BURKE, WILLIAMS & SORENSEN, LLP
1901 Harrison Street - Suite 900
Oakland, California 94612-3501
voice 510.273.8780 - fax 510.839.9104
www.bwslaw.com

Our File No.: 07588.0007
gthomas@bwslaw.com

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VIA E-MAIL ONLY

Jeffrey L. Bornstein, Esq.
Kara J. Janssen, Esq.
Ernest J. Galvan, Esq.
jbornstein@rbgg.com
kjanssen@rbgg.com
egalvan@rbgg.com

Hon. Nathaniel M. Cousins
ncpo@cand.uscourts.gov

Brendon Woods
Alameda County Public Defender
Brendon.Woods@acgov.org

Diana Weiss
CJA Supervising Attorney
Diana_Weiss@cand.uscourts

David L. Anderson
United States Attorney
David.l.anderson@usdoj.gov

Stephen G. Kalar
N.D. Cal. Federal Public Defender
Steven_kalar@fd.org

Re: Public Production Pursuant to Court Order [Dkt. No. 85]
***Babu et al. v. County of Alameda, et al.*, United States District Court for the Northern District of California Case No.: 4:18-cv-07677**

Dear All:

Pursuant to the Court's March 30, 2020 "Order After Hearing RE: Santa Rita Jail COVID-19 Response" [Dkt. No. 85], enclosed please find the following document:

1. Santa Rita Jail Outbreak Master Plan, updated March 29, 2020

Thank you for your attention to this matter. Please do not hesitate to contact me should you have any questions or concerns.

Sincerely,

Gregory B. Thomas

Gregory B. Thomas

TOP
Encl.
Cc: Paul Mello, Esq., Samantha Wolff, Esq., Temitayo Peters, Esq., Ben Rice, Esq.

wellpath SM

To hope and healing.

Santa Rita Jail Outbreak Control Master Plan

ACSO Webpage DRAFT

Updated: March 29, 2020

Approved by: Jess Waldura, Medical Director &
Jen Diaz, Health Services Administrator

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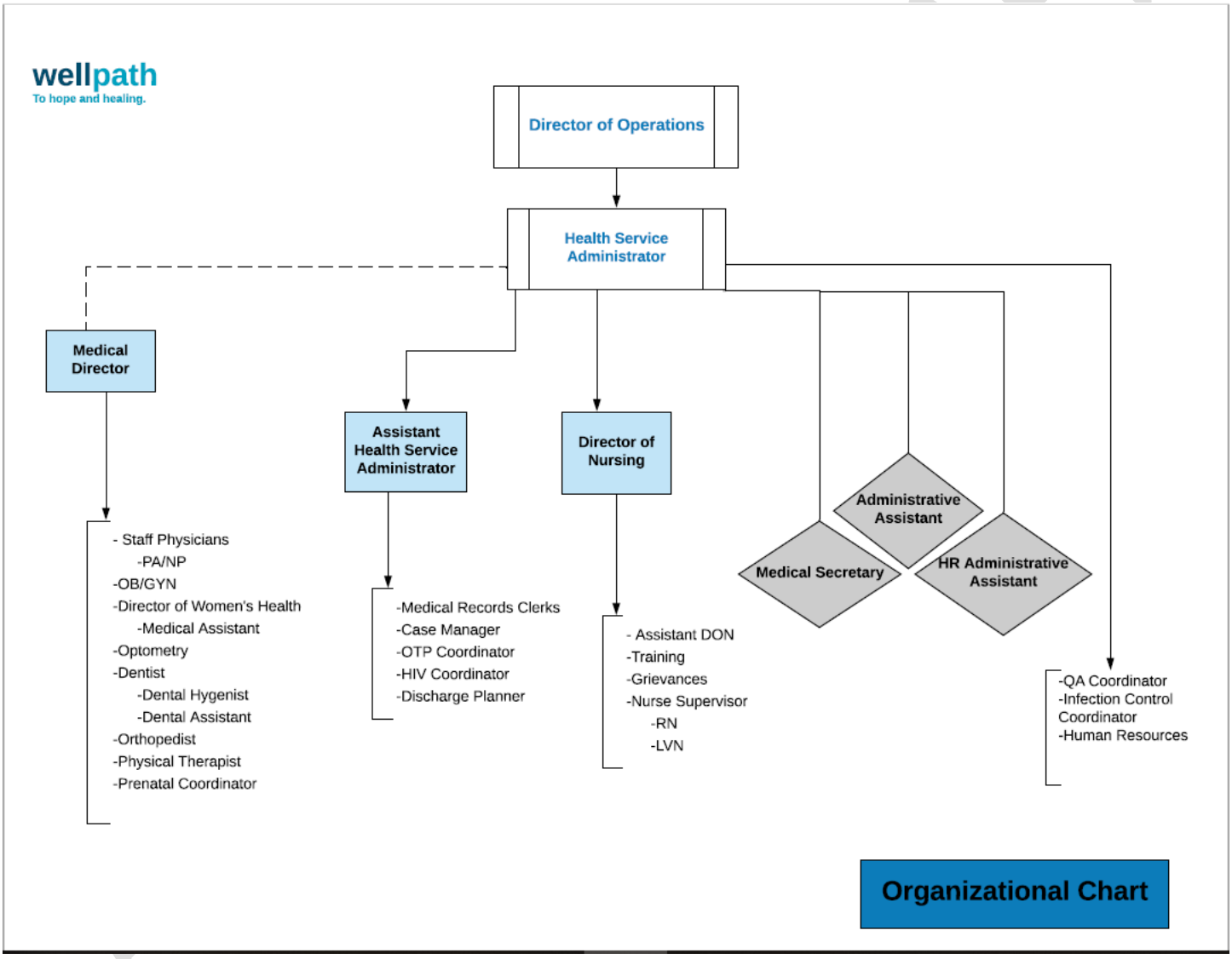
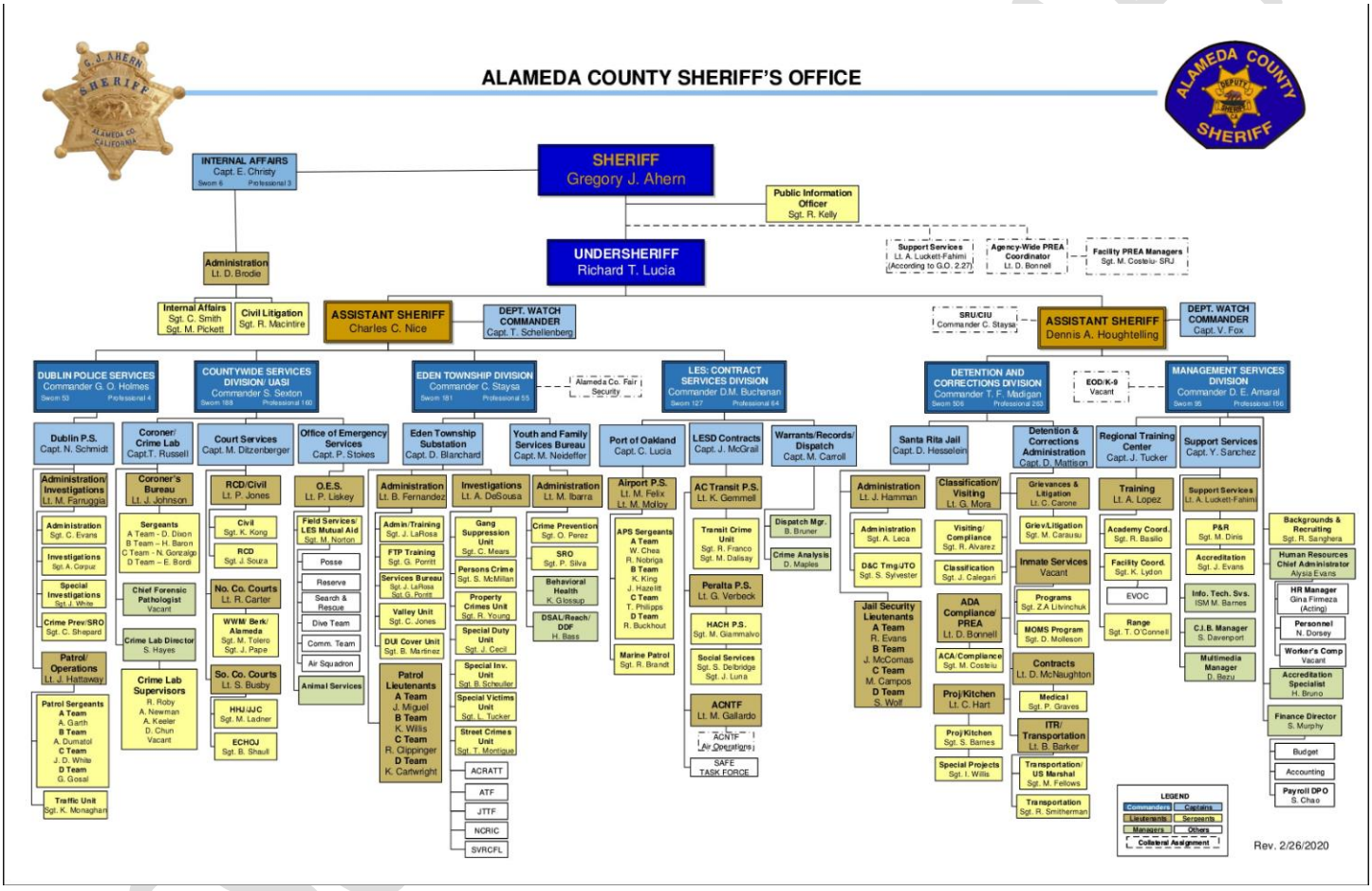
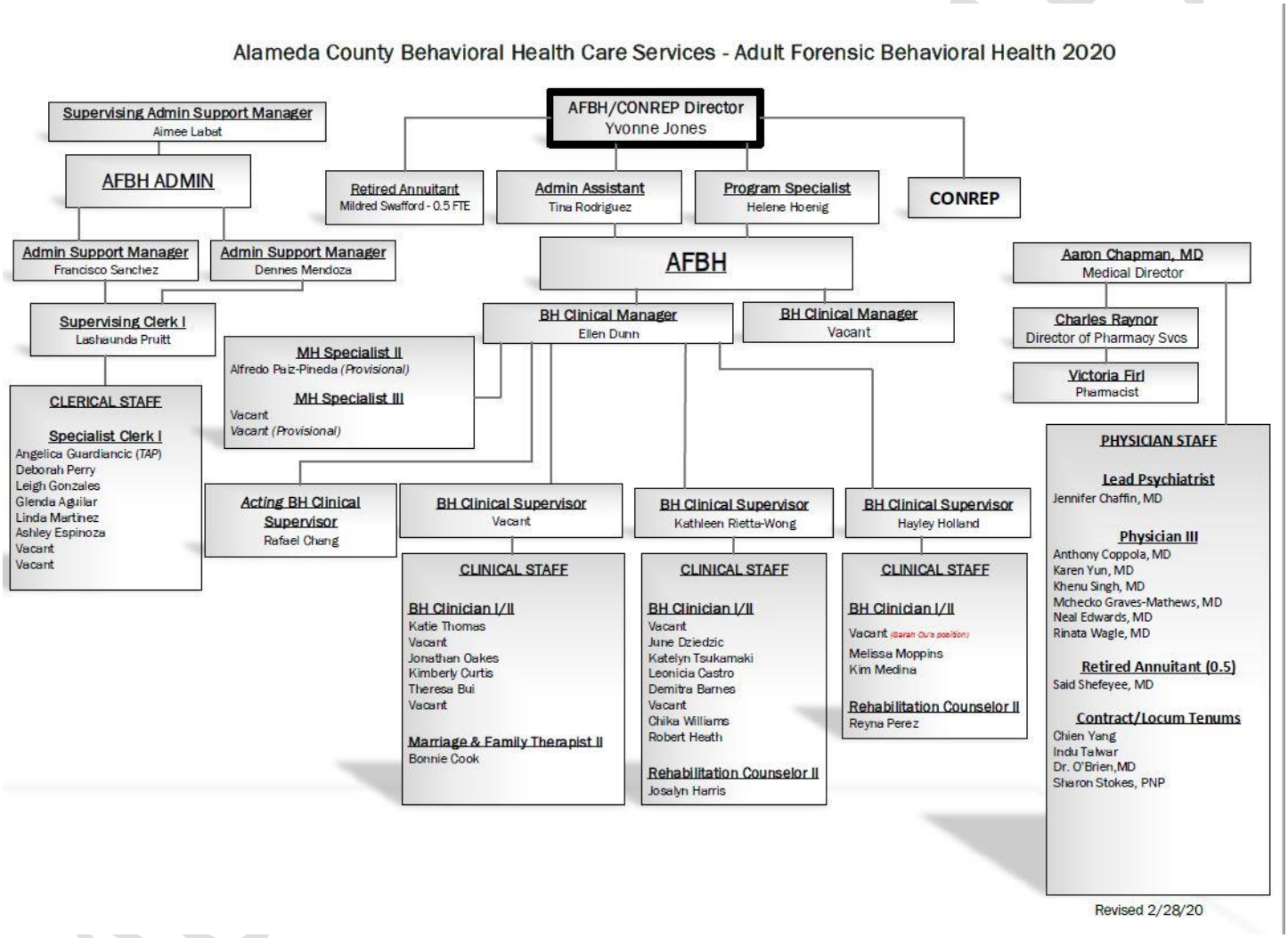
Wellpath (SRJ) Organizational Chart



ACSO Organizational Chart



AFBH Organizational Chart



Email Distribution List

1. Wellpath: Health Services Administrator, Assistant Health Services Administrator, Director of Nursing, Medical Director, Infection Control Coordinator, Supervising Registered Nurses, Medical Providers, Regional medical Director, Regional Director of Operations

2. ACSO: Clinic Sergeant, Contract Lieutenant, Watch Commanders from all shifts, Classification Lieutenant, Classification Sergeant, Visiting/USM Sergeant, Supply Lieutenant, ITR Lieutenant, Inmate Services Lieutenant or Admin Sergeant, Admin Lieutenant, Compliance Lieutenant, Admin Captain, D&C Captain, and Commander

3. AFBH: AFBH Director, AFBH Clinical Manager, AFBH Supervisors. AFBH Lead Psychiatrist, and AFBH Administrative Support Manager

4. Pharmacy Manager

5. Contractors: Food Service, Housekeeping, GSA/BMD

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Infection Control Master Plan for Outbreaks

Record Keeping	
1. A line list should be kept and updated with new cases and new quarantined units as soon as they are identified.	Infection Control RN/ Record-Keeping RN
2. A second line list should be kept to keep track of those who have been exposed. This line list should include details about the level of exposure when possible.	Infection Control RN/ Record-Keeping RN
3. A separate line list should be kept track staff who fall ill or are on leave for other reasons.	HSA/Infection Control RN/ Record-Keeping RN
4. The line lists should be reviewed daily and new details added as they occur	Infection Control RN
5. A daily summary log of events should be kept	Infection Control RN
Communication	
1. An email list should be set up to include the following: a. Wellpath: HSA, AHSA, DON, Medical Director, Infection Control RN, Supervising RNs, core Medical Providers, Regional Medical Director, Regional Director of Operations b. ACSO: Clinic Sergeant, Contracts Lieutenant, Watch Commanders from all teams, Classification Lieutenant, Classification Sergeant, Visiting/USM Sergeant, Supply Lieutenant, ITR Lieutenant, Inmate Services Lieutenant or Admin Sergeant, Admin Lieutenant, Compliance Lieutenant, Admin Captain, D&C Captain, Commander c. AFBH Clinical Manager, AFBH Leadership d. Pharmacy Manager e. Contractors: Food service, Housekeeping, GSA/BMD	Medical Director/HSA/Contracts Lieutenant
1. Supervising RNs are in charge of notifying the Wellpath Admin Team, the Infection Control Team, and the Watch Commander of new cases/quarantined units via email.	Supervising RNs/ Record-Keeping RN
2. Daily communication should take place between key staff via email and/or in person a. Daily meetings should occur if the situation is changing rapidly	Medical Director/HSA/Infection Control RN

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b. The line list and the daily summary log should be emailed daily	
3. Communication should be set up with Alameda County Public Health Department	Medical Director/Infection Control RN
4. The line list, summary log, and other updates should be emailed daily to the ACPHD	Infection Control RN
Supplies	
1. PPE supplies: masks, gloves, hand sanitizer etc. should be secured for both staff and inmates. Eye protection and gowns should be available when needed.	Infection Control RN/AHSA/Supply Lieutenant
2. Testing: adequate supplies of lab tests for the illness should be secured	Infection Control RN/AHSA/Lab staff
3. Medications: adequate supplies of medications should be secured	Infection Control RN/Pharmacy
Staff Protection	
1. Staff should be informed of an outbreak promptly	HSA/ACSO Captains
2. Staff will have their temperature taken and a symptom screen done before entering the facility. Persons with temperature ≥ 100˚ or symptoms of cough, shortness of breath, myalgias or URI symptoms will be sent home until they are afebrile and feeling well for at least 3 days.	HSA/ACSO Captains
3. All staff should wear appropriate PPE when in contact with potentially infected individuals. Staff should wear an N95 mask, goggles and gloves, and should don a gown if in close proximity to a patient, especially when performing procedures likely to expose them to respiratory secretions.	HSA/ACSO Captains
4. If N95 masks are not available, staff should wear surgical masks and attempt to maintain distance from the patient.	HSA/ACSO Captains
5. Staff should have surgical masks available to hand to possibly infected inmates	HSA/Supply Lieutenant
6. Any staff displaying signs of illness should sent home until they are no longer contagious and/or their quarantine period is lifted.	HSA/ACSO Captains
7. Staff who have had contact with confirmed or suspected COVID-19 cases should self-quarantine at home for 14 days.	HSA/ACSO Captains
8. As staffing gets short, staff who think they may have been exposed to COVID-19 may continue to work if asymptomatic. They should perform a temperature check and symptom screen twice a day, and should self-quarantine if they display any signs or symptoms.	HSA/ACSO Captains

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ITR Procedures

1. Arrestees who have not reported symptoms of COVID-19 to the arresting agency will receive an initial COVID-19 screener in the tent outside the lobby during the outbreak.	Director of Nursing/ITR Lieutenant
2. Arrestees reporting symptoms of COVID-19 or exposure risk to the arresting agency will remain in the car for their initial screening for COVID-19.	Director of Nursing/ITR Lieutenant
3. Arrestees will be questioned about current COVID-19 symptoms (including fever, cough, shortness of breath, body aches, or cold/flu symptoms), or about contact with known or suspected COVID-19 cases, or travel to high risk countries.	Director of Nursing/ITR Lieutenant
4. Arrestees arriving at ITR reporting concerning symptoms should be provided with appropriate PPE while being assessed for fitness for incarceration.	Director of Nursing/ITR Lieutenant
5. Usual acceptance policies should be followed during an outbreak. Inmates who would normally be accepted will be accepted, as long as the facility has current capacity to provide appropriate housing (isolation, OPHU etc.), and medical care for the inmate.	Director of Nursing/ITR Lieutenant/Watch Commanders
6. If an arrestee with concerning symptoms or high risk history is accepted past the bubble, they must be placed in an isolation room in ITR during processing, and the room should be wiped down with antiseptic wipes after their departure.	Director of Nursing/ITR Lieutenant
7. If there are not enough isolation cells in ITR, the sick can be cohorted with the sick (red), and the at-risk should be cohorted with the at-risk (yellow).	Director of Nursing/ITR Lieutenant
8. Ideally, healthy inmates with increased risk for COVID-19 complications (pregnant, over 65, over 50 with co-morbid conditions - orange) should be cohorted away from the sick or at-risk while held in ITR.	Director of Nursing/ITR Lieutenant

