UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

EDWARD BANKS, *et al.*, **Plaintiffs,** **v.** **QUINCY BOOTH, *et al.*,** **Defendants.**	**Civil Action No. 20-00849 (CKK)**

NOTICE IN RESPONSE TO THE COURT'S APRIL 1, 2020 ORDER

Pursuant to the Court's Order of March 31, 2020 and the Minute Order of April 1, 2020, defendants provide the following information and documents:

1. [A] list of the names of the approximately 94 inmates who have been sentenced to misdemeanors and who Defendants are considering for release.

Plaintiffs' counsel acknowledged, in an email last evening, that they had received that list in coordination with Judge McKenna's Order issued in *In re Sentenced Misdemeanants*, No. 2020 CNC 000120 (Super. Ct. of D.C.). Because this is a public filing, that list will not be attached here. Attached is the Department of Corrections (DOC) Good Time Credits Policy 4341.1B (as updated by Change Notice on March 18, 2020 and April 1, 2020). On March 18, 2020, in response to the COVID-19 Response Emergency Amendment Act of 2020, DOC doubled the number of good time credits (GTC) eligible residents could receive each month from 10 to 20 credits. *See* March 18, 2020 Change Notice. Eligible residents could receive a maximum of 6 GTCs for good behavior and 14 GTCs for participation in rehabilitation programs, work details, and special projects. *See id*. Then, on March 30, 2020, DOC again modified its GTC policy to allow eligible residents to

receive the maximum 20 GTCs each month simply for good behavior. *See* April 1, 2020 Change Notice.

2. [T]he numbers of people who have been tested for COVID-19 and a break-down of the identities of those individuals (such as inmates, visitors, etc.) and the results of those tests; the date on which Defendants began testing people coming into the jails; the number and a breakdown of the results of COVID-19 tests which have been done on those who were incarcerated prior to the date on which Defendants began testing all incoming inmates.

DOC began screening inmates on March 13, 2020, and began testing inmates on March 15, 2020. DOC does not test visitors or staff. New residents are not tested upon entry to DOC's facilities consistent with World Health Organization (WHO), Centers for Disease Control (CDC) and Department of Health (DOH) guidelines of not testing individuals unless they are symptomatic. Six inmates have tested positive, 2 negative, and DOC is awaiting the results of 9 tests.

3. [A]ll relevant written procedures and practices concerning COVID-19; and Defendants['] process which is in place or will be put in place to allow legal counsel to communicate with their clients electronically or by other means.

Attached are the COVID-19 protocols of Unity Health Care (DOC's contractor); DOC's COVID-19 screening protocol; Unity Health Care and DOC's Pandemic Policy (2018, currently being revised); DOC's Pandemic Flu Plan (2009, currently being revised)[1]; and written guidance to DOC's Medical Director received from an epidemiologist at DOH on March 30, 2020. DOC also provides regular updates on its website regarding COVID-19 measures. *See* https://doc.dc.gov/page/coronavirus-prevention.

To facilitate the legal calls of the residents in DOC's custody, DOC's case management team allows residents to use their desk phones to make legal calls. Case management also entered into an agreement with the Public Defender Service (PDS) regarding its residents' legal calls. Each

[1] This document is marked "Confidential," so will be filed subsequently under seal.

weekday morning, by 9:00 am, the case management office receives a list of requested legal calls from PDS's Deputy Trial Chief. The case management office then has all of the residents available for their legal calls. Last Friday, however, DOC developed a new telephone system with its telecommunication partners, where each resident is allowed to make a free, unrecorded and unmonitored 10-minute call, each day, to the registered number of their attorney of record. The new system removes the case management office from the process except for verifying the attorneys' numbers and ensuring that the numbers are uploaded into the new system. The case management office has been uploading private attorneys' numbers to the new system as they receive them. On Tuesday, March 31, 2020, DOC learned that PDS's list of attorney names and numbers would not be ready until Friday, April 3, 2020. Despite this new process, the case management office is making reasonable efforts to ensure that all inmates have access to legal calls.

With regard to video conferencing, DOC is hosting video/teleconferenced hearings in three different areas for three different courts. DOC hosts hearings for the D.C. Superior Court, the U.S. District Court for the District of Columbia, and the Maryland District Court. In accordance with a meeting DOC had last week with Chief Judge Howell, each court has its own video/teleconferencing module at DOC where residents can video conference with the court and call their attorneys before and after their hearings. At times, there have been technology issues and delays as facility staff have adjusted to new processes but, overall, DOC has transitioned from no video or telephone court hearings in its facilities to three different areas with minimal problems. DOC's IT and operations staff are committed to increasing this capability.

Dated: April 1, 2020.

Respectfully submitted,

KARL A. RACINE
Attorney General for the District of Columbia

TONI MICHELLE JACKSON
Deputy Attorney General
Public Interest Division

/s/ Fernando Amarillas
FERNANDO AMARILLAS [974858]
Chief, Equity Section

/s/ Andrew J. Saindon
ANDREW J. SAINDON [456987]
Senior Assistant Attorney General
MICAH BLUMING [1618961]
PAMELA DISNEY [1601225]
Assistant Attorneys General
441 Fourth Street, N.W., Suite 630 South
Washington, D.C. 20001
(202) 724-6643
(202) 730-1470 (f)
andy.saindon@dc.gov
micah.bluming@dc.gov
pamela.disney@dc.gov

Counsel for Defendants

	DISTRICT OF COLUMBIA DEPARTMENT OF CORRECTIONS **CHANGE NOTICE**	**EFFECTIVE DATE:**	April 1, 2020	**Page 1 of 3**
		OPI:	OPERATIONS	
		REVIEW DATE:	September 14, 2020	
		Approving Authority	Quincy L. Booth Director	
	SUBJECT:	**GOOD TIME CREDITS – 4341.1B**		
	NUMBER:	**Change Notice #19-002**		
	Attachments:	**PP 4341.1 Good Time Credit - Attachment 1**		

APPROVED:

Signature on File

Quincy L. Booth, Director

3/30/2020
Date Signed

DISTRICT OF COLUMBIA DEPARTMENT OF CORRECTIONS	**EFFECTIVE DATE:**	April 1, 2020	**Page 2 of 3**
	SUPERSEDES:	None	
CHANGE NOTICE	**REVIEW DATE:**	September 14, 2020	
SUBJECT:	**GOOD TIME CREDITS – 4341.1B**		
NUMBER:	**Change Notice # 19-002**		
Attachments:	**PP 4341.1 Good Time Credit - Attachment 1**		

1. **PURPOSE AND SCOPE.** The Department of Corrections (DOC) may award Good Time Credits (GTC) to eligible misdemeanants for good behavior and successful participation in rehabilitative programs, work details, and special projects.

