be washed before the first use.
- It is recommended that staff wash cloth face coverings at home after each shift. They can be washed with other clothing.
- Launder items using the warmest water setting, and dry completely.
- Clean and disinfect clothes hampers or use a liner that can be washed or thrown away.

APPENDIX F. INFORMATION FOR INMATES – CLOTH FACE COVERINGS (ENGLISH)

Cloth Face Coverings

Help Slow the Spread of COVID-19



- Based on guidance from the CDC, the BOP now recommends all inmates wear cloth face coverings when indicated.
- All inmates will receive a cloth face covering.
- This covering is re-useable and should not be thrown away.
- It is still important to maintain social distancing of 6 feet, when indicated.

How to Wear a Cloth Face Covering

- Make sure it fits snugly, but comfortably, against the side of the face. Secure with ties or ear loops.
- Use a covering with multiple layers of fabric, but make sure it allows for breathing without restriction.
- Be careful not to touch your eyes, nose, or mouth when removing—and wash hands immediately after.
- Do not put used face coverings where others can touch them.
- Do not touch or use anyone else's face covering. Assume that used masks are contaminated until they are laundered.
- When not using your cloth face covering, store it in your personal locker where the cover will not become soiled or picked up by others.
- If you must take off your face covering and then put it back on before laundering, be sure that the part of the covering that was facing out stays facing out. (Consider marking the outside or inside).

Routinely Wash Cloth Face Coverings

- The covering should be washed before the first use.
- Inmates should send cloth face coverings through the institution wash cycles with other clothing.
- Launder face coverings using the warmest water setting, and dry completely.

APPENDIX G. INFORMATION FOR INMATES – CLOTH FACE COVERINGS (SPANISH)

Máscara faciales de tela

Ayuda a disminuir/evitar la propagación de COVID-19

- Basado en la guía del CDC, el BOP ahora recomienda que todos los reclusos usen cubiertas/máscaras de tela para la cara cuando se indique.
- Todos los reclusos recibirán una cubierta/máscara de tela para la cara.
- Esta cubierta/máscara es reutilizable y no debe desecharse.
- Todavía es importante mantener el distanciamiento social de 6 pies, cuanda se indique.

Cómo usar una cubierta/ máscara facial

- Asegúrese de que quede ajustada y comoda a los lados de su cara. Asegúrelo con las tiras o las bandas elasticas para las orejas.
- Use una máscara con varias capas de tela pero asegúrese de que permita respirar sin restricciónes.
- Tenga cuidado de no tocarse los ojos, la nariz, o la boca cuando se retire y lavese las manos inmediatamente despues de retirarla.
- No coloque la cubierta facial usada donde otros puedan tocarla.
- No toque ni use la cuberta facial/máscara de otra persona. Suponga que las máscaras usadas estan contaminadas hasta que sean lavadas.

- Cuando no use la cubierta de máscara de su cara, guárdela en su casillero personal, donde la cubierta/máscara no se ensucie ni sea accesible a otra persona.
- Si debe quitarse la máscara y luego volvérsela a poner antes de lavarla, asegúrese de que la parte de la cubierta que estaba hacia afuera permanezca hacia afuera. (Considere marque el exterior o el interior de la máscara.)

Lave rutinariamente la tela que cubre la cara

- La cubierta debe lavarse antes del primer uso.
- Los reclusos deben enviar las cubiertas de tela a la lavanderia de la institución con su ropa.
- Lave las máscara con la configuración de agua más cáliente y seque completamente.

APPENDIX H. PPE DONNING SKILL TESTING SHEET

COVID-19 Personal Protective Equipment Donning

SKILLS TESTING SHEET

STUDENT NAME: _____ **DATE:** _____

Skill Step	Critical Performance Criteria	✓ if done correctly
Following the protocol for PPE placement (donning) minimizes the risk for disease transmission: • The **DONNING PROCEDURE** should be used for observation, quarantine, and medical isolation transmission-based precautions. • Exact **PPE** may differ based on availability, as well as type of room utilized (AIIR with anteroom, single room without anteroom, or dorm type space). • **EQUIPMENT:** Gloves, gown, N95 **OR** surgical mask, eye goggles, mask with shield or face shield (PPE availability), non-touch waste container close to door inside room and just outside door at entry.		
1.	• **Address personal hygiene issues, hydration, and importance of not touching face.** • **Remove unnecessary jewelry and equipment.** • **Kevlar vest/protective vest are worn per policy.**	
2.	• **Perform hand hygiene.**	
3.	• **Don gloves.**	
4.	• **Don gown.** • **Tie or secure in the back.**	
5.	**Depending on use of N95 respirator, surgical mask, or surgical mask with eye shield:** **a. Don N95 respirator:** • **Only fit-tested individuals may wear N95s; facial hair cannot interfere with mask seal. See NIOSH site for facial hair styles that can interfere with the respirator seal:** https://www.cdc.gov/niosh/npptl/pdfs/FacialHairWmask11282017-508.pdf • **Adjust to fit.** • **Conduct a user seal check: Exhale to check for air leakage; inhale and check for slight mask collapse.** **b. Don surgical mask or surgical mask with eye shield:** • **Adjust to fit.**	
6.	**Don safety glasses, goggles, or face shield:** • **Glasses, goggles, or face shield sit on top or go over the mask** • **Adjust for vision and coverage**	

Donning PPE Skills (circle one): **PASS** **FAIL**

Instructor Signature: _____

Instructor Printed Name: _____

PPE Donning SKILLS TESTING SHEET, Page 1 of 1

APPENDIX I. PPE DOFFING SKILLS TESTING SHEET

COVID-19 Personal Protective Equipment Doffing

SKILLS TESTING SHEET

STUDENT NAME: _____ **DATE:** _____

Skill Step	Critical Performance Criteria	✓ if done correctly
	Following the protocol for PPE removal (doffing) minimizes the risk for disease transmission: • The **DOFFING PROCEDURE** should be used for observation, quarantine, and medical isolation transmission-based precautions. • Exact **PPE** may differ based on availability, as well as type of room utilized (AIIR with anteroom, single room without anteroom, or dorm type space). • Doffing has been modified to accommodate a lack of anteroom and the possibility of eye protection re-use. Facilities may create a doffing space or tape-off a designated doffing area immediately outside of room. • Hand hygiene can be performed between any step of the process. • **EQUIPMENT:** A non-touch waste container close to door inside room and just outside door at exit. Receptacle for contaminated eye protection/face shield.	
1.	• **If no anteroom is available, exit out of room to doff all PPE. If anteroom is available doff gloves and gown in room.** • **Ensure that the doffing area contains a non-touch waste bin, hand sanitizer, and a receptacle for contaminated eye protection and reusable face shields.**	
2.	• **Remove and discard gloves (pull off slowly and do not snap).** • **Dispose of gloves in waste bin next to door.**	
3.	**Remove Gown:** **a. Release the tie; then, grasp the gown at the hip area, and pull the gown down and away from the sides of your body.** **b. Once the gown is off your shoulders, pull one arm at a time from the sleeves of the gown so that the gown arms are bunched at your wrists.** **c. Remove gown from wrists.** **c. Roll the exposed side of the gown inward until it's a tight ball.** **d. Dispose of the gown in waste bin next to door.**	
5.	• **Immediately perform hand hygiene.**	
6.	**Based on type of eye protection:** **a. Remove safety glasses/goggles.** • **Carefully grasp edges only, without touching skin or eye.** • **Place in container designated for contaminated glasses or goggles to be cleaned and disinfected.** **b. Remove face shield.** • **Tilt your head forward slightly, grab the back strap with one hand, close eyes and pull it up and over head. (*Do not touch front of face shield.)*** • **Dispose of the face shield OR** • **Place in container designated for contaminated face shields to be cleaned and disinfected.**	
	PPE DOFFING SKILLS TESTING SHEET, Page 1 of 2	

