

March 07, 2023

Austin Evers
American Oversight
1030 15th Street, NW
Suite B255
Washington, DC 20005

RE: ICE FOIA Case Number 2020-ICFO-34943

Dear Mr. Evers:

This letter is the final response to your Freedom of Information Act (FOIA) request to U.S. Immigration and Customs Enforcement (ICE), dated April 21, 2020. You have requested memoranda, protocols, or guidance regarding the practice of segregating groups of detainees or inmates suspected of having symptoms of or exposure to the novel coronavirus within processing or detention centers, also referred to as “cohorting” or “cohort quarantine”. All Immigration and Customs Enforcement (ICE) directives, orders, decision memoranda, protocols, or guidance regarding the practice of segregating groups of detainees or inmates suspected of having symptoms of or exposure to the novel coronavirus within processing or detention centers, also referred to as “cohorting” or “cohort quarantine.” All responsive records from March 1, 2020, through the date of the search. ICE has considered your request under the FOIA, 5 U.S.C. § 552.

A search of the ICE Office of Policy (OPP) for records responsive to your request produced no records. However, a search of the ICE Office of Enforcement & Removal Operations (ERO) produced 267 pages that are responsive to your request. Portions of the 267 pages will be withheld pursuant to Exemptions of the FOIA as described below.

ICE has applied FOIA Exemptions to protect from disclosure

ICE has applied FOIA Exemptions 6 and 7(C) to protect from disclosure the names, e-mail addresses, and phone numbers of DHS employees contained within the documents.

FOIA Exemption 6 exempts from disclosure personnel or medical files and similar files the release of which would cause a clearly unwarranted invasion of personal privacy. This requires a

www.ice.gov

U.S. Department of Homeland Security
500 12th St., SW
Washington, D.C. 20536



U.S. Immigration and Customs Enforcement

balancing of the public's right to disclosure against the individual's right to privacy. The privacy interests of the individuals in the records you have requested outweigh any minimal public interest in disclosure of the information. Any private interest you may have in that information does not factor into the aforementioned balancing test.

FOIA Exemption 7(C) protects records or information compiled for law enforcement purposes that could reasonably be expected to constitute an unwarranted invasion of personal privacy.

This exemption takes particular note of the strong interests of individuals, whether they are suspects, witnesses, or investigators, in not being unwarrantably associated with alleged criminal activity. That interest extends to persons who are not only the subjects of the investigation, but those who may have their privacy invaded by having their identities and information about them revealed in connection with an investigation. Based upon the traditional recognition of strong privacy interest in law enforcement records, categorical withholding of information that identifies third parties in law enforcement records is ordinarily appropriate. As such, I have determined that the privacy interest in the identities of individuals in the records you have requested clearly outweigh any minimal public interest in disclosure of the information. Please note that any private interest you may have in that information does not factor into this determination.

You have a right to appeal the above withholding determination. Should you wish to do so, you must send your appeal and a copy of this letter, within 90 days of the date of this letter following the procedures outlined in the DHS FOIA regulations at 6 C.F.R. Part 5 § 5.8. You may submit your appeal electronically at GILDFOIAAppeals@ice.dhs.gov or via regular mail to:

U.S. Immigration and Customs Enforcement
Office of the Principal Legal Advisor
U.S. Department of Homeland Security
500 12th Street, S.W., Mail Stop 5900
Washington, D.C. 20536-5900

Your envelope and letter should be marked "FOIA Appeal." Copies of the FOIA and DHS regulations are available at www.dhs.gov/foia.

Provisions of FOIA allow DHS to charge for processing fees, up to \$25, unless you seek a waiver of fees. In this instance, because the cost is below the \$25 minimum, there is no charge.

If you need any further assistance or would like to discuss any aspect of your request, please contact the FOIA office and refer to FOIA case number **2020-ICFO-34943**. You may send an e-mail to ice-foia@ice.dhs.gov, call toll free (866) 633-1182, or you may contact our FOIA Public Liaison, Marcus Francis, in the same manner. Additionally, you have a right to right to seek dispute resolution services from the Office of Government Information Services (OGIS) which mediates disputes between FOIA requesters and Federal agencies as a non-exclusive alternative to litigation. If you are requesting access to your own records (which is considered a Privacy Act request), you should know that OGIS does not have the authority to handle requests made under the Privacy Act of 1974. You may contact OGIS as follows: Office of Government Information Services, National Archives and Records Administration, 8601 Adelphi Road-OGIS, College Park, Maryland 20740-6001, e-mail at ogis@nara.gov; telephone at 202-741-5770; toll free at 1-877-684-6448; or facsimile at 202-741-5769.

Sincerely,

Angela M. Flores

(A)Supervisory Paralegal Specialist

Enclosure(s): 267 page(s)



Interim Reference Sheet on 2019-Novel Coronavirus (COVID-19): Detainee Care Version 10.0, April 24, 2020

Key changes

Version 10.0

- Updated criteria for discontinuing isolation
- Updated requirements for notifications to local or state health departments prior to release
- Emphasized recommendations to not transfer or transport detainees that are in isolation, are febrile, symptomatic, have pending test results or that were exposed to a person with confirmed or suspected COVID-19 in the past 14 days

Situation Summary

The CDC is closely monitoring an outbreak caused by a novel (new) coronavirus (COVID-19). The situation is evolving and expanding with community transmission occurring in multiple countries including the United States. For the most current information, check the CDC information pages at <https://www.cdc.gov/coronavirus/2019-ncov/index.html> frequently for updates. CDC interim guidance for health care professionals, including clinical criteria, is available at <https://www.cdc.gov/coronavirus/2019-nCoV/clinical-criteria.html>.

ICE Health Service Corps Recommendations

- *Note: recommendations will be updated if and as necessary to address the evolving public health situation. See also 2019 Novel Coronavirus Resource Page including [Reducing the Risk of COVID-19 Transmission](#) and [Dental Care - Prioritizing Care and Staying Safe](#)*

1. During intake medical screening:

- a. Ask all detainees if they have had close contact¹ with a person with laboratory-confirmed COVID-19 in the past 14 days
 - i. If the detainee responded yes to 1a), assess for fever and symptoms of respiratory illness.
 - If the detainee has a fever and/or symptoms of respiratory illness, refer to ISOLATION below.
 - If the detainee does not have fever or respiratory illness, refer to EXPOSURE-BASED COHORTING, below.

- b. If the detainee has fever and/or symptoms or respiratory illness and if they have not had close contact¹ with a person with laboratory-confirmed COVID-19 or their respiratory secretions in the past 14 days → refer to a medical provider (see ENCOUNTER below).
 - c. Educate all detainees to include the importance of hand washing and hand hygiene, covering coughs with the elbow instead of with hands, and requesting sick call if they feel ill.
 - i. Illness Prevention and Patient Education resources in multiple languages are available on the 2019 Novel Coronavirus Resource Page.
- 2. ENCOUNTER. During sick call, health assessment, or other clinical encounter in which a detainee presents with or complains of fever and/or respiratory illness, or is observed with signs of fever and/or respiratory illness:**
- a. **If the detainee had close contact¹ with a person with laboratory-confirmed COVID-19 or their respiratory secretions in the past 14 days**
 - i. → refer to ISOLATION below.
 - b. If the detainee has not had close contact¹ with a person with laboratory-confirmed COVID-19 or their respiratory secretions in the past 14 days, then
 - i. → Providers should use their judgment to determine if a patient has signs and symptoms compatible with COVID-19 and whether the patient should be isolated and tested. Decisions on which patients receive testing should be based on the epidemiology of COVID-19, as well as the clinical course of illness. Providers are strongly encouraged to test for other causes of respiratory illness, including infections such as influenza.
 - ii. See Reducing the Risk of COVID-19 Transmission and Dental Care - Prioritizing Care and Staying Safe
 - iii. See SPECIMEN COLLECTION AND LABORATORY TESTING below.
 - c. Educate detainees to include the importance of hand washing and hand hygiene, covering coughs with the elbow instead of with hands, and requesting sick call if they feel ill.
 - i. Illness Prevention and Patient Education resources in multiple languages are available on the 2019 Novel Coronavirus Resource Page.
- 3. ISOLATION and management of detainees with fever and/or symptoms of respiratory illness and who are suspected or confirmed to have COVID-19:**
- a. See Coronavirus Disease 2019 (COVID-19) | Housing Symptomatic Detainees
 - b. See Reducing the Risk of COVID-19 Transmission and Dental Care - Prioritizing Care and Staying Safe.
 - c. Place a tight-fitting surgical mask on the detainee.
 - d. Promptly consult with a medical provider, preferably the Clinical Director or designee.

- e. Place the detainee in a private medical housing room, ideally in an airborne infection isolation room if available. If no single occupancy medical housing unit room is available, placement in other areas of the facility may be utilized to house the ill detainee separately from the general detention population.
- f. Call the local and/or state health department for notification and guidance.
- g. Laboratory testing for COVID-19 is now available through commercial laboratories including LabCorp and through local and/or state health departments.
 - i. See SPECIMEN COLLECTION AND LABORTORY TESTING below.
 - ii. Report positive test results for COVID-19 promptly to the local or state health department
- h. If the detainee has underlying illness or is acutely ill, or symptoms do not resolve, consult with the Regional Clinical Director, and/or Infectious Disease program.
- i. If the detainee is referred to a local hospital, call the hospital in advance to notify of the recent relevant travel history and respiratory symptoms and to coordinate how manage the detainee safely.
- j. Promptly notify the facility's staff responsible for infection prevention and control (e.g., in IHSC facilities, notify the Infection Prevention Officer, or the Facility Healthcare Program Manager (if the facility does not have an Infection Prevention Officer position); if the Infection Prevention Officer or Facility Healthcare Program Manager is not available, IHSC staff should notify the Infection Prevention Group at #IHSC_PHSP_IPO@ice.dhs.gov.
- k. Facilities without IHSC medical staffing should notify their assigned Field Medical Coordinator.
- l. IHSC Infection Prevention Officers, Facility Healthcare Program Managers, Field Medical Coordinators, or designees should notify the Regional Infection Prevention Supervisory Nurse immediately.
- m. Detainees isolated for respiratory illness and who have epidemiologic risk for COVID-19 exposure should wear a tight-fitting surgical mask when outside of the isolation room.
- n. See REPORTING below.
- o. The contagious period for COVID-19 is still uncertain.
 - i. A person with COVID-19 is thought to be contagious starting 48 hours before symptom onset
 - ii. If the detainee tests negative for COVID-19 and fever and/or symptoms persist, consult with the Regional Clinical Director and/or Infectious Disease Program
- p. Educate detainees to include the importance of hand washing and hand hygiene, covering coughs with the elbow instead of with hands, and requesting sick call if they feel ill.
 - i. [Illness Prevention and Patient Education](#) resources in multiple languages are available on the [2019 Novel Coronavirus Resource Page](#).

4. CRITERIA FOR DISCONTINUING ISOLATION

- a. The decision to discontinue Transmission-Based Precautions should be made using a test-based strategy or a non-test-based strategy (i.e., time-since-illness-onset and time-since-recovery strategy).
- b. Detainees that meet criteria for discontinuation of transmission-based precautions can be housed in general population.
 - i. ***Febrile and/or symptomatic patient, test-based strategy (preferred if the patient is immunocompromised)***
 - *Resolution* of fever without the use of fever-reducing medications **AND**
 - *Improvement* in respiratory symptoms (e.g., cough, shortness of breath), **AND**
 - Negative results of a Food and Drug Administration(FDA) Emergency Use Authorized (EUA) COVID-19 molecular assay for detection of SARS-CoV-2 from at least two consecutive nasopharyngeal swab specimens collected ≥ 24 hours apart (total of two negative specimens). See Interim Guidelines for Collecting, Handling, and Testing Clinical Specimens for 2019 Novel Coronavirus, **AND**
 - A minimum of 14 days have passed since the first specimen collection resulting in a positive confirmatory test with an FDA EUA COVID-19 molecular assay for detection of SARS-CoV-2.
 - ii. ***Febrile and/or symptomatic patient, non-test-based strategy***
 - At least 3 days (72 hours) have passed since recovery defined as resolution of fever without the use of fever-reducing medications **and** improvement in respiratory symptoms (e.g., cough, shortness of breath); **AND**,
 - At least 7 days have passed since symptoms first appeared, **AND**
 - A minimum of 14 days have passed since the first specimen collection resulting in a positive confirmatory test for an FDA EUA COVID-19 molecular assay for detection of SARS-CoV-2.
 - iii. ***Afebrile and asymptomatic patient, non-test-based strategy***
 - A minimum of 14 days have passed since the first specimen collection resulting in a positive confirmatory test for an FDA EUA COVID-19 molecular assay for detection of SARS-CoV-2.

5. SPECIMEN COLLECTION AND LABORATORY TESTING for COVID-19

- a. Laboratory testing for COVID-19 is available through commercial laboratories including LabCorp and through local and/or state health departments.
- b. See **Specimen Collection instructions on the 2019 Novel Coronavirus Resource Page**.
 - i. LabCorp ordering codes are 2019 Novel Coronavirus (COVID-19), NAA; TEST: 139900.

