APPENDIX 9: MEMO TEMPLATE FOR NOTIFICATION OF COVID-19 CASES AND CONTACTS RELEASED TO THE COMMUNITY

State of California
Department of Corrections and Rehabilitation

CALIFORNIA CORRECTIONAL HEALTH CARE SERVICES

Memorandum

CONFIDENTIAL

Date :

To : Local Health Officer: _____
OR Designee: _____
Local Heath Jurisdiction: _____
Fax # or email: _____

Subject: **COVID-19 Contact or Case (Confirmed or Suspected)**

The person identified below was or will be ☐ *transferred* ☐ *paroled* ☐ *released to post-release community supervision (PRCS)* to your institution/region on _____ (Date).

☐ The person is a **contact** to a confirmed case of COVID-19. The last date of exposure was _____(Date). The incubation period will end on _____(Date).

☐ The person has a ☐ *confirmed* ☐ *suspected* **case of COVID-19.**

The date of symptom onset was _____(Date).

Symptoms ☐ *have improved.* ☐ *have not improved.*

☐ Fever resolved w/out antipyretics on _____(Date).

☐ The patient subsequently tested negative for COVID-19 on _____(Date/s).

Identifying information for the person:

Name (Last, First): _____ Date of Birth: _____

Soc Sec #: _____-_____-_____ CDCR #: _____

Address and phone (if available): _____

If paroled or released to PRCS, contact info for parole or probation officer:

_____

For further information contact:

Institution: _____

Name of Public Health Nurse or Designee: _____

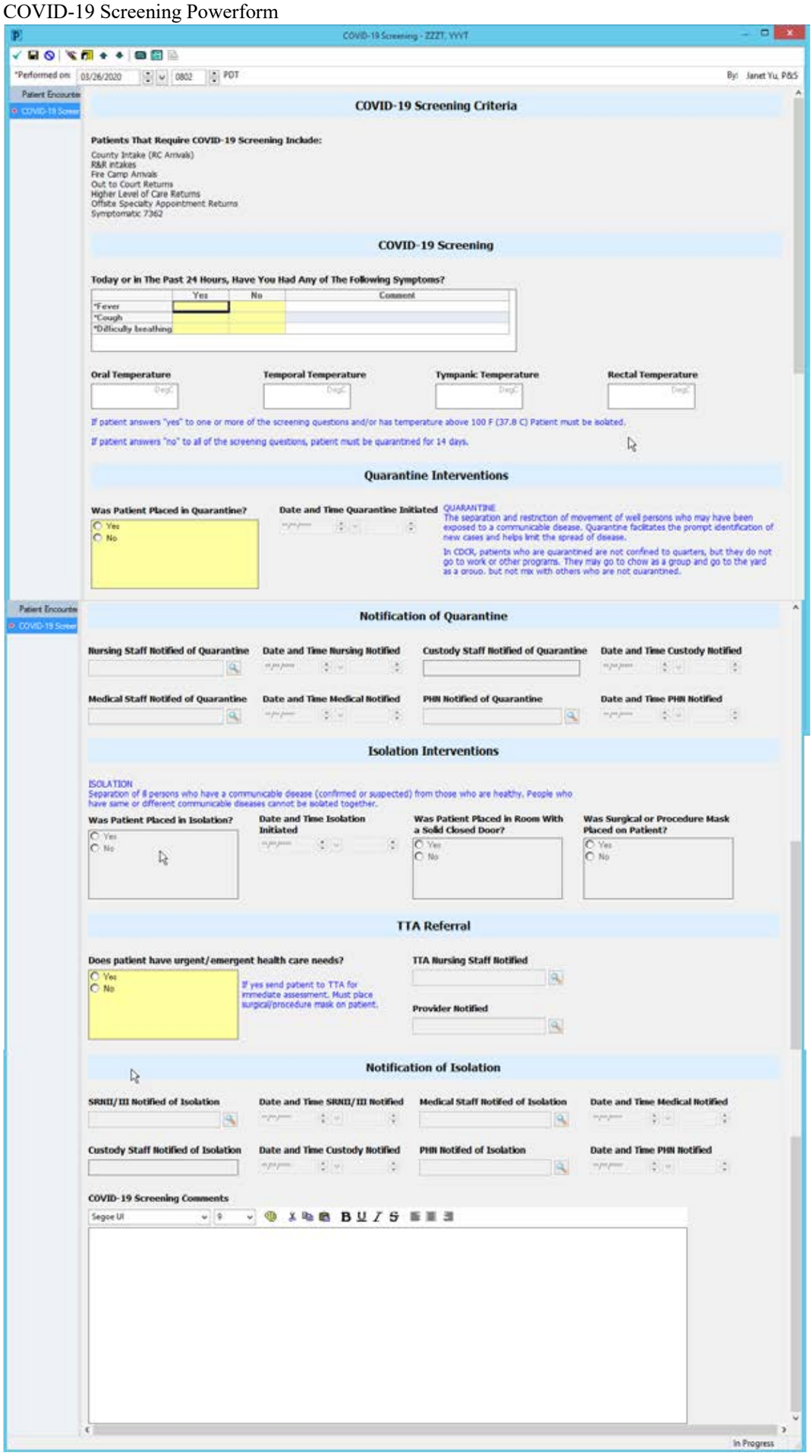
Phone Number: _____ Fax Number: _____

March 2020 *Page 1 of 1*

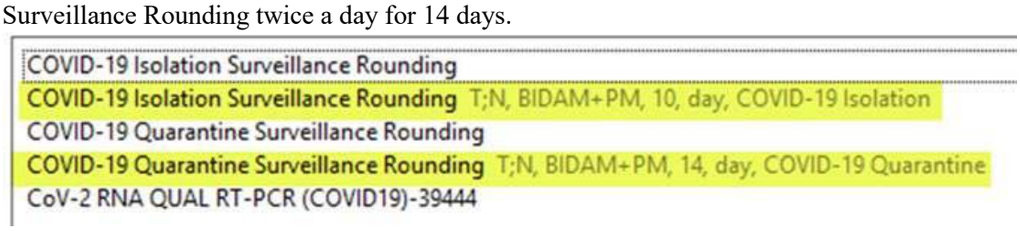
APPENDIX 10: COVID-19 POWERFORM INSTRUCTIONS; SCREENING, ISOLATION, AND QUARANTINE SURVEILLANCE

ORDERING PATHWAY: Adhoc > All Items > CareMobile Nursing Task > Surveillance Round

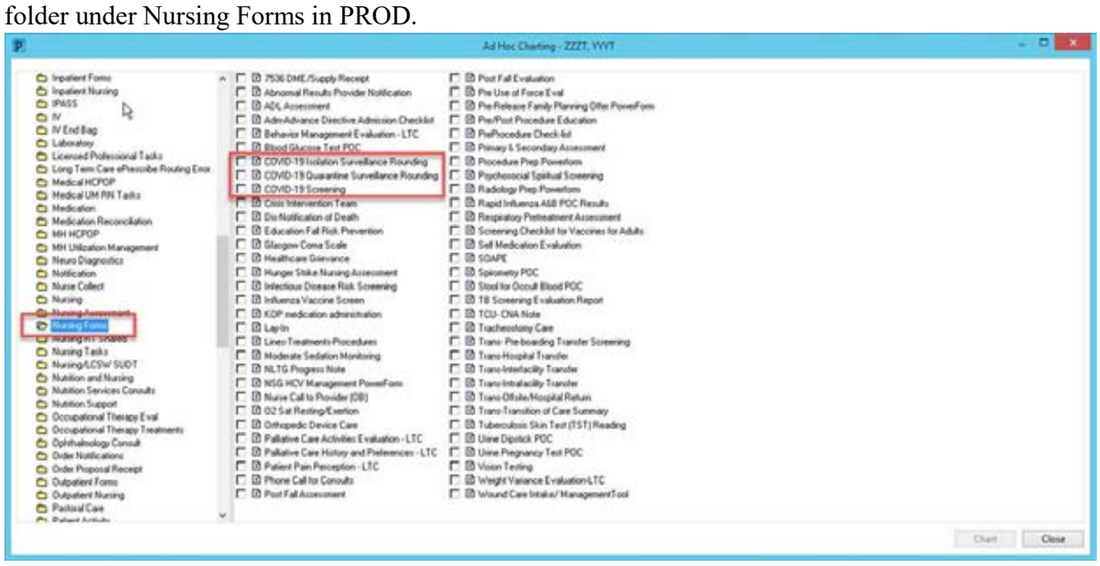
1. COVID-19 Screening Powerform



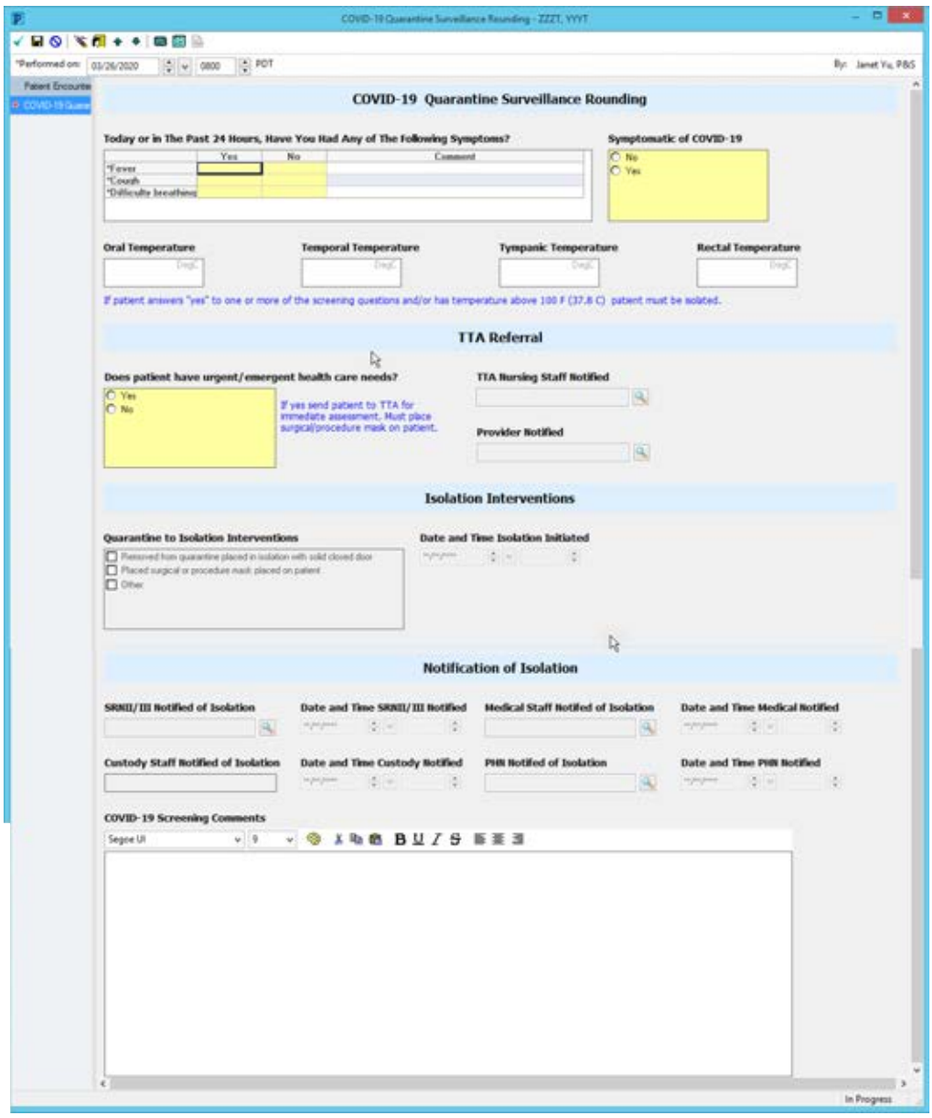
2. COVID-19 Isolation Surveillance Rounding twice a day for 10 days and COVID-19 Quarantine Surveillance Rounding twice a day for 14 days.



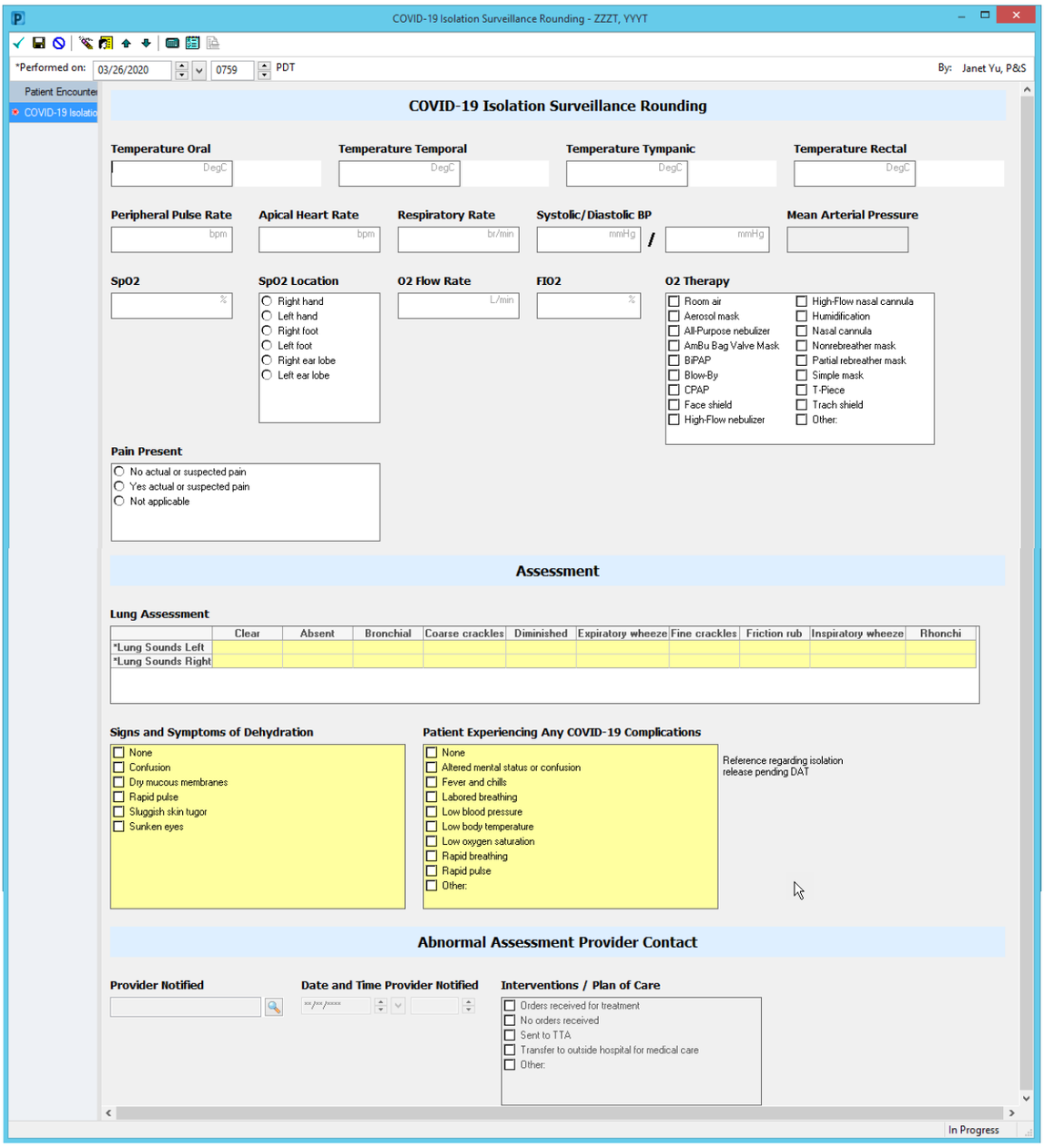
3. Once these orders are placed, it will trigger a task for the nurse to complete the appropriate Surveillance Rounding Powerform. These powerforms are currently viewable in the Adhoc folder under Nursing Forms in PROD.



COVID-19 Quarantine Surveillance Rounding



COVID-19 Isolation Surveillance Rounding



ATTACHMENT N

State of California Department of Corrections and Rehabilitation

Memorandum

Date: April 10, 2020

To: CDCR Extended Executive Staff

Subject: **INCREASE IN LAUNDRY SERVICES IN RESPONSE TO COVID-19 FACE MASKS DISTRIBUTION**

This memorandum is to notify all institutions that washable cloth barrier face masks will be issued to all inmates as a result of COVID-19. Masks will be manufactured by California Prison Industry Authority (CalPIA), received by CalPIA Administrators, and delivered to Wardens at each institution. Institutions will initially receive three face masks per inmate for immediate distribution, with a later distribution providing two additional face masks per inmate, for a total of five face masks per inmate per institution.

Masks should be laundered before being issued to inmates. Institutions will be notified by the Department Operations Center (DOC) of face mask deliveries no sooner than three days before the shipment is due to arrive.

As each institution receives their order, laundry services will be required to increase to a daily basis. If an increase in funding and the encumbered Purchase Order (PO) is needed, please complete the attached survey to note the increased funding needs. **Please return this spreadsheet to the DOC via email at DOCCOVID19@cdcr.ca.gov by COB Monday 4/13/20**. The DOC will coordinate funding allotments with the Budget Management Branch. In addition, please submit the required Encumbrance Adjustment Request – OBS450 to the ICSHelpdesk.

CalPIA is aware of the increased need and is prepared to provide the additional services. The following institutions do not participate in the agreement with CalPIA and therefore will need to increase the laundry services at their institutions, as applicable:

Adult

- California City Correctional Facility (CAC) - Laundering facility onsite.
- California Correctional Center (CCC) - Laundering facility onsite.
- California Correctional Institution (CCI) - Laundering facility onsite.
- Correctional Training Facility (CTF) - Laundering facility onsite.
- High Desert State Prison (HDSP) - Laundering facility onsite.
- Northern California Women's Facility (NCWF) - Services not needed. Warm shutdown site, no inmates/wards.
- Sierra Conservation Center (SCC) - Laundering facility onsite.

Juvenile

- Estrella (ECF) - Services not needed. Warm shutdown site, no inmates/wards.
- Stark (HGS) - Services not needed. Warm shutdown site, no inmates/wards

- Pine Grove (PGYCC) - Laundering facility onsite for youth items. Kitchen has an S&E for towels and aprons.
- Sierra Youth (SYCRCC)
- Ventura Youth (VYCF) - Laundering facility onsite.

For institutions utilizing an outside contractor for laundry services, the contractor must be noticed to inform them of an increase in services. **Notify the contact below if the contractor is unable to meet the increased need in services.** Following the assignment above, please ensure there is sufficient funding in current year laundry POs to accommodate the increase.

Increased laundry services are expected to continue until all inmates have been issued a total of five masks, as detailed above. Upon completion of distribution, laundry services will revert back to their normal schedule, as each inmate will have enough face masks to rotate into the normal laundry schedule and maintain a clean mask in their possession for usage.