7.	**Remove surgical mask or N95 respirator. (*Surgical mask may have eye shield.*)** ➔ *It is important that you not touch the front of the mask!* **a. Tilt your head forward slightly.** **b. Use two hands to grab the bottom strap; close eyes; pull out and over the head.** **c. Next, use both hands; grab the upper strap; close eyes; pull out and over the head.** **d. Keep tension on upper strap as you remove it, which will let the mask fall forward.** **e. Dispose of the mask or N-95 OR place it into labeled container (paper bag labeled with person's name) to be reused.**	
8.	**Perform hand hygiene at sink or use hand sanitizer.**	

Doffing PPE Skills (circle one): **PASS** **FAIL**

Instructor Signature: _____

Instructor Printed Name: _____

PPE Doffing Skills Testing Sheet, Page 2 of 2

APPENDIX J. ABBOTT ID NOW COMPETENCY AND PERFORMANCE ASSESSMENT

Abbott ID NOW™ Competency and Performance Assessment (PAGE 1)

SKILLS TESTING SHEET

STUDENT NAME: _____ **DATE:** _____

Skill Step	Critical Performance Criteria	✓ if done correctly
	Trainer should review all material listed below and verify that the trainee has read and understands the appropriate procedures or manufacturer instructions involved.	
1.	Trainee reads and understands procedure.	
2.	Trainer discusses principle of test procedure so that trainee understands scope and purpose of the test.	
3.	Trainer identifies the materials needed to perform test, and trainee knows location of these materials.	
4.	Trainee observes proper sample collection and handling.	
5.	Trainee observes test procedure being performed by trainer.	
6.	Trainee performs the procedure and should be able to: a. Identify proper sample type, use of the appropriate collection device, labeling, and handling of samples. b. Organize work area for testing. c. Perform quality control (QC) samples and training panel prior to performing patient samples. d. Set up timer and follow incubation times per the procedure. e. Interpret the results: • Positive • Negative • Invalid f. Decontaminate and clean work area, including proper disposal of hazardous waste and sharps.	
7.	Data entry/computer: a. Test order and accessioning. b. QC and interpretation of results. c. Report results and log QC data.	

Trainee Comments: _____

Trainee Signature: _____

Trainer Comments: _____

Trainer Signature: _____

Abbott ID NOW™ Competency and Performance Assessment (PAGE 2)

INSTRUCTIONS FOR TRAINER

PURPOSE:

The ability of each person to perform their duties should be assessed following training, and periodically thereafter. Retraining and reassessment of employee performance needs to be done when problems are identified with employee performance. The training and assessment program should be documented and specific for each job description. Activities requiring judgment or interpretive skills need to be included in the assessment.

INSTRUCTIONS FOR COMPLETING THE PERFORMANCE ASSESSMENT:

1. Record the facility name and location.
2. Record the employee's name and the procedure being observed.
3. Have the employee perform the procedure.
4. Record whether the steps completed were satisfactory or unsatisfactory, note any comments, and document any corrective action needed.
5. Sign and date the form.
6. Have the employee sign and date the form and provide comments.
7. Complete forms should be filed with the staff member's credentialing and training documents

Adapted from:
https://www.cdc.gov/labquality/docs/waived-tests/15_255581-test-or-not-test-booklet.pdf

APPENDIX K. ABBOTT ID NOW TRAINING LOG

Abbott ID NOW™ Certification of Training

Check all that apply: ☐ FLU A/B 2 ☐ Strep A 2 ☐ RSV ☐ COVID-19

The following personnel are responsible for running the ID NOW at _____ and have been thoroughly in-serviced on the test and test procedure.

Training has included:

- Review of the package insert.
- Demonstration of the product assay.
- Successful performance of the ID NOW assays and interpretation of results.
- Completion of **APPENDIX J.** Abbott ID Now Competency and Performance Assessment

Names of the personnel who have trained with the ID NOW and are responsible for reporting patient results are listed below:

Staff Person's Name (printed)	Staff Person's Signature	Date of Signature

Signature of Supervisor responsible for personnel and testing:

_____ _____

Signature *Date of Signature*

APPENDIX L. SAMPLE INCIDENT REPORT NARRATIVE FOR INMATES REFUSING COVID-19 TESTING

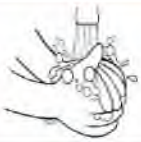
On _____(date), _____(inmate's name) , Reg. No. _____(number), refused a direct order to submit to testing for the COVID-19 virus as part of the testing initiative to prevent the transmission of a life-threatening disease to other staff and inmates. The Bureau tests an inmate for an infectious or communicable disease when the test is necessary to verify transmission following exposure to bloodborne pathogens or to infectious body fluid. An inmate who refuses diagnostic testing is subject to an incident report for refusing to obey an order (Program Statement 6190.04).

APPENDIX M. RESPIRATORY INFECTION MEDICAL ISOLATION ROOM SIGN

On the following page is a printable ***Respiratory Medical Isolation Precautions*** sign for posting on the doors of **MEDICAL ISOLATION UNITS**.

Respiratory/Eye Medical Isolation Precautions

PRECAUCIONES de aislameiento médico

ANYONE ENTERING THIS ROOM SHOULD USE: ***todas las peronas que entren e esta habitacion tienen que:***	
	**HAND HYGIENE** ***Hygiene De las Manos***
	**N95 RESPIRATOR (fit-tested)** ***Respirador N95***
	**GOWN** ***Bata***
	**EYE PROTECTION** ***Protección para los ojos si contacto cercano***
	**GLOVES** ***Guantes***
	**PATIENT WEARS CLOTH FACE COVERING WHEN OTHERS ENTER ROOM AND DURING MOVEMENT.** ***Lleva cubierta de tela para la cara.***
	**KEEP DOOR CLOSED AT ALL TIMES!** ***Mantenga la puerta cerrada en todo momento***

APPENDIX N. QUARANTINE ROOM SIGN

On the following page is a ***Respiratory Infection Quarantine Precautions*** sign for posting on the doors of housing units being used for **INTAKE, TRANSFER, AND RELEASE OBSERVATION AND QUARANTINE**.

Respiratory/Eye Observation/Quarantine Precautions

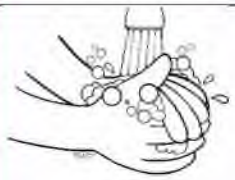
PRECAUCIONES de Sala de Cuarentena o Observación

TO PREVENT THE SPREAD OF INFECTION,

ANYONE ENTERING THIS ROOM SHOULD USE:

Para prevenir el esparcimiento do infecciones,

todas las peronas que entren e esta habitacion tienen que:



HAND HYGIENE

Hygiene De Las Manos

SURGICAL MASK

PATIENT WEARS CLOTH FACE COVERING WHEN OTHERS ENTER ROOM AND DURING MOVEMENT.

Lleva cubierta de tela para la cara.

