MODULE 4. MEDICAL ISOLATION AND QUARANTINE

WHAT'S NEW

VERSION 2.0

- **CLOSE CONTACT** definition updated
- Updates to Medical Isolation Housing and General Considerations*: If medical isolation in single cells is necessary (inmates are not cohorted), Psychology Services staff should be consulted to ensure inmates proposed for single celling are not particularly vulnerable individuals and/or to make recommendations.*
- Updates to Housing Considerations for Quarantine: *If quarantining in single cells is necessary (inmates are not cohorted), Psychology Services staff should be consulted to ensure inmates proposed for single celling are not particularly vulnerable individuals and/or to make recommendations.*
- Updates to Symptomatic Persons in Medical Isolation: added reference to monoclonal antibodies for COVID-19, clarified documentation of daily assessments requirement.

MODULE 4 TABLE OF CONTENTS

A. DEFINITIONS

MEDICAL ISOLATION: Confining individuals with suspected (displaying symptoms) or confirmed (based on a positive point of care [POC] or commercial laboratory test) COVID-19 infection, either to single rooms or by **COHORTING** them with other viral infection patients.

QUARANTINE: In the context of COVID-19, refers to separating (in an individual room or **COHORTING** in a unit) asymptomatic persons who may have been exposed to the virus to **(1)** observe them for symptoms and signs of the illness during the incubation period, and **(2)** keep them apart from other incarcerated individuals.

- The BOP utilizes **THREE CATEGORIES OF QUARANTINE**: Exposure, intake, and release/transfer.
- All BOP COVID-19 quarantine categories utilize a test-in/test-out strategy.

CASE refers to an individual who has a positive test for COVID-19 **OR** who has symptoms consistent with COVID-19, but has not yet been tested or whose test results are pending.

CLOSE CONTACT: In the context of COVID-19, an individual is considered a close contact if they have not been wearing appropriate PPE **and**:

- Have been within 6 feet of an infected person for a cumulative total of 15 minutes or more over a 24-hour period starting from 2 days before illness onset (or, for asymptomatic patients, 2 days prior to test specimen collection) **OR**
- Had direct contact with infectious secretions of a COVID-19 case.

Considerations when assessing close contacts include the proximity to the infected person, duration of exposure, and the clinical symptoms of the person with COVID-19 (i.e., coughing likely increases exposure risk as does an exposure to severely ill persons).

COHORTING: The practice of grouping patients infected or colonized with or potentially exposed to the same infectious agent together to confine their care to one area and prevent contact with susceptible patients. In the BOP, this may refer to housing inmates of similar infection status together rather than in single cells.

SYMPTOMATIC: People with confirmed COVID-19 have reported a wide range of symptoms that typically appear 2–14 days after exposure to the virus. People with confirmed or suspected COVID-19 infection presenting with any of the following symptoms are considered symptomatic:

- Fever or chills
- Cough
- Shortness of breath or difficulty breathing
- Fatigue
- Muscle or body aches
- Headache
- New loss of taste or smell
- Sore throat
- Congestion or runny nose
- Nausea or vomiting
- Diarrhea

B. GENERAL GUIDANCE

1. GENERAL HOUSING CONSIDERATIONS FOR QUARANTINE AND MEDICAL ISOLATION

- Each institution will identify and designate specific **QUARANTINE** and **MEDICAL ISOLATION** areas within the institution—prior to need.
- Plan for separate physical locations (dedicated housing areas and bathrooms) to:
  - **ISOLATE** individuals with confirmed COVID-19 (individually or cohorted).
  - **ISOLATE** individuals with suspected COVID-19, separate from confirmed cases.
  - **QUARANTINE** close contacts (see *definition* above) of those with confirmed or suspected COVID-19 (ideally individually; cohorted if necessary).
  - **QUARANTINE** new intakes and release/transfer inmates—separately from inmates who are exposed close contacts in quarantine.
- The plan should include contingencies for identifying multiple locations if numerous infected individuals and/or close contacts are identified and require medical isolation or quarantine simultaneously. See **MEDICAL ISOLATION** and **QUARANTINE** sections below for more detailed cohorting considerations.
- When identifying spaces for isolation and quarantine, consider spaces not being utilized such as those used for education, religious services, visiting, recreation, or facilities. Tents, shower stations, and mobile hand hygiene stations may need to be obtained to create separate spaces at some facilities.
- When possible, it is recommended that a room be designated near each housing unit and intake area to evaluate and test individuals with COVID-19 symptoms.
- **RESTRICTIONS ON MOVEMENT:** To the extent possible, quarantined and medically isolated inmates should be restricted from being transferred, having visits, or mixing with the general population.

