Oregon Department of Corrections
COVID-19 Response and Recovery Plan

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First edition


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OREGON DEPARTMENT OF CORRECTIONS COVID-19 Response and Recovery Plan

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Section I.

A. Definitions

COVID-19 Prevention Strategies-Strategies for everyday operations: COVID-19 prevention strategies that correctional and detention facilities should keep in place at all times, even when the COVID-19 Community Level is low. **Enhanced COVID-19 prevention strategies:** Additional COVID-19 prevention strategies for facilities to use when the COVID-19 Community Level is medium or high, or when facility-level factors indicate increased risk.

Close contact of a COVID-19 case– In the context of novel coronavirus (COVID-19), an individual is considered a close contact if that person (a) has been less than six feet of a confirmed or suspected COVID-19 case, and has been in the presence of that person for a cumulative total of 15 minutes or more over a 24-hour period (as determined by ODOC's Infectious Diseases Control Provider), or (b) has had direct contact with infectious secretions from a COVID-19 case (e.g., has been coughed on). Close contact can occur while caring for, living with, visiting, or sharing a common space with a confirmed or suspected COVID-19 case..

Cohorting– Cohorting refers to the practice of isolating multiple laboratory-confirmed COVID-19 cases together as a group or quarantining close contacts of a case together as a group. Ideally, cases should be isolated individually, and close contacts should be quarantined individually. However, some correctional facilities do not have enough individual cells to do so and must consider Cohorting as an alternative.

Confirmed vs. Suspected COVID-19 case – A confirmed case has received a positive result from a COVID-19 laboratory test, with or without symptoms. A suspected case shows symptoms of COVID-19 but either has not been tested or is awaiting test results. If test results are positive, a suspected case becomes a confirmed case.

Medical Isolation – Medical isolation refers to the physical separation of an individual with confirmed or suspected COVID-19 infection to prevent their contact with others and reduce the risk of transmission. In this context, isolation does NOT refer to punitive isolation for behavioral infractions within the custodial setting. Staff are encouraged to use the term "medical isolation" to avoid confusion, and should ensure that the conditions in medical isolation spaces are distinct from those in punitive isolation. Adults in Custody (AICs) in medical isolation should receive regular visits from medical staff and should have access to mental health services. To the extent possible, provide amenities of regular housing, consistent within the purpose of quarantine and the resources of the institution.

Respiratory Isolation – Respiratory isolation is used to prevent transmission of organisms by means of droplets that are sneezed or breathed into the environment.

Respiratory Triage Unit – Area designated for respiratory isolation of patients outside of Health Services.

Quarantine –Quarantine refers to the physical separation of an individual who has had close contact with someone with confirmed or suspected COVID-19 to determine whether they develop symptoms or test positive for the disease. Quarantine reduces the risk of transmission to others if the individual is later found to have COVID-19.

Physical Distancing – Physical distancing is the practice of increasing the space between individuals and decreasing the frequency of contact to reduce the risk of spreading COVID-19 (ideally to maintain at least six feet between all individuals, even those who are asymptomatic). Physical distancing strategies can be applied on an individual level (e.g., avoiding physical contact), a group level (e.g., canceling group activities where individuals will be in close contact), and an operational level (e.g., rearranging chairs in the dining hall to increase distance between them).

Symptoms – Symptoms of COVID-19 include fever, cough, shortness of breath, repeated shaking with chills, muscle pain, headache, sore throat, congestion or runny nose, nausea or vomiting, diarrhea, and new loss of taste or smell. Like other respiratory infections, COVID-19 can vary in severity from mild to severe. When severe, pneumonia, respiratory failure, and death are possible. COVID-19 is a novel disease, therefore the full range of signs and symptoms, the clinical course of the disease, and the individuals and populations most at risk for disease and complications are not yet fully understood. Monitor the Center for Disease Control and Prevention (CDC) website for updates on these topics. Symptoms of COVID-19 | CDC

B. Introduction to General COVID-19

The Oregon Department of Corrections (ODOC) operates 12 prisons across the state, employees 4,500 people and incarcerates approximately 12,500 adults. ODOC has been planning and preparing for COVID-19 since February 2020, before the first confirmed cases in the United States. The agency has a Continuity of Operations Plan (COOP) to ensure critical services will continue if emergency occurs. ODOC has a specific COOP for each institution and division, which identifies essential functions and how to maintain continuity should an incident affect staff, those in ODOC's care and custody, buildings, or equipment.

ODOC is collaborating with local public health officials, coordinating with the Oregon Health Authority (OHA), and following the CDC https://www.cdc.gov/coronavirus/2019-ncov/community/correction-detention/guidance-correctional-detention.htmlrecommendations to prevent the spread of COVID-19 in Oregon.

Due to Covid-19 being a novel virus, COVID-19 policies have required rapid revision and adaptability. With that being noted, this plan is subject to change based on additional guidance from CDC, OHA or OSHA. DOC is committed to adhering to CDC, OHA and OSHA guidance and requirements.

SECTION 2

Agency Centralized Plan

Systematically, as time has progressed, and the country experienced different variants of the COVID-19 virus, overall plans, policies, and designs with respect to housing of AICs have been necessarily modified and adapted. One such change involves where an AIC will be housed after testing positive for COVID-19. Each facility statewide has produced an isolation and quarantine plan specific to their institution. Each facility will typically house their own positive and suspected positive AICs, unless the level of care needed has escalated beyond the capability of the facility or local hospital, or the facility lacks adequate amount of space to isolate the positive AICs from the rest of the population.