GLOVES

Guantes

GOWN FOR CLOSE CONTACT

Bata

EYE PROTECTION

Protección para los ojos

APPENDIX O. MEDICAL ISOLATION CHECKLIST

MEDICAL ISOLATION CHECKLIST FOR COVID-19	
CATEGORY	**TASKS**
MOVE TO MEDICAL ISOLATION:	• Have the inmate wear a **FACE COVERING** en route to the designated medical isolation area. Staff escorts will wear PPE to include gloves, gown, eye protection and N95. • Movement to medical isolation should be accomplished promptly for any inmate with confirmed or suspected COVID-19 infection.
TAKE TRANSMISSION-BASED PRECAUTIONS: • **STANDARD PRECAUTIONS**; use of PPE and hand hygiene for contact, eye protection, and droplets.	Use **(1) HAND HYGIENE** (before & after gloves) and **(2) PPE** (gloves, gown, eye protection, N-95) for entry into room, direct contact, escort, or open grid units or dorms. • **PRIOR TO ENTERING ROOM:** Perform hand hygiene. Don (put on) gloves, gown, fit-tested respirator (N95), and eye protection. (*See PPE donning checklist Appendix H .)* • **EXITING ROOM WITH AN ANTEROOM:** Stay ≥ 6 feet from patient, if possible; doff (remove) and dispose of gloves & gown, and then exit the room. In the anteroom, perform hand hygiene, doff eye protection, N-95 respirator, and repeat hand hygiene. • **IF NO ANTEROOM IS AVAILABLE:** Exit room to doff all PPE in a designated doffing area (taped off area) located immediately outside of the room. (*See PPE doffing checklist Appendix I.)*
PLACE SIGNAGE	Place ***Respiratory/Eye Medical Isolation Precautions*** *sign* on the door. (See *Appendix M*.)
INMATE EDUCATION	Advise and educate the inmate regarding possible COVID-19 illness: Reportable signs and symptoms, social distancing, and wearing of face covering. Provide education sheets.
COMMUNICATION	• Report COVID-19 case(s) to facility leadership, QIIPC, public health authority, and Regional QIIPC Consultants. • If the inmate's condition deteriorates (respiratory distress) and emergent transportation to local hospital is necessary, call ahead for guidance and direction before transfer.
DOCUMENTATION	• Place the inmate on **MEDICAL HOLD** in BEMR and Sentry for the duration of the isolation. • HP code as **U07.1 COVID confirmed (test positive)** or **U07.2 COVID suspect/probable** in BEMR. • Document inmate status **DAILY** in BEMR, including any test results and changes in condition.
STAFF INTERACTION	• Limit the number of staff interactions with ill inmate(s); dedicate certain personnel, if possible. • **DIRECT CONTACT PPE** includes N95, eye protection, gloves, and gown. Inmates should wear a face covering or mask when staff enters the room or when moving around the unit.
MEDICAL ISOLATION CHECKLIST, Page 1 of 2	

MEDICAL ISOLATION CHECKLIST FOR COVID-19	
CATEGORY	**TASKS**
MEDICAL EQUIPMENT & MEDICAL CARE	• Dedicate medical equipment to the area, if possible. • Provide supportive care, with frequent assessment for shortness of breath or O2 decompensation (pulse oximetry). • Have preparations in place for transfer to hospital, if needed.
FOOD SERVICE	Use regular or disposable dishware (dispose of in regular trash).
LAUNDRY	• Standard precautions; wear gown if contact with dirty laundry is expected. • Do not shake dirty laundry. • Double-bag when taking from isolation to laundry. Wash with normal laundry, in hot water and drying at high temperatures. • Disinfect dirty carts after use.
VISITS	In-person visits will be suspended until the end of medical isolation. Consult local leadership for exceptions.
TELEPHONE CALLS	Phone should be cleaned and disinfected with disposable towel and a product from *EPA List N*.
TRASH	• Double-bag in clear waste bags and dispose of as regular trash. • Ensure that trash is **NOT** processed by recycling.
CLEANING & DISINFECTION	• Provide supplies to clean/disinfect room. Utilize disinfectant from *EPA List N*. • Ideally, cleaning is performed by the inmate, or by staff at the time of inmate care to prevent additional entry into room.
RELEASE FROM MEDICAL ISOLATION FOR ASYMPTOMATIC INMATES	Utilize a **TIME-BASED** approach for releasing inmates with asymptomatic COVD-19 from medical isolation: • Asymptomatic inmates can be released from medical isolation 10 days after the date of their first positive PCR test.
RELEASE FROM MEDICAL ISOLATION FOR SYMPTOMATIC INMATES	Utilize a **SYMPTOM-BASED** approach for releasing inmates with symptomatic COVD-19 from medical isolation: • Inmates with **MILD OR MODERATE SYMPTOMS** can be released from medical isolation 10 days after symptom onset and resolution of fever for at least 24 hours, without the use of fever-reducing medications, and with improvement of other symptoms. • Inmates with **SEVERE SYMPTOMS** requiring hospitalization or **SEVERELY IMMUNOCOMPROMISED** inmates can be released from medical isolation 20 days after symptom onset. A **TEST-BASED APPROACH** may also be considered with Regional Medical Director consultation.
TERMINAL CLEANING	• If possible, the isolated inmate should clean the room before leaving. • After waiting 24 hours (if possible), the isolation area should be cleaned again with an EPA List N registered disinfectant—while wearing gloves, gown, and other PPE recommended by the disinfectant manufacturer **AND** based on the condition of the room (i.e., if splashes are anticipated, wear mask and eye protection).
MEDICAL ISOLATION CHECKLIST, Page 2 of 2	

APPENDIX P. QUARANTINE CHECKLIST

OBSERVATION/QUARANTINE CHECKLIST FOR COVID-19	
CATEGORY	**TASKS**
MOVE ASYMPTOMATIC INMATES TO OBSERVATION OR QUARANTINE, PER COVID-19 RESPONSE PLAN MODULES 4 AND 6	• Inmates should wear a **FACE COVERING** or surgical mask while being escorted to observation or quarantine. PPE for escort staff is noted below. • They should preferably be designated to a single room with solid door. • **IF SINGLE HOUSING IS NOT AVAILABLE, THE INMATES MAY BE COHORTED WITH THEIR RESPECTIVE GROUP** – exposed contacts, intake, or pre-release/pre-transfer. Inmates in each category should be housed separately from inmates in other categories. • **INMATES TEST IN/TEST OUT OF ALL CATEGORIES OF OBSERVATION OR QUARANTINE.** The point-of-care (POC) or commercial (PCR) lab tests may be used for admission to observation or quarantine.
TAKE TRANSMISSION-BASED PRECAUTIONS: • **STANDARD PRECAUTIONS**; use of PPE and hand hygiene for contact, eye protection, and droplets.	• **HAND HYGIENE** (before and after wearing gloves). • **PPE** (gloves, eye protection, surgical mask, and gown) for staff having direct contact (including medical care, escort, or transport) or opening food trap or entering inmate room. • For **QUARANTINE** in open units, open doors, or open bars, consider use of N95 respirator. • **IF NOT ENTERING ROOM AND ≥ 6 FEET AWAY**, a gown may not be necessary. • **PRIOR TO ENTERING ROOM OR INMATE CONTACT:** Perform hand hygiene. Don (put on) gloves, gown, surgical mask, and eye protection. (*See PPE donning checklist Appendix H for specifics.)* • **EXITING ROOM WITH AN ANTEROOM:** Have inmate(s) move back to a social distance ≥ 6 feet; doff (remove) gloves & gown, and then exit the room. In the anteroom, perform hand hygiene, doff eye protection and mask, and repeat hand hygiene. • **IF NO ANTEROOM IS AVAILABLE:** Exit out of room to doff all PPE in a designated doffing area (taped off area) located immediately outside of room. **(***See doffing checklist Appendix I for specifics.)* • Used PPE is disposed of in regular trash, with a receptacle in the doffing area, as well as place for any items to be recycled.
PLACE SIGNAGE	Place a ***Respiratory/Eye Infection Observation/Quarantine Precautions*** sign on the door. (See *Appendix N.*)
INMATE EDUCATION	Advise and educate inmates to report symptoms of COVID-19 illness. Educate them to maintain social distance and wear face coverings. Provide education sheets.
QUARANTINE CHECKLIST, Page 1 of 3	

