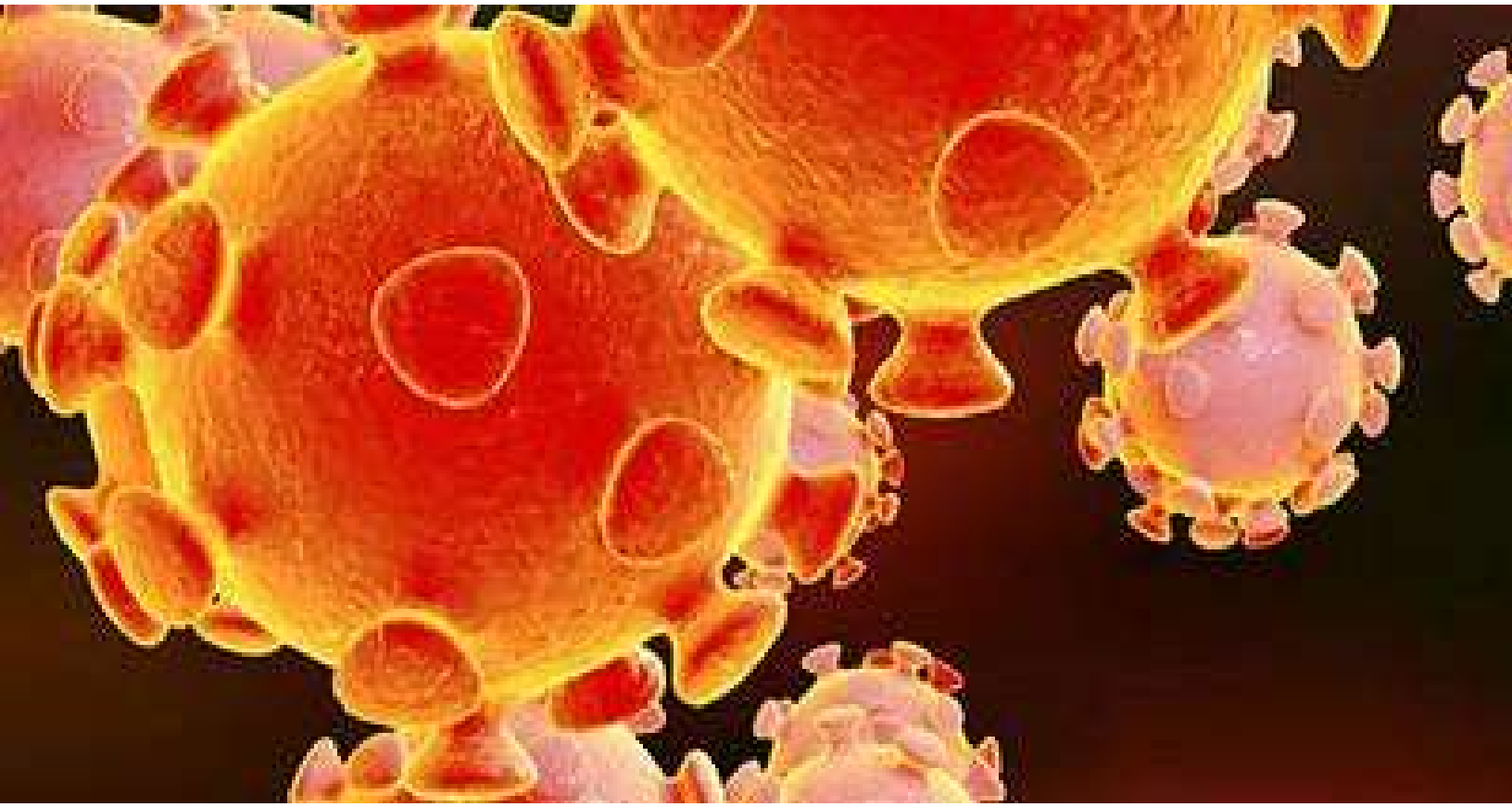
Exhibit F

COVID-19: Interim Guidance for Health Care and Public Health Providers



Public Health Nursing Program

Version 2.0

CALIFORNIA CORRECTIONAL
HEALTH CARE SERVICES

Table of Contents

ACRONYM LIST

AHRQ	Agency for Healthcare Research and Quality
AIDS	Acquired Immune Deficiency Syndrome
AOD	Administrative Officer of the Day
AIIR	Airborne infection isolation room
BMI	Body Mass Index
CCHCS	California Correctional Health Care Services
CDC	Centers for Disease Control and Prevention
CDCR	California Department of Corrections and Rehabilitation
CDPH	California Department of Public Health
CLIA	Clinical Laboratory Improvement Amendments
CME	Chief Medical Executive
CNE	Chief Nurse Executive
COVID-19	Coronavirus Disease 2019
DON	Director of Nurses
EHRS	Electronic Health Record System
EPA	Environmental Protection Agency
HCP	Heath Care Personnel
HCW	Health Care Worker
HIV	Human Immunodeficiency Virus
HLOC	Higher Level of Care
ICN	Infection Control Nurse
ILI	Influenza-like illness
LHD	Local Health Department
MDI	Metered-dose Inhalers
NCPR	Nurse Consultant Program Review
NIOSH	National Institute for Occupational Safety and Health
NP	Nasopharyngeal
OSHA	Occupational Safety and Health Administration
OEHW	Office of Employee Health and Wellness OEHW
OP	Oropharyngeal
PPE	Personal protective equipment
PAPR	Powered air purifying respirator
PORS	Preliminary Report of Infectious Disease or Outbreak form
PHB	Public Health Branch
PHN	Public Health Nurse
PhORS	Public Health Outbreak Response System
QM	Quality Management
RIDT	Rapid Influenza Diagnostic Test
RSV	Respiratory syncytial virus
RT-PCR	Reverse Transcription Polymerase Chain Reaction
RTWC	Return to Work Coordinator
TAT	Turnaround time
URI	Upper Respiratory Infection
VCM	Viral Culture Media
WHO	World Health Organization

COVID-19: Interim Guidance for Health Care and Public Health Providers

RECORD OF CHANGES

Version 2.0 Changes:

Diagnostic Testing includes updated lab test names, ordering instructions for Coronavirus Disease 2019 (COVID-19) and rapid influenza point of care testing, new stability data, Saturday pick-ups, and a new testing algorithm.

