WA DOC COVID19 Quarantine Removal Plan

Based on the decrease in clinical severity of COVID-19 over time due to an increase in the number of fully vaccinated individuals, the number of individuals with a personal history of recent COVID-19 infection, and less virulent circulating COVID-19 variants, the recommended clinical strategy to respond to COVID-19 is changing. Following updated WA Department of Health (DOH) guidelines, Clinical Leadership is transitioning from a transmission mitigation strategy to a risk mitigation strategy. This model will prioritize decreasing COVID-19 hospitalizations and deaths while de-escalating several of the main transmission mitigation strategies, such as the widespread use of quarantine and mass testing.

Clinical Leadership is waiting for the updated CDC guidelines for Correctional settings so we can continue development of the upcoming version 34 COVID-19 guidelines. Therefore, the purpose of this document is to provide relevant guidance as we transition into removing quarantine as one of our key mitigation strategies and modify associated measures when applicable. A large number of strategies will remain unchanged, so please review the current version 33.1 of the DOC COVID-19 guidelines and the current CDC Guidelines for correctional facilities as needed.

SCREENING AND TESTING:

1. Will only test for COVID19 if patients are symptomatic, upon patient request, or if patient is identified as exposed to a positive individual. This applies to all prison facilities and Reentry Centers.
   a. Testing will not be mandatory. Patients that decline testing will return to housing unit.
   b. In the case of Reentry Centers, patient that decline testing or have been exposed should be encouraged to remain in their room. No mandatory quarantine is recommended. The rest of residents should be informed of an increased risk of COVID19 exposure. See below for additional testing recommended during influenza season.

2. Inter-system transfers to Reception Centers or other facilities (intake patients, patients in on a violation or transfers from outside hospitals):
   a. Screen with temperature/symptom check and RAT test everyone on intake coming into DOC.
   b. All county buses arriving to reception centers will be RAT tested as they are intake patients that require initial screening.
   c. Intake separation will continue per DOH recommendations and current CDC guidelines.
      ▪ Patients will be RAT tested on Day 0 upon arrival, and then on Day 7. All positives will be sent to isolation per protocol.
      ▪ Upon completion of 7 days, if patients are negative, they will be eligible to move out of intake separation and into designated housing units.
      ▪ Intake separation patients that test negative will not be on quarantine even if exposed to positive patients.
      ▪ Intake separation does not apply to intra-system transfers (between facilities and/or Reentry centers).

3. If positive RAT, follow isolation protocols in a separate living area per current DOC version 33.1 COVID19 guidelines. For Reentry Centers, patients that test positive should continue to transfer to DOH facilities for isolation.
   a. If symptomatic and RAT negative or exposed and RAT negative, patients should be tested for influenza or other pathogens per protocol (see below for details). Patients
that test negative are to continue without medical isolation and may return to their assigned housing. For Reentry Centers, no movement restrictions should be enforced in these cases.

b. Population living in units that will house the exposed or symptomatic patients that are RAT negative will be notified of potentially increased COVID19 risk in their unit.
   - This will be done through a sign posted at the entrance of every unit stating there is a risk of COVID19 exposure in the unit and that each patient is encouraged to wear a mask and/or N95. Clinical Leadership will develop and provide this poster to facilities.
   - With this information use of masks or N95 respirators will be up to each individual.
   - PPE should be made available at every area.
   - Posters with information on COVID19 symptoms, available testing upon request and available treatment options will be placed in each unit. Clinical Leadership will develop and provide these posters to facilities.

4. Patients who are at high risk (age, comorbidities, etc., see list at [CDC designated high risk conditions](https://www.cdc.gov/coronavirus/2019-ncov/healthcare-professionals/management-spread.html)) will be notified of their high-risk status so they can make an informed decision on what measures they will take and to notify Health Services if they develop symptoms. In the case of Reentry Centers, high-risk patients should contact a community provider.

   a. For Reception Centers, they will be notified through a reverse kite template stating their high-risk status. Clinical Leadership will develop and provide this template to facilities.
   b. For housing units where patients have completed their physicals and classification, patients have already undergone counseling and have been informed of their high-risk status during the physical. A sign informing of the current risk of COVID19 will be posted in the unit’s entrance. This sign will serve as a stoplight with three stages: Baseline COVID19 risk in unit, possible COVID19 exposure in unit and outbreak status (confirmed COVID19 cases in unit).
   c. Above screening testing plan would not change with community levels (green, yellow or red).

5. If a COVID19 positive test is identified in a housing unit, then the entire unit will be notified of increased risk due to potential exposure to COVID19. This will happen through the unit entrance poster.

   a. RAT testing would only be offered and recommended to the close contacts (cellies, coworkers or any other known close contacts) following PPE matrix definition.
   b. No unit-wide testing is required after identification of positive cases in a unit, except for IPUs, SAGE (CRCC) and WSR (MCC) units (see below).
   c. Testing will not be mandatory. Patients that decline will return to housing unit.