OBSERVATION/QUARANTINE CHECKLIST FOR COVID-19	
CATEGORY	**TASKS**
COMMUNICATION AND DOCUMENTATION	• Notify facility leadership, QIIPC, HSA, psychology, and Regional QIIPC consultants of observation or quarantine situation. • Place a **MEDICAL HOLD** in BEMR and Sentry for the duration of the observation or quarantine. Code inmate(s) according to their category: Intake Observation (Z0489-I), Quarantine due to Exposure (Z0489-E), or Release/Transfer Observation (Z0489-T). • Enter testing, entry, and exit symptoms, signs, and temperature screening (as indicated) in BEMR. • For "exposure" quarantine, conduct symptom/temp screens at least once **DAILY** (due to the probability that some will become ill). Daily screens can be conducted by non-healthcare staff after training completion. Any **POSITIVE SYMPTOMS** are reported to healthcare staff for assessment, testing and isolation.
STAFF INTERACTION	• Staff assessments not requiring direct contact will be conducted with social distancing of ≥ 6 feet away. • Limit the number of staff interactions with inmates and take measures to reduce the number of staff interacting with inmates on observation or quarantine status. Dedicate personnel to the unit, if possible.
MEDICAL EQUIPMENT	• Dedicate medical equipment to the unit, if possible. • Clean and disinfect after/between use.
MEDICAL CARE IF INMATES BECOME SYMPTOMATIC	• **MEDICALLY ISOLATE INMATES PROMPTLY** if they become symptomatic (cough, SOB, HA, dizziness, fatigue, loss of taste or smell, sore throat, N&V, chest pain) and/or an oral temperature ≥ 100.4 F (equivalent temps are 101°F for tympanic/ear and 100°F for forehead/non-contact). • Positive symptoms require assessment, clinical encounter, testing, and move to isolation. Limit close or direct contact. Provide necessary medical care as needed.
FOOD SERVICE	• Use regular trays or disposable dishware.
LAUNDRY	• Wear gloves. • Regular central laundry processes are acceptable. • Do not shake dirty laundry. • Disinfect dirty carts after use.
VISITS	In-person visits will be suspended until the end of observation or quarantine. Consult local leadership for exceptions.
TELEPHONE CALLS	Phone is cleaned and disinfected after each use with registered disinfectant from *EPA List N*.
TRASH	• Wear **GLOVES** and **DOUBLE-BAG** in clear waste bags; • Ensure that trash is **NOT** processed by recycling.
CLEANING/DISINFECTION	• Provide supplies to inmate to clean and disinfect the room. • Use disinfectant from *EPA List N*.
QUARANTINE CHECKLIST, Page 2 of 3	

OBSERVATION/QUARANTINE CHECKLIST FOR COVID-19	
CATEGORY	**TASKS**
DISCONTINUATION OF OBSERVATION OR QUARANTINE	• Complete proper length of observation or quarantine as required in COVID-19 Response Plan Modules 4 and 6. • If possible, **DO NOT ADD INDIVIDUALS TO AN EXISTING OBSERVATION OR QUARANTINE** after the observation or quarantine clock has started. If new inmates are added into an observation or quarantine cohort or anyone in the cohort becomes positive, the clock starts back at zero. • **PRIOR TO RELEASE FROM OBSERVATION OR QUARANTINE, ASYMPTOMATIC INMATES SHOULD UNDERGO COVID-19 TESTING AND TEST NEGATIVE.** • A **POC** test or commercial **PCR** test should be performed for inmates releasing to the general population and for releases or transfers.
TERMINAL CLEANING	• Inmates should clean the area at end of observation or quarantine, if possible. • If inmates in observation or quarantine became **SYMPTOMATIC**, wait 24 hours (if possible), and then clean and disinfect with an *EPA List N* registered disinfectant with PPE recommended by the disinfectant manufacturer (i.e., gloves, gown, and if splashes are anticipated, wear mask and eye protection).
QUARANTINE CHECKLIST, Page 3 of 3	

APPENDIX Q. COVID-19 CODING CLINICAL REFERENCE GUIDE

CODE	DESCRIPTION	WHEN TO USE
J1282	Pneumonia due to coronavirus disease 2019	For a patient with pneumonia confirmed as due to COVID-19. • Also, add code *U07.1 COVID-19* to the health problem list.
J208	Acute bronchitis due to other specified organisms	For a patient with acute bronchitis due to other specified organism **OR** associated with COVID-19. • If associated with COVID-19, also add code *U07.1 COVID-19* to the health problem list. • If a diagnosis has **NOT** been established, and it is suspected/probable also add code *U07.2 Suspect/probable COVID-19 case* to the health problem list.
J22	Unspecified acute lower respiratory infection	For a patient with lower respiratory infection not otherwise specified **OR** associated with COVID-19. Do **NOT** use this code for acute upper respiratory infection (J069). • If associated with COVID-19 also add code *U07.1 COVID-19* to the health problem list. • If a diagnosis has **NOT** been established, and it is suspected/probable also add code *U07.2 Suspect/probable COVID-19 case* to the health problem list.
J40	Bronchitis, not specified as acute or chronic	For a patient with bronchitis not otherwise specified **OR** bronchitis, not specified as acute **OR** associated with COVID-19. • If associated with COVID-19 also add code *U07.1 COVID-19* to the health problem list. • If a diagnosis has **NOT** been established, and it is suspected/probable also add code *U07.2 Suspect/probable COVID-19 case* to the health problem list.
J80	Acute respiratory distress syndrome	For a patient with acute respiratory distress syndrome (ARDS) **OR** associated with COVID-19. • If associated with COVID-19 also add code *U07.1 COVID-19* to the health problem list. • If a diagnosis has **NOT** been established, and it is suspected/probable also add code *U07.2 Suspect/probable COVID-19 case* to the health problem list.
J960	Acute respiratory failure	For a patient with acute respiratory failure **OR** associated with COVID-19. • If associated with COVID-19 also add code *U07.1 COVID-19* to the health problem list. • If a diagnosis has **NOT** been established, and it is suspected/probable also add code *U07.2 Suspect/probable COVID-19 case* to the health problem list.
J961	Chronic respiratory failure	For a patient with chronic respiratory failure **OR** associated with COVID-19. • If associated with COVID-19 also add code *U07.1 COVID-19* to the health problem list. • If a diagnosis has **NOT** been established, and it is suspected/probable also add code *U07.2 Suspect/probable COVID-19 case* to the health problem list.

Continues on next page

CODE	DESCRIPTION	WHEN TO USE
J988	Other specified respiratory disorders	For a patient with a respiratory infection not otherwise specified **OR** associated with COVID-19. • If associated with COVID-19 also add code *U07.1 COVID-19* to the health problem list. • If a diagnosis has **NOT** been established, and it is suspected/probable also add code *U07.2 Suspect/probable COVID-19 case* to the health problem list.
M3581	Multisystem inflammatory syndrome	For a patient with multisystem inflammatory syndrome (MIS) **OR** associated with COVID-19. • If associated with COVID-19 also add code *U07.1 COVID-19* to the health problem list. • If a diagnosis has **NOT** been established, and it is suspected/probable also add code *U07.2 Suspect/probable COVID-19 case* to the health problem list.
M3589	Other specified systemic involvement of connective tissue	For a patient with other specified systemic involvement of connective tissue **OR** associated with COVID-19. • If associated with COVID-19 also add code *U07.1 COVID-19* to the health problem list. • If a diagnosis has **NOT** been established, and it is suspected/probable also add code *U07.2 Suspect/probable COVID-19 case* to the health problem list.
R051	Acute Cough	For a patient with acute cough **OR** associated with COVID-19. • If associated with COVID-19 also add code *U07.1 COVID-19* to the health problem list. • If a diagnosis has **NOT** been established, and it is suspected/probable also add code *U07.2 Suspect/probable COVID-19 case* to the health problem list.
R052	Subacute Cough	For a patient with subacute cough **OR** associated with COVID-19. • If associated with COVID-19 also add code *U07.1 COVID-19* to the health problem list. • If a diagnosis has **NOT** been established, and it is suspected/probable also add code *U07.2 Suspect/probable COVID-19 case* to the health problem list.
R053	Chronic Cough	For a patient with chronic cough **OR** associated with COVID-19. • If associated with COVID-19 also add code *U07.1 COVID-19* to the health problem list. • If a diagnosis has **NOT** been established, and it is suspected/probable also add code *U07.2 Suspect/probable COVID-19 case* to the health problem list.
R509	Fever	For a patient with fever **OR** for patients presenting with fever associated with COVID-19. • If associated with COVID-19 also add code *U07.1 COVID-19* to the health problem list. • If a diagnosis has **NOT** been established, and it is suspected/probable also add code *U07.2 Suspect/probable COVID-19 case* to the health problem list.