The Treatment section was expanded.

Transmission information was updated to highlight possible asymptomatic shedding.

A definition was added for the end of a COVID-19 outbreak.

Updated isolation and quarantine distancing to include space shortages.

Additional clarification was added regarding reporting and notifications.

Additional PPE scenarios were added.

The General Infection Control Precautions section was updated to include supply shortage strategies.

Expanded Contact Investigation section.

Evaluation and Treatment Algorithm for suspect and confirmed COVID-19 patients.

The criteria for release from isolation was changed to require COVID-19 laboratory testing based on updated CDC guidance.

The guidance for when patients are paroling during the outbreak has been expanded.

Environmental control guidance has been expanded.

This document serves to provide INTERIM guidance for the clinical management of SARS-CoV-2 virus pandemic at CDCR facilities. Due to the quickly changing guidelines from the Centers for Disease Control (CDC), the World Health Organization (WHO), and other scientific bodies, information may change rapidly and will be updated in subsequent versions. Revision dates are located at the bottom left of the document. Substantive changes will be posted to the website if occurring before release of updated versions.

This guidance supersedes the COVID-19 Interim Guidance for Health Care and Public Health Providers, Document 1.0.

This guidance supersedes the 2019 Seasonal Influenza Guidance except where noted.

COVID-19: Interim Guidance for Health Care and Public Health Providers

INTRODUCTION

Coronaviruses are a large family of viruses that are common in many different species of animals; some coronaviruses cause respiratory illness in humans. COVID-19 is caused by the novel (new) coronavirus SARS-CoV-2. It was first identified during the investigation of an outbreak in Wuhan, China, in December 2019. Early on, many ill persons with COVID-19 were linked to a live animal market indicating animal to person transmission. There is now evidence of person to person spread, as well as community spread (i.e., persons infected with no apparent high risk exposure contact). On March 11, 2020, the WHO recognized COVID-19 to be a pandemic.

CLINICAL MANIFESTATIONS / CASE PRESENTATION OF COVID-19

People with COVID-19 generally develop signs and symptoms, including respiratory symptoms and fever, 5 days (average) after exposure, with a range of 2-14 days after infection.

Typical Signs and Symptoms

- **Common:** Fever, dry cough, fatigue, shortness of breath.
- **Less common:** sputum production, sore throat, headache, myalgia or arthralgia, chills.
- **<5% occurrence:** nausea, vomiting, diarrhea, nasal congestion
- **Note:** 50% of cases are afebrile at time of testing, but develop fever during the course of the illness. Therefore, patients may not be febrile at initial presentation.

Mild to Moderate Disease

Approximately 80% of laboratory confirmed patients have had mild to moderate disease, which includes non-pneumonia and pneumonia cases. Most people infected with COVID-19 related virus have mild disease and recover.

Severe Disease

Approximately 14% of laboratory confirmed patients have severe disease (dyspnea, respiratory rate ≥30/minute, blood oxygen saturation ≤93%, and/or lung infiltrates >50% of the lung field within 24-48 hours).

Critical Disease

Approximately 6% of laboratory confirmed patients are critical (respiratory failure, septic shock, and/or multiple organ dysfunction/failure).

Older patients and patients with co-morbid conditions (see list below) are at higher risk of mortality and morbidity with COVID-19.

Persons at High Risk for Severe Morbidity and Mortality from COVID-19 Disease*	
Age >65	Most important risk factor and risk increases with each decade
Diabetes	All carry increased risk if uncontrolled
Hypertension	
Cardiovascular disease	
Chronic lung disease or moderate to severe asthma	
Chronic Kidney Disease	ESRD/Hemodialysis and End Stage Liver Disease carry increased risk
Liver Disease/Cirrhosis	
Cerebrovascular disease	
Cancer	
Immunocompromised patients	Transplants, immune deficiencies, HIV, Prolonged use of corticosteroids, chemotherapy or other immunosuppressing medications
Severe obesity (Body mass index [BMI] > 40)	
Pregnancy	
Patients with multiple chronic conditions	
Consider those patients categorized as High Risk in the Quality Management (QM) Master Registry QM Master Registry. For more information on the risk definitions for each condition, see: Clinical Risk Condition Specifications	
*Quality Management has released a COVID-19 Registry and Patient Risk Assessment Tool. The COVID-19 registry lists every patient at a specific institution and indicates which risk factors apply to each patient. **The registry is updated twice daily** and draws from multiple data sources, including the electronic health record system, claims data, and the Strategic Offender Management System (SOMS) to compile risk factor data. This tab of the registry also includes release date information for each individual, in the even that patients are considered for early release during the pandemic. Please refer to the COVID-19 Registry.	

DIFFERENTIAL DIAGNOSIS

All patients presenting with influenza-like illness (ILI) should be tested using the approach detailed below. Fevers can be intermittent or absent. Dyspnea is not always perceived. Hence, a low threshold for identifying ILI, especially for those with cough, should be enacted.

Influenza is currently still widespread in California. The Respiratory syncytial virus (RSV) season generally coincides with that of influenza. Regardless of the known disease signs, symptoms, and epidemiology that may distinguish influenza or other viral respiratory infections from COVID-19, **no clinical factors can be relied upon to rule out COVID-19** and laboratory testing is required.

When influenza is no longer prevalent in the community, it is less likely to be the cause of ILI. Until California Department of Public Health (CDPH) downgrades influenza transmission to "sporadic" for the region where your institution is located, assume influenza is prevalent (see CDPH Weekly Influenza Report). In 2019, influenza remained widespread through early April, regional in mid-April, and sporadic in May

RSV testing is indicated if it will affect clinical management. Consider testing for RSV in vulnerable populations, including those with heart or lung disease, bone marrow and lung transplant recipients, frail older adults, and those with multiple underlying conditions.

Please refer to the California Correctional Health Care Services (CCHCS) Public Health Branch Influenza Guidance Document for further direction on Influenza diagnosis and management and the California Department of Public Health's webpage on Influenza and other respiratory pathogens.