Facilities have developed plans throughout the pandemic that allow for facility essential services modification based on the levels of COVID-19 in the facilities. These plans address housing of isolated, quarantined, and non-quarantined AICs. These plans also established processes for recreation, meals, law library access, religious services, additional services, and program areas and set operational means for each facility. These plans will allow each facility/division to operate independently at the direction of the Functional Unit Manger or their designee to dictate the statuses of their facility/division and what services will be modified or not modified.

Oregon Department of Corrections has been operating under the guidance of CDC, OHA and the AOC. As the AOC prepares for shuttering, facilities maintain guidance through this document and their previous approved facility specific plans. For information from current CDC Guidance please see the following link. Guidance on Management of Coronavirus Disease 2019 (COVID-19) in Correctional and Detention Facilities | CDC

As the pandemic has evolved, it has become appropriate to shift to a localized COVID-19 response and to deactivate the AOC unless ODOC determines that there is a need to re-activate it. However, consultation, guidance and assistance will continue to be available for ODOC Administration at DL COVID-19 Resource Team. This will require all the DOC facilities to govern themselves through appropriate modification of services and operations based on the amount of COVID-19 in the institution and the potential for an outbreak. As with the tier system, increasing preventative measures can happen immediately based on the possible outbreak in each area. However, the de-escalation of preventative measures or re-opening of facilities should be evaluated and implemented incrementally using the Facility-level Factors identified below to ensure the slowing or stopping of the spread of the virus. The Facility-level Factors to be considered listed below and are not all inclusive, but all areas of operations should be reviewed and included in the prevention of spreading and stopping the virus.

Effective immediately, the Agency will utilize the following color-coded system for informing decisions on managing COVID-19 within our facilities. This system will replace the tier system previously utilized by DOC. Each positive case will be evaluated and investigated as a potential outbreak which will inform COVID-19 management and risk mitigation. For de-escalation the Office of the Chief of Security will designate the appropriate Color Code for each facility every Monday. The three-color Codes are as follows, and are based

upon COVID-19 risk assessment, as outlined by CDC guidance

- Green – defined by no active cases of COVID-19 within a correctional facility. Green status allows facilities to initiate and continue modification of enhanced COVID-19 prevention measures.

- Yellow – defined by an active case, reduced transmission within a correctional facility, or a COVID-19 Community Level of medium or high in the community in which the facility is located (including when there are no active cases of COVID-19 within the facility). Yellow status requires institutions to consult DL COVID-19 Resource Team on which enhanced prevention strategies can be continued to be modified.

- Red – defined by active transmission within a correctional facility. Red status requires active management and mitigation by utilization of enhanced COVID-19 prevention measures based upon consultation.

During periods of escalation or de-escalation of COVID-19 cases, the DL COVID-19 Resource Team will be consulted to determine appropriate changes to enhanced preventions measures.

1. Applying, sustaining, and modifying COVID-19 prevention measures

Following CDC Guidance for Strategies for Everyday Operations (*Guidance for Correctional & Detention Facilities*, updated May 3, 2022, Section 3) the following strategies will be utilized as COVID-19 Strategies for Everyday Operations:

- Provide COVID-19 Vaccines and boosters
- Maintain standard infection control
- Maintain everyday operations testing strategies
- Prevent introduction from the community
- Prepare for outbreaks
- Maintain temperature and symptom screening
- Maintain the COVID-19 Audit Team

Facilities should maintain, at all times, the following aspects of standard infection control, monitoring, and capacity to respond to cases of COVID-19:

- **Provide COVID-19 vaccination, including boosters:** Continue to provide and encourage up to date COVID-19 vaccination for staff members and AICs (including additional doses for people who are immunocompromised and others who are eligible for them, and boosters).
- **Maintain standard infection control:** Maintain optimized ventilation, handwashing, proper mask wearing (when masking is required), and cleaning and disinfection for standard prevention of infectious diseases, including COVID-19. Ensure that recommended personal protective equipment (PPE) is available for staff and AICs.
- **Maintain SARS-CoV-2 testing strategies:** Maintaining a robust testing program (including both diagnostic and screening testing) can help prevent or reduce transmission in congregate settings and

provide critical data for ongoing assessment. Maintain the testing strategies below to the maximum extent possible based on facility resources and supplies.

- **Diagnostic testing** should be performed for anyone who shows signs or symptoms of COVID-19 and for anyone who has been potentially exposed or identified as a close contact of someone with COVID-19, regardless of COVID-19 vaccination and booster status.
- **Routine screening testing** should be performed for all AICs at intake and prior to release regardless of COVID-19 vaccination and booster status.

Assess residents' risk for severe health outcomes from COVID-19 and ensure timely treatment after infection for those who are eligible for COVID-19 therapeutics. For facilities without onsite healthcare capacity, have a plan in place to ensure timely access to care offsite. See Nonhospitalized Patients: General Management | COVID-19 Treatment Guidelinesexternal icon

- **Prevent COVID-19 introduction from the community:** Regardless of their vaccination and booster status, exclude staff members from work if they have symptoms of COVID-19, test positive for SARS-CoV-2, or have been potentially exposed or identified as a close contact of someone with COVID-19. Unless deemed crisis operations; these decisions will continue to be evaluated by the Contact Tracing team.
- **Prepare for outbreaks:** Monitor community data to be prepared for an outbreak and maintain the ability to effectively communicate to staff members and AICs about what to expect if an outbreak occurs. Maintain the ability to respond quickly to an outbreak, including the ability to scale up medical isolation and quarantine.
  It is important that the response to COVID-19 in correctional and detention facilities consider the broader mental health impacts for AICs and staff, both for those with and without pre-existing mental illness. Some COVID-19 prevention measures, such as prolonged quarantine periods, repeated isolation, and restrictions on visitation and programming, are known to lead to negative impacts on mental health and well-being.