Continues on next page

CODE	DESCRIPTION	WHEN TO USE
R0602	Shortness of breath	For a patient with shortness of breath **OR** for patients presenting with shortness of breath associated with COVID-19 • If associated with COVID-19 also add code *U07.1 COVID-19* to the health problem list. • If a diagnosis has **NOT** been established, and it is suspected/probable also add code *U07.2 Suspect/probable COVID-19 case* to the health problem list.
U07.1	COVID-19	Code only a confirmed diagnosis of the 2019 novel coronavirus disease (COVID-19) as documented by the provider or documentation of a positive COVID- 19 test result. • Do **NOT** use *U07.1* for suspected, possible, probable, or inconclusive COVID-19 *(see code U07.2).* • **Do NOT use this code for COVID-19 Reinfection, use code *U07.3.***
U07.2	Suspect/probable COVID-19 case	For individuals with a suspected/probable virus. Add other symptoms to this code such as cough, fever, etc.
U07.3	COVID-19 Reinfection	For individuals who now present with new symptoms, having had a previous diagnosis of COVID-19 and recovered from the first round of COVID-19 diagnosis, 90 days from the symptoms or positive test result (whichever occurs first).
U09.9	Post COVID-19 condition, unspecified	For sequela of COVID-19, or associated symptoms or conditions that develop following a previous COVID-19 infection, assign a code(s) for the specific symptom(s) or condition(s) related to the previous COVID-19 infection, if known, and code *U09.9, Post COVID-19 condition, unspecified.* • Code U09.9 should **NOT** be assigned for manifestations of an active (current) COVID-19 infection.
Z0489-E	Quarantine due to exposure	For individuals who need to be placed in quarantine due to exposure.
Z0489-I	Intake Observation	For intake individuals who need to be placed in observation.
Z0489-T	Release/Transfer Observation	For release/transfer individuals who need to be placed in observation.
Z28310	Unvaccinated for COVID-19	For patients who acknowledge they are not vaccinated. • Patient must sign a COVID-19 consent refusing the vaccine. • This code should not be used for individuals who are **NOT** eligible for the COVID-19 vaccines, as determined by the healthcare provider.
Z28311	Partially vaccinated for COVID-19	For patients who acknowledge they have received dose 1 of 2 and agree to complete the series. • Verify dose (if possible) and document in BEMR. A COVID-19 consent must be completed for additional vaccines administered. • This code should not be used for individuals who are **NOT** eligible for the COVID-19 vaccines, as determined by the healthcare provider.
Z8616	Personal history of COVID-19	For patients with a history of COVID-19

Continues on next page

CODE	DESCRIPTION	WHEN TO USE
Z9222	Personal history of monoclonal drug therapy	For patients with a history of monoclonal drug therapy.
Z9911	Dependence on respirator [ventilator] status	Add code *U07.1 COVID-19*, *J961, Chronic respiratory failure*, followed by code Z9911 Dependence on respirator [ventilator] status.

Note: BOP Quality Improvement/Infection Prevention & Control Coordinators have the rights to enter, update or entry error erroneous BEMR ICD10 codes.

APPENDIX R. PRIORITIZATION OF HEALTH CARE SERVICES DURING DISRUPTIONS

NORMAL CONDITIONS	SCOPE OF SERVICES
Normal resources and demands	No change in scope of services
MILD DISRUPTION	**NEAR-NORMAL SCOPE OF SERVICES**
Disruptions: • Slightly reduced health care staffing. • Some inmates ill; few severely ill. • Community hospitalization available. • Rearranged health care staffing/roles.	**Possible adjustments include:** • Alter site of care for patients with COVID-like symptoms. • Reduce preventive health care services (continue TB screening, influenza and pneumococcal vaccination). • Maintain a chronic care clinic. Identify and monitor inmates defined by the CDC as being at risk for serious illness if infected with COVID-19. • Provide care for minor ailments, as feasible.
MODERATE DISRUPTION	**REVISED MEDICAL CARE SCOPE OF SERVICES**
Disruptions: • Health care staffing somewhat reduced. • Some shortages of supplies/medication. • Limited laboratory capability. • Many inmates ill; some severely ill.	**Possible adjustments include:** • Prioritize delivery of chronic care. • Minimize patients on directly observed therapy consistent with guidance from the medical director. • Postpone most preventive health care except TB screening and vaccinations for influenza and pneumonia. • Focus on key life-saving care. • Send severely ill to the hospital. • Postpone care for low priority health problems.
SEVERE DISRUPTION	**TOTAL SYSTEM / SCOPE OF SERVICES ALTERATION**
Disruptions: • Health care staffing significantly reduced. • Significant shortages of supplies/medications. • No laboratory capability; no chest radiography. • Numerous inmates ill; many severely ill. • No community hospitalization available.	**Possible adjustments include:** • Focus on key live-saving care. • Cohort sickest inmates; provide palliative care. • Deliver care in accordance with priorities established by the BOP Medical Director and in consultation with the Regional Medical Director.

APPENDIX S. TRIAGE OF MEDICAL AND MENTAL HEALTH CONDITIONS DURING DISRUPTIONS

TABLE 1. Examples of Conditions to be Seen for Same-Day Emergency/Urgent Care Visit

MEDICAL

- Acute chest pain
- Acute abdomen: Severe, rebound tenderness, absent bowel sounds, or localized to RLQ
- Unstable diabetes (BS<60, or >350 and symptomatic)
- Asthma/significant dyspnea
- Acute ophthalmology disturbance (foreign body sensation, a sudden change in vision)
- Hemoptysis or night sweats
- Seizure/syncope
- Stroke/TIA symptoms
- 2nd/3rd-degree burns
- High temp (>101), sepsis
- Acute musculoskeletal injuries (limb immobility, open fracture; any injury requiring completion of an injury assessment form)
- Severe acute headache
- Hematemesis
- Melena or hematochezia (acute of unknown origin)
- Severe hypertension (SBP >170, DBP>110, or symptomatic)
- Intractable nausea/vomiting/diarrhea.
- Development of gangrene/open diabetic ulcer/ significant cellulitis, and open draining wounds
- Eye injuries: Foreign object (penetrating and non-penetrating), corneal abrasion, blurred vision, pain
- Testicular pain (r/o torsion)
- Acute uterine bleeding (Hct drops 6% within 4 hrs.)
- New onset peripheral edema or orthopnea
- Male inmates with UTIs
- Rash: Any intensely pruritic or vesicular rash; a rash consistent with scabies, varicella, small pox, herpes zoster, or otherwise unexplained
- New onset of incapacitating pain
- Altered mental status
- HIV+ inmate with fever, headache, mental status and/or changes of loss of vision

MENTAL HEALTH

- Thoughts of self-harm
- Thoughts of harm towards others
- New onset hallucinations
- New onset delusions
- New onset anxiety attacks
- Manic symptoms
- Severe depression
- Drug or alcohol withdrawal
- New onset severe medication side effects

(TRIAGE OF MEDICAL AND MENTAL HEALTH CONDITIONS DURING DISRUPTIONS, page 1 of 2)

TABLE 2. Examples of Conditions to be Seen Within 24–48 Hours	
MEDICAL	
• Asthma, no acute distress • Acute infections w/symptoms (fever, cough) • Earache, suspected infection	• Medication renewals for chronic conditions such as angina, diabetes, HTN, TB, psychotropics
MENTAL HEALTH	
• Moderate depression • Hypomania • Recurrence of anxiety symptoms/attacks	• Chronic psychotic symptoms • New, mild-to-moderate medication side effects