2. **POLICY**

   a. It is DOC policy to award GTC to inmates consistent with DC Code § 24-221.01, et seq. and as amended in §§ 24-221.03 c(c)) (March 26, 2016).

   b. GTC shall be applied to the person's minimum term of imprisonment to determine the date of eligibility for release.

   c. No inmate shall receive more than a total of twenty (20) GTC per calendar month for good behavior.

   d. Once GTC are awarded, they are vested and cannot be forfeited.

   e. When found guilty of one or more Class I or Class II offenses as defined in PM 5300.1, GTC that were given at sentence computation for good behavior may be forfeited.

   f. Good Time Credits forfeited or withheld because of disciplinary violations may be restored in accordance with this directive.

3. **APPLICABILITY**

   This policy shall apply to every inmate of a District of Columbia correctional institution who is serving a sentence for a misdemeanor pursuant to section 3(b) of An Act to Establish a Board of Indeterminate Sentence and Parole for the District of Columbia (DC Official Code § 24-221.01, et seq. and as amended in § 24-221.03c(c)) (March 26, 2016).

AUTHORITY

   a. DC Code § 24-211.02, Powers; Promulgation of Rules

   b. DC Code §§ 24-221-.01c(c), District of Columbia Good Time Credits Act of 1986, effective May 17, 2011, is amended by adding a new Section 601.02.

c. DC Code § 24-101, et seq., Transfer of Prison System to Federal Authority.

d. COVID-19 Response Emergency Amendment Act of 2020.

SUMMARY OF CHANGES. *Pursuant* to COVID-19 Response Emergency Amendment Act of 2020***,*** Sec. 313, Good Time Credits***,*** the below changes will apply to GTC for 180 days effective upon signing of this change notice.

The number of GTC that can be earned is changed as follows:

Section 10 "General Rules" (c) *is amended by striking the number ten "10" and inserting the number twenty "20" in its place*.

Section 11 "Applying Good Time Credit" (a1**)** *is amended by striking the number three "3" and inserting the number twenty "20" in its place.*

Section **11 "Applying Good Time Credit" (b.2) "Rehabilitative Program, Work Detail and Special Projects**" *is amended by striking section 11b*

NEW VERBIAGE-
Section 2 "Policy" (c). No inmate shall receive more than a total of twenty (20) GTC per calendar month for good behavior and positive participation in rehabilitative programs, details or special projects.

Section **10** ***"General Rules" (c).*** An inmate shall not earn more than twenty (20) GTC per full calendar month.

Section 11 "Applying Good Time Credit" (a.1) An inmate sentenced for a misdemeanor and whose conduct complies with institutional rules shall be eligible to receive GTC of up to twenty (20) credits per calendar month for good behavior.

Section **11 "Applying Good Time Credit" (b.2) "Rehabilitative Program, Work Detail and Special Projects**" *is amended by striking section 11b*

ACTION. File this Change Notice in front of "Good Time Credits" dated January 17th, 2017.

	DISTRICT OF COLUMBIA DEPARTMENT OF CORRECTIONS **CHANGE NOTICE**	**EFFECTIVE DATE:**	March 18, 2020	**Page 1 of 4**
		OPI:	OPERATIONS	
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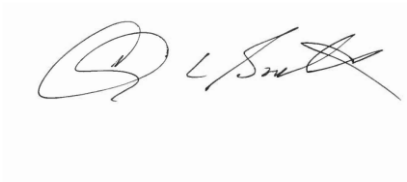
APPROVED:

Signature on File



Quincy L. Booth, Director

3/18/20

Date Signed

DISTRICT OF COLUMBIA DEPARTMENT OF CORRECTIONS	**EFFECTIVE DATE:**	March 18, 2020	**Page 2 of 4**
	SUPERSEDES:	None	
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   a. It is DOC policy to award GTC to inmates consistent with DC Code § 24-221.01, et seq. and as amended in §§ 24-221.03 c(c)) (March 26, 2016).

   b. GTC shall be applied to the person's minimum term of imprisonment to determine the date of eligibility for release.

   c. No inmate shall receive more than a total of twenty (20) GTC per calendar month for good behavior and positive participation in rehabilitative programs, details or special projects.

   d. Once GTC are awarded for successful program participation, work details or special projects, they are vested and cannot be forfeited.

   e. When found guilty of one or more Class I or Class II offenses as defined in PM 5300.1, GTC that were given at sentence computation for good behavior may be forfeited and credits for successful programming that have not yet been awarded, may be withheld.

   f. Good Time Credits forfeited or withheld because of disciplinary violations may be restored in accordance with this directive.

3. **APPLICABILITY**

   This policy shall apply to every inmate of a District of Columbia correctional institution who is serving a sentence for a misdemeanor pursuant to section 3(b) of An Act to Establish a Board of Indeterminate Sentence and Parole for the District of Columbia (DC Official Code § 24-221.01, et seq. and as amended in § 24-221.03c(c)) (March 26, 2016).

DISTRICT OF COLUMBIA DEPARTMENT OF CORRECTIONS	**EFFECTIVE DATE:**	March 18, 2020	**Page 3 of 4**
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a. DC Code § 24-211.02, Powers; Promulgation of Rules

b. DC Code §§ 24-221-.01c(c), District of Columbia Good Time Credits Act of 1986, effective May 17, 2011, is amended by adding a new Section 601.02.

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The number of GTC that can be earned is changed as follows:

Section 10 "General Rules" (c) *is amended by striking the number ten "10" and inserting the number twenty "20" in its place*.

Section 11 "Applying Good Time Credit" (a1**)** *is amended by striking the number three "3" and inserting the number six "6" in its place.*

***Section* 11 "Applying Good Time Credit" (b.2) "Rehabilitative Program, Work Detail and Special Projects**" *is amended by striking the number seven "7" and inserting the number fourteen "14" in its place.*

NEW VERBIAGE-
Section 2 "Policy" (c). No inmate shall receive more than a total of twenty (20) GTC per calendar month for good behavior and positive participation in rehabilitative programs, details or special projects.

***Section* 10 *"General Rules" (c)*.** An inmate shall not earn more than twenty (20) GTC per full calendar month.

DISTRICT OF COLUMBIA DEPARTMENT OF CORRECTIONS **CHANGE NOTICE**		**EFFECTIVE DATE:**	March 18, 2020	**Page 4 of 4**
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SUBJECT:	**GOOD TIME CREDITS – 4341.1B**			
NUMBER:	**Change Notice # 19-002**			
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Section 11 "Applying Good Time Credit" (a.1) An inmate sentenced for a misdemeanor and whose conduct complies with institutional rules shall be eligible to receive GTC of up to six (6) credits per calendar month for good behavior.

Section 11 "Applying Good Time Credit" (b.2) No more than a total of fourteen (14) credits shall be applied for each calendar month of participation in a combination of programs, work details and/or special projects.

ACTION. File this Change Notice in front of "Good Time Credits" dated January 17th, 2017.

UNITY HEALTH CARE, INC.
DEPARTMENT OF CORRECTIONS HEALTH CENTER

CORONAVIRUS PROTOCOL

SUBJECT: Coronavirus (COVID-19)

PURPOSE: To provide guidelines for early identification and to prevent the spread of coronavirus (COVID-2019) in the central detention facility (CDF and the correctional treatment facility (CTF).