- **SIGNAGE:** The doors to both quarantined and medical isolation units should remain closed.
  - Print out color medical isolation and quarantine signs to be placed on the door of the room or unit, indicating isolation or quarantine, and the recommended personal protective equipment (**PPE**). Printable signs are available in the **APPENDICES**.
  - Cohorted groups should not be in contact with other cohorts. To prevent co-mingling of cohorts and to help correctional staff when moving inmates for showers, phone, computer time and recreation, consider quarantine signs in different colors for each separate cohorted group.
- Provide individuals under medical isolation or quarantine with tissues and, if permissible, a lined no-touch trash receptacle (the liner allows for easier, no-touch emptying). Instruct them to:
  - Cover their mouth and nose with a tissue when they cough or sneeze.
  - Dispose of used tissues immediately in the lined trash receptacle.
  - Wash hands immediately with soap and water for at least 20 seconds.

2. STAFF ASSIGNMENTS AND TRAINING

- **STAFF ASSIGNMENTS:**
  - Staff assignments to quarantine and medical isolation spaces should remain as consistent as possible. These staff should limit their movements to other parts of the facility as much as possible.
  - If staff must serve multiple areas of the facility, ensure that they change **PPE** when leaving the isolation or quarantine space.
  - If a shortage of **PPE** supplies necessitates reuse, ensure that staff always move from areas of low exposure to areas of high exposure risk while wearing the same PPE, to prevent **CROSS-CONTAMINATION**.
    - *For example, start in a housing unit where no one is known to be infected, then move to a space used as quarantine for close contacts, and end in an isolation unit.*
- **STAFF TRAINING:**
  - Train staff and inmate workers on appropriate **PPE** use in quarantine and medical isolation. (Refer to **MODULE 2** for information on PPE.)
  - Train staff and inmate workers on how to appropriately **CLEAN AND DISINFECT** high-touch hard and soft surfaces in quarantine and medical isolation areas. (Refer to **MODULE 1** for more information on cleaning and disinfection.)

3. PERSONAL PROTECTIVE EQUIPMENT (PPE)

MEDICAL ISOLATION and QUARANTINE have different requirements for the use of PPE. Refer to **MODULE 2** for the specific PPE to be used in each situation, as well as supply chain management.

- **LOCATIONS:** A **PPE DONNING OR DOFFING AREA** should be designated at the entry and exit to both quarantine and isolation. The **PPE DONNING AND DOFFING AREAS** can be created with assistance from the facilities department, or an area can be taped off for a visual indication of where to don and doff PPE.
- **SUPPLIES FOR PPE DONNING AREA:** The **DONNING AREA** (place where PPE is put on) should have the following: Hand hygiene supplies, gloves in different sizes, face shields, goggles or glasses for eye protection, surgical masks or N95 or other respirators in different sizes, and gowns or coveralls in different sizes.
- **SUPPLIES FOR PPE DOFFING AREA:** The **DOFFING AREA** (place where PPE is removed) should have the following: Hand hygiene supplies, a waste receptacle (with clear bags), a container to place reusable equipment that needs to be cleaned and disinfected, a disinfectant, and possibly hangers (3M stick-up hangers) to place reusable items (i.e., gown).
- **INSTRUCTIONAL POSTERS:** PPE **DONNING** and **DOFFING** areas should have signage designating the use of each space as well as instructions for donning or doffing PPE. CDC posters and fact sheets for donning and doffing PPE can be found here: *https://www.cdc.gov/coronavirus/2019-ncov/hcp/using-ppe.html*

4. LAUNDRY

- Laundry from individuals in COVID-19 medical isolation or quarantine can be washed with other individuals' laundry.
- Persons handling laundry from known or suspected COVID-19 cases should wear a gown/coveralls and disposable gloves, discarding them after use and performing hand hygiene.
- Do not shake dirty laundry—to minimize the potential of dispersing virus through the air.
- Clean and disinfect dirty clothes bins after use.