As a reminder, the increased costs in laundry services should be documented on an Attachment I, COVID-19 Cost Reporting, as directed by the Budget Management Branch assignment issued on March 13, 2020.

For any questions or concerns, please contact Bedeth Victorioso, Staff Services Manager III, at **Bedeth.Victorioso@cdcr.ca.gov** or (916) 255-6208, or the DOC via email at **DOCCOVID19@cdcr.ca.gov.**

VIRUS SAFETY LAUNDRY GUIDE

Health experts advise washing your cloth face covering frequently, ideally after each use, or at least daily, along with your clothes.

Have a bag or bin to keep cloth face coverings and clothes in until they can be laundered.

Machine wash all clothes, coverings with detergent, hot water and dry on a hot cycle.

If you must re-wear your cloth face covering before washing, wash your hands immediately after putting it back on and avoid touching your face.

ATTACHMENT O

CALIFORNIA CORRECTIONAL HEALTH CARE SERVICES

MEMORANDUM

Date:	April 6, 2020
To:	California Department of Corrections and Rehabilitation (CDCR) - All Staff California Correctional Health Care Services (CCHCS) - All Staff
From:	*Original signed by:* Heidi M. Bauer, MD MS MPH Public Health Epi/Surveillance Lead Public Health Branch *Original signed by:* Diane O'Laughlin, FNP-BC, DNP Headquarters Chief Nurse Executive Public Health and Infection Prevention
Subject:	**COVID-19 Personal Protective Equipment (PPE) Guidance and Information**

The purpose of this memo is to provide information and resources related to COVID-19 and the continuously evolving status personal protective equipment (PPE) supply availability. The information below is intended to guide the use of PPE as we move forward in responding to this pandemic. In-depth guidance is provided in the COVID-19: Interim Guidance for Healthcare and Public Health Providers.

TYPES OF MASKS

Filtering facepiece respirator N95: An "N95" is a type of respirator which removes at least 95 percent of particles from the air that are breathed through it. An N95 currently has two recommended uses:

- Staff person accompanying individuals with respiratory symptoms in a transportation vehicle.
- A staff person present during "aerosol producing procedures" on suspect or confirmed COVID19 cases such as COVID-19 testing, CPR, etc. or providing high-contact patient care such as bathing someone confirmed to have COVID-19.

More information about N95 and surgical masks:

- Understanding the difference between N95 and Surgical Masks
- Proper use and disposal of PPE
- Facial hair and PPE use

Use of Privately Owned Masks and Respirators and Reusable barrier masks (cloth/washable): "The Joint Commission (TJC) issued a statement on March 31, 2020, supporting the use of standard face masks and/or respirators provided from home when health care organizations cannot provide access to protective equipment that is commensurate with the risk health care workers are exposed to amid the COVID-19 pandemic. The CDCR/CCHCS will follow the TJC recommendations for privately owned PPE,

MEMORANDUM

including N95 and surgical masks. Please wash reusable cloth masks between each use using hot water with regular detergent and dry completely on hot setting.

EXTENDING THE USE OF PPE (MEDICAL EQUIPMENT MASKS)

The CDC has put out guidance on extending the use of medical equipment masks. There is not an exact determination on the number of safe reuses for these masks and those decisions must be made based on a number of variables per CDC guidelines such as impact respirator function and contamination over time.

RESOURCES

The **COVID-19 Quick Guide Poster** follows Center for Disease Control (CDC) guidelines for COVID-19 management. This quick guide defines quarantine, who to isolate, COVID-19 case actions and how to perform appropriate surveillance during the COVID-19 pandemic. The COVID-19 Quick Guide Poster pairs with the Personal Protective Equipment (PPE) Guide Poster, number 2 below, to inform staff on what type of PPE they will need.

The **COVID-19 Protective Equipment (PPE) Guide Poster** adopts CDC guidelines as of March 29, 2020, which reflect the CDC's recommendations for optimizing PPE supplies (link below). The PPE guide poster reinforces 6 foot social distancing, and gives guidance for individuals who must be within 6 feet for a prolonged period of time of suspected/confirmed COVID-19 individuals.

A **COVID-19 Quick Reference Pocket Guide** is intended to keep on person as a resource for PPE, quarantine, isolation and surveillance.

The CDC also provides recommendations for optimizing PPE supplies.

These resource tools, TJC statement on privately owned face masks, and current available supplies should all be considered when determining the type of PPE staff will use for the safety of staff and the population. Please place the posters in high traffic staff areas to remind staff of these key concepts for COVID-19 management. Please assure your staff is aware of these resource tools.

Thank you all for your cooperation, as we continue to work together to guard against the spread of COVID-19 and to keep our staff and patients protected.

CALIFORNIA CORRECTIONAL HEALTH CARE SERVICES

MEMORANDUM

Date:	April 6, 2020
To:	California Department of Corrections and Rehabilitation (CDCR) All Staff California Correctional Health Care Services (CCHCS) All Staff
From:	*Original Signed By* Connie Gipson Director, Division of Adult Institutions California Department of Corrections and Rehabilitation *Original Signed By* R. Steven Tharratt, MD, MPVM, FACP Director of Health Care Operations and Statewide Chief Medical Executive California Correctional Health Care Services
Subject:	**STAFF USE OF PERSONAL PROTECTIVE EQUIPMENT (PPE)**

We understand the importance and urgency surrounding the availability and use of personal protective equipment (PPE), particularly masks, for CDCR/CCHCS staff and the incarcerated population. Our top priority is doing everything we can to provide appropriate protection to slow the spread of COVID-19 within our institutions.

We must face the reality that during this global pandemic, CDCR and CCHCS are not immune from the unprecedented demand for more PPE to protect those on the frontlines. While we are not the only organization impacted by this shortage, we are working every day to increase our supplies, including reusable barrier cloth masks manufactured by the California Prison Industry Authority (CALPIA). While we work to expand our supply, we all need to do our part to make sure that PPE, especially masks, are utilized in the most appropriate and efficient way possible. We need a mutual understanding of PPE and develop innovative solutions to help increase our supply.

See COVID-19 Personal Protective Equipment (PPE) Guidance and Information from CDCR/CCHCS Public Health.

PPE including “medical grade” masks (N95 and surgical) should only be used by both CDCR and CCHCS staff as recommended in the memo above. The Centers for Disease Control and Prevention (CDC) and California Department of Public Health (CDPH) issued guidance recommending face cloth covering in the general public and in close quarters. We understand that additional facial protection can potentially limit “droplet” transmission while also offering some peace of mind to our staff, their families, stakeholders and our population. To help address this moment of need, CALPIA has

started manufacturing two-ply, cotton, reusable barrier masks that we will start distributing to our population in quarantine settings this week. Distribution of the masks will begin for inmates in quarantine and medically fragile inmates. As CALPIA continues to expand the production of these masks, we will also make them available to the general population and staff who do not have access to face coverings as a precautionary measure as supply allows. CALPIA is making 800 masks per day between two locations and will continue to ramp up to full production to meet the expected needs.

CALPIA also began ramping up their brand new production of hand sanitizer, which has already started arriving at most institutions and locations. We are extremely grateful for CALPIA and our population workers providing these valuable services in such a short time frame.

FACE COVERINGS (REUSABLE BARRIER CLOTH MASKS)

While we continue internal production and procurement of PPE, CDCR and CCHCS will also follow the recently released guidance from The Joint Commission (TJC), a trusted health care accreditation organization, by allowing staff to bring in a personal supply of reusable barrier (cloth) masks and approved medical masks if supply is not readily available. Any personally provided mask must be appropriate for the workplace and cannot contain any inherently offensive logos, graphics or text. Designer face masks that have skulls, "gate keeper," "punisher," logos, etc. on them (motorcycle type) would not be appropriate and employees will not be permitted to wear while on duty. The Department assumes no responsibility for personally owned face coverings. Staff will be required to remove face coverings for identification purposes at entry points.

Recommended PPE as described should be utilized first; if recommended PPE is not available use the most comparable coverage.

EXPANDING SUPPLY

The CDCR and CCHCS procurement teams are rigorously searching for PPE supplies, especially masks, to purchase. If you have a lead, please send the information to COVID19@cdcr.ca.gov. We are looking into innovative solutions we may never have considered before, such as smaller supply vendors and more. Our top priority is the safety of all those who live and work in our facilities, and we are doing all we can to get you the protection you need.

Please continue to provide feedback to the local leadership at your facility, headquarters and the CDCR/CCHCS COVID-19 Department Operations Center.

We truly appreciate all of our staff working hard on the front lines as we are making unprecedented changes to our operations to keep everyone healthy and safe. There are sure to be changes over the next several weeks, and so we thank you for the flexibility, patience and support for that you all have provided to each other. We are all CDCR Strong.

ATTACHMENT P

COVID-19 QUICK GUIDE

QUARANTINE
Exposed to confirmed COVID-19 case with no signs or symptoms. Screening questions and temperatures twice daily. In cases of extreme hardship, screening and temperatures a minimum of once daily may be approved jointly by the local CEO, CNE and CME

SUSPECT: ALONE
Sick – Individuals with signs and symptoms. Test for Influenza and COVID-19 immediately. Vital signs and 02 SATS twice daily. Await diagnoses & monitor symptoms. (DO NOT house with other sick people, as we DO NOT know the pathogen). If suspect confirmed as positive for COVID-19, move to COVID-19 CASE status.

COVID-19: ISOLATE
Sick – Individuals with confirmed COVID-19 diagnosis. Vitals signs and 02 SATS twice daily. Assess for worsening symptoms & recovery. (DO isolate CONFIRMED COVID-19 together, as we DO know the pathogen. DO NOT house COVID-19 cases with influenza cases).

COVID-19 QUICK GUIDE

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COVID-19 STAFF PPE GUIDE

Screener less than 6 feet from staff or visitor	Surgical mask, eye protection, hand hygiene
Person less than 6 feet from quarantined individual	Surgical mask, eye protection, hand hygiene (gloves if contact)
Person less than 6 feet from suspect individual	Surgical mask, eye protection, gloves, hand hygiene
Person less than 6 feet from confirmed COVID-19 case	Surgical mask, eye protection, gloves, hand hygiene
Person accompanying any patients with respiratory symptoms in transport vehicle	Respirator N95, eye protection, gown, gloves
Person less than 6 feet from confirmed COVID-19 case & aerosol producing procedure (COVID-19 testing, CPR etc.) OR high contact patient care (bathing, etc.)	Respirator N95, eye protection, gown, gloves

COVID-19 STAFF PPE GUIDE

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ATTACHMENT Q

CALIFORNIA CORRECTIONAL HEALTH CARE SERVICES

MEMORANDUM

Date: April 15, 2020

To: Wardens
Chief Executive Officers

From:
Original Signed By
Connie Gipson
Director, Division of Adult Institutions
California Department of Corrections and Rehabilitation

Original Signed By
R. Steven Tharratt, MD, MPVM, FACP
Director of Health Care Operations and Statewide Chief Medical Executive
California Correctional Health Care Services

Subject: **CALPIA CLOTH FACE BARRIER/MASK**

As an on ongoing effort to prevent further exposure of COVID-19, the following information is intended to provide guidance on the use of cloth masks by staff and inmates/patients who are performing day-to-day activities within our institutions. This guidance is not a substitute for health care and custody staff following current Centers for Disease Control and Prevention or county health department recommendations in dealing with suspected, quarantine or diagnosed patients. Staff and inmates/patients are required to wear a face barrier once a supply of two (2) face barriers/masks per correctional staff and inmate/patient has been delivered to the institution. Staff may bring in their own face coverings as previously communicated.

Staff working or performing duties on institutional grounds shall wear a cloth face covering at a minimum. In addition, maintaining social distancing requirements when moving about the institution for routine tasks is still recommended. These masks are not intended for direct patient care scenarios.

Inmates shall use a cloth face covering within the institution during the following activities:

- Any situation that requires movement outside of cell or while in a dorm setting
- During interactions with other inmates (ex: yard time, canteen, dayroom)
- Movement to and from for health care appointments
- Movement to and from medication administration areas

MEMORANDUM

Wardens and Chief Executive Officers should work together in developing an informational directive to all staff and inmate/patients on this wear requirement. Institutions, CIM, LAC, CHCF, have received their masks and therefore this expectation is effective immediately.

If you have any questions, please email DOCCOVID19@cdcr.ca.gov.

ATTACHMENT R

Memorandum

Date: April 8, 2020

To: Associate Directors, Division of Adult Institutions
Wardens

Subject: **COVID-RELATED CLEANING PROTOCOLS FOR INSTITUTIONS**

The California Department of Corrections and Rehabilitation's priority is to protect the health and well-being of our staff and the offender population as well as providing a safe environment. The purpose of the memorandum is to reduce staff and inmate exposure to the coronavirus (COVID-19) within our institutions by providing guidance on cleaning and disinfection protocols as recommended by the Centers for Disease Control and Prevention (CDC). Due to the current COVID-19 pandemic, and out of an abundance of caution, we are distributing information on best practices for cleaning and disinfecting your work areas.

According to the CDC definitions, retrieved March 3, 2020, from: https://cdc.gov/Coronavirus/2019-ncov/comunity/organizations/cleaning-disinfection:

Cleaning - refers to the removal of dirt and impurities, including germs, from surfaces. Cleaning alone does not kill germs. But by removing the germs, it decreases their number and therefore any risk of spreading infection.

Disinfecting - works by using chemicals, for example EPA-registered disinfectants, to kill germs on surfaces. This process does not necessarily clean dirty surfaces or remove germs. But killing germs remaining on a surface after cleaning further reduces any risk of spreading infection.

Staff are to ensure that assigned porters are thoroughly cleaning communal areas (dayrooms, showers, restrooms, offices, etc.) a minimum of twice per shift during second and third watches with the option to clean more often if needed. The area porters will initial the cleaning schedule template (see attachment) documenting the time it was complete. Staff will sign the sheet verifying that they have reviewed and ensured the additional cleaning was completed. As we increase our cleaning times, we must continue to practice social distancing when possible.

It is recommended staff increase the frequency in which they disinfect the touchpoints (i.e. telephones, tables, door knobs, desk areas, etc.) by using Sani Guard 24/7 in their work area. Once the Sani Guard has been applied to a surface, it should be allowed to set for 10 minutes to maximize its effectiveness.

Attached is essential information on the cleaning solutions used in the institutions, and dilution ratios for mixing Cell Block and Sani Guard 24/7.

If you have any additional questions, please contact your Mission Associate Director.

CONNIE GIPSON
Director
Division of Adult Institutions

PROTOCOL: CLEAN AND DISINFECT for emerging pathogen COVID-19

Best Practices : CLEAN AND DISINFECT for emerging pathogen COVID-19

Option 1 -

CELL BLOCK 64 - Refer to label instructions for Adenovirus type7. Mix 8oz of CELL BLOCK 64 to one gallon of water. Apply to surface, lightly agitate and let disinfectant set on the surface for a minimum of 10 minutes, then wipe clean.

Option 2 -

Clean with Cell Block 64 at the normal dilution ratio of 2 oz per gallon of water (chemical dispensers are set to this ratio). Apply Cell Block 64, agitate and let set on surface for a minimum of 10 minutes and wipe dry. Apply SANI-GUARD 24/7 at 3 oz per 5 gallons of water (refer to Sani Guard 24/7 label instructions for H1N1). Allow disinfectant to remain wet on the surface for a minimum of 10 minutes and wipe off or let air dry.

Option 3-

Disinfect only - **PLEASE NOTE**, surface must be free of debris and clean before applying Sani Guard 24/7.

Refer to product label instructions for H1N1. Dilute 3oz of Sani Guard 24/7 to 5 gallons of water. Apply solution to non porous surfaces and remain wet for a minimum of 10 minutes. Wipe or let air dry.

CELL BLOCK 64 LABEL

Please review the entire bottle label before use.

From the Cell Block 64 Label:

DILUTION (1:64)	2 oz. per gallon of water	8 oz. per 4 gallons of water	12 oz. per 6 gallons of water
(660 ppm quat)	4 oz. per 2 gallons of water	10 oz. per 5 gallons of water	

DIRECTIONS FOR USE

It is a violation of Federal law to use this product in a manner inconsistent with its labeling.
This product is not for use on medical device surfaces.
DISINFECTION /CLEANING/DEODORIZING DIRECTIONS: Remove heavy soil deposits from surface, then thoroughly wet surface with a use-solution of 2 ounces of the concentrate per gallon of water. Use 8 oz. per gallon of water to kill Adenovirus Type 7.
The use-solution can be applied with a cloth, mop, sponge, or coarse spray or by soaking. For sprayer applications, use a coarse spray device. Spray 6-8 inches from the surface, rub with a brush, cloth or sponge. Do not breathe spray. Let solution remain on surface for a minimum of 10 minutes. Rinse or allow to air dry. Rinsing of floors is not necessary unless they are to be waxed or polished.
Food contact surfaces must be thoroughly rinsed with potable water. This product must not be used to clean the following food contact surfaces: utensils, glassware and dishes.

(Continued directions for use.)
CLEANING AND DISINFECTING HARD NONPOROUS SURFACES ON PERSONAL PROTECTIVE EQUIPMENT RESPIRATORS:
Preclean equipment if heavily soiled to ensure proper surface contact. Add 2 oz. of this product to one gallon of water. Use 8 oz per gallon of water to kill Adenovirus Type 7. Gently mix for a uniform solution. Apply solution to hard, nonporous surfaces of the respirator with a brush, coarse spray device, sponge, or by immersion. Thoroughly wet all surfaces to be disinfected. Treated surfaces must remain wet for 10 minutes. Remove excess solution from equipment prior to storage. Comply with all OSHA regulations for cleaning respiratory protection equipment (29 CFR §1910.134).