DIAGNOSTIC TESTING

Testing for influenza and the virus that causes COVID-19 is important for establishing the etiology of ILI. **During the COVID-19 pandemic, testing for respiratory pathogens shall be ordered by providers as part of the evaluation of all patients with ILI.** See Figure 1 for the testing algorithm and more details in the text below.

To be inclusive of the need for testing with both influenza and COVID-19 in the differential, ILI can be defined by having a fever >100°F, OR cough OR unexplained/new dyspnea.

Two approaches can be taken to testing: concurrent COVID-19 and influenza testing; or a tiered approach using a point of care influenza test followed by COVID-19 testing if the influenza test is negative.

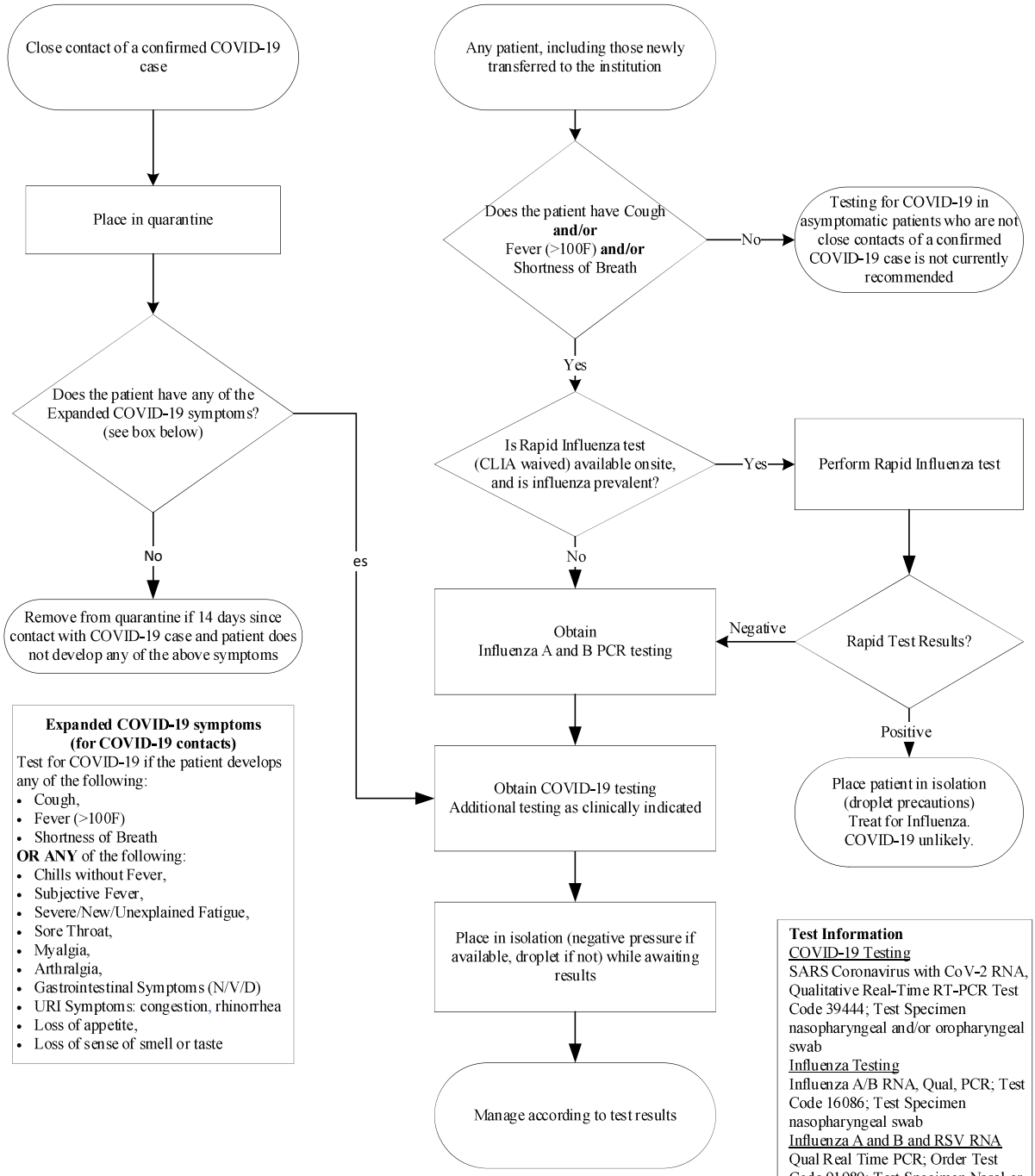
The following patients should be tested immediately for COVID-19:

- Patients who are close contacts of confirmed cases (should be in quarantine) who develop any symptoms of illness, even if mild or not classic for COVID-19. Such symptoms include: chills without fever/subjective fever, severe/new/unexplained fatigue, sore throat, myalgia, arthralgia, gastrointestinal symptoms (Nausea/Vomiting/Diarrhea/loss of appetite), upper respiratory infection (URI) symptoms like nasal/sinus congestion and rhinorrhea, and loss of the sense of smell or taste.

Patients without symptoms do not need testing at this time. This guidance may change with emerging science.

Clinicians should use their judgment in testing for other respiratory pathogens.

FIGURE 1: ALGORITHM FOR RESPIRATORY VIRAL TESTING IN SYMPTOMATIC PATIENTS



Note: Guidelines cannot replace personalized evaluation and management decisions based on individual patient factors

RAPID INFLUENZA CLINICAL LABORATORY IMPROVEMENT AMENDMENTS (CLIA) WAIVED DIAGNOSTIC TEST (RIDT)

Please refer to RIDT ordering instructions.

While influenza remains prevalent, rapid test kits for point of care influenza testing may be used to quickly identify influenza infections. Patients with influenza or a respiratory ailment of another etiology are unlikely to be co-infected with COVID-19 related virus. Therefore, COVID-19 testing is unnecessary if influenza is confirmed.