6. ***INFECTIOUS DISEASE PUBLIC HEALTH ACTIONS***

- a. Educate detainees to include the importance of hand washing and hand hygiene, covering coughs with the elbow instead of with hands, and requesting sick call if they feel ill.
 - i. Illness Prevention and Patient Education resources in multiple languages are available on SharePoint.
- b. See also 05-06-G-02 Infectious Disease Public Health Actions Guide: Isolation and Management of Detainees Exposed to Infectious Organisms.

7. **EXPOSURE-BASED COHORTING**

- a. **Known exposure to a person with confirmed COVID-19**
 - i. Implement cohorting with restricted movement for detainees housed with the ill detainee or who have been in close contact¹ with the ill person for the duration of the most recent incubation period (14 days after most recent exposure to an ill person).
 - ii. Refer exposed detainees with new onset fever and/or respiratory illness to a medical provider for evaluation.
 - iii. Discontinue cohorting when 14-day incubation period completes with no new cases.
- b. **Exposure to a person with fever or symptoms being evaluated or under investigation for COVID-19 but not confirmed to have COVID-19**
 - i. Implement cohorting with restricted movement for detainees housed with the ill detainee or who have been in close contact¹ with the ill person for the duration of the most recent incubation period.
 - ii. Refer exposed detainees with new onset fever and/or respiratory illness to a medical provider for evaluation.
 - iii. If the index patient is subsequently confirmed to have COVID-19, see ***Known exposure to a person with confirmed COVID-19*** above.
 - iv. Discontinue cohorting if the index patient receives an alternate diagnosis that excludes COVID-19.
 - v. Any of the cohorted detainees with exposure risk should complete their initial 14-day monitoring period (i.e., for asymptomatic monitoring).
- c. **Visit dorms daily and remind detainees that medical services are available.**
 - i. Educate patients to report if they feel ill or feverish.
 - ii. Remind custody staff to report any patients they are concerned about, with special attention to those who might have fever, cough, or shortness of breath.
 - iii. Promote access to care through sick call and urgent care services.
 - iv. *Provide frequent patient education via town halls and similar dorm visits to reinforce detainee knowledge about how to access care.*

8. ***Recommendations to the Field Office Director or Designee and the Facility Administrator or Warden for routine intake cohorting***
- Consider housing separately from GP all new intakes for 14 days before they enter the facility's general population (SEPARATELY from other individuals who are cohorted due to contact with a COVID-19 case).
 - This could be individual housing or as a routine intake cohort.
 - If housed as a routine intake cohort, consider allowing each individual to be moved to the general population after 14 days if no fever or symptoms.
 - If any person in the routine intake cohort does develop fever or symptoms, the cohort status would be changed to an *exposure-based cohort*
 - Routine intake cohorts do not require tracking or reporting
9. ***Recommendations to the Field Office Director or Designee Regarding Detainee Release and Special Circumstance Movement***
- Recommend all detainees being released be given the fact sheets *Steps to help prevent the spread of COVID-19 if you are sick* and *Stop the spread of germs*.
 - Recommend the following considerations if decisions are made to release in the U.S. detainees with confirmed or suspected COVID-19 and detainees exposed to a person with confirmed or suspected COVID-19:**
 - For all detainees that have tested positive for COVID-19 (including detainees that have completed the isolation period) and for afebrile and asymptomatic detainees that must be released before the recommended cohorting period is complete, discuss release of the individual with state or local health department with as much advance notice as possible, preferably at least 24 hours advance notice**
 - Provide the health department with the detainee's name, intended address, email address, all available telephone numbers, and planned mode of transportation to their intended destination**
 - Coordinate with the health department to facilitate any needed public health actions; examples of public health actions include but are not limited to delivering health officer orders and making the detainee available for transportation if arranged by the health department.**
 - Facilitate safe transport, continued shelter, and medical care, as part of release planning.
 - Make direct linkages to community resources to ensure proper medical isolation and access to medical care if needed.
 - Coordinate with the detainee for a family member or friend to provide transportation
 - Advise the detainee to avoid public transportation, commercial ride sharing (e.g., Uber, Lyft), and taxis

- iii. Give the detainee the CDC's *What To Do if You Are Sick* fact sheet (see [2019 Novel Coronavirus Resource Page | Illness Prevention Patient Education](#))
- c. Detainees under isolation or cohorting should be permitted to attend other medically necessary appointments with advance coordination with the receiving facility
- d. Detainees under isolation or cohorting should not be restricted from movement to facilitate a medically- or behaviorally-necessary placement
- e. If a detainee under isolation or cohorting must be moved to another facility; the receiving facility must be notified of the isolation or cohorting end dates
 - i. **Recommend to Field Office Director or designee that detainees that are in isolation, are febrile, symptomatic, have pending test results or that were exposed to a person with confirmed or suspected COVID-19 in the past 14 days NOT BE TRANSFERRED OR TRANSPORTED UNLESS MEDICALLY NECESSARY.**
- ii. See [IHSC Interim COVID-19 Risk Assessment](#) on the [2019 Novel Coronavirus Resource Page](#).
- f. **If a detainee is inadvertently removed that is febrile and/or symptomatic, that tests positive for COVID-19, that has a pending test result for COVID-19, or that was exposed to a person with confirmed or suspected COVID-19 in the past 14 days, recommend that the Field Office Director or designee notify the respective consulate so notifications and public health actions can occur.**

10. REPORTING

- a. Document any ill detainee who is suspected of having COVID-19 on the [Lower Respiratory Illness Tracking Tool](#).
- b. Document exposure-based cohorting through routine IHSC cohort reporting protocols using the [Cohort Tracker](#).
- c. Any employee known to have a positive test result for COVID-19 must be promptly reported to the local or state health department in accordance with local or state public health laws and permissible exemptions under the Health Insurance Portability and Accountability Act (HIPAA) requiring notifications to public health departments for conducting investigations and interventions and to avert a serious threat to public health and safety. Reported must include the employee's name, date of birth, address, phone number, and testing location.

¹**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)

If such contact occurs while not wearing recommended personal protective equipment or PPE (e.g., gowns, gloves, NIOSH-certified disposable N95 respirator, eye protection), criteria for PUI consideration are met.

Resources and references

- [2019 Novel Coronavirus Resource Page](#) on SharePoint
- [Reducing the Risk of COVID-19 Transmission](#)
- [Illness Prevention and Patient Education](#) resources in multiple languages are available on SharePoint.
- [COVID-19 Questions and Responses](#) on SharePoint for submitting questions, receiving responses from IHSC subject matter experts, and viewing all questions and responses

IHSC Official Guidance

Guidance number	Guidance name	Type
05-02	Occupational Health Directive	Policy
05-02 G-04	Occupational Health Guide: Workforce Health	Guide
05-02 G-1	Occupational Health Guide: Bloodborne Pathogens and Other Potentially Infectious Materials	Guide
05-02 G-2	Occupational Health Guide: Personal Protective Equipment Program	Guide
05-02-G-03	Occupational Health Guide: Respiratory Protection Program	Guide
05-04	Environmental Health Directive	Policy
05-04 G-01	IHSC Environmental Health Guide	Guide
05-06	Infectious Disease Public Health Actions Directive	Policy
05-06 G-01	Infectious Disease Public Health Actions Guide: Contact and Outbreak Investigation Guide	Guide
05-06 G-02	Infectious Disease Public Health Actions Guide: Isolation and Management of Detainees Exposed to Infectious Organisms	Guide
05-06 G-03	Infectious Disease Public Health Actions Guide: Surveillance and Reporting	Guide

- [Infection Control: Novel Coronavirus 2019 \(COVID-19\) | CDC](#)
- [Interim Guidance: Healthcare Professionals 2019-nCoV | CDC \(including CDC website listing of geographic area\(s\) with widespread or sustained community transmission](#)
- [Resources for Correctional and Detention Facilities | CDC](#)
- [CDC | Coronavirus Disease 2019 \(COVID-19\)](#)
- [2019 Novel Coronavirus \(2019-nCoV\) | TDSHS](#)
- [nCOV2019 | CDPH](#)
- [Novel Coronavirus Outbreak 2020 | Washington State Department of Health](#)
- [ADHS - Highlighted Infectious Diseases for Arizona - Coronavirus Disease 2019 \(COVID-19\)](#)
- [Coronavirus | NYC Health](#)
- [2019 Novel \(New\) Coronavirus | NYDOH](#)
- [2019 Novel Coronavirus \(2019-nCoV\) | Florida Department of Health](#)
- [NJ Department of Health | Communicable Disease Service | COVID-2019 \(Novel Coronavirus\)](#)
- [Pennsylvania Department of Health | Coronavirus](#)
- [2019 Novel Coronavirus \(2019 nCoV\) | Frequently Asked Questions | IDPH](#)

Points of contact for questions

- [IHSC Staff: COVID-19 Questions and Responses](#) on SharePoint for submitting questions, receiving responses from IHSC subject matter experts, and viewing all questions and responses
 - Regional Infection Prevention Supervisory Nurses, PHSP Unit Senior Public Health Analyst, PHSP Unit Chief
- [Facilities without IHSC Medical Staffing](#): Assigned Field Medical Coordinators
- [Public health agencies: IHSC InfectionPrevention@ice.dhs.gov](#)

Appendix A: Intake Screening Questions

Updated April 6, 2020

1. **Have you been in close contact with a person with laboratory-confirmed 2019 novel coronavirus or their respiratory secretions in the past 14 days?**
 - Last date you had contact with that person: mm/dd/yyyy
2. If yes to #1:
 - **Have you had fever and/or respiratory illness with onset in the past 14 days?**
 - **If yes, what date did you first notice symptoms?: mm/dd/yyyy**
 - **If yes**, isolate and refer to a medical provider, add Medical Hold, notify FHPM, IPO, or designee.
 - See [Reducing the Risk of COVID-19 Transmission](#)
 - **If no, implement EXPOSURE-BASED COHORTING;** house in single room (preferred) if available, implement daily checks for 14 days after initial DHS apprehension, add Medical Hold, notify FHPM, IPO, or designee.
3. If no fever, respiratory illness, or close contact with a person with laboratory-confirmed 2019 novel coronavirus or their respiratory secretions in the past 14 days.
 - Routine intake



Interim Reference Sheet on 2019-Novel Coronavirus (COVID-19)

ICE Health Service Corps (IHSC)

Version 5.0, February 28, 2020

What's new in this version

- Updates have been made for screening to identify detainees with revised CDC criteria for epidemiologic risk of COVID-19 exposure and to specify the start of the 14-day monitoring period from the date of initial DHS apprehension. Epidemiologic travel risk now includes travel from or through geographic areas with widespread or sustained community transmission
- Appendix A screening questions were updated to include steps to identify detainees with epidemiologic risk of COVID-19 exposure per revised CDC criteria and direct them to monitoring, and to specify to start the 14-day monitoring period from the date of initial DHS apprehension.
- Appendix B is updated
- Appendix C is updated
- Appendix D and Appendix E were removed; instead a SharePoint link to the document [IHSC Interim COVID-19 exposure risk assessment 2020028.pdf](#) is available

Situation Summary

The CDC is closely monitoring an outbreak caused by a novel (new) coronavirus (COVID-19) first identified in Wuhan City, Hubei Province, China. The situation is evolving and expanding. For the most current information, check the CDC information pages at <https://www.cdc.gov/coronavirus/2019-ncov/index.html> frequently for updates.

While most of the people identified with COVID-19 have association with mainland China, there have been people identified with COVID-19 throughout the world, including the United States with community transmission occurring in multiple countries.

CDC interim guidance for health care professionals, including clinical criteria, is available at <https://www.cdc.gov/coronavirus/2019-nCoV/clinical-criteria.html>

ICE Health Service Corps Recommendations

Note: recommendations will be updated if and as necessary to address the evolving public health situation.

1. ***During intake medical screening:***

- a. **Ask all detainees if they have had close contact¹ with a person with laboratory-confirmed COVID-19 in the past 14 days**
- b. **Ask all detainees what countries they have traveled from or through in the past two weeks**
 - i. Check whether these countries include geographic area(s) with widespread or sustained community transmission*
 - ii. ***Please see CDC website listing of geographic area(s) with widespread or sustained community transmission at <https://www.cdc.gov/coronavirus/2019-ncov/hcp/clinical-criteria.html>**
 - iii. **If the detainee responded yes to 1a and/or the detainee traveled from or through geographic area(s) with widespread or sustained community transmission* in the past 14 days (1b), assess for fever and symptoms of respiratory illness.**
 - a. If the detainee has a fever and/or symptoms of respiratory illness, refer to #4 below
 - b. If the detainee does not have fever or respiratory illness, refer to #2 below
 - c. For IHSC-staffed medical clinics, add a Global Alert / Medical Alert in the electronic health record that states, *“Epidemiologic risk of possible COVID-19 exposure. The last reported date of possible exposure was mm/dd/yyyy.”*
Click [here](#) for the eCW guide for adding a Global Alert.