From the Sani-Guard 24-7 Label:

Sani-Guard 24-7 is a hospital Disinfectant, Bactericidal according to the current AOAC Disinfectants Use-Dilution Method. Fungicidal according to the AOAC Fungicidal Test, and Virucidal* according to the virucidal qualification, modified in the presence of 5% organic serum against:

Bacteria:
Burkholderia cepacia
Campylobacter jejuni [Campylobacter]
Corynebacterium ammoniagenes
Escherichia coli [E. coli]
Escherichia coli pathogenic strain O157:H7 [pathogenic E. coli]
Klebsiella pneumoniae [Klebsiella]
Listeria monocytogenes [Listeria]
Pseudomonas aeruginosa [Pseudomonas]
Salmonella enterica [Salmonella]
Salmonella typhi [Salmonella]
Shigella dysenteriae [Shigella]
Staphylococcus aureus [Staph]
Staphylococcus aureus - Community Associated Methicillin-Resistant [CA-MRSA] [NRS123] [USA400]
Staphylococcus aureus - Methicillin-Resistant [MRSA]
Yersinia enterocolitica

Viruses:
*Adenovirus Type 5
*Adenovirus Type 7
*Hepatitis B Virus [HBV]
*Hepatitis C Virus [HCV]
*Herpes Simplex Virus Type 1 [Herpes]
*Herpes Simplex Virus Type 2 [Herpes]
*Human Coronavirus
*Human Immunodeficiency Virus Type 1 [HIV-1] [AIDS Virus]
*Influenza A2 / Hong Kong Influenza Flu Virus
*Norovirus - Feline Calicivirus
*SARS Associated Human Coronavirus
*Vaccinia Virus [Pox Virus]

Fungi:
Aspergillus niger
Trichophyton mentagrophytes

DILUTION:

Disinfection (1:213)	3 oz. per 5 gallons of water [450 ppm active quat]
Sanitizer (1:256)	1/2 oz. per gallon of water [2 1/2 oz. per 5 gallons of water] [400 ppm active quat]
Sanitizer (1:512)	1/4 oz. per gallon of water [1 oz. per 4 gallons of water] [1 1/4 oz. per 5 gallons of water] [200 ppm active quat]
Sanitizer (1:640)	1/5 oz. per gallon of water [1 oz. per 5 gallons of water] [150 ppm active quat]

DIRECTIONS FOR USE

It is a violation of Federal law to use this product in a manner inconsistent with its labeling.

DISINFECTION / VIRUCIDAL*/ FUNGICIDAL / MOLD AND MILDEW CONTROL DIRECTIONS:
Add 3 oz. of Sani-Guard 24-7 per 5 gallons of water (or equivalent dilution) to disinfect hard, nonporous surfaces.
Before use in federally inspected meat and poultry food processing plants and dairies, food products and packaging materials must be removed from the room or carefully protected. When used on surfaces in areas such as locker rooms, dressing rooms, shower and bath areas and exercise facilities, this product is an effective fungicide against Trichophyton mentagrophytes (the athlete's foot fungus). Apply use-solution with a cloth, mop, sponge, sprayer or by immersion, thoroughly wetting surfaces. For sprayer applications, use a coarse spray device. Spray 6 - 8 inches from surface, rub with brush, sponge or cloth. Do not breathe spray.
Note: For spray applications, cover or remove all food products.
Treated surfaces must remain wet for 10 minutes. Wipe dry with a clean cloth, sponge or mop or allow to air dry. Rinse food contact surfaces such as counter tops, tables, picnic tables, exteriors of appliances and/or stove tops with potable water prior to reuse. Do not use on glasses, dishes or utensils as a disinfectant. For heavily soiled areas, preclean first.

CALPIA
Quality Products ★ Changed Lives ★ A Safer California

Memorandum

Date: March 25, 2020

To: CALPIA Healthcare Customers

From: California Prison Industry Authority • 560 East Natoma Street • Folsom, California 95630-2200

Subject: **SARS-CoV-2 Supplemental Communication**

CALPIA was notified by Lonza, LLC, manufacturer of components used in the production of Cell Block 64 and Sani-Guard 24-7, of the following:

On March 13, 2020 (updated March 19), EPA published an updated list N (https://www.epa.gov/pesticide-registration/list-n-disinfectants-use-against-sars-cov-2) for disinfectant products with emerging viral pathogen and Human Coronavirus claims for use against SARS-CoV-2, the cause of COVID disease.

"Inclusion on this list does not constitute an endorsement by EPA. There may be additional disinfectants that meet the criteria for use against SARS-CoV-2. EPA will update this list with additional products as needed."

Lonza, LLC offers many registrations that were evaluated and accepted by EPA under the Emerging Viral Pathogen program (EVP) listed in Annex 1, and Human Coronavirus listed in Annex 2.

Key clarification:
Annex 1 listed products can make efficacy claims against SARS-CoV-2 in accordance with EPA's Emerging Viral Program.

Annex 2 listed products can be used against SARS-CoV-2 by people only when Annex 1 products are not available. Lonza has submitted Annex 2 products to the EPA to make efficacy claims against SARS-CoV-2 in accordance with EPA's Emerging Viral program. This communication will be updated when Annex 2 product reviews are completed and accepted by the EPA to make claims.

For any supplemental registration based upon any of these listed EPA registered products, customers may make off-label* communications in the following formats:

Cell Block 64 (HWS-64)
COVID-19 is caused by SARS-CoV-2, a novel coronavirus. Cell Block 64 kills similar viruses and therefore can be used against SARS-CoV-2 when used in accordance with the directions for use against Adenovirus type 7 on hard, non-porous surfaces. Refer to the CDC website at https://www.cdc.gov/coronavirus/2019-ncov/index.html for additional information.

Sani-Guard 24-7 (BARDAC 205M-10)
COVID-19 is caused by SARS-CoV-2, a novel coronavirus. Sani-Guard 24-7 (BARDAC 205M-10) kills similar viruses and therefore can be used against SARS-CoV-2 when used in accordance with the directions for use against Norovirus on hard, non-porous surfaces. Refer to the CDC website at https://www.cdc.gov/coronavirus/2019-ncov/index.html for additional information.

If you have any questions, please contact CALPIA at chemicals@calpia.ca.gov.

*Label: The written, printed, or graphic matter on, or attached to, the pesticide or device or any of its containers or wrappers. (https://www.epa.gov/sites/production/files/2018-04/documents/chap-03-mar-2018_1.pdf)

Specialty Ingredients

Lonza

ANNEX 1

NUGEN® MB⁵A Family	EPA Reg. #	Supporting Viral Claim
NUGEN® MB⁵A-256	6836-361	Norovirus (Norwalk Virus) or Rotavirus
NUGEN® MB⁵A -128	6836-362	Norovirus (Norwalk Virus) or Rotavirus
NUGEN® MB⁵A -64	6836-363	Norovirus (Norwalk Virus) or Rotavirus

NUGEN® MB⁵N Family	EPA Reg. #	Supporting Viral Claim
NUGEN® MB⁵N-256	6836-364	Norovirus (Norwalk Virus)
NUGEN® MB⁵N-128	6836-365	Norovirus (Norwalk Virus)
NUGEN® MB⁵N-64	6836-366	Norovirus (Norwalk Virus)

Lonzagard® RCS™ Family	EPA Reg. #	Supporting Viral Claim
Lonzagard® RCS-256 Plus	6836-349	Enterovirus D68 or Norovirus
Lonzagard® RCS-256	6836-346	Enterovirus D68 or Norovirus
Lonzagard® RCS-128 Plus	6836-348	Enterovirus D68 or Norovirus
Lonzagard® RCS-128	6836-347	Enterovirus D68 or Norovirus

Lonzagard® R-82 Family	EPA Reg. #	Supporting Viral Claim
Lonzagard® R-82	6836-78	Norovirus (Norwalk Virus)
Lonzagard® S-18	6836-77	Norovirus (Norwalk Virus)
Lonzagard® S-21	6836-75	Norovirus (Norwalk Virus)
Lonzagard® DC-103	6836-152	Norovirus (Norwalk Virus)
Lonzagard® R-82F	6836-139	Norovirus (Norwalk Virus)
Lonzagard® S-18F	6836-136	Norovirus (Norwalk Virus)
Lonzagard® S-21F	6836-140	Norovirus (Norwalk Virus)

Lonzagard® HWS Family	EPA Reg. #	Supporting Viral Claim
Lonzagard® HWS-256	47371-129	Adenovirus type 7
Lonzagard® HWS-128	47371-130	Adenovirus type 7
Lonzagard® HWS-64	47371-131	Adenovirus type 7
Lonzagard® HWS-32	47371-192	Adenovirus type 7

Lonzagard® Bardac® 205M Family	EPA Reg. #	Supporting Viral Claim
Bardac® 205M 1.3%	6836-277	Norovirus (Norwalk Virus)
Bardac® 205M 2.6%	6836-302	Norovirus (Norwalk Virus)
Bardac® 205M 5.2%	6836-303	Norovirus (Norwalk Virus)
Bardac® 205M 7.5%	6836-070	Norovirus (Norwalk Virus)
Bardac® 205M 10%	6836-266	Norovirus (Norwalk Virus)
Bardac® 205M 14.08%	6836-278	Norovirus (Norwalk Virus)
Bardac® 205M 23%	6836-305	Norovirus (Norwalk Virus)
Bardac® 205M RTU	6836-289	Norovirus (Norwalk Virus)

Disinfecting Wipes Family	EPA Reg. #	Supporting Viral Claim
Lonzagard® Disinfectant Wipes	6836-313	Rotavirus
Lonzagard® Disinfectant Wipes Plus 2	6836-340	Norovirus (Norwalk Virus)

NUGEN® EHP Family	EPA Reg. #	Supporting Viral Claim
NUGEN® EHP RTU	6836-385	Norovirus (Norwalk Virus)
NUGEN® EHP Wipe	6836-388	Norovirus (Norwalk Virus)

Specialty Ingredients

Lonza

ANNEX 2

Bardac® 205M Family	EPA Reg. #	Coronavirus Claim
Bardac® 205M 50%	6836-233	Human Coronavirus SARS Associated Coronavirus

Disinfectant wipes Family	EPA Reg. #	Coronavirus Claim
NUGEN® 2M Disinfectant wipes	6836-372	Human Coronavirus SARS Associated Coronavirus
Lonzagard® Disinfectant Wipes Plus	6836-336	Human Coronavirus SARS Associated Coronavirus

Cleaning Schedule Week of:_____

Monday

Date:_____

1st Watch

Area:_____

Areas	Time	Time	Time
Restroom			
Showers			
Sinks			
Dayroom			

Inmate Name:_____

Staff Signature:_____

2nd Watch

Area:_____

Areas	Time	Time	Time
Restroom			
Showers			
Sinks			
Dayroom			

Inmate Name:_____

Staff Signature:_____

3rd Watch

Area:_____

Areas	Time	Time	Time
Restroom			
Showers			
Sinks			
Dayroom			

Inmate Name:_____

Staff Signature:_____

Tuesday

Date:_____

1st Watch

Area:_____

Areas	Time	Time	Time
Restroom			
Showers			
Sinks			
Dayroom			

Inmate Name:_____

Staff Signature:_____

2nd Watch

Area:_____

Areas	Time	Time	Time
Restroom			
Showers			
Sinks			
Dayroom			

Inmate Name:_____

Staff Signature:_____

3rd Watch

Area:_____

Areas	Time	Time	Time
Restroom			
Showers			
Sinks			
Dayroom			

Inmate Name:_____

Staff Signature:_____

Wednesday

Date:_____

1st Watch

Area:_____

Areas	Time	Time	Time
Restroom			
Showers			
Sinks			
Dayroom			

Inmate Name:_____

Staff Signature:_____

2nd Watch

Area:_____

Areas	Time	Time	Time
Restroom			
Showers			
Sinks			
Dayroom			

Inmate Name:_____

Staff Signature:_____

3rd Watch

Area:_____

Areas	Time	Time	Time
Restroom			
Showers			
Sinks			
Dayroom			

Inmate Name:_____

Staff Signature:_____

Thursday

Date:_____

1st Watch

Area:_____

Areas	Time	Time	Time
Restroom			
Showers			
Sinks			
Dayroom			

Inmate Name:_____

Staff Signature:_____

2nd Watch

Area:_____

Areas	Time	Time	Time
Restroom			
Showers			
Sinks			
Dayroom			

Inmate Name:_____

Staff Signature:_____

3rd Watch

Area:_____

Areas	Time	Time	Time
Restroom			
Showers			
Sinks			
Dayroom			

Inmate Name:_____

Staff Signature:_____

Friday

Date:_____

1st Watch

Area:_____

Areas	Time	Time	Time
Restroom			
Showers			
Sinks			
Dayroom			

Inmate Name:_____

Staff Signature:_____

2nd Watch

Area:_____

Areas	Time	Time	Time
Restroom			
Showers			
Sinks			
Dayroom			

Inmate Name:_____

Staff Signature:_____

3rd Watch

Area:_____

Areas	Time	Time	Time
Restroom			
Showers			
Sinks			
Dayroom			

Inmate Name:_____

Staff Signature:_____

Saturday

Date:_____

1st Watch

Area:_____

Areas	Time	Time	Time
Restroom			
Showers			
Sinks			
Dayroom			

Inmate Name:_____

Staff Signature:_____

2nd Watch

Area:_____

Areas	Time	Time	Time
Restroom			
Showers			
Sinks			
Dayroom			

Inmate Name:_____

Staff Signature:_____

3rd Watch

Area:_____

Areas	Time	Time	Time
Restroom			
Showers			
Sinks			
Dayroom			

Inmate Name:_____

Staff Signature:_____

Sunday

Date:_____

1st Watch

Area:_____

Areas	Time	Time	Time
Restroom			
Showers			
Sinks			
Dayroom			

Inmate Name:_____

Staff Signature:_____

2nd Watch

Area:_____

Areas	Time	Time	Time
Restroom			
Showers			
Sinks			
Dayroom			

Inmate Name:_____

Staff Signature:_____

3rd Watch

Area:_____

Areas	Time	Time	Time
Restroom			
Showers			
Sinks			
Dayroom			

Inmate Name:_____

Staff Signature:_____

*Please ensure there are disinfectant and paper towels near ALL telephones

*Cleaning at a minimum of every 3 hours

ATTACHMENT S

Memorandum

Date: APR 10 2020

To: Associate Directors, Division of Adult Institutions
Wardens
Chief Executive Officers

Subject: **SCREENING OF CRITICAL INMATE WORKERS**

In response to current the Coronavirus Disease 2019 (COVID-19) pandemic the California Department of Corrections (CDCR) and California Correctional Health Care Services (CCHCS) are implementing the following precautions to reduce exposure to both inmates and staff.

Screening Process
Prior to releasing a critical inmate worker, the housing unit floor officer shall ask three screening questions to determine if the inmate has symptoms of influenza-like illness (ILI) including COVID-19. The screening shall include asking an inmate the following questions: Do you have a cough? Do you have a fever? Do you have difficulty breathing? If the critical inmate worker answers no to all the questions, they shall be allowed to report to work. If the critical inmate worker answers yes to any of the questions, the housing unit floor officer shall notify their immediate supervisor, and the inmate's work supervisor that the inmate will not be reporting to work.

The custody supervisor who was notified by the housing unit floor officer shall contact the nursing staff on the affected facility of the initial screening outcome. Custody escorting staff and the affected inmate shall don appropriate personal protective equipment and the inmate shall be escorted to the triage screening area for medical evaluation. If a positive screen for ILI/COVID-19 is a result of the medical evaluation, the inmate shall be housed as appropriate based upon custody and clinical protocols. If a negative screen for ILI/COVID-19 is a result of the medical evaluation, the inmate shall be escorted back to his assigned housing unit.

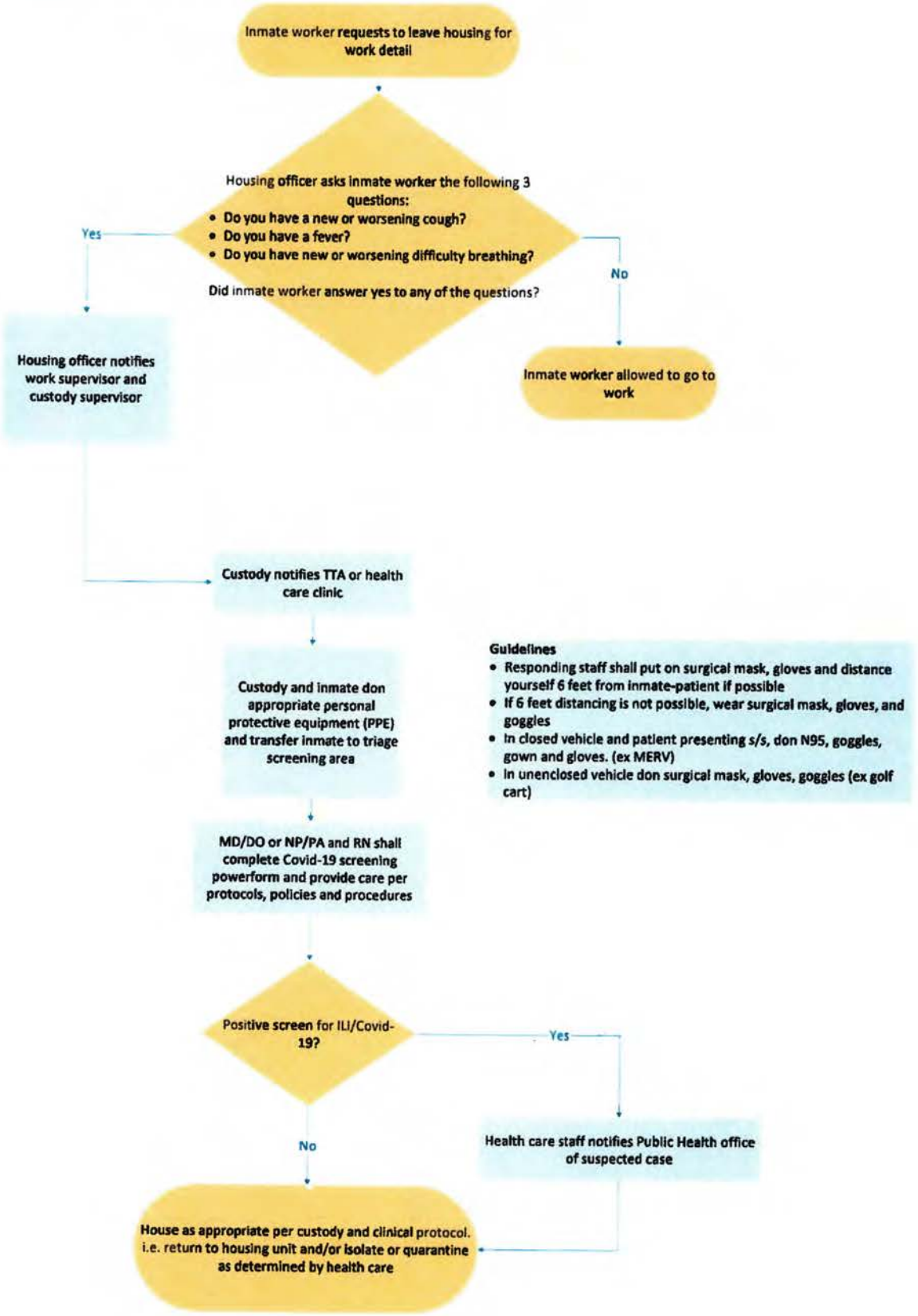
The health and safety of all individuals within the institution is our top priority. Please work together at the institution to operationalize the process provided above.