General Quarantine Procedures

1. If possible, new books should be quarantined for 14 days before being introduced into the general population	HSA/Captains/Medical Director
2. Inmates displaying symptoms consistent with COVID-19 will be housed in the OPHU if very ill, or in isolation cells around the base = **Red**	Medical Director/Classification Lieutenant
3. Inmates who are well, but considered at increased risk for COVID-19 complications (pregnant, older than 65, chronic medical conditions) will be housed in “Vulnerable” Housing = **Orange**	Medical Director/Classification Lieutenant
4. Inmates who have had contact with known or suspected COVID-19, or	Medical

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persons with a high risk travel history should be cohorted for a 14 day quarantine period in a special housing unit = **Yellow**	Director/Classification Lieutenant
5. Any pod or housing unit that was previously health (**Green**), but develops a case of suspected COVID-19 will have the index case removed to isolation cells (**Red**) and the housing unit/pod will be placed on quarantine for 14 days (**Yellow**) or until testing comes back negative on the index patient.	Medical Director/Captains/Watch Commanders
6. A sign will be posted outside of each pod/housing unit displaying the quarantine status, the start date, and possible release date.	Infection Control Nurse
7. Inmates should be given sufficient space during meals, pod time, etc. to practice social distancing	
8. During quarantine, there should be no new inmates transferred into the pod or housing unit.	Medical Director/Captains/Watch Commanders
9. No inmates will leave the quarantined area for clinic appointments, classes, visiting, work etc.	Medical Director/Captains/Watch Commanders
10. Commissary will be allowed, but workers who are delivering the packages must wear PPE and wash their hand in between units.	Medical Director/Captains/Watch Commanders
11. All staff working in the quarantined area are allowed in wearing appropriate PPE, and using careful hand hygiene, especially before entering other pods or housing units.	Medical Director/Captains/Watch Commanders
## Environmental Controls and Hygiene	
1. High-touch surfaces in common areas (both inmate and staff areas) should be wiped with antiseptic wipes several times each day. If antiseptic wipes are not available, diluted bleach solution (5 tablespoons (1/3rd cup) bleach per gallon of water or 4 teaspoons bleach per quart of water) should be used.	HSA/Captains
2. Staff should clear shared equipment (radios, keys, blood pressure cuffs, etc.) several times per day and at the end of each shift.	HSA/Captains
3. Soap should be made available to all inmates and the importance of proper hand hygiene should be reinforced.	HSA/Captains
## Management of Inmate Workers during Quarantine	
4. Inmate workers in quarantined areas should not participate in work during the lockdown.	Supply Lieutenant/Vendors
5. Custody should anticipate an alternative plan for providing food, laundry etc. during the quarantine.	Supply Lieutenant/Vendors

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6. Medical staff should be prepared to screen substitute workers during the quarantine.	Director of Nursing/Supply Lieutenant
7. Inmate workers assigned to ITR should be provided with adequate PPE and trained on proper hand hygiene and facility disinfection techniques. At the end of their shift they should be provided with a change of clothes and wash their hands carefully before returning to their housing units.	Director of Nursing/Supply Lieutenant
Court	
1. At present, county court has been canceled, but federal court will be in session	Captains
2. Any inmate displaying symptoms of COVID-19, claiming contact with a person with known or suspected COVID-19, or with high risk travel history will be prevented from going to court until they are out of quarantine.	Medical Director/Captains
3. Asymptomatic inmates with no known contact with COVID-19 may go to court.	Medical Director/Captains
Visiting/Attorneys	
1. Contact visits are suspended during the outbreak. Video visits will be allowed.	Medical Director/Captains
2. Attorney visits will be non-contact during the outbreak.	Medical Director/Captains
Programs	
1. Programs and classes will be suspended during the outbreak	Captains
Weekenders	
1. Then weekender program will be suspended during the outbreak	Captains
Non-Essential Workers/Outside Contractors	
1. Currently all workers at SRJ are considered to be essential to operations and will be allowed into the facility. Workers who usually enter through the rear will be re-directed to the front of the building for a temperature check.	Captains
Transfer to other Facilities during Quarantine	
1. No inmates should be transferred from locked-down units until the quarantine has been lifted on that unit.	Medical Director/Captains/Watch Commanders
2. The list of inmates due for transfer should be reviewed the night before to make sure none of the individuals are coming from quarantined units – If quarantined inmates are identified the Watch Commander should be notified as soon as possible.	Supervising RNs/ Watch Commanders

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3. Inmates being transferred from non-quarantined units should have a symptom screen and a temperature check (if applicable) before boarding the bus – symptomatic inmates should be held back at Santa Rita until they are well.	Medical Director/Captains/Watch Commanders
Release/Discharge Planning	
1. Inmates who are sick and are being released must wear protective equipment and be escorted alone to an isolation cell in ITR prior to release. - The Public Health Department will be alerted about the release if indicated.	Medical Director/Captains/Watch Commanders
2. Inmates who are sick or on quarantine and are being released will have their temperatures taken and have a symptom screen before release, and if positive, will be instructed to return home immediately to self-quarantine.	Director of Nursing/ITR Lieutenant
3. Pts being released may have 14 days of discharge meds instead of the usual 7 days.	Medical Director/Discharge Planners
4. Pts who are released with labs tests pending will have the infection control team track the labs, and when they are available, will contact the patient to inform them of the results.	Infection Control Team
5. Homeless inmates will attempt to be placed in temporary housing on release	Discharge Planners

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Infection Control Measures for Different Housing Units at SRJ

SAMPLE: INFECTION CONTROL MEASURES FOR DIFFERENT HOUSING UNITS AT SRJ

Single Cell Setting

- Index case
    - Isolated (OPHU or their cell)
        - If the pt. is being moved to the OPHU necessary precautions during movement (e.g. mask) and kept in negative air flow cell if indicated
    - Treatment based on clinical presentation – don't wait for lab results
    - OK to have pod time alone
    - No movement to other parts of the jail x 7 days
- Close contacts
    - N/A
- Pod/HU-mates
    - No isolation or prophylactic treatment needed for pod-mates

Double Cell Setting

- Index case
    - Isolated (in OPHU or single cell)
        - If the pt. is being moved to the OPHU necessary precautions during movement (e.g. mask) and kept in negative air flow cell if indicated
    - Treatment based on clinical presentation – don't wait for lab results
    - No pod time x 7 days
    - No movement to other parts of the jail x 7 days
- Close contacts
    - Cellmate to be isolated (single cell)
    - Treated prophylactically
    - No pod time x 7 days
    - No movement to other parts of the jail x 7 days
- Pod/HU-mates
    - Monitor other inmates with direct contact with index case for signs and symptoms
    - No movement to other parts of the jail x 7 days

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Dormitory Setting

- Index case
    - Isolated (in OPHU or single cell)
        - If the pt. is being moved to the OPHU necessary precautions during movement (e.g. mask) and kept in negative air flow cell if indicated
    - Treatment based on clinical presentation – don't wait for lab results
    - No pod time x 7 days
    - No movement to other parts of the jail x 7 days
- Close contacts
    - Interview index case and identify close contacts in pod/bunk mates
    - Strong consideration for isolation
    - Strong consideration for prophylactic treatment
    - Pod time only with other exposed inmates x 7 days
    - No movement to other parts of the jail x 7 days
- Pod/HU-mates
    - Monitor other inmates with direct contact with index case for signs and symptoms
    - Pod time with other un-exposed inmates x 7 days
    - No movement to other parts of the jail x 7 days

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Sporadic and Cluster Outbreak Procedures by Outbreak

Testing, treatment, isolation, and quarantine procedures will vary according to the illness and the type of inmate housing. The following should be filled out at the beginning of the outbreak to guide care.

Sporadic Cases

Single Cell Setting/Solo Rec Time

	Suspected Case	Close Contacts	Other Pod/HU Inmates
Testing			
Medication			
Isolation			
Pod Time			
Quarantine			

Single Cell Setting/Group Rec Time

	Suspected Case	Close Contacts	Other Pod/HU Inmates
Testing			
Medication			
Isolation			
Pod Time			
Quarantine			

Double Cell Setting/Rec Time in Pods

	Suspected Case	Close Contacts	Other Pod/HU Inmates
Testing			
Medication			
Isolation			
Pod Time			
Quarantine			

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Double Cell Setting/Rec Time in Common Area			
	Suspected Case	**Close Contacts**	**Other Pod/HU Inmates**
Testing			
Medication			
Isolation			
Pod Time			
Quarantine			
Dormitory Setting/Rec time in Common Area			
	Suspected Case	**Close Contacts**	**Other Pod/HU Inmates**
Testing			
Medication			
Isolation			
Pod Time			
Quarantine			

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Cluster/Outbreak

Single Cell Setting/Solo Rec Time

	Suspected Case	Close Contacts	Other Pod/HU Inmates
Testing			
Medication			
Isolation			
Pod Time			
Quarantine			

Single Cell Setting/Group Rec Time

	Suspected Case	Close Contacts	Other Pod/HU Inmates
Testing			
Medication			
Isolation			
Pod Time			
Quarantine			

Double Cell Setting/Rec Time in Pods

	Suspected Case	Close Contacts	Other Pod/HU Inmates
Testing			
Medication			
Isolation			
Pod Time			
Quarantine			

Double Cell Setting/Rec Time in Common Area

	Suspected Case	Close Contacts	Other Pod/HU Inmates

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Testing			
Medication			
Isolation			
Pod Time			
Quarantine			

Dormitory Setting/Rec time in Common Area

	Suspected Case	Close Contacts	Other Pod/HU Inmates
Testing			
Medication			
Isolation			
Pod Time			
Quarantine			

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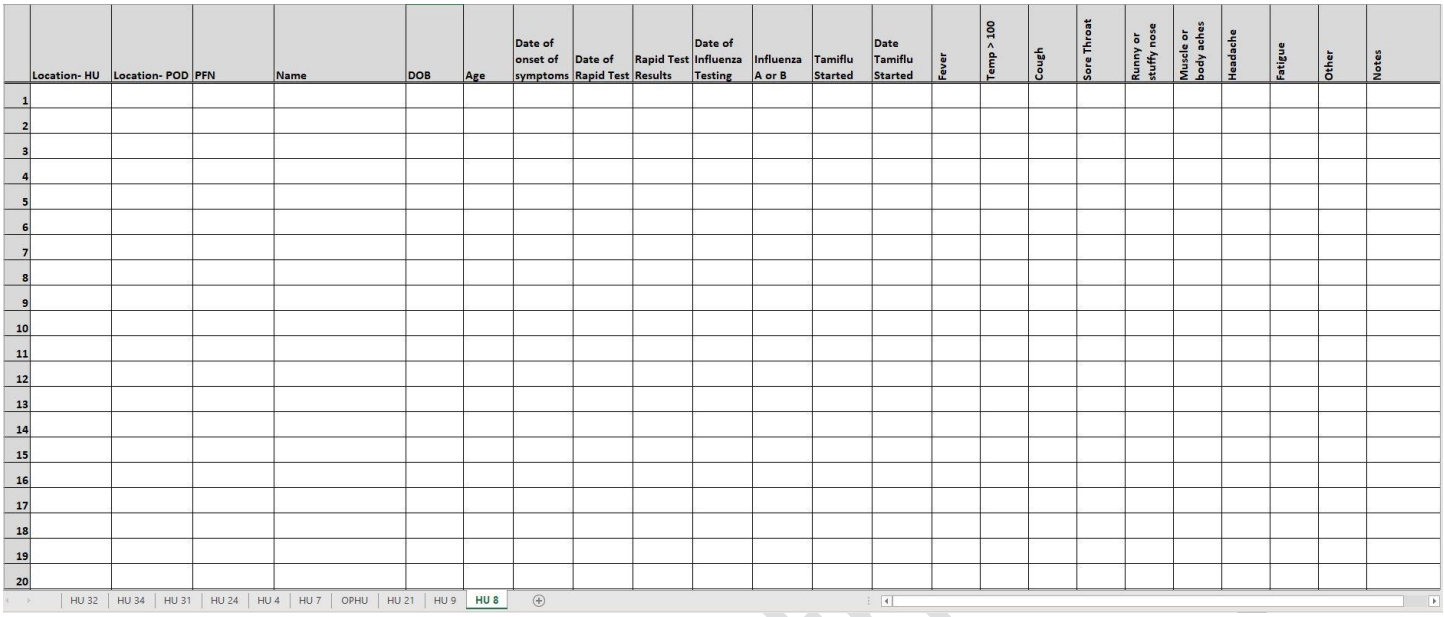
Line List of PUI and/or Confirmed Cases- Inmates



	Location- HU	Location- POD	PFN	Name	DOB	Age	Date of onset of symptoms	Date of Rapid Test	Rapid Test Results	Date of Influenza Testing	Influenza A or B	Tamiflu Started	Date Tamiflu Started	Fever	Temp > 100	Cough	Sore Throat	Runny or stuffy nose	Muscle or body aches	Headache	Fatigue	Other	Notes
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HU 32 | HU 34 | HU 31 | HU 24 | HU 4 | HU 7 | OPHU | HU 21 | HU 9 | HU 8

1. There needs to be two separate line lists kept daily.

2. The Infection Control Nurse is responsible for ensuring the inmate line list is up to date and sent to all applicable parties, daily. The two-line lists are:

    a. The suspected/confirmed case line list is to be updated daily and emailed to DPH at: AcuteCD@acgov.org
    b. The exposed/ unconfirmed case line list needs to be updated daily and emailed to the HSA, AHSA, DON, and Medical Director

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Line List of PUI and/or Confirmed Cases- Employees

	Name of Staff with PUI Contact	Employee Phone Number	Employee Address	Date of Contact	Location of Contact	Date of Quarantine	Date of COVID test	Testing facility	Results of COVID test	Temp >100.4	Cough	SOB	Other	Contact with PUI or confirmed COVID Person	Confirmed COVID Case	Notes
1																
2																
3																
4																
5																
6																
7																
8																
9																

1. There needs to be one employee line list kept daily.

2. The Heath Services Administrator is responsible for ensuring the employee line list is up to date and sent to all applicable parties, daily. The one line list is:

    a. The suspected/confirmed case line list is to be updated daily and emailed to DPH at: AcuteCD@acgov.org
    b. An employee line list needs to be updated daily and emailed to HSA, AHSA, DON, Medical Director, RDO, and RVP

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Employee Phone Number Roster

Name	Cell
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Emergency Staffing Plan

	0% call off	10% call off (multiply base staff x 0.1)	20% call off (multiple base staff x 0.2)	30% call off (multiple base staff x 0.3)	40% call off (multiply base staff x 0.4)	50% call off (multiply base staff x 0.5)
Weekend Staffing all shifts	71 staff	7.1 staff out	14.2 staff out	21.3 staff out	28.4 staff out	35.5 staff out
Weekday Staffing All shifts	106 staff	10.6 staff out	21.2 staff out	31.8 staff out	42.4 staff out	53 staff out
Weekday	Day Shift: Booking RN Infirmary RN Infirmary MD Med Pass LVN Clerk MA Doctor Sick Call RN Mid-level provider Dentist Dental Hygienist Dental Assistant Dietician Perinatal Coordinator MAT Coordinator Discharge Planner Case Manager Quality Assurance Coordinator Infection Control Coordinator OB MD Director of Women's Health Physical Therapist Ortho MD OTP Coordinator Optometry HSA AHSA DON Medical Director AA's PM Shift: Booking RN Infirmary RN	Day Shift: Booking RN Infirmary RN Infirmary MD Med Pass LVN Clerk MA Doctor Sick Call RN Mid-level provider Dentist Dental Hygienist Dental Assistant Dietician Perinatal Coordinator MAT Coordinator Discharge Planner Case Manager Quality Assurance Coordinator Infection Control Coordinator OB MD Director of Women's Health Physical Therapist Ortho MD OTP Coordinator Optometry HSA AHSA DON Medical Director AA's	Day Shift: Booking RN Infirmary RN Infirmary MD Med Pass LVN Clerk MA Doctor Sick Call RN Mid-level provider Dentist Dental Hygienist Dental Assistant Dietician Perinatal Coordinator MAT Coordinator Discharge Planner Case Manager Quality Assurance Coordinator Infection Control Coordinator OB MD Director of Women's Health Physical Therapist Ortho MD OTP Coordinator Optometry HSA AHSA DON	Day Shift: Booking RN Infirmary RN Infirmary MD Med Pass LVN Clerk MA Doctor Sick Call RN Mid-level provider Dentist Dental Hygienist Dental Assistant Dietician Perinatal Coordinator MAT Coordinator Discharge Planner Case Manager Quality Assurance Coordinator Infection Control Coordinator OB MD Director of Women's Health Physical Therapist Ortho MD OTP Coordinator Optometry HSA AHSA DON Medical Director AA's	Day Shift: Booking RN Infirmary RN Infirmary MD Med Pass LVN Clerk MA Doctor Sick Call RN Mid-level provider Dentist Dental Hygienist Dental Assistant Dietician Perinatal Coordinator MAT Coordinator Discharge Planner Case Manager Quality Assurance Coordinator Infection Control Coordinator OB MD Director of Women's Health Physical Therapist Ortho MD OTP Coordinator Optometry HSA AHSA DON Medical Director AA's	Day Shift: Booking RN Infirmary RN Infirmary MD Med Pass LVN Clerk MA Doctor Sick Call RN Mid-level provider Dentist Dental Hygienist Dental Assistant Dietician Perinatal Coordinator MAT Coordinator Discharge Planner Case Manager Quality Assurance Coordinator Infection Control Coordinator OB MD Director of Women's Health Physical Therapist Ortho MD OTP Coordinator Optometry HSA AHSA DON