2. **MONITORING of detainees with exposure risk who do not present with fever or symptoms:**

- a. See also [IHSC Interim COVID-19 exposure risk assessment 2020028.pdf](#).
- b. For detainees with travel history from or through geographic area(s) with widespread or sustained community transmission* in the past 14 days and/or detainees who have had close contact¹ with a person with laboratory-confirmed COVID-19 in the past 14 days who do not present with fever or symptoms of respiratory illness → monitor for 14 days after initial DHS apprehension and observe daily for fever and/or symptoms of respiratory illness
 - i. ***Please see CDC website listing of geographic area(s) with widespread or sustained community transmission at <https://www.cdc.gov/coronavirus/2019-ncov/hcp/clinical-criteria.html>**
- c. House detainees under monitoring in a single cell room if available or as a cohort for 14 days after initial DHS apprehension.

- d. Refer also to appendix A, Intake Screening Questions and Appendix B, Intake Screening and Early Management Algorithm
 - e. If detainee is housed in a facility without IHSC medical staffing, medical staff should notify their assigned IHSC Field Medical Coordinator.
 - f. Request a medical alert in following usual protocols stating that “the detainee is under observation through mm/dd/yyyy due to recent travel from or through geographic area(s) with widespread or sustained community transmission” Release the medical alert at the completion of the 14-day monitoring period.
 - g. During the 14-day monitoring period, if an asymptomatic detainee under monitoring must be released in the U.S., notify the local health department and provide information on the detainee including the intended address and telephone number of the detainee’s intended destination.
 - h. Document any asymptomatic detainee under monitoring on the Lower Respiratory Illness Tracking Tool
 - i. For monitoring of asymptomatic detainees, it is not necessary to contact the local health department.
3. ***During sick call, health assessment, or other clinical encounter in which a detainee presents with or complains of fever and/or respiratory illness, or is observed with signs of fever and/or respiratory illness:***
- a. Ask all detainees what countries they have traveled from or through in the past two weeks
 - i. Check whether these countries include geographic area(s) with widespread or sustained community transmission*
 - ii. ***Please see CDC website listing of geographic area(s) with widespread or sustained community transmission at <https://www.cdc.gov/coronavirus/2019-ncov/hcp/clinical-criteria.html>**
 - b. **If the detainee has traveled from or through geographic area(s) with widespread or sustained community transmission*in the past 14 days, or if they have had close contact¹ with a person with laboratory-confirmed COVID-19 or their respiratory secretions in the past 14 days**
 - i. → refer to #4 below
4. ***ISOLATION and management of detainees with fever and/or symptoms of respiratory illness and who have traveled from or through geographic area(s) with widespread or sustained community transmission at in the past 14 days or have had close contact¹ with a person with laboratory-confirmed COVID-19 or their respiratory secretions in the past 14 days:***
- a. See [IHSC Interim COVID-19 exposure risk assessment 2020028.pdf](#).
 - b. Place a tight-fitting surgical mask on the detainee
 - c. Promptly consult with a medical provider, preferably the Clinical Director or designee

- d. Place the detainee in a private medical housing room, ideally in an airborne infection isolation room if available. If no single occupancy medical housing unit room is available, placement in other areas of the facility may be utilized to house the ill detainee separately from the general detention population
- e. **Implement strict hand hygiene and standard, airborne and contact precautions, including use of eye protection**
 - i. **Increase hand hygiene and routine cleaning of surfaces**
 - ii. **Appropriate personal protective equipment includes gloves, gowns, N95 respirators, and goggles or face shields**
- f. Call the local and/or state health department for notification and to request guidance on medical evaluation and procedures for specimen collection and testing for COVID-19
- g. If the detainee has underlying illness or is acutely ill, or symptoms do not resolve, consult with the Regional Clinical Director, and/or Infectious Disease program.
- h. If the detainee is referred to a local hospital, call the hospital in advance to notify of the recent relevant travel history and respiratory symptoms and to coordinate how manage the detainee safely.
- i. Promptly notify the facility's staff responsible for infection prevention and control (e.g., in IHSC facilities, notify the Infection Prevention Officer, or the Facility Healthcare Program Manager (if the facility does not have an Infection Prevention Officer position); if the Infection Prevention Officer or Facility Healthcare Program Manager is not available, IHSC staff should notify the Infection Prevention Group at #IHSC_PHSP_IPO@ice.dhs.gov
- j. Facilities without IHSC medical staffing should notify their assigned Field Medical Coordinator
- k. IHSC Infection Prevention Officers, Facility Healthcare Program Managers, Field Medical Coordinators, or designees should notify the Regional Infection Prevention Supervisory Nurse immediately.
- l. Detainees isolated for respiratory illness and who have epidemiologic risk for COVID-19 exposure should wear a tight-fitting surgical mask when outside of the room under airborne and contact precautions
- m. Document any ill detainee who is suspected of having COVID-19 on the [Lower Respiratory Illness Tracking Tool](#)
- n. The contagious period for COVID-19 is still undetermined
 - i. If the detainee tests positive for COVID-19 and fever and symptoms have resolved, consult with the Infectious Disease Program and/or local health department regarding appropriate release from isolation
 - ii. If the detainee tests negative for COVID-19, had high or medium exposure risk, and fever and symptoms have resolved, release from isolation after completion of the 14-day monitoring period after initial DHS apprehension
 - a. See also [IHSC Interim COVID-19 exposure risk assessment 2020028.pdf](#)

- iii. If the detainee tests negative for COVID-19 and fever and/or symptoms persist, consult with the Regional Clinical Director and/or Infectious Disease Program

5. *Infectious disease public health actions:*

- a. See also [05-06-G-02 Infectious Disease Public Health Actions Guide: Isolation and Management of Detainees Exposed to Infectious Organisms](#)
- b. Known exposure to a person with confirmed COVID-19**
 - i. Implement cohorting with restricted movement for detainees housed with the ill detainee or who have been in close contact¹ with the ill detainee for the duration of the most recent incubation period (14 days after most recent exposure to an ill detainee)
 - ii. Monitor cohorted detainees daily to observe for fever and symptoms of respiratory illness
 - iii. Refer exposed detainees with new onset fever and/or respiratory illness to a medical provider for evaluation
 - iv. Discontinue cohorting when 14-day incubation period completes with no new cases
- c. Exposure to a person with fever or symptoms being evaluated or under investigation for COVID-19 but not confirmed to have COVID-19**
 - i. Implement cohorting with restricted movement for detainees housed with the ill detainee or who have been in close contact¹ with the ill detainee for the duration of the most recent incubation period
 - ii. Monitor cohorted detainees daily to observe for fever and symptoms of respiratory illness
 - iii. Refer exposed detainees with new onset fever and/or respiratory illness to a medical provider for evaluation
 - iv. If the index patient is subsequently confirmed to have COVID-19, see section 5.b above
 - v. Discontinue cohorting if the index patient receives an alternate diagnosis that excludes COVID-19
 - vi. Any of the cohorted detainees with exposure risk should complete their initial 14-day monitoring period (i.e., for asymptomatic monitoring)
- d. Report cohorting through routine IHSC cohort reporting protocols
- e. Document any asymptomatic and afebrile detainees under monitoring for COVID-19 on the [Lower Respiratory Illness Tracking Tool](#)
- f. Recommend to Field Office Director or designee that detainees cohorted due to high or medium exposure risk or known exposure to an ill person not be transferred or transported.
 - i. See [IHSC Interim COVID-19 exposure risk assessment 2020028.pdf](#)
- g. If a cohorted detainee must be released in the U.S., notify the local health department including the intended address and telephone numbers of the detainee's intended destination.

¹Per CDC COVID-19 guidance (<https://www.cdc.gov/coronavirus/2019-nCoV/clinical-criteria.html>), a close contact is currently defined as:

- a) being within approximately 6 feet (2 meters), or within the room or care area, of a novel coronavirus case for a prolonged period of time while not wearing recommended personal protective equipment or PPE (e.g., gowns, gloves, NIOSH-certified disposable N95 respirator, eye protection); close contact can include caring for, living with, visiting, or sharing a health care waiting area or room with a novel coronavirus case.— *or* —
- b) having direct contact with infectious secretions of a novel coronavirus case (e.g., being coughed on) while not wearing recommended personal protective equipment.

See CDC's Interim Healthcare Infection Prevention and Control Recommendations for Patients Under Investigation for 2019 Novel Coronavirus. 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 novel coronavirus (e.g., coughing likely increases exposure risk as does exposure to a severely ill patient). Special consideration should be given to those exposed in health care settings.

Resources and references

IHSC Official Guidance

Guidance number	Guidance name	Type
05-02	Occupational Health Directive	Policy
05-02 G-04	Occupational Health Guide: Workforce Health	Guide
05-02 G-1	Occupational Health Guide: Bloodborne Pathogens and Other Potentially Infectious Materials	Guide
05-02 G-2	Occupational Health Guide: Personal Protective Equipment Program	Guide
05-02-G-03	Occupational Health Guide: Respiratory Protection Program	Guide
05-04	<u>Environmental Health Directive</u>	Policy
05-04 G-01	<u>IHSC Environmental Health Guide</u>	Guide
05-06	<u>Infectious Disease Public Health Actions Directive</u>	Policy
05-06 G-01	<u>Infectious Disease Public Health Actions Guide: Contact and Outbreak Investigation Guide</u>	Guide
05-06 G-02	<u>Infectious Disease Public Health Actions Guide: Isolation and Management of Detainees Exposed to Infectious Organisms</u>	Guide
05-06 G-03	<u>Infectious Disease Public Health Actions Guide: Surveillance and Reporting</u>	Guide

- **Infection Control: Novel Coronavirus 2019 (COVID-19) | CDC**
- **Interim Guidance: Healthcare Professionals 2019-nCoV | CDC (including CDC website listing of geographic area(s) with widespread or sustained community transmission**
- CDC | Coronavirus Disease 2019 (COVID-19)
- 2019 Novel Coronavirus (2019-nCoV) | TDSHS
- nCOV2019 | CDPH
- Novel Coronavirus Outbreak 2020 | Washington State Department of Health
- Coronavirus | NYC Health
- 2019 Novel (New) Coronavirus | NYDOH
- 2019 Novel Coronavirus (2019-nCoV) | Florida Department of Health
- 2019 Novel Coronavirus (2019 nCoV) | Frequently Asked Questions | IDPH

Points of contact for questions

- IHSC Staff: Regional Infection Prevention Supervisory Nurses, PHSP Unit Senior Public Health Analyst, PHSP Unit Chief
- Facilities without IHSC Medical Staffing: Assigned Field Medical Coordinators
- Public health agencies: IHSC_InfectionPrevention@ice.dhs.gov