5. FOOD SERVICE ITEMS AND MEALS

- Meals should be provided to medically isolated or quarantined individuals in their spaces, if possible.
- In some facilities, cohorted quarantined inmates may be allowed to go together to meals when they can eat as a separate group and maintain social distancing (i.e., provide more space between individuals in the dining hall by removing every other chair and using only one side of the table).
  - Cohorted inmates should wear facial coverings (except when they are eating) and maintain social distancing any time they are out of their personal area.
  - The food service area must be cleaned and disinfected between groups.
- Disposable food service items can be disposed of in regular trash.
- Non-disposable food service items should be handled with gloves and washed as normal.
- Persons handling used food items from either quarantine or medical isolation should wear a gown or coveralls (to protect clothing from spills) and disposable gloves. Perform hand hygiene after removing gloves.

6. CLEANING AND DISINFECTION

Spaces where quarantined or medically isolated inmates have spent time must be cleaned and disinfected while in use and after discharge (see **MODULE 1** for more detailed information)**:**

- If possible, the inmate(s) should assist in cleaning and disinfecting their areas prior to their discharge from quarantine or medical isolation.
- Ensure that persons performing cleaning and disinfection of medical isolation or quarantine areas are wearing the recommended PPE for the product and the space being cleaned. Refer to **MODULE 2** for required PPE.

7. RECREATION

- **MEDICAL ISOLATION:** Inmate recreation will be suspended while in medical isolation. The institution should provide other means for inmates to occupy their time such as reading materials, educational materials, etc.
- **QUARANTINE:** If recreation is allowed for quarantine and occurs as a group, it should be limited to established cohorts, whenever possible, and the recreation area cleaned and disinfected between and after use (see **MODULE 1**). If recreation is suspended, the institution should provide other means for inmates to occupy their time such as reading materials, educational materials, etc.

C. MEDICAL ISOLATION

MEDICAL ISOLATION is a critical infection control measure for COVID-19. It separates inmates who are symptomatic and/or who test positive for COVID-19 (symptomatic or asymptomatic) from the general population and other staff.

- As soon as an individual develops symptoms of COVID-19 or tests positive for SARS-CoV-2, they should be given a cloth face covering (if not already wearing one and if it can be worn safely), immediately placed under medical isolation in a separate environment from other individuals, and medically evaluated.

  ➔ *Anyone who has trouble breathing, or is unconscious, incapacitated, or otherwise unable to remove the mask without assistance should not wear a cloth face covering.*
- Refer to the **MEDICAL ISOLATION CHECKLIST** in the **APPENDICES** for a summary of all medical isolation requirements.

MEDICAL ISOLATION for COVID-19 should be distinct in name and practice from the use of restrictive housing for disciplinary or administrative reasons—even though limited housing availability may require the use of cells normally used for restrictive housing. To avoid being placed in these conditions, inmates may hesitate to report their COVID-19 symptoms. This can lead to continued transmission within shared housing spaces and, potentially adverse health outcomes for infected individuals.

Ensure that MEDICAL ISOLATION is operationally distinct—with different conditions of confinement compared to restrictive housing, even if the same cells are used for both. For example:

- Ensure that individuals under medical isolation receive regular visits from medical staff.
- Ensure that individuals under medical isolation or quarantine have access to mental health services.
- Make efforts to provide similar access to radio, TV, reading materials, personal property, and commissary as would be available in the individuals' regular housing units.

- Consider allowing increased telephone privileges without a cost barrier to maintain mental health and connection with others while isolated.