1. If RIDT is available at your facility and influenza prevalence is high, test symptomatic patients.

    a. RIDT is only useful for ruling in influenza when prevalence is high. When the CDPH specifies that **influenza transmission has downgraded to "sporadic" for your institution's geographic area, DO NOT USE the RIDT tests** any longer and instead use only the reverse transcription polymerase chain reaction (RT-PCR). CDPH Weekly Influenza Report

    b. Headquarters Public Health Branch (PHB) will send notification of when RIDT is no longer useful due to decreased prevalence in your geographic area.

2. Due to unreliable sensitivity, if the RIDT result is negative, further testing is always indicated. Order the influenza A/B RNA Qualitative PCR and COVID-19 RNA Qualitative PCR (see below).

COVID-19 TESTING

IMPORTANT: COVID-19 RT-PCR testing should be ordered as "ASAP". Please do not order as "routine" (delays one week) or "STAT" (will not process). Please refer to the COVID-19 Testing Fact Sheet on Lifeline.

CDC recommends that specimens should be collected as soon as possible once a suspect case is identified, regardless of the time of symptom onset.

For initial diagnostic testing for COVID-19, **the preferred specimen is a nasopharyngeal (NP) swab**. Only one swab is needed and the NP specimen has the best sensitivity. Oropharyngeal (OP) swabs may also be obtained. NP or OP swabs should be collected in a Viral Culture Media (VCM) tube (green-cap provided by Quest). E-swabs (system kit with swab collection and medium all-in-one) may be used if VCM is not available.

Testing both NP and OP further increases sensitivity. If collecting both a NP and OP swab, they both can be put in the same VCM tube. When testing supplies/swabs are in short supply, test using only one NP specimen.

Please note: Use a separate order and collect a separate specimen for each viral test being conducted (e.g., one or two swabs for influenza, and one or two swabs for SARS-CoV-2 RT-PCR).

Patients may self-swab. The patient should be educated that NP is best, however, if NP is too challenging, a nares samples may be collected. ONLY FOAM SWABS can be used for NARES collection: for example: Puritan 6' Sterile Standard Foam Swab w/ Polystyrene Handle.

Nares Collection instructions: Use a single foam swab for collecting specimens from both nares of a symptomatic patient. Insert foam swab into 1 nostril straight back (not upwards). Once the swab is in place, rotate it in a circular motion 2 times and keep it in place for 15 seconds. Repeat this step for the second nostril using the same swab. Remove foam swab and insert the swab into an acceptable viral transport medium listed in this guide.

NP Swab Technique: Insert the swab into one nostril parallel to the palate, gently rotating the swab inward until resistance is met at the level of the turbinates; rotate against the nasopharyngeal wall (approximately 10 sec) to absorb secretions.

Please note: Sputum inductions are not recommended as a means for sample collection.

Quest is accepting specimens for SARS-CoV-2 RNA, Qualitative Real-Time RT-PCR testing (Enter "covid" into the order search menu and choose: "**CoV-2 RNA Qual RT-PCR**" in Cerner; Quest Test Code: **39444**). ***Order as "ASAP".***

1. Samples can be sent to Quest Monday through Saturday. There is NO Sunday pick up.
2. Preferred specimen: NP swab or OP swab collected in, VCM medium (green-cap) tube. If collecting two swabs, both can be put in one transport medium tube.
3. Separate NP/OP Swab: Collect sample using a separate NP or OP swab for other tests (i.e., influenza test) requiring NP or OP swab. DO NOT COMBINE swabs in one tube for both COVID-19 and influenza test.
4. Storage and Transport: COVID-19 specimens are stable at room temperature (not >77°F) or refrigerated (35.6°F between 46.4°F) for 5 days.
5. Frozen (-20°C or -68°F) specimens are stable for 7 days.
6. Follow standard procedure for storage and transport of refrigerated samples.
7. Cold packs/pouches must be utilized if samples are placed in a lockbox.
8. COVID-19 is not a STAT test and a STAT pick-up cannot be ordered.
9. Turnaround time (TAT), published as 3-4 days, may be delayed initially due to high demand

Testing policy may change as CDC recommendations change. See: CDC Guidelines for Collecting, Handling and Testing Clinical Specimens

PRECAUTIONS FOR SPECIMEN COLLECTION:

- When collecting diagnostic respiratory specimens (e.g., NP swab) from a possible COVID-19 patient, the Heath Care Personnel (HCP) in the room should wear an N-95 respirator, eye protection, gloves, and a gown during collection HCP present during the procedure

should be limited to only those essential for that patient's care and procedure support. Specimen collection should be performed in a normal examination room with the door closed.

- Clean and disinfect procedure room surfaces promptly as described in the environmental infection control section of the CDC Interim Infection Prevention and Control Recommendations for Patients with Suspected or Confirmed Coronavirus Disease 2019 (COVID-19) in Healthcare Settings

OTHER DIAGNOSTICS

Chest X-ray, CT scans, and lab testing (e.g., CBC, D-Dimer, CRP and Procalcitonin) are generally used in the inpatient setting and found to assist in prediction of progression to respiratory failure.

TREATMENT

While certain medications show the potential to have modest benefit, at this point the treatment of COVID-19 is largely supportive. Key treatment considerations are below:

- Oxygen: use if needed to maintain O_2 saturation at or above 92% or near baseline.

  *Note: the use of **routine nasal cannula or face tent is preferred** to high-flow nasal cannula as the latter has the potential to aerosolize respiratory droplets.*

- Analgesia and antipyretics: consider acetaminophen and/or NSAIDs if needed and not contraindicated.

  Note: there have been theoretical concerns about the use of NSAIDs for fever or pain in COVID-19, however clinical data have not demonstrated an increased risk of adverse outcomes and the WHO has clarified that is does not recommend against NSAID use in patients with COVID-19.

- Bronchodilators: if bronchodilators are needed (i.e. reactive airway disease or wheezing and respiratory distress), nebulized medications should be avoided given the potential to aerosolize the virus; **metered-dose inhalers (MDIs) are preferred** and older clinical data suggest equivalence between MDIs and nebulized medications in patients who are able to use them.

- IV fluids: IVFs are not needed for most patients but dehydration can occur due to nausea and vomiting or lack of appetite. Those in need for IVF due to inability to take oral hydration or in suspected sepsis should immediately be transferred to a higher level of care (HLOC).