Appendix A: Intake Screening Questions

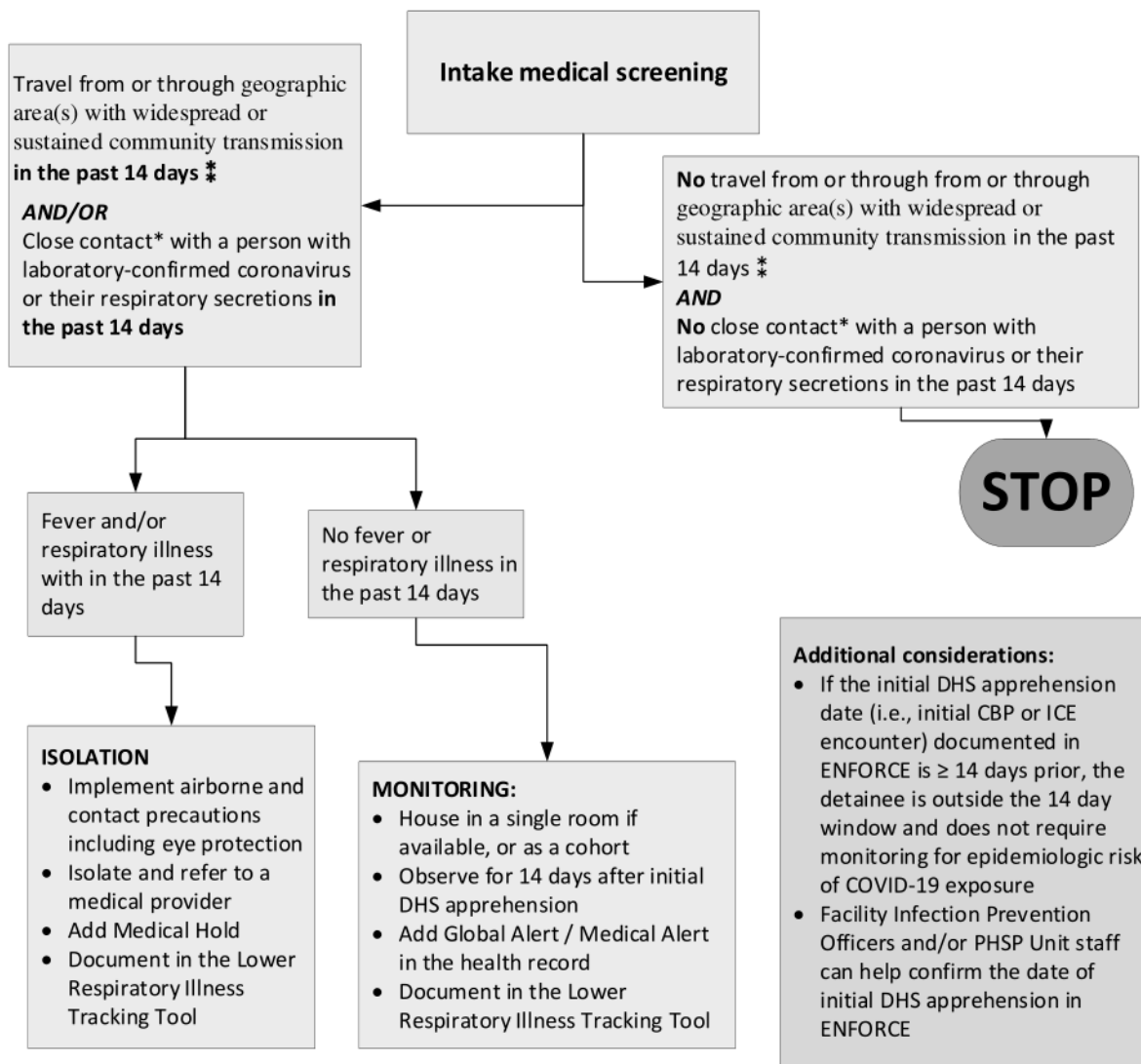
Updated February 28, 2020

1. **Have you been in close contact with a person with laboratory-confirmed 2019 novel coronavirus or their respiratory secretions in the past 14 days?**
 - Last date you had contact with that person: mm/dd/yyyy**OR**
2. **What countries have you traveled from or through in the past two weeks?**
 - Check whether the detainee traveled from or through geographic area(s) with widespread or sustained community transmission* in the past 14 days?
 - ***Please see CDC website listing of geographic area(s) with widespread or sustained community transmission at <https://www.cdc.gov/coronavirus/2019-ncov/hcp/clinical-criteria.html>**
3. If yes to #1 **or** the detainee traveled from or through geographic area(s) with widespread or sustained community transmission* in the past 14 days? (#2):
 - **Have you had fever and/or respiratory illness with onset in the past 14 days?**
 - **If yes, what date did you first notice symptoms?: mm/dd/yyyy**
 - **If yes, implement standard, airborne, and contact precautions including eye protection, isolate and refer to a medical provider, add Medical Hold, notify FHPM, IPO, or designee.**
 - **If no, implement MONITORING;** house in single room (preferred) if available, implement daily checks for 14 days after initial DHS apprehension, add Medical Hold, notify FHPM, IPO, or designee.
4. If no travel from or through geographic area(s) with widespread or sustained community transmission* in the past 14 days **AND** no close contact with a person with laboratory-confirmed 2019 novel coronavirus or their respiratory secretions in the past 14 days?
 - ***Please see CDC website listing of geographic area(s) with widespread or sustained community transmission at <https://www.cdc.gov/coronavirus/2019-ncov/hcp/clinical-criteria.html>**
 - Routine intake
 - If the initial DHS apprehension date (i.e., initial CBP or ICE encounter) documented in ENFORCE is ≥ 14 days prior, the detainee is outside the 14 day window and does not require monitoring for the epidemiologic risk of COVID-19 exposure
 - Facility Infection Prevention Officers and/or PHSP Unit staff can help confirm the date of initial DHS apprehension in ENFORCE

***Please see CDC website listing of geographic area(s) with widespread or sustained community transmission at <https://www.cdc.gov/coronavirus/2019-ncov/hcp/clinical-criteria.html>**

Appendix B

ICE Health Service Corps Interim Recommendations for Screening and Early Management for 2019 Novel Coronavirus (COVID-19) Updated February 28, 2020



* Please see CDC website listing of geographic area(s) with widespread or sustained community transmission at <https://www.cdc.gov/coronavirus/2019-ncov/hcp/clinical-criteria.html>

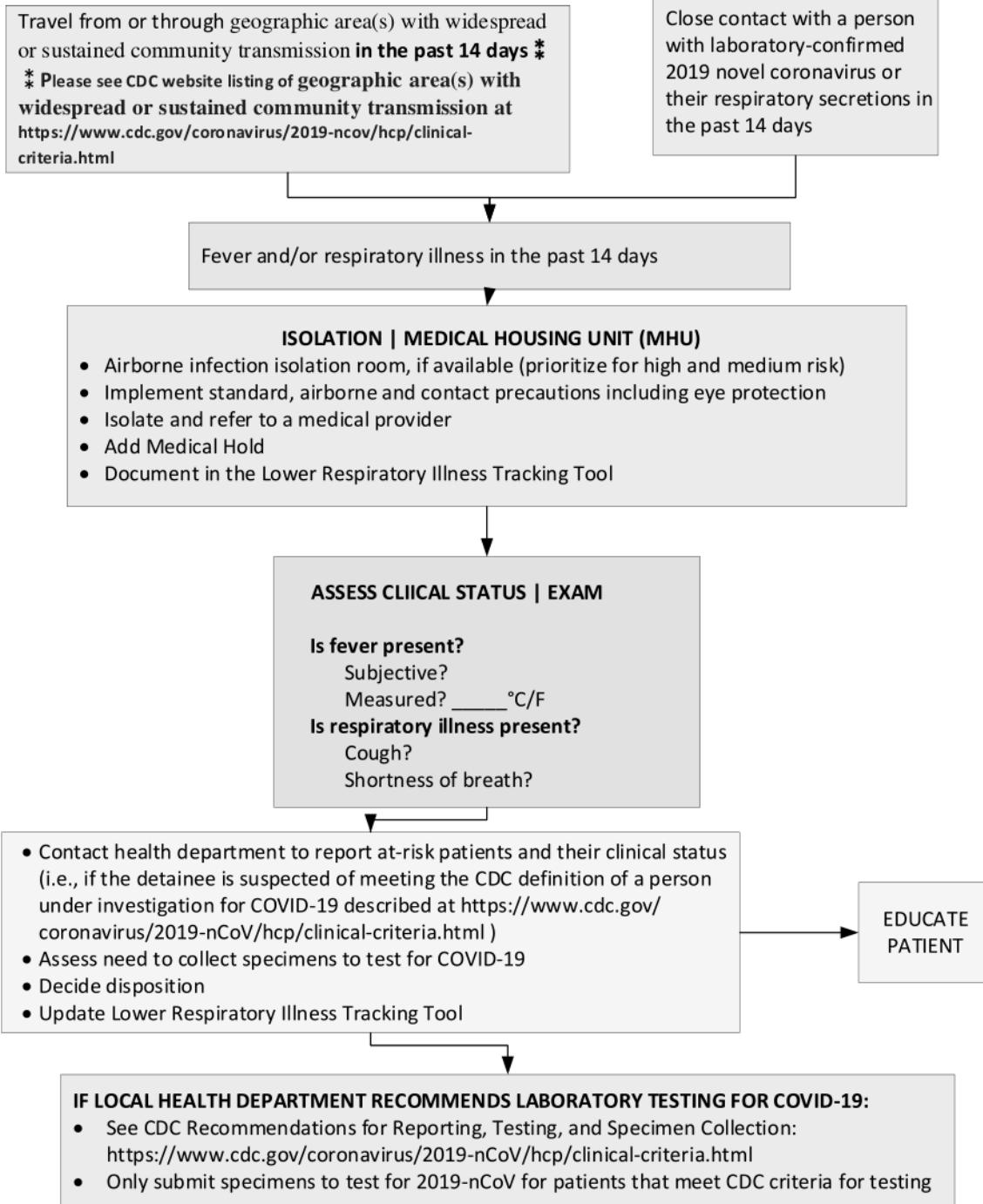
*Close contact is defined as—

a) being within approximately 6 feet (2 meters), or within the room or care area, of a COVID-19 case for a prolonged period of time while not wearing recommended personal protective equipment or PPE (e.g., gowns, gloves, NIOSH-certified disposable N95 respirator, eye protection); close contact can include caring for, living with, visiting, or sharing a health care 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) while not wearing recommended personal protective equipment.

Appendix C

ICE Health Service Corps Interim Recommendations For 2019 Novel Coronavirus (COVID-19) Risk | Isolation, Assessment, and Early Management Updated February 28, 2020





Interim Reference Sheet on 2019-Novel Coronavirus (COVID-19)

ICE Health Service Corps (IHSC)

Version 5.1, March 3, 2020

WHAT'S NEW

Version 5.1

- Information added to emphasize that medical staff should educate detainees to include hygiene, covering coughs, and requesting sick call if ill
- Add a link to [Illness Prevention and Patient Education](#) resources in multiple languages on SharePoint, including signage
- Added a link to [COVID-19 FAQs](#) on SharePoint for submitting questions, receiving responses from IHSC subject matter experts, and viewing all questions and responses
- Added a link to a [2019 Novel Coronavirus Resource Page](#) on SharePoint

Version 5.0

- Updates have been made for screening to identify detainees with revised CDC criteria for epidemiologic risk of COVID-19 exposure and to specify the start of the 14-day monitoring period from the date of initial DHS apprehension.
- Epidemiologic travel risk now includes travel from or through geographic areas with widespread or sustained community transmission
- Appendix A screening questions were updated to include steps to identify detainees with epidemiologic risk of COVID-19 exposure per revised CDC criteria and direct them to monitoring, and to specify to start the 14-day monitoring period from the date of initial DHS apprehension.
- Appendix B is updated
- Appendix C is updated
- Appendix D and Appendix E were removed; instead a SharePoint link to the document [IHSC Interim COVID-19 exposure risk assessment 2020028.pdf](#) is available

Situation Summary

The CDC is closely monitoring an outbreak caused by a novel (new) coronavirus (COVID-19) first identified in Wuhan City, Hubei Province, China. The situation is evolving and expanding. For the most current information, check the CDC information pages at <https://www.cdc.gov/coronavirus/2019-ncov/index.html> frequently for updates.

While most of the people identified with COVID-19 have association with mainland China, there have been people identified with COVID-19 throughout the world, including the United States with community transmission occurring in multiple countries.

CDC interim guidance for health care professionals, including clinical criteria, is available at <https://www.cdc.gov/coronavirus/2019-nCoV/clinical-criteria.html>

ICE Health Service Corps Recommendations

Note: recommendations will be updated if and as necessary to address the evolving public health situation.

1. During intake medical screening:

- a. Ask all detainees if they have had close contact¹ with a person with laboratory-confirmed COVID-19 in the past 14 days
- b. Ask all detainees what countries they have traveled from or through in the past two weeks
 - i. Check whether these countries include geographic area(s) with widespread or sustained community transmission*
 - ii. *Please see CDC website listing of geographic area(s) with widespread or sustained community transmission at <https://www.cdc.gov/coronavirus/2019-ncov/hcp/clinical-criteria.html>
 - iii. **If the detainee responded yes to 1a and/or the detainee traveled from or through geographic area(s) with widespread or sustained community transmission* in the past 14 days (1b),** assess for fever and symptoms of respiratory illness.
 - a. If the detainee has a fever and/or symptoms of respiratory illness, refer to #4 below
 - b. If the detainee does not have fever or respiratory illness, refer to #2 below
 - c. For IHSC-staffed medical clinics, add a Global Alert / Medical Alert in the electronic health record that states, “*Epidemiologic risk of possible COVID-19 exposure. The last reported date of possible exposure was mm/dd/yyyy.*”” Click [here](#) for the eCW guide for adding a Global Alert.

- iv. Educate detainees to include the importance of hand washing and hand hygiene, covering coughs with the elbow instead of with hands, and requesting sick call if they feel ill.
 - a. Illness Prevention and Patient Education resources in multiple languages are available on SharePoint.

2. MONITORING of detainees with exposure risk who do not present with fever or symptoms:

- a. See also IHSC Interim COVID-19 exposure risk assessment 2020028.pdf.
- b. For detainees with travel history from or through geographic area(s) with widespread or sustained community transmission*in the past 14 days and/or detainees who have had close contact¹ with a person with laboratory-confirmed COVID-19 in the past 14 days who do not present with fever or symptoms of respiratory illness → monitor for 14 days after initial DHS apprehension and observe daily for fever and/or symptoms of respiratory illness
 - i. ***Please see CDC website listing of geographic area(s) with widespread or sustained community transmission at <https://www.cdc.gov/coronavirus/2019-ncov/hcp/clinical-criteria.html>**
- c. House detainees under monitoring in a single cell room if available or as a cohort for 14 days after initial DHS apprehension.
- d. Refer also to appendix A, Intake Screening Questions and Appendix B, Intake Screening and Early Management Algorithm
- e. If detainee is housed in a facility without IHSC medical staffing, medical staff should notify their assigned IHSC Field Medical Coordinator.
- f. Request a medical alert in following usual protocols stating that “the detainee is under observation through mm/dd/yyyy due to recent travel from or through geographic area(s) with widespread or sustained community transmission” Release the medical alert at the completion of the 14-day monitoring period.
- g. During the 14-day monitoring period, if an asymptomatic detainee under monitoring must be released in the U.S., notify the local health department and provide information on the detainee including the intended address and telephone number of the detainee’s intended destination.
- h. Document any asymptomatic detainee under monitoring on the Lower Respiratory Illness Tracking Tool
- i. For monitoring of asymptomatic detainees, it is not necessary to contact the local health department.