ASO What If DRAFT

	Director AA's PM Shift: Booking RN Infirmary RN Med pass LVN Clerk Noc Shift: Booking RN Infirmary RN Med pass LVN	Med pass LVN Clerk Noc Shift: Booking RN Infirmary RN Med pass LVN	Medical Director AA's PM Shift: Booking RN Infirmary RN Med pass LVN Clerk Noc Shift: Booking RN Infirmary RN Med pass LVN	PM Shift: Booking RN Infirmary RN Med pass LVN Clerk Noc Shift: Booking RN Infirmary RN Med pass LVN	PM Shift: Booking RN Infirmary RN Med pass LVN Clerk Noc Shift: Booking RN Infirmary RN Med pass LVN	Medical Director AA's PM Shift: Booking RN Infirmary RN Med pass LVN Clerk Noc Shift: Booking RN Infirmary RN Med pass LVN
Weekend	Day Shift: Booking RN Infirmary RN Infirmary MD Med Pass LVN Clerk MA Sick Call RN Mid-level provider PM Shift: Booking RN Infirmary RN Med pass LVN Clerk Noc Shift: Booking RN Infirmary RN Med pass LVN	Day Shift: Booking RN Infirmary RN Infirmary MD Med Pass LVN Clerk MA Sick Call RN Mid-level provider PM Shift: Booking RN Infirmary RN Med pass LVN Clerk Noc Shift: Booking RN Infirmary RN Med pass LVN	Day Shift: Booking RN Infirmary RN Infirmary MD Med Pass LVN Clerk MA Sick Call RN Mid-level provider PM Shift: Booking RN Infirmary RN Med pass LVN Clerk Noc Shift: Booking RN Infirmary RN Med pass LVN	Day Shift: Booking RN Infirmary RN Infirmary MD Med Pass LVN Clerk MA Sick Call RN Mid-level provider PM Shift: Booking RN Infirmary RN Med pass LVN Clerk Noc Shift: Booking RN Infirmary RN Med pass LVN	Day Shift: Booking RN Infirmary RN Infirmary MD Med Pass LVN Clerk MA Sick Call RN Mid-level provider PM Shift: Booking RN Infirmary RN Med pass LVN Clerk Noc Shift: Booking RN Infirmary RN Med pass LVN	Day Shift: Booking RN Infirmary RN Infirmary MD Med Pass LVN Clerk MA Sick Call RN Mid-level provider PM Shift: Booking RN Infirmary RN Med pass LVN Clerk Noc Shift: Booking RN Infirmary RN Med pass LVN
Impact by Custody	N/A	Minimal	At Minimum state standards, decreased access to units and some units will be locked down	No Night movement, no night medication pass, changed mealtime/type, probably full facility lock-down, very limited to no off-site medical appointments / transportation, no visits	All facilities in full lock-down, access to units limited to man downs and absolute essential care	All facilities in full lock-down, access to units limited to man downs and absolute essential care

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Action Plan	Full Services	Absorb, Minimal impact on services, would be similar to weekend/holiday staffing	Admin Assistant may have to take over clerical or Medical Assistant duties.	Consider going to mandatory 12-hour shifts if not done before. Response to emergencies, communicable disease, and chronic disease care will be priority. RN's will be helping with mid-level duties and vice versa.	On 12 hours shifts, mid-level staff assist with nursing duties, response to emergencies, intakes and acute illness is priority. All admin duties stopped, DON providing direct care full time.	12-hour shifts, staff pulled to fill vacancies to cover any position or shift is guaranteed
Medical Services Impact	Full Services	Minimal impact or services, custody/patients should not notice impact	Decreased services: probably stop doing labs and H&P's, but still seeing patients for sick call visits.	Decreased services: will probably have to stop/decrease all treatments, health histories, and routine physical exams, X-rays, limited dental services to priority 1 only, and change majority of inmates to self-medication KOP. Non-essential medications may be removed from medication pass.	Very Limited Services: Only essential medications that cannot be given as self-medication or KOP are passed (life threatening conditions, major infections, debilitating pain, psychosis, etc.) Response to emergent, urgent, acute illness is priority.	Extremely Limited: Only essential medications that cannot be given as self-medication or KOP are passed (life threatening conditions, major infections, debilitating pain, psychosis, etc.) Response to emergent, urgent, acute illness is priority.

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Alameda County- Influenza Guidelines

ALAMEDA COUNTY HEALTH CARE SERVICES AGENCY
PUBLIC HEALTH DEPARTMENT

Colleen Chawla, Director
Kimi Watkins-Tartt, Director
Erica Pan, MD, MPH, Interim County Health Officer

Division of Communicable Disease Control and Prevention
1000 Broadway, Ste 500
Oakland, Ca 94607

Nicholas Moss, MD, MPH, Acting Director
Tel (510) 267-3250
Fax (510) 273-3744

Instructions for Containment activities at Santa Rita Jail

The top priority is to immediately administer influenza antiviral medication (e.g., oseltamivir) to treat active infections and prevent infections in exposed persons who are not yet ill. Inmates and staff with suspected influenza should be treated immediately. Inmates and staff in the affected housing units who do not have influenza symptoms should receive preventive antiviral treatment (chemoprophylaxis). If possible, start chemoprophylaxis for all individuals at the same time to most effectively reduce transmission. See **Antiviral Treatment** and **Antiviral Chemoprophylaxis** sections below

Reporting and communication

- Continue to actively monitor inmates and staff for ILI symptoms
    - The definition of Influenza-like Illness (ILI) is fever (temperature ≥ 100° F or 37.8° C) AND cough and/or sore throat in the absence of a known cause other than influenza
- Record required information about persons with ILI or who have tested positive for influenza on the attached line list form. Fax updated listings daily to Alameda County Public Health Department (ACPHD) at 510-273-3744. An updated line list with all requested information (name, location, date symptoms started, symptoms, etc.) is essential for ACPHD to be able to determine when outbreak control measures may end.
- Provide the names, email addresses, and phone numbers (including afterhours contact information) for key points of contact at WellPath and the Alameda County Sheriff's Office. The Acute Communicable Disease Section is the main point of contact at the Alameda County Public Health Department during business hours, Mon-Fri, 8:30 am to 5 pm (tel. 510-267-3250; fax 510-273-3744; email acutecd@acgov.org). The ACPHD Duty Officer on call is the main point of contact after hours and on weekends and holidays; call Alameda County Fire Dispatch at 925-422-7595 and ask to speak with the Public Health Duty Officer on call.

Antiviral treatment

- Treat all inmates with confirmed influenza or ILI with influenza antiviral medication as soon as possible, ideally within 48 hours of symptom onset
- Do not wait for laboratory test results to initiate treatment

Antiviral chemoprophylaxis for outbreak control

- Provide antiviral chemoprophylaxis to **all** inmates in affected housing units and staff who may have rotated through the affected units since the outbreak was detected
- If the supply of antiviral medication is currently limited, prioritize as follows until additional supply is available:
    1. Cellmates of an inmate with confirmed influenza or ILI
    2. Inmates sleeping within 6 feet of an inmate with confirmed influenza or ILI

3. Pod-mates of an inmate with confirmed influenza or ILI

- Continue antiviral chemoprophylaxis for at least 2 weeks and at least 7 days after the last known case was identified, whichever is longer

Inmate placement and activity management

- Do not place new inmates into or transfer inmates out of affected housing units
- Isolate inmates with symptoms if possible; or group inmates who have influenza symptoms together
- Avoid congregate dining; serve meals in cells/pods
- Inmates from affected housing units should not mix with inmates from unaffected units during activities.
- All activities or classes that require comingling of inmates should be cancelled until the outbreak is contained

Managing inmate court appearances and release

- Inmates from unaffected housing units may be transported per usual procedures
- Inmates from affected housing units may appear in court if the following precautions are taken:
    - If the inmate has **no symptoms:**
        - Inmate wears a surgical mask during transport and in court
        - Accompanying law enforcement personnel provide hand sanitizer for inmate to clean hands when entering and exiting the courtroom
    - If the inmate **has symptoms of influenza**:
        - Reschedule court date until 7 days after the inmate first became ill, or 24 hours after fever or respiratory signs and symptoms are gone, whichever is longer
        - If rescheduling court date is not possible or affects the date of release from custody, the inmate must wear a surgical mask during transport and in court
        - The inmate should be transported in a single vehicle
        - If unable to transport the inmate alone, place a surgical mask on the inmate and maintain physical separation of at least six feet from other inmates on transport vehicle
        - Have accompanying law enforcement personnel provide hand sanitizer for inmate to clean hands when entering and exiting the court room

New Guidance: Managing inmate transfer to San Quentin or other detention facilities

- **Do NOT** transfer any inmates from housing units affected by the influenza outbreak to other facilities or to other units until the outbreak is over
- Inmates scheduled to be transferred should be assessed prior to getting on the bus
    - Assess temperature
    - Assess for symptoms of influenza like illness

- If they have fever or any respiratory symptoms, inmate should not be transferred
- Isolate symptomatic inmate and test for influenza
- Identify which housing unit the symptomatic inmate came from and actively monitor for additional inmates with symptoms while awaiting results of testing
- Report to Alameda County Public Health Department updates on surveillance and testing

- Inmates who are being released and were in affected housing units should be given influenza antiviral treatment. Inmates who had confirmed influenza or ILI should be given enough medication to complete their treatment course. Inmates without symptoms who are at high risk of complications should be given a prescription for 7 days of oseltamivir and advised to seek medical care if they develop fever and cough or sore throat

ACSO

Influenza Signage

INFLUENZA (FLU) Cleaning to Prevent the Flu

Cleaning to Prevent the Flu

How long can the flu virus live on objects, such as doorknobs and tables?

The flu virus can "live" on some surfaces for up to 48 hours. Routine cleaning of surfaces may reduce the spread of flu.

What kills flu viruses?

Flu viruses are killed by heat above 167° F [75° C]. Common household cleaning products can also kill the flu virus, including products containing:

- chlorine
- hydrogen peroxide
- detergents (soap)
- iodophors (iodine-based antiseptics)
- alcohols

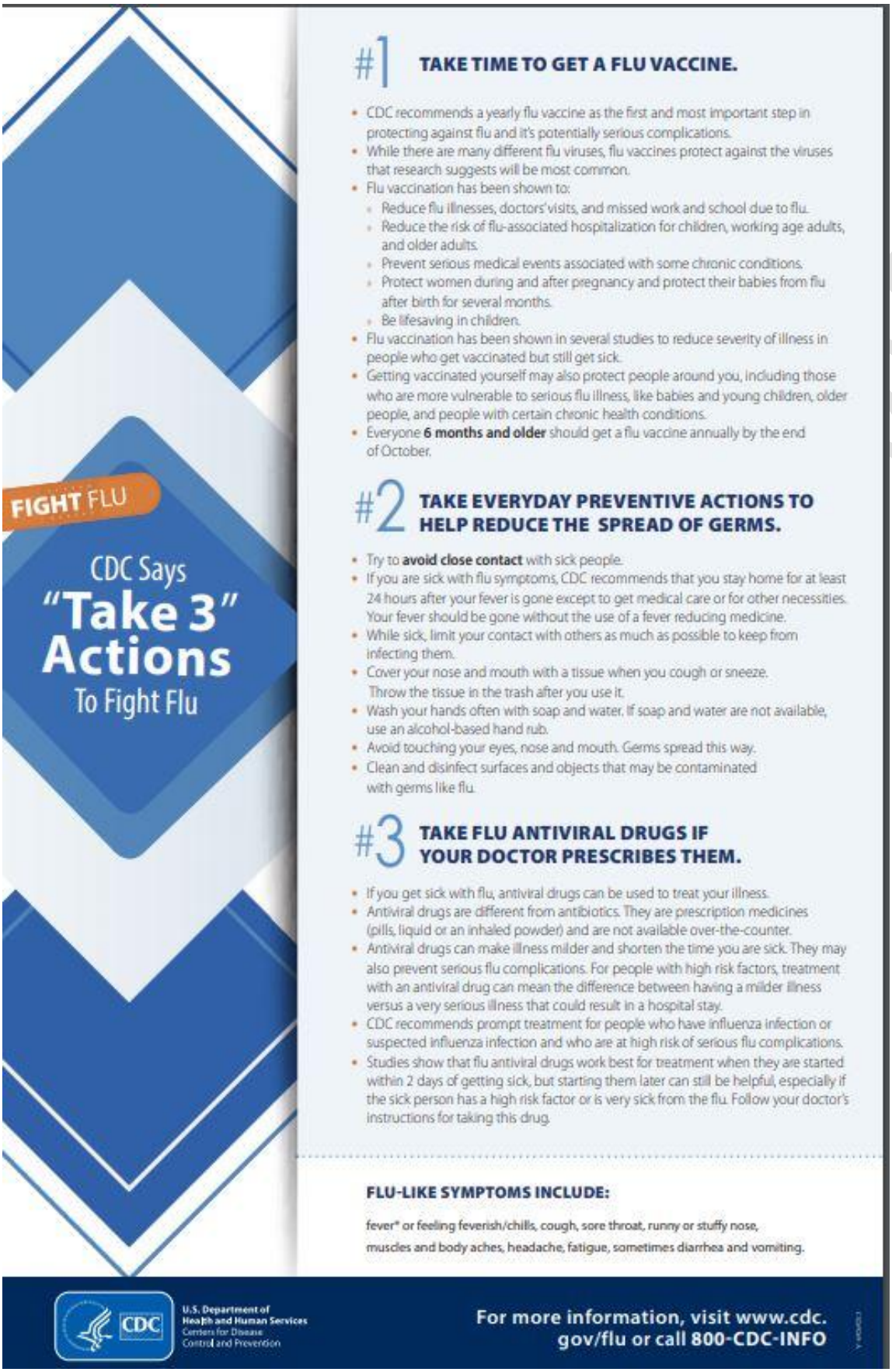
How should a caregiver handle a sick person's tissues or other items?

Make sure to wash your hands after touching the sick person. Also wash after handling their tissues or laundry.

For more information call CDC info at 1-800-CDC-INFO (232-4636) or go to www.cdc.gov/flu.

U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

CS 290778-A/2018


FIGHT FLU
CDC Says
"Take 3" Actions
To Fight Flu
#1 TAKE TIME TO GET A FLU VACCINE.
• CDC recommends a yearly flu vaccine as the first and most important step in protecting against flu and it's potentially serious complications.
• While there are many different flu viruses, flu vaccines protect against the viruses that research suggests will be most common.
• Flu vaccination has been shown to:
◦ Reduce flu illnesses, doctors' visits, and missed work and school due to flu.
◦ Reduce the risk of flu-associated hospitalization for children, working age adults, and older adults.
◦ Prevent serious medical events associated with some chronic conditions.
◦ Protect women during and after pregnancy and protect their babies from flu after birth for several months.
◦ Be lifesaving in children.
• Flu vaccination has been shown in several studies to reduce severity of illness in people who get vaccinated but still get sick.
• Getting vaccinated yourself may also protect people around you, including those who are more vulnerable to serious flu illness, like babies and young children, older people, and people with certain chronic health conditions.
• Everyone 6 months and older should get a flu vaccine annually by the end of October.
#2 TAKE EVERYDAY PREVENTIVE ACTIONS TO HELP REDUCE THE SPREAD OF GERMS.
• Try to avoid close contact with sick people.
• If you are sick with flu symptoms, CDC recommends that you stay home for at least 24 hours after your fever is gone except to get medical care or for other necessities. Your fever should be gone without the use of a fever reducing medicine.
• While sick, limit your contact with others as much as possible to keep from infecting them.
• Cover your nose and mouth with a tissue when you cough or sneeze. Throw the tissue in the trash after you use it.
• Wash your hands often with soap and water. If soap and water are not available, use an alcohol-based hand rub.
• Avoid touching your eyes, nose and mouth. Germs spread this way.
• Clean and disinfect surfaces and objects that may be contaminated with germs like flu.
#3 TAKE FLU ANTIVIRAL DRUGS IF YOUR DOCTOR PRESCRIBES THEM.
• If you get sick with flu, antiviral drugs can be used to treat your illness.
• Antiviral drugs are different from antibiotics. They are prescription medicines (pills, liquid or an inhaled powder) and are not available over-the-counter.
• Antiviral drugs can make illness milder and shorten the time you are sick. They may also prevent serious flu complications. For people with high risk factors, treatment with an antiviral drug can mean the difference between having a milder illness versus a very serious illness that could result in a hospital stay.
• CDC recommends prompt treatment for people who have influenza infection or suspected influenza infection and who are at high risk of serious flu complications.
• Studies show that flu antiviral drugs work best for treatment when they are started within 2 days of getting sick, but starting them later can still be helpful, especially if the sick person has a high risk factor or is very sick from the flu. Follow your doctor's instructions for taking this drug.
FLU-LIKE SYMPTOMS INCLUDE:
fever* or feeling feverish/chills, cough, sore throat, runny or stuffy nose, muscles and body aches, headache, fatigue, sometimes diarrhea and vomiting.
CDC
U.S. Department of Health and Human Services
Centers for Disease Control and Prevention
For more information, visit www.cdc.gov/flu or call 800-CDC-INFO

DRAFT

Interim Infection Prevention and Control Recommendations for Patients with Confirmed Coronavirus Disease 2019 (COVID-19) or Persons Under Investigation for COVID-19 in Healthcare Settings

1. Minimize Chance for Exposures

Ensure facility policies and practices are in place to minimize exposures to respiratory pathogens including SARS-CoV-2, the virus that causes COVID-19. Measures should be implemented before patient arrival, upon arrival, and throughout the duration of the affected patient's presence in the healthcare setting.

- **Before Arrival**
  - When scheduling appointments, instruct patients and persons who accompany them to call ahead or inform HCP upon arrival if they have symptoms of any respiratory infection (e.g., cough, runny nose, fever[1]) and to take appropriate preventive actions (e.g., wear a facemask upon entry to contain cough, follow triage procedures).
  - If a patient is arriving via transport by emergency medical services (EMS), the driver should contact the receiving emergency department (ED) or healthcare facility and follow previously agreed upon local or regional transport protocols. This will allow the healthcare facility to prepare for receipt of the patient.
- **Upon Arrival and During the Visit**
  - Take steps to ensure all persons with symptoms of suspected COVID-19 or other respiratory infection (e.g., fever, cough) adhere to respiratory hygiene and cough etiquette, hand hygiene, and triage procedures throughout the duration of the visit. Consider posting visual alerts (e.g., signs, posters) at the entrance and in strategic places (e.g., waiting areas, elevators, cafeterias) to provide patients and HCP with instructions (in appropriate languages) about hand hygiene, respiratory hygiene, and cough etiquette. Instructions should include how to use facemasks (See definition of facemask in Appendix) or tissues to cover nose and mouth when coughing or sneezing, to dispose of tissues and contaminated items in waste receptacles, and how and when to perform hand hygiene.
  - Ensure that patients with symptoms of suspected COVID-19 or other respiratory infection (e.g., fever, cough) are not allowed to wait among other patients seeking care. Identify a separate, well-ventilated space that allows waiting patients to be separated by 6 or more feet, with easy access to respiratory hygiene supplies. In some settings, medically-stable patients might opt to wait in

a personal vehicle or outside the healthcare facility where they can be contacted by mobile phone when it is their turn to be evaluated.

- Ensure rapid triage and isolation of patients with symptoms of suspected COVID-19 or other respiratory infection (e.g., fever, cough):
  - Identify patients at risk for having COVID-19 infection before or immediately upon arrival to the healthcare facility.
    - Implement triage procedures to detect persons under investigation (PUI) for COVID-19 during or before patient triage or registration (e.g., at the time of patient check-in) and ensure that all patients are asked about the presence of symptoms of a respiratory infection and history of travel to areas experiencing transmission of SARS-CoV-2, the virus that causes COVID-19, or contact with possible COVID-19 patients.
  - Implement respiratory hygiene and cough etiquette (i.e., placing a facemask over the patient's nose and mouth if that has not already been done) and isolate the PUI for COVID-19 in an Airborne Infection Isolation Room (AIIR), if available.
    - See recommendations for "Patient Placement" below. Additional guidance for evaluating patients in U.S. for COVID-19 infection can be found on the CDC COVID-19 website.
  - Inform infection prevention and control services, local and state public health authorities, and other healthcare facility staff as appropriate about the presence of a person under investigation for COVID-19.
- Provide supplies for respiratory hygiene and cough etiquette, including 60%-95% alcohol-based hand sanitizer (ABHS), tissues, no touch receptacles for disposal, and facemasks at healthcare facility entrances, waiting rooms, patient check-ins, etc.