- **Maintain the COVID-19 Audit Team:**
  Due to the Agency Operation Center being deactivated a new Agency Covid-19 Audit team will be established. The team will be comprised of two units, one east and one west. Each team will consist of a team leader from Audits, one union member, one manager and AIC participation as appropriate. The east unit will visit and conduct audits at SRCI, PRCF, EOCI, TRCI, WCCF, and DRCI. The west unit will visit and conduct audits at CRCI, SCI, OSCI, CCIC/CCCF, OSP, and SFFC. Audits should be completed at a frequency determined by the COVID-19 Resource Team.

1 Infection Prevention Assessme

Facility-level factors:

Applying or modifying COVID-19 prevention measures at the facility level should consider data on local trends and facility-level factors that reflect the unique characteristics, operations, and populations within each facility.

As epidemiologic trends shift due to new variants and other factors, administrators may consider strengthening or relaxing COVID-19 prevention measures for individual facilities based on the five primary metrics listed below. No single metric should be used alone in decision-making. Consult with local public health partners in decision-making about modifying prevention measures, especially for facilities without internal public health or infectious disease experts. Any relaxing of prevention measures should be conducted in a stepwise fashion, one prevention measure at a time, with continued diagnostic testing and screening in place to carefully monitor for cases of COVID-19 in the facility before making changes to additional prevention measures. Communicate clearly with staff and AICs about any changes made to procedures.

- **Vaccination coverage:** Determine the proportion of staff and AICs who are up to date on their COVID-19 vaccines. COVID-19 vaccines are highly effective in preventing severe illness, hospitalization, and death from COVID-19. Although not enough information is available to determine a specific level of vaccination coverage needed to modify facility-level prevention measures, maximizing up to date COVID-19 vaccination coverage is critical to protect staff members and AICs.

- **Transmission in the facility:** Evaluate the current and historical level of COVID-19 transmission within the facility.

- **Transmission in the community:** Monitor the level of COVID-19 transmission in the surrounding community.

  CDC recommends using COVID-19 Community Levels to guide individual and community decisions about when to apply specific COVID-19 prevention strategies. COVID-19 Community Levels are categorized as low, medium, and high based on the number of COVID-19 cases in a given community and the impact of severe disease on community-based healthcare systems. Visit the CDC website to check any county's current COVID-19 Community Level and to see more detail about how these levels are determined.
  Consider the community where the facility is located as well as the communities from which AICs originate and where staff members live. County-level transmission indicators can be found on CDC's COVID Data Tracker website. Maintain prevention measures when community transmission levels are higher since introduction of the virus into the facility is more likely during those times.

- **Demographic and health-related characteristics:** Determine the proportions of the facility's AICs and staff who are at increased risk for severe COVID-19 illness. Consider the potential impact of prolonged mitigation measures on mental health.
  Maintain facility-level prevention strategies for longer durations in facilities with high proportions of people at increased risk for severe illness.

- **Facility structural and operational characteristics**: Assess how facility characteristics and operational protocols can contribute to SARS-CoV-2 spread within the facility.
  Maintain COVID-19 prevention measures for longer durations in facilities where the layout (e.g., dorm/open barracks vs. individual cells), ventilation, or movement patterns inhibit physical distancing

or the frequency of air exchange, and where staff members work across multiple units that otherwise have no shared close contacts.

Enhanced prevention strategies should not be lifted when transmission is occurring within the facility. Because of the risk of unrecognized infection, a single new case of SARS-CoV-2 infection in a staff member or AIC in a correctional or detention facility should be evaluated as a potential outbreak. (However, if a AIC tests positive at intake but has not had close contact with other members of the facility's population and is immediately placed in medical isolation, this person's positive test result could be considered an isolated case rather than transmission in the facility.)If historical transmission levels in the facility have been high or if outbreak response has been difficult, maintain COVID-19 prevention measures for a longer duration.

Enhanced COVID-19 Prevention Strategies:

In addition to the Strategies for Everyday Operations described above, facilities should add enhanced COVID-19 prevention strategies when the COVID-19 Community Level is medium or high, or when facility-level factors indicate increased risk. Facilities may employ apply any enhanced prevention strategies at any time, even when the CDC COVID-19 Community Level is low. Depending on the risk in different areas of the facility, enhanced prevention strategies can be applied across an entire facility or can be targeted to a single housing unit, wing, or building. The following preventative measures can be considered for modification:

- Enhanced testing strategies
- Mask policies
- In-person visitation
- In-person community contact Court appearances, work release
- Core Services and Group activities
- Physical distancing

Mask policies: Staff and AICs may choose to continue wearing masks, if not required. All masks will be provided by the Agency at no cost to the staff or AIC. The Agency has developed a prioritization for modification to masking measures.

If a facility raises beyond green, modification of enhanced preventative strategies will be completed via consultation with DL COVID-19 Resource Team. The areas to be considered will be housing unit where the COVID-19 case originated. Close contact tracing will be conducted, and further masking of other areas may be required based on work/programs etc. Masks will be worn by all AICs and staff members assigned to or come into contact with the quarantined and/or isolated areas; with the exception, when immediately eating/drinking, and if in the AICs immediate bunk area.

First, the Agency has bifurcated our sites into two groups. The first group are areas in which AICs reside and work, e.g. Institutions, CDC, etc. The second group are those areas with no direct contact with AICs, e.g. Head Quarters, 22nd St, Pharmacies, etc. Areas beyond the secured perimeter of a facility, that do not have AIC contact in which staff work (control centers, armed posts, mobiles etc.)

Those sites in which AICs work, but do not reside, staff are required to mask while AICs are present effective 3/11/2022, or until further notice.