3. *During sick call, health assessment, or other clinical encounter in which a detainee presents with or complains of fever and/or respiratory illness, or is observed with signs of fever and/or respiratory illness:*

- a. Ask all detainees what countries they have traveled from or through in the past two weeks

- i. Check whether these countries include geographic area(s) with widespread or sustained community transmission*
 - ii. ***Please see CDC website listing of geographic area(s) with widespread or sustained community transmission at <https://www.cdc.gov/coronavirus/2019-ncov/hcp/clinical-criteria.html>**
 - b. **If the detainee has traveled from or through geographic area(s) with widespread or sustained community transmission*in the past 14 days, or if they have had close contact¹ with a person with laboratory-confirmed COVID-19 or their respiratory secretions in the past 14 days**
 - i. → refer to #4 below
 - c. Educate detainees to include the importance of hand washing and **hand** hygiene, covering coughs with the elbow instead of with hands, and requesting sick call if they feel ill.
 - i. Illness Prevention and Patient Education resources in multiple languages are available on SharePoint.
- 4. *ISOLATION and management of detainees with fever and/or symptoms of respiratory illness and who have traveled from or through geographic area(s) with widespread or sustained community transmission at in the past 14 days or have had close contact¹ with a person with laboratory-confirmed COVID-19 or their respiratory secretions in the past 14 days:***
- a. See IHSC Interim COVID-19 exposure risk assessment 2020028.pdf.
 - b. Place a tight-fitting surgical mask on the detainee
 - c. Promptly consult with a medical provider, preferably the Clinical Director or designee
 - d. Place the detainee in a private medical housing room, ideally in an airborne infection isolation room if available. If no single occupancy medical housing unit room is available, placement in other areas of the facility may be utilized to house the ill detainee separately from the general detention population
 - e. **Implement strict hand hygiene and standard, airborne and contact precautions, including use of eye protection**
 - i. **Increase hand hygiene and routine cleaning of surfaces**
 - ii. **Appropriate personal protective equipment includes gloves, gowns, N95 respirators, and goggles or face shields**
 - f. Call the local and/or state health department for notification and to request guidance on medical evaluation and procedures for specimen collection and testing for COVID-19
 - g. If the detainee has underlying illness or is acutely ill, or symptoms do not resolve, consult with the Regional Clinical Director, and/or Infectious Disease program.

- h. If the detainee is referred to a local hospital, call the hospital in advance to notify of the recent relevant travel history and respiratory symptoms and to coordinate how manage the detainee safely.
- i. Promptly notify the facility's staff responsible for infection prevention and control (e.g., in IHSC facilities, notify the Infection Prevention Officer, or the Facility Healthcare Program Manager (if the facility does not have an Infection Prevention Officer position); if the Infection Prevention Officer or Facility Healthcare Program Manager is not available, IHSC staff should notify the Infection Prevention Group at #IHSC_PHSP_IPO@ice.dhs.gov
- j. Facilities without IHSC medical staffing should notify their assigned Field Medical Coordinator
- k. IHSC Infection Prevention Officers, Facility Healthcare Program Managers, Field Medical Coordinators, or designees should notify the Regional Infection Prevention Supervisory Nurse immediately.
- l. Detainees isolated for respiratory illness and who have epidemiologic risk for COVID-19 exposure should wear a tight-fitting surgical mask when outside of the room under airborne and contact precautions
- m. Document any ill detainee who is suspected of having COVID-19 on the [Lower Respiratory Illness Tracking Tool](#)
- n. The contagious period for COVID-19 is still undetermined
 - i. If the detainee tests positive for COVID-19 and fever and symptoms have resolved, consult with the Infectious Disease Program and/or local health department regarding appropriate release from isolation
 - ii. If the detainee tests negative for COVID-19, had high or medium exposure risk, and fever and symptoms have resolved, release from isolation after completion of the 14-day monitoring period after initial DHS apprehension
 - a. See also [IHSC Interim COVID-19 exposure risk assessment 2020028.pdf](#)
 - iii. If the detainee tests negative for COVID-19 and fever and/or symptoms persist, consult with the Regional Clinical Director and/or Infectious Disease Program
- o. Educate detainees to include the importance of hand washing and hand hygiene, covering coughs with the elbow instead of with hands, and requesting sick call if they feel ill.
 - i. [Illness Prevention and Patient Education](#) resources in multiple languages are available on SharePoint.

5. *Infectious disease public health actions:*

- a. Educate detainees to include the importance of hand washing and hand hygiene, covering coughs with the elbow instead of with hands, and requesting sick call if they feel ill.
 - i. [Illness Prevention and Patient Education](#) resources in multiple languages are available on SharePoint.

- b. See also [05-06-G-02 Infectious Disease Public Health Actions Guide: Isolation and Management of Detainees Exposed to Infectious Organisms](#)
- c. **Known exposure to a person with confirmed COVID-19**
 - i. Implement cohorting with restricted movement for detainees housed with the ill detainee or who have been in close contact¹ with the ill detainee for the duration of the most recent incubation period (14 days after most recent exposure to an ill detainee)
 - ii. Monitor cohorted detainees daily to observe for fever and symptoms of respiratory illness
 - iii. Refer exposed detainees with new onset fever and/or respiratory illness to a medical provider for evaluation
 - iv. Discontinue cohorting when 14-day incubation period completes with no new cases
- d. **Exposure to a person with fever or symptoms being evaluated or under investigation for COVID-19 but not confirmed to have COVID-19**
 - i. Implement cohorting with restricted movement for detainees housed with the ill detainee or who have been in close contact¹ with the ill detainee for the duration of the most recent incubation period
 - ii. Monitor cohorted detainees daily to observe for fever and symptoms of respiratory illness
 - iii. Refer exposed detainees with new onset fever and/or respiratory illness to a medical provider for evaluation
 - iv. If the index patient is subsequently confirmed to have COVID-19, see section 5.b above
 - v. Discontinue cohorting if the index patient receives an alternate diagnosis that excludes COVID-19
 - vi. Any of the cohorted detainees with exposure risk should complete their initial 14-day monitoring period (i.e., for asymptomatic monitoring)
- e. Report cohorting through routine IHSC cohort reporting protocols
- f. Document any asymptomatic and afebrile detainees under monitoring for COVID-19 on the [Lower Respiratory Illness Tracking Tool](#)
- g. Recommend to Field Office Director or designee that detainees cohorted due to high or medium exposure risk or known exposure to an ill person not be transferred or transported.
 - i. See [IHSC Interim COVID-19 exposure risk assessment 2020028.pdf](#)
- h. If a cohorted detainee must be released in the U.S., notify the local health department including the intended address and telephone numbers of the detainee's intended destination.

¹Per CDC COVID-19 guidance (<https://www.cdc.gov/coronavirus/2019-nCoV/clinical-criteria.html>), a close contact is currently defined as:

- a) being within approximately 6 feet (2 meters), or within the room or care area, of a novel coronavirus case for a prolonged period of time while not wearing recommended personal protective equipment or PPE (e.g., gowns, gloves, NIOSH-certified disposable N95 respirator, eye protection); close contact can include caring for, living with, visiting, or sharing a health care waiting area or room with a novel coronavirus case.— *or* —
- b) having direct contact with infectious secretions of a novel coronavirus case (e.g., being coughed on) while not wearing recommended personal protective equipment.

See CDC's [Interim Healthcare Infection Prevention and Control Recommendations for Patients Under Investigation for 2019 Novel Coronavirus](#). 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 novel coronavirus (e.g., coughing likely increases exposure risk as does exposure to a severely ill patient). Special consideration should be given to those exposed in health care settings.

Resources and references

- [2019 Novel Coronavirus Resource Page on SharePoint](#) [Illness Prevention and Patient Education](#) resources in multiple languages are available on SharePoint.
- [COVID-19 FAQs](#) on SharePoint for submitting questions, receiving responses from IHSC subject matter experts, and viewing all questions and responses

IHSC Official Guidance

Guidance number	Guidance name	Type
05-02	Occupational Health Directive	Policy
05-02 G-04	Occupational Health Guide: Workforce Health	Guide
05-02 G-1	Occupational Health Guide: Bloodborne Pathogens and Other Potentially Infectious Materials	Guide
05-02 G-2	Occupational Health Guide: Personal Protective Equipment Program	Guide
05-02-G-03	Occupational Health Guide: Respiratory Protection Program	Guide
05-04	Environmental Health Directive	Policy
05-04 G-01	IHSC Environmental Health Guide	Guide

Guidance number	Guidance name	Type
05-06	Infectious Disease Public Health Actions Directive	Policy
05-06 G-01	Infectious Disease Public Health Actions Guide: Contact and Outbreak Investigation Guide	Guide
05-06 G-02	Infectious Disease Public Health Actions Guide: Isolation and Management of Detainees Exposed to Infectious Organisms	Guide
05-06 G-03	Infectious Disease Public Health Actions Guide: Surveillance and Reporting	Guide

- [Infection Control: Novel Coronavirus 2019 \(COVID-19\) | CDC](#)
- [Interim Guidance: Healthcare Professionals 2019-nCoV | CDC \(including CDC website listing of geographic area\(s\) with widespread or sustained community transmission\)](#)
- [CDC | Coronavirus Disease 2019 \(COVID-19\)](#)
- [2019 Novel Coronavirus \(2019-nCoV\) | TDSHS](#)
- [nCoV2019 | CDPH](#)
- [Novel Coronavirus Outbreak 2020 | Washington State Department of Health](#)
- [ADHS - Highlighted Infectious Diseases for Arizona - Coronavirus Disease 2019 \(COVID-19\)](#)
- [Coronavirus | NYC Health](#)
- [2019 Novel \(New\) Coronavirus | NYDOH](#)
- [2019 Novel Coronavirus \(2019-nCoV\) | Florida Department of Health](#)
- [NJ Department of Health | Communicable Disease Service | COVID-2019 \(Novel Coronavirus\)](#)
- [Pennsylvania Department of Health | Coronavirus](#)
- [2019 Novel Coronavirus \(2019 nCoV\) | Frequently Asked Questions | IDPH](#)

Points of contact for questions

- [IHSC Staff: COVID-19 FAQs](#) on SharePoint for submitting questions, receiving responses from IHSC subject matter experts, and viewing all questions and responses
 - Regional Infection Prevention Supervisory Nurses, PHSP Unit Senior Public Health Analyst, PHSP Unit Chief
- [Facilities without IHSC Medical Staffing](#): Assigned Field Medical Coordinators
- [Public health agencies: IHSC InfectionPrevention@ice.dhs.gov](#)