2. Adherence to Standard, Contact, and Airborne Precautions, Including the Use of Eye Protection

Standard Precautions assume that every person is potentially infected or colonized with a pathogen that could be transmitted in the healthcare setting. Elements of Standard Precautions that apply to patients with respiratory infections, including those caused by COVID-19, are summarized below. Attention should be paid to training on correct use, proper donning (putting on) and doffing (taking off), and disposal of any PPE.

This document does not emphasize all aspects of Standard Precautions (e.g., injection safety) that are required for all patient care; the full description is provided in the Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings. All HCP (see section 3 for measures for non-HCP visitors) who enter the room of a patient with

known or suspected COVID-19 (i.e., PUI) should adhere to Standard, Contact, and Airborne Precautions, including the following:

- **Patient Placement**
  - Place a patient with known or suspected COVID-19 (i.e., PUI) in an AIIR that has been constructed and maintained in accordance with current guidelines.
    - AIIRs are single patient rooms at negative pressure relative to the surrounding areas, and with a minimum of 6 air changes per hour (12 air changes per hour are recommended for new construction or renovation). Air from these rooms should be exhausted directly to the outside or be filtered through a high-efficiency particulate air (HEPA) filter before recirculation. Room doors should be kept closed except when entering or leaving the room, and entry and exit should be minimized. Facilities should monitor and document the proper negative-pressure function of these rooms.
    - If an AIIR is not available, patients who require hospitalization should be transferred as soon as is feasible to a facility where an AIIR is available. If the patient does not require hospitalization they can be discharged to home (in consultation with state or local public health authorities) if deemed medically and socially appropriate. Pending transfer or discharge, place a facemask on the patient and isolate him/her in an examination room with the door closed. Ideally, the patient should not be placed in any room where room exhaust is recirculated within the building without HEPA filtration.
  - Once in an AIIR, the patient's facemask may be removed. Limit transport and movement of the patient outside of the AIIR to medically-essential purposes. When not in an AIIR (e.g., during transport or if an AIIR is not available), patients should wear a facemask to contain secretions.
  - Personnel entering the room should use PPE, including respiratory protection, as described below.
  - Only essential personnel should enter the room. Implement staffing policies to minimize the number of HCP who enter the room.
    - Facilities should consider caring for these patients with dedicated HCP to minimize risk of transmission and exposure to other patients and other HCP.
  - Facilities should keep a log of all persons who care for or enter the rooms or care area of these patients.
  - Use dedicated or disposable noncritical patient-care equipment (e.g., blood pressure cuffs). If equipment will be used for more than one patient, clean and

disinfect such equipment before use on another patient according to manufacturer's instructions.

- HCP entering the room soon after a patient vacates the room should use respiratory protection. (See personal protective equipment section below) Standard practice for pathogens spread by the airborne route (e.g., measles, tuberculosis) is to restrict unprotected individuals, including HCP, from entering a vacated room until sufficient time has elapsed for enough air changes to remove potentially infectious particles (more information on clearance rates under differing ventilation conditions is available). We do not yet know how long COVID-19 remains infectious in the air. In the interim, it is reasonable to apply a similar time period before entering the room without respiratory protection as used for pathogens spread by the airborne route (e.g., measles, tuberculosis). In addition, the room should undergo appropriate cleaning and surface disinfection before it is returned to routine use.

- **Hand Hygiene**
  - HCP should perform hand hygiene using ABHS before and after all patient contact, contact with potentially infectious material, and before putting on and upon removal of PPE, including gloves. Hand hygiene in healthcare settings also can be performed by washing with soap and water for at least 20 seconds. If hands are visibly soiled, use soap and water before returning to ABHS.
  - Healthcare facilities should ensure that hand hygiene supplies are readily available in every care location.
- **Personal Protective Equipment**
  Employers should select appropriate PPE and provide it to HCP in accordance with OSHA's PPE standards (29 CFR 1910 Subpart I)external icon. HCP must receive training on and demonstrate an understanding of when to use PPE; what PPE is necessary; how to properly don, use, and doffpdf icon PPE in a manner to prevent self-contamination; how to properly dispose of or disinfect and maintain PPE; and the limitations of PPE. Any reusable PPE must be properly cleaned, decontaminated, and maintained after and between uses. Facilities should have policies and procedures describing a recommended sequence for safely donning and doffing PPE:
  - **Gloves**
    - Perform hand hygiene, then put on clean, non-sterile gloves upon entry into the patient room or care area. Change gloves if they become torn or heavily contaminated.
    - Remove and discard gloves when leaving the patient room or care area, and immediately perform hand hygiene.
  - **Gowns**

        - Put on a clean isolation gown upon entry into the patient room or area. Change the gown if it becomes soiled. Remove and discard the gown in a dedicated container for waste or linen before leaving the patient room or care area. Disposable gowns should be discarded after use. Cloth gowns should be laundered after each use.
    - **Respiratory Protection**
        - Use respiratory protection (i.e., a respirator) that is at least as protective as a fit-tested NIOSH-certified disposable N95 filtering facepiece respirator before entry into the patient room or care area. See appendix for respirator definition.
        - Disposable respirators should be removed and discarded after exiting the patient's room or care area and closing the door. Perform hand hygiene after discarding the respirator.
        - If reusable respirators (e.g., powered air purifying respirator/PAPR) are used, they must be cleaned and disinfected according to manufacturer's reprocessing instructions prior to re-use.
        - Respirator use must be in the context of a complete respiratory protection program in accordance with Occupational Safety and Health Administration (OSHA) Respiratory Protection standard (29 CFR 1910.134external icon). Staff should be medically cleared and fit-tested if using respirators with tight-fitting facepieces (e.g., a NIOSH-certified disposable N95) and trained in the proper use of respirators, safe removal and disposal, and medical contraindications to respirator use.
    - **Eye Protection**
        - Put on eye protection (e.g., goggles, a disposable face shield that covers the front and sides of the face) upon entry to the patient room or care area. Remove eye protection before leaving the patient room or care area. Reusable eye protection (e.g., goggles) must be cleaned and disinfected according to manufacturer's reprocessing instructions prior to re-use. Disposable eye protection should be discarded after use.
- **Use Caution When Performing Aerosol-Generating Procedures**
    - Some procedures performed on COVID-19 patients could generate infectious aerosols. In particular, procedures that are likely to induce coughing (e.g., sputum induction, open suctioning of airways) should be performed cautiously and avoided if possible.
    - If performed, these procedures should take place in an AIIR and personnel should use respiratory protection as described above. In addition:
        - Limit the number of HCP present during the procedure to only those essential for patient care and procedural support.

        - Clean and disinfect procedure room surfaces promptly as described in the section on environmental infection control below.
- **Diagnostic Respiratory Specimen Collection**
    - Collecting diagnostic respiratory specimens (e.g., nasopharyngeal swab) are likely to induce coughing or sneezing. Individuals in the room during the procedure should, ideally, be limited to the patient and the healthcare provider obtaining the specimen.
    - HCP collecting specimens for testing for SARS-CoV-2, the virus that causes COVID-19, from patients with known or suspected COVID-19 (i.e., PUI) should adhere to Standard, Contact, and Airborne Precautions, including the use of eye protection.
    - These procedures should take place in an AIIR or in an examination room with the door closed. Ideally, the patient should not be placed in any room where room exhaust is recirculated within the building without HEPA filtration.
- **Duration of Isolation Precautions for PUIs and confirmed COVID-19 patients**
    - Until information is available regarding viral shedding after clinical improvement, discontinuation of isolation precautions should be determined on a case-by-case basis, in conjunction with local, state, and federal health authorities.
    - Factors that should be considered include: presence of symptoms related to COVID-19 infection, date symptoms resolved, other conditions that would require specific precautions (e.g., tuberculosis, *Clostridioides difficile),* other laboratory information reflecting clinical status, alternatives to inpatient isolation, such as the possibility of safe recovery at home.
    - For additional information refer to the Interim Considerations for Disposition of Hospitalized Patients with COVID-19.

3. Manage Visitor Access and Movement Within the Facility

- Establish procedures for monitoring, managing and training visitors.
- Restrict visitors from entering the room of known or suspected COVID-19 patients (i.e., PUI). Alternative mechanisms for patient and visitor interactions, such as video-call applications on cell phones or tablets should be explored. Facilities can consider exceptions based on end-of-life situations or when a visitor is essential for the patient's emotional well-being and care.
- Visitors to patients with known or suspected COVID-19 (i.e., PUI) should be scheduled and controlled to allow for:
    - Screening visitors for symptoms of acute respiratory illness before entering the healthcare facility.

- Facilities should evaluate risk to the health of the visitor (e.g., visitor might have underlying illness putting them at higher risk for COVID-19) and ability to comply with precautions.
- Facilities should provide instruction, before visitors enter patients' rooms, on hand hygiene, limiting surfaces touched, and use of PPE according to current facility policy while in the patient's room.
- Facilities should maintain a record (e.g., log book) of all visitors who enter patient rooms.
- Visitors should not be present during aerosol-generating procedures.
- Visitors should be instructed to limit their movement within the facility.
- Exposed visitors (e.g., contact with COVID-19 patient prior to admission) should be advised to report any signs and symptoms of acute illness to their health care provider for a period of at least 14 days after the last known exposure to the sick patient.

- All visitors should follow respiratory hygiene and cough etiquette precautions while in the common areas of the facility.

4. Implement Engineering Controls

- Consider designing and installing engineering controls to reduce or eliminate exposures by shielding HCP and other patients from infected individuals. Examples of engineering controls include physical barriers or partitions to guide patients through triage areas, curtains between patients in shared areas, closed suctioning systems for airway suctioning for intubated patients, as well as appropriate air-handling systems (with appropriate directionality, filtration, exchange rate, etc.) that are installed and properly maintained.

5. Monitor and Manage Ill and Exposed Healthcare Personnel

- Movement and monitoring decisions for HCP with exposure to COVID-19 should be made in consultation with public health authorities. Refer to the Interim U.S. Guidance for Risk Assessment and Public Health Management of Healthcare Personnel with Potential Exposure in a Healthcare Setting to Patients with Coronavirus Disease 2019 (COVID-19) for additional information.
- Facilities and organizations providing healthcare should implement sick leave policies for HCP that are non-punitive, flexible, and consistent with public health guidance.

6. Train and Educate Healthcare Personnel

- Provide HCP with job- or task-specific education and training on preventing transmission of infectious agents, including refresher training.
- HCP must be medically cleared, trained, and fit tested for respiratory protection device use (e.g., N95 filtering facepiece respirators), or medically cleared and trained in the use of an alternative respiratory protection device (e.g., Powered Air-Purifying Respirator, PAPR) whenever respirators are required. OSHA has a number of respiratory training videosexternal icon.
- Ensure that HCP are educated, trained, and have practiced the appropriate use of PPE prior to caring for a patient, including attention to correct use of PPE and prevention of contamination of clothing, skin, and environment during the process of removing such equipment.

7. Implement Environmental Infection Control

- Dedicated medical equipment should be used for patient care.
- All non-dedicated, non-disposable medical equipment used for patient care should be cleaned and disinfected according to manufacturer's instructions and facility policies.
- Ensure that environmental cleaning and disinfection procedures are followed consistently and correctly.
- Routine cleaning and disinfection procedures (e.g., using cleaners and water to pre-clean surfaces prior to applying an EPA-registered, hospital-grade disinfectant to frequently touched surfaces or objects for appropriate contact times as indicated on the product's label) are appropriate for COVID-19 in healthcare settings, including those patient-care areas in which aerosol-generating procedures are performed. Products with EPA-approved emerging viral pathogens claims are recommended for use against COVID-19. These products can be identified by the following claim:
    - "[Product name] has demonstrated effectiveness against viruses similar to COVID-19 on hard non-porous surfaces. Therefore, this product can be used against COVID-19 when used in accordance with the directions for use against [name of supporting virus] on hard, non-porous surfaces."
    - This claim or a similar claim, will be made only through the following communications outlets: technical literature distributed exclusively to health care facilities, physicians, nurses and public health officials, "1-800" consumer information services, social media sites and company websites (non-label related). Specific claims for "COVID-19" will not appear on the product or master label.
    - See additional information about EPA-approved emerging viral pathogens claimsexternal icon.

    - If there are no available EPA-registered products that have an approved emerging viral pathogen claim for COVID-19, products with label claims against human coronaviruses should be used according to label instructions.
- Management of laundry, food service utensils, and medical waste should also be performed in accordance with routine procedures.
- Detailed information on environmental infection control in healthcare settings can be found in CDC's Guidelines for Environmental Infection Control in Health-Care Facilities and Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings [section IV.F. Care of the environment].

8. Establish Reporting within Healthcare Facilities and to Public Health Authorities

- Implement mechanisms and policies that promptly alert key facility staff including infection control, healthcare epidemiology, facility leadership, occupational health, clinical laboratory, and frontline staff about known or suspected COVID-19 patients (i.e., PUI).
- Communicate and collaborate with public health authorities.
    - Promptly notify state or local public health authorities of patients with known or suspected COVID-19 (i.e., PUI). Facilities should designate specific persons within the healthcare facility who are responsible for communication with public health officials and dissemination of information to HCP.

Appendix: Additional Information about Respirators and Facemasks:
Information about Respirators:

- A respirator is a personal protective device that is worn on the face, covers at least the nose and mouth, and is used to reduce the wearer's risk of inhaling hazardous airborne particles (including dust particles and infectious agents), gases, or vapors. Respirators are certified by the CDC/NIOSH, including those intended for use in healthcare.
- Respirator use must be in the context of a complete respiratory protection program in accordance with OSHA Respiratory Protection standard (29 CFR 1910.134external icon). HCP should be medically cleared and fit-tested if using respirators with tight-fitting facepieces (e.g., a NIOSH-approved N95 respirator) and trained in the proper use of respirators, safe removal and disposal, and medical contraindications to respirator use.
- NIOSH information about respirators
- OSHA Respiratory Protection eToolexternal icon

Filtering Facepiece Respirators (FFR) including N95 Respirators

- A commonly used respirator is a filtering facepiece respirator (commonly referred to as an N95). Filtering facepiece respirators are disposable half facepiece respirators that filter out particles.
- To work properly, FFRs must be worn throughout the period of exposure and be specially fitted for each person who wears one (this is called "fit-testing" and is usually done in a workplace where respirators are used).
- Three key factors for an N95 respirator to be effectivepdf icon
- FFR users should also perform a user seal check to ensure proper fit each time an FFR is used.
- More information on how to perform a user seal checkpdf icon

See a list of NIOSH-approved N95 respirators

Powered Air-Purifying Respirators (PAPRs)

- Powered air-purifying respirators (PAPRs) have a battery-powered blower that pulls air through attached filters, canisters, or cartridges. They provide protection against gases, vapors, or particles, when equipped with the appropriate cartridge, canister, or filter.
- Loose-fitting PAPRs do not require fit testing and can be used with facial hair.
- A list of NIOSH-approved PAPRs is located on the NIOSH Certified Equipment List

Information about Facemasks:

- If worn properly, a facemask helps block respiratory secretions produced by the wearer from contaminating other persons and surfaces (often called source control).
- Facemasks are cleared by the U.S. Food and Drug Administration (FDA) for use as medical devices. Facemasks should be used once and then thrown away in the trash.

Interim Guidance for Healthcare Facilities: Preparing for Community Transmission of COVID-19 in the United States

Key Considerations for Healthcare Facilities:

Currently there are no medications to treat or vaccines to prevent COVID-19. Therefore, community approaches to slowing transmission including appropriate hand hygiene, cough etiquette, social distancing, and reducing face-to-face contact with potential COVID-19 cases are needed to slow disease transmission and reduce the number of people who get sick. In each healthcare facility, the primary goals include:

- Provision of the appropriate level of medical care
- Protecting healthcare personnel and non-COVID-19 patients accessing healthcare from infection
- Preparing for a potential surge in patients with respiratory infection
- Preparing for potential personal protective equipment supply and staff shortages

Purpose of this document: This interim guidance outlines goals and strategies for all U.S. healthcare facilities to prepare for and respond to community spread of coronavirus disease-2019 (COVID-19). Although it is not possible to predict the future course of the outbreak, planning for a scenario in which many persons become ill and seek care at the same time is an important part of preparedness and can improve outcomes if an outbreak occurs. Therefore, preserving healthcare system functioning is paramount. It is critical for healthcare facilities to continue to provide care for all patients, irrespective of COVID-19 infection status, at the appropriate level (e.g., home-based care, outpatient, urgent care, emergency room, or hospitalization). Facilities may need to respond to a surge in patients requiring care. Concentrated efforts will be required to mobilize all aspects of healthcare to reduce transmission of disease, direct people to the right level of care, and decrease the burden on the healthcare system.

Public health guidance will shift as the COVID-19 outbreak evolves. All healthcare facilities should be aware of any updates to local and state public health recommendations.

Key Goals for the U.S. healthcare system in response to the COVID-19 outbreak are to:

1. Reduce morbidity and mortality
2. Minimize disease transmission
3. Protect healthcare personnel
4. Preserve healthcare system functioning

Actions to take now to prepare for an outbreak of COVID-19

1. Designate a time to meet with your staff to educate them on COVID-19 and what they may need to do to prepare. The following may be useful resources to share information about COVID-19:
    - How COVID-19 spreads
    - Clinical management of COVID-19 patients
    - Infection prevention and control recommendations for COVID-19

2. Explore alternatives to face-to-face triage and visits. The following options can reduce unnecessary healthcare visits and prevent transmission of respiratory viruses in your facility:
    - Instruct patients to use available advice lines, patient portals, on-line self-assessment tools, or call and speak to an office/clinic staff if they become ill with symptoms such as fever, cough, or shortness of breath.
    - Identify staff to conduct telephonic and telehealth interactions with patients. Develop protocols so that staff can triage and assess patients quickly.
    - Determine algorithms to identify which patients can be managed by telephone and advised to stay home, and which patients will need to be sent for emergency care or come to your facility.
    - Instruct patients that if they have respiratory symptoms they should call before they leave home, so staff can be prepared to care for them when they arrive.

3. Plan to optimize your facility's supply of personal protective equipment in the event of shortages. Identify flexible mechanisms to procure additional supplies when needed.
4. Prepare your facility to safely triage and manage patients with respiratory illness, including COVID-19. Become familiar with infection prevention and control guidance for managing COVID-19 patients.
    - Visual alerts (signs, posters) at entrances and in strategic places providing instruction on hand hygiene, respiratory hygiene, and cough etiquette
    - Ensure supplies are available (tissues, waste receptacles, alcohol-based hand sanitizer)
    - Facemasks are available at triage for patients with respiratory symptoms
    - Create an area for spatially separating patients with respiratory symptoms. Ideally patients would be >6 feet apart in waiting areas.