For sites in which AICs reside and work, e.g., institutions, the following is the prioritization of masking modifications. All five of the metrics mentioned above were utilized in development of this prioritization. This stepped approach is intended to modify masking incrementally, in a manner that begins with situations that have the least amount of risk to those with increased risk.

The first grouping of masking modifications maybe implemented at the effective date of this plan for facilities at green status. These modifications include relaxed masking requirements in:

- Outdoor areas
- No mask requirement for active movement between areas of the institution
- Housing Units

After two weeks and observation from the last modification, institutions that continue to be green may proceed with the following masking modifications:

- Removal of masks while in indoor breakrooms within the secured perimeter
- Removal of masking in congregate areas in which AICs mix from various housing units while indoors. Some examples would include but are not limited to:
    - Areas in which AICs mix from different units, interior recreation areas, gymnasiums
    - Visiting
    - Classroom
    - Religious Services
    - Sites where AIC work, but do not reside

Masking requirements in the following areas are required based upon OHA (OR333-018-1010) and OHSA (OAR 437-001-0744) rules and will not be subject to modification until further notification from ODOC Administration

- Health Services Clinic areas
- Areas in which aerosol generating activities occur
- CCCF Intake Center-CCCF will develop plan for Intake Center and masking, to be approved by AOC

In-person visitation: Suspending in-person visitation should only be done in the interest of the AICs' physical health and the health of the community. Visitation is important to maintain AICs' mental health. If visitation is suspended, facilities should identify alternative ways for AICs to communicate with their families, friends, and other visitors.

- If transmission in the facility and/or substantial community transmission is occurring, restrict non-essential vendors, volunteers, and tours from entering the facility or sections where transmission has been occurring.

- Consider restricting visitation when there is moderate to high community transmission to prevent the introduction of the virus into the facility.
- If facilities maintain in-person visitation during periods of higher risk:
    - Require visitors to wear cloth masks, disposable procedure masks, or respirators (unless contraindicated) and perform symptom and exposure screening and temperature checks for all visitors and volunteers on entry.
    - Display signage and other communications materials outside visiting areas explaining the COVID-19 symptom screening and temperature check process. Ensure that materials are understandable for non-English speakers, those with low literacy, and people with disabilities.
    - Exclude visitors and volunteers who do not clear the screening process or who decline screening or are not wearing masks or respirators (unless contraindicated).
    - Provide alcohol-based hand sanitizer with at least 60% alcohol in visitor entrances, exits, and waiting areas.
    - Consider using protective barriers in visitation rooms
    - Use physical distancing and visual cues such as stickers or decals to maintain physical distancing.
    - Instruct visitors to postpone their visit if they have symptoms of COVID-19.
    - Additional preventative measures may be added on a facility level based upon institution facility level factors and county community rates.

Core Services and Group activities:

The Agency has prioritized services that have been designated Essential Services as these are the services that have the greatest impact on the physical and mental health of the AIC population. These services should be prioritized when making determinations regarding modification of operations to prevent the spread within a facility. The following list are the services that are determined to be essential. Any modification of restricting Essential Services will require consultation with stakeholders from all divisions of the Agency that are impacted and may also include consultation with Health Services and Oregon DOJ as needed.

Essential Services and group activities:

- All Health Services
- Alternative Incarceration Program (AIP)
- Substance Abuse Treatment
- Visiting
- Law libraries
- Attorney visits
- Yard
- Meals
- Religious services

The list of other services is not all encompassing and covers services not listed in the above essential services. Other services may be modified on an institutional basis based upon the five metrics.

Other services and group activities

- Jobs and Programming
- Work crews
- Barbershops
- Library
- Education
- Cognitive Classes
- Canteen
- OCE
- Institution based classes, and other Contractor serviced classes

All areas that are not governed by the facilities will develop plans and submit to the facilities Management/COVID Team for approval. Such areas include areas such as Law Library, Library, Education, facility specific programs i.e. AIP, Jlad, Alcohol and Drug treatment etc.

Table 1: Strategies for Everyday Operations vs. Enhanced Prevention Strategies

COVID-19 Prevention Strategy	Strategies for Everyday Operations*	Enhanced COVID-19 Prevention Strategies*
Up to date COVID-19 vaccination	✓	
Standard infection control	✓	
Enhanced ventilation†		✓
Testing		
symptomatic people	✓	
close contacts of people with COVID-19	✓	
all AICs at intake (or routine observation period)	✓	
before transfer		✓
before/after community visits		✓
before release	✓	
routine screening testing		✓
Access to COVID-19 therapeutics	✓	
Medical isolation & quarantine	✓	

Well-fitting masks/respirators		
offer to AICs and staff	✓	
universal indoor masking		✓
Prepare for outbreaks	✓	
Routine observation periods during transfer/release protocols		✓
Minimize movement and contact across housing units and with the community		✓
Physical distancing		✓

2. Communication

- Provide AICs and staff with up-to-date information about COVID-19 and changes to facility policies on a regular basis.
- Train staff on the facility's COVID-19 plans.
- Address concerns related to reporting symptoms (e.g., being sent to medical isolation), and explain that quarantine and medical isolation are not the same as disciplinary solitary confinement. In addition, ensure that medical isolation and quarantine are truly operationally distinct from disciplinary solitary confinement.
- Post signs throughout the facility about ways staff and AICs can protect themselves and others from COVID-19. Example signage and other communications materials are available on the CDC website

3. Vaccination

All areas associated with the Oregon Department of Corrections will: Stay Up to Date with Your Vaccines | CDC

- Ensure that vaccines and boosters are available for all staff and AICs in order to stay up to date.
- Promote COVID-19 vaccination by educating the staff and AICS on the effectiveness, safety, and importance of vaccines; consider recruiting AICs who received the vaccine to be peer supporters to encourage other AICs to get the vaccine and recruiting staff peers to encourage staff vaccination.
- Work with local health departments, healthcare providers, and community organizations on effective ways to increase vaccination uptake, informed by input from AICs about why they may not wish to receive the vaccine.