POLICY: All detainees entering the Central Detention Facility (CDF) or Correctional Treatment Facility (CTF) shall be appropriately screened, evaluated and treated as clinically indicated for coronavirus at the time of intake.

PROCEDURE:

I. Coronavirus

Coronaviruses are a large family of viruses that are known to cause illness ranging from the common cold to more severe diseases such as Severe Acute Respiratory syndrome (SARS) and Middle East Respiratory Syndrome (MERS). A novel (new) coronavirus (COVID-19) is a new strain of coronavirus that has not been previously identified in humans. The COVID-19 is the cause of an outbreak of respiratory illness first detected in Wuhan, Hubei province, China. There have been cases of community spread of COVID-19 reported in several states. Community spread means spread of an illness for which the source of infection is unknown. It spreads from person-to-person. At this time, however, most people in the United States will have little immediate risk of exposure to this virus. Information on coronavirus disease 2019 remains limited but CDC has published clinical criteria for assessment of patients in healthcare settings.

II. Screening and Symptoms

A. All inmates shall be screened for coronavirus at intake.

B. All intakes shall be screened for symptoms, history and contacts.

Screening Questions:

1. Have you traveled outside of the US within the past 14 days? (Areas of concern currently are China, Iran, Italy, Japan or South Korea and areas of widespread community transmission both abroad and the US – please refer to the CDC website as these areas are being updated daily)
2. Have you had contact in the past 14 days traveled from an area with widespread or ongoing community spread of COVID-19?
3. Have you had contact in the past 14 days with a person who has confirmed COVID-19 (Coronavirus infection)?
4. Do you have any of the following symptoms? Fever (subjective or confirmed T≥100.4°F) or cough or shortness of breath?

Symptoms may appear **2-14 days after exposure**:

Clinical Features	&	Epidemiologic Risk
Fever[1] **or** signs/symptoms of lower respiratory illness (e.g. cough or shortness of breath)	**AND**	Any person, including healthcare workers[2], who has had close contact[3] with a laboratory-confirmed[4] COVID-19 patient within 14 days of symptom onset
Fever[1] **and** signs/symptoms of a lower respiratory illness (e.g., cough or shortness of breath) requiring hospitalization	**AND**	A history of travel from affected geographic areas[5] (see below) within 14 days of symptom onset
Fever[1] with severe acute lower respiratory illness (e.g., pneumonia, ARDS) requiring hospitalization and without alternative explanatory diagnosis (e.g., influenza)[6]	**AND**	No source of exposure has been identified

Close contact is defined as—
a) being within approximately 6 feet (2 meters) of a COVID-19 case for a prolonged period of time; close contact can occur while caring for, living with, visiting, or sharing a healthcare waiting area or room with a COVID-19 case
– or –
b) having direct contact with infectious secretions of a COVID-19 case (e.g., being coughed on)

III. Management

A. Inmates answering "yes" to one or more of the screening questions shall be evaluated by a provider. The provider shall:
   i. Don a facemask with eye protection and gloves
   ii. Assess for fever or symptoms of lower respiratory illness (e.g. cough or shortness of breath)
B. Inmates found to have both exposure and illness present, the provider shall:
   i. Place a facemask over the inmate's nose and mouth
   ii. Isolate the inmate in a private room or a separate area. Room doors should be kept closed except when entering or leaving the room, and entry and exit should be minimized.
C. Healthcare providers should immediately notify their infection control personnel 202-698-0403 and then contact DC Health immediately in the event of suspected infection for 2019-nCoV by calling 202-576-1117 (during business hours) or 844-493-2652 (after business hours). DC Health will determine if testing for COVID-19 is needed and give instruction on how to do this.
D. If the case does not meet the current case definition but is highly suspicious, please contact DC Health for consultation.
E. Treatment is supportive to help relieve symptoms. No specific antiviral is recommended.
F. Dedicated equipment should be used for patient care.
G. All non-dedicated, non-disposable medical equipment used for patient care should be cleaned and disinfected according to manufacturer's instructions and agency policies.
H. Inmate care that involves being within 6 feet of patients should be managed using standard, contact and airborne precautions and wearing personal protective equipment (PPE) (gloves, gown, N95 respirator, eye protection – goggles or face shield) until transmissible infectiousness is ruled out.

IV. Containment

A. Inmates suspected of having coronavirus shall be given a facemask and housed on a designated unit for patients suspected of having COVID-19 (Coronavirus infection). Monitoring efforts will be followed per instructions from DC Health. If an inmate becomes ill while on a regular housing unit, the correctional officer will call medical urgent care for further instructions. Patients MUST MEET THE DEPARTMENT OF HEALTH'S CRITERIA FOR A SUSPECTED CASE OF COVID-19 INFECTION in order to be housed on the unit designated for suspected COVID-19 infection.

B. If the patient suspected of having COVID-19 was on a housing unit, that unit shall then QUARANTINED (current recommendations are for 14 days). Medical will work closely with the DC DOH in this case regarding monitoring and ongoing recommendations for management. Discontinuing these efforts will be made on a case-by-case basis, in consultation with DC Health.

C. Inmates shall be instructed to cover coughing and sneezing with a tissue and throw away in the regular trash after use; maintain good hand hygiene by washing hands with soap and water; avoid touching eyes, nose or mouth without clean hands; avoid sharing personal items; and to report the first sign of illness to the officer / medical.

D. Attending staff and security, as well as medical, must use standard, contact and airborne precautions and wear appropriate personal protective equipment (PPE) (gloves, gown, N95 respirator, eye protection – goggles or face shield protection) until transmissible infectiousness is ruled out.

E. The DC DOH should be contacted regarding any medical staff or security staff who are considered to have a moderate or high-risk exposure to an inmate suspected of having or confirmed to have COVID-19. Exposure classifications can be found at: https://www.cdc.gov/coronavirus/2019-ncov/php/risk-assessment.html

V. Infection Control

A. Environmental cleaning and disinfection:
Cleaning and disinfection of environmental surfaces are important components of routine infection control in healthcare facilities. Environmental cleaning and disinfection for coronavirus follows the same general principles used in other healthcare settings.

i. Dedicated equipment should be used for patient care of ill individuals. Then routine cleaning of the equipment shall be done along with cleaning of the room or area used.
ii. All non-dedicated, non-disposable medical equipment used for patient care should be cleaned and disinfected according to manufacturer's instructions and agency policies.
iii. After patient is discharged/transferred, the room(s) or area used shall be closed off prior to cleaning for a minimum of 4 hours and up to 24 hours (if possible) to minimize potential for exposure to respiratory droplets. If possible, open doors and windows to increase circulation in the area.
iv. Use of EPA-registered disinfectant according to manufacturer's instructions for routine cleaning of surfaces, frequently touched areas (elevator buttons, tabletops, doors, doorknobs, handles, desks, toilets, faucets, sinks, common areas where staff/others provide services and objects).

v. Dirty surfaces should be cleaned first with soap and water then with the EPA-registered disinfectant.
vi. Staff cleaning should wear disposable gloves and gowns for all tasks in the cleaning process, including handling trash, and use of eye protection when deemed necessary. Upon completion of cleaning, gloves and gowns should be removed carefully to avoid contamination of the wearer and the surrounding area.
vii. Handwashing should be performed after removing gloves.
viii. Follow facility procedures for regular cleaning of patient occupied cells. Patient cells/areas shall be cleaned at least daily and prior to another patient moving into the cell with the CDC approved disinfecting agent.