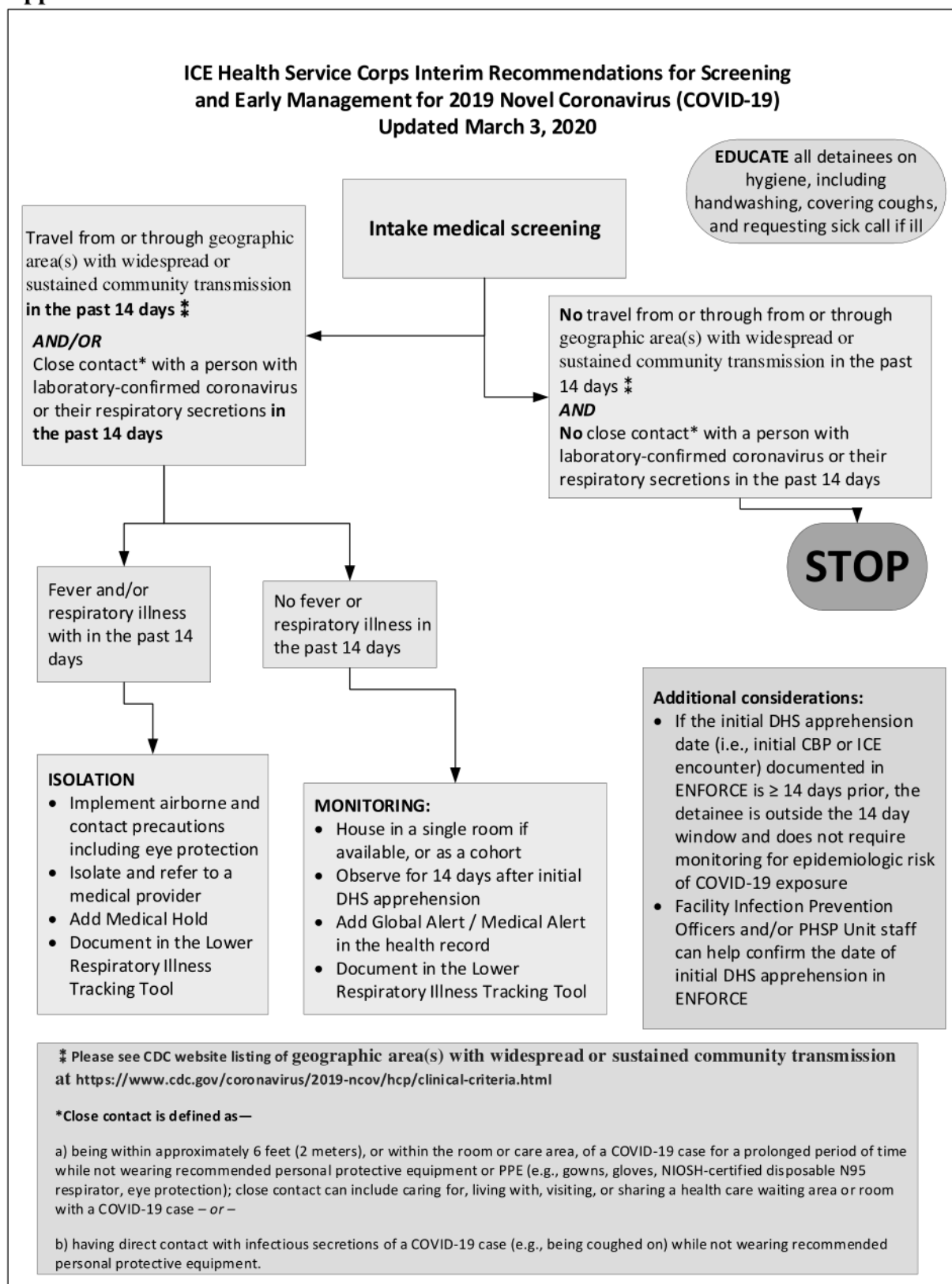
Appendix A: Intake Screening Questions

Updated February 28, 2020

1. **Have you been in close contact with a person with laboratory-confirmed 2019 novel coronavirus or their respiratory secretions in the past 14 days?**
 - Last date you had contact with that person: mm/dd/yyyy**OR**
2. **What countries have you traveled from or through in the past two weeks?**
 - Check whether the detainee traveled from or through geographic area(s) with widespread or sustained community transmission* in the past 14 days?
 - ***Please see CDC website listing of geographic area(s) with widespread or sustained community transmission at <https://www.cdc.gov/coronavirus/2019-ncov/hcp/clinical-criteria.html>**
3. If yes to #1 **or** the detainee traveled from or through geographic area(s) with widespread or sustained community transmission* in the past 14 days? (#2):
 - **Have you had fever and/or respiratory illness with onset in the past 14 days?**
 - **If yes, what date did you first notice symptoms?: mm/dd/yyyy**
 - **If yes, implement standard, airborne, and contact precautions including eye protection**, isolate and refer to a medical provider, add Medical Hold, notify FHPM, IPO, or designee.
 - **If no, implement MONITORING**; house in single room (preferred) if available, implement daily checks for 14 days after initial DHS apprehension, add Medical Hold, notify FHPM, IPO, or designee.
4. If no travel from or through geographic area(s) with widespread or sustained community transmission* in the past 14 days **AND** no close contact with a person with laboratory-confirmed 2019 novel coronavirus or their respiratory secretions in the past 14 days?
 - ***Please see CDC website listing of geographic area(s) with widespread or sustained community transmission at <https://www.cdc.gov/coronavirus/2019-ncov/hcp/clinical-criteria.html>**
 - Routine intake
 - If the initial DHS apprehension date (i.e., initial CBP or ICE encounter) documented in ENFORCE is ≥ 14 days prior, the detainee is outside the 14 day window and does not require monitoring for the epidemiologic risk of COVID-19 exposure
 - Facility Infection Prevention Officers and/or PHSP Unit staff can help confirm the date of initial DHS apprehension in ENFORCE

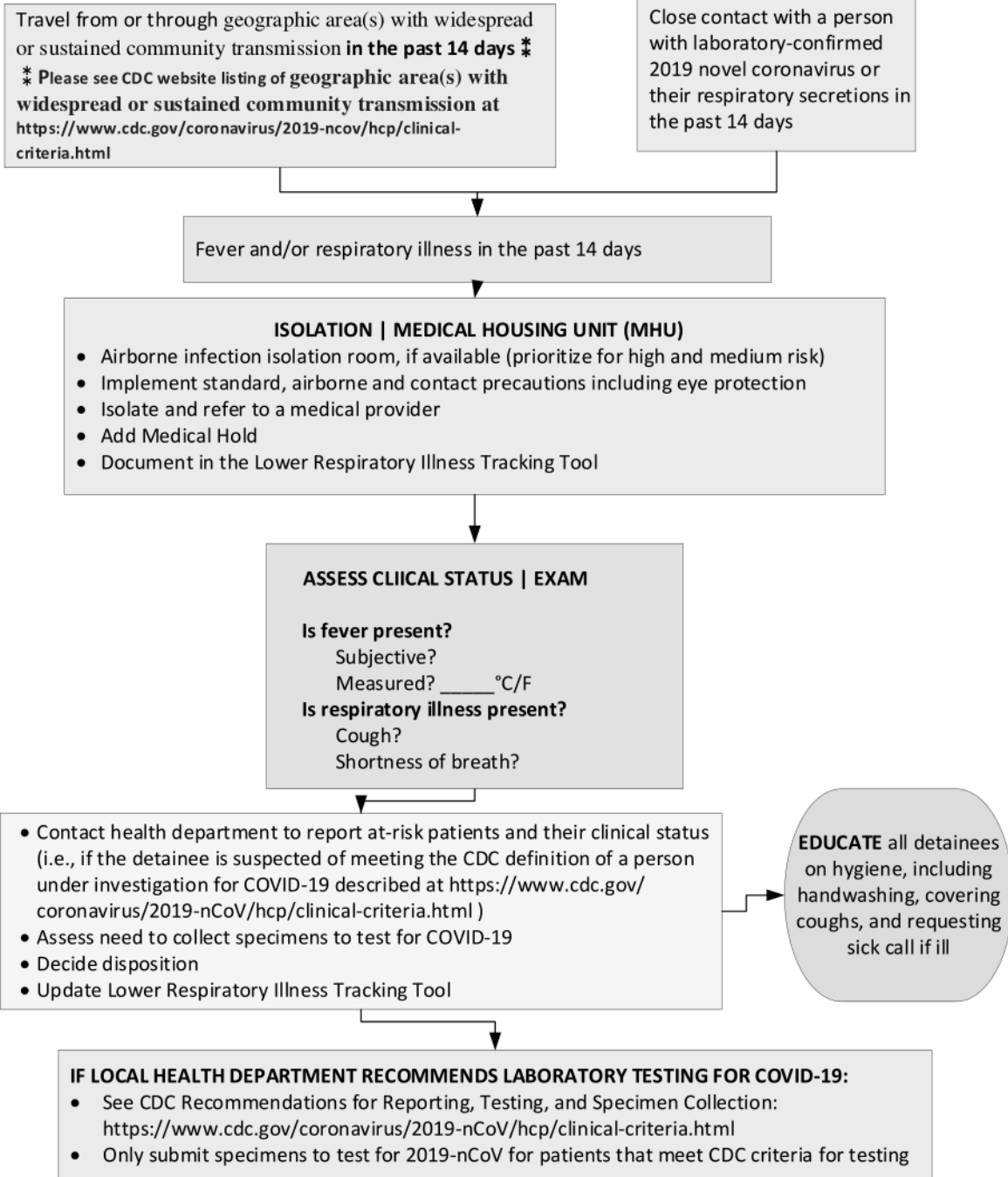
***Please see CDC website listing of geographic area(s) with widespread or sustained community transmission at <https://www.cdc.gov/coronavirus/2019-ncov/hcp/clinical-criteria.html>**

Appendix B



Appendix C

ICE Health Service Corps Interim Recommendations For 2019 Novel Coronavirus (COVID-19) Risk | Isolation, Assessment, and Early Management Updated March 3, 2020





Interim Reference Sheet on 2019-Novel Coronavirus (COVID-19)

ICE Health Service Corps (IHSC)

Version 7.0, March 11, 2020

WHAT'S NEW

Version 7.0

- Recommendations to reduce the risk of transmission now link to a separate [Reducing the Risk of COVID-19 Transmission](#) document on the [2019 Novel Coronavirus Resource Page](#)
- [Reducing the Risk of COVID-19 Transmission](#) incorporates Centers for Disease Control and Prevention (CDC) guidance including but not limited to the following:
 - [Interim Infection Prevention and Control Recommendations for Patients with Suspected or Confirmed Coronavirus Disease 2019 \(COVID-19\) in Healthcare Settings](#)
 - [Strategies for Optimizing the Supply of N95 Respirators](#)
 - [Recommended Guidance for Extended Use and Limited Reuse of N95 Filtering Facepiece Respirators in Healthcare Settings](#)
 - [Frequently Asked Questions about Personal Protective Equipment](#)
 - [Transmission-Based Precautions](#)

Version 6.0

- Information added to convey that revised CDC guidance expands testing to a wider group of symptomatic patients. Providers should use their judgment to determine if a patient has signs and symptoms compatible with COVID-19 and whether the patient should be tested. Decisions on which patients receive testing should be based on the epidemiology of COVID-19, as well as the clinical course of illness. Providers are strongly encouraged to test for other causes of respiratory illness, including infections such as influenza.
- Information added to convey that testing is now available through LabCorp and other commercial laboratories.

Situation Summary

The CDC is closely monitoring an outbreak caused by a novel (new) coronavirus (COVID-19). The situation is evolving and expanding with community transmission occurring in multiple

countries. For the most current information, check the CDC information pages at <https://www.cdc.gov/coronavirus/2019-ncov/index.html> frequently for updates.

CDC interim guidance for health care professionals, including clinical criteria, is available at <https://www.cdc.gov/coronavirus/2019-nCoV/clinical-criteria.html>.

ICE Health Service Corps Recommendations

- *Note: recommendations will be updated if and as necessary to address the evolving public health situation. See also [2019 Novel Coronavirus Resource Page](#) including [Reducing the Risk of COVID-19 Transmission](#)*

1. ***During intake medical screening:***

- Ask all detainees if they have had close contact¹ with a person with laboratory-confirmed COVID-19 in the past 14 days**
- Ask all detainees what countries they have traveled from or through in the past two weeks**
 - Check whether these countries include geographic area(s) with widespread or sustained community transmission.*
 - *Please see CDC website listing of geographic area(s) with widespread or sustained community transmission at <https://www.cdc.gov/coronavirus/2019-ncov/hcp/clinical-criteria.html>.**
 - If the detainee responded yes to 1a and/or the detainee traveled from or through geographic area(s) with widespread or sustained community transmission* in the past 14 days (1b), assess for fever and symptoms of respiratory illness.**
 - If the detainee has a fever and/or symptoms of respiratory illness, refer to #4 ISOLATION below.
 - If the detainee does not have fever or respiratory illness, refer to #2 MONITORING, below.
 - For IHSC-staffed medical clinics, add a Global Alert / Medical Alert in the electronic health record that states, “*Epidemiologic risk of possible COVID-19 exposure. The last reported date of possible exposure was mm/dd/yyyy.*””
Click [here](#) for the eCW guide for adding a Global Alert.
- If the detainee has fever and/or symptoms or respiratory illness and has not traveled from or through area(s) with sustained community transmission* in the past 14 days and if they have not had close contact¹ with a person with laboratory-confirmed COVID-19 or their respiratory secretions in the past 14 days → refer to a medical provider (see #3 ENCOUNTER below).
- Educate all detainees to include the importance of hand washing and hand hygiene, covering coughs with the elbow instead of with hands, and requesting sick call if they feel ill.

- i. Illness Prevention and Patient Education resources in multiple languages are available on the 2019 Novel Coronavirus Resource Page.

2. MONITORING of detainees with exposure risk who do not present with fever or symptoms:

- a. See also IHSC Interim COVID-19 Risk Assessment on the 2019 Novel Coronavirus Resource Page.
- b. For detainees with travel history from or through geographic area(s) with sustained community transmission* in the past 14 days and/or detainees who have had close contact¹ with a person with laboratory-confirmed COVID-19 in the past 14 days who do not present with fever or symptoms of respiratory illness → monitor for 14 days after initial DHS apprehension and observe daily for fever and/or symptoms of respiratory illness.
 - i. ***Please see CDC website listing of international area(s) with sustained transmission at <https://www.cdc.gov/coronavirus/2019-ncov/hcp/clinical-criteria.html>.**
- c. House detainees under monitoring in a single cell room if available or as a cohort for 14 days after initial DHS apprehension.
- d. Refer also to appendix A, Intake Screening Questions and Intake Screening and Early Management Algorithm on the 2019 Novel Coronavirus Resource Page.
- e. If detainee is housed in a facility without IHSC medical staffing, medical staff should notify their assigned IHSC Field Medical Coordinator.
- f. Request a medical alert in following usual protocols stating that “the detainee is under observation through mm/dd/yyyy due to recent travel from or through geographic area(s) with widespread or sustained community transmission” Release the medical alert at the completion of the 14-day monitoring period.
- g. During the 14-day monitoring period, if an asymptomatic detainee under monitoring must be released in the U.S., notify the local health department and provide information on the detainee including the intended address and telephone number of the detainee’s intended destination.
- h. Document any asymptomatic detainee under monitoring on the Lower Respiratory Illness Tracking Tool.
- i. For monitoring of asymptomatic detainees, it is not necessary to contact the local health department.