4. Infection Prevention and Control

For more Infection Prevention Control information for healthcare workers, see CDC's Infection Control Guidance for Healthcare Professions about Coronavirus (COVID-19).

Hand hygiene

- All staff members and AICs should use everyday preventive actions including regularly washing their hands, avoiding touching their eyes, nose, and mouth, and covering their cough.
- Facilities should ensure that staff members and AICs have adequate access to hand hygiene materials at no cost. These materials should include soap, water, and clean towels or hand sanitizer.

Cleaning and disinfection

- Facilities should adhere to CDC recommendations for cleaning and disinfection during the COVID-19 response.
- Facilities should have a plan in place to restock supplies as needed during a COVID-19 outbreak.

Ventilation

- As a strategy for everyday operations, facilities should ensure that ventilation systems operate properly and provide acceptable indoor air quality for the current occupancy level for each space. Improvements and repairs should be made as necessary.
- As an enhanced prevention strategy, facilities should use enhancements to code-minimum ventilation requirements to improve overall ventilation in the facility. For more information about ventilation considerations and strategies to improve ventilation, such as increasing the introduction of outdoor air, using portable HEPA filters, and using upper room or in-duct ultraviolet germicidal irradiation systems (UVGI), see COVID-19 Ventilation in Buildings. These options should be identified, obtained, and tested in advance of higher risk periods to be ready to deploy when needed.

Physical distancing (enhanced measure)

- Physical distancing is the practice of increasing the space between individuals and decreasing frequency of contact to reduce the risk of spreading a disease (ideally maintaining at least 6 feet between all people, even those who do not have symptoms). Physical distancing strategies can be applied on an individual level (e.g., avoiding physical contact), a group level (e.g., canceling group activities where people would be in close contact), and an operational level (e.g., rearranging chairs in the dining hall to increase distance between them or using protective barriers if space is limited).
- Make a list of possible physical distancing strategies that could be implemented as needed at different stages of transmission intensity. When distancing is not possible, protective barriers may be used in areas such as offices and classrooms. Strategies will need to be tailored to the individual space in the facility and the needs of the AICs and staff.
- Consider options to prevent overcrowding (e.g., diverting new intakes to other facilities with available capacity, and encouraging alternatives to incarceration and other decompression strategies where allowable).

- When feasible and consistent with security priorities, encourage staff members to maintain a distance of 6 feet or more from a person with COVID-19 symptoms while interviewing, escorting, or interacting in other ways. Staff members should always wear recommended PPE when in close contact with a person with COVID-19 symptoms.
- If there are people with COVID-19 inside the facility, prevent unnecessary movement between different parts of the facility and mixing of people from different housing units. For example, maintain consistent duty assignments for staff across shifts to prevent transmission across different facility areas, and modify AIC work detail assignments so that each detail includes only AICs from a single housing unit.
- If possible, designate a room near each housing unit to evaluate AICs with COVID-19 symptoms, rather than having them walk through the facility to the medical unit. If this is not feasible, consider staggering sick call.

Symptom screening and temperature checks

- Screening for COVID-19 symptoms (including temperature checks) and asking about recent exposure can help identify staff members or visitors who should be excluded from a facility before entry and AICs (at intake or in the existing population) who should be evaluated for potential medical isolation or quarantine. Symptom screening alone will not prevent all transmission, since it is largely based on voluntary self-report and will not identify people with asymptomatic infection.
- Symptom screening and temperature checks should be used in combination with a screening testing program to minimize the risk of SARS-CoV-2 transmission. Symptom screening and temperature checks should be conducted daily during the quarantine period among AICs who have been exposed to someone with COVID-19.

Routine Mask or Respirator Use

- When masking is required, all staff members and AICs should wear a well-fitting cloth or disposable procedure mask or a respirator as much as possible while indoors (unless contraindicated), even in areas not used for quarantine or medical isolation. If masks or respirators are not worn outdoors, ensure that physical distancing is maintained. Correct and consistent mask or respirator use is key to preventing the spread of droplets and very small particles that contain the virus (i.e., source control). Provide masks or respirators at no cost to AICs and staff and clean or replace them routinely.
- Considerations for choosing a mask or respirator:
    - Masks and respirators can provide different levels of protection depending on the type of product and how they are used. Choose the most protective mask or respirator that fits well and can be worn consistently.
    - Loosely woven cloth products provide the least protection; layered finely woven products offer more protection; well-fitting disposable procedure masks and KN95s offer even more protection, and well-fitting National Institute for Occupational and Safety & Health (NIOSH)-approved respirators (including N95s) offer the highest level of protection.
    - When possible based on facility resources and supply, offer different types of masks and respirators to staff and AICs so that they can choose the option that fits them best and that they can wear consistently. The options that are offered in correctional and detention facilities may be limited by safety and security considerations, such as concerns about metal nose wires.

In environments where the risk of transmission is higher (e.g., post-exposure quarantine units) and safety and security considerations allow, AICs should be offered masks or respirators providing the same level of protection as those provided to staff in a similar environment.

- Clearly explain the purpose of masks and respirators and when their use may be contraindicated.

5. Testing Considerations

Testing will continue as deemed appropriate by Health Services staff. There are many considerations to evaluate for testing i.e. Transport, Release, Symptomatic, Close Contact, Intakes, etc.