TABLE 3. Conditions Requiring Evaluation Within 72 Hours	
MEDICAL	
• Cough • Sore throat/URI without temp • Constipation (unrelieved by OTC meds)	• Headache – Chronic • Skin rash with s/s of itch, pain, spreading
MENTAL HEALTH	
• Mild depression • Chronic anxiety under treatment	

TABLE 4. Conditions Requiring Evaluation Within One Week	
MEDICAL	
• Tuberculosis prophylaxis/evaluation/clearance • Chronic rash, blisters, calluses, corns, jock itch, athlete's foot • Hemorrhoids • Gastritis (without nausea/vomiting/diarrhea)	• Eye problems other than described in above tables • All other medication refills • Convalescence and or Duty Status inquiries
MENTAL HEALTH	
• Chronic medication side effects	

TABLE 5. Conditions Requiring Evaluation Within Two Weeks
MEDICAL
• Musculoskeletal pain, chronic, no recent injury • Back pain, chronic • Allergies, chronic

(TRIAGE OF MEDICAL AND MENTAL HEALTH CONDITIONS DURING DISRUPTIONS, page 2 of 2)

APPENDIX T. CPAP or BiPAP in USE Signage

On the next page is a printable sign to be placed on the door of a room where a CPAP or BiPAP is in use.

Respiratory Precautions

Airborne/Contact/Eye Protection

CPAP or BiPAP IN USE

PRECAUCIONES de Sala de Cuarentena

TO PREVENT THE SPREAD OF INFECTION,

ANYONE ENTERING THIS ROOM SHOULD USE:

Para prevenir el esparcimiento do infección,
cualquiera que entre e esta habitación debe utilizar:

	**HAND HYGIENE** ***Hygiene De Las Manos***
	**N-95 RESPIRATOR (Fit-Tested)** ***Respirador N-95***
	**GOWN** ***Bata***
	**Eye Protection** ***Protección para los ojos si contacto cercano***
	**Gloves** ***Guantes***
	**Door to this room remains closed <u>when CPAP or BiPAP is in use</u>.** ***La puerta de esta habitación permanence cerrada <u>cuando se usa CPAP o BiPAP</u>.***

APPENDIX U. SWITCHING TO A NON-VENTED FULL-FACE MASK FOR CPAP OR BIPAP

In patients with severe sleep apnea with co-morbidities such as morbid obesity, pulmonary hypertension, cardiomyopathy, etc., even the temporary discontinuation of BiPAP or CPAP may constitute a higher risk. When the decision is made to allow the patient to continue using CPAP/BiPAP, the machine must be set up and used with a full-face, non-vented CPAP mask with an in-line viral filter attached to the intake and exhalation ports. The viral filters should be changed daily. See the diagram on the next page for setup.

→ *See MODULE 7 for more information about aerosol generating procedures (AGPs).*

SWITCHING TO A NON-VENTED FULL-FACE MASK FOR CPAP AND BIPAP

(ResMed Non-vented full-face mask – Small #61739, Med #61740, Lge #61741)

Covers mouth & nose. Has no holes in the mask or elbow attachment on the mask:

1. From the elbow on the mask, attach a **SWIVEL CONNECTOR** (Respironics #7041):

2. From there, attach a **VIRAL FILTER** (Airlife #001851):

3. From the viral filter, attach an **EXHALATION PORT** (Respironics #312149):

4. The remainder of the CPAP is unchanged!

APPENDIX V. COVID-19 SCREENING TOOL FOR STAFF, CONTRACTORS, AND VISITORS

CORONAVIRUS DISEASE 2019 (COVID-19) ENHANCED SCREENING TOOL STAFF/CONTRACTORS/VISITORS

DATE: _____

1. TEMPERATURE: _____ °F **METHOD:** ☐ MOUTH ☐ EAR ☐ FOREHEAD	
☐ **If temperature is: (mouth) ≥ 100.4°F OR (ear) ≥101°F OR (forehead) ≥ 100°F**	
2A. OTHER SYMPTOMS (completed by employee, contractor or visitor)	
☐ Yes ☐ No	**New-Onset Cough** # of days: ____
☐ Yes ☐ No	**New-Onset trouble speaking/difficulty breathing**
☐ Yes ☐ No	**Fever or chills in the past 24 hours**
☐ Yes ☐ No	**New onset loss of taste or smell**
2B. COVID-19 VACCINE (completed by employee, contractor or visitor)	
☐ Yes ☐ No	**Received COVID-19 Vaccine in the past 72 hours**
☐ Contact the Medical Officer on call for the institution to provide disposition: Disposition by Medical Officer after assessing symptoms: ☐ Leave ☐ Work If staff is being sent home, please provide them a copy of this document and a copy of *Memo for the Local Health Department/Personal Healthcare Provider* for COVID-19 testing.	
3. NOTIFICATION OF LOCAL HUMAN RESOURCES DEPARTMENT	
☐ If Individual is placed on leave, share document with HR Office for T&A purpose. ☐ **HR OFFICE:** Please have HSD place this document in the Employee's Medical Folder (Blue Folder) if leave is indicated.	
Staff Name (Last, First): _____ **Year of Birth:** _____ **Institution:** _____ **State:** _____	

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APPENDIX W. COVID-19 MEDICAL ISOLATION INFIRMARY GUIDANCE

Under certain circumstances, establishment of an onsite infirmary at an institution may be necessary. Considerations include the number of symptomatic patients, institution resources and local healthcare resources. The decision to stand up an infirmary should be made in consultation between the institution and regional and central office leadership.

1. GENERAL GUIDELINES FOR INFIRMARY SET-UP

- **PATIENT CRITERIA FOR ADMISSION TO THE MEDICAL ISOLATION INFIRMARY**
  - Criteria for admission to and discharge from the infirmary should be reviewed in consultation with the Clinical Director.
  - Admission to and discharge from the infirmary will occur only on the order of a physician or designated authorized health professional.
  - Follow guidance in **MODULE 4** for medical isolation guidance.
  - Eligible patients include the following:
    - COVID-19 patients (positive, probable, or suspected) with mild to moderate symptoms.
    - COVID-19 patients who are hemodynamically stable with mild to moderate symptoms and requiring 2–3 liters of oxygen per nasal cannula to maintain O2 saturation above 90%.
    - COVID-19 patients post-hospitalization who are still being treated as positive and are hemodynamically stable, requiring continued medical observations or treatment (e.g., IV antibiotics, oxygen, etc.).
      - *Patients returning from the hospital who have completed treatment for COVID-19 infection, and have met CDC criteria for release from isolation, should* ***NOT*** *be placed in the isolation infirmary.*

- **STAFFING PATTERN**
  - The team may consist of six members, including one Medical Officer, one Advanced Practice Provider (APP), and four Registered Nurses (RN) per 5–10 bed infirmary—based on the patients' medical acuity. Infirmary bed estimates generally range from 0.5 to 1 percent of the population (i.e., 5 to 10 medical infirmary beds per 1,000 inmates).
  - A Medical Officer should be on call 24 hours per day for the infirmary.
  - A Medical Officer should evaluate patients daily, as required by the severity of their illnesses.
  - At least two RNs should be on each shift. This allows for continuous coverage of the unit in case one RN has to step off the unit for any reason, as well as allowing the RNs to watch out for breaks in each other's PPE.
  - There should be health care personnel on duty 24 hours per day, seven days per week, who make rounds a minimum of once per shift—and more often, as required by patients' needs and physicians' orders. A health care provider is to remain in the infirmary at all times.
  - Patients should always be within sight or hearing of a health care staff member (e.g., call lights, buzzer system).