CONNIE GIPSON
Director
Division of Adult Institutions

Electronically Signed
STEVEN THARRATT, MD, MPVM, FACP
Director, Health Care Operations
Statewide Chief Medical Executive

Attachments

Covid-19: Inmate Worker



CALIFORNIA CORRECTIONAL HEALTH CARE SERVICES

Covid-19: Housing

Type of Housing Unit Location for Influenza (Flu) and Covid-19

Quarantine/ Contact Housing

Confirmed Influenza or Covid-19 exposure
Without signs and symptoms

High Risk Patients should be isolated in single cell status.
(Example: High Risk 1&2, over 65, comorbidities, pregnant)

Quarantine housing
Quarantine Period: 14 days

Develops signs and symptoms

No → Return to regular housing once quarantine completed

Yes → **Suspect Housing**

Suspect with signs and symptoms of ILI

Individually Isolated

Quarantine/ Contact without signs and symptoms

Guidelines

- If any signs and symptoms of ILI develops move that inmate-patient to suspect housing
- If housing location is in a cell setting and signs and symptoms develop for any inmate-patient: cellmate restarts quarantine time of 14 days
- If housing location is in a dorm setting and signs and symptoms develop for any inmate-patient: entire cohort restarts quarantine time 14 days.

Suspect with signs and symptoms of ILI

Guidelines

- Flu and Covid-19 diagnosed via laboratory testing
- If confirmed Covid-19, transfer to confirmed Covid-19 housing
- If confirmed flu, transfer to confirmed flu housing
- May house all sick patients in one building as long as each individual is isolated

Guidelines for Housing

Institutional leadership shall identify housing locations as follows:

Quarantine:
May be dorm setting
High risk patients (High Risk 1&2, over 65, comorbidities, pregnant) move to isolation

Suspect:
Individually celled, solid door preferred
May house all sick patients in one building as long as each individual is isolated

Confirmed:
Flu patients can cohort with other flu patients
Covid-19 patients can cohort with other Covid-19 patients

- Influenza-like illness has signs and symptoms such as chills, sore throat, fever, cough can be seen in both Covid-19 and flu. However, diagnosis will be determined by laboratory testing

Confirmed diagnosed via lab results

Flu Housing

Covid-19 Housing

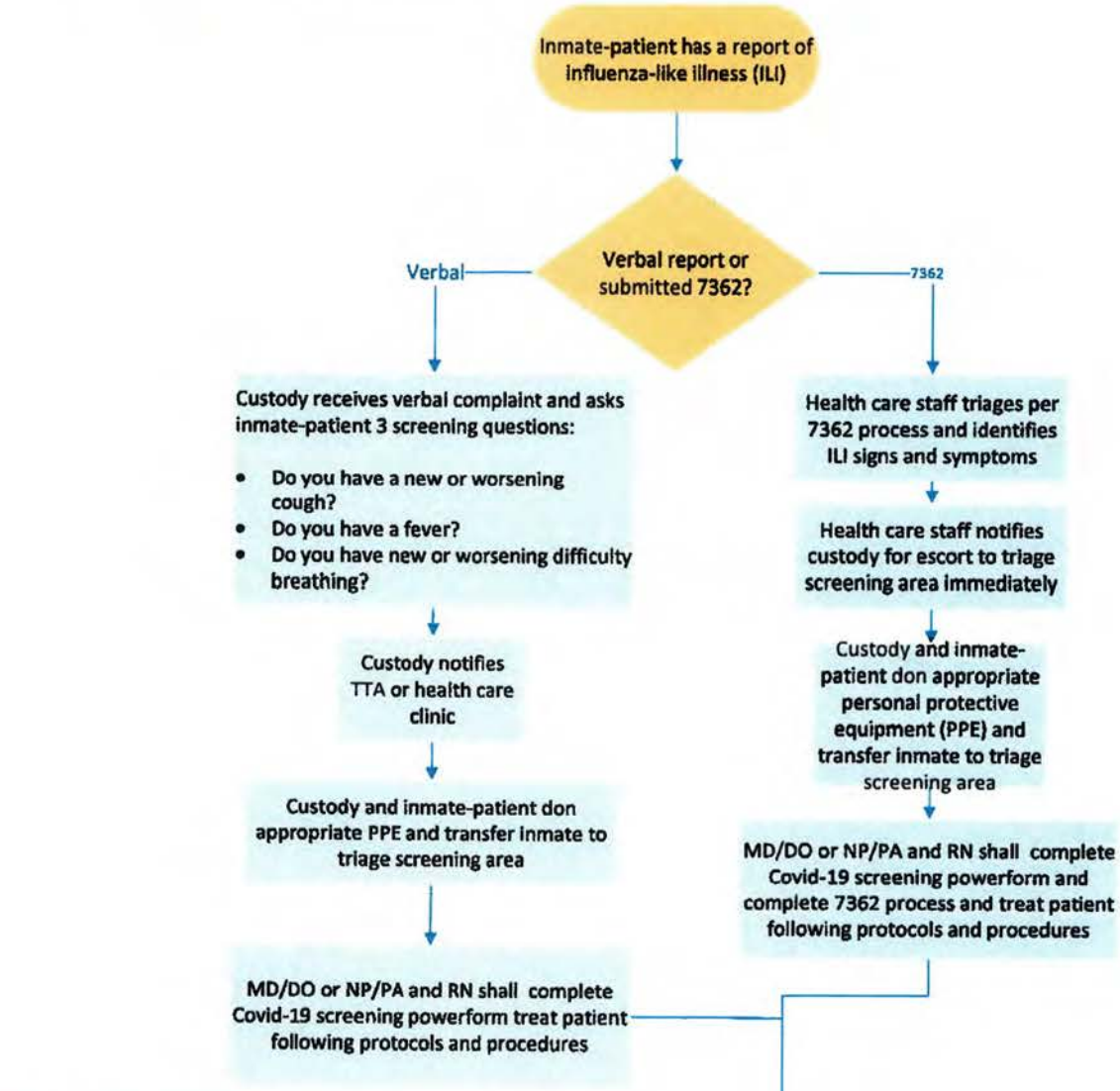
Confirmed diagnosed via lab results
Guidelines

- Single cell, can cohort with same diagnosis

Guidelines for discharge

- 7 days after onset of symptoms and 3 days without fever (100.4 degrees Fahrenheit) without use of antipyretics or resolution of symptoms, whichever is longer

Covid-19: Self-Declaration

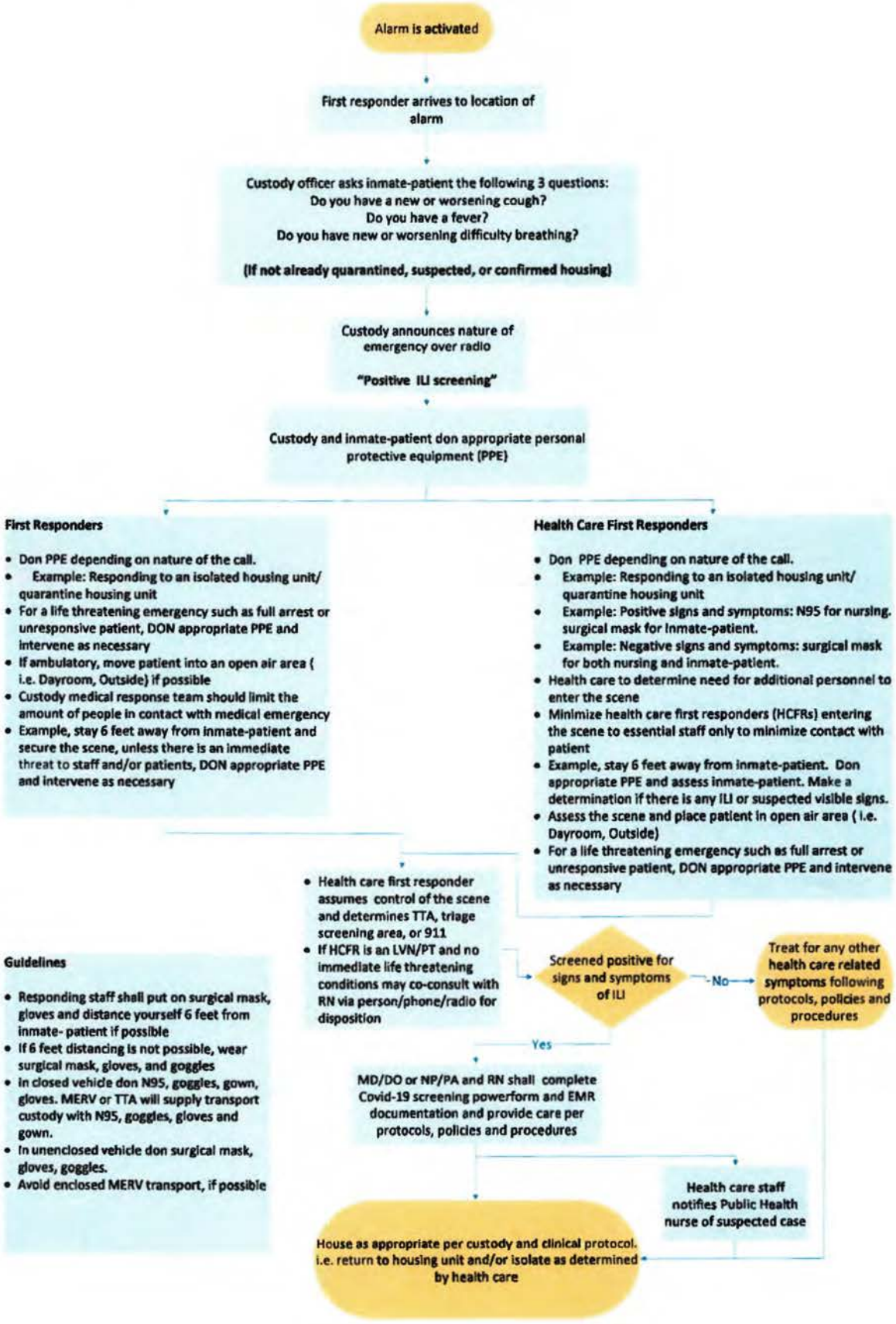


Guidelines

- Institutional leadership shall identify:
- Health care staff assigned to triage screening area, including MD/DO or PA/NP and RN
- Screen patients in designated triage screening area:
- Existing building/space (preferred choice)
- Temporary covered location (secondary choice)
- Responding staff shall put on surgical mask, gloves and distance yourself 6 feet from inmate-patient if possible
- If 6 feet distancing is not possible, wear surgical mask, gloves, and goggles
- In closed vehicle with patient presenting with s/s don N95, goggles, gown, gloves. (ex MERV)
- In unenclosed vehicle don surgical mask, gloves, goggles. (ex golf cart)
- Avoid enclosed MERV transport, if possible

CALIFORNIA CORRECTIONAL HEALTH CARE SERVICES

Covid-19: Emergency Medical Response Process



CALIFORNIA CORRECTIONAL HEALTH CARE SERVICES

ATTACHMENT T

Division of Adult Institutions Pandemic Operation Guidelines

Operational Condition Normal (OPCON) Core Functions	Category	Operation	Triggering Event
Operations	Safety Security	Normal	• Able to sustain normal operations and perform all Non-essential and Essential Functions
	Feeding	Normal	
	Medication	Normal	
	Health Care Access	Normal	
	Mental Health Care	Normal	
	Showers	Normal	
	Committee's	Normal	
Program Activities	Mail	Normal	
	Visiting	Normal	
	Education	Normal	
	Vocation	Normal	
	Religious Services	Normal	
	Self-Help	Normal	
	Yard Activity	Normal	
	Dayroom Activity	Normal	
	Volunteers/Contractors	Normal	
Privileges	Phone calls	Normal	
	Canteen	Normal	
	Packages	Normal	
	In-cell Activities	Normal	
Population/Transportation	Intra-facility Transfers	Normal	
	RC Processing	Normal	
	Out to Court	Normal	
	Medical Guarding Transportation	Normal	

Division of Adult Institutions Pandemic Operation Guidelines

Operational Condition – Alpha (OPCON) Core Functions	Category	Operation	Triggering Event:
Operations	Safety Security	Normal	• Some modifications to Program Activities Modification to Program Activities/Transportation and population to minimize exposure or to address staff limitations which may occur in any discipline (custody, non custody, health care, mental health, etc) impacting daily operation. • Custody Staffing levels between 80-89% of authorized posts filled. As workload is shed, use custody resources as overtime avoidance.
	Feeding	Normal	
	Medication	Normal	
	Health Care Access	Normal	
	Mental Health	Normal	
	Showers	Normal	
	Committee's	Normal increasing social distancing	
Program Activities	Mail	Normal	
	Visiting	May be cancelled or reduced	
	Education	May be cancelled or reduced	
	Vocation	May be cancelled or reduced	
	Religious Services	May be cancelled or reduced. May become in unit roving support	
	Self-Help	May be cancelled or reduced. May become in unit roving support	
	Yard Activity	Normal	
	Dayroom Activity	Normal	
	Volunteers/Contractors	May be cancelled or reduced	
Privileges	Phone calls	Normal	
	Canteen	Normal	
	Packages	Normal	
	In-cell Activities	Normal	
	Intra-facility Transfers	Select Transfer jurisdictions identified for closure	
Population/Transportation	RC Processing	Cluster incoming from County. Possible reduced intake or closure of intake as directed by health care.	
	Out to Court	Normal	
	Medical Guarding Transportation	Emergent/Urgent Continues some routine appointments may be cancelled.	

Division of Adult Institutions Pandemic Operation Guidelines

Operational Condition – Bravo (OPCON) Core Functions	Category	Operation	Triggering Event:
Operations	Safety Security	Normal	• Increased Modification to Program Activities/Transportation and Population to minimize exposure and/or to address isolation /quarantines and/or to address some staff limitations in any discipline (custody, non custody health care, mental health, etc) impacting daily operations. • Custody staffing level between 70-79% of authorized posts filled. As Workload is shed, use custody resources as overtime avoidance.
	Feeding	Increase Social Distancing /May cell feed.	
	Medication	Evaluate staffing availability and needs of health care. Some instances of cell front or podium distribution as directed by local health care.	
	Health Care Access	Appointments completed as directed by Health Care (Refer to Clinical Operations Plan)	
	Mental Health Care	Mental Health Groups and one on ones completed as directed by Mental Health (Refer to Mental Health Emergency Plan)	
	Showers	Normal	
	Committee's	Normal increasing social distancing	
Program Activities	Mail	Normal	
	Visiting	Cancelled	
	Education	Cancelled	
	Vocation	Cancelled	
	Religious Services	Cancelled. Provide roving support	
	Self-Help	Cancelled	
	Yard Activity	Reduce by 50%	
	Dayroom Activity	Reduced by 50%	
	Volunteers/Contractors	Cancelled	
Privileges	Phone calls	Normal	
	Canteen	Normal	
	Packages	Normal	
	In-cell Activities	Normal	
Population/Transportation	Intra-facility Transfers	Select Transfer types may be stopped	
	RC Processing	Cluster incoming from County. Possible reduced intake or closure of intake as directed by health care	
	Out to Court	Check local jurisdictions for closure	
	Medical Guarding Transportation	Emergent/Urgent Continues some routine appointments may be cancelled.	

Division of Adult Institutions Pandemic Operation Guidelines

Operational Condition – Charlie (OPCON) Core Functions	Category	Operation	Triggering Event:
Operations	Safety Security	Normal	• Significant Modifications to Program Activities/ Transportation and Population/Core Functions due to increased mitigation measures to minimize exposures and/or isolations/ quarantines and/or to address increased staff limitations in any discipline (custody, non custody, health care, mental health, etc) impacting daily operation. • Staffing level between 60-69% of authorized posts filled. • Custody resources focused on core essential operations in priority. • Use Peace Officer resources in the institution to perform essential duties such as counselors assisting with CO duties. • Use custody resources from Statewide Transportation Unit to assist with vacancies as available. • Identify additional strike team resources for custody and shift schedule changes needed to maximize resources.
	Feeding	Cell feeding only due to limited custody staff resources	
	Medication	Continue best method based on staff resource availability as directed by Health Care. May increase instances of cell front or podium distribution by local health care	
	Health Care Access	Urgent (Refer to Clinical Operations Plan)	
	Mental Health Care	Mental Health Groups and one on ones completed as directed by Mental Health (Refer to Mental Health Emergency Plan)	
	Showers	Normal	
	Committee's	Normal increasing social distancing	
Program Activities	Mail	Normal	
	Visiting	Cancelled	
	Education	Cancelled	
	Vocation	Cancelled	
	Religious Services	Cancelled. Provide roving support	
	Self-Help	Cancelled	
	Yard Activity	Reduce by 50%	
	Dayroom Activity	Reduced by 50%	
	Volunteers/ Contractors	Cancelled	
Privileges	Phone calls	Normal	
	Canteen	Normal	
	Packages	Normal	
	In-cell Activities	Consider increases to include: 1) reading material 2) activities 3) TV, Radio, Tablet Access (if possible)	
Population/Transportation	Intra-facility Transfers	Select Transfer types may be stopped	
	RC Processing	Cluster incoming from County. Possible reduced intake or closure of intake as directed by health care	
	Out to Court	Check local jurisdictions for closure	
	Medical Guarding Transportation	Emergent/Urgent Continues some routine appointments may be cancelled as directed by health care.	

Division of Adult Institutions Pandemic Operation Guidelines

Operational Condition-Delta (OPCON) Core Functions	Category	Operation	Triggering Event
Operations	Safety Security	Normal	• Extensive Modifications to Program Activities/ Transportation and Population/Core Functions due to mitigation efforts to minimize exposure and/or increased isolation/quarantine and/or increased staff limitations in any discipline (custody, non custody, health care, mental health, etc) impacting daily operation. • Extensive custody vacancies resulting in minimal custody staffing levels. Staffing level between 59-50% or below of authorized post filled. • Custody resources focused only on the most critical functions in priority order. • Possible shift modifications to maximize resources available. • All available Peace Officers performing core most critical essential duties (Counselors, Management, etc.). • All available non-custody perform any identified essential functions as appropriate such as feeding, delivering mail, etc. • Use strike team resources identified to include neighboring institutions, other identified institution staff, Statewide
	Feeding	Cell feeding only due to limited custody staff resources	
	Medication	Best method of efficiency as determined by health care (may include cell front or podium pass)	
	Health Care Access	Only Urgent/Emergent as determined by health care (Refer to Clinical Operations Plan)	
	Mental Health Care	Cancelled groups/one on ones due to lack of custody staff. MH cell front only unless urgent/emergent (Refer to Mental Health Emergency Plan)	
	Showers	In the event of extreme staff shortages, may be reduced/cancelled only for the duration required due to extreme custody staff shortages	
	Committee's	Cancelled except for extreme urgency	
Program Activities	Mail	May be delayed due to staff shortages	
	Visiting	Cancelled	
	Education	Cancelled	
	Vocation	Cancelled	
	Religious Services	Cancelled	
	Self-Help	Cancelled	
	Yard Activity	Cancelled	
	Dayroom Activity	Cancelled	
	Volunteers/ Contractors	Cancelled	
Privileges	Phone calls	May be reduced/cancelled due to staff shortages	
	Canteen	Only essential items and delivery may be delayed due to staff or inventory shortages. May be cancelled in extreme circumstances.	
	Packages	May be reduced based on availability of staff to process	
	In-cell Activities	Provide increased 1) reading material 2) activities 3) TV, Radio, Tablet Access (if possible)	

	Packages	May be reduced based on staff to process	Transportation, HQ staff, Parole as available for essential core functions
Population/Transportation	Intra-facility Transfers	Increased number of Select Transfer Types Stopped	
	RC Processing	If intake continues, cluster county intake. Increased reductions of intake. Possible complete intake closure.	
	Out to Court	Check local jurisdiction for closures. Continue only as per court orders	
	Medical Guarding Transportation	Emergent/Urgent. Only critical appointments as directed by medical due to severe custody staff shortages.	