6. RAT testing screening before Dental visits will continue.

7. Reentry Centers no longer have to RAT test patients when they arrive to their facility since pre-transfer testing will be taking place. The rest of the intake process should continue.

   a. Reentry Centers no longer have to RAT patients routinely on a weekly basis. Testing is now only as above, for patients that are symptomatic, requesting a test, or have been exposed to a COVID19 positive patient.
8. Essential workers should only get tested if symptomatic, asking for a test, or identified as exposed to a COVID19 positive patient. Testing workers before DNR, kitchen, etc. is no longer needed unless above situations.

9. RAT testing should be offered upon release from DOC. Testing should be made available in case:
   a. Patient is going to private housing with high-risk relatives/individuals and requests testing.
   b. Testing is required by a halfway house or similar housing.
   c. Release to county jail for court orders.
   d. Testing should be documented in the patient’s chart.

10. RAT testing upon admission to all IPUs will continue. RAT testing is no longer necessary upon discharge from IPUs.

11. Units with high-risk patients (IPUs, SAGE-CRCC and WSR-MCC) will continue with current quarantine and testing protocols:
   a. Symptomatic patients should continue to be placed in isolation per version 33.1 COVID19 guidelines. Unconfirmed but symptomatic patients should be in a separate area from isolated confirmed COVID19 positive patients.
   b. Unit-wide testing will continue per version 33.1 COVID19 guidelines.
   c. MCC and CRCC should plan on having areas for isolation and quarantine for these SAGE and WSR, respectively. CRCC patients that require isolation will be moved to WSP.

12. Rapid Antigen Testing will be the main testing platform in all above scenarios. PCR testing will continue to be used per current version 33.1 guidelines for unit-wide testing when high-risk units (IPUs, SAGE, WSR) go into quarantine/outbreak.

13. Per current protocol, patients with respiratory symptoms that test COVID19 RAT negative should be offered a rapid influenza test during Influenza season (October through March- Flu season variable depending on DOH data).

14. Symptomatic patients that test negative for COVID19 will be offered a follow up COVID19 RAT in 48-72hrs from initial testing. If positive, isolation protocol would be followed. If patient declines again or test is negative, no need for further follow up.

INFECTION PREVENTION:

15. Isolation: will continue to be required for those patients testing RAT positive per current CDC guidelines and DOC Version 33.1 COVID19 Guidelines.
   a. See below for updated testing protocol to release patients from isolation.
   b. Patients that are currently on isolation will now be tested per the updated protocol (see below) and released from isolation earlier if indicated.
   c. For Reentry Centers, patients that require isolation will continue to transfer to a DOH facility.

16. Quarantine: in the general population, patients exposed to COVID19-positive or symptomatic patients that test negative, would not require quarantine.
   a. Exception will be all IPUs, SAGE (CRCC) and WSR (MCC) units.
   b. Quarantine status for all other units will be lifted effective immediately, if applicable. Serial unit-wide testing will be stopped. Patients in these units will now be allowed to go to work, programming, gym, visitation, Dental and Medical services following current protocols.
17. Cohorting units will no longer be recommended to improve access to services.

18. There will be no active opt in/opt out strategy, but counseling on risk factors should continue during physicals at intake, and patients should be given the opt in/out form to sign in case measures have to become more restrictive in the future.
   a. In the case of Reentry Centers, individuals transferring to a Reentry Center will have this form completed by Medical prior to transfer. If this is not the case, then Reentry Center staff should complete this form in the intake process.
   b. Opt In/Out forms should remain in the chart in case they are needed in the future. Clinical Leadership will update the form to fit this current change.

19. PPE Use:
   a. Since there will now be an inherent risk of COVID19 in most units that will not be on quarantine, Custody staff will be encouraged to wear PPE according to their individual level or risk.
   b. Health Services staff will continue to be required to wear a surgical mask at every Health Services area per DOH mask mandate.
   c. N95 masks provide the best protection in case individuals consider themselves to be at high risk.
   d. Full PPE, including N95 masks, will continue to be required when any staff is working in areas where patients are in isolation, as well as quarantine areas for IPUs, SAGE and WSR when applicable.
   e. For all staff interacting with symptomatic patients (at risk for COVID19, flu, etc), full PPE should be used, including N95 masking.
   f. If there are questions, please refer to updated PPE matrix, chain of command or Clinical Leadership.

ISOLATION STATUS:

20. If patients are noted to be symptomatic but test negative for COVID19 and influenza (if applicable) or decline testing, they would not go to an additional isolation area, except for IPUs, SAGE and WSR. They would return to the unit.
   a. For Reentry Centers, symptomatic patients that test negative should be encouraged to remain in their rooms, but no movement restriction in the facility or community should be imposed.
   b. The unit and high-risk patients would be notified of possible increased risk for COVID19 as above, so they can take mitigation measures based on their individual risk.