Testing

Infection prevention protocols, PPE usage, and staff screening have been instituted according to CDC guidance at: https://www.cdc.gov/coronavirus/2019-ncov/community/correction-detention/guidance-correctional- detention.html, and after initial OHA review. The Oregon State Public Health Lab (OSPHL) has authorized priority testing of symptomatic AICs and staff. The plan will be subject to change according to further OHA/CDC guidance and expanded testing capability.

Per CDC guidelines, if a patient becomes symptomatic, the facility will place the AIC in medical isolation. A COVID test will be completed for all symptomatic patients if determined appropriate by a provider. AIC will remain on medical isolation until the test comes back. If the test is negative the AIC may be released to return to General Population (GP) if deemed appropriate by a provider.

Diagnostic testing

Diagnostic testing is intended to identify current infection and is performed when a person has signs or symptoms consistent with COVID-19, or when a person is asymptomatic (without symptoms) but has recent known or suspected exposure to someone with COVID-19. See Overview of Testing for SARS-CoV-2 for details.

Testing and managing persons with signs or symptoms consistent with COVID-19, regardless of vaccination or booster status

- **AICs with symptoms**, regardless of COVID-19 vaccination or booster status, should be moved to medical isolation in a separate environment from other people (ideally individually), medically evaluated, and tested. If the test result is positive, medical isolation should continue for 10 days. Multiple AICs with confirmed COVID-19 can be housed as a cohort (in a dorm or cell environments) regardless of the date of their positive test result. Facility staff should carefully evaluate and support the mental health needs of AICs during medical isolation.
- **Staff members with symptoms**, regardless of COVID-19 vaccination and booster status, should be excluded from work and advised to seek testing. If the test result is positive, staff members should be excluded from work for 10 days. (However, staff may use the guidance for the general public for duration of isolation when they are not at work.) See section below on isolation duration for staff during routine vs. crisis operations.
- **Visitors with symptoms**, regardless of COVID-19 vaccination and booster status, should be denied entry and encouraged to seek testing through their healthcare providers or local health department.

Testing asymptomatic persons with recent known or suspected exposure to SARS-CoV-2

Because of the potential for asymptomatic and pre-symptomatic transmission, close contacts (people

who were less than 6 feet away from an infected person for a total of 15 minutes or more over a 24-hour period) should be tested *regardless of their COVID-19 vaccination or booster status*.
In correctional and detention facilities, contact tracing to identify each individual's close contacts, including visitors, can be difficult. Therefore, people considered to be close contacts may include all persons defined by a particular setting/location (such as all AICs and staff members assigned to a dormitory or unit where a case has been identified). Refer to the quarantine considerations section for information about quarantine for people with known or suspected exposure to SARS-CoV-2 in correctional and detention facilities.

- **Initial tests**: All persons with known or suspected exposure to someone with COVID-19, *regardless of their COVID-19 vaccination and booster status*, should receive an initial diagnostic test as soon as possible after they have been identified as a close contact (but not within the first 24 hours after exposure/close contact, since a test is unlikely to be positive that quickly). If the initial test is negative, they should receive a second diagnostic test at least 5 days after the exposure/close contact. (If the initial test was performed at least 5 days after the exposure/close contact, a second test is not needed.) Depending on local laboratory capacity, rapid point-of-care tests may offer the shortest turnaround time to facilitate timely action based on results.

Serial re-testing of a quarantined cohort: If quarantine cohorts are used (i.e., people who are exposed are quarantined together rather than individually due to space constraints or mental health concerns), facilities should conduct serial re-testing of the entire quarantined cohort, regardless of their vaccination and booster status.

- Facilities should re-test people quarantined as a cohort every 3–7 days until testing identifies no new cases in the cohort for 10 days since the most recent positive result. The testing interval should be based on the stage of an ongoing outbreak (i.e., testing every 3 days can allow for faster outbreak control in the context of an escalating outbreak; testing every 5–7 days is sufficient when transmission has slowed).

- Anyone testing positive should be removed from the cohort, placed in medical isolation, and the 10-day quarantine period should re-start for the remainder of the cohort.

- Testing people with prior diagnosis of SARS-CoV-2 infection: People who have recovered from SARS-CoV-2 infection within the past 90 days and have been re-exposed to SARS-CoV-2 may not need to be tested but should still receive regular temperature and symptom screening checks. If a person develops new symptoms during the 90-day period after their initial infection, and an evaluation fails to identify a diagnosis other than SARS-CoV-2 infection (e.g., influenza), then the person warrants evaluation for SARS-CoV-2 reinfection in consultation with an infectious disease or infection control expert.

Transfer Testing

- **AICs transporting from Intake (enhanced prevention strategy)** need to complete a 10-day quarantine per protocol.
A rapid PCR test will need to be completed within 24 hours of transport.
Upon arrival at receiving institution, AICs will need another rapid PCR within 24 hours – quarantining

until a negative PCR result is obtained.
AICs can be housed appropriately after negative PCR result is verified by HS staff.

- **AICs transporting to outside medical trips/In person court proceedings/outside facility trips (enhanced prevention strategy)** will need a negative rapid PCR result within 24 hours of transport.
  Upon return to the institution, AICs will need a rapid PCR within 24 hours – quarantining until a negative PCR result is obtained.
  AICs can be housed appropriately after negative PCR result is verified by HS staff.

  a. Before community visits. If performing testing before community visits, test AICs leaving the facility as close as possible (and no more than 3 days prior) to the day of the visit (e.g., medical trips, court appearances, community programs). If community transmission is high, facilities can consider testing 5 days after return, in which the AIC should be quarantined until the negative test is received. The following link will show county/community transmission rate https://www.cdc.gov/coronavirus/2019-ncov/your-health/covid-by-county.html

- **AICs transporting between facilities (enhanced prevention strategy)** will need a negative rapid PCR result within 24 hours of transport.
  Upon arrival at receiving institution, AICs will need a rapid PCR within 24 hours – quarantining until a negative PCR result is obtained.
  AICs can be housed appropriately after negative PCR result is verified by HS staff.