REFERENCES:

I. https://www.cdc.gov/coronavirus/2019-ncov/index.html

TRAVEL TO CHINA OR **CLOSE CONTACT WITH** a person known to have Coronavirus (COVID-19)
Question by DOC/MA/Nurse

Provider gets alert from DOC/MA/Nurse about a patient who has traveled to a high risk area OR was in close contact with a known person with Coronavirus

- Provider dons facemask with eye protection and gloves
- Provider assesses for fever or symptoms of lower respiratory illness (e.g. cough or shortness of breath (SOB))
- Provider confirms **both exposure and illness are present**
- **Provider confirms patient is wearing a mask**

Health Services Administrator (HSA), Medical Director, and Director of Infection Prevention:

- ✓ Coordinates process with provider
- ✓ Lists all staff exposed to patient
- ✓ Documents all exposed contacts
- ✓ Contacts DC Health Department
- ✓ Calls DOC Medical Director
- ✓ Contacts Shift Supervisor
- ✓ Instructs further actions on site including staff and patient movement
- ✓ Ascertains room is isolated and not used until cleaned per protocol
- ✓ Keeps log
- ✓ Writes incident report

Travel Screening Questions

Have you traveled to **China, Iran, Italy, Japan or South Korea** in the past 14 days?

Have you had known close contact in the past 14 days with a person who travelled to **China, Iran, Italy, Japan or South Korea** or a person under investigation for COVID-19?

Have you had contact in the past 14 days with a person who has known or suspected COVID-19, or has had symptoms of COVID-19?

Have you had contact in the past 14 days traveled from an area with widespread or ongoing community spread of COVID-19?

Symptom Screening Question

Have you experienced any of these symptoms in the past 14 days: **SUBJECTIVE**/Confirmed Fever T≥100.4°F or cough or shortness of breath?

Travel history confirmed with Travel Screening Questions on left

YES

Notify HSA, Medical Director, and Director of Infection Prevention or Designee

Symptom screening question POSITIVE

YES Do a Rapid Influenza Test

Flu test positive. Evaluate and treat.

NO

Assess patient temperature with non-contact thermometer

Temperature 100.4 or above OR Cough or Shortness of breath

YES Coronavirus Suspected

- Provider places facemask on patient
- Isolate patient in private room or a separate area
- Wear the appropriate PPE

NO: Coronavirus NOT Suspected

Assess level of risk per boxes below

Report/Monitor
Asymptomatic patients with high-, some, or low-risk exposures in the past 14 days to DC Health Department. Patient temperature, SOB and other symptoms to be monitored twice daily; Notify Provider if symptomatic.

See reverse side of this form for CDC classifications of risk as of March 5, 2020.

Healthcare providers should **immediately** notify their infection control personnel 202-698-0403 and then contact DC Health immediately in the event of a PUI for 2019-nCoV by calling 202-576-1117 (during business hours) or 844-493-2652 (after business hours).

If the case does not meet the current case definition but is **highly suspicious**, please contact DC Health for consultation.

CDC classifications of risk as of March 5, 2020:

All exposures apply to the 14 days prior to assessment and recommendations apply until 14 days after the exposure event.

High-Risk	Medium Risk	Low Risk	No Identifiable Risk
-Living in the same household as, being an intimate partner of, or providing care in a non-healthcare setting (such as a home) for a person with symptomatic laboratory-confirmed COVID-19 infection ***without using recommended precautions*** for home care and home isolation --The same risk assessment applies for the above-listed exposures to a person diagnosed clinically with COVID-19 infection outside of the United States who did not have laboratory testing. -Travel from Hubei Province, China	-Close contact with a person with symptomatic laboratory-confirmed COVID-19 infection, and not having any exposures that meet a high-risk definition. --The same risk assessment applies for close contact with a person diagnosed clinically with COVID-19 infection outside of the United States who did not have laboratory testing. --On an aircraft, being seated within 6 feet (two meters) of a traveler with symptomatic laboratory-confirmed COVID-19 infection; this distance correlates approximately with 2 seats in each direction -Living in the same household as, an intimate partner of, or caring for a person in a non-healthcare setting (such as a home) to a person with symptomatic laboratory-confirmed COVID-19 infection *while consistently using recommended precautions* for home care and home isolation -Travel from mainland China outside Hubei Province AND not having any exposures that meet a high-risk definition	-Being in the same indoor environment (e.g., a classroom, a hospital waiting room) as a person with symptomatic laboratory-confirmed COVID-19 for a prolonged period of time but not meeting the definition of close contact -On an aircraft, being seated within two rows of a traveler with symptomatic laboratory-confirmed COVID-19 but not within 6 feet (2 meters) AND not having any exposures that meet a medium- or a high-risk definition	-Interactions with a person with symptomatic laboratory-confirmed COVID-19 infection that do not meet any of the high-, medium- or low-risk conditions above, such as walking by the person or being briefly in the same room.

Hello Beth,

Thank you for your email. Based on CDC's guidance, an individual is considered a close contact if they have been within approximately 6 feet of COVID-19 case for a prolonged period of time or have had direct contact with infectious secretions from a COVID-19 case (e.g. have been coughed on). Close contact can occur while caring for, living with, visiting or sharing a common space with a COVID-19 case. **Data to inform the definition of close contact are limited.** Considerations when assessing close contact include the duration of exposure (e.g. longer exposure time likely increases exposure risk) and the clinical symptoms of the person with COVID-19 (e.g. coughing likely increases exposure risk, as does exposure to a severely ill patient).

If workforce is an issue at the DOC, as mentioned in my previous email dated March 27th, the following CDC guidance for Healthcare workers(HCW) can be adapted for staff at your facility:

- "Facilities could consider allowing asymptomatic HCP who have had an exposure to a COVID-19 patient to continue to work after options to improve staffing have been exhausted and in consultation with their occupational health program. These HCP should still report temperature and absence of symptoms each day prior to starting work. Facilities could have exposed HCP wear a facemask while at work for the 14 days after the exposure event if there is a sufficient supply of facemasks. If HCP develop even mild symptoms consistent with COVID-19, they must cease patient care activities, don a facemask (if not already wearing), and notify their supervisor or occupational health services prior to leaving work."
- The above guidance can be applied to the staff, where they can continue working until they develop symptoms. If they develop symptoms at work, to leave the facility and reach out to their healthcare provider. The healthcare provider will work with DC Department of Health to coordinate testing for symptomatic staff members

Lastly, officers who have had close contact with officers exposed to the positive case have no identifiable risk at this time. However if they develop symptoms, then your facility sick policies should be implemented. It is critical to implement some everyday measures like performing verbal screening at the beginning of the shift for staff, temperature checks if possible OR self-monitoring of symptoms consistent with COVID-19 to reduce the spread of this virus in your facility.