21. Reentry Centers should continue to transfer patients that need isolation to DOH facilities.

22. Facilities should continue to plan on having isolation areas.
   a. Separating isolated patients follows current CDC guidelines and should be done at all facilities when operationally possible.
   b. Isolation space should not interfere with other vital processes for patient wellbeing (programming, gym, visitation areas) unless completely necessary.
   c. For facilities that do not have the infrastructure or resources to operationalize isolation of patients in separate areas following CDC guidelines (e.g., camps), the following mitigation strategies should be followed:
- Move positive patients to a separate area within the available units that maximizes distance from the rest of the population.
  - Can single-person room the positive individual behind closed doors if possible.
  - If available, a dorm/tier could be reserved for isolation only so population does not need to be moved out of single-person rooms.
- Use of HEPA filters in the areas surrounding isolated patients.
- Notify rest of population of increased risk and promote mask and N95 wearing, availability of testing upon request and treatment options if needed.
- Encourage facilities to discuss with HQ Clinical Leadership for strategizing potential separate isolation space.

23. Clearing from isolation, based on updated DOH recommendations:
   a. When not on outbreak status:
      - If a patient tested positive for COVID19 and had symptoms, isolation can be lifted after 10 days have gone by since symptoms first appeared if:
        - No fever for 24 hours without use of fever reducing-medication, AND
        - Symptoms have improved.
      - If a patient tested positive for COVID19, but is asymptomatic, isolation can be lifted after 10 days have gone by since the positive test date if patient remains asymptomatic.
        - If the patient develops symptoms after testing positive, the 10-day isolation would start over from the day of symptoms onset. Would then follow the recommendations above for lifting isolation in symptomatic patients.
      - There is no longer a recommendation for requiring a negative RAT for lifting a 10 day isolation when not in outbreak status. After 10 days, immunocompetent patients who were asymptomatic or had mild or moderate disease can be released from isolation.
   b. When on outbreak status:
      - Isolation will continue to be for 7 days and require a negative COVID19 RAT on Day 7 to clear isolation.
   c. If severe and/or immunocompromised:
      - Isolate for at least 10 days and up to 20 days. Must have two sequential negative RATs 24-48 hours apart to end isolation.
      - May begin RAT on or after day 10 only if fever free for 24 hours without using fever-reducing medication and symptoms have improved.
      - If the first RAT is still positive, may repeat 72hrs later to re-start the process of lifting isolation.

QUARANTINE STATUS:

24. No need for quarantine except for IPUs, SAGE and WSR. Refer to version 33.1 for current details.
   a. Would continue with 10-day quarantine duration for these high-risk groups, per current version 33.1 COVID19 guideline.
25. Apart from IPUs, SAGE and WSR, there is no longer need for unit/tier-wide testing as mentioned above. Patient population can continue with all activities, as mentioned above.
26. Reentry Centers will no longer offer off-site quarantine options for high-risk patients. Each patient should take mitigation measures depending on their individual risk, including N95 use, self-quarantining in their individual room, etc.

TRANSPORTATION:

27. Intra-system transfers apply to all transfers in between DOC facilities, including prisons, camps and Reentry Centers:
   a. Pre-transfer testing with RAT only 24-48hrs prior to transfer will be recommended regardless of community levels status.
   b. Only RAT positive patients will be placed on isolation. The rest can continue to transfer regardless of exposure status.
   c. No longer need to test transferred patients upon arrival to DOC facilities, as long as patients were tested prior to transfer.
28. Testing will not be mandatory, but strongly encouraged. Declination of test would not prevent transfer.

OUTBREAK STATUS:

29. DOC outbreak definition will remain the same for now, new definition will come out on the next version 34 COVID19 guideline.
   a. Outbreak status will no longer trigger quarantine or mass testing.
   b. Outbreak status is to inform of higher risk of COVID19 transmission to the unit population and staff.
   c. Outbreak status is to be posted in the sign at the unit entrance so that patients are aware of higher risk of COVID19, see above for details.
   d. Outbreak status information in a unit might also be useful for patients and families planning on visitation schedules.
   e. Outbreak status will no longer affect or prevent transfers, programming, gym, visitation, access to Dental or Medical care.
30. Per current version 33.1 COVID19 guideline, the timeframe to lift outbreak status will continue to be 21 days. The definitions for Limited Area Outbreak, Facility Wide Outbreak and the resulting need for masking and testing will continue at this time until updated CDC guidelines and version 34 of DOC COVID19 guidelines is released.

CLUSTER STATUS:

31. Will continue with the current definition for cluster, as it would trigger testing in units like IPUs, SAGE or WSR and inform of COVID19 risk in the facilities.
   a. Cluster status in units other than IPUs, SAGE or WSR would no longer trigger unit-wide testing.
32. The timeframe to lift cluster status will continue per current protocols. The definitions for Limited Area Cluster, Facility Wide Cluster will continue at this time until updated CDC guidelines and version 34 of DOC COVID19 guidelines is released.
33. Serial testing for staff will continue to depend on community levels per current protocols.