- Corticosteroids: many patients in China received steroids for severe COVID-19, however the clinic benefit of steroids is not clear and there is data for other respiratory pathogens suggesting prolonged viral shedding in patients receiving steroids; **currently steroids are not recommended** and most US providers are not using them unless clinically indicated for another reason.

- Antivirals:

- Hydroxychloroquine: favorable toxicity profile, demonstrates potent *in* vitro *activity* but currently has limited clinical data (below); if no contraindications, providers could consider using hydroxychloroquine to treat COVID-19 in patients with lower respiratory tract infections requiring hospitalization (as some other health systems are doing).
  - Dose: 400mg PO q12 x2 on day one, then 200mg PO q12 on days 2-5
  - Dosing in renal dysfunction: no adjustment
  - Pregnancy/lactation: no known risk in limited human data
  - Adverse effects: QTc prolongation, hemolytic anemia in those with G6PD deficiency, increased risk of hypoglycemia in patients with diabetes on glucose-lowering agents

  Note: a retrospective study of 26 patients receiving hydroxychloroquine (with or without azithromycin for bacterial superinfection) compared to 16 untreated controls in patients with COVID-19 showed shortened viral shedding but 6 patients in the treatment arm were dropped due from the analysis with poor outcomes (death, transfer to ICU, no follow up) and clinical outcomes have not been reported.

  Note: chloroquine suspected to have similar activity but availability is limited

- Lopinavir/ritonavir (Kaletra): showed no improvement in clinical outcomes or the duration of viral shedding in a placebo controlled trial of patients with severe COVID-19.
- Remdesivir: experimental IV therapy (not FDA approved) that showed no efficacy against Ebola but does have potent *in vitro* activity against SARS-CoV-2; is currently only available through a compassionate use protocol and as part of a phase II clinical trial.

TRANSMISSION

The virus is thought to spread mainly from person-to-person via infected droplets. This direct transmission occurs between people who are in close proximity with one another (within 3.6 feet). The policy for 6 foot distancing has been adopted to be conservative. When an infected individual breathes, coughs, or sneezes, infectious respiratory droplets land in the mouths, noses or airways of people who are nearby.

The virus is highly transmissible, even when only having mild symptoms. Viral shedding is highest around the time of symptom onset.

More evidence is emerging regarding asymptomatic transmission. Studies have demonstrated viral shedding 1 to 3 days prior to symptom onset. Among patients infected with COVID-19 who were asymptomatic at the time of testing, the mean time to symptom development was 3 days. Further, among patients whose infection has resolved, viral shedding may continue for two or more weeks after recovery. Transmission from asymptomatic individuals has been demonstrated

and may be responsible for 6-13% of COVID-19 cases. The infectious period for this virus is now considered to be 48 hours prior to symptom onset.

Airborne transmission (virus suspended in air or carried by dust that may be transported further than 6 feet from the infectious individual) is a possible mode of transmission, but not currently thought to be a major driver of the pandemic However, aerosol generating procedures will cause significant airborne transmission.

Contact transmission is when a person becomes infected with the COVID-19 virus by touching a contaminated surface (fomite) or person, and then touching their own mouth, nose, or their eyes. Research shows longevity of viable virus particles on fomites, but infectiousness of this modality is unclear at this time

Fecal shedding during and after symptom resolution has been found; however, the infectiousness of the fecal viral particles is unclear.

COVID-19: Interim Guidance for Health Care and Public Health Providers

COVID-19 RELATED PUBLIC HEALTH DEFINITIONS

TABLE 1: CASE DEFINITIONS

CONFIRMED COVID-19 CASE	A positive laboratory test for the virus that causes COVID-19 in at least one respiratory specimen. The tests no longer need to be confirmed by CDC
CONFIRMED INFLUENZA CASE	A positive point-of-care or laboratory test for influenza virus in a respiratory specimen in a patient with influenza-like illness
SUSPECTED COVID-19 / INFLUENZA CASE HIGH SUSPECT	**HIGH SUSPECT**: Any fever, respiratory symptoms, or evidence of a viral syndrome in a patient who had close (within 6 feet and prolonged [generally ≥30 minutes]) contact with a confirmed case of COVID-19 within 14 days of onset **OR** Linkage to a high risk group defined by public health during an outbreak (for example: an affected dorm, housing unit, or yard) but without a test result for COVID-19
SUSPECTED COVID-19 / INFLUENZA CASE LOW SUSPECT	**LOW SUSPECT**: Fever **OR** cough **OR** shortness of breath (dyspnea) with evidence of a viral syndrome (ILI) of unknown etiology in a person without test results for COVID-19 or influenza and without high-risk exposure

TABLE 2: NON-CASE DEFINITIONS

ASYMPTOMATIC CONTACT OF COVID-19	A person without symptoms who has had close (within 6 feet and prolonged [generally ≥30 minutes]) contact with a confirmed COVID-19 case **OR** Direct contact with secretions with a confirmed case of COVID-19 within the past 14 days, who has had no symptoms of COVID-19 AND who has had no positive tests for COVID-19
ASYMPTOMATIC CONTACT OF INFLUENZA	A person who has had close contact (within 6 feet) with an infectious influenza case within the past five days
CONTACT OF A CONTACT	The contact of an asymptomatic contact is NOT to be included in the exposure cohort. The patient does not need to wear a mask. Health care workers do not need PPE

COVID-19: Interim Guidance for Health Care and Public Health Providers

OUTBREAK OF COVID-19

Two or more confirmed cases of COVID-19 in patients with symptom onset dates within 14 days of each other in the same housing unit OR at least one confirmed case of COVID-19 in a patient with epidemiological linkage (e.g., close contact during infectious period) to another confirmed COVID-19 case in a patient or a staff member at the same institution.