- **LOCATION OF THE MEDICAL ISOLATION INFIRMARY**
  - Each institution varies, and coordination with the local executive staff will be necessary to determine a suitable location.
  - The location of the medical isolation infirmary unit can be co-located within the medical isolation unit.
  - The institutional pandemic plan, in consultation with facility's personnel, will identify a location. In addition to structures in place at the institution, the institution may also consider utilizing large temporary structures like tents.
    - Consider utilizing a location large enough to house the patients and their necessary belongings. Approximately 72 square feet (12' L x 6' W) should be allowed for each patient, to ensure that there is at least six feet between patients' beds, and safe walkways of at least three feet between the head and foot of the bed.
    - Ensure that there is at least a six-foot wide egress aisle for safe evacuation of the unit if necessary.
  - Housing Units can be utilized for Infirmary Medical Isolation in order of precedence, as determined by the CDC guidance provided in **MODULE 4**.
  - Ideally, the location will have a sink with running water, soap, and paper towels. If this is not feasible, ensure adequate alcohol-based hand sanitizer is available.
  - Ideally, the locations should have separate entrance and exit locations.
    - The entrance/exit locations require space for donning and doffing of PPE, as well as a means of performing hand hygiene.
    - Proper donning of appropriate PPE will be completed prior to entering the unit.
    - Proper doffing of PPE will be completed upon exiting the unit.
    - Refer to **MODULE 2** for additional guidance on PPE.
  - Access to toilets and shower facilities for patients, and toileting facilities for staff.
  - If space is utilized that does not have emergency lighting, portable emergency lighting will be needed.

- **NECESSARY SUPPLIES**
  - *The list below is in addition to the Suggested Infirmary Supply and Equipment List identified* below
  - Signage as recommended in the various **MODULES**.
  - In accordance with fire and safety codes, a mechanism to separate patients in the absence of walls when privacy is necessary: Foldable panels, privacy screens, a sheet draped between the beds, etc.
  - Stocked hand hygiene station(s): Running water, soap, paper towels, and/or alcohol-based hand sanitizer, as outlined in **MODULE 1**.
  - PPE: Sufficient supply of gowns, gloves, N95 masks, goggles, and face shields in multiple sizes, as outlined in **MODULE 2**.
  - Dedicated computer terminal(s) for health care providers to document and review information on the patients.

- Telephone:
  - If secure: A regular phone with dial-out access to outside of the institution should be utilized.
  - If unable to make secure: The telephone will ring directly to Control, like the suicide watch phone. This phone would be available for staff working in the unit to receive phone calls, while still preventing inmates from using the phone to make outside calls.
- Cleaning supplies as outlined in **MODULE 1**.
- Mechanisms to properly secure the following items on the unit:
  - Needles, sharps, syringes – behind two locks.
  - Medication – behind at least one lock (excludes controlled substances).
- Dedicated non-critical medical equipment: Vital signs machine, stethoscope, non-touch and oral thermometers, pulse oximetry device, blood glucose meter, etc. These will need to be disinfected appropriately between patients, following the manufacturer's recommendations, if supplies do not allow for one device per patient.

- Cleaning and disinfecting of the unit completed in accordance with the guidance in **MODULES 1 AND 4**.

2. DOCUMENTATION

- Documentation should occur in BEMR.
  - Health Services should work with the local computer services and facilities to provide additional computer terminals where needed.
  - Cleaning and disinfection of computer equipment located in a medical isolation infirmary should be accomplished frequently in accordance with the manufacturer's recommendations.
  - Paper documentation has the following drawbacks:
    - Creates gaps in the patient record and prohibits the capture of data needed for the COVID-19 reporting requirements.
    - Leads to potential medical/medication errors.
    - Creates a vehicle for transmission of the COVID-19 virus (minimal paper should be used because it cannot be easily disinfected).
- In addition to documentation required for Medical Isolation (refer to **MODULE 4**), documentation in BEMR should include infirmary admission and discharge notes, along with daily clinical encounter notes

3. PHARMACY:

- Stock of individually bottled over-the-counter items to treat symptoms. A provider with prescribing authority will need to document an order for the patient to receive these items; nurses and paramedics may utilize approved protocols.
  - Examples include, but are not limited to:
    - Acetaminophen
    - Ibuprofen
    - Cough medicine
  - The Clinical Director can modify this list to meet the needs of the patient population.

4. Suggested Infirmary Supply and Equipment List

Intravenous Delivery			
Item	**Need**	**Item**	**Need**
IV starter kits		IV poles	10
Transparent dressings (i.e., Tegaderm, Opsite)		IV fluids (NS, 1/2NS, LR, 1/2NS, or NS with 5% Dextrose)	
Clear and paper tape		IV tubing sets and extension	
IV catheters (16, 18, and 20 gauge)		Alcohol wipes	
3 cc syringes			
Oxygen Delivery			
Item	**Need**	**Item**	**Need**
O2 tanks with roller stand holder		Bag valve mask	
Oxygen concentrator Christmas trees		Non-rebreather mask	
Oxygen cylinder key		Nasal cannula	
O2 concentrators		Simple face mask	
Portable suction machine		Albuterol multi-dose inhalers (nebulizers are not recommended)	
Yankauer suction set – tubing & canister			
Miscellaneous			
Item	**Need**	**Item**	**Need**
PPE (gowns, gloves, eye protection, masks)		Vital signs monitors	10
Cots, pillows, and blankets		Thermometers (oral and touch free)	
Tall large trash cans	5	Probe covers for oral thermometer	
Influenza testing supplies or kits		Portable Pulse Ox machines	
COVID-19 testing supplies or kits		Patient scale	1
EPA registered disinfectant wipes		Glucometer w/ testing supplies	
EPA registered disinfectant solution		Stethoscopes	
Hand wash stations		Oral fluid supplement (ORS, Gatorade)	
Hand sanitizer		Bed wedges	
Automated external defibrillator (AED)	1	Stretcher, backboard, and wheel chair	
Portable cart for nurse to provide care at bedside or cell to cell		Refrigerator or cooler (to hold potential samples)	

(COVID-19 Medical Isolation Infirmary Guidance, page 4 of 4)

APPENDIX X. COVID-19 TIPS FOR OFFICIAL TRAVEL USING COMMERCIAL VENDORS

To reduce the risk of infection among the traveling workforce, limit close contact with others by maintaining a distance of at least 6 feet while at work and in public, when possible.

- **Don't** come to work if you are sick. Please notify your supervisor and stay home, except to get medical care. Discuss your work situation with supervisor before returning to work.

- Afterhours: Stay in your hotel room to the extent possible. Eat in your hotel room with either room service or delivery service. If in-room food delivery options is not available, get take-out from the hotel restaurant or another restaurant nearby.
    - Limit activities in public to essential errands, such as getting food.

- Wash your hands often with soap and water for at least 20 seconds. Use hand sanitizer with at least 60% alcohol if soap and water aren't available.

  Key times to wash your hands include:
    - Before preparing and serving food and beverages
    - Before eating food
    - Before and after work breaks and shifts
    - After touching frequently touched surfaces
    - After removing gloves or other personal protective equipment (PPE)

- Avoid touching your eyes, nose, and mouth with unwashed hands.

- Cover your mouth and nose with a tissue when you cough or sneeze, or use the inside of your elbow. Throw used tissues in the trash and immediately wash hands with soap and water for at least 20 seconds or use hand sanitizer containing at least 60% alcohol.

- Wear a face covering while around other people when indicated, especially in situations where you cannot maintain proper social distancing (6ft.) from others.

Monitor your health and practice social distancing outside of work. Further COVID-19 Guidance for all staff can be located on the Agency's COVID-19 Sallyport Page.

If you get sick with fever, cough, or trouble breathing during travel, stop working immediately, put on a mask, notify your supervisor, and separate yourself from others to the extent possible while you seek medical attention as appropriate.