Plan to Take the Following Actions if COVID-19 is spreading in your community

1. Work with local and state public health organizations, healthcare coalitions, and other local partners to understand the impact and spread of the outbreak in your area.

2. Designate staff who will be responsible for caring for suspected or known COVID-19 patients. Ensure they are trained on the infection prevention and control recommendations for COVID-19 and proper use of personal protective equipment.
3. Monitor healthcare workers and ensure maintenance of essential healthcare facility staff and operations:
    - Ensure staff are aware of sick leave policies and are encouraged to stay home if they are ill with respiratory symptoms.
    - Be aware of recommended work restrictions and monitoring based on staff exposure to COVID-19 patients.
    - Advise employees to check for any signs of illness before reporting to work each day and notify their supervisor if they become ill.
    - Do not require a healthcare provider's note for employees who are sick with respiratory symptoms before returning to work.
    - In settings of widespread transmission, your facility may consider screening staff for fever or respiratory symptoms before entering the facility.
    - Make contingency plans for increased absenteeism caused by employee illness or illness in employees' family members that would require them to stay home. Planning for absenteeism could include extending hours, cross-training current employees, or hiring temporary employees.

4. When possible, manage mildly ill COVID-19 patients at home.
    - Assess the patient's ability to engage in home monitoring, the ability for safe isolation at home, and the risk of transmission in the patient's home environment.
    - Caregivers and sick persons should have clear instructions regarding home care and when and how to access the healthcare system for face-to-face care or urgent/emergency conditions.
    - If possible, identify staff who can monitor those patients at home with daily "check-ins" using telephone calls, text, patient portals or other means.
    - Engage local public health, home health services, and community organizations to assist with support services (such as delivery of food, medication and other goods) for those treated at home.

Considerations for specific settings (In addition to above)

1. **Outpatient facilities**
    - Reschedule non-urgent outpatient visits as necessary.
    - Consider reaching out to patients who may be a higher risk of COVID-19-related complications (e.g., elderly, those with medical co-morbidities, and potentially

other persons who are at higher risk for complications from respiratory diseases, such as pregnant women) to ensure adherence to current medications and therapeutic regimens, confirm they have sufficient medication refills, and provide instructions to notify their provider by phone if they become ill.
    - Consider accelerating the timing of high priority screening and intervention needs for the short-term, in anticipation of the possible need to manage an influx of COVID-19 patients in the weeks to come.
    - Symptomatic patients who need to be seen in a clinical setting should be asked to call before they leave home, so staff are ready to receive them using appropriate infection control practices and personal protective equipment.
    - Eliminate patient penalties for cancellations and missed appointments related to respiratory illness.

2. **Inpatient facilities**
    - Reschedule elective surgeries as necessary.
    - Shift elective urgent inpatient diagnostic and surgical procedures to outpatient settings, when feasible.
    - Limit visitors to COVID-19 patients.
    - Plan for a surge of critically ill patients and identify additional space to care for these patients. Include options for:
        - Using alternate and separate spaces in the ER, ICUs, and other patient care areas to manage known or suspected COVID-19 patients.
        - Separating known or suspected COVID-19 patients from other patients ("cohorting").
        - Identifying dedicated staff to care for COVID-19 patients.

3. **Long term care facilities**
    - Limit visitors to the facility
    - Post visual alerts (signs, posters) at entrances and in strategic places providing instruction on hand hygiene, respiratory hygiene, and cough etiquette
    - Ensure supplies are available (tissues, waste receptacles, alcohol-based hand sanitizer)
    - Take steps to prevent known or suspected COVID-19 patients from exposing other patients
    - Limit the movement of COVID-19 patients (e.g., have them remain in their room)
    - Identify dedicated staff to care for COVID-19 patients.
    - Observe newly arriving patients/residents for development of respiratory symptoms.

Shifting Healthcare Delivery Modes during a COVID-19 Outbreak in the United States

Several major impacts can be anticipated during a severe outbreak that could affect the operations of healthcare facilities. These include surges in patients seeking care, the potential for workforce absenteeism from personal or family illness, and effects from social distancing measures such as school closures. Healthcare facilities will likely need to adjust the way they triage, assess and care for patients using methods that do not rely on face-to-face care.

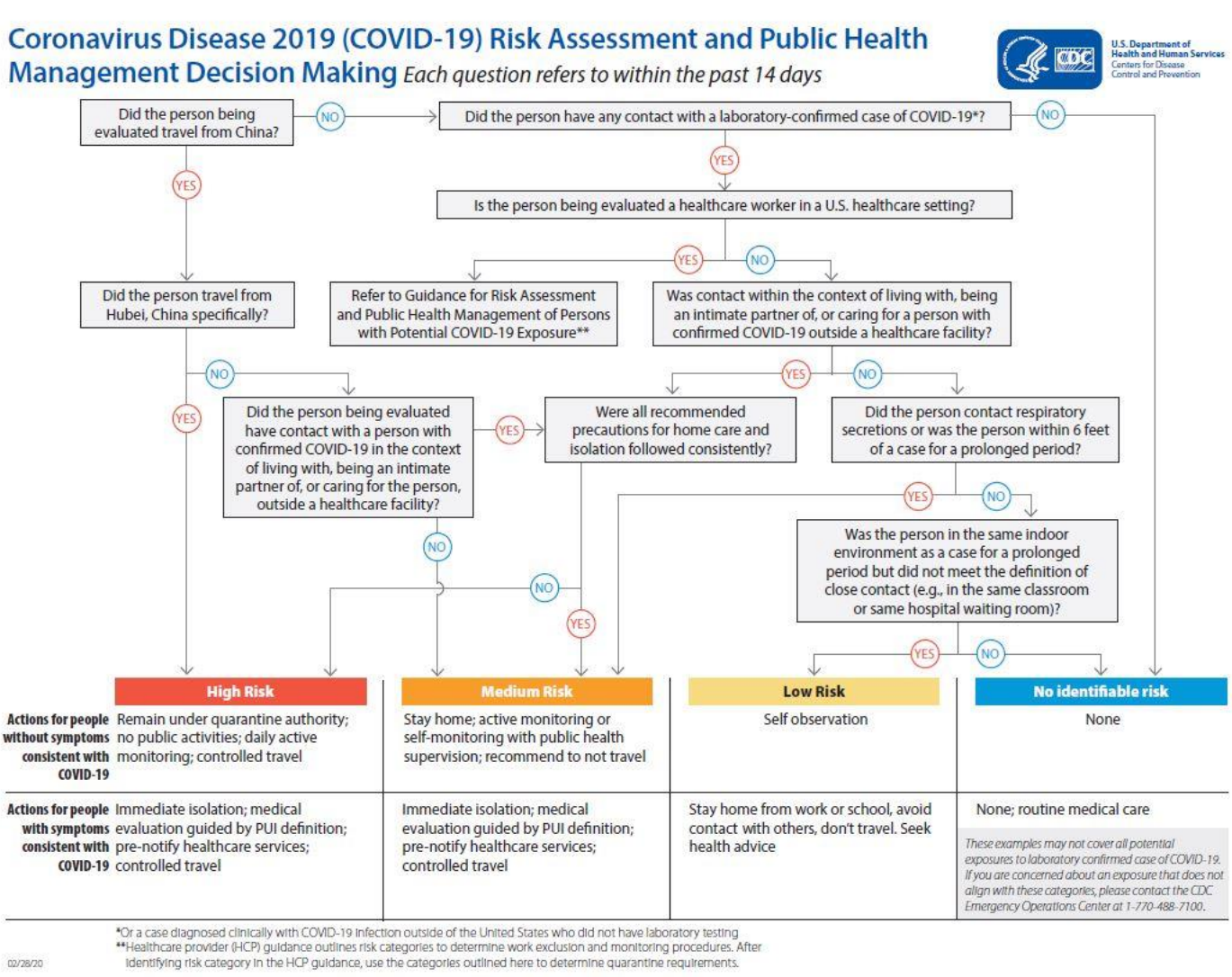
Shifting practices to triaging and assessing ill patients (including those affected by COVID-19 and patients with other conditions) remotely using nurse advice lines, provider "visits" by telephone, text monitoring system, video conference, or other telehealth and telemedicine methods can reduce exposure of ill persons with staff and minimize surge on facilities. Many clinics and medical offices already use these methods to triage and manage patients after hours and as part of usual practices. Recent reports suggest that approximately 80% of COVID-19 patients (of all ages) have experienced mild illness[i]. Managing persons at home who are ill with mild disease can reduce the strain on healthcare systems—however, these patients will need careful triage and monitoring.

Promoting the increased use of telehealth

- Healthcare facilities can increase the use of telephone management and other remote methods of triaging, assessing and caring for all patients to decrease the volume of persons seeking care in facilities.
- If a formal "telehealth" system is not available, healthcare providers can still communicate with patients by telephone (instead of visits), reducing the number of those who seek face-to-face care.
- Health plans, healthcare systems and insurers/payors should message beneficiaries to promote the availability of covered telehealth, telemedicine, or nurse advice line services

Shifts in the way that healthcare is delivered during a COVID-19 outbreak response will be complex. Thorough and consistent communications between all components of the public health and healthcare system will be needed in every community. For example, providers in medical offices, clinics, and other outpatient settings must be informed and know their roles. Pre-hospital care by emergency management services (EMS) and public-safety answering points (PSAPs) will also need to be aware of any altered transport guidance so they can conduct in-home assessments and triage per local guidance.

DPH Risk Assessment Management Decision Making



Person Under Investigation (PUI) Form

CDC 2019-nCoV ID: _____ Form Approved: OMB: 0920-1011 Exp. 4/23/2020

.....PATIENT IDENTIFIER INFORMATION IS NOT TRANSMITTED TO CDC.....

Patient first name _____ Patient last name _____ Date of birth (MM/DD/YYYY): ___/___/___

.....PATIENT IDENTIFIER INFORMATION IS NOT TRANSMITTED TO CDC.....

Human Infection with 2019 Novel Coronavirus
Person Under Investigation (PUI) and Case Report Form

Reporting jurisdiction: _____ Case state/local ID: _____
Reporting health department: _____ CDC 2019-nCoV ID: _____
Contact ID [a]: _____ NNDSS loc. rec. ID/Case ID [b]: _____

a. Only complete if case-patient is a known contact of prior source case-patient. Assign Contact ID using CDC 2019-nCoV ID and sequential contact ID, e.g., Confirmed case CA102034567 has contacts CA102034567 -01 and CA102034567 -02. [b]For NNDSS reporters, use GenV2 or NETSS patient identifier.

Interviewer information

Name of interviewer: Last _____ First _____

Affiliation/Organization: _____ Telephone _____ Email _____

Basic information

What is the current status of this person?
- ☐ Patient under investigation (PUI)
- ☐ Laboratory-confirmed case

Report date of PUI to CDC (MM/DD/YYYY): _____

Report date of case to CDC (MM/DD/YYYY): _____

County of residence: _____
State of residence: _____

Ethnicity:
- ☐ Hispanic/Latino
- ☐ Non-Hispanic/ Latino
- ☐ Not specified

Sex:
- ☐ Male
- ☐ Female
- ☐ Unknown
- ☐ Other

Race (check all that apply):
- ☐ Asian
- ☐ Black
- ☐ White
- ☐ Other, specify: _____
- ☐ American Indian/Alaska Native
- ☐ Native Hawaiian/Other Pacific Islander
- ☐ Unknown

Date of birth (MM/DD/YYYY): ___/___/___
Age: _____
Age units(yr/mo/day): _____

Date of first positive specimen collection (MM/DD/YYYY): ___/___/___
☐ Unknown ☐ N/A

Did the patient develop pneumonia?
☐ Yes ☐ Unknown ☐ No

Did the patient have acute respiratory distress syndrome?
☐ Yes ☐ Unknown ☐ No

Did the patient have another diagnosis/etiology for their illness?
☐ Yes ☐ Unknown ☐ No

Did the patient have an abnormal chest X-ray?
☐ Yes ☐ Unknown ☐ No

Was the patient hospitalized?
☐ Yes ☐ No ☐ Unknown

If yes, admission date 1 ___/___/___ (MM/DD/YYYY)
If yes, discharge date 1 ___/___/___ (MM/DD/YYYY)

Was the patient admitted to an intensive care unit (ICU)?
☐ Yes ☐ No ☐ Unknown

Did the patient receive mechanical ventilation (MV)/intubation?
☐ Yes ☐ No ☐ Unknown
If yes, total days with MV (days) _____

Did the patient receive ECMO?
☐ Yes ☐ No ☐ Unknown

Did the patient die as a result of this illness?
☐ Yes ☐ No ☐ Unknown

Date of death (MM/DD/YYYY): ___/___/___
☐ Unknown date of death

Symptoms present during course of illness:
- ☐ Symptomatic
- ☐ Asymptomatic
- ☐ Unknown

If symptomatic, onset date (MM/DD/YYYY): ___/___/___ ☐ Unknown

If symptomatic, date of symptom resolution (MM/DD/YYYY): ___/___/___
☐ Still symptomatic ☐ Unknown symptom status
☐ Symptoms resolved, unknown date

Is the patient a health care worker in the United States? ☐ Yes ☐ No ☐ Unknown

Does the patient have a history of being in a healthcare facility (as a patient, worker or visitor) in China? ☐ Yes ☐ No ☐ Unknown

In the 14 days prior to illness onset, did the patient have any of the following exposures (check all that apply):
- ☐ Travel to Wuhan
- ☐ Travel to Hubei
- ☐ Travel to mainland China
- ☐ Travel to other non-US country specify: _____
- ☐ Household contact with another lab-confirmed COVID-19 case-patient
- ☐ Community contact with another lab-confirmed COVID-19 case-patient
- ☐ Any healthcare contact with another lab-confirmed COVID-19 case-patient ☐ Patient ☐ Visitor ☐ HCW
- ☐ Animal exposure
- ☐ Exposure to a cluster of patients with severe acute lower respiratory distress of unknown etiology
- ☐ Other, specify: _____
- ☐ Unknown

If the patient had contact with another COVID-19 case, was this person a U.S. case? ☐ Yes, nCoV ID of source case: _____ ☐ No ☐ Unknown ☐ N/A

Under what process was the PUI or case first identified? (check all that apply): ☐ Clinical evaluation leading to PUI determination
☐ Contact tracing of case patient ☐ Routine surveillance ☐ EpiX notification of travelers; if checked, DGMQID _____
☐ Unknown ☐ Other, specify: _____

Public reporting burden of this collection of information is estimated to average 30 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing this burden to CDC/ATSDR Reports Clearance Officer; 1600 Clifton Road NE, MS D-74 Atlanta, Georgia 30333; ATTN: PRA (0920-1011).

CDC 2019-nCoV ID: _____ Form Approved: OMB: 0920-1011 Exp. 4/23/2020

Human Infection with 2019 Novel Coronavirus
Person Under Investigation (PUI) and Case Report Form

Symptoms, clinical course, past medical history and social history

Collected from (check all that apply): ☐ Patient interview ☐ Medical record review

During this illness, did the patient experience any of the following symptoms?	Symptom Present?
Fever >100.4F (38C)[c]	☐ Yes ☐ No ☐ Unk
Subjective fever (felt feverish)	☐ Yes ☐ No ☐ Unk
Chills	☐ Yes ☐ No ☐ Unk
Muscle aches (myalgia)	☐ Yes ☐ No ☐ Unk
Runny nose (rhinorrhea)	☐ Yes ☐ No ☐ Unk
Sore throat	☐ Yes ☐ No ☐ Unk
Cough (new onset or worsening of chronic cough)	☐ Yes ☐ No ☐ Unk
Shortness of breath (dyspnea)	☐ Yes ☐ No ☐ Unk
Nausea or vomiting	☐ Yes ☐ No ☐ Unk
Headache	☐ Yes ☐ No ☐ Unk
Abdominal pain	☐ Yes ☐ No ☐ Unk
Diarrhea (≥3 loose/looser than normal stools/24hr period)	☐ Yes ☐ No ☐ Unk
Other, specify: _____	

Pre-existing medical conditions? ☐ Yes ☐ No ☐ Unknown

Chronic Lung Disease (asthma/emphysema/COPD)	☐ Yes	☐ No	☐ Unknown	
Diabetes Mellitus	☐ Yes	☐ No	☐ Unknown	
Cardiovascular disease	☐ Yes	☐ No	☐ Unknown	
Chronic Renal disease	☐ Yes	☐ No	☐ Unknown	
Chronic Liver disease	☐ Yes	☐ No	☐ Unknown	
Immunocompromised Condition	☐ Yes	☐ No	☐ Unknown	
Neurologic/neurodevelopmental	☐ Yes	☐ No	☐ Unknown	(If YES, specify) _____
Other chronic diseases	☐ Yes	☐ No	☐ Unknown	(If YES, specify) _____
If female, currently pregnant	☐ Yes	☐ No	☐ Unknown	
Current smoker	☐ Yes	☐ No	☐ Unknown	
Former smoker	☐ Yes	☐ No	☐ Unknown	

Respiratory Diagnostic Testing

Test	Pos	Neg	Pend.	Not done
Influenza rapid Ag ☐ A ☐ B	☐	☐	☐	☐
Influenza PCR ☐ A ☐ B	☐	☐	☐	☐
RSV	☐	☐	☐	☐
H. metapneumovirus	☐	☐	☐	☐
Parainfluenza (1-4)	☐	☐	☐	☐
Adenovirus	☐	☐	☐	☐
Rhinovirus/enterovirus	☐	☐	☐	☐
Coronavirus (OC43, 229E, HKU1, NL63)	☐	☐	☐	☐
M. pneumoniae	☐	☐	☐	☐
C. pneumoniae	☐	☐	☐	☐
Other, Specify: _____	☐	☐	☐	☐