CLOSE CONTACT	Within 6 feet and prolonged [generally ≥30 minutes]) contact with a confirmed case of COVID-19 within 14 days of onset Examples: – Occupying the same 2-4 bed unit as the infected case – Occupying adjacent beds in a large ward with the infected case – Sharing indoor space, e.g., classroom, friends, groups, yard, or shower – Exposure to the infected case in an entire housing unit(s) where the infected case was housed while infectious – Being directly coughed or sneezed upon (even though may be transient encounter) – Inmate worker/volunteer caring for a patient with COVID-19 without PPE – Resident transferring from a facility with sustained COVID-19 transmission in the last 14 days

ISOLATION

Separation of ill persons who have a communicable disease (confirmed or suspected) from those who are healthy. People who have different communicable diseases (e.g., one patient with COVID-19 and one with influenza), or who may have different diseases should not be isolated together. Isolation setting depends on the type of transmission-based precautions that are in effect. For airborne precautions, an airborne infection isolation room (AIIR) is the ideal setting; a private room with a solid, closed door is an alternative. Precautionary signs and PPE appropriate to the level of precautions should be placed outside the door to the isolation room.

QUARANTINE

The separation and restriction of movement of well persons who may have been exposed to a communicable disease. Quarantine facilitates the prompt identification of new cases and helps limit the spread of disease by preventing new people from becoming exposed. In CDCR, patients who are quarantined are not confined to quarters, but they do not go to work or other programs. They may go to the dining hall as a group and go to the yard as a group, but not mix with others who are not quarantined. Social distancing between quarantined individuals should be implemented when at all possible.

COHORTING

Cohorting is the practice of grouping together patients who are infected with the same organism to confine their care to one area and prevent contact with other patients. It also can conserve respirator use in times of shortage. Cohorts are created based on clinical diagnosis, microbiologic confirmation when available, epidemiology, and mode of transmission of the infectious agent. When single patient rooms are not available, patients with a confirmed viral respiratory pathogen may be placed in the same room.

For more information on cohorting of isolated patients, CDC currently refers to the following: 2007 Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settingspdf icon, or https://www.cdc.gov/coronavirus/2019-ncov/hcp/respirators-strategy/conventional-capacity-strategies.html

PROTECTIVE SHELTER IN PLACE

During the COVID-19 pandemic, CCHCS institutions may implement additional measures to protect vulnerable patients who are at increased risk for severe COVID-19 disease (e.g., single-cell or protected housing area, limited movement, separate dining and yard time, and telemedicine services). Patients in protective shelter in place should be educated regarding their risk and how to protect themselves, early symptom recognition and request for medical attention, and the availability of testing for COVID-19. These patients are not on quarantine and do not need daily symptom surveillance rounds.

MEDICAL HOLD

Prohibition of the transfer of a patient to another facility except for legal or medical necessity. In CDCR, medical holds are employed for both isolation and quarantine.

END OF AN INFLUENZA OUTBREAK

- An influenza outbreak ends when there are no new cases in the housing unit for 5-7 days since the onset of symptoms in the last identified new case. Refer to CCHCS Influenza Guidance Document, 2019 Influenza Guidance.

END OF A COVID-19 OUTBREAK

- A COVID-19 outbreak ends when there are no new cases in the housing unit for 14 days since the onset of symptoms in the last identified new case.

INITIAL NOTIFICATIONS

- If health care or custody staff become aware of or observe symptoms consistent with COVID-19 (e.g., fever, cough, or shortness of breath) in a patient, staff person, or visitor to the institution, they should immediately notify the Public Health Nurse (PHN) or PHN alternate (often the Infection Control Nurse[ICN]).
    - For employee exposures, please refer to Health Care Department Operations Manual (HCDOM) section on Employee Exposure Control.

- When a patient with fever or cough or shortness of breath is identified, institutional processes for notification to the PHN or PHN alternated must be established for ongoing surveillance and reporting.
- Laboratory confirmed COVID-19 cases and suspect cases of COVID-19 shall immediately be reported to the PHN or PHN alternate by phone or Electronic Health Record System (EHRS) messaging.
- A patient with symptoms consistent with COVID-19 should be immediately referred to a provider for evaluation.
- If a patient has a confirmed case of COVID-19, the PHN, ICN, or designee should immediately notify institutional leadership, including the Chief Executive Officer (CEO), Chief Medical Executive (CME), Chief Nurse Executive (CNE), Warden, and Public Information Officer (PIO).
- Institutional leadership is responsible for notifying the Office of Employee Health and Wellness (OEHW) and Return to Work Coordinator (RTWC) of the possibility of employees exposed to COVID-19 related virus.

REPORTING

The PHN or PHN alternate is responsible for reporting of respiratory illness and outbreaks to the PHB and the local health department (LHD).

- Single or hospitalized cases of COVID-19, outbreaks of ILI, and influenza should be reported to the PHB via the Public Health Outbreak Response System (PhORS) http://pors/. Single cases of lab-confirmed influenza and single cases of ILI that result in hospitalization or death should be reported to PhORS.

- Confirmed COVID-19 cases should be immediately reported by telephone to the LHD. Outbreaks of COVID-19 should also be immediately reported to the LHD. Follow usual guidelines for reporting influenza to the LHD. CCHCS Influenza Guidance Document 2019 on Lifeline. See Appendix 11 for a LHD contact list.

- Notify CCHCS PHB immediately at CDCRCCHCSPublicHealthBranch@cdcr.ca.gov if there are significant developments at the institution (e.g., first time the institution is monitoring one or more contacts, first confirmed case at the institution, or first COVID-19 contact investigation at the institution.)
- The following events require same-day reporting to the COVID-19 SharePoint: https://cdcr.sharepoint.com/sites/cchcs_ms_phos. No report is needed if there are no new cases/contacts and no significant updates to existing cases/contacts.
    - **All new suspected and confirmed COVID-19 cases.**
    - **All new COVID-19 contacts.**
    - For previously reported cases: new lab results, new symptoms, new hospitalizations, transfers between institutions, discharges/paroles, releases from isolation, and deaths.