These recommendations are derived from the Centers for Disease Control guidance document at the following link: *https://www.cdc.gov/coronavirus/2019-ncov/travelers/airline-toolkit.html*

APPENDIX Y. STAFF AND INMATE COVID-19 CONTACT INVESTIGATION AND TRACING WORKSHEET

Definitions:

- **Common COVID-19 symptoms:** Fever, cough, shortness of breath, headache, sore throat, general feeling of being unwell (myalgia or fatigue), diarrhea or nausea, and acute onset loss of taste or smell.
- **Infectious period:** Person is contagious at onset of symptoms and possibly two days prior to symptom onset (e.g., if symptoms began on Sunday, ask about activities starting on Friday).
- **Asymptomatic infection:** When a person may be contagious but has no symptoms.
- **Incubation period:** The time from exposure to illness onset. The average incubation period may be 3-5 days (range 2-14 days).
- **Exposed to SARS-CoV-2:** In general, a person needs to be in close contact with a sick person to get infected. Close contact includes:
  - Living in the same household or room and sharing close space (bathroom) with a person with COVID-19
  - Caring for a sick person with COVID-19
  - Being within 6 feet (about two arms-length) of a person with COVID-19 for about 15 minutes, OR
  - Being in direct contact with secretions from a sick person with COVID-19 (e.g., being coughed on, sharing cups or utensils, sharing personal items, kissing, etc.)

Points to Consider:

- This tool, which can be used for staff or inmates, assists to guide contact tracing at the institution level. The goal of interviewing the index case and contacts of the index case is to establish the infectious period and identify other potentially exposed persons.
- It is critically important that time be spent establishing trust with persons before conducting an interview and making sure that the person understands the purpose of the contact investigation. For languages other than English, utilize an interpreter, if needed.
- The questions below should be used to guide the contact investigation interview. Depending on the person's responses, additional questions may be asked as follow-up on their answers. If a question is not applicable, note N/A.
  - Inmates: If inmate is unavailable for an interview (i.e., they are in the hospital), information can be obtained from cellmates, job supervisors, unit officers or teams, etc.
  - Staff: If staff is unavailable for an interview, information can be obtained from human resources, department heads or Admin LT, etc.

    DO NOT file interview documentation in the inmate's medical record or staff record.

➔ *Refer to Module 5. Surveillance for additional information related to contract tracing and the CDC https://www.cdc.gov/coronavirus/2019-ncov/php/principles-contact-tracing.html for additional information regarding contact tracing*

Contact Tracing Worksheet

Inmate Name:_____ **Registration #:**_____ **Facility Intake Date:**_____

Staff Name: _____**DEPT:**_____**FACILITY:**_____

Interviewer Name: _____ **Interview Date:** _____

1. Review the COVID-19 diagnosis with the person:

☐ Assess the person's knowledge of the condition

☐ Describe COVID-19, how it is diagnosed and treated, and the treatment plan

☐ Describe how COVID-19 is transmitted (exposure to infectious respiratory fluids)

☐ Discuss the need to identify potentially exposed contacts

☐ Describe how a close contact is defined

2. Obtain COVID-19 vaccination history

3. Have you received a COVID-19 vaccine? ☐ YES ☐ NO

If YES, when and what manufacturer?

_____

4. Obtain infection history:

a. Have you had any close contact with a person with a confirmed or probable diagnosis of COVID-19 in the last 2 weeks? ☐ YES ☐ NO

If YES, where and when?

_____

b. Have you had a positive COVID-19 test result? ☐ YES ☐ NO

If YES, where and when?

_____

c. Have you been diagnosed with COVID-19? ☐ YES ☐ NO

If YES, where and when?

_____

(continued on next page)

5. Ask about medical history *(INMATES only).* What other medical conditions do you have?

6. Ask about a history of COVID-19 symptoms.

YES	NO	Have you had any of the following symptoms in the **last two weeks**?	If YES, how long have you had them? When did they start?
		Cough	
		Fever or subjective fever (felt feverish)	
		Shortness of breath	
		Chills	
		Muscle aches	
		Lethargy or fatigue	
		Headache	
		Nasal congestion	
		Chest pain or tightness	
		Sore throat	
		Loss of taste or smell	
		Nausea	
		Vomiting	
		Diarrhea (>3 loose stools in 24 hours)	
		Abdominal pain	
Date of symptom onset:			

7. Ask about the risk factors.

YES	NO	Please answer the following questions	When and Where?
		Are you living/quarantined with someone diagnosed with COVID-19 in the last two weeks?	
		Have you had contact with someone diagnosed with COVID-19 (i.e., > 15 minutes cumulative time over 24 hours and within < 6 feet)?	
		Are you part of a carpool to work or use public transit?	

(continued on next page)

8. If symptoms began prior to arrival at the facility *(INMATES only)*:

a. Where were you living?

_____

b. Who were you living with?

_____

c. How were you transferred to this facility and when (e.g., plane, bus, van)? Were you sitting at least six feet from others?

_____

d. Did you come from a non-BOP facility or were you intermingled with non-BOP inmates in transit?

_____

9. Please describe your previous day-to-day activities at your facility:

Time of Day	Daily Activities (lunch, education, training, meetings, breaks, free time)
Morning	
Mid-Day	
Afternoon	
Evening	

10. Has the above activity been your pattern during the period since___/___/___(2 days before symptom onset) or has the way you spend your time changed in any way? If changed, how and when did your pattern change? _____

_____

11. Did you spend time with any staff outside of your assigned duty post (i.e. lunch, visits, socializing, and institution gym) in the 2 days prior to illness? (*STAFF only)* ☐ YES ☐ NO

_____

(continued on next page)

12. Please tell me if you have been involved in any of the following activities, in the last two days (*INMATES only*).

YES	NO	Activity	Where?	When?	With whom?
		Watching TV?			
		Playing cards or games?			
		Religious services?			
		Recreation or sports?			
		Work?			
		Education?			
		Library?			
		Using common phones?			
		Using common computer?			
		Sharing food or drink?			
		Wear a facial covering?		How often?	
		Other:			

13. In the two days prior to symptom onset (or if asymptomatic, in the two days prior to testing), who have you sat or stood near for more than 15 minutes (this may be cumulative contact time)? (Prompt for potential activities in question 5-9) (**For STAFF:** Only close contacts who work at the institution)

(continued on next page)

14. Are there any staff members with whom you have had close contact with? ☐ YES ☐ NO

Name of Staff	When?	Where?	Were you wearing a mask or face covering?

15. Is there any other information that might help identify anyone else you have been in contact with? Is there anyone else who you're concerned could have become infected with COVID-19 by being near you?

_____
_____
_____
_____
_____

16. Do you have any questions about COVID-19?

_____
_____
_____
_____
_____

APPENDIX Z. STAFF POSITIVE CASE FORM

Per **PS6701.01,** all employees are required to report a COVID-19 positive test through their institution human resources department to *BOP-HSD-StaffCovidNotifications-S@bop.gov*. In addition to completion of this form, a copy/screenshot of the laboratory results or healthcare provide statement indicating the results should also be included. The subject line for the email should include: "**COVID-19 Staff + Results – Name of Institution**"

Employee Name	
Institution	
Employee Department	
Unit(s)/Facility worked 48 hours prior to symptoms or positive test	
TDY date and institution (f applicable)	
Last day of work	
First date of symptoms (list symptoms if available)	
Test date	
Test confirmation date	
Test report date	
Was staff member vaccinated?	
If Yes, what was the date of last vaccination?	
Did COVID-19+ staff spend an accumulated time of more than 15 min with anyone (lunch, breaks)? If yes, provide # of staff contacts.	
Provide # of known staff positive contacts. Were staff contacts notified?	
Number of known inmate contacts	
Are any inmates quarantined and being tested as result of exposure? If yes, provide # of inmates and unit(s)	

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