3. ENCOUNTER. During sick call, health assessment, or other clinical encounter in which a detainee presents with or complains of fever and/or respiratory illness, or is observed with signs of fever and/or respiratory illness:

- a. Ask all detainees what countries they have traveled from or through in the past two weeks.
 - i. Check whether these countries include international area(s) with sustained transmission.*

- ii. ***Please see CDC website listing of international area(s) with sustained transmission at <https://www.cdc.gov/coronavirus/2019-ncov/hcp/clinical-criteria.html>.**
 - b. **If the detainee has traveled from or through area(s) with sustained community transmission* in the past 14 days, or if they have had close contact¹ with a person with laboratory-confirmed COVID-19 or their respiratory secretions in the past 14 days**
 - i. → refer to #4 ISOLATION below.
 - c. If the detainee has not traveled from or through area(s) with sustained community transmission* in the past 14 days and if they have not had close contact¹ with a person with laboratory-confirmed COVID-19 or their respiratory secretions in the past 14 days then
 - i. → Providers should use their judgment to determine if a patient has signs and symptoms compatible with COVID-19 and whether the patient should be tested. Decisions on which patients receive testing should be based on the epidemiology of COVID-19, as well as the clinical course of illness. Providers are strongly encouraged to test for other causes of respiratory illness, including infections such as influenza.
 - ii. See [Reducing the Risk of COVID-19 Transmission](#)
 - iii. See #5 SPECIMEN COLLECTION AND LABORATORY TESTING below.
 - d. Educate detainees to include the importance of hand washing and hand hygiene, covering coughs with the elbow instead of with hands, and requesting sick call if they feel ill.
 - i. [Illness Prevention and Patient Education](#) resources in multiple languages are available on the [2019 Novel Coronavirus Resource Page](#).
- 4. ISOLATION and management of detainees with fever and/or symptoms of respiratory illness and who have traveled from or through geographic area(s) with widespread or sustained community transmission at in the past 14 days or have had close contact¹ with a person with laboratory-confirmed COVID-19 or their respiratory secretions in the past 14 days:**
- a. See [IHSC Interim COVID-19 Risk Assessment on the 2019 Novel Coronavirus Resource Page](#).
 - b. See [Reducing the Risk of COVID-19 Transmission](#)
 - c. Place a tight-fitting surgical mask on the detainee.
 - d. Promptly consult with a medical provider, preferably the Clinical Director or designee.
 - e. Place the detainee in a private medical housing room, ideally in an airborne infection isolation room if available. If no single occupancy medical housing unit room is available, placement in other areas of the facility may be utilized to house the ill detainee separately from the general detention population.
 - f. Call the local and/or state health department for notification and guidance.

- g. Laboratory testing for COVID-19 is now available through commercial laboratories including LabCorp and through local and/or state health departments.
- i. See #5 SPECIMEN COLLECTION AND LABORTORY TESTING below.
- h. If the detainee has underlying illness or is acutely ill, or symptoms do not resolve, consult with the Regional Clinical Director, and/or Infectious Disease program.
- i. If the detainee is referred to a local hospital, call the hospital in advance to notify of the recent relevant travel history and respiratory symptoms and to coordinate how manage the detainee safely.
- j. Promptly notify the facility's staff responsible for infection prevention and control (e.g., in IHSC facilities, notify the Infection Prevention Officer, or the Facility Healthcare Program Manager (if the facility does not have an Infection Prevention Officer position); if the Infection Prevention Officer or Facility Healthcare Program Manager is not available, IHSC staff should notify the Infection Prevention Group at #IHSC_PHSP_IPO@ice.dhs.gov.
- k. Facilities without IHSC medical staffing should notify their assigned Field Medical Coordinator.
- l. IHSC Infection Prevention Officers, Facility Healthcare Program Managers, Field Medical Coordinators, or designees should notify the Regional Infection Prevention Supervisory Nurse immediately.
- m. Detainees isolated for respiratory illness and who have epidemiologic risk for COVID-19 exposure should wear a tight-fitting surgical mask when outside of the isolation room.
- n. Document any ill detainee who is suspected of having COVID-19 on the [Lower Respiratory Illness Tracking Tool](#).
- o. The contagious period for COVID-19 is still undetermined.
 - i. If the detainee tests positive for COVID-19 and fever and symptoms have resolved, consult with the Infectious Disease Program and/or local health department regarding appropriate release from isolation.
 - ii. If the detainee tests negative for COVID-19, had high or medium exposure risk, and fever and symptoms have resolved, release from isolation after completion of the 14-day monitoring period after initial DHS apprehension.
 - iii. See also [IHSC Interim COVID-19 Risk Assessment on the 2019 Novel Coronavirus Resource Page](#).
 - iv. If the detainee tests negative for COVID-19 and fever and/or symptoms persist, consult with the Regional Clinical Director and/or Infectious Disease Program
- p. Educate detainees to include the importance of hand washing and hand hygiene, covering coughs with the elbow instead of with hands, and requesting sick call if they feel ill.
 - i. [Illness Prevention and Patient Education](#) resources in multiple languages are available on the [2019 Novel Coronavirus Resource Page](#).

5. SPECIMEN COLLECTION AND LABORATORY TESTING for COVID-19

- a. Laboratory testing for COVID-19 is available through commercial laboratories including LabCorp and through local and/or state health departments.
- b. See **Specimen Collection instructions on the 2019 Novel Coronavirus Resource Page**.
 - i. LabCorp ordering codes are 2019 Novel Coronavirus (COVID-19), NAA; TEST: 139900.

6. Infectious disease public health actions:

- a. Educate detainees to include the importance of hand washing and hand hygiene, covering coughs with the elbow instead of with hands, and requesting sick call if they feel ill.
 - i. Illness Prevention and Patient Education resources in multiple languages are available on SharePoint.
- b. See also 05-06-G-02 Infectious Disease Public Health Actions Guide: Isolation and Management of Detainees Exposed to Infectious Organisms.
- c. **Known exposure to a person with confirmed COVID-19**
 - i. Implement cohorting with restricted movement for detainees housed with the ill detainee or who have been in close contact¹ with the ill detainee for the duration of the most recent incubation period (14 days after most recent exposure to an ill detainee).
 - ii. Monitor cohorted detainees daily to observe for fever and symptoms of respiratory illness.
 - iii. Refer exposed detainees with new onset fever and/or respiratory illness to a medical provider for evaluation.
 - iv. Discontinue cohorting when 14-day incubation period completes with no new cases.
- d. **Exposure to a person with fever or symptoms being evaluated or under investigation for COVID-19 but not confirmed to have COVID-19**
 - i. Implement cohorting with restricted movement for detainees housed with the ill detainee or who have been in close contact¹ with the ill detainee for the duration of the most recent incubation period.
 - ii. Monitor cohorted detainees daily to observe for fever and symptoms of respiratory illness.
 - iii. Refer exposed detainees with new onset fever and/or respiratory illness to a medical provider for evaluation.
 - iv. If the index patient is subsequently confirmed to have COVID-19, see section 5.b above.
 - v. Discontinue cohorting if the index patient receives an alternate diagnosis that excludes COVID-19.
 - vi. Any of the cohorted detainees with exposure risk should complete their initial 14-day monitoring period (i.e., for asymptomatic monitoring).

- e. Report cohorting through routine IHSC cohort reporting protocols.
- f. Document any asymptomatic and afebrile detainees under monitoring for COVID-19 on the Lower Respiratory Illness Tracking Tool.
- g. Recommend to Field Office Director or designee that detainees cohorted due to high or medium exposure risk or known exposure to an ill person not be transferred or transported.
- i. See IHSC Interim COVID-19 Risk Assessment on the 2019 Novel Coronavirus Resource Page.
- h. If a cohorted detainee must be released in the U.S., notify the local health department including the intended address and telephone numbers of the detainee's intended destination.

¹**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)

Resources and references

- [2019 Novel Coronavirus Resource Page](#) on SharePoint
- [Reducing the Risk of COVID-19 Transmission](#)
- [Illness Prevention and Patient Education](#) resources in multiple languages are available on SharePoint.
- [COVID-19 Questions and Responses](#) on SharePoint for submitting questions, receiving responses from IHSC subject matter experts, and viewing all questions and responses

IHSC Official Guidance

Guidance number	Guidance name	Type
05-02	Occupational Health Directive	Policy
05-02 G-04	Occupational Health Guide: Workforce Health	Guide
05-02 G-1	Occupational Health Guide: Bloodborne Pathogens and Other Potentially Infectious Materials	Guide
05-02 G-2	Occupational Health Guide: Personal Protective Equipment Program	Guide
05-02-G-03	Occupational Health Guide: Respiratory Protection Program	Guide
05-04	Environmental Health Directive	Policy
05-04 G-01	IHSC Environmental Health Guide	Guide
05-06	Infectious Disease Public Health Actions Directive	Policy
05-06 G-01	Infectious Disease Public Health Actions Guide: Contact and Outbreak Investigation Guide	Guide
05-06 G-02	Infectious Disease Public Health Actions Guide: Isolation and Management of Detainees Exposed to Infectious Organisms	Guide
05-06 G-03	Infectious Disease Public Health Actions Guide: Surveillance and Reporting	Guide

- [Infection Control: Novel Coronavirus 2019 \(COVID-19\) | CDC](#)
- [Interim Guidance: Healthcare Professionals 2019-nCoV | CDC \(including CDC website listing of geographic area\(s\) with widespread or sustained community transmission\)](#)
- [CDC | Coronavirus Disease 2019 \(COVID-19\)](#)
- [2019 Novel Coronavirus \(2019-nCoV\) | TDSHS](#)
- [nCOV2019 | CDPH](#)
- [Novel Coronavirus Outbreak 2020 | Washington State Department of Health](#)
- [ADHS - Highlighted Infectious Diseases for Arizona - Coronavirus Disease 2019 \(COVID-19\)](#)

- [Coronavirus | NYC Health](#)
- [2019 Novel \(New\) Coronavirus | NYDOH](#)
- [2019 Novel Coronavirus \(2019-nCoV\) | Florida Department of Health](#)
- [NJ Department of Health | Communicable Disease Service | COVID-2019 \(Novel Coronavirus\)](#)
- [Pennsylvania Department of Health | Coronavirus](#)
- [2019 Novel Coronavirus \(2019 nCoV\) | Frequently Asked Questions | IDPH](#)

Points of contact for questions

- **IHSC Staff:** [COVID-19 Questions and Responses](#) on SharePoint for submitting questions, receiving responses from IHSC subject matter experts, and viewing all questions and responses
 - Regional Infection Prevention Supervisory Nurses, PHSP Unit Senior Public Health Analyst, PHSP Unit Chief
- **Facilities without IHSC Medical Staffing:** Assigned Field Medical Coordinators
- **Public health agencies:** IHSC_InfectionPrevention@ice.dhs.gov

Appendix A: Intake Screening Questions

Updated March 11, 2020

1. **Have you been in close contact with a person with laboratory-confirmed 2019 novel coronavirus or their respiratory secretions in the past 14 days?**
 - Last date you had contact with that person: mm/dd/yyyy**OR**
2. **What countries have you traveled from or through in the past two weeks?**
 - Check whether the detainee traveled from or through geographic area(s) with widespread or sustained community transmission*in the past 14 days?
 - ***Please see CDC website listing of geographic area(s) with widespread or sustained community transmission at <https://www.cdc.gov/coronavirus/2019-ncov/hcp/clinical-criteria.html>**
3. If yes to #1 **or** the detainee traveled from or through geographic area(s) with widespread or sustained community transmission*in the past 14 days? (#2):
 - **Have you had fever and/or respiratory illness with onset in the past 14 days?**
 - **If yes, what date did you first notice symptoms?: mm/dd/yyyy**
 - **If yes, isolate and refer to a medical provider, add Medical Hold, notify FHPM, IPO, or designee.**
 - See [Reducing the Risk of COVID-19 Transmission](#)
 - **If no, implement MONITORING;** house in single room (preferred) if available, implement daily checks for 14 days after initial DHS apprehension, add Medical Hold, notify FHPM, IPO, or designee.
4. If no travel from or through geographic area(s) with widespread or sustained community transmission* in the past 14 days AND no close contact with a person with laboratory-confirmed 2019 novel coronavirus or their respiratory secretions in the past 14 days?
 - ***Please see CDC website listing of international area(s) with sustained transmission at <https://www.cdc.gov/coronavirus/2019-ncov/hcp/clinical-criteria.html>**
 - Routine intake
 - If the initial DHS apprehension date (i.e., initial CBP or ICE encounter) documented in ENFORCE is ≥ 14 days prior, the detainee is outside the 14 day window and does not require monitoring for the epidemiologic risk of COVID-19 exposure
 - Facility Infection Prevention Officers and/or PHSP Unit staff can help confirm the date of initial DHS apprehension in ENFORCE

***Please see CDC website listing of international area(s) with sustained transmission at <https://www.cdc.gov/coronavirus/2019-ncov/hcp/clinical-criteria.html>**

From: ERO Assistant Directors
Sent: Tue, 10 Mar 2020 17:32:22 +0000
To: Undisclosed recipients:
Subject: Interim Reference Sheet on 2019-Novel Coronavirus (COVID-19) [CMD]
Attachments: IHSC Interim Reference Sheet COVID-19- Version 6.pdf



Enforcement and Removal Operations Assistant Director for Custody Management

To: Field Office Directors, Deputy Field Office Directors

The ICE Health Service Corps (IHSC) has developed guidance for IHSC-staffed facilities to help in the risk assessment and management of individuals with potential exposure to Novel Coronavirus (COVID-19). ERO Custody Management (CM) is requesting that you share the attached reference sheet with facilities in your area of responsibility for possible adoption at their sites.