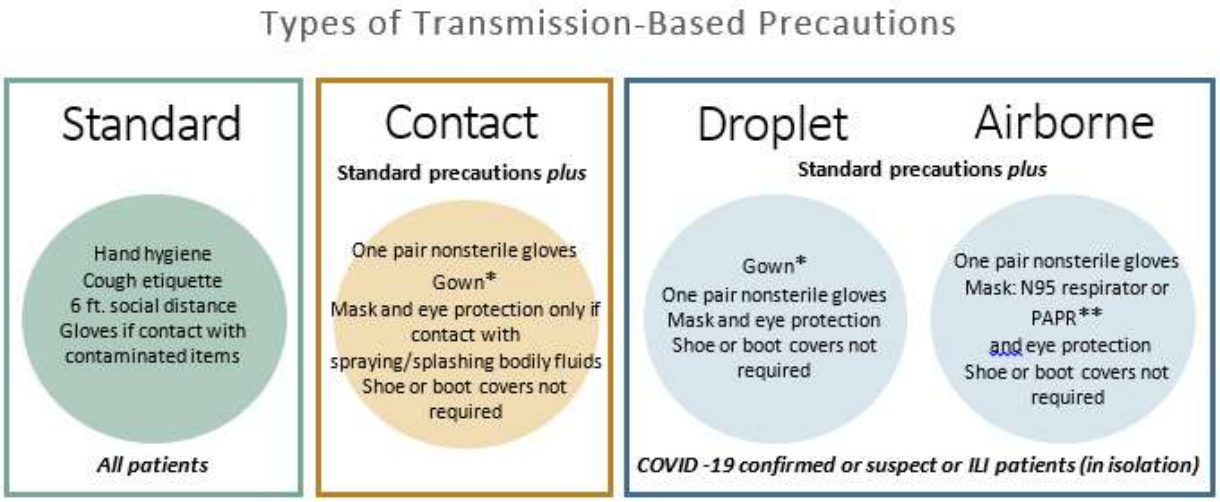
- For previously reported contacts of cases: new exposures, transfers between institutions, discharges/paroles, and releases from quarantine.

- Refer to the COVID-19 Case and Contact SharePoint Reporting tool (Appendix 5) for step-by-step instructions on using the tool and definitions.

COVID-19 INFECTION CONTROL PRECAUTIONS

As a general principle, at all times, staff and inmates should practice standard precautions and staff should be familiar with the different types of transmission-based precautions needed to protect themselves and perform their duties. See Table 3.

TABLE 3: STANDARD, AIRBORNE, AND DROPLET PRECAUTIONS PPE



PPE SCENARIOS FOR ILI, INFLUENZA, and COVID-19

This section describes the PPE recommended for several of the patient-care activities being conducted by staff. See Table 4 "Recommended Personal Protective Equipment (PPE) for Incarcerated/Detained Persons and Staff in a Correctional Facility during the COVID-19 Response."

During this time period, when there may be a shortage of some PPE supplies, consult Table 4 for suggested alternatives. When the recommendation is for a N95, surgical/procedure masks are acceptable alternative when the supply chain of respirators cannot meet the demand. The available N95 respirators should be prioritized for procedures that pose a high risk to staff. These procedures or activities include the following:

- **Procedures with splashes and sprays**
- **Aerosol generating procedures (anyone in the room)**
- **Procedures where very close or prolonged exposure to a COVID-19 case**
- **CDCR staff engaged in vehicle transport of patients with respiratory symptoms**

STAFF PPE FOR ILI / SYMPTOMATIC PATIENT

Patients presenting with ILI should be considered infectious for COVID-19 until proven otherwise. Standard, contact, droplet, and airborne precautions, plus eye protection are recommended for any patient with ILI symptoms. A N95 Respirator, gloves, gown, face shield or other eye protection are recommended. A N95 is preferred, however, based on potential supply shortages, surgical/procedure masks are an acceptable alternative when the supply chain cannot meet the demand. During this time, available N95s and gowns should be prioritized for health care workers (HCW) engaged in procedures that are likely to generate respiratory aerosols or HCWs and custody engaged in vehicle transport.

STAFF PPE FOR SUSPECTED AND CONFIRMED COVID-19 CASE

Standard, contact, droplet, and airborne precautions, plus eye protection are recommended for any patient with suspected or confirmed COVID-19 infection. A N95 Respirator, gloves, gown, face shield or other eye protection are the recommended PPE. A N95 is preferred, however, based on potential supply shortages, surgical/procedure masks are an acceptable alternative when the supply chain cannot meet the demand. During this time, available N95s and gowns should be prioritized for HCWs engaged in procedures that are likely to generate respiratory aerosols or HCWs and custody engaged in vehicle transport.

STAFF PPE FOR CONFIRMED INFLUENZA CASE

Standard, contact, and droplet precautions are recommended for patients with confirmed influenza. A surgical/procedure mask, gloves, and gown are the recommended PPE. During this time, if there is a shortage of gowns, gowns should be prioritized for HCWs engaged in procedures that are likely to generate respiratory aerosols or HCWs and custody engaged in vehicle transport.

STAFF PPE FOR SURVEILLANCE OF ASYMPTOMATIC CONTACT OF A CASE

Standard, contact, and droplet precautions are recommended. A surgical/procedure mask, eye protection, and gloves are the recommended PPE.

PPE FOR CONTACT OF A CONTACT

Standard precautions are sufficient for the patient who is a contact of a contact.

For further information on standard, contact, and airborne precautions:
Refer to HCDOM, Chapter 3 Article 8, Communicating Precautions from Health Care Staff to Custody Staff and
https://www.cdc.gov/coronavirus/2019-ncov/infection-control/infection-prevention-control-faq.html