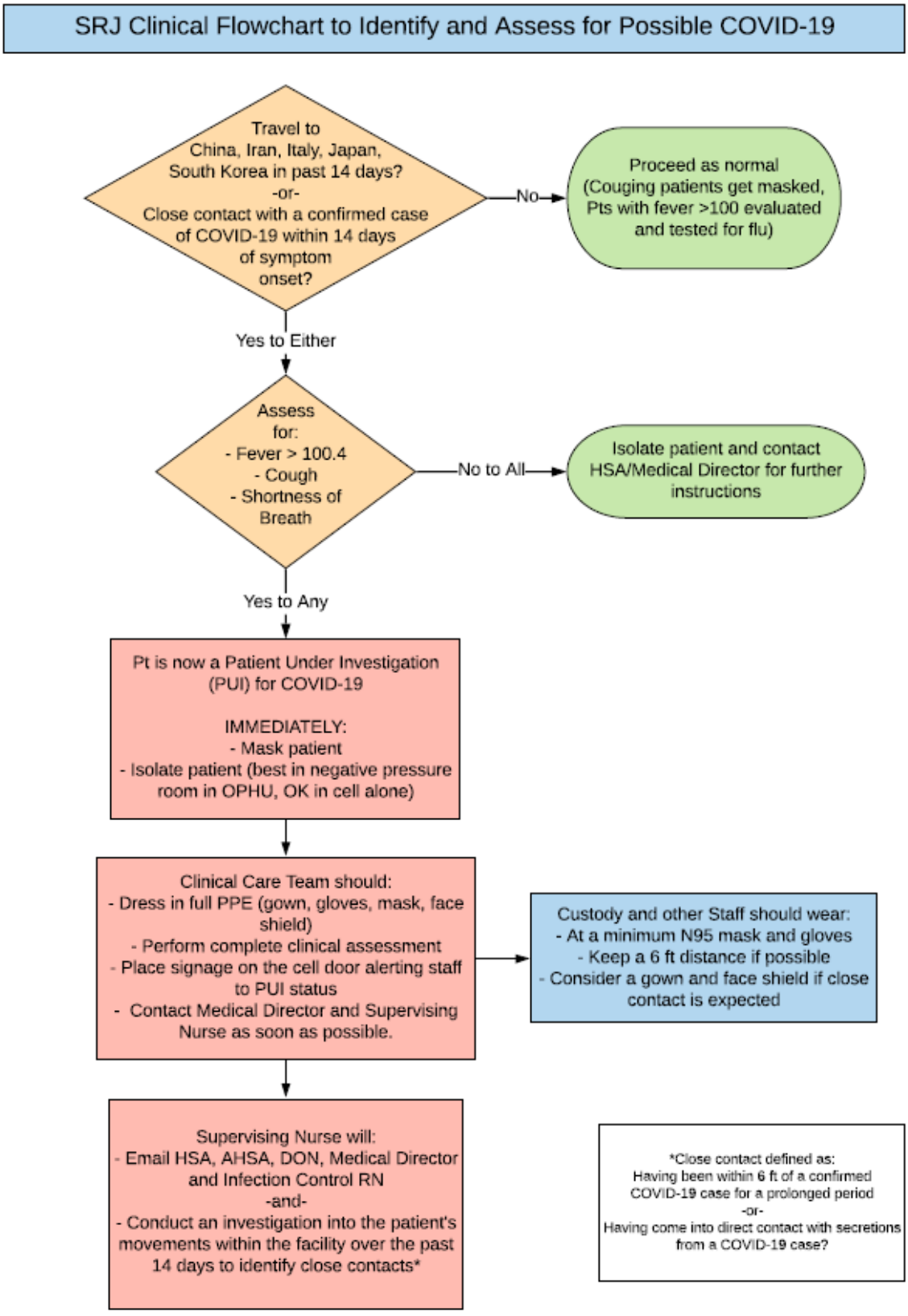
Specimens for COVID-19 Testing

Specimen Type	Specimen ID	Date Collected	Sent to CDC	State Lab Tested
NP Swab			☐	☐
OP Swab			☐	☐
Sputum			☐	☐
Other, Specify: _____			☐	☐

Additional State/local Specimen IDs: _____

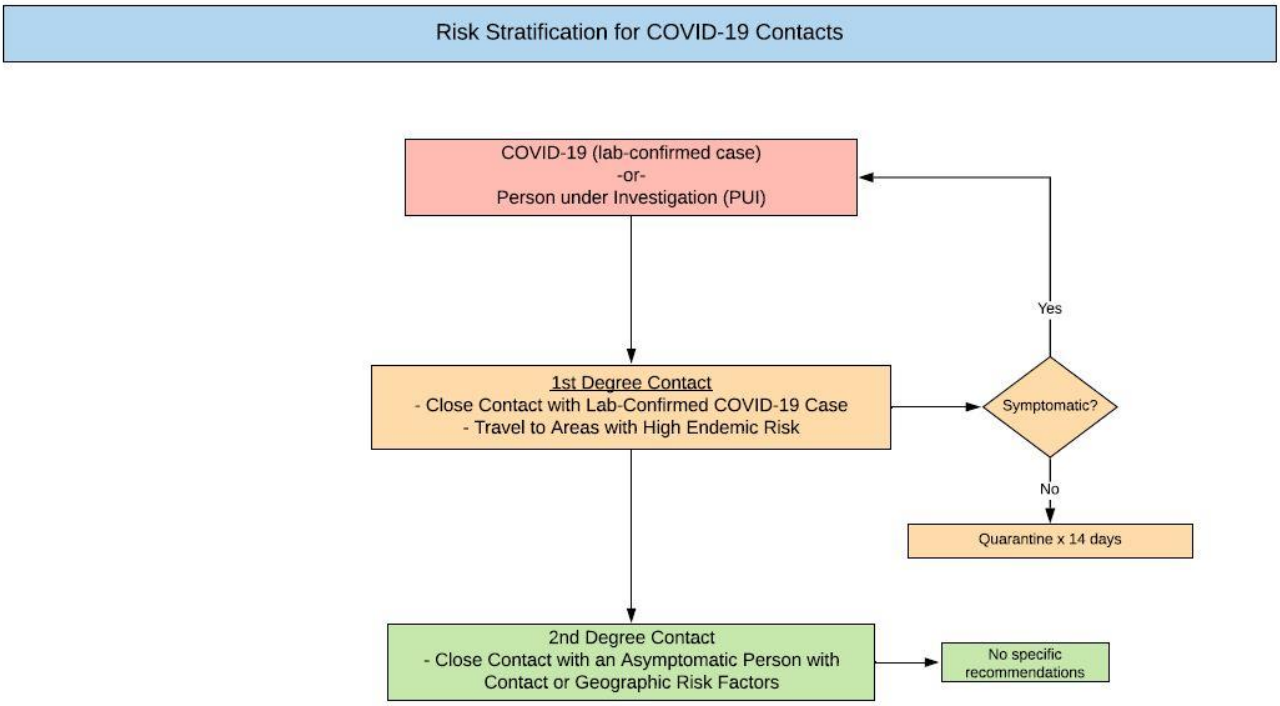
Public reporting burden of this collection of information is estimated to average 30 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing this burden to CDC/ATSDR Reports Clearance Officer; 1600 Clifton Road NE, MS D-74 Atlanta, Georgia 30333; ATTN: PRA (0920-1011).

SRJ Clinical Flowchart to Identify and Assess COVID-19



Waldura, MD/Wellpath Santa Rita Jail 3/4/2020

Risk Stratification for COVID-19 Contacts



ACSO Wellp

Summary Table of SRJ COVID Management

	Definition	Preferred Housing	Alternate Housing	Record Keeping	Close Contacts	HCP Precautions	Custody Precautions	Court/ Appointments
COVID-19 Case or Person under Investigation	Lab-confirmed case or symptomatic person with geographic or contact risk	AIIR in OPHU	Isolation	Log of movements into/out cell	Quarantine	Full PPE	Mask/Gloves or Full PPE	OK to Leave for Medical Care Only
Asymptomatic High Risk Person	Asymptomatic person with geographic or contact risk	Quarantine	n/a	Log of movements	n/a	??	??	OK to Leave for Medical Care Only
Secondary Contact	Contact of an Asymptomatic High Risk Contact	No restrictions	n/a	n/a	n/a	n/a	n/a	No restrictions

ACSO Wellpath

START Rapid Triage of patients and housing recommendations

Green:

Patient presenting with no symptoms and no known contact with a PUI.

Housing: Can be housed per classification with no restrictions

HU's: Any (with the exception of OPHU, Vulnerable HU, or sick HU)

Orange:

Patient presenting as high risk vulnerable and is asymptomatic. (Criteria: >=65, Ages >50 with diabetes, heart disease, lung disease, kidney disease, immunosuppressive medications, AIDS, etc.)

Housing: Vulnerable HU

HU's: Vulnerable HU, or OPHU (if sick enough)

Yellow:

Patient presenting with no known symptoms but contact with a PUI (can be suspected OR confirmed), or personal history of travel.

Housing: Must be housed in an isolation cell for 14 days, or cohorted with another inmate in the yellow category

HU's: Ad Sep/ Seg, (NOT vulnerable HU)

Red:

Patient presenting with any COVID-19 symptoms regardless of contact with a PUI

Housing: Must be housed in an isolation cell for 14 days, sick HU, or placed in the OPHU if clinically indicated.

HU's: Ad Sep/Seg, sick HU, OPHU

Emergency:

Patient presenting with any COVID-19 symptoms that appear life threatening

Housing: Must be transported to the ED with all PPE in place. Transporting deputy must be donned in PPE as well.

ACSO Wellpath DRAFT

Management of Staff or Inmates Exposed to Confirmed Cases of COVID-19

COVID-19 Case: Category RED

1. Definition: A lab-confirmed case of COVID-19
2. Guidance:
   #1 CDC: Interim Infection Prevention and Control Recommendations for Patients with Suspected or Confirmed Coronavirus Disease 2019 (COVID-19) in Healthcare Settings
   #2 CDC: Interim Clinical Guidance for Management of Patients with Confirmed Coronavirus Disease (COVID-19)
   #3 CDC: Preventing the Spread of Coronavirus Disease 2019 in Homes and Residential Communities
   #4 CDC: Interim Guidance for Homeless Sheltersq

Person with Suspected COVID-19: Category RED

1. Definition: Symptomatic patient with either fever >100, cough, and/or shortness of breath (with or without known contact or travel risk)
2. Guidance:
   #1 CDC: Interim Infection Prevention and Control Recommendations for Patients with Suspected or Confirmed Coronavirus Disease 2019 (COVID-19) in Healthcare Settings

Person with Potential Exposure to COVID-19: **Category YELLOW**

1. Definition: Asymptomatic person who, within the past 14 days, had *close contact* with a lab-confirmed or suspected COVID-19 case, or who had a history of travel to high risk countries.
2. Close contact defined as:
   a. Being within approximately 6 feet (2 meters) of a patient with COVID-19 (or PUI) for a prolonged period of time (~10 minutes).
   b. Having direct contact with infectious secretions from a patient with COVID-19 (or PUI). Infectious secretions may include sputum, serum, blood, and respiratory droplets. This does not include interacting with a patient with full PPE on.
3. Guidance:
   #5 CDC: Evaluating and Testing Persons for Coronavirus Disease 2019 (COVID-19)
   #6 CDC: Interim US Guidance for Risk Assessment and Public Health Management of Persons with Potential Coronavirus Disease 2019 (COVID-19) Exposures: Geographic Risk and Contacts of Laboratory-confirmed Case
   #1 CDC:Interim Infection Prevention and Control Recommendations for Patients with Suspected or Confirmed Coronavirus Disease 2019 (COVID-19) in Healthcare Settings
   #6 CDC: Interim U.S. Guidance for Risk Assessment and Public Health Management of Healthcare Personnel with Potential Exposure in a Healthcare Setting to Patients with Coronavirus Disease (COVID-19)

High Risk Vulnerable Person: **Category ORANGE**

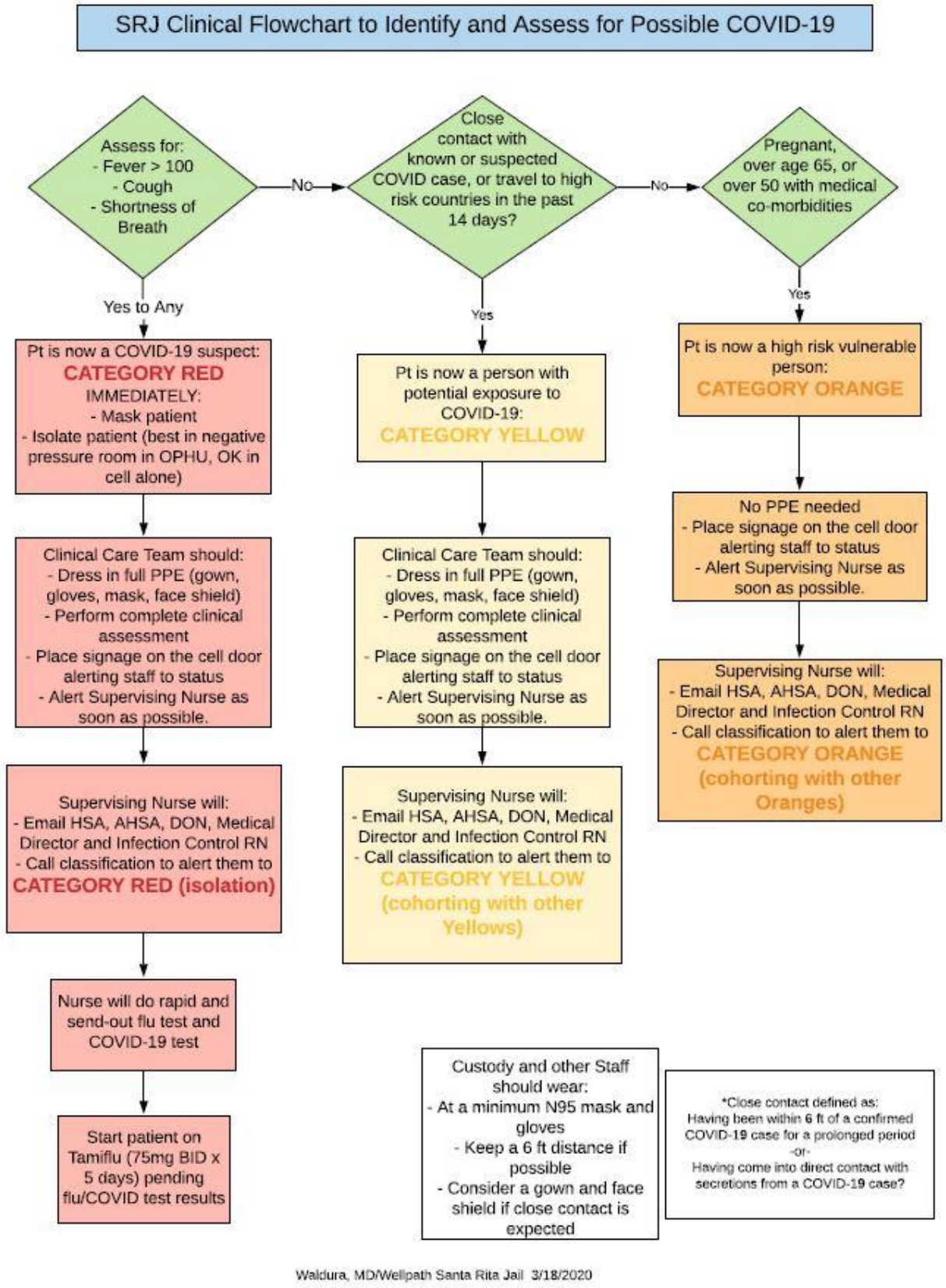
1. Definition: Asymptomatic person who is at high risk for COVID-19 complications including age ≥ 65, or age ≥ 50 with chronic medical problems.
2. Guidance:
   #2 CDC: Interim Clinical Guidance for Management of Patients with Confirmed Coronavirus Disease (COVID-19)

Secondary Contact: Category GREEN

1. Definition: Close contact of a Person with Potential Exposure to COVID-19 (a "contact of a contact")
2. Guidance:
   #5 CDC: Interim US Guidance for Risk Assessment and Public Health Management of Persons with Potential Coronavirus Disease 2019 (COVID-19) Exposures: Geographic Risk and Contacts of Laboratory-confirmed Cases

ASO Wellpath DRAFT

Clinical Flowchart to Identify and Assess Patients



ITR Pod Worker Guidelines

It is important that any ITR pod worker that is feeling sick to report to medical staff in HU immediately. The ITR pod worker will remain in HU until evaluated by medical staff. Also, if an ITR pod worker feels that they may have been in contact with someone with the flu or flu like symptoms to notify medical for evaluation.

In preventing the spread of germs, it is key for all ITR pod works to practice good hand hygiene with frequent hand washing and the practice of good cough etiquette.

All ITR pod works must be provided daily with the following:

- Gloves (frequent glove change)
- Daily clothing change
- Hand sanitizer
- Sanitizer wipes to wipe down all surfaces

N-95 mask will be provided to the pod workers during their shift in ITR. Please note that the N-95 can be reused more than once, unless mask is obviously soiled or saturated.

Once pod workers have completed their shift, they must be provided with a change of clothing and proper hand washing before returning to HU.

ACSO Wellpath DRAFT

California Dental Association Recommendations- During a COVID Outbreak

- **The California Dental Association strongly recommends that dentists practicing in California voluntarily suspend non-urgent or non-emergency dental care during an outbreak.** As always, it is expected that dentists will continue to be available as needed for emergency care and services

- CDA is strongly advising dental offices to limit patient treatment to only care for those patients with urgent oral health needs. Reducing patient visits to urgent care only will reduce risk of disease exposure for your patients, your staff and yourself.

- Dentists should proceed with treatment if the patient is in pain, if infection is present or if nontreatment will severely inhibit normal operation of a patient's teeth and mouth or negatively impact their health in the next three to six months. Patients who have received recent treatment requiring the removal of sutures would also be considered appropriate for treatment. All other treatments can be delayed until the COVID-19 crisis has eased.

Patients should be screened for active disease prior to providing dental care in the office. Take note of:

- Any individual who exhibits or reports signs of acute respiratory illness such as coughing, fever and shortness of breath. Take temperature readings.
- Recent travel to any locations designated by the CDC to have a Level 3 Travel Health Notice for COVID-19. Verify when the patient returned to the United States.
- Close contact with an individual, such as a family member or co-worker, diagnosed with COVID-19 within the last two weeks.

To reduce the production of aerosols during dental treatment, which is also advised during this time of increased transmissibility:

- Avoid or minimize operations that can produce droplets or aerosols; use rubber dams as much as possible.
- Rinse the oral cavity slowly, avoiding unnecessary splatter.
- Use high-speed evacuation for all dental procedures producing an aerosol.
- Have patient use an antimicrobial rinse before starting a dental procedure; ADA suggests using 1% hydrogen peroxide.
- Avoid or minimize procedures that may induce coughing, such as taking routine intraoral X-rays.

- Face masks should be used by people who show symptoms of COVID-19 to help prevent the spread of the disease to others. Dentists are advised to only proceed with appointments for patients who do not show symptoms, and the CDC does not recommend a face mask for people who are well.

ASO Wellness DRAFT

if patient has COVID

- If urgent dental treatment is necessary, dental personnel and medical providers should work together to determine the appropriate precautions to take on a case-by-case basis and decide whether the dental facility is an appropriate setting to provide the necessary services to the potentially infectious patient, as dental settings are not typically designed to carry out all of the transmission-based precautions recommended for hospital and other ambulatory care settings.

ADA Calls Upon Dentists to Postpone Elective Procedures *(March 16, 2020)*

The American Dental Association (ADA) recognizes the unprecedented and extraordinary circumstances dentists and all health care professionals face related to growing concern about COVID-19. The ADA is deeply concerned for the health and well-being of the public and the dental team.

In order for dentistry to do its part to mitigate the spread of COVID-19, the ADA recommends dentists nationwide postpone elective procedures for the next three weeks. Concentrating on emergency dental care will allow us to care for our emergency patients and alleviate the burden that dental emergencies would place on hospital emergency departments.

As health care professionals, it is up to dentists to make well-informed decisions about their patients and practices. The ADA is committed to providing the latest information to the profession in a useful and timely manner.

The ADA is continually evaluating and will update its recommendation on an ongoing basis as new information becomes available.