1. HOUSING AND GENERAL CONSIDERATIONS

- Ideally, **MEDICAL ISOLATION** will be in a single, well-ventilated room with a solid door and an attached bathroom.
- When housing inmates in medical isolation as a **COHORT**:
  - **ONLY** persons with **LABORATORY-CONFIRMED** COVID-19 should be placed under medical isolation together as a cohort.
  - Do **NOT** cohort **CONFIRMED** COVID-19 cases with inmates who are **SUSPECTED** of having COVID-19.
  - Ensure that cohorted groups of people with confirmed COVID-19 wear **CLOTH FACE COVERINGS** whenever anyone (including staff) enters the isolation space.
    - *Anyone who has trouble breathing, or is unconscious, incapacitated, or otherwise unable to remove the mask without assistance should not wear a cloth face covering.*
  - When possible, use **ONE LARGE SPACE** for cohorted medical isolation, rather than several smaller spaces. This practice will conserve PPE and reduce the chance of cross-contamination across different parts of the facility.
- **TRANSFERS:** If possible, avoid transferring infected individuals to another facility, unless necessary for medical care. Refer to **MODULE 6** for additional guidance.
- **AEROSOL-GENERATING PROCEDURES:** If a patient who is in medical isolation must undergo a procedure that is likely to generate aerosols (e.g., suctioning, administering nebulized medications, testing for COVID-19), they should be placed in a separate room. An N-95 respirator (not a surgical mask), gloves, gown, and face protection should be used by staff. (For more information, see **MODULE 7**.)
- **DEDICATED MEDICAL EQUIPMENT**: If possible, use disposable or dedicated medical equipment in medical isolation (i.e., blood pressure cuffs). Equipment should be left in the medical isolation area and decontaminated in accordance with manufacturer's instructions between cohorts.
- **IN-PERSON COURT APPEARANCES:** Inmates in COVID **MEDICAL ISOLATION** should not have in-person court appearances unless absolutely necessary. Having the inmate appear via telephone hearing should be strongly considered. A video teleconference (VTC), if accessible, can also be used as an alternative.
- **MEDICAL ISOLATION IN SINGLE CELLS:** If medical isolation in single cells is necessary (inmates are not cohorted), Psychology Services staff should be consulted to ensure inmates proposed for single celling are not particularly vulnerable individuals and/or to make recommendations.

2. MONITORING AND DOCUMENTATION

- *Only medical staff can screen and assess patients in **MEDICAL ISOLATION**.*
- *Refer to **MODULE 3** for additional information on screening and testing.*

SYMPTOMATIC PERSONS IN MEDICAL ISOLATION

- Assess at least daily for temperature and for symptoms of illness and decompensation, including asking about shortness of breath and cough. Other objective data may include respiratory rate, as well as pulse and oxygen saturation by pulse oximetry.
- Assessments for symptomatic inmates in medical isolation should be **DOCUMENTED** in the medical record.
- Date of entry into and out of isolation and daily assessments should be noted in the medical record.
- A physician or advanced practice provider (APP) will be notified for any of the following: pulse oximetry less than 94%, pulse greater than 100, temp > than 101°F, or respiratory rate > 22 per minute.
- **EMERGENCY WARNING SIGNS:** A low threshold should be used for deciding to transport an inmate to an **OUTSIDE HOSPITAL** if any of the following emergency warning signs for COVID-19 are noted:
  - Trouble breathing
  - Persistent pain or pressure in the chest
  - New confusion
  - Inability to wake or stay awake
  - Bluish lips or face
- **TREATMENT:** Two monoclonal antibody products, bamlanivimab and casarivimab/imdevimab, have received Emergency Use Authorization (EUA) for treatment of persons with mild to moderate COVID-19 symptoms who are at risk for severe disease. Providers should consult with their Regional Medical Director and monitor updates from the CDC on the latest treatment guidelines.
  - Refer to **Appendices** for *COVID-19 Clinical Assessment Protocol*
  - Refer to the **BOP MONOCLONAL Antibodies for COVID-19 Clinical Guidance Document**
- **ISOLATION INFIRMARY:** Under certain circumstances, establishment of an onsite infirmary at an institution may be necessary. Considerations include the number of symptomatic patients, institution resources and local healthcare resources. The decision to stand up an infirmary should be made in consultation between the institution with regional and central office leadership. Refer to **APPENDICES** for COVID-19 Medical Isolation Infirmary Guidance.