  In cases where AICs are transporting to/from institutions with **active transmission** (red level), AICs will need to quarantine 10 days at the sending institution – prior to rapid PCR testing within 24 hours of transport, regardless of vaccination/booster status.
  Upon arrival at receiving institution, AICs will need a rapid PCR within 24 hours – quarantining until a negative PCR result is obtained.
  AICs can be housed appropriately after negative PCR result is verified by HS staff.

- **Release Testing -**Test AICs leaving the facility as close as possible (and no more than 3 days prior) to the day of the release (whether into the community or to a halfway house or other transitional location). Testing before release is particularly important if AICs will be housed in other congregate settings (e.g., homeless shelters, group homes, or halfway houses) or in households with persons who are at higher risk of severe illness from COVID-19, including older adults and people with certain medical conditions. Notify public health authorities for assistance arranging medical isolation upon release for people who have a positive test result.

Contact Tracing Team

With each positive Staff member, a contact tracing form is completed by a manager and forwarded to DL DOC Contact Tracing Team

This process will continue, it allows for a current review of the cases that are still occurring amongst staff at the facilities, and with continued evolution through variants the Contact Tracing Team will have the

most up to date guidance on appropriate actions to be taken.

Adult in custody cases will still be contact traced by the assigned staff member at each location, these will still be forwarded DL DOC Contact Tracing Team. Additionally, a comprehensive running list of staff positive cases and AIC positive cases will be maintained by staff designated at each facility, and unit. This list will be mailed to the Chief of Security or their designee each Monday. This will allow for a comprehensive state list to be maintained, and updates to Oregon Health Authority to be completed.

6. Medical isolation and quarantine

Facilities should have a plan in place to ensure that *separate physical locations* (dedicated housing areas and bathrooms) have been identified to:

- Medically isolate AICs with *suspected* COVID-19 (ideally individually while awaiting test results)
- Medically isolate AICs with *confirmed* COVID-19 (individually or as a cohort)
- Quarantine AICs identified as close contacts of those with confirmed or suspected COVID-19 (ideally individually, but as a cohort if necessary)

Facilities' medical isolation and quarantine plans should include expansion contingencies to prepare for surges in cases and/or close contacts. Regardless of the location, facilities should ensure that placement in medical isolation or quarantine does not create barriers to access to medical or mental health care.

Note that facilities may determine that single-cell housing is not advisable in some situations due to mental health concerns. If close contacts are quarantined as a cohort, keep the number housed together as small as possible to minimize the risk of further transmission.

AICs with confirmed COVID-19 may be housed in medical isolation as a cohort (rather than in single cells). Cohorting AICs during medical isolation can mitigate some mental health concerns associated with individual isolation and can increase capacity for medical isolation during case surges. Considerations for cohorted medical isolation include:

- Only AICs with *laboratory-confirmed* COVID-19 should be housed together as a cohort. Do not cohort those with confirmed COVID-19 together with those with suspected COVID-19, with close contacts of people with confirmed or suspected COVID-19, or with those with other illnesses.
- When choosing a space to cohort groups of AICs with confirmed COVID-19, use a single, large, well-ventilated room with solid walls and a solid door that closes fully. Using a single room will conserve PPE and reduce the chance of cross-contamination across different parts of the facility.

Movement of AICs who are housed in medical isolation or quarantine units should be restricted as follows:

- Keep AICs movement outside the medical isolation/quarantine space to an absolute minimum.
- Serve meals inside the medical isolation/quarantine space.
- Provide medical care inside the medical isolation/quarantine space, unless it is not physically possible to do so, or unless an AIC needs to be transferred to a healthcare facility.

- Exclude medically isolated/quarantined AICs from all group activities outside the medical isolation/quarantine space.
- Where possible, restrict medically isolated/quarantined AICs from leaving the facility (including transfers to other facilities) during the medical isolation/quarantine period, unless released from custody or a transfer is necessary for medical care, infection control, lack of medical isolation/quarantine space, or extenuating correctional, judicial, or security concerns.
- Staff assignments to quarantine spaces should remain as consistent as possible, and these staff members should limit their movements to other parts of the facility. These staff members should wear recommended PPE appropriate for their level of contact with people under medical isolation/quarantine. See PPE section below.
- Clean and disinfect areas used by people with COVID-19 on an ongoing basis during medical isolation.

Quarantine for Releasing AICs

A 10-day pre-release quarantine will be required when the county/community transmission is yellow or red status from the county the AIC is releasing from (see COVID 19 Community Levels/COVID 19 Data Tracker) and/or institution transmission is active (red status). COVID Data Tracker website

Quarantine for staff members

All staff members who have been exposed to someone with COVID-19 should be advised to seek testing and should be excluded from work for 10 days after their last exposure, regardless of their vaccination and booster status. (However, staff may use the guidance for the general public for duration of quarantine when they are not at work.) See section below on recommended quarantine duration for staff during short-term periods of crisis operations (e.g., severe staffing shortages).