Please refer to CDC's guidance on correctional and detention facilities for more information:
https://www.cdc.gov/coronavirus/2019-ncov/community/correction-detention/guidance-correctional-detention.html

Thank you,

Best,

Shreya

Shreya Khuntia, MBBS,MPH
Epidemiologist- Influenza and COVID-19 response
Center for Policy, Planning and Evaluation (CPPE)

shreya.khuntia@dc.gov
899 North Capitol St NE, 6th Fl, Washington, DC 20002
dchealth.dc.gov

DC | HEALTH GOVERNMENT OF THE DISTRICT OF COLUMBIA MURIEL BOWSER, MAYOR

UNITY HEALTH CARE

UNITY HEALTH CARE, INC.

DEPARTMENT:	**TITLE:**	**POLICY #:**
CENTRAL DETENTION AND CORRECTIONAL TREATMENT FACILITES HEALTH SERVICES DIVISION	**MEDICAL PLAN FOR PANDEMIC INFLUENZA**	**CF 210**
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REVIEWED BY: Diana Lapp, MS	**EFFECTIVE DATE:** April 10, 2008	**DATE(S) REVISED:** April 15, 2011 May 30, 2014 July 31, 2016 October 1, 2018
APPROVED BY CMO: Danielle Doctor MD	**APPROVED BY CEO:** Vincenta Kearse	

PURPOSE: Unity Health Care (UHC) and DC Department of Corrections (DOC) recognize the importance of establishing an action plan for the identification and management of a pandemic influenza outbreak. The plan shall provide guidance and direction to staff in managing seasonal and pandemic influenza at the DOC Central Detention Facility (CDF) and Correctional Treatment Facility (CTF).

POLICY: It is the policy of Unity Health Care at the DOC implement a strategic approach for screening and preventing the transmission of pandemic influenza, should patients become ill with influenza. The plan provides general guidance and is intended to be consistent with Center for Disease Control and Prevention (CDC). All employees are to comply with the guidelines and any related changes from CDC.

BACKGROUND:

I. Influenza is a highly infectious viral illness that causes yearly seasonal epidemics. The complications of influenza can cause death. Influenza virus is transmitted in most cases by droplets through coughing and sneezing of infected persons but it can be transmitted by direct contact. An annual influenza vaccination is the best method of protection against influenza.

II. Influenza viruses are unique in their ability to cause sudden infection in all age groups on a global scale. A flu pandemic occurs when a new virus appears that people have not been exposed to before. The new virus would spread as easily as normal seasonal flu, through coughing and sneezing. Since the virus is new, the human immune system will have no pre-existing immunity against it. People who are infected by the new virus may become more seriously ill than if they have the normal seasonal flu.

III. A pandemic influenza is a global outbreak of a new influenza A that is very different from the current and recently circulating human seasonal influenza A viruses. Pandemics occurs when new (novel) influenza A viruses emerge which are able to infect people easily and spread from person to person in an efficient and sustained way. Can occur in waves, with each wave having the ability to last for several weeks, with the possibility of widespread infections in each wave

simultaneously in different parts of the world. This will cause disruptions to daily life and essential services, as well as high levels of illness, death, social disruptions and economic loss. An influenza pandemic has a greater potential to cause rapid increases in illness and death than virtually any other health threat.

IV. The occurrence of a pandemic cannot be determined. However, the impact of the next pandemic could have a devastating effect on the health and well being of the American public. A pandemic event will strain resources needed to minimize disruption of the government and community. In the event of a pandemic, special requirements for surveillance, rapid delivery of vaccines and antiviral drugs, allocation of limited medical resources, and expansion of health care service to meet a surge in demand for care.

V. Clinical presentation - The reported symptoms of influenza-like illness (ILI) have ranged from typical seasonal influenza-like symptoms (e.g., fever, chills, cough, sore throat, fatigue and muscle aches) to eye infections (conjunctivitis), pneumonia, acute respiratory distress, viral pneumonia, and other severe and life-threatening complications.

VI. Influenza is primarily transmitted from person to person via large droplets that are generated when an infected person coughs or sneezes; these large droplets can then settle on the mucosal surfaces (mouth or nose) of the upper respiratory tracts of susceptible persons who are within 3 - 6 feet of an infected person. Less often, a person might also get the flu by touching a surface or object that has flu virus on it and then touching their own mouth or nose. Adults can spread influenza to others from the day before getting symptoms to approximately 5 - 7 days after illness onset. However, the amount of virus shed, and presumably infectivity, decreases rapidly by 3 - 5 days after onset in an experimental human infection model. Young children also might shed virus several days before illness onset, and children can be infectious for 10 or more days after onset of symptoms. Severely immunocompromised persons can shed virus for weeks or months.

DEFINITIONS:

I. **SEASONAL (OR COMMON) FLU** – is a contagious respiratory illness caused by influenza viruses that can be transmitted person to person. Most people have some immunity, and a vaccine is available.

II. **PANDEMIC FLU** – occurs where a non-human novel influenza virus gains the ability for efficient and sustained human-to-human transmission then spreads easily from person to person worldwide. For example, avian influenza A (H5N1) and avian influenza H7N9.

III. **MEDICAL ISOLATION** – separation or restricted movement of ill persons with a contagious disease; housed in a separate room with a separate toilet, handwashing facility, soap, and single-use towels, and with appropriate accommodations for showering.

IV. **QUARANTINE** – separation or restricted movement of well persons presumed to have been exposed to a contagion, while they are in the incubation period.

PROCEDURES:

I. Precautions:

A. In the era of re-emerging communicable disease, basic infection control precautions are the cornerstone of the approach to prevent transmission of communicable diseases in health care facilities. The basic level of infection control precautions (standard precautions), when used

appropriately will be effective in preventing transmission of most communicable diseases in health care facilities. Facilitating compliance with these basic precautions will be emphasized.

B. Available evidence suggests that transmission of human influenza viruses occurs through multiple routes including large droplets, direct and indirect contact, and droplet nuclei. However, observational studies conducted in health care facilities suggests that droplet transmission is the major mode of transmission in that setting and standard precautions plus droplet precautions are recommended for the care of patients infected with seasonal influenza or ILI. The following serves as a guide.