ASYMPTOMATIC, COVID-19 PATIENTS IN MEDICAL ISOLATION

- Asymptomatic inmates in medical isolation should be **ASSESSED DAILY** by health services staff for signs and symptoms of COVID-19.
- When feasible, the assessments for asymptomatic inmates in medical isolation should be **DOCUMENTED** in the medical record under temperature screening in flowsheets. The comment box is used for documenting that the inmate remains asymptomatic.
- **AT A MINIMUM**, asymptomatic inmates in medical isolation should have a clinical encounter reviewing their time in isolation and a symptom screen upon release from medical isolation.

RELEASE FROM MEDICAL ISOLATION

- Release from medical isolation should be noted in the medical record and the Health problem code updated to note "**RESOLVED**." Sentry coding is noted as "**RECOVERED**."
- Refer to the **COVID-19 Coding Clinical Reference Guide** located in the **APPENDICES** for the correct diagnosis codes.

3. RELEASE FROM MEDICAL ISOLATION

Testing for release from COVID-19 medical isolation is not recommended in most cases. The BOP follows the CDC guidance to determine when to discontinue medical isolation as discussed below:

➔ *See Discontinuation of Isolation for Persons with COVID-19 Not in Healthcare Settings, available at: https://www.cdc.gov/coronavirus/2019-ncov/hcp/disposition-in-home-patients.html .*

TABLE 1. CDC DEFINITIONS OF COVID-19 ILLNESS SEVERITY

• **MILD ILLNESS:** Individuals who have any of the various signs and symptoms of COVID-19 (i.e., fever, cough, sore throat, malaise, headache, muscle pain) without shortness of breath, dyspnea, or abnormal chest imaging. • **MODERATE ILLNESS:** Individuals who have evidence of lower respiratory disease by clinical assessment or imaging, and an oxygen saturation (SpO2) > 94% on room air. • **SEVERE ILLNESS:** Individuals who have a respiratory frequency 30 breaths per minute, SpO2 <94% on room air (or for patients with chronic hypoxemia, a decrease from baseline of >3%), and lung infiltrates >50% • **CRITICAL ILLNESS:** Persons with respiratory failure, septic shock, and/or multiple organ dysfunction. • **SEVERELY IMMUNOCOMPROMISED:** Includes conditions such as being on chemotherapy for cancer, untreated HIV infection with CD4 lymphocyte count <200, combined primary immunodeficiency disorder, and receipt of prednisone > 20mg/day for more than 14 days.
SOURCE: *https://www.cdc.gov/coronavirus/2019-ncov/hcp/disposition-hospitalized-patients.html#definitions*

- **ASYMPTOMATIC INMATES** who test positive and never develop symptoms **can be released from medical isolation** when at least 10 days have passed since the date of their first COVID-19 positive RT-PCR test.
- **INMATES WITH MILD OR MODERATE SYMPTOMS**, who tested positive or negative, **can be released from medical isolation** at least 10 days after symptom onset, resolution of fever for at least 24 hours without the use of fever reducing medications, **and** if symptoms (e.g., cough, shortness of breath) have improved.
- **INMATES WITH SEVERE SYMPTOMS REQUIRING HOSPITALIZATION, OR SEVERELY IMMUNOCOMPROMISED INMATES, can be released from medical isolation** 20 days after symptom onset, resolution of fever for at least 24 hours without the use of fever reducing medications, and if symptoms have improved
  - ➔ *Although the above strategies are appropriate for COVID-19 patients who are severely immunocompromised, the CDC indicates a test-based approach may also be considered in these cases. Consultation with the Regional Medical Director is recommended prior to using a test-based strategy in this scenario.*