Key Components to DAI Pandemic Operation Guidelines:

- Applicability and effectiveness of the individual Mitigation Controls may vary from site to site.
- As part of the ongoing assessment of OPCON levels, the CDCR determines whether a certain Mitigation Control is applied locally, regionally, or statewide.
- Any CDCR communication regarding OPCON levels will include indication of the applicable sites and notification of the applicable departmental personnel and stakeholders.
- The higher the OPCON level, the greater the hardship and strain on CDCR staff and offenders. It is therefore the goal of CDCR to remain in an elevated OPCON level for only the duration required. If it is no longer necessary to remain in an increased OPCON level, the review process for return to the next lower level will be initiated.
- Institutional Executive team will triage and prioritize essential programs. All decisions regarding elevating and lowering OPCON levels will be made by the institutional Warden (assisted by the recommendation of the executive leadership).
- Individual sites may operate in different OPCON levels at the same time.
- Reference the Clinical Operations Plan for details related to health care pandemic operations.
- Reference the Mental Health Emergency Plan for details related to mental health pandemic operations.

ATTACHMENT U

CALIFORNIA CORRECTIONAL
HEALTH CARE SERVICES

MEMORANDUM

Date: March 25, 2020

To: Chief Executive Officers
Chief Psychiatrists
Chief of Mental Health
Senior Psychiatrist, Supervisors

From:
EUREKA C. DAYE, Ph.D., MPH, MA, CCHP
Deputy Director (A)
Statewide Mental Health Services

Subject: **COVID-19 – MENTAL HEALTH DELIVERY OF CARE GUIDANCE**

In response to the current coronavirus disease 2019 (COVID-19) pandemic and out of an abundance of caution the California Department Corrections and Rehabilitation (CDCR) Statewide Mental Health Program (SMHP) is taking necessary precautions to reduce exposure to Coleman patients and mental health staff by addressing exceptional allowances provided. This memorandum provides guidance for the delivery of mental health care with the understanding that new challenges and impacts of COVID-19 may permit more restrictions at some institutions than others as we move through this difficult time and may likewise lead to interim changes in practice and/or policy exceptions not otherwise allowed by the *Mental Health Services Delivery System Program Guide 2009 Revision.*

Clinical leadership (to include Chief Executive Officers, Chiefs of Mental Health, Chief Nurse Executives, Chief Medical Executives, and the Chief Psychiatrist) shall assess program capacity and make determinations on admission and discharge practices based on factors to include available workforce, known COVID-19 exposure, etc.. Leadership must consider individual patient needs, facility-system flows, and the degrees of risk when making these decisions.

To ensure patients continue to receive the most appropriate and effective interventions necessary to meet their needs, each clinical provider shall assess the patient's needs and continue to deliver services as appropriate in person, or via tele-health technology such as WebEx, Citrix, and other solutions.

The attached chart serves as a guide and provides a tiered approach on the delivery of care dependent upon each institution's staffing and operational circumstances. The CEOs, in consultation with the Wardens, will determine which tier shall be applied each day. Tier One

represents operating close to Program Guide requirements, while Tier Four represents dramatically decreased resources. The following factors shall be taken into consideration when determining the tier an institution will operate within:

- Clinical and custodial staffing levels
- Space availability
- Social distancing requirements
- Local and statewide restrictions on movement
- Quarantines and Isolations

Mental Health Patients

Mental health patients are at increased risk for escalation in depression, anxiety, panic attacks, psychomotor agitation, psychotic symptoms, delirium, and suicidality during this COVID-19 pandemic. Sources of stress include social isolation, decreased sensory stimulation, lack of access to standard clinical programing, diminished coping strategies, and limited outdoors or out-of-cell exercise and activities. We are focused on three critical areas during this COVID-19 pandemic: 1) Preserving life; 2) Stabilizing of acute mental health deterioration; 3) Helping the mental health population cope.

Provisions of Treatment

To the extent possible, institutions shall follow current Program Guide policies and procedures including, but not limited to: clinical contacts, group and treatment requirements, emergent and urgent referral processes, crisis intervention, suicide prevention, and inpatient referrals. However, to ensure patients receive the essential care and support services during this time of fewer onsite staff and various restrictions on patient movement the below and attached guidelines provide direction on ways to provide services and minimize the risk to both patients and staff:

- Individual clinical contacts shall continue while maintaining social distancing. As institutions move toward less patient movement measures and staffing levels decrease, individual contacts should be triaged by emergent referrals, patient acuity and levels of care.
- Interdisciplinary Treatment Teams (IDTT) shall continue while maintaining social distancing. In lieu of the tradition setting, the use of technology should be optimized to ensure attendance by all IDTT members. The best solution is to turn team meetings into teleconference meetings, with staff calling in from their individual offices.
- Groups shall continue but may be reduced in size in order to adhere to social distancing requirements. In addition, alternative locations should be explored. Larger classrooms or vocational space, temporarily closed during this time, could be used to allow for social distancing for groups. Develop in-cell Recreational Therapy and other group activities that can be conducted and distributed.
- Patients in isolation and/or quarantine will not attend groups but shall be provided with therapeutic treatment packets, workbooks, and other in cell activities and shall receive daily rounding by a primary clinician and a psychiatrist.

- Psychiatry and primary care clinicians should be consulted urgently on patients expressing suicidal ideation or intent, psychosis, medication side effects, incomplete symptom control, or acute agitation.
- Psychiatry should also be consulted for other non-urgent significant psychiatric symptoms as usual.
- In the event of severe staffing shortages, frequent mental health wellness and surveillance rounding is required with liaison between psychiatrists, psychologists, suicide prevention coordinators and recreational therapists to identify significant concern for a patient's mental health sequelae. These rounds are to identify any urgent/emergent clinical issues including but not limited to acute suicidality.
- Issues identified through these rounds are to be promptly brought to the attention of the assigned psychiatrist.
- Staff performing rounds shall use appropriate personal protective equipment (PPE) as determined by public health.
- Psychiatry encounters may be via tele-psychiatry during the COVID-19 pandemic as approved by the hiring authority (See section on tele-psychiatry below for details).

Suicide Prevention

As much as possible, all Suicide Risk Assessments shall continue per policy and patients identified as a suicide risk will receive an in-person mental health evaluation. As operational abilities are impacted due to staff reductions, the clinician assessing the patient for suicidality will conduct the Columbia screener and a full mental health status exam and do the following:

1. If the patient screens positive, he/she shall be placed in alternative housing and be referred to a Mental Health Crisis Bed (MHCB). Within 24 hours of placement in the MHCB or if the patient remains in alternative housing longer than 24 hours, a full Suicide-Risk and Self-Harm Evaluation shall be completed.
2. If the patient screens negative, the clinician shall establish a safety plan with the patient and he/she can be returned to housing with a consult order for the primary clinician to see the patient with an urgent or routine referral.
   - All (5) five-day follow-ups will be completed in person, per policy, while maintaining social distancing.
   - As the operational abilities begin to limit clinical contacts and services, Administrative Segregated Unit workbooks shall be distributed to Enhanced Out-Patient housing units and the Correctional Clinical Case Management System population for in-cell activities.
   - Suicide Prevention and Response Focus Improvement Team Coordinators shall distribute the high risk list to all primary clinicians and psychiatrists. Cell visit check-ins with these patients shall be conducted by a mental health provider, in addition to the required scheduled appointments.

Inpatient Referrals and Services

As of March 17, 2020, the Department of State Hospitals (DSH) has temporarily suspended patient transfers to and from CDCR. As a result, patients referred to a higher level of care of at least a restrictive housing of a DSH facility will remain at CDCR. The below information and reminders are critical to ensure all patients currently housed or awaiting placement to an inpatient bed receive the appropriate care and oversight during this time.

- All referrals to higher levels of care shall continue as clinically indicated and determined by the IDTT.
- Patients housed out of their least-restrictive housing due to the inability to transfer to DSH, shall be placed in the least restrictive housing available within CDCR.
- As wait times increase, every effort shall be made to provide these patients with the services commensurate with their level of care. This includes providing enhanced out-of-cell time and therapeutic activities as well as daily rounds, as operations allow, while awaiting transfer.
- Patients housed in an MHCB awaiting transfer to a higher level of care and patients in alternative housing awaiting transfer to an MHCB will be provided enhanced out-of-cell time and therapeutic activities as well as daily rounds, as operations allow, while awaiting transfer.
- Inpatient licensed beds shall not be closed to admissions by the institutions without going through the proper authorization and notification process.

Patient Education

Clinical focus shall be on supporting patients by encouraging questions and helping them understand the current pandemic situation. Clarify misinformation and misunderstandings about how the virus is spread and that not every respiratory disease is COVID-19. Provide comfort and extra patience. Check back with patients on a regular basis or when the situation changes. Recognize that feelings such as loneliness, boredom, fear of contracting disease, anxiety, stress, and panic are normal reactions to a stressful situation such as a disease outbreak.

Key communication messages to mental health patients:

- The importance of reporting fever and/or cough or shortness of breath along with reporting if another patient is coughing in order to protect themselves. Indicate how these reports should be made.
- Reminders about good-health habits to protect themselves, emphasizing hand hygiene.
- Plans to support communication with family members if visits are curtailed.
- Plans to keep patients safe, including social distancing.

Patient Isolation (Symptomatic Patients)

A critical infection control measure for COVID-19 is to promptly separate patients who are sick with fever or respiratory symptoms away from other patients in the general population. Precautionary signs shall be placed outside the isolation cell and PPE appropriate protocols shall be followed.

Quarantine (Asymptomatic Exposed Patients)

The purpose of quarantine is to assure that patients who are known to have been exposed to the virus are kept separated from other patients with restriction of movement to assess whether they develop viral infection symptoms.

- Exposure is defined as having been in a setting where there was a high likelihood of contact with respiratory droplets and/or body fluids of a person with suspected or confirmed COVID19.
- Examples of close contact include sharing eating or drinking utensils, riding in close proximity in the same transport vehicle, or any other contact between persons likely to result in exposure to respiratory droplets.
- The door to the Quarantine Unit should remain closed. A sign should be placed on the door of the room indicating that it is a Quarantine Unit which lists recommended personal protective equipment (PPE).
- Medical Holds are employed for both isolation and quarantine. A temporary prohibition of the transfer of patients with the exception of legal or medical necessity is now in place.

Social Distancing

To stop the spread of COVID-19, social distancing must be employed. CDC officials recommend avoiding large gatherings of more than 10 people and maintaining a distance of 6 feet from other people. This reduces the chance of contact with those knowingly or unknowingly carrying the infection.

Patient-to-Patient; Patient-to-Staff Social Distancing

If group spaces are too small to accommodate the 6-feet rule, consider smaller group sizes in the interim. Groups can be smaller with higher frequency or this may mean needing to decrease the number of treatment offerings. Say to the patients that because of the COVID19, "We have a policy of keeping at least 6 feet of distance between patients and staff and patients and each other, which is why I'm sitting here and you're sitting there." If you don't say it, many patients may misinterpret social distancing (i.e. "my clinician is scared of me"). Maximize disinfection of all areas used for group and 1:1 treatment.

Tele-Psychiatry and Social Distancing

With the latest expansion of tele-psychiatry waivers, exceptions issued by the Center for Medicare and Medicaid Services (CMS), tele-psychiatry may be used to minimize any COVID-19 impacts that could disrupt the daily psychiatric services to patients. Psychiatrists who are unable to come into the institution because of personal risk factors (age > 65, chronic medical condition, etc.) or are under a personal quarantine who are otherwise fit to work can be authorized to use WebEx to conduct patient visits from a home computer that has a camera, speaker, and microphone. A state laptop with a VPN or any home computer with Citrix can access the EHRS.

- Each clinician who is providing tele-services will require a tele-presenter within the institution.
- Tele-presenters can include Medical Assistant, Certified Nursing Assistant, Licensed Vocational Nurse, Registered Nurse, or any other healthy employee who is available to assist. This could include support staff who are on Administrative Time Off.
- Presenters shall be provided PPE as needed based upon public health recommendations. Successful use of tele-psychiatry will require clinic space, tele-health equipment, IT assistance, scheduling organization, escort support, frequently updated telephone and email contact lists, and local executive leadership support.

cc: Diana Troche, DDS, Undersecretary
Joseph Bick, MD, CCHP, Director
Connie Gipson, Director
Regional Health Care Executives
Deputy Directors

Tier	Inpatient Referrals	Suicide Prevention	Provision of Treatment	Evaluations (Pre-Release, MDO)
Tier One: Delivery of care continues with minor modifications up to and including: • Patient movement permitted between and within CDCR facilities. • Minor movement restrictions within specific housing units or yards. • Temporary suspension of transfers to DSH. • Adequate clinical staff are on site and available to provide services • Sufficient beds and staff are available for 1:1 watch and alternative housing. • Social Distancing Required	Referrals continue per policy. Patients out of LRH, due to bed unavailability (DSH unlocked dorm) will be placed in the least restrictive housing available within CDCR.	**Suicide Risk Assessments:** Continue to complete per policy. **Five day follow ups:** Complete in person per policy, while maintaining social distancing. **Referrals:** Continue to respond to referrals in accordance with MHPG timelines.	**IDTT:** Continue with social distancing. Optimize use of technology including VTC, SKYPE, conference calls, or other electronic alternatives. **Groups:** Continue but may be reduced in size or in alternative non confidential locations (e.g. day room, class rooms) for social distancing. **Individual contacts:** Continue, with social distancing. **Patients on isolation:** Provide with treatment packets/therapeutic activities to complete in cell. Treatment team members visit cell daily. **Personal Protective Equipment:** Those rounding in quarantined and isolated areas must be provided appropriate personal protective equipment (PPE) based upon the most recent public health recommendations. All staff shall receive training in the appropriate use of PPE.	**Pre-Release Planning:** All required activities to occur when social distancing can be followed. **MDO Evaluations:** MDO evaluations will continue and patients meeting MDO criteria will be admitted to DSH. If MDO evaluator cannot enter a facility review will occur remotely and the evaluator will work with the MDO Coordinator (CCI) at the facility to arrange for a telephonic interview.

Tier	Inpatient Referrals	Suicide Prevention	Provision of Treatment	Evaluations (Pre-Release, MDO)
Tier Two: Minor movement restrictions and staff limitations impacting daily operations. • Patient movement permitted between and within CDCR facilities • Minor movement restrictions within specific housing units and/or yards • Temporary suspension of transfers to DSH. • Minor clinical staffing shortages requires triage for services • Sufficient beds and staff are available for 1:1 watch and alternative housing. • Social distancing required	Referrals continue per policy. As wait times increase, patients shall be provided enhanced care, which may include, but not limited to, daily rounds, out of cell time, and therapeutic activities as operations allow, while awaiting transfer. Patients awaiting MHCB will be placed in alternative housing on 1:1 status per current policy. Treatment frequency should be that of MHCB patients, when operations allow, while awaiting transfer.	**Suicide Risk Assessments:** Columbia Screener may be used with a mental status examination for suicide screening when staffing shortages prevent use of SRASHE. Patients identified as suicide risk will receive in person evaluation. **Five day follow ups:** Complete in person per policy, while maintaining social distancing. **Referrals:** Triage referrals responding to emergent and urgent first, and triage routine referrals for urgency. **Prevention:** Distribute ASU Workbooks to outpatient housing units (EOP) for in-cell activities. SPRFIT Coordinators distribute the high risk list to all primary clinicians. PCs to conduct cell visits for check-ins with individuals on this list. These visits should be in addition to required scheduled appointments. If decompensation is noted, patients should be brought out for assessment.	**Treatment may be triaged as follows as staffing shortages and space access are decreased:** **Triage Guidelines:** Individual contacts as follows: - Emergent referrals - Patients on high risk list - Patients in inpatient facilities - Patients awaiting transfer to inpatient LOC - Patients in segregated housing - Patients in EOP level of care - Patients in CCCMS level of care **IDTT:** Continue with social distancing. Optimize use of technology including VTC, SKYPE, conference calls, or other electronic alternatives. **Groups:** Continue but may be reduced in size or in alternative non confidential locations (e.g. day room, class rooms) for social distancing. May be triaged. - CCCMS groups may be reduced or cancelled to redirect resources to EOP and inpatient programs. -Consider altering work schedules to stagger groups and offer into late evenings and weekends.	**Pre-Release Planning:** Prioritize the ROIs to those releasing only to L.A. county and San Diego county Prioritize completion of the PRPA for those releasing to L.A. and San Diego counties first. The assigned psychiatrist will continue to be notified of the release date. Provide groups in accordance with group guidelines in treatment activities section of this document Complete 5150 requests per standard process Complete transportation Chrono's per standard process Conduct pre-release CCAT when possible (dependent upon outside clinician availability) **MDO Evaluations:** MDO evaluations will continue and patients meeting MDO criteria will be admitted to DSH. Evaluators will bundle evaluations for a single visit to reduce the number of trips to a facility. If MDO evaluator cannot enter a facility review will occur remotely and the evaluator will work with the MDO Coordinator (CCI) at the

Tier	Inpatient Referrals	Suicide Prevention	Provision of Treatment	Evaluations (Pre-Release, MDO)
			-Develop in cell RT and other group activities and distribute when group offerings decrease. **Patients on isolation:** Provide with treatment packets to complete in cell. Treatment team members visit cell daily. **Psychiatry:** Psychiatrists check in & check out daily with Chief Psychiatrist to track availability and coverage. Updated contact lists and workflows will be determined and provided by each institution up to and including contact list for: - Nursing - MHCB/TTA/CTC - Institutional leadership (Chief Psychiatrist, CMH, CEO) - Medical providers - Pharmacists - Custody command chain - Telepsychiatry Seniors - Medication lines Begin to Triage as follows: Admissions and discharges and related inpatient processes Suicide watch assessments and orders - Suicide precaution assessments and orders - Emergency Medication orders during patient crisis, PC 2602s - Seclusion and Restraints "Face to Face" assessments or renewals - Stat Labs for patients with suspected toxicity e.g. Lithium)	facility to arrange for a telephonic interview.