C. Standard precautions – strict hand hygiene and the use of Personal Protective Equipment (PPE) is essential to the prevention of infection. To minimize transmission, the following shall be followed:

1. Cover mouth and nose with a tissue when coughing or sneezing and dispose of used tissue in waste container.
2. Use a surgical mask if coughing is persistent, when a mask can be tolerated.
3. After contact with respiratory secretions wash hands with soap and water or use an alcohol-based hand rub. Avoid touching eyes, nose and mouth without cleaning hands.
4. If hands are visibly dirty or soiled with blood or other body fluids or if broken skin might have been exposed to potentially infectious materials, hands should be washed thoroughly with soap and water.
5. Staff should use gloves and change them often.
6. Wash hands before putting on the gloves and after removing the gloves. Gloves should be changed between patient contacts.
7. Stand, sit at least 3 - 6 feet from the other person, or avoid contact if possible.
8. Staff should utilize PPE such as a properly fitted mask, gowns, and goggles while engaging in any activities that may potentiate exposure to splashes or sprays of any body fluids. Staff should remove a soiled gown as promptly as possible and wash hands to avoid transfer of microorganisms to staff, or to other patients or environments.
9. Masks worn by medical staff shall comply with National Institute of Occupational Safety and Health (NIOSH) standard N-95 or better, and shall be individually fit tested per Occupational Safety and Health Administration (OSHA) guidelines.
10. All disposable items such as masks, gloves, goggles, and gowns shall be disposed of accordance with policy CF202 (Infection Prevention and Control).
11. Heavily soiled waste must be placed in a red bag and disposed. When transporting soiled linens use gloves followed by hand hygiene. Laundry personnel should use standard precautions and perform hand hygiene after removing PPE that has been in contact with soiled linen/laundry. Linens only require normal washing in hot water and detergent.
12. When possible, staff should ensure that reusable eating utensils/items be washed in a dishwasher with detergent at the recommended water temperature. If dishwashers are not available, detergent and water shall be used. Rubber gloves shall be used if washing with hand washing.
13. Disposable items shall be discarded with other general waste.

D. Droplet precautions – droplets are generated primarily during coughing, sneezing, and talking. Transmission occurs when infectious droplets are propelled through the air onto another person but due to their large size can only travel distances of 3 feet or less. To minimize transmission, the following shall be followed:

1. Infected patients must wear a surgical mask when in direct contact with other individuals.
2. Maintain 3 – 6 feet distance from infected individuals.

3. The movement and transport of patients outside the isolations room/area should be for essential purposes only. The receiving area should be informed as soon as possible prior to the patient's arrival so the precautions should be instituted.
4. The use of surgical masks shall be used by pandemic influenza infected patients and should be worn by suspected or confirmed pandemic influenza infected patients during transport or when care is necessary outside of the isolation room/area. The patient should perform hand hygiene after contact with respiratory secretions.
5. If a mask cannot be tolerated the patient may cover his/her mouth and nose with a tissue during coughing or sneezing. The patient should perform hand hygiene after coughing or sneezing.

II. Suspected or confirmed cases:

A. Early identification and isolation (when clinically indicated) of infectious diseases is essential. Medical staff shall inquire about any infectious diseases or signs and symptoms of ILI upon intake into the DOC.

B. Any patient suspected by medical staff to have ILI during incarceration shall wear a surgical mask and be immediately transported to the medical unit or if possible the patient shall be seen in their housing unit sick call room in order to limit patient movement. The patient will be tested for Influenza A and B, then treated as clinically indicated.

C. For patients confirmed to have ILI, the patient shall be placed in a single cell in the housing unit or monitored on the medical unit as medically indicated. If single cell rooms are not available, patients infected with the same organisms may be cohorted (share rooms).

D. Patients that present without symptoms but report having contact with influenza or suspected influenza shall be quarantined by restricting the patient's movement until medical staff is able to determine that the person can be cleared to the general population.

E. Patients identified by medical personnel as being high risk for the developing influenza shall be afforded the opportunity to receive the vaccination when vaccine is available by Centers for Disease Control (CDC) and according to the guidelines. Management of influenza shall be the sole province of the providers caring for the patient population. Care should focus on fever reduction, hydration, and comfort measures as well as prevention and containment strategies.

III. Environmental cleaning and disinfection:

A. Patient cells/areas shall be cleaned at least daily and prior to another patient moving into the cell with the CDC approved disinfecting agent or 10% solution of bleach (1 part bleach and 9 parts cold water).

B. In addition to daily cleaning of floors and other horizontal surfaces, special attention should be given to cleaning and disinfecting frequently touched surfaces to at least include doors, doorknobs, bed rails, sinks, and televisions. Isopropyl (rubbing alcohol) 70% and ethyl alcohol 60% are disinfectants to be used on smooth metal surfaces, tabletops, and other surfaces on which bleach cannot be used. Note: These cleaning agents are flammable and toxic. To be used in well-ventilated areas. Avoid inhalation. Keep away from heat sources, electrical equipment, flames and hot surfaces. Allow it to dry completely. Surface disinfecting wipes are also a suitable substitute.

C. Care must be taken to only utilize damp rather than dry dusting or sweeping so to limit the possibility of airborne exposure to infected material. Dust horizontal surfaces by moistening a cloth with a small amount of disinfectant.

D. Mop heads shall be changed and laundered daily and dried thoroughly before storage or reuse.

IV. Handling of patient care equipment – handle used patient-care equipment soiled with blood, body fluids, secretions, or excretions in a manner that prevents skin and mucous membrane exposures, contamination of clothing, and transfer or microorganisms to other staff, patients, or environments. Ensure that reusable equipment is not used for the care of another patient until it has been cleaned and reprocessed appropriately.

V. Management of staff

A. Although influenza cannot be prevented studies have shown that vaccination can limit the possibility of developing illness. Staff especially health care workers are encouraged to receive the influenza vaccination. According to scientists the vaccine will not be available until 4 to 6 months after the onset of the pandemic flu and be available in limited supplies. Antiviral medication could be given as a prevention strategy but is also limited in supply and CDC guidelines will direct the medical community who should receive this medication under a triage system.

B. Surveillance and management of all UHC and DOC staff working on the quarantine/isolation units, especially health care workers caring for pandemic influenza infected patients, shall include:

1. Health care workers reporting any ILI exposures to the supervisor.
2. Health care workers who have a fever and/or are symptomatic notify his/her supervisor and will be instructed to seek medical attention.
3. If diagnosed with ILI, return to work only after cleared to do so by their treating health care provider.
4. Check temperature daily and monitor for symptoms of influenza-like illness (cough, sore throat, difficulty breathing) for 10 days after possible influenza exposure. Health care staff shall have temperature checked once per shift. The UHC Infection Prevention Specialist or designee will work with a correctional liaison from CDF/CTF to designate "Flu-Managers" who shall orchestrate this process and be responsible for monitoring temperature and symptoms.
5. In the event of a fever (over 100.4F) or the development of ILI, staff must immediately limit their interactions with others, exclude themselves from public areas, and notify their supervisor and provider that they are symptomatic and that they may be infected with influenza.

VI. Management in the event of a pandemic influenza within the facility

A. General guidelines

1. Once medical staff confirm a case of ILI, the UHC Medical Director or designee shall immediately notify the facility Warden, DOC Medical Director, and DC Health.
2. Standard, airborne, and droplet precautions as described above shall be instituted immediately and the patient shall be isolated.