ACSO Wellpath DRAFT

COVID-19 Preparedness Assessment Tool

Coronavirus Disease (COVID-19) Preparedness Assessment Tool

wellpath℠

Planning for pandemic COVID-19 is critical for ensuring a sustainable healthcare delivery system within correctional facility settings. Wellpath has developed the following checklist to help prison and jail systems to self-assess and improved their preparedness for responding to pandemic COVID-19.

Given the differences among systems, individual facilities should adapt this checklist to meet their unique needs. This checklist is to be used as one tool in developing an overall pandemic COVID-19 plan for correctional systems, as well as individual facilities. Health Services Administrators (HSA) should incorporate information from state, regional, and local health departments and emergency management agencies/authorities into their system and individual facility pandemic COVID-19 plan.

All contact information specified below should include the names, titles, and contact information (i.e. office phone, cell phone, email, and physical addresses) for individuals or organizations. This checklist should be completed and provided to the Regional Director of Operations for tracking and for use should the HSA and other site leaders be unable to provide direction to the site by March 13, 2020. Once completed and forwarded please complete the attestation of completion in HealthStream.

The PPC or other authorized personnel including the HSA may modify the plan in response to evolving circumstances that may represent a threat to the well-being and safety of the inmates and/or personnel.

Pandemic COVID-19 preparedness and response plan committee

Completed	In Progress	Not Started	
☑	☐	☐	Form a multidisciplinary planning committee to address pandemic COVID-19 preparedness specifically. Alternatively, pandemic COVID-19 preparedness can be address by an existing committee with appropriate skills, knowledge, and relevant mission can address pandemic COVID-19 preparedness.
☑	☐	☐	Appoint members of the planning committee to include (as applicable in site settings) the representatives listed in the table below:
☑	☐	☐	Assign responsibility for communication with inmates, staff, and the community regarding the status and impact of pandemic COVID-19 in the facility. Develop a plan for back up if that person becomes ill during a pandemic. Having one voice that speaks for the facility during a pandemic will help ensure the delivery of timely and accurate information.
☑	☐	☐	Identify one of more representatives from acute care hospitals as committee liaisons that may facilitate hospitalization or seriously ill inmates or facilitate transfer of patients into the correctional facility. (Table provided as a guide)
☑	☐	☐	Assign a person(s), with back-up identified, who is responsible for monitoring Federal and State public health advisories with other appropriate information sources and notifying the pandemic COVID-19 coordinator and the planning committee when pandemic COVID 19 is reported in the Unites States as well as within the geographic area of the correctional facility.
☑	☐	☐	Assign a person(s), who is responsible for tracking and reporting suspected and confirmed cases of COVID-19 in inmates and staff (i.e. weekly or daily number of inmates and staff with and location, potential exposures). Institute a system for tracking illness trends to ensure that the facility can detect stressors that may affect operating capacity, including staffing and supply needs during a pandemic.

Committee Name: Alameda County, CA

Page 1 of 9

Committee Representative	Name/Title	Contact Information (office phone, cell, email)	Alternative Representative
PPC Coordinator	[redacted]	[redacted]	
Secretary/Director/ Commissioner/ Warden/Sheriff			[redacted]
Medical Director			
Health Service Representatives*			
Infection Control Expert			
Environment Health Officer/POC			
Maintenance Director			
Staff Trainer(s) Education Coordinator			
Dietary Services Coordinator/Director			
Pharmacist			
Security Coordinator/Director			
Human Resources Representative			
Communications Director and Coordinator			
Acute Hospital Name			
State/Federal Public Health advisories Monitor			

*The local HSA/site leader, or their designee as appropriate, is designated by Wellpath as the Health Care Pandemic Preparedness Coordinator (PPC) and to coordinate pandemic Covid-19 response planning in collaboration with local agencies.

Pandemic COVID-19 preparedness and response additional contact information

Completed	In Progress	Not Started	
☑	☐	☐	List points of contact for COVID-19 pandemic preparedness in the local and state health departments.

Agency	Contact Name and Title	Contact Information (office phone, cell, email)	Alternative Representative
Local Health Dept.	ACPHD	Erica Pan	
State Health Dept.	TBD	—	
State Corrections Dept.	N/a	—	
Other:			
Other:			

Completed	In Progress	Not Started	
☑	☐	☐	List local, regional, or state emergency preparedness groups

Emergency Preparedness Groups	Contact Name and Title	Contact Information (office phone, cell, email)	Alternative Representative
City	N/a	—	
County	OES	(925)551-6700	
Other regional	N/a	—	

Pandemic COVID-19 preparedness and response plan activation

Completed	In Progress	Not Started	
☑	☐	☐	Designate authority (and back-up individuals) to activate the correctional system pandemic COVID-19 plan.
☑	☐	☐	Identify what situation/trigger will signal activation of the agency's COVID-19 pandemic response plan, altering operations (e.g. shutting down non-critical operations, operations in affected areas, or concentrating resources on critical activities) as well as returning to normal operations.

Description of situation or activity that will trigger the activation of the agency pandemic COVID-19 response plan: >1 COVID-19 case

Pandemic COVID-19 preparedness and response education and training plan

Each system and facility should develop or obtain an education and training program to ensure that all personnel understand the implications of and control measures for pandemic COVID-19 and the current system/facility and community response plans.

Completed	In Progress	Not Started	
☑	☐	☐	Designate responsibility for coordinating education and training on pandemic COVID-19, including identifying and facilitating access to available programs, as well as tracking which personnel have completed the training.
☑	☐	☐	Develop a plan for how education and training will be provided to ensure that all personnel understand 1. COVID-19 fundamentals 2. hand hygiene, coughing/sneezing etiquette 3. how to prepare and plan for families of staff 4. community mitigation interventions (e.g. social distancing etc.) 5. the implication and control measure for pandemic COVID-19 6. the current facility and community response plans. -Training materials, power point and flyers are available on WOW-
☑	☐	☐	Provide training for law enforcement officers, office managers, medical or nursing personnel, and others as needed for performance of assigned emergency response roles.
☑	☐	☐	Describe how education will be provided to patients on the implications of the COVID-19 pandemic plan and current control measures. Materials to be provided in language appropriate format for visual, hearing, or other disabilities and reading ability.
☑	☐	☐	Post instructional signs that illustrate correct infection control procedures in all appropriate locations, including offices, restrooms, waiting rooms, processing rooms, detention facilities, vehicles, etc.
☑	☐	☐	Ensure that communications are available in appropriate formats for individuals with disabilities (e.g. visual or hearing impairments) and limited English proficiency. (Wellpath will translate corporate released patient and visitor facing printed communications into Spanish, additional language needs will be as requested/needed)

Describe the education and training plan for staff and patients:

- emergency staff meeting held on 3/16/2020
- weekly-daily multi-disciplinary response meetings
- daily email blast
- signage

Pandemic COVID-19 preparedness and response supply management plan

Completed	In Progress	Not Started	
☑	☐	☐	Develop a primary plan and contingency plan to address supply shortages, including detailed procedures for the pre-pandemic acquisition of supplies through normal channels as well as procedures for replenishing supplies under crisis conditions.
☑	☐	☐	Stock recommended personal protective equipment and environmental infection control supplies and make plans to distribute to employees, contractors, and others (including detainees) as needed. Supplies may include: • tissues • waste receptacles and bags • single use disinfection wipes • alcohol-based hand cleaner (containing at least 60% alcohol) • Red bags • Yellow contaminated laundry bags • Rice or disintegrating bags for contaminated laundry • EPA registered disinfectants labeled for human COVID-19 A virus may be used for cleaning offices, waiting rooms, bathrooms, examination rooms, and detention facilities. PPE may include: • Gloves • surgical masks • respirators (disposable N95s or higher respirators or reusable respirators) • eye protection • protective cover wear (e.g. impervious aprons.)
☑	☐	☐	Estimate consumable resource needs as above and including medications for approximately six to eight weeks and consider stockpiling these quantities depending on storage capacity, purchasing flexibility, and other facility-specific considerations.

Describe the supply management plan: AHSA ordering MA working daily to procure & stock supplies

Pandemic COVID-19 preparedness and response staffing plan

Completed	In Progress	Not Started	
☑	☐	☐	Complete Staffing Plan During Facility-Wide High Call-Off Situations for up to 50% call off. Include impact to security and health care, and the action plan for staff as more staff call-off. Keep in mind that absences may occur due to personal illness, family member illness, community mitigation measures, quarantines, school, childcare, or business closures, public transportation disruptions, or fear of exposure to ill individuals, as well as first responder, National Guard, or military reserve obligations.
☑	☐	☐	Identify critical job functions and plan now for to cover those functions in case of prolonged absenteeism during a pandemic. Develop succession plans for each critical.
☑	☐	☐	Consider protocols for restricting staff who are assigned to work on affected units from working on other units.
☑	☐	☐	Identify employees who may need to stay home if schools dismiss student and childcare programs close for a prolonged period (up to 12 weeks) during a severe pandemic. Advise employees not to bring their children to the workplace if childcare cannot be arranged. Plan for alternative staffing or staffing schedules based on your identification of employees who may need to stay home.
☑	☐	☐	Identify personnel who are at increased risk for COVID-19 complications (e.g. pregnant women, immunocompromised workers, over age of 70) and develop plan for addressing their needs by placing them on administrative leave, altering their work location or other appropriate alternatives during a pandemic health crisis consistent with the EEO laws.
☑	☐	☐	Provide cross training of facility staff to help sustain operating capacity
☑	☐	☐	IF use contracted medical staffing: Arrangements should be made for voluntary or mandatory crisis staffing on a collaborative basis. Contract providers do not have the same authority as the state to require mandatory overtime, so cooperative planning is necessary.
☑	☐	☐	Include local and regional groups or alternate agencies/Wellpath locations to collaborate on addressing widespread healthcare staffing shortages during a crisis.
☑	☐	☐	Develop a mechanism for employees to immediately report their own possible COVID-19 illness during a pandemic. (24-7)
☑	☐	☐	Employees who develop COVID-19 like symptoms while at the worksite should leave as soon as possible. Explore the availability of resources for testing for COVID-19 in coordination with local and state health departments.

Attach completed Staffing Plan During Facility-Wide High Call-off Situations, list of employees and their contact information with any extenuating situations associated with the pandemic that may impact their ability to work.

Describe additional staffing plans here:

development of
emergency staffing plan

Pandemic COVID-19 preparedness and response plan for identification and health care

A Plan for surveillance (monitoring) and detection of seasonal and pandemic COVID-19 in inmates and staff.

Completed	In Progress	Not Started	
☑	☐	☐	Initiate use of the Coronavirus Supplemental Screening tool (available on WOW) for the detection, evaluation, diagnosis, and treatment of inmates and personnel with symptoms of COVID-19 and housing placement of new inmates with known or suspected pandemic.
☑	☐	☐	Develop procedures for implementing respiratory hygiene/cough etiquette for staff and inmates throughout the facility. Deploy and use Respiratory Hygiene Kits.
☑	☐	☐	Identify areas within the facility that could be used to create additional acute care beds for expanded healthcare capacity; discuss availability with local and regional planning groups.
☑	☐	☐	Create procedures for cohorting inmates with known or suspected pandemic COVID-19 using one or more of the following strategies: 1. Confining ill and exposed inmates to their cells 2. Placing inmates with symptoms of pandemic COVID-19 together in one area of the facility 3. Closing off units that have symptomatic inmates.
☑	☐	☐	Develop criteria and procedures for transfer of inmates with known or suspected pandemic COVID-19 to hospitals, if it becomes necessary; and clinical management of inmates who need hospitalization but must remain in the facility due to limited hospital beds.
☑	☐	☐	Plan for discharging released inmates with known or suspected pandemic COVID-19
☑	☐	☐	Develop criteria and protocols for limiting non-essential visitors, including an education and communication strategy for visitors. Develop screening procedures for pandemic COVID-19 screening of all persons coming into the facility.
☑	☐	☐	Plan for disinfection of common areas and cells between patients?
☑	☐	☐	Specify criteria and protocols for appropriately closing the facility to new admissions, including notification of feeder jails and reception (intermediary classification and assessment) centers
☑	☐	☐	Specify criteria for releasing inmates from custody to decrease population in facility. For example- minimum security released on own recognizance; who is authorized to implement this?

Describe details of response plan:

Where will additional acute care beds/quarantine unit(s) be for expanded healthcare needs? OPHU & Isolation cells in HU's

What disinfection procedures will be used between inmate housing and in common areas to prevent spread? Antibacterial wipes

Can the facility be closed to new admissions? NO If yes, under what situation will that happen, and who is authorized to make that call? all restricted movement needs to be reported to BSCC.

What procedures for transporting known or suspected inmates will be used? Masks for patients & full PPE for staff

Will visitors be screened? NO How? non-contact visits

Will visiting be closed? Who is authorized to implement this change? non-contact visits & signage is posted

What will the procedure be for releasing suspected or confirmed patients from custody be? masks & wipe downs communication & public health

Additional Plans: outbreak master plan is created.

Pandemic COVID-19 preparedness and response for deceased persons

Completed	In Progress	Not Started	
☐	☐	☐	Address expanding morgue capabilities with local hospitals and other relevant institutions.
☐	☐	☐	Identify an area in the facility that could be used as a temporary morgue.

Describe plan for expanding morgue capabilities:

Coronavirus Disease (COVID-19) Preparedness Assessment Tool

wellpath

Pandemic COVID-19 preparedness and response coordination plan:

Completed	In Progress	Not Started	
☑	☐	☐	Review pandemic COVID-19 preparedness and response plan with key stakeholders inside and outside the agency, including employee representatives, and determine opportunities for collaboration, modification of the plan, and the development of complementary responsibilities.
☑	☐	☐	Share preparedness and response plans with other correctional agencies and law enforcement support agencies in your community, region, or state in order to share resources, identify collaboration strategies, and improve community response efforts. Develop, review, and modify local and state mutual aid agreements, if necessary. Mutual aid during a COVID-19 pandemic cannot be counted on as multiple jurisdictions in a given region may be affected simultaneously and have limited aid to offer.
☑	☐	☐	Coordinate all requests for assistance with the next higher-level governmental entity (e.g., local officials coordinate with State officials; State officials coordinate with Federal officials). Coordination is essential to ensure the assets: (1) can be provided in accordance with existing laws, (2) the requested resources are available. During a pandemic COVID-19, assistance from the next higher level of government may be limited due to competing higher priority demands and the effects of the pandemic on these assets.
☑	☐	☐	Integrate planning with emergency service and criminal justice organizations such as courts, law enforcements, probation and parole, social services, multi-jurisdictional entities, public works, and other emergency management providers (fire, EMS, mutual aid, etc.)
☑	☐	☐	Security functions are essential during a pandemic COVID-19. Through your city or county attorney, corporation counsel or other appropriate authority, collaborate with the Office of the State Attorney General to clarify and review security needs and resources available to your facility.
☑	☐	☐	Collaborate with local and/or State public health agencies to assist with the possible investigation of contacts within a suspected outbreak, the enforcement of public health orders, as well as the provision of security, protection, and possibly, critical supplies to quarantined persons. Each law enforcement agency will need to interact with local, State, county, and tribal public health officials to define the extent of the authorities provided from State legislation, develop procedures for the local initiation, implementation, and use of those authorities, as well as define protections from liability for law enforcement that may arise from quarantine and isolation enforcement. Operational planning must be flexible enough to address all scenarios in an all hazards environment, and in light of emerging infectious diseases.

Prepared by: Jen Diaz Date: 7/9/2020

For Site Name/Site Number: Alameda-1000

Corrections Representative: Danny McNaughton Date: _____

Public Health Representative: _____ Date: _____

Wellpath Regional Review: _____ Date: _____

Covid-19 Pandemic Plan implemented? ☐no ☐ yes; Date: _____

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RED ALERT

Patient(s) with Known or Suspected COVID-19

(Patient(s) are currently sick. Please mask the patient and wear full PPE yourself).

HU _____

CELL(S) _____

Inmate placement and activity management

- Patient is to be isolated and med scratched form all movement.
- Contact classification and medical before moving inmate anywhere in or out of facility.

QUARANTINE INITIATED ON _____

QUARANTINED LIFTED ON_____

ASO Wellpath DRAFT

YELLOW ALERT

Patient(s) with Exposure to COVID-19

(Patient(s) are currently asymptomatic but may be infected. Please mask the patient and wear full PPE yourself).

HU _____

CELL(S) _____

Inmate placement and activity management

- Patient may interact with any other yellow housed inmates.
- Contact classification and medical before moving inmate outside of yellow HU or cell

QUARANTINE INITIATED ON _____

QUARANTINED LIFTED ON_____

ACSO Wellpath DRAFT

ORANGE ALERT

High-Risk Vulnerable Patient(s)

(Patient(s) are currently healthy. Please mask yourself for patient protection.)

HU _____

CELL(S) _____

Inmate placement and activity management

- Patient may interact with any other healthy inmate or staff member.
- Contact classification and medical before transferring inmate outside of orange HU or cell

QUARANTINE INITIATED ON _____

QUARANTINED LIFTED ON____(Not applicable)_____

ACSO Wellpath DRAFT

GREEN ALERT

Healthy Patient(s)

(Patient(s) are currently healthy. No known COVID-19 risk or exposure. No PPE required).

HU _____

CELL(S) _____

Inmate placement and activity management

- No restrictions on inmate movement.

DATE POSTED ON _____

ACSO Wellpath DRAFT

COVID-19 Testing Instructions

Nasopharyngeal (NP) specimen collection for COVID-19 testing

1. Assemble the supplies needed. For sample collection, have the swab and universal transport media, specimen label and biohazard bag available.

   If the patient has a lot of mucous in the nose, this can interfere with collection. Have the patient use a tissue to gently clean the nasal passage before a swab is taken.

2. 

   Open the swab container and remove the swab, taking care not to touch the tip to any surface or lay it down.

3. 

   Hold the swab with fingers placed on the score line. With the patient seated, if possible, tilt their head back 70 degrees, support the back of their head with your non-dominant hand.

   Gently insert Nasopharyngeal (NP) Dry Flocked Swab into the nostril along the septum floor of the nose extending straight back until the posterior nasopharynx is reached (distance from nostrils to external opening of ear).

   Rotate the swab several times while the swab is in contact with the nasopharyngeal wall.

4. 

   Place NP swab into the Universal Transport Medium and break (snap) off at the indictor line on the swab. Replace cap and screw cap on securely.

   Label sample and place in biohazard bag.

   Freeze specimen and keep frozen.

5. Submit sample on one requisition, with test code 139900 — COVID-19.

To avoid delays in turnaround time when requesting multiple tests on frozen samples, please submit separate frozen specimens for each test requested.

LabCorp

Oropharyngeal (OP) specimen collection for COVID-19 testing

1. Assemble the supplies needed. For sample collection, have Universal Transport Medium (UTM) with included swabs, specimen label and biohazard bag available.

2. Open the UTM package and remove one swab, taking care not to touch the tip to any surface or lay it down.

3. Hold the swab with fingers placed on the scoreline.

   Gently insert swab into back of the throat and tonsillar area. Rub the swab over both tonsillar pillars and the posterior oropharynx and avoid touching the tongue, teeth, and gums.