As essential workers, DOC employees who are identified as close contacts quarantine for 10 days. However, if they are asymptomatic, and have not tested positive they may continue to work providing they continue to monitor for symptoms, use a well-fitting paper mask (procedure mask or surgical mask), practice sanitation protocols, and practice social distancing. This is the case as long as they continue to be asymptomatic. If ANY symptoms develop (cough, tickle in your throat, fever, etc.) , no matter how minor, the close contact employee should go home and seek advice from their medical provider. https://www.cdc.gov/coronavirus/2019-ncov/symptoms-testing/symptoms.html

- If quarantine duration is reduced for staff members during crisis-level operations, then facility management should require exposed staff members to:
    - Continue to self-monitor for symptoms of COVID-19 through day 10 after known or suspected exposure to or close contact with a person with COVID-19
    - Immediately isolate if symptoms of COVID-19 occur
- Adhere to all recommended prevention strategies, including wearing a well-fitting mask or respirator, physical distancing, and maintaining good hand hygiene

7. Medication for prevention of severe disease

The CDC has recently updated guidance for Correctional Facilities related to the COVID 19 pandemic. The guidance consolidates three previous communications involving COVID 19 management, testing, and quarantine. https://www.cdc.gov/coronavirus/2019-ncov/community/correction-detention/guidance-correctional-detention.html

The guidance briefly discusses anti-viral/monoclonal antibody therapy for individuals with mild to moderate disease.

The FDA has expanded Emergency Use Authorization (EUAs) for use of certain investigational monoclonal antibody medications to prevent SARS-CoV-2 infection, including in correctional populations, under the following conditions:

- There is an occurrence of COVID-19 in other individuals in the same institutional setting, and;
- The patient being treated is not fully vaccinated or is not expected to mount an adequate immune response to complete COVID-19 vaccination, and;
- The patient being treated is at higher risk for progression to severe COVID-19, including hospitalization or death (e.g., they have certain comorbidities). https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/index.html

In addition, antiviral medications are now available that are effective in preventing severe outcomes from COVID-19. These medications can be ordered at no cost either through the office of the Assistant Secretary for Preparedness and Response (ASPR) within the Department of Health and Human Services, the manufacturer, or possibly through their usual mechanism for obtaining medications. The National Institute of Health COVID-19 Treatment Guidelines external icon provide information about these drugs and describe what is known about their effectiveness. Medications are not a substitute for vaccination.

Please see attached information from NIH (link above) regarding use of anti-viral/monoclonal antibody therapy for patients with mild to moderate COVID 19 disease who are at risk of progression to severe COVID 19. The first attachment contains a treatment algorithm to guide decision-making regarding treatment options for this population. The second attachment contains tier-based guidelines for treatment in settings where there is a supply shortage of medication(s).

Pharmacy has obtained Paxlovid for AIC use. Updates will be provided periodically on drug procurement and overall supply.

If an AIC is diagnosed with mild to moderate COVID-19 disease and the DOC treatment provider would like to request antiviral therapy (i.e., Paxlovid), please contact the ODOC Medical Director and/or Chief of Pharmacy with this request along with the following information/documentation:

- Date of symptom onset
- Current symptoms
- COVID-19 test result
- Age

- Vaccination/booster status

If you are considering monoclonal antibody therapy, please provide the same documentation as for Paxlovid and contact Medical Director and/or Chief of Pharmacy.

Please also see – 'Underlying Medical Conditions Associated with Higher Risk for Severe COVID 19: Information for Healthcare Professionals' see https://www.cdc.gov/coronavirus/2019-ncov/hcp/clinical-care/underlyingconditions.html#:~:text=Main%20Findings%3A,the%20strongest%20association%20with%20death or Underlying Medical Conditions Associated with Higher Risk for Severe COVID-19: Information for Healthcare Professionals | CDC

8. Considerations for reentry programming

- If a person preparing for release is not up to date on their COVID-19 vaccines, offer vaccination again. If they decline, provide them with information about where they can get vaccinated after release.
- Provide screening testing before release for all AICs, regardless of COVID-19 vaccination and booster status.
- Provide AICs about to be released with COVID-19 prevention information, hand hygiene supplies, and masks or respirators, when appropriate
- When possible, encourage AICs who are being released to seek housing options among their family or friends in the community, to prevent crowding in other congregate settings such as homeless shelters. When linking AICS to shared housing, link preferentially to accommodations with the greatest capacity for physical distancing.

Section 3

Documentation

Each Department of Corrections facility will maintain their COVID-19 plans, ensuring that appropriate changes are made to the plans as necessary. The facility will document when they are opening and closing services, the documentation will include the five-primary metrics (see section 2, 1) and how the decision was based on the metrics.

Plans should include details about what each level of the color-coded system applies to which preventive strategy and what (non-essential) services will be allowed based upon the five-primary metrics.

Decision making shall be based on the five-primary metrics as listed below

- Vaccination coverage (AIC and staff)
- Transmission in the facility (current and historical)

- Transmission in the community (current levels of transmission in community institution is located, and where employees and visitors commute from, severity of illness and hospital capacity)
- Demographic and health-related characteristics
- Facility structural and operational characteristics
- Testing acceptance rate

Institution Plans will continue to keep the following Strategies for Everyday Operations in place.

- Provide COVID-19 Vaccines and boosters
- Maintain standard infection prevention and control
- Maintain temperature and symptom screening
- Maintain testing strategies
- Prevent introduction from the community
- Prepare for outbreaks
- Medication for Prevention of severe Covid-19 disease

Institutional Plans will include modifications to Enhanced COVID-19 Prevention Strategies.
The following prevention strategies can be considered for modification:

- Mask policies (as set out above)
- In-person visitation
- In-person community contact such as Court appearances, work release, etc.
- Non-essential Services and Group activities

Facilities will continue to maintain plans for medical isolation and quarantine of AIC's.

COVID-19 tracking

Each facility/division will maintain a current list of both positive staff and positive AIC cases. The list will be emailed to the Chief of Security or designee each Monday. This will allow for accurate lists to be maintained and distributed to internal and external stakeholders, as necessary. Additionally, it will allow for the adjustment of facility color code level each Monday.