3. Full infection control barriers to include standard, contact, and droplet precautions (plus eye protection if sprays/splashes of secretions are anticipated) are MANDATORY and shall remain in place for seven days after the resolution of the fever.
4. Appropriate signage shall be placed on the patient's cell where it is visible by all staff.
5. Staff members having direct contact with any individual shall use a NIOSH –certified N-95 particulate respirator after being fit-tested. If an N-95 respirator is not immediately available then a tightly-fitting surgical or procedure mask should be used.
6. In the event that there is one case of pandemic influenza within the:
   a. Community:
      i. Education regarding ILI and infection prevention and control should be reinforced and immediately report ILI.
      ii. Health care workers, officers, and patients should be encouraged to adhere to good hygiene habits such as hand hygiene, respiratory/cough etiquette, and avoid touching eyes, nose, and mouth.
      iii. Increase environmental cleaning and disinfecting frequently touched surfaces to at least include doors, doorknobs, beds, rails, sinks, and televisions.
      iv. Begin to conduct surveillance of ILI within the facility at intake and sick call.
   b. Facility:
      i. Immediately isolate (or cohort) patients with ILI in the patient's cell or housing unit.
      ii. Patients will be screened at sick call to identify patients with ILI or as medically indicated.
      iii. Upon direction from the Facility Warden, all visitations shall be ceased and the facility shall go under lock down status. No movement inside or outside of the facility shall take place until restrictions are lifted by the Warden. Visitation restrictions will last the duration of the pandemic wave, which may be up to eight weeks.
7. The Deputy Warden of Operations shall inform the patient population of the pandemic plan and actions being taken to reduce the amount of patients and possible exposure to the virus.
8. Medical staff are expected to come to work and will be told to stay home if they are sick with "ILI." It can be expected that large percentage of the UHC and DOC staff will not arrive to work. Staff will maintain contact with their supervisors.
9. It will be the responsibility of the Health Services Administrator to assess and plan accordingly. Essential staff (all direct care providers (including discharge planners), managers, directors, procurement clerk, infection prevention specialist, pharmacy staff, driver, and one administrative assistant) will be expected to report to work as scheduled and staff my be required to work in another department as needed to provide essential services.
10. Only essential services will take place during lock down to include:
    a. Providing medical care and medication administration.
    b. Removal and disposal of garbage.
    c. Food preparation and distribution.
    d. Laundry operations.
    e. Patients will be allowed to shower 3 times per week.

B. Organizational roles and responsibilities:

1. Health Service Administrator
   a. Notifies DOC.
   b. Recommends activation of the pandemic flu plan in the event of a confirmed case of pandemic flu.
   c. Helps to determine isolation, quarantine, and social distancing measures.
   d. Requests Medical Director to request vaccines, antivirals and medical supplies.

e. Activates immunization or medication clinics and other UHC activities.
f. Ensures availability of and training for communications equipments

2. Medical Director
   a. Advises the Health Service Administrator regarding policy decisions.
   b. Coordinates and ensures the assignment of health care staff roles.
3. Infection Prevention Specialist
   a. Available as liaison as assigned.
   b. Provides logistical support to departmental activities.
   c. Maintains communication with hospitals and first responders.
   d. Provides backup to Director of Nursing.
4. Director of Nursing
   a. Coordinates training and assigns duties for staff and reassigned staff.
   b. Help to coordinate the implementation of immunization or antiviral medication distribution.

C. Patient housing:

1. Housing determinations will largely depend on the location of patients infected with the pandemic flu virus. Correctional officers or other staff will be trained and may need to assist medical with routine tasks (i.e. pushing hydration, monitoring status, alerting you to breathing difficulties or s/s of pneumonia.
2. All patients who were housed in the same unit as the infected individual but are asymptomatic shall remain in that unit for 10 days after the infected individual was moved to the housing unit, or any other designated area. This measure shall be instituted to limit the possibility of contamination into other units.
3. In the event that the number of confirmed pandemic flu cases exceeds the number of beds available in isolated/quarantined housing unit(s), the North 3 (CDF) and C4B (CTF) Units shall be authorized by the Warden to serve as housing for infected individuals.
4. Infected patients shall be given surgical masks which will be exchanged every 24 hours or sooner if needed. They will also be given 10% bleach solution to be used to clean all surfaces of their cells.

D. Patients requiring hospitalization:

1. It is the assumption that hospitals will be ill-equipped to respond to a pandemic. Within a short time of the onset of the disease in the population, hospitals will be overwhelmed by the influx of patients and high absenteeism of staff. This leads the DOC facilities to prepare to care for the ill patients with the flu.
2. Any patient sick with the flu virus and develops severe respiratory syndromes with low oxygen levels and are in need of respirator, will be transported to an acute care hospital for treatment.

E. Keep-On-Person (KOP) medications shall be modified – in a pandemic, the demands upon the medical staff members' time will be great. As soon as practical, the time consumed by medication rounds must be reduced as much as possible. KOP medications will be distributed for 10 days at a time (increasing from 7 days) and sick call medication packet quantity will be doubled. In addition, as many patients as possible shall be placed on KOP, carried out as set forth in CF402 (Medication Services). Self medication will reduce demand upon staff time and aid in reducing possibility of cross contamination. Self medication will be utilized to the greatest extent possible, with each medication considered case by case.

F. Handling of food – standard precautions are recommended for handling dishes and eating utensils used by a patient with known or possible pandemic influenza:

1. Wash reusable dishes and utensils in a dishwater with recommended water temperature.
2. Disposable dishes and utensils (e.g., used in an alternative care site set-up for large numbers of patients) should be discarded with other general waste.
3. Wear gloves when handling patient trays, dishes, and utensils.

G. Environmental cleaning and disinfection:

1. Cleaning and disinfection of environmental surfaces are important components of routine infection control in healthcare facilities. Environmental cleaning and disinfection for pandemic influenza follow the same general principles used in other healthcare settings.
2. Cleaning and disinfection of patient-occupied cells: wear gloves in accordance with facility policies for environmental cleaning and wear a surgical or procedure mask in accordance with droplet precautions. Gowns are not necessary for routine cleaning of an influenza patient's cell.
3. Keep areas around the patient free of unnecessary supplies and equipment to facilitate daily cleaning.
4. Use any EPA-registered detergent-disinfectant. Follow manufacturer's recommendations for use-dilution (i.e., concentration), contact time, and care in handling. A 10:1 water to bleach mixture may be substituted.
5. Follow facility procedures for regular cleaning of patient occupied cells. Give special attention to frequently touched surfaces (e.g., bedrails, tables, call buttons/bells, telephones, lavatory surfaces including safety/pull-up bars, doorknobs, commodes) in addition to floors and other horizontal surfaces.
6. Clean and disinfect spills of blood and body fluids in accordance with current recommendations for isolation precautions.