4. Place swab into the UTM and break (snap) off at the indictor line on the swab. Replace cap and screw cap on securely.

   Label sample and place in biohazard bag.

   Freeze specimen and keep frozen.

5. Submit sample on one requisition, with test code 139900 — COVID-19.

To avoid delays in turnaround time when requesting multiple tests on frozen samples, please submit separate frozen specimens for each test requested.

OP Storage/Shipping requirements.

Samples/specimens should be shipped frozen due to limited stability at 2°-8°C. Refrigerated swabs submitted within 72 hours will be accepted.

LabCorp

www.LabCorp.com

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Specimen Collection and Shipping Instructions

2019 Novel Coronavirus (COVID-19), NAA — Nasopharyngeal & Oropharyngeal Swabs

The LabCorp **2019 Novel Coronavirus (COVID-19), NAA [139900]** test is available for ordering by physicians or other authorized healthcare providers anywhere in the U.S. The test detects the presence of SAR-CoV-2, the virus that causes COVID-19, and is for use with patients who meet guidance for evaluation of COVID-19 infection.

LabCorp does not currently collect specimens for COVID-19 testing. Patients for whom testing has been ordered should not be sent to a LabCorp location to have a COVID-19 specimen collected.

Test ordering info

The test number for 2019 Novel Coronavirus (COVID-19), NAA is 139900. Test **must** be ordered, and specimen collected, by a physician or other authorized healthcare provider.

Sample requirements

Nasopharyngeal (NP) or oropharyngeal (OP) specimens collected on swabs with synthetic tips are preferred. Swabs should be transported in Universal Transport Medium (UTM). For complete test details, including other acceptable specimen types, visit the LabCorp Test Menu.

Causes for rejection

Swabs with calcium alginate or cotton tips; swabs with wooden shafts; refrigerated samples greater than 72 hours old; room temperature specimen submitted; improperly labeled; grossly contaminated; broken or leaking transport device; collection with substances inhibitory to PCR including heparin, hemoglobin, ethanol, EDTA concentrations >0.01M.

Turnaround Time

Current turnaround time for COVID-19 testing is estimated between 3-4 days.

Supplies needed for collection

Nasopharyngeal swab collection — A Nasopharyngeal Dry Flocked Swab that is placed and transported in UTM is the preferred method. However, any synthetic swab (dacron, rayon, polyester) of appropriate size and configuration can be used.

For NP swab collection, discard the two swabs included in the UTM. UTM is for transport only.

Oropharyngeal swab collection — Specimen should be collected using a synthetic swab that is placed and transported in UTM.

For OP swab collection, either UTM swabs or a synthetic swab can be used for specimen collection.

Specimen label and biohazard bag are also needed.

Preferred swab for NP sample collection. **Note:** Cap color may vary.

Supply order #: 93307

UTM tube for transport. Do **not** send swab dry.

Supply order #: 24674

LabCorp

March 10, 2020

Page 1 of 2

Specimen Collection and Shipping Instructions

2019 Novel Coronavirus (COVID-19), NAA — Nasopharyngeal & Oropharyngeal Swabs

Nasopharyngeal (NP) collection

1. Assemble the supplies needed. For sample collection, have the synthetic swab (Nasopharyngeal Dry Flocked Swab preferred) and Universal Transport Medium (UTM), specimen label and biohazard bag available.
2. If the patient has a lot of mucous in the nose, this can interfere with collection. Have the patient use a tissue to gently clean the nasal passage before a swab is taken.
3. Open the swab package and remove the swab, taking care not to touch the tip to any surface or lay it down.
4. With the patient seated, if possible, tilt their head back 70 degrees, support the back of their head with your non-dominant hand.
5. Holding the swab in your hand, gently insert NP swab into the nostril along the septum floor of the nose extending straight back until the posterior nasopharynx is reached (distance from nostrils to external opening of ear). Rotate the swab several times while the swab it in contact with the nasopharyngeal wall.
6. Place NP swab into the UTM and break (snap) off at the indictor line on the swab. Replace cap and screw cap on securely.
7. Label sample and place in biohazard bag.
8. Freeze specimen and keep frozen.
9. Submit sample on one requisition, with test code 139900 — COVID-19.
10. To avoid delays in turnaround time when requesting multiple tests on frozen samples, **please submit separate frozen specimens for each test requested**.

Oropharyngeal (OP) collection

1. Assemble the supplies needed. For sample collection, have Universal Transport Medium (UTM) with included swabs, specimen label and biohazard bag available.
2. Open the UTM package and remove one swab, taking care not to touch the tip to any surface or lay it down.
3. Holding the swab in your hand, gently insert swab into back of the throat and tonsillar area. Rub the swab over both tonsillar pillars and the posterior oropharynx and avoid touching the tongue, teeth, and gums.
4. Place swab into the UTM and break (snap) off at the indictor line on the swab. Replace cap and screw cap on securely.
5. Label sample and place in biohazard bag.
6. Freeze specimen and keep frozen.
7. Submit sample on one requisition, with test code 139900 — COVID-19.
8. To avoid delays in turnaround time when requesting multiple tests on frozen samples, **please submit separate frozen specimens for each test requested**.

NP & OP Storage/Shipping requirements

Samples/specimens **should** be shipped frozen due to limited stability at 2°-8°C. Refrigerated swabs submitted within 72 hours will be accepted.

Preferred swab for NP sample collection. **Note:** Cap color may vary.

Supply order #: 93307

UTM tube for transport. Do **not** send swab dry.

Supply order #: 24674

LabCorp

www.LabCorp.com

March 10, 2020

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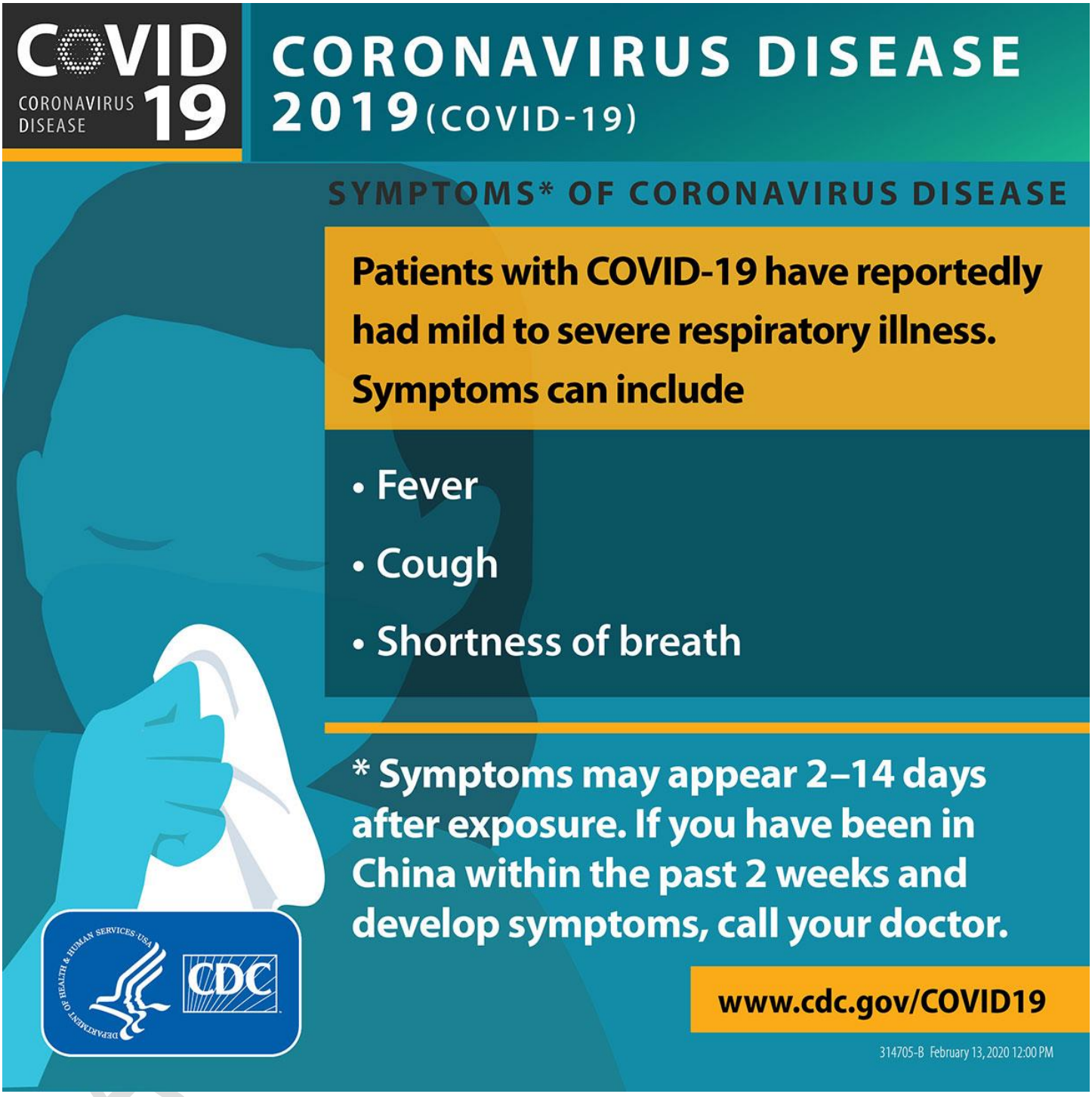
COVID-19 Signage



Additional Communication Resources

Cheat Sheet of Quarantined Housing Units

Housing Unit	Total # Of current Symp PT's	Total # of Cumulative Symp. PT's	Release Date, IF no new cases

RED ALERT

Influenza Lock Down

(Staff may enter- Masks are recommended)

HU _____

PODS _____

Inmate placement and activity management

- Do not place new inmates or transfer inmates into affected housing units
- Isolate inmates with symptoms if possible; or group inmates who have influenza symptoms together
- Avoid congregate dining; serve meals in cells/pods
- All activities, medical appointments, visits, and classes should be cancelled for affected housing units/pods until the outbreak is contained

Managing inmate court appearances and release

- Inmates from unaffected housing units may be transported per usual procedures
- Inmates from affected housing units may appear in court if the following precautions are taken:
    - If the inmate has **no symptoms:**
        - Inmate wears a surgical mask during transport and in court
        - Accompanying law enforcement personnel provide hand sanitizer for inmate to clean hands when entering and exiting the courtroom
    - If the inmate **has symptoms of influenza**:
        - Med scratch from court for a minimum of 7 days from the beginning of symptoms.
- Inmates who are being released and were in affected housing units should be given a mask upon transfer to ITR.

LOCK DOWN INITIATED ON _____

LOCK DOWN LIFTED ON_____

IF NO NEW SYMPTOMATIC PATIENTS APPEAR

(Subject to Watch Commander's approval)

ASO Medical DRAFT

ALAMEDA COUNTY SHERIFF's OFFICE – SANTA RITA JAIL

EMERGENCY FEEDING PLAN

(Revision: 6/1/2018)

BSCC - Title 15: 1243 - (k)

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This plan is prepared for uninterrupted meal service under possible emergency conditions that may include facility lockdowns, union/public transportation strikes, extreme natural events such as earthquakes, flooding and fires, along with transportation challenges and power failures within the facility.

ACSO Food Service Department will respond to every emergency scenario with plans to ensure no offender misses a meal.

Food Supplies Inventory:

At any given time, Food Service Department has enough inventory of products to feed the population at both ACSO facilities for at least (3) days.

Food Safety and Security During Lockdowns:

If a disturbance in the facility requires a lockdown, Food Service Managers and staff will act according to the instructions provided by the Facility Command and Security Staff. Under conditions where instructions are not available, Food Service Managers will act as below:

- Immediately secure the kitchen.
- All potential weapons (Utensils) returned to the shadow board.
- Exterior entrances, including loading docks and tunnel doors will be secured.
- All dry and cold storage areas will be secured.
- Elevator will be secured at the warehouse level.
- Unnecessary movement in the food service area will cease.
- Everyone will secure the immediate area they are in and wait for further instructions.

Meal Service During Lockdowns or Other Emergency Conditions Where There is No Inmate Worker Availability:

- At any given time, Food Service Department will have two extra days of trayed/bagged up meals available in addition to the day of the emergency.
- In addition there are two days of prepared entrees in cryovac bags and side dishes in tubs, at any given time.
- If ample amount of trayed up meals are not available, local Aramark Hourly and Management personnel will be able to tray up enough meals to serve the ACSO facilities for three days.
- If the emergency relating to no inmate worker availability is expected to continue for more than three days, and if deemed necessary, Aramark will mobilize, up to 1 Manager and 4 Hourly Associates each from all other seven Districts within Aramark Correctional Services Western Region Team, for a total of 7 Managers and 28 Hourly Employees to assist the Local Aramark Team of 4 Managers and 30 Employees for the duration of the emergency up to two weeks. Further need to use other Aramark resources will be decided on and agreed upon mutually between ACSO Administration and Aramark.

Service During Utility Interruptions Due to Natural and Other Emergency Conditions:

When kitchen equipment is inoperable for periods in excess of three days, due to loss of utilities, temporary menus developed by Aramark Registered Dietitians will be served (Exhibit A). These menus may be repeated in the event of longer disruptions. Different options of the menu will be provided for varying availability of utilities.

No Electricity/Refrigeration:

If refrigeration is not available, cooler/freezer temperatures may be maintained by large volumes of dry and block ice purchased from our purveyors, if transportation is possible.

If transportation is not possible, another option that will be used to keep milk and/or highly needed other food items refrigerated for a limited period of time is to keep the motors of the refrigerated Aramark trucks running with box coolers turned on.

No Natural Gas or Electricity For Cooking or Refrigeration:

A simple menu is available for use without the need for any utility for at least three days.

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Tainted or No Potable Water:

- Food Service Managers will ensure that tap water will be boiled if the emergency condition necessitates as such or as recommended by public officials
- If there is no tap water available, initially, Food Service Managers may utilize the available stock of 5 gallon water bottles for one day.
- If there is no tap water and if transportation is possible, Food Service Managers will arrange to have potable water from a purveyor delivered in a licensed tanker or haul it from an approved public water supply in food grade 5 gallon bottles and 32 gallon tubs.
- Food Service Managers will switch to paper service trays and/or brown bags, immediately after depleting the available plastic trays that are already prepared.
- Equipment and personal hygiene will be maintained through the use of sanitizing chemicals that are regularly stocked.

Total Loss of Kitchen / Inventory:

If the emergency event is specific only to Dublin, CA and/or SRJ, Aramark will arrange to transport sack meals from neighboring Correctional Facilities or other lines of business that Aramark operates Food Service at (i.e. Hospitals, universities/schools, business dining facilities and sports/leisure locations) for three days. Further days of service that needs to be provided will be mutually decided on and agreed upon between the ACSO Administration and Aramark.

Temporary Suspension of the Regulatory Food Service Requirements:

If the emergency situation necessitates the implementation of the Emergency Menu, a balanced meal will still be available, yet, regulatory requirements will be suspended as per below Title 15 article. All efforts will be made to meet the medical diet needs. No preference diets (i.e. religious, vegetarian…etc.) will be served during emergencies.

Title 15 § 1012. Emergency Suspensions of Standards or Requirements.

Nothing contained herein shall be construed to deny the power of any facility administrator to temporarily suspend any standard or requirement herein prescribed in the event of any emergency which threatens the safety of a local detention facility, its inmates or staff, or the public. Only such regulations directly affected by the emergency may be suspended. The facility administrator shall notify the Board in writing in the event that such a suspension lasts longer than three days. Suspensions lasting for more than 15 days require approval of the chairperson of the Board. Such approval shall be effective for the time specified by the chairperson. Note: Authority cited: Sections 6024 and 6030, Penal Code. Reference: Section 6030, Penal Code

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EXHIBIT A – EMERGENCY MENU OPTIONS

OPTION 1

No refrigeration, steam, or cooking gas needed

Assumptions:

- Potable water is available for food preparation

Breakfast

Fresh Fruit or Juice	1 @ OR ½ cup
Dry Cereal	1 ½ cup
Bread	2 slices
Peanut Butter	2 pck
Jelly	½ oz or 1 @
**Milk	8 oz

Lunch

Cheese	3 oz
Bread	4 slices
Condiments	2 @
Fruit	1 @ OR ½ cup
Sandwich Cookies	3 @
Beverage	8 oz

OPTION 2

No refrigeration needed

Assumptions:

- Potable water is available for food preparation
- Steam and cooking gas are available

Breakfast

Fresh Fruit or Juice	1 @ OR ½ cup
Hot Cereal	1 ½ cup
Bread	4 slices
Jelly	½ oz or 1 @

Lunch

Peanut Butter	4 Tbsp
Bread	4 slices
Jelly	1 oz or 2 @
Carrots	1 pack
Fruit	1 @ OR ½ cup
Cookies	3 @
Beverage	8 oz

OPTION 3

No refrigeration needed

Assumptions:

- Potable water is available for food preparation
- Steam and cooking gas are available

Breakfast

Fresh Fruit or Juice	1 @ OR ½ cup
Hot Cereal	1 ½ cup
Bread	2 slices
Jelly	½ oz or 1 @

Lunch

Plain canned tuna	3 oz
Bread	4 slices
Condiments	1 @ each
Vegetable	1/2 c
Fruit	1 @ OR ½ cup
Cookies	3 @
Beverage	8 oz

Alameda County Emergency Operations Plan: Epidemic/Infectious Disease 2.4.8

1.4.8 Epidemic/Infectious Disease

2.4.8.1 Description of Hazard

Infectious diseases are caused by pathogenic organisms, which can be a virus, bacteria, fungi, or parasites. Disease can affect any living organism, including people, animals, and plants. Diseases spread directly (through infection) and indirectly (through secondary effects). Some diseases can directly affect both people and animals. The major concern with respect to disease in humans is the evolution of an epidemic or pandemic resulting from a disease that is virulent, with a high morbidity rate combined with a high mortality rate. Infectious diseases can also be released intentionally as a weapon of terror. The risk of a terror attack in Alameda County is discussed in **Section 2.4.13**.

Pandemics are different from seasonal outbreaks of influenza that are caused by subtypes of influenza viruses that already circulate among people. Pandemic outbreaks are usually caused by entirely new subtypes to which the population has no immunity because the subtype has either never circulated among people or has not circulated for a long time. Seasonal influenza occurs routinely worldwide each year, causing an average of 36,000 deaths annually in the United States.

2.4.8.2 Previous Events

In 1918, the world experienced a severe influenza pandemic, the Spanish Flu. Claims were made that worldwide fatalities were between 20 and 50 million. Here in the United States deaths were claimed to be near 700,000.3

Most recent, in April 2009, a new strain of the flu virus called swine flu (or H1N1 flu virus) emerged. The virus was first detected in the United States and has spread around the world. Swine flu spreads in much the same way that seasonal influenza viruses spread. Like seasonal flu, H1N1 in humans can vary in severity from mild to severe. Severe disease with pneumonia, respiratory failure, and death is possible with the H1N1 flu infection. In June 2009, the World Health Organization declared that a global pandemic of H1N1 flu was underway.

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