D. QUARANTINE

➔ *Refer to the **Quarantine Checklist** in the **APPENDICES** for a summary of all quarantine requirements.*

- **The BOP utilizes three categories of QUARANTINE:**
  - **EXPOSURE:** Close contacts of a suspected or confirmed case of COVID-19
  - **INTAKE:**
    - New admissions to a BOP facility
    - Inmates returning from the community to a BOP facility (e.g., an extended time in an emergency department or crowded waiting area; residing overnight in the community or alternative setting such as hospitalization, furlough, writ return, etc.)
  - **RELEASE/TRANSFER:**
    - Inmates being released back into the community (residential reentry center, home confinement, or full-term release)
    - Inmates being transferred to another BOP facility or correctional jurisdiction
- **All BOP COVID-19 quarantine categories** utilize a test-in/test-out strategy, with a quarantine duration of at least 14 days (the incubation period of the SARS-CoV2 virus).
- **Exceptions to quarantine requirements:**
  - Inmates previously diagnosed with COVID-19 do not need to be quarantined within 90 days of their initial symptom onset (for symptomatic cases) or their initial COVID-19 positive test (for asymptomatic cases) if they have met the current CDC release from isolation criteria.
  - Immediate releases from custody *and in consultation with regional medical director* because of statutory or judicial requirements. Refer to **MODULE 6** for additional guidance for immediate releases.

TABLE 2. COMPARISON OF QUARANTINE TYPES IN THE BOP

TYPE OF QUARANTINE	ADMISSION	INTERVAL BETWEEN ADMISSION & DISCHARGE	DISCHARGE	DOCUMENTATION
INTAKE	• SS/TC[1] • Testing (Abbott or commercial)[2]	No interval medical rounds if no known contacts and no exposures or positive tests at intake.	• SS/TC within 24 hours of discharge from quarantine • Testing (commercial lab)	BEMR documentation of admission and discharge SS/TC by HS staff; ordering of test; test results.
EXPOSURE		SS/TC twice-daily is preferred. Once-daily is acceptable; consider when large numbers in quarantine or substantial staffing shortages.	• SS/TC within 24 hours of discharge from quarantine • Testing (commercial lab)	BEMR documentation of admission and discharge SS/TC by HS staff; ordering of test; test results. Interval SS/TCs are documented in the flow sheet.
RELEASE/ TRANSFER		No interval medical rounds required unless inmate is in SHU.	• SS/TC within 24 hours of discharge from quarantine • Testing (commercial lab for most)[3]	BEMR documentation of admission and discharge SS/TC by HS staff; ordering of test; test results.

[1] **SS/TC** = Symptom screen and temperature check; may be performed by Health Services (**HS**) staff or trained non-Health Services staff

[2] **Abbott rapid tests are preferred** when an inmate is symptomatic or when the expected turnaround time (TAT) for a commercial test is prolonged (e.g. > 7days).

[3] **A commercial PCR lab test is preferred** for most discharges from quarantine. **Exceptions include: 1)** BOP inmates transferring to another BOP facility may have an Abbott ID Now COVID-19 test if the commercial lab test TATs is expected to be greater than 7 days and if the inmate will be quarantined upon arrival at their gaining facility. **2)** Immediate releases in which there is insufficient time to obtain commercial lab test results, regardless of TATs.

1. ADMISSION TO QUARANTINE

- **PPE:** An inmate being moved to quarantine should wear a facial covering. Escorting staff in contact with the person should wear gloves, surgical mask, face shield or goggles, and a gown or coveralls.
- **DURATION OF QUARANTINE** is a minimum of 14 days.

2. HOUSING CONSIDERATIONS FOR QUARANTINE

- *To reduce the risk of transmission while in quarantine, facilities should make every effort to quarantine inmates **INDIVIDUALLY** in cells with solid walls and doors. **COHORTING** should only be practiced if there are no viable options to house them individually.*
- ***Different categories of quarantine (Intake, Exposure, and Release/Transfer) should be housed separately.***
- **COHORTING:**
  - Inmates housed in a single or double cell who co-mingle (e.g. shower in a community bathroom, recreate as a group, etc.) are considered to be cohorted. To the extent possible, these groups

should be limited in number (e.g., 10) and kept consistent with the same inmates throughout the duration of quarantine.