H. Cleaning and disinfection after patient discharge or transfer – follow standard facility procedures for post-discharge cleaning of an isolation room or cell of an infected patient.

1. Clean and disinfect all surfaces that were in contact with the patient or might have become contaminated during patient care. No special treatment is necessary for window curtains, ceilings, and walls unless there is evidence of visible soiling.
2. Do not spray (i.e., fog) occupied or unoccupied cells with disinfectant. This is a potentially dangerous practice that has no proven disease control benefit.

I. Handling of laundry – standard precautions are recommended for linen and laundry that might be contaminated with respiratory secretions from patients with pandemic influenza:

1. Place soiled linen directly into a laundry bag in the patient's cell. Contain linen in a manner that prevents the linen bag from opening or bursting during transport and while in the soiled linen holding area.
2. Wear gloves and gown when directly handling soiled linen and laundry (e.g., bedding, towels, personal clothing) as per standard precautions. Do not shake or otherwise handle soiled linen and laundry in a manner that might create an opportunity for disease transmission or contamination of the environment.
3. Wear gloves for transporting bagged linen and laundry.
4. Perform hand hygiene after removing gloves that have been in contact with soiled linen and laundry.
5. Wash and dry linen according to routine standards and procedures.

J. Intake – when pandemic conditions are declared, a member of the medical staff shall be present in the intake area at any time patients are processed into the facility. At intake, newly

committed patients shall be directed into either quarantine or isolation as their history and/or symptoms dictate.

K. Reporting – in the event of a rapidly spreading airborne viral infection, such as influenza, accurate reporting of cases is essential to the mounting of appropriate public health responses. All lab results will be reviewed by the Medical Director, or designee. Any confirmed cases will be reported to DC Health as required by law. The UHC Medical Director, or designee, will be notified of any suspected cases and communicate with the Warden and the DOC Medical Director as to cases needing quarantine or isolation.

L. Release and discharge – in the event that an patient's sentence has been completed, the following shall serve as guidelines for releasing an patient back to the community:

1. If an patient is being quarantined and not positive for influenza or display signs/symptoms of flu, the patient will be released and sent home.
2. If an patient is positive for influenza or display signs/symptoms of flu and has a home, medical shall notify the Health Department.
3. If an patient is positive for influenza or display signs/symptoms of flu and does not have a home to go to, the Discharge Planning Coordinator and DOC Medical Director shall contact DC Health or his/her designee to arrange for appropriate medical housing in the community as per the District of Columbia's pandemic flu plan.

M. Care of the deceased:

1. In the event of an patient or staff death within the facility and the remains can not be immediately removed for any reason, the remains shall be treated as if infectious. Full personal protective equipment (mask, face shield, gown and gloves) shall be worn at all times when handling remains.
2. The body shall be fully sealed in an impermeable body bag prior to any transfer. The exterior of the body bag should remain clean and dry.
3. The Department of Corrections shall provide a temporary refrigerated morgue truck vehicle number 47 to hold up to forty bodies. Overflow refrigeration will be provided by DOC in their walk-in freezer box 23. All deceased bodies will be held in temporary refrigeration until arrangements are made for pick up by the D.C. morgue.

N. Procurement and positioning of equipment and supplies:

1. The medical department shall compile a list of supplies and equipment, both durable and consumable, required to sustain operations for a minimum of four weeks. This shall include a room of supplies to enable care for patients with severe illness from influenza and, at a minimum, shall include:
   a. A store of disposable specification N-95 respirators in assorted styles and sizes (9,000 minimum)
   b. A saccharine fit test kit with quantity of consumable components sufficient to perform 1000 test
   c. 2400 Disposable exposure control gowns in assorted sizes from medium to extra large
   d. 36 eighteen gauge intravenous catheters, intravenous administration sets, Tegoderm bandages and other consumable supplies sufficient for the placement of 400 IV's
   e. IV fluids (5% Dextrose in ½ Normal Saline (192 liters) and ½ Normal Saline (48 liters) to be ordered immediately upon pandemic announcement
   f. 5000 electronic thermometer probe covers
   g. 4000 disposable tab type oral thermometer (e.g. NEXTEMP or equivalent) for patient self screening

h. A minimum of 100 Rapid Test Kits for Influenza A/B
i. Viral culture transport media sufficient for 400 tests
j. A minimum of 50 courses of treatment of Tamiflu
k. 2 box (50 per case) of disposable eye shields
l. 16 liters of alcohol based hand sanitizer (available in two liter pump style containers) to provider refill capability
m. 40 eight ounce containers of alcohol based hand sanitizer to be positioned in all work spaces
n. 40 two ounce containers of alcohol based hand sanitizer for medical staff to carry on person
o. 24 containers germicidal wipes (e.g. SANI-CLOTH or equivalent)
p. 50 large size sharps disposal containers
q. 200 large size bio-hazard waste disposal bags
r. 100 body bags (impermeable)
s. 400 pairs of safety glasses
t. 4 cases (4000) Disposable surgical masks
u. 4 cases (200) nasal oxygen administration cannulas

2. These numbers more than likely will change, depending upon DC Health.
3. The Medical Department shall also formulate a plan to ensure an uninterrupted supply of medications for patients, and shall execute a plan to provide influenza immunizations to all patients, and staff members (if needed). Patients taking prescription medication shall be placed on self-medication contracts to the greatest extent feasible, consistent with current medical treatment guidelines.
4. When the start of pandemic is announced, the Medical Department shall assess current supply of oxygen concentration units, filled portable oxygen cylinders, electronic thermometers, the I.V. fluids described above and pulse oximeters and facilitate ordering and purchasing as needed.

VII. Training:

A. All staff members shall receive annual training in influenza. Additionally, all staff shall receive training in the selection and use of personal protective equipment, cough etiquette and hand hygiene.

B. Medical staff members shall receive additional training in infection control precautions, and shall demonstrate knowledge and competence in medical treatment guidelines for the diagnosis and treatment of influenza.

C. Patients shall be provided with educational materials regarding cough etiquette and hand hygiene, and influenza.

VIII. Sources – the sources and contacts for the supplies and equipment required by the medical department are as follows:

A. For all pharmaceuticals:

DOC pharmacy services
Beth Mynett (beth.mynett@dc.gov)
(202) 594-6298
(202) 698-3281 (fax)

B. Diagnostic laboratory equipment and supplies:

Laboratory Corporation of America (LABCORP)
Acct # 08550105
(703)399-5180

C. All other medical equipment and supplies:

Physician Sales and Service (PSS)
Erika Miller
Acc t# 331938688
(800) 321-4313 (customer service)
(703) 593-0775 (cell phone)

Moore Medical
Mike Beardsly
Acct # 21231862
(800) 234-1464 ext 5693
(860) 463-4684

REVIEW - this plan shall be reviewed annually and updated as necessary.

REFERENCES:

I. www.cdc.gov

II. www.pandemicflu.gov

III. National Commission on Correctional Health Care (2018). Standard for Health Care Services in Jails, Infection Control Program, J-B-02.