MODULE 4. MEDICAL ISOLATION AND EXPOSURE QUARANTINE

WHAT'S NEW

- Exposure quarantine is required for all inmates regardless of vaccination status
- Exposure quarantine is decreased from 14 to 10 day duration
- Inmates in EXPOSURE QUARANTINE (asymptomatic and with negative test results) do not require daily temperature checks. Inmates who become symptomatic or test positive for COVID, will be placed on isolation and continue to require daily temperature checks.
- Medical Isolation of 10 days is still required of all inmates who become symptomatic/test positive for COVID
- Either POC testing (Abbott ID Now, BinaxNOW) or a commercial PCR lab may be used for testing into or out of quarantine.

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A. DEFINITIONS

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.

QUARANTINE: In the context of COVID-19, refers to separating (in an individual room or cohorting in a unit) asymptomatic 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 **DIFFERENT CATEGORIES OF QUARANTINE** – exposure, intake, 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.

→ *Refer to* the *BOP Pandemic Plan Module 6. Inmate Movement for quarantine requirements for inmate movement.*

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: 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.

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). This is also known as Exposure Quarantine.
  - **QUARANTINE**, when indicated, new intakes and release/transfer inmates separately from inmates who are exposed close contacts in quarantine. This is also known as **Intake** or **RELEASE/TRANSFER QUARANTINE**
- 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 spaces, 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 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.*

- The BOP utilizes different categories of quarantine as described above. Selecting inmate patients for each type of quarantine will be made according to the *COVID-19 Modified Operations Matrix*, and **MODULE 6.**
- **All BOP COVID-19 quarantine categories** 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.
  - Refer to **MODULE 6** for detailed guidance for Intake, release/transfer and all movement procedures to include immediate releases, hospital trips, court appearances, etc.

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.
  - If an entire housing unit is being managed as an exposure quarantine due to contact with a case from the same housing unit, the entire housing unit may need to be treated as a cohort and quarantine in place.
  - 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

- **EXPOSURE QUARANTINE:** Inmates in exposure quarantine should be screened at least once daily for COVID-19 symptoms. Twice-daily screening may be considered for patients with high-risk conditions.
- **INTAKE AND RELEASE/TRANSFER QUARANTINE:** Daily COVID-19 symptom screens and temperature checks are not required routinely for intake and release/transfer quarantine. Symptoms screen and temperature checks are only required upon entry and exit from release/transfer quarantine.
  - Refer to **MODULE 6** regarding inmate movement and the timing of the test-in/ test-out quarantine strategy.
- **All types of quarantine** 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 in quarantine.

- 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 are 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 and release/transfer for inmates previously diagnosed with COVID-19.