N95 SHORTAGE GUIDANCE

- N95 and other disposable respirators should not be shared by multiple HCW.
- Existing CDC and National Institute for Occupational Safety and Health (NIOSH) guidelines recommend a combination of approaches to conserve supplies while safeguarding health care workers in such circumstances. https://www.cdc.gov/niosh/topics/hcwcontrols/recommendedguidanceextuse.html and https://www.cdc.gov/coronavirus/2019-ncov/hcp/respirators-strategy/index.html
    - **Extended use** refers to the practice of wearing the same N95 respirator for repeated close contact encounters with several different patients, without removing the respirator between patient encounters. Extended use is well suited to situations wherein multiple patients with the same infectious disease diagnosis, whose care requires use of a respirator, are cohorted (e.g., housed on the same hospital unit). HCP remove only gloves and gowns (if used) and perform hand hygiene between patients with the same diagnosis (e.g., confirmed COVID-19) while continuing to wear the same eye protection and respirator.
    - **Re-use** refers to the practice of using the same N95 respirator by one HCW for multiple encounters with different patients but removing it after each encounter. Restrict the number of reuses to the maximum recommended by the manufacturer or to the CDC recommended limit of no more than five uses per device.
    - To maintain the integrity of the respirator, it is important for HCP to hang used respirators in a designated storage area or keep them in a clean, breathable container such as a paper bag between uses. It is not recommended to modify the N95 respirator by placing any material within the respirator or over the respirator. Modification may negatively affect the performance of the respirator and could void the NIOSH approval.
    - All reusable respirators, must be cleaned and disinfected according to manufacturer's reprocessing instructions prior to re-use.
- Examples of N95 alternatives:
    - Powered air-purifying respirator (PAPR) which is reusable and has a whole/partial head and face shield breathing tube and battery operated blower and particulate filters, can be used if available. Loose fitting PAPRs do not require fit-testing and can be worn by people with facial hair. Do not use in surgical settings.
    - N95 respirators or respirators that offer a higher level of protection should be used (instead of a facemask) when performing or present for an aerosol-generating procedure. Such procedures should be prioritized in times of N95 shortages, and extended wear not employed.

When the supply chain is restored, staff should adhere to the PPE recommendations for specific transmission-based precaution.

TABLE 4. RECOMMENDED PERSONAL PROTECTIVE EQUIPMENT (PPE) FOR INCARCERATED/DETAINED PERSONS AND STAFF IN A CORRECTIONAL FACILITY DURING THE COVID-19 RESPONSE*

Classification of Individual Wearing PPE	N95 respirator	Surgical mask	Eye Protection	Hand Hygiene or Gloves (if contact)	Gown/ Coveralls
Incarcerated/Detained Persons					
Asymptomatic incarcerated/detained persons (under quarantine as close contacts of a COVID-19 case)	Apply face masks for source control as feasible based on local supply, especially if housed as a cohort				
Incarcerated/detained persons who are confirmed or suspected COVID-19 cases, or showing symptoms of COVID-19.		✓			
Incarcerated/detained persons in a work placement handling laundry or used food service items from a COVID-19 case or case contact.				✓	✓
Incarcerated/detained persons in a work placement cleaning areas where a COVID-19 case has spent time.	Additional PPE may be needed based on the product label.			✓	✓
Staff					
Staff having direct contact with asymptomatic incarcerated/detained persons under quarantine as close contacts of a COVID-19 case (but not performing temperature checks or providing medical care).		✓	✓	✓	
Staff performing temperature checks on any group of people (staff, visitors, or incarcerated/detained persons), or providing medical care to asymptomatic quarantined persons.		✓	✓	✓	
Staff having direct contact with symptomatic persons or offering medical care to confirmed or suspected COVID-19 cases.		✓**	✓	✓	
Persons accompanying any patients with respiratory symptoms in a transport vehicle.	✓		✓	✓	✓
Staff present during a procedure on a confirmed or suspected COVID-19 case that may generate respiratory aerosols and other procedures (e.g. COVID-19 testing, CPR, etc.) or high contact patient care (bathing, etc.).	✓		✓	✓	✓
Staff handling laundry or used food service items from a COVID-19 case or case contact				✓	✓
Staff cleaning an area where a COVID-19 case has spent time.	Additional PPE may be needed based on the product label.			✓	✓

* Table created using recommendations from the Centers for Disease Control and Prevention "Interim Guidance on Management of Coronavirus Disease 2019 (COVID-19) in Correctional and Detention Facilities", March 23, 2020.

** A NIOSH-approved N95 is preferred. However, based on local and regional situational analysis of PPE supplies, face masks are an acceptable alternative when the supply chain of respirators cannot meet the demand. During this time, available respirators should be prioritized for procedures that are likely to generate respiratory aerosols, which would pose the highest exposure risk to staff.

CONTROL STRATEGY FOR SUSPECTED AND CONFIRMED CASES OF COVID-19

ILI CASE AND OUTBREAK IDENTIFICATION

Currently, influenza and COVID-19 are prevalent. When patients from facilities are transferred from a facility with known influenza or COVID-19, they will not require quarantine unless notified by the sending facility that the patient has had a potential exposure. Incoming patients with a potential exposure should be quarantined for 14 days.

In new seasons, screening for ILI should begin as soon as seasonal influenza or COVID-19 is identified in any correctional facility. Patients should be triaged as soon as possible upon arrival to a facility (right after leaving the transportation bus) for symptom assessment prior to allowing patients to gather together in groups. If a patient presents with ILI symptoms, place a surgical facemask on the patient and isolate them until a health care provider can clinically assess and evaluate them.

For the control strategy for confirmed cases of influenza, see CCHCS Seasonal Influenza Infection Prevention and Control Guidance

CHECKLIST FOR IDENTIFYING COVID-19 SUSPECTS

- ☐ Examine test results provided by laboratory looking for positive COVID-19 and other communicable diseases requiring public health action.
- ☐ Examine COVID-19 tests ordered in the last 24 hours to identify patients with ILI.
- ☐ Examine TTA logs for patients who had respiratory symptoms.
- ☐ Coordinate with Utilization Management (UM) nurse on patients who are out to medical with ILI/pneumonia.
- ☐ Review the daily movement sheet to identify patients that may have been sent out for HLOC due to ILI/respiratory symptoms.
- ☐ Attend daily Patient Care (PC) clinic huddles, as time permits, to identify any patients being seen that day with complaints of ILI symptoms.
- ☐ Establish a sustainable process by which Public Health and Infection Control staff are notified of patients that are put on precautions for ILI after hours.

ILI/ SUSPECTED COVID-19 STRATEGIC CONTROL STEPS

- Immediately mask patients when COVID-19 is suspected. Surgical or procedure masks are appropriate for patients. If there is a shortage of surgical/procedure masks, have the patients use tissue when coughing and/or cloth/bandana.
- Patients should be placed in AIIR as soon as possible (can order in EHRS). If AIIR is not immediately available, the patient shall be placed in a private room with the door closed.