- If an entire housing unit is being managed as an exposure quarantine due to contact with a case from the same housing unit, the entire housing unit may need to be treated as a cohort and quarantine in place.
- If a cohort co-mingles with any other cohort the 14-day quarantine period must be reset for all groups.
- If quarantined as a cohort, the 14-day quarantine period must be reset to zero if an inmate in the cohort becomes symptomatic or new inmates are added to the quarantine.

- **PLACEMENT OF BEDS IN COHORTED QUARANTINE:** As feasible, the beds/cots of inmates quarantined as a cohort should be placed at least 6 feet apart. Consider alternating head-to-foot sleeping positions, if feasible.
- **QUARANTINING IN SINGLE CELLS:** If quarantining in single cells is necessary (inmates are not cohorted), Psychology Services staff should be consulted to ensure inmates proposed for single celling are not particularly vulnerable individuals and/or to make recommendations.

HOUSING OPTIONS IN ORDER OF PREFERENCE

The CDC lists the following options for housing inmates in QUARANTINE, in order of preference from top to bottom:

- Separately, in single cells with solid walls and solid doors that close fully.
- Separately, in single cells with solid walls, but without solid doors.
- As a cohort, in a large, well-ventilated cell with solid walls, a solid door that closes fully, and at least 6 feet of personal space assigned to each individual in all directions.
- As a cohort, in a large, well-ventilated cell with solid walls and at least 6 feet of personal space assigned to each individual in all directions, but without a solid door.
- As a cohort, in single cells without solid walls or solid doors, preferably with an empty cell between occupied cells creating at least 6 feet of space between individuals.
- As a cohort, in multi-person cells without solid walls or solid doors, preferably with an empty cell between occupied cells. Employ social distancing strategies.
- As a cohort, in the individuals' regularly assigned housing unit, but with no movement outside the unit. Employ social distancing strategies related to housing in the Prevention section above to maintain at least 6 feet of space between individuals. Place beds head-to-foot instead of head-to-head to create more space.
- Safely transfer to another facility with capacity to quarantine.

  → *Transfer should be avoided due to the potential to introduce infection to another facility; proceed ONLY if no other options are available.*

- **HIGHER-RISK INMATES:** Ideally, do **NOT** cohort individuals who are at higher risk of severe illness and mortality from COVID--19, including persons 65 and older or with certain co-occurring conditions.

  → *See the CDC's guidance "People Who Are at Higher Risk for Severe Illness" at: https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/people-at-higher-risk.html*

- **MEDICAL REFERRAL CENTERS:** At MRCs, the facility's exposure quarantine area for COVID-19 should be in a separate area from the medical units (Nursing Care Center [NCC] units, ambulatory care units, etc.), whenever possible. MRC intake transfers that need to be quarantined on a medical unit due to care

level for other medical conditions should be quarantined in a single room with solid walls and door, placed on droplet and standard transmission precautions, with full COVID-19 PPE worn by staff when entering the room. Donning and doffing PPE appropriately and practicing hand hygiene is critical. To the extent possible, staff interventions with the inmate in quarantine should be limited.