Tier	Inpatient Referrals	Suicide Prevention	Provision of Treatment	Evaluations (Pre-Release, MDO)
			- Renewing expiring psychiatric medications - Medication changes as necessary - Confirming lack of psychiatric medication-related medical issues - IDTT participation - Routine psychiatric follow up **Telepsychiatry:** Psychiatrists who are assigned to work on-site who are no longer able to come into the institution (for example >65 years old, high risk medical condition, quarantine but still able to work) can use WebEx to conduct patient visits from any home computer with a camera/ speaker/ microphone. A state laptop with a VPN (or any home computer with Citrix) can access EHRS. - Staff that could be used as telepresenters is decided by each institution to include: • MA or CNA • Any staff unable to perform their assigned duties during the crisis (with training), e.g. - Dental - ATO - support staff - any healthy state personnel - Any Mental Health provider (Group leader, RT, SW, LCSW, PhD/ PsyD) - LVN, RN	

Tier	Inpatient Referrals	Suicide Prevention	Provision of Treatment	Evaluations (Pre-Release, MDO)
			- Any medical provider (PA, NP, MD) All telepresenters require personal protective equipment as in Tier 1 This will also require: office space, tele-health equipment, IT assistance, OT organization, Custody escort support, contact lists as in tier 2, and local leadership support	

Tier	Inpatient Referrals	Suicide Prevention	Provision of Treatment	Evaluations (Pre-Release, MDO)
Tier Three Movement restrictions within facilities and staffing shortages requires substantial change in standard practice • Patient movement permitted between most CDCR facilities. • Movement restrictions are in effect within the institutions. • Temporary suspension of transfers to DSH. • Substantial clinical staffing shortages requires increased triage for services • There may be insufficient beds and/or staff for alternative housing and 1:1 watch.	Referrals continue per policy. **If staffing and space become unavailable:** **Alt Housing Location:** Patients who can be safely watched in their existing cell will be placed on 1:1 watch (must be single cell status, items removed per watch policy). These patients will be treated as MHCB patients for all clinical contacts as operations allow. **1:1 Watch:** When there are not enough staff for 1:1 watch, patients in alternative housing may be placed on 2:1 watch if the location allows for good line of sight and patients are next door to one another, allowing continuous watch of each. CEO to determine when this can be applied and will provide the direction above with oversight for safety.	**Suicide Risk Assessments:** *See Tier two* **Five day follow ups:** *See Tier Two* **Referrals:** *See Tier Two* **Prevention:** *See Tier Two and Provision of Treatment Column*	**Rounding:** Every day, every patient in the Mental Health Services Delivery System (CCCMS, EOP, MHCB, ICF, ACUTE) shall be rounded on by at least one of the following designated staff to include: CNA, Psychologist, LVN, Recreational Therapists, PTs, RNs, or Social Workers, by building and yard. The review includes questions of immediate, acute suicidality and/or medical concerns. Patients who answer in the affirmative must be brought to the attention of the assigned psychiatrist at least once a day (preferably twice) at fixed times for treatment. When patients respond in the affirmative: - A consult order shall be placed per current policy. - MH clinicians will address emergent issues per current policy. - Patients will be placed on a list for discussion with the psychiatrist. Rounds shall be documented in the healthcare record as follows: Nursing: Iview psych tech daily rounds. MH Clinicians: MH PC Progress note. Personal protective equipment required as in tier 1.	**Pre-Release Planning:** ROIs to those releasing only to L.A. county and San Diego county ONLY. Complete the PRPA for those releasing to L.A. and San Diego counties. For releases to other counties, the IMHPC or PC or other clinician who knows the patient, will determine if exigent circumstances related to release exist, and if so, will attempt to communicate those needs to the respective community stakeholders via email. Document efforts in a pre-release planning progress note. The assigned psychiatrist will continue to be notified of the release date. Provide groups in accordance with group guidelines in treatment activities section of this document. Complete 5150 requests per standard process Complete transportation Chrono's per standard process Conduct pre-release CCAT when possible (dependent upon outside clinician availability) **MDO Evaluations:** *See Tier Two*

Tier	Inpatient Referrals	Suicide Prevention	Provision of Treatment	Evaluations (Pre-Release, MDO)
			As ability to provide out of cell groups decreases: - RTs play music and conduct other activities on the unit - Continue to replenish supply of in cell treatment materials. Direct Staff and Care as follows: - Emergent referrals - Five Day Follow Ups - Patients on high risk list - Patients in inpatient facilities - Patients awaiting transfer to inpatient facility - Patients in segregated housing - Patients in EOP level of care - Patients in CCCMS level of care **Telepsychiatry: As per tier 2 above**	

Tier	Inpatient Referrals	Suicide Prevention	Provision of Treatment	Evaluations (Pre-Release, MDO)
Tier Four Patient movement restrictions between and within facilities is suspended and significant staffing shortages require substantial change in standard practice • Patient movement is not permitted between most CDCR facilities. • Patient movement restrictions in most units and/or yards within facilities • Temporary suspension of transfers to DSH. • Substantial clinical staffing shortages requires further triage for services • Insufficient beds and/or staff available for 1:1 watch and alternative housing.	*See Tier Three*	*See Tier Three*	*See Tier Three* **Psychiatry Services** Any physician, NP, or PA serves as psychiatrists for the plans in Tier 2 and 3 above. Laptops with VPN (or home computers with Citrix) provide for chart access from home, for the equivalent of basic on-call coverage. Local triage (by Chief Psychiatrist and CMH) to establish referral priority for tele-health.	**Pre-Release Planning:** - ROIs will not be completed - The PRPA will not be completed For releases, the IMHPC or PC or other clinician who knows the patient, will determine if exigent circumstances related to release exist, and if so, will attempt to communicate those needs to the respective community via email. The assigned psychiatrist will continue to be notified of the release date. - Complete 5150 requests per standard process - Complete transportation Chrono's per standard process - Conduct pre-release CCAT when possible (dependent upon outside clinician availability) **MDO Evaluations:** *See Tier Two*

ATTACHMENT V

CALIFORNIA CORRECTIONAL HEALTH CARE SERVICES

MEMORANDUM

Date:	April 5, 2020
To:	Chief Executive Officers Chief Psychiatrists Chiefs of Mental Health Senior Psychiatrist, Supervisors
From:	Joseph Bick, MD (signature on file) Director (A), Division of Health Care Services
Subject:	**COVID-19 SCREENING PRIOR TO MENTAL HEALTH TRANSFERS**

Referrals to Mental Health Inpatient care shall continue when a patient requires such placement to prevent serious harm to self or others or to address serious mental health decompensation. Transfers must take place in a manner that minimizes the risk for transmission of COVID-19. Therefore, all Mental Health patients shall be screened for COVID-19 within 12 hours of transfer from one facility to another.

Screening shall be performed by a medical or psychiatric physician in consultation with the institution public health or infection control nurse prior to the patient leaving a facility. The clearance shall be clearly documented in a transfer note in the chart. Prior to patient transfer, the content of the note shall also be verbally communicated from the sending psychiatrist or other medical physician to the Chief or Senior psychiatrist at the receiving institution.

The following information shall be included in the transfer note:

1. Title Note: Medical screening transfer note
2. Referring Institution
3. Receiving Institution
4. Does the patient have a new or worsening cough? [Y/N]
5. Does the patient have a fever (>100 F)? [Y/N]
6. Is the patient experiencing new or worsening shortness of breath? [Y/N]
7. Is the patient currently on isolation? [Y/N]
8. Is the patient currently on quarantine? [Y/N]
9. Is the patient known to be a contact of a confirmed COVID -19 case? [Y/N]
10. Include the patient's vitals for the last 14 days as available
11. Rationale for recommending transfer.

cc: Diana Toche, DDS, Undersecretary of Healthcare
Steve Tharratt, MD, Director Healthcare Operations
Connie Gibson, Director, Division of Adult Institutions
Eureka C. Daye, Deputy Director (A), Statewide Mental Health
Renee Kanan, MD, MPH, Chief Quality Officer, Deputy Director of Medical Services
Barbara Barney-Knox, Deputy Director of Nursing (A), Statewide Chief Nurse Executive
Jay Powell, Associate Warden, HCPOP
Regional Health Care Executives
Regional Chief Nurse Executives
Regional Deputy Medical Executives
Deputy Directors

ATTACHMENT W

CALIFORNIA CORRECTIONAL
HEALTH CARE SERVICES

MEMORANDUM

Date: April 10, 2020

To: Associate Directors, Division of Adult Institutions
Wardens
Chief Executive Officers
Chiefs of Mental Health
Chief/Senior Psychiatrists
Chief Medical Executives
Chief Nurse Executives
Psychiatric Inpatient Program Executive Directors

From:

EUREKA C. DAYE, Ph.D., MPH, MA, CCHP
Deputy Director (A)
Statewide Mental Health Program

CONNIE GIPSON
Director
Division of Adult Institutions

BARBARA BARNEY-KNOX
Deputy Director (A), Nursing
California Correctional Health Care Services

Subject: **COVID EMERGENCY MENTAL HEALTH TREATMENT GUIDANCE AND COVID TEMPORARY TRANSFER GUIDELINES AND WORKFLOW**

This memorandum announces the release of the COVID Emergency Mental Health Treatment Guidance and COVID Temporary Transfer Guidelines and Workflow (attached). These documents provide guidance to the field regarding temporary treatment-in-place and the activation of temporary housing for patients referred to an inpatient level of care but may not be able to transfer to another institution due to restrictions on transportation related to COVID-19.

When a patient requires emergency inpatient care to prevent serious harm to self or others or to address serious mental health decompensation, referrals to mental health inpatient level of care shall continue per the COVID Temporary Transfer Guidelines and Workflow, and following procedures detailed in the previously released COVID-19 Screening Prior to Mental Health Transfers.

A Temporary Mental Health Unit (TMHU) is a consolidation of high acuity patients in adjacent cells where treatment can be provided to a group of individuals who require similar inpatient

MEMORANDUM

treatment. Institutions shall identify clusters of cells for a TMHU per the COVID Emergency Mental Health Treatment Guidance. Local custody and healthcare leadership shall work together to identify the TMHU locations.

The determination for the TMHU location shall be based upon space availability and the following considerations:

1. **Suicide Resistant**
2. **Line of sight from the officers' station**
3. **Contiguous grouping of cells**
4. **Proximity to treatment space**
5. **Available space in the unit for out-of-cell activities**
6. **Functional loud-speaker system**
7. **Reasonable access to an exercise yard**

To ensure staff awareness of this guidance, Wardens and Chief Executive Officers (CEOs) shall ensure training on this memorandum is completed and submit a proof of practice memorandum identifying the housing location of each TMHU. Wardens shall ensure all chief deputy wardens, associate wardens, captains, and lieutenants receive On-the-Job training and submit a proof of practice memorandum to their respective mission's Associate Director. CEOs shall ensure applicable healthcare staff receive On-the-Job training and submit a proof of practice memorandum to the respective Regional Mental Health Administrators. Proof of practice memorandums shall be submitted within 30 days from the date of this memorandum.

If you have questions or require additional information related to this memorandum, you may contact the Mental Health Policy Unit by email: CDCR MHPolicyUnit@cdcr.

Attachment

cc: Angela Ponciano
Laura Ceballos, Ph.D.
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CDCR COVID Temporary Transfer Guidelines & Workflow

In an attempt to limit the transmission of COVID-19, all non-emergency movement shall be immediately curtailed. When a patient requires emergency inpatient care to prevent serious harm to self or others or to address serious mental health decompensation, referrals to Mental Health Inpatient care shall continue, including place-in orders to Intermediate Care Program (ICF), Acute Psychiatric Program (APP), or Mental Health Crisis Bed (MHCB). The best option is to place the patient in an available bed in an ICF, APP, or MHCB within the same institution. The next best option is for the patient to be housed and treated in the same institution within a Temporary Mental Health Unit, as described in a separate document regarding treatment to be rendered in these units, titled COVID Emergency Mental Health Treatment Guidance. The third option is for Enhanced Level of Care Treatment modalities in cells designated for this, which may include the patient's own cell, as described in a separate document regarding treatment to be rendered in these units, titled COVID Emergency Mental Health Treatment Guidance. The fourth option, when patients are not psychiatrically safe in their current environment and for whom none of the prior options are available or protective, is to transfer the patient to another institution that has safer options, while also balancing the substantial risks of COVID in this pandemic. All transfer requests to other facilities will be reviewed as described below, and HCPOP will not act on the place-in order without approval from the Regional Mental Health Administrator or the IRU.

Inpatient Referrals to a Different Facility:

I. Institution Review: Transfer out of the patient's current facility shall not proceed unless meeting the criteria below, as assessed by the treatment team:
   1. an imminent, life-threatening emergency necessitates transfer, or
   2. serious mental health decompensation necessitates transfer, and
   3. the life-threatening condition or serious decompensation cannot be reasonably treated at the institution.

II. When a transfer is not clinically necessary, alternate strategies for managing the patient within the institution must be implemented. A medical hold shall be placed by the primary care physician or psychiatric physician to prevent movement.

III. If transfer to an MHCB is pursued, Regional Review is required: If the referral meets the criteria above, the primary clinician shall email and call the Regional Mental Health Administrator or designee. They shall include an explanation of why the criteria above have been met. The Regional Mental Health Administrator must then consult with the Regional Deputy Medical Executive. HCPOP will not transfer patients to a new facility without receiving approval from the Mental Health Administrator.

IV. If transfer to an ICF or APP program is pursued, IRU Review is required: When a local treatment team requests an inpatient transfer to another facility at an Acute or Intermediate level of care, the request, describing the criteria in Section I above that have been met, shall be sent by email to the IRU inbox at CDCR DHCS DSH Referral Updates@CDCR (m_cdcrdchcsdmhreferupdate@cdcr.ca.gov).
   1. IRU shall hold referrals not meeting the above criteria as incomplete, and shall not move these referrals forward for endorsement by HCPOP.

2. When the IRU approves an inpatient transfer to another facility, the approval shall be communicated by the IRU to HCPOP.

V. For transfer to ICF, APP, or MHCB: The treatment team and reviewers shall also consider if the patient currently has symptoms consistent with COVID-19, has possible exposure to a COVID-19 case and is therefore in quarantine, is symptomatic in isolation (suspect case), or is a confirmed case in isolation. There must be medical clearance by a local medical physician or psychiatric physician in consultation with the institution public health or infection control nurse prior to the patient leaving a facility.
   1. The clearance shall be clearly documented by the primary care physician or psychiatrist in a transfer note, to be included in the chart, addressing the factors included in Attachment A.
   2. The content of the note should also be orally communicated from the sending psychiatrist or other medical physician to the Chief or Senior psychiatrist at the receiving institution so appropriate measures can be taken prior to patient arrival.

VI. Acceptance Procedure: Prior to acceptance of an inter-facility patient transfer into an ICF, APP, or MHCB, a psychiatrist shall review all inpatient referrals including the medical transfer note information and the risk factors noted above.
   1. If there are substantial concerns regarding the patient's medical risk, or risk to other patients and staff at the facility given the referring information, a discussion must occur with the referring clinician and psychiatrist, to weigh the risks and determine a final outcome. If there is a disagreement between the referring and accepting institutions, Mental Health leadership at headquarters will assist in resolving the issue.
      a. Any decision not to accept MHCB referrals shall be immediately communicated to HCPOP.
      b. Any decision not to accept ICF or APP referrals made by the medical director due to infection control concerns shall be entered in the "MH Acute/ICF Disposition" order by selecting "More information needed" and notifying the IRU of the need for the patient to remain at the referring institution due to COVID-19 concerns.

VII. Transfer Procedure: Prior to transfer, emergency medical services, custody transportation, and the receiving facility should all be informed of any precautions to be taken as per CDCR CCHCS HC DOM 3.1.9 Health Care Transfer. A facemask shall be maintained on the patient throughout transfer. If a patient refuses to wear a facemask, the patient shall be placed in an area of the van that relatively isolates the patient and officers should wear protective equipment when transporting the patient to and from the van in accordance with CDCR's Covid-19 Staff PPE Guide: https://www.cdcr.ca.gov/covid19/wp-content/uploads/sites/197/2020/03/PPE-GUIDE-POSTER4.pdf
Consideration may also be given to having the patient wear a spit mask for the escort to and from the van.
   1. If a patient is already on isolation or quarantine, the isolation or quarantine should be maintained and completed at the new facility.

VIII. HCPOP and the IRU will track all inpatient referrals and any exceptions to transfer timelines.

If an inpatient bed becomes available, the institutional staff may determine which patient should be placed into that bed based upon clinical acuity, place that patient in the bed, and notify HCPOP and/or IRU via email as follows:

1. MHCB Placements: email MHCB.HCPOP@cdcr.ca.gov indicating the patient's name, CDCR number, bed number the patient is or will be placed into, and the date and time of placement.
2. ICF and ACUTE Placements: email cdcrdmhreferralupdate@cdcr.ca.gov and ripaupdates@hcpop.ca.gov indicating the patient's name, CDCR number, bed number the patient is or will be placed into, and the date and time of placement.

Discharges

ICF, APP, and MHCB discharges are to stay at their current facility whenever possible. If a patient must transfer to a different facility due to irreconcilable custodial issues (e.g. enemy concerns, staff separation alerts), clinical staff will complete COVID-19 clinical screening and document this screening utilizing the guidelines in Attachment A. Clinical staff will inform the Classification and Parole Representative if any personal protective equipment is needed during transfer and will inform the receiving Chief or Senior Psychiatrist regarding the patient's transfer and any treatment needs including those related to COVID 19 risks.

Attachment A

Medical Transfer Note

The following information shall be included in the transfer note in EHRS, and orally communicated to the receiving institution's Chief or Senior psychiatrist; if they are unavailable, it should be communicated to the Chief of Mental Health:

1. Title Note: Medical transfer note
2. Referring Institution
3. Receiving Institution
4. Does the patient have a new or worsening cough? [Y/N]
5. Does the patient have a fever (>100 F)? [Y/N]
6. Is the patient experiencing new or worsening shortness of breath? [Y/N]
7. Is the patient currently on isolation? [Y/N]
8. Is the patient currently on quarantine? [Y/N]
9. Is the patient known to be a contact of a confirmed COVID-19 case? [Y/N]
10. Include the patient's vitals for the last 14 days as available
11. Rationale for recommending transfer.

ATTACHMENT X

COVID Emergency Mental Health Treatment Guidance

Introduction

The purpose of this document is to provide guidance to the field regarding management of patients requiring inpatient treatment.

For all patients requiring inpatient mental health treatment (PIP or MHCB), the first choice for admission will be determined by HCPOP and located within an ICF, APP, or MHCB, as available at the same institution. However, it is recognized that not all facilities have these levels of care, or local units may be at full capacity. As such, institutions must endeavor to develop treatment commensurate with the patient's needed level of care.

Institutions shall follow the MHCB referral policy and patients shall be placed in alternative housing for no longer than 24 hours or until HCPOP assigns a bed at the local MHCB (whichever occurs first) and if one is not available, the patient will be placed in a temporary mental health unit (TMHU), if available.