3. MONITORING AND DOCUMENTATION DURING QUARANTINE

- Each type of quarantine uses a test-in/test-out strategy.
- Refer to **MODULE 6** regarding inmate movement and the timing of the test-in/ test-out quarantine strategy.
- On admission to and discharge from any type of quarantine, inmates in quarantine should have their COVID-19 symptoms, temperature screening, and testing results documented in the medical record.
  - The screening for COVID-19 includes symptoms, temperature, and a COVID-19 PCR test from a nasopharyngeal, mid-turbinate, or anterior nares swab.
  - Either POC testing (Abbott ID Now) or a commercial lab may be used for testing into quarantine.
  - Refer to **MODULE 3** for guidance regarding testing of inmates in quarantine.
- It may be helpful to maintain a **ROSTER** of inmates who are in quarantine, including cell assignment, date of placement in quarantine, projected end date of quarantine, date of placement in that specific cell, cell mate or members of the cohort, and designated facility.
- **INTAKE AND RELEASE/TRANSFER QUARANTINE:** Daily COVID-19 symptom screens and temperature checks are not required routinely for intake and release/transfer quarantine.
- **EXPOSURE QUARANTINE:** Inmates in exposure quarantine should be screened at least once daily for COVID-19 symptoms, including a temperature reading. Twice-daily screening is preferred when feasible.
  - *Non-healthcare staff—trained to obtain temperatures and record yes or no answers to a symptom screen and documenting on a roster—can assist health services staff to complete daily screenings. Any positive screening is reported promptly to healthcare staff for further assessment, planning and intervention.*
  - A physician or Advanced Practice Provider (APP) will be notified for any of the following: Inmates who become symptomatic or have a temperature (Mouth) ≥ 100.4˚F, (Ear) ≥ 101˚F, or (Forehead) ≥ 100˚F need to be isolated promptly**.** Upon assessment, the physician or APP should document assessment in the medical record.
  - Refer to the **COVID-19 Coding Clinical Reference Guide** in the **APPENDICES** for correct diagnosis codes.

5. OTHER QUARANTINE CONSIDERATIONS

QUARANTINE OF INMATES PREVIOUSLY DIAGNOSED WITH COVID-19

- Current evidence indicates that people who have recovered from COVID-19 can continue to shed detectable levels of virus for up to 90 days after illness onset. However, the virus levels are considerably lower than during illness and are in ranges that are unlikely to be contagious. Patients that have met release from isolation criteria are no longer considered infectious, even though they may continue to test positive for up to 90 days. If at least 90 days has passed from the onset of their initial illness or positive test, they should be managed as any other individual with no prior history of infection.

- Refer to **MODULE 6** for guidance regarding intake and release/transfer for inmates previously diagnosed with COVID-19.

QUARANTINE ISSUES ASSOCIATED WITH COURT

A number of variables affect the risk of COVID-19 transmission during in-person court appearances and will determine some of the specific management strategies that are needed at each location.

- When possible, inmates in any type of **QUARANTINE** should delay in-person court appearances until they are tested and COVID-19 negative at the end of quarantine. Telephone or VTC appearances are recommended alternatives.
- The U.S. Marshalls Service (**USMS**) takes responsibility for the inmate from the time they leave the BOP institution until their return. Each USMS district may have their own procedures. Individual courts may also have different COVID-19 prevention/mitigation procedures and requirements. The risk or likelihood of mixing with non-quarantined, non-BOP inmates while BOP inmates are with the USMS and the courts is essential to determining their risk of COVID-19 exposure.
- The frequency of an inmate's court appearance and the number of inmates going to a court at any one time are also important factors to consider.
- **It is recommended that each BOP detention center contact the USMS and the court** to ascertain their COVID-19 mitigation procedures and consult with Regional Health Services staff on developing an individualized strategy. The following are general principles to follow:
  - **BOP officials will request that BOP inmates be cohorted only with their own housing or quarantine cohort** and not be mixed with inmates from other housing units or other institutions, or transported with inmates from other institutions to the extent possible while at court.
  - **Upon return to the detention center, inmates should test-in/ test-out of a 14-day quarantine** if they were exposed to other inmates from other housing units or locations (e.g., county jails).
  - **Inmates who were not previously in quarantine** prior to their court appearance, were outside of the institution for less than 24 hours, were not exposed to other inmates between departure and return to the facility and where proper precautions were maintained including use of face coverings, social distancing and PPE by transporting and court staff, may return to their housing unit upon return to their institution after being screened.
  - **Testing an inmate immediately after a one-day court appearance** would have little utility and is not recommended. However, an Abbott ID NOW test can be used before a court appearance on a case-by-case basis, especially if the test is required by the court.