Definitions

2:1 Suicide Watch: This type of suicide watch allows for one staff member to conduct suicide watch duties for two patients simultaneously. Clear, direct, and full visibility into both cells must be made by the observer at the same time.

Collaborative Team Treatment: Where there are severe shortages of PPE and/or tele-presenters, every available member of the treatment team could separately call into a single laptop (or other device) and a single tele-presenter could host 10 to 15 minute joint sessions with each patient at the open cell door. If the patient can be safely be brought to a confidential space or room, this is preferable, but not required in the collaborative team treatment model.

Enhanced Level of Care Treatment: When a patient is referred to an inpatient level of care and is unable to transfer to an inpatient bed, the inmate will receive an enhanced level of care treatment which is summarized later in this document. In this instance, the maximum possible out-of-cell time and other resources should be made available for patients.

Inpatient Treatment: Mental Health Crisis Bed (MHCB), Acute Psychiatric Program (APP), and Intermediate Care Facility (ICF) levels of care.

Temporary Mental Health Unit (TMHU): A Temporary Mental Health Unit (TMHU) is a consolidation of high acuity patients in adjacent cells where treatment can be provided to a group of individuals who require inpatient treatment. The treatment is an enhanced level of treatment which is summarized later in this document. Institutions shall identify a location where there are preferably 10-15 contiguous available cells that can be utilized for mental health treatment. The treatment offered should be as close as possible to treatment offered in an unlicensed mental health crisis bed units (MHCBUs). This is not alternative housing.

Treat in Place: An appropriate cell where enhanced level of care treatment can be provided.

Overview

Current Level of Care/Housing	Level of Care Referral	Placement Preference
GP, CCCMS, EOP	MHCB	1st Local MHCB 2nd Temporary Mental Health Unit 3rd Treat in Place 4th Transfer to an external MHCB
MHCB	APP	1st Transfer to local PIP 2nd Treat-in-place within MHCB 3rd Transfer to an external PIP
GP, CCCMS	ICF	1st Transfer to local PIP 2nd Temporary Mental Health Unit 3rd Treat in place 4th Transfer to an external PIP
MHCB	ICF	1st Transfer to local PIP 2nd Treat-in-place within MHCB or EOP 3rd Transfer to an external PIP
EOP	ICF	Treat in place or TMHU or EOP. This is determined based upon clinical judgment

The Temporary Mental Health Unit (TMHU) should be considered when an institution is able to designate a cluster of cells for patients in outpatient settings who require similar inpatient mental health treatment.

Enhanced level of care treatment should be considered when various levels of inpatient care are needed. This enhanced level of care can occur if, for example, a patient is in a crisis bed or a TMHU, but the patient requires a higher level of care, like acute inpatient care (APP). Enhanced level of care treatment should also occur for patients requiring inpatient care, for example MHCB level of care, but who are in various locations throughout an institution, for example if an institution is unable to establish a TMHU due to physical plant, staffing, or COVID-exposure concerns, or if all TMHU beds are filled. Additionally, enhanced level of care treatment-in-place should be considered for patients who have been referred to inpatient treatment but are not in acute distress requiring immediate inpatient treatment. An institution can have both a TMHU and additionally offer enhanced level of care treatment-in-place for patients who may need inpatient care, but be physically located throughout the institution.

For patients who are confirmed positive for COVID-19 or in quarantine for a suspected positive, the preference would be to treat-in-place to limit movement and exposure unless they meet criteria for transfer (see I in CDCR COVID Temporary Transfer Guidelines & Workflow document).

Temporary Mental Health Unit

A Temporary Mental Health Unit (TMHU) is a consolidation of high acuity patients in adjacent cells where treatment can be provided to a group of individuals who require similar inpatient treatment.

Institutions shall identify a location where there are preferably 10-15 available cells that can function as an unlicensed MHCBU-like setting. This is not alternative housing. These units shall:

- Allow for potential 1:1 and 2:1 suicide watch
- Enable ease of tracking patients for the mental health clinicians, custodial personnel, and nurses.
- Whenever possible, make it easier to perform milieu-based therapeutic alternatives such as groups (including educational groups specific to COVID-19), based upon CDCR COVID-19 guidelines.
- Enable staff to coordinate activities for patients.

Location of Temporary Mental Health Unit

Institutions shall identify clusters of cells for the TMHU based upon space availability and taking into account Local Operating Procedure for Alternative Housing. Priority considerations for location:

1. Restricted housing, such as LTRHU, STRHU, GP ASU, EOP Hub, PSU, or SHU, will be managed on a case-by-case basis, with further guidance to come.
2. Suicide Resistant housing units (ligature points, friable items for ingestion, etc.)
3. Line of sight from the officers' station
4. Contiguous grouping of cells
5. Proximity to treatment space
6. Available space in the unit for out-of-cell activities
7. Functional loud-speaker system
8. Reasonable access to an exercise yard

All TMHU cells will be visually marked within the unit so staff are aware of their location.

Multiple TMHUs can be established to accommodate custody level and potential enemy concerns.

Staffing

Clinical Leadership (to include Chief Executive Officers, Chiefs of Mental Health, Chief Nurse Executives, Chief Medical Executives, and the Chief Psychiatrist) shall assess program capacity and make determinations on admission and discharge practices based on factors to include available workforce, known COVID-19 exposure, etc. Leadership must consider individual patient needs, facility-system flows, and the degrees of risk when making these decisions.

Interdisciplinary Treatment Teams

The initial IDTT shall occur within 72 hours of patient's placement in the TMHU. Routine IDTTs shall occur every 7 days until the patient can be safely transferred to an inpatient environment. During IDTT, all available team members shall review the patient's treatment needs, progress and goals. Additionally, the treatment team members shall discuss the provision of issue and property from a clinical perspective and assess the presence or absence of serious clinical deterioration. IDTTs may occur via teleconference.

Where staffing allows, the required IDTT members identified in the MHSDS Program Guide, Mental Health Crisis Bed shall be present.

Issuance of Property and Privileges

Property and privileges should be provided in the Mental Health Patient Issue order for each patient. Additionally, these should be reviewed during the initial IDTT. The provision of property and privileges must be considered and communicated to all members of the treatment team. Considerations shall be for:

- Clothing
- Writing implements
- Paper
- Books
- Phone calls
- Yard time
- Mental Health Observation
- Access to the library cart
- In-cell activities, games, puzzles, tablets, physical and other activities with the recreational therapist.
- Dayroom
- Group therapy

Clinical teams shall refer to the memo titled, "Mental Health Crisis Bed Privileges Revision" dated February 14, 2017 when determining issuance of property for patients in the TMHU. All orders for level of observation, issuance and property shall be standing orders and updated as clinically indicated.

Specific Treatment Considerations

The delivery of care to patients in the TMHU will be evaluated daily. The delivery of care will be adjusted based on the total percentage of staff available for patient care and direct activities.

Required Elements of Treatment Options in the TMHU

- All patients placed in the TMHU due to acute suicidality will be on 1:1 suicide watch until the treatment team can assess and determine the appropriate level of observation based upon clinical need and the patient's presentation. If the patient was admitted to the temporary mental health treatment unit for suicidality, the individual sessions should include safety planning development and enhancements to assist the patient in identifying and utilizing modifiable behaviors for ongoing safety from self-harm (see memorandum, "Updated Mental Health Crisis Bed – Referral, Referral Rescission, and Discharge Policy and Procedures" dated October 18, 2018).
    - For patients on 1:1 suicide watch, the psychiatrist will make contact with a designated nursing staff, preferably before and after the clinical contact with the patient, to review pertinent information noted during the suicide watch.
    - Suicide precautions (15-minute checks) are not authorized unless the cell has previously been found to be suicide-resistant.
- Interdisciplinary huddles shall be utilized to disseminate clinical information about patients housed in the TMHU.
    - If in-person huddles cannot be accomplished safely, while adhering to social distancing, huddles shall occur telephonically.

- Individual treatment out-of-cell shall occur daily and will be conducted by either the primary clinician or the psychiatrist, whenever possible. Supplemental treatment options provided in-cell should be reviewed during individual sessions and the clinician should provide feedback on the work the patient has completed with the in-cell activities.
- Rounding
    - Rounding shall occur twice per day, when possible, but no less frequently than at least once per day by a clinical social worker, psychologist, or psychiatrist. At least once per day, results from the rounding must be communicated to the psychiatrist covering the temporary mental health treatment unit if the psychiatrist did not perform the rounding.
- All patients in the TMHU shall have at least equal access to existing resources, out-of-cell time and privileges that other inmates and patients have in the housing unit where the TMHU is located:
    - Yard
    - Showers
    - Phone Calls
- The patient can be afforded other resources, unless clinically contraindicated by the IDTT, such as:
    - JPAY tablets
    - Radios
    - Electronic Appliance Loaner Program
    - Reading materials
    - See section entitled "Supplemental Treatment Options"
- Recreational Therapy
    - Increased Recreational Therapy, developed through collaboration with all members of the treatment team to determine the most effective activities for the patient, given his or her unique treatment teams.
    - If the patient cannot receive recreational therapy outside of his or her cell, due to COVID exposure risk, recreational therapy shall be focused on activities that the patient can engage in while in his or her cell. Examples are mindfulness activities, yoga, guided imagery, meditation, music therapy, community milieu activities, and physical activities to improve both physical and mental health wellbeing.
- Individual treatment
    - Confidential individual treatment by a member of the treatment team shall occur each day, where safe to do so.
    - Primary clinicians shall focus their efforts during individual treatment not just on the primary mental health treatment goals for the patient, but also how to adjust to being in close quarters for extended periods of time due to the COVID crisis.
    - Supplemental treatment options provided in-cell should be reviewed during individual sessions and the clinician should provide feedback on the work the patient has completed with the in-cell activities.

<u>Supplemental Treatment Options in the TMHU</u>

In addition to the required elements of TMHU treatment, other optional treatment modalities can be considered.

- If/when necessary consider utilizing Collaborative Team Treatment, as described below:

- Where necessary due to staffing, a tele-presenter with portable equipment such as a laptop with a camera, microphone, and speakers could connect to the same WebEx meeting with any available members of the treatment team attending by video conference. The team members would be able to participate on their own personal computers. The tele-presenter would then carry the laptop to the patient's cell front, where the entire treatment team would be able to engage in a collaborative session. It is preferable for cell doors to be open when conducting this cell side treatment modality.
- This is a strategy to minimize the amount of ingress and egress required within the entire institution, particularly for quarantined areas. This achieves the of goal minimizing the amount of potential staff and patient exposure, while maintaining an ability for the entire team to gather accurate information about the status of the patient, discuss patient care together, and develop & coordinate plans together.
- If PPE or tele-presenters are not available in sufficient quantities, the tele-presenter could then be the only member of the treatment team required to don and doff scarce protective equipment.
- Tele-presenter selection. The current working emergency COVID plan notes “staff that could be used as tele-presenters is decided by each institution to include:
  - Medical Assistant
  - Any staff unable to perform their assigned duties during the crisis (with training), e.g.
  - Dental
  - Staff on administrative time off
  - Support staff
  - Any healthy state personnel
  - Any Mental Health provider (Group leader, RT, SW, LCSW, PhD/ PsyD)
  - LVN, RN, CNA, Psych Techs
  - Any medical provider (PA, NP, MD)"
  - During the COVID crisis, any of the above staff may serve as tele-presenters in a priority to be determined by the CEO in consultation with the Chief Psychiatrist, Director of Mental Health, Supervising Dentist, Chief Nurse Executive, and other leadership as necessary, based on local availability and necessary duties. Volunteers could be selected first, and if re-direction to tele-presenter duty continues to be necessary, they could be assigned based on inverse seniority. To reinforce, these decisions are at the discretion of the CEO, in consultation with the Chief Psychiatrist and other leadership.

- Group therapy and structured out-of-cell time
  - Group therapy shall occur in small groups (3-4 people) where space allows them to remain at least 6 feet apart and the area can be sanitized between each group member.
  - For individuals on suicide watch, consider having the staff member monitor patient while in group, when feasible and safe.
  - If no groups can be run, then PM yard should be considered.
  - Dayroom
  - All out of cell activity offered within the TMHU will be documented on the 114-A

<u>Discharge Criteria</u>

If a patient no longer requires inpatient mental health treatment, the discharge IDTT shall rescind the referral to the higher level of care. Upon discharge, the primary clinician shall complete a full discharge SRASHE with Safety Planning Intervention. Additionally, orders for five-day follow ups and custody discharge checks shall be made.

Higher Level of Care Triage

When a local inpatient bed becomes available, the treatment team will triage all patients in the TMHU, or in other locations who are waiting for an inpatient bed, and determine which patient is most acutely mentally ill and that individual will be assigned to the available MHCB.

Enhanced Level of Care Treatment

When a patient is referred to an inpatient level of care and is unable to transfer to an inpatient bed, a TMHU, or is already in an inpatient setting, treatment will be provided in the patient's housing unit until transfer can occur. In this instance, the maximum possible out-of-cell time and other resources should be made available for patients.

Patients receiving enhanced treatment-in-place for acute suicidality shall be placed on 1:1 suicide watch.

- For patients on 1:1 suicide watch, the psychiatrist will make contact with a designated nursing staff, preferably before and after the clinical contact with the patient, to review pertinent information noted during the suicide watch.
- Suicide precautions (15-minute checks) are not authorized unless the cell has previously been found to be suicide-resistant.

StaffingClinical Leadership (to include Chief Executive Officers, Chiefs of Mental Health, Chief Nurse Executives, Chief Medical Executives, and the Chief Psychiatrist) shall assess program capacity and make determinations on admission and discharge practices based on factors to include available workforce, known COVID-19 exposure, etc. Leadership must consider individual patient needs, facility-system flows, and the degrees of risk when making these decisions.

Enhanced Level of Care Treatment Modalities

When possible, all treatment shall be conducted in a confidential space. This includes both individual and group treatment.

- Individual treatment out-of-cell shall occur daily and will be conducted by either the primary clinician or the psychiatrist, whenever possible. Supplemental treatment options provided in-cell should be reviewed during individual sessions and the clinician should provide feedback on the work the patient has completed with the in-cell activities.
- Rounding
    - Rounding shall occur twice per day, when possible, but no less frequently than at least once per day by a clinical social worker, psychologist, or psychiatrist. At least once per day, results from the rounding must be communicated to the psychiatrist covering the temporary mental health treatment unit if the psychiatrist did not perform the rounding.

- All patients in the TMHU shall have at least equal access to existing resources, out-of-cell time and privileges that other inmates and patients have in the housing unit where the TMHU is located:
    - Yard
    - Showers
    - Phone Calls
- The patient can be afforded other resources, unless clinically contraindicated by the IDDT, such as:
    - JPAY tablets
    - Radios
    - Electronic Appliance Loaner Program
    - Reading materials
    - See section entitled "Supplemental Treatment Options"
- Recreational Therapy
    - Increased Recreational Therapy, developed through collaboration with all members of the treatment team to determine the most effective activities for the patient, given his or her unique treatment teams.
    - If the patient cannot receive recreational therapy outside of his or her cell, due to COVID exposure risk, recreational therapy shall be focused on activities that the patient can engage in while in his or her cell. Examples are mindfulness activities, yoga, guided imagery, meditation, music therapy, community milieu activities, and physical activities to improve both physical and mental health wellbeing.
- Individual treatment
    - Confidential individual treatment by a member of the treatment team shall occur each day, where safe to do so.
    - Primary clinicians shall focus their efforts during individual treatment not just on the primary mental health treatment goals for the patient, but also how to adjust to being in close quarters for extended periods of time due to the COVID crisis.
    - Supplemental treatment options provided in-cell should be reviewed during individual sessions and the clinician should provide feedback on the work the patient has completed with the in-cell activities.
- Group therapy
    - Group therapy shall occur in small groups (3-4 people) where space allows them to remain at least 6 feet apart and the area can be sanitized between each group member.
    - For individuals on suicide watch, consider having the staff member monitor patient while in group, when feasible and safe.
    - If no groups can be run, then PM yard should be considered.
    - Cell front CNA nursing activities
        - Based upon the patient's acuity and clinical determination, the CNA conducting suicide watch can engage the patient utilizing CNA activities.
- When possible, interdisciplinary huddles should be utilized to disseminate clinical information about patients receiving Enhanced Level of Care Treatment.

<u>Resources for Supplemental In-Cell Treatment</u>

- Primary clinicians to utilize clinical resources to allow patients to complete therapeutic work, determined by their treatment goals listed in the master treatment plan.
- Recreational Therapists will offer patients access to in-cell activities.
  - Institutions should use any stock of ASU Workbooks for outpatient settings, as these workbooks provide many activities for individuals while in-cell.
  - Recreational Therapy resources have been provided to all institutions that cover gratitude journals, mindfulness meditation and yoga, and stress management through art.
- Mindfulness and guided meditation videos have been created by the Mental Health Training Unit for distribution to institutional televisions to be played for all patients to engage in while in-cell.
- Resources have been sent to all Chiefs of Mental Health for in-cell therapeutic work. It is expected that the clinical teams will review these resources and provide clinically relevant activities to patients.
- Meta-sourced free self-help guides
  - https://mindremakeproject.org/2018/11/12/free-printable-pdf-workbooks-manuals-and-self-help-guides/
  - http://www.evworthington-forgiveness.com/diy-workbooks
- Anger Management
  - Evidence-based curriculum using CBT and DBT skills to address behavior change
- Start Now - Forensic Version
  - CBT/DBT based curriculum that covers a broad set of topics that will be useful for all patients.
- Depression/Anxiety/Mood disorders
  - Evidence-based curriculum is being provided to all institutions.

Monitoring

The Regional Mental Health Administrators (RMHA) will monitor all TMHUs and treatment-in-place locations established in their respective region each day. The goal of this daily oversight is to ensure the various components of the TMHU and enhanced treatment-in-place are occurring and are appropriate for the patients.

ATTACHMENT Y

COVID Emergency Mental Health Treatment Guidance For MAX Custody Patients

When a MAX custody patient is referred to an inpatient bed, the patient shall be placed in an available inpatient bed within the institution by HCPOP whenever possible. If no inpatient bed is available, the patient shall be placed under observation as clinically appropriate until the following occurs within 24 hours:

1. The Warden or designee will review the case and determine if a specialized ICC is necessary to consider suspension of MAX custody status.
2. If a specialized ICC is warranted, it will be held with mental health participation as usual to assess the patient's reason for MAX custody designation and to determine if the MAX custody can be suspended to allow housing and mental health treatment as per the COVID-19 Temporary Emergency Transfer Guidelines document.
3. If the specialized ICC suspends the MAX custody designation, then treatment and transfer will follow the COVID-19 Temporary Emergency Transfer Guidelines document.
4. If the committee determines MAX custody cannot be suspended, the MAX custody patient shall be housed in a TMHU for a maximum of 10 days, that can be located in the following locations in the following priority:
    a. EOP ASU Hub/PSU
    b. STRH/LTRH
    c. ASU

MAX Custody TMHU Location

Institutions shall identify a location where there are preferably 5-15 available clustered cells in a segregation setting as specified above. This is not alternative housing. All TMHU cells will be visually marked within the unit so staff are aware of their location. These units shall:

1. Allow for potential 1:1 and 2:1 suicide watch
2. Enable ease of tracking patients for mental health clinicians, custodial personnel, and nurses.
3. Whenever possible, make it easier to perform milieu-based therapeutic alternatives such as groups (including educational groups specific to COVID-19), based upon CDCR COVID-19 guidelines.
4. Enable staff to coordinate activities for patients.
5. Take the following into consideration:
    a. Line of sight from the officers' station.
    b. Proximity to treatment space.
    c. Available space in the unit for out-of-cell activities.
    d. Functional loud-speaker system.
    e. Reasonable access to an exercise yard.
    f. Suicide Resistant housing units (ligature points, friable items for ingestion, etc.). Retrofitted Intake Cells shall be used as first priority for the newly admitted segregation inmates as per policy. In the event the institution has enough retrofitted Intake Cells for their new admits, the institution may consider using a few Intake Cells for their TMHU.

MAX Custody TMHU Treatment and Services

1. The patient will be offered at least 5 hours of structured, out-of-cell treatment during the week (this can include participation in existing ASU groups, or TMHU-patient-specific groups with RTs, nursing staff, or clinicians).
2. The patient will be offered at least 15 hours of unstructured out-of-cell time during the week (including yard in which social distancing is observed).
3. All group therapy should be considered in the context of the potential spread of infection, and should only be performed where it can be done safely.
4. The Sergeant and psychiatrist and/or primary clinician shall have a daily discussion regarding patients' participation in out-of-cell treatment, yard, meals, phone calls, showers and other information related to the patients programming.
5. Interdisciplinary treatment teams (IDTTs) will be held at 72 hours, and again at 7 days from the date of placement.
6. Treatment team members will track whether patients are availing themselves of the opportunity to program out of cell for at least the 5 hours of structured treatment and 15 hours of unstructured out of cell time. If the patient is not participating due to mental health reasons, the subsequent IDTT shall include a discussion of alternate treatment strategies to be considered.
7. If the patient is demonstrating signs of clinical decompensation, they would be moved from the segregation unit in a timely manner.
8. At seven days from the date of placement, an IDTT will be held. If it is determined that the patient is not improving or stabilizing sufficiently to decrease their level of care to the level prior to referral, the patient will be referred to an MHCB and must be transferred to an inpatient unit potentially at another facility within 10 days from the date of placement, following procedures described in the COVID-19 Temporary Emergency Transfer Guidelines.
9. Staffing: Clinical Leadership (to include Chief Executive Officers, Chiefs of Mental Health, Chief Nurse Executives, Chief Medical Executives, and the Chief Psychiatrist) shall assess program capacity and make determinations on admission and discharge practices based on factors to include available workforce, known COVID-19 exposure, etc. Leadership must consider individual patient needs, facility-system flows, and the degrees of risk when making these decisions.
10. All of the following services as per the COVID-19 Emergency Mental Health Treatment Guidance document:
    a. Issuance of Property and Privileges: Property and privileges should be provided in the Mental Health Patient Issue order for each patient. Additionally, these should be reviewed during the initial IDTT. The provision of property and privileges must be considered and communicated to all members of the treatment team. Considerations shall be for:
        - Clothing
        - Writing implements
        - Paper
        - Books
        - Phone calls
        - Yard time
        - Mental Health Observation
        - Access to the library cart

- In-cell activities, games, puzzles, tablets, physical and other activities with the recreational therapist.
- Group therapy

b. Clinical teams shall refer to the memo titled, "Mental Health Crisis Bed Privileges Revision" dated February 14, 2017 when determining issuance of privileges for patients in the TMHU. All orders for level of observation, issuance and privileges shall be standing orders and updated as clinically indicated.

c. The delivery of care to patients in the TMHU will be evaluated daily, and adjusted based on the total percentage of staff available for patient care and direct activities.

d. All patients placed in the TMHU due to acute suicidality will be on 1:1 suicide watch until the treatment team can assess and determine the appropriate level of observation based upon clinical need and the patient's presentation. If the patient was admitted to the temporary mental health treatment unit for suicidality, the individual sessions should include safety planning development and enhancements to assist the patient in identifying and utilizing modifiable behaviors for ongoing safety from self-harm (see memorandum, "Updated Mental Health Crisis Bed – Referral, Referral Rescission, and Discharge Policy and Procedures" dated October 18, 2018).
   - For patients on 1:1 suicide watch, the psychiatrist will make contact with a designated nursing staff, preferably before and after the clinical contact with the patient, to review pertinent information noted during the suicide watch.
   - Suicide precautions (15-minute checks) are not authorized unless the cell has previously been found to be suicide-resistant.

e. Interdisciplinary huddles shall be utilized to disseminate clinical information about patients housed in the TMHU.

f. If in-person huddles cannot be accomplished safely, while adhering to social distancing, huddles shall occur telephonically.

g. Individual treatment out-of-cell shall occur daily and will be conducted by either the primary clinician or the psychiatrist, whenever possible. Supplemental treatment options provided in-cell should be reviewed during individual sessions and the clinician should provide feedback on the work the patient has completed with the in-cell activities.

h. Rounding shall occur twice per day, when possible, but no less frequently than at least once per day by a clinical social worker, psychologist, or psychiatrist. At least once per day, results from the rounding must be communicated to the psychiatrist covering the temporary mental health treatment unit if the psychiatrist did not perform the rounding.

i. All patients in the TMHU shall have at least equal access to existing resources, out-of-cell time and privileges that other inmates and patients have in the housing unit where the TMHU is located:
   - Yard
   - Showers
   - Phone Calls

j. The patient shall be afforded other resources, unless clinically contraindicated by the IDTT, such as:
    - JPAY tablets
    - Radios
    - Electronic Appliance Loaner Program
    - Reading materials
    - See section entitled "Supplemental Treatment Options" below

k. Recreational Therapy
    - Increased Recreational Therapy, developed through collaboration with all members of the treatment team to determine the most effective activities for the patient, given his or her unique treatment teams.
    - If the patient cannot receive recreational therapy outside of his or her cell, due to COVID exposure risk, recreational therapy shall be focused on activities that the patient can engage in while in his or her cell. Examples are mindfulness activities, yoga, guided imagery, meditation, music therapy, community milieu activities, and physical activities to improve both physical and mental health wellbeing.

l. Individual treatment
    - Confidential individual treatment by a member of the treatment team shall occur each day, where safe to do so.
    - Primary clinicians shall focus their efforts during individual treatment not just on the primary mental health treatment goals for the patient, but also how to adjust to being in close quarters for extended periods of time due to the COVID crisis.
    - Supplemental treatment options provided in-cell should be reviewed during individual sessions and the clinician should provide feedback on the work the patient has completed with the in-cell activities.

m. Supplemental Treatment Options in the TMHU: In addition to the required elements of TMHU treatment, other optional treatment modalities can be considered. If/when necessary consider utilizing Collaborative Team Treatment, as described below:
    - Where necessary due to staffing, a tele-presenter with portable equipment such as a laptop with a camera, microphone, and speakers could connect to the same WebEx meeting with any available members of the treatment team attending by video conference. The team members would be able to participate on their own personal computers. The tele-presenter would then carry the laptop to the patient who should be secured within a TTM in a confidential location, where the entire treatment team would be able to engage in a collaborative session.
    - This is a strategy to minimize the amount of ingress and egress required within the entire institution, particularly for quarantined areas. This achieves the of goal minimizing the amount of potential staff and patient exposure, while maintaining an ability for the entire team to gather

accurate information about the status of the patient, discuss patient care together, and develop & coordinate plans together.

- If PPE or tele-presenters are not available in sufficient quantities, the tele-presenter could then be the only member of the treatment team required to don and doff scarce protective equipment.
- Tele-presenter selection. The current working emergency COVID plan notes "staff that could be used as tele-presenters is decided by each institution to include:
  i. Medical Assistant
  ii. Any staff unable to perform their assigned duties during the crisis (with training), e.g.
    1. Dental
    2. Staff on administrative time off
    3. Support staff
    4. Any healthy state personnel
  iii. Any Mental Health provider (Group leader, RT, SW, LCSW, PhD/ PsyD)
  iv. LVN, RN, CNA, Psych Techs
  v. Any medical provider (PA, NP, MD)"

  During the COVID crisis, any of the above staff may serve as tele-presenters in a priority to be determined by the CEO in consultation with the Chief Psychiatrist, Director of Mental Health, Supervising Dentist, Chief Nurse Executive, and other leadership as necessary, based on local availability and necessary duties. Volunteers could be selected first, and if re-direction to tele-presenter duty continues to be necessary, they could be assigned based on inverse seniority. To reinforce, these decisions are at the discretion of the CEO, in consultation with the Chief Psychiatrist and other leadership.
- Group therapy and structured out-of-cell time
  i. All group therapy should be considered in the context of the potential spread of infection, and should only be performed where it can be done safely.
  ii. When safely possible, it is preferable to have group therapy occur in small groups (3-4 people) where space allows them to remain at least 6 feet apart and the area can be sanitized between each group member.
  iii. When safely possible, group Therapy shall occur in an existing mental health treatment area with TTMs. For individuals on suicide watch, consider having the staff member monitor patient while in group, when feasible and safe.
  iv. If no groups can be run, then PM yard should be considered.
  v. All out of cell activity offered within the TMHU will be documented on the 114-A

n. Discharge Criteria: If a patient no longer requires inpatient mental health treatment, the discharge IDTT shall rescind the referral to the higher level of care. Upon discharge, the primary clinician shall complete a full discharge SRASHE with

Safety Planning Intervention. Additionally, orders for five-day follow ups and custody discharge checks shall be made.

ATTACHMENT Z

CDCR COVID EOP Temporary Transfer Guidelines & Workflow

In an attempt to limit the transmission of COVID-19, all non-emergency movement shall be immediately curtailed, as per constantly evolving circumstances which require flexibility and adaptation as events and requirements change due to COVID-19. All movement within a facility can continue, taking into consideration COVID status. All transfer requests to other facilities will be reviewed as described below, and HCPOP will not act on the place-in order without approval from the Regional Mental Health Administrator or the IRU.

Outpatient Referrals to a Different Facility:

All outpatient external transfers or releases from segregated housing to mainline mental health programs at other institutions, to include transfers from desert institutions, transfers from stand-alone ASUs to STRH, CCCMS to EOP, and EOP to CCCMS will not occur unless the following exists:

I. Institution Review: Transfer out of the patient's current facility shall not proceed unless meeting the criteria below, as assessed by the treatment team:
   1. an imminent, life-threatening emergency necessitates transfer, or
   2. serious mental health decompensation necessitates transfer, and
   3. the life-threatening condition or serious decompensation cannot be reasonably treated at the institution.

II. If transfer is pursued, Regional Review is required: If the referral meets the criteria above, the Chief of Mental Health or Chief Psychiatrist shall email and call the Regional Mental Health Administrator or designee. They shall include an explanation of why the criteria above have been met. The Regional Mental Health Administrator must then consult with the Regional Deputy Medical Executive. The Division of Adult Institutions and/or HCPOP will not transfer patients to a new facility without receiving approval from the Mental Health Administrator.

When a transfer is not clinically necessary, alternate strategies for managing the patient within the institution must be implemented. When full staffing is available, EOP programming should be offered at the standard Program Guide mandated frequency and quality of care (Page 12-3-13: Inmate-patients awaiting EOP transfer shall have updated individualized treatment plans to address patient's current clinical needs [CDCR 7388, *Mental Health Treatment Plan*]. While awaiting EOP transfer, inmate-patients shall be seen on an at least weekly basis by the PC, as clinically indicated, with ongoing assessment of emergency transfer criteria). In institutions that do not have levels of staffing sufficient to provide standard EOP programming, they should be treated in accordance with the Tier Chart. This includes patients released via ICC from an EOP ASU Hub program, but unable to be placed on any EOP yard at the same institution (e.g. due to widespread safety concerns); these patients may be placed on a local CCCMS yard while applying the same criteria for consideration of transfer.

ATTACHMENT AA

State of California Department of Corrections and Rehabilitation

Memorandum

Date: April 1, 2020

To: Associate Directors, Division of Adult Institutions
Wardens
Chief Executive Officer
Chiefs of Mental Health
Chiefs of Psychiatry

Subject: **COVID- 19 ELECTRONIC APPLIANCE PROGRAM FOR RESTRICTED HOUSING INMATES**

The purpose of this memorandum is to announce the implementation of the Electronic Appliance Loaner Program in all restricted housing areas. Restricted housing shall encompass those inmates confined to quarters who are not permitted normal release, therefore require a greater degree of supervision than normal. This program has been developed in order to enhance the Department's in-cell activities in response to the COVID-19 pandemic. This program implementation shall remain in effect during the duration of the pandemic. Upon resolution, the memorandum dated January 22, 2014, titled, *Multi-Powered Radio Loaner Program in Administrative Segregation Units*, and memorandum dated August 4, 2017, titled *Electronic Tablet Loaner Program in Administrative Segregation and Short-term Restricted Housing*, shall reconvene.

The electronic appliance loaner program shall be implemented within all restricted housing units. Upon placement into restricted housing, all offenders shall be offered an electronic appliance as described below. Staff shall also ensure all appliances have been disinfected prior to any issuance or redistribution from one inmate to another. The process will be as follows:

- Initial Intake
  - During the initial 72-hour intake period, a loaner crank radio shall be issued if available.
- After Intake, the following may be provided:
  - Television
    - If the assigned cell has power capabilities and a television service provider, a television may be issued.
      - If the offender has a television in their personal property, it shall be retrieved and provided to the inmate.
      - If the inmate does not have an electronic appliance in their personal property, a loaner television shall be issued first.
      - In the event the cell does not have power capabilities, or there are not sufficient loaner televisions, staff shall issue the inmate a crank radio as outlined below.

- Radios
  - If the assigned cell has power capabilities and the offender has a corded radio in their personal property, it shall be retrieved and provided to the inmate.
  - If the assigned cell does not have power capabilities, a loaner crank radio shall be issued.
  - Should radios not be available, a wait list by date of placement shall be established and issued by arrival date order.

Expectations

- Inmates will be allowed to keep the appliance until they are released from restricted housing, or issued an entertainment appliance from their personal property.
- All property restrictions relative to entertainment appliances within restricted housing shall be suspended during this program.
- Each institution shall ensure each loaner electronic appliance is issued a state property tag for accountability.
- The restricted housing supervisor shall be responsible to ensure the assigned property officer and inmate complete a CDCR 128-B, Electronic Appliance Loaner Program Agreement form upon issuance.
- The assigned property officer will track issuance of the appliance on a distribution log, and will ensure the appliance is in proper working order. Upon release from restricted housing, the inmate shall relinquish the loaner electronic appliance.
- If the electronic appliance has been altered or destroyed, the restricted housing supervisor shall determine if it was intentional or unintentional. In the event it has been determined to be intentional, staff shall utilize progressive discipline per California Code of Regulations Section 3312. In addition, the inmate will be charged the full replacement cost.
- Those institutions authorized to use the Electronic Tablet Loaner Program in their restricted housing units shall continue to offer tablets as a viable electronic appliance.

Wardens are directed to implement these procedures immediately. Provide proof of practice to your respective Mission Associate Director within 1 week of the date of this memoradum. In addition to this directive, Wardens are encouraged to collaborate with Mental Health managers and provide innovative methods to assist in combating boredom and encouraging mental stimulation within their restricted housing settings.

If you have any questions, contact Lourdes White, Captain, Mental Health Compliance Team, at (916) 835-5679 or Lourdes.White@cdcr.ca.gov.

CONNIE GIPSON
Director
Division of Adult Institutions

Original Signed by:
JOSEPH BICK, M.D.
Director
Health Care Services

Attachments

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ATTACHMENT AB

State of California Department of Corrections and Rehabilitation

Memorandum

Date: April 1, 2020

To: Associate Directors, Division of Adult Institutions
Wardens
Chief Executive Officers
Chiefs of Mental Health
Chief Psychiatrists
Senior Psychiatrists, Supervisors

Subject: **COVID-19 PROGRAMMING OPPORTUNITIES FOR INMATES PARTICIPATING IN THE MENTAL HEALTH SERVICES DELIVERY SYSTEM IN RESTRICTED HOUSING**

The purpose of this memorandum is to announce the implementation of third watch programming opportunities within restricted housing in response to the current Coronavirus (COVID-19) disease. This program implementation shall remain intact during the duration of the pandemic. At the resolution, all programming will reconvene to their original format.

In the event mental health groups and clinical one-to-ones are unable to occur in the restricted housing units, wardens will ensure evening (PM) yard is provided to inmates in the mental health services delivery system. For those units designated to quarantine status, all movement will be in accordance with current departmental expectation. This direction has been developed in order to maximize out-of-cell time and enhance the Department's suicide prevention efforts during this pandemic. The attached listing identifies those institutions and their respective restricted housing units already staffed to provide PM yard. Due to the direction to increase evening programming opportunity within every mental health restricted housing program, the wardens without staffing for PM yard will have the authority to approve overtime on an as needed basis. All overtime detail code for this program will be coded as "MHYD" to accurately capture expenditures and a weekly report of incurred overtime will be reported to the respective Associate Director.

Wardens are encouraged to collaborate with Mental Health managers and provide innovative methods to assist in combating boredom and encouraging mental stimulation within their restricted housing settings. Wardens shall also ensure precautions are taken for both staff and inmate safety to include procedures to limit risk of exposure and transmittal of illness (social distancing) from inmate to inmate.

If you have any questions, contact Lourdes White, Captain, Mental Health Compliance Team, via email at Lourdes.White@cdcr.ca.gov or via phone at (916) 835-5679.

Associate Directors, Division of Adult Institutions
Wardens
Chief Executive Officers
Chiefs of Mental Health
COVID-19 Programming Opportunities for Inmates Participating in the Mental Health Services Delivery System in Restricted Housing
Page 2

CONNIE GIPSON
Director
Division of Adult Institutions

EUREKA C. DAYE, Ph.D., MPH, MA, CCHP
Deputy Director (A)
Statewide Mental Health Program

Attachment

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Lourdes White
Mental Health Regional Administrators
Regional Healthcare Executives

Mental Health Restricted Housing
Third Watch Yard

INST	Housing Designation
COR	ASU-STRH
HDSP	ASU-STRH
KVSP	ASU-STRH
PBSP	ASU-STRH
LAC	ASU-STRH
CMC	EOP ASU
PVSP	STRH
SATF	STRH
SVSP	STRH
SAC	STRH