Situational updates and Frequently Asked Questions (FAQs) about the rapidly evolving coronavirus can be found at www.cdc.gov/coronavirus/2019-ncov/about/index.html. For questions about the IHSC interim reference sheet, please contact IHSC Taskings at IHSCTaskings@ice.dhs.gov.

(b)(6); (b)(7)(C)

Acting ERO Assistant Director, Custody Management

This message was sent in concurrence with AD Field Operations.

This message expires one year from the date it was sent, pursuant to ERO policy.

~~NOTICE: This communication may contain privileged or otherwise confidential information. If you are not an intended recipient or believe you have received this communication in error, please do not print, copy, retransmit, disseminate, or otherwise use this information. Please inform the sender that you received this message in error and delete the message from your system.~~



Interim Reference Sheet on 2019-Novel Coronavirus (COVID-19)

ICE Health Service Corps (IHSC)

Version 6.0, March 6, 2020

WHAT'S NEW

Version 6.0

- Information added to convey that revised CDC guidance expands testing to a wider group of symptomatic patients. Providers should use their judgment to determine if a patient has signs and symptoms compatible with COVID-19 and whether the patient should be tested. Decisions on which patients receive testing should be based on the epidemiology of COVID-19, as well as the clinical course of illness. Providers are strongly encouraged to test for other causes of respiratory illness, including infections such as influenza.
- Information added to convey that testing is now available through LabCorp and other commercial laboratories.

Version 5.1

- Information added to emphasize that medical staff should educate detainees to include hygiene, covering coughs, and requesting sick call if ill.
- Add a link to [Illness Prevention and Patient Education](#) resources in multiple languages on SharePoint, including signage.
- Added a link to [COVID-19 Questions and Responses](#) on SharePoint for submitting questions, receiving responses from IHSC subject matter experts, and viewing all questions and responses.
- Added a link to a [2019 Novel Coronavirus Resource Page](#) on SharePoint.

Version 5.0

- Updates have been made for screening to identify detainees with revised CDC criteria for epidemiologic risk of COVID-19 exposure and to specify the start of the 14-day monitoring period from the date of initial DHS apprehension.
- Epidemiologic travel risk now includes travel from or through geographic areas with widespread or sustained community transmission.

Situation Summary

The CDC is closely monitoring an outbreak caused by a novel (new) coronavirus (COVID-19). The situation is evolving and expanding with community transmission occurring in multiple countries. For the most current information, check the CDC information pages at <https://www.cdc.gov/coronavirus/2019-ncov/index.html> frequently for updates.

CDC interim guidance for health care professionals, including clinical criteria, is available at <https://www.cdc.gov/coronavirus/2019-nCoV/clinical-criteria.html>.

ICE Health Service Corps Recommendations

Note: recommendations will be updated if and as necessary to address the evolving public health situation.

1. During intake medical screening:

- a. **Ask all detainees if they have had close contact¹ with a person with laboratory-confirmed COVID-19 in the past 14 days**
- b. **Ask all detainees what countries they have traveled from or through in the past two weeks**
 - i. Check whether these countries include geographic area(s) with widespread or sustained community transmission.*
 - ii. ***Please see CDC website listing of geographic area(s) with widespread or sustained community transmission at <https://www.cdc.gov/coronavirus/2019-ncov/hcp/clinical-criteria.html>.**
 - iii. **If the detainee responded yes to 1a and/or the detainee traveled from or through geographic area(s) with widespread or sustained community transmission* in the past 14 days (1b), assess for fever and symptoms of respiratory illness.**
 - a. If the detainee has a fever and/or symptoms of respiratory illness, refer to #4 ISOLATION below.
 - b. If the detainee does not have fever or respiratory illness, refer to #2 MONITORING, below.
 - c. For IHSC-staffed medical clinics, add a Global Alert / Medical Alert in the electronic health record that states, “*Epidemiologic risk of possible COVID-19 exposure. The last reported date of possible exposure was mm/dd/yyyy.*”
Click [here](#) for the eCW guide for adding a Global Alert.
- c. If the detainee has fever and/or symptoms or respiratory illness and has not traveled from or through area(s) with sustained community transmission* in the past 14 days and if they have not had close contact¹ with a person with laboratory-confirmed COVID-19 or their respiratory secretions in the past 14 days → refer to a medical provider (see #3 ENCOUNTER below).

- d. Educate all detainees to include the importance of hand washing and hand hygiene, covering coughs with the elbow instead of with hands, and requesting sick call if they feel ill.
- i. Illness Prevention and Patient Education resources in multiple languages are available on the 2019 Novel Coronavirus Resource Page.

2. MONITORING of detainees with exposure risk who do not present with fever or symptoms:

- a. See also IHSC Interim COVID-19 Risk Assessment on the 2019 Novel Coronavirus Resource Page.
- b. For detainees with travel history from or through geographic area(s) with sustained community transmission* in the past 14 days and/or detainees who have had close contact¹ with a person with laboratory-confirmed COVID-19 in the past 14 days who do not present with fever or symptoms of respiratory illness → monitor for 14 days after initial DHS apprehension and observe daily for fever and/or symptoms of respiratory illness.
 - i. ***Please see CDC website listing of international area(s) with sustained transmission at <https://www.cdc.gov/coronavirus/2019-ncov/hcp/clinical-criteria.html>.**
- c. House detainees under monitoring in a single cell room if available or as a cohort for 14 days after initial DHS apprehension.
- d. Refer also to appendix A, Intake Screening Questions and Intake Screening and Early Management Algorithm on the 2019 Novel Coronavirus Resource Page.
- e. If detainee is housed in a facility without IHSC medical staffing, medical staff should notify their assigned IHSC Field Medical Coordinator.
- f. Request a medical alert in following usual protocols stating that “the detainee is under observation through mm/dd/yyyy due to recent travel from or through geographic area(s) with widespread or sustained community transmission” Release the medical alert at the completion of the 14-day monitoring period.
- g. During the 14-day monitoring period, if an asymptomatic detainee under monitoring must be released in the U.S., notify the local health department and provide information on the detainee including the intended address and telephone number of the detainee’s intended destination.
- h. Document any asymptomatic detainee under monitoring on the Lower Respiratory Illness Tracking Tool.
- i. For monitoring of asymptomatic detainees, it is not necessary to contact the local health department.

3. ***ENCOUNTER. During sick call, health assessment, or other clinical encounter in which a detainee presents with or complains of fever and/or respiratory illness, or is observed with signs of fever and/or respiratory illness:***
- a. Ask all detainees what countries they have traveled from or through in the past two weeks.
 - i. Check whether these countries include international area(s) with sustained transmission.*
 - ii. ***Please see CDC website listing of international area(s) with sustained transmission at <https://www.cdc.gov/coronavirus/2019-ncov/hcp/clinical-criteria.html>.**
 - b. **If the detainee has traveled from or through area(s) with sustained community transmission* in the past 14 days, or if they have had close contact¹ with a person with laboratory-confirmed COVID-19 or their respiratory secretions in the past 14 days**
 - i. → refer to #4 ISOLATION below.
 - c. If the detainee has not traveled from or through area(s) with sustained community transmission* in the past 14 days and if they have not had close contact¹ with a person with laboratory-confirmed COVID-19 or their respiratory secretions in the past 14 days then
 - i. → Providers should use their judgment to determine if a patient has signs and symptoms compatible with COVID-19 and whether the patient should be tested. Decisions on which patients receive testing should be based on the epidemiology of COVID-19, as well as the clinical course of illness. Providers are strongly encouraged to test for other causes of respiratory illness, including infections such as influenza.
 - ii. See #5 SPECIMEN COLLECTION AND LABORATORY TESTING below.
 - d. Educate detainees to include the importance of hand washing and hand hygiene, covering coughs with the elbow instead of with hands, and requesting sick call if they feel ill.
 - i. Illness Prevention and Patient Education resources in multiple languages are available on the [2019 Novel Coronavirus Resource Page](#).
4. ***ISOLATION and management of detainees with fever and/or symptoms of respiratory illness and who have traveled from or through geographic area(s) with widespread or sustained community transmission at in the past 14 days or have had close contact¹ with a person with laboratory-confirmed COVID-19 or their respiratory secretions in the past 14 days:***
- a. See IHSC Interim COVID-19 Risk Assessment on the 2019 Novel Coronavirus Resource Page.
 - b. Place a tight-fitting surgical mask on the detainee.
 - c. Promptly consult with a medical provider, preferably the Clinical Director or designee.

- d. Place the detainee in a private medical housing room, ideally in an airborne infection isolation room if available. If no single occupancy medical housing unit room is available, placement in other areas of the facility may be utilized to house the ill detainee separately from the general detention population.
- e. **Implement strict hand hygiene and standard, airborne and contact precautions, including use of eye protection.**
 - i. **Increase hand hygiene and routine cleaning of surfaces.**
 - ii. **Appropriate personal protective equipment includes gloves, gowns, N95 respirators, and goggles or face shields.**
- f. Call the local and/or state health department for notification and guidance.
- g. Laboratory testing for COVID-19 is now available through commercial laboratories including LabCorp and through local and/or state health departments.
 - i. See #5 SPECIMEN COLLECTION AND LABORTORY TESTING below.
- h. If the detainee has underlying illness or is acutely ill, or symptoms do not resolve, consult with the Regional Clinical Director, and/or Infectious Disease program.
- i. If the detainee is referred to a local hospital, call the hospital in advance to notify of the recent relevant travel history and respiratory symptoms and to coordinate how manage the detainee safely.
- j. Promptly notify the facility's staff responsible for infection prevention and control (e.g., in IHSC facilities, notify the Infection Prevention Officer, or the Facility Healthcare Program Manager (if the facility does not have an Infection Prevention Officer position); if the Infection Prevention Officer or Facility Healthcare Program Manager is not available, IHSC staff should notify the Infection Prevention Group at #IHSC_PHSP_IPO@ice.dhs.gov.
- k. Facilities without IHSC medical staffing should notify their assigned Field Medical Coordinator.
- l. IHSC Infection Prevention Officers, Facility Healthcare Program Managers, Field Medical Coordinators, or designees should notify the Regional Infection Prevention Supervisory Nurse immediately.
- m. Detainees isolated for respiratory illness and who have epidemiologic risk for COVID-19 exposure should wear a tight-fitting surgical mask when outside of the room under airborne and contact precautions.
- n. Document any ill detainee who is suspected of having COVID-19 on the [Lower Respiratory Illness Tracking Tool](#).
- o. The contagious period for COVID-19 is still undetermined.
 - i. If the detainee tests positive for COVID-19 and fever and symptoms have resolved, consult with the Infectious Disease Program and/or local health department regarding appropriate release from isolation.
 - ii. If the detainee tests negative for COVID-19, had high or medium exposure risk, and fever and symptoms have resolved, release from isolation after completion of the 14-day monitoring period after initial DHS apprehension.

- iii. See also [IHSC Interim COVID-19 Risk Assessment on the 2019 Novel Coronavirus Resource Page](#).
- iv. If the detainee tests negative for COVID-19 and fever and/or symptoms persist, consult with the Regional Clinical Director and/or Infectious Disease Program
- p. Educate detainees to include the importance of hand washing and hand hygiene, covering coughs with the elbow instead of with hands, and requesting sick call if they feel ill.
 - i. [Illness Prevention and Patient Education](#) resources in multiple languages are available on the [2019 Novel Coronavirus Resource Page](#).

5. ***SPECIMEN COLLECTION AND LABORATORY TESTING for COVID-19***

- a. Laboratory testing for COVID-19 is available through commercial laboratories including LabCorp and through local and/or state health departments.
- b. See **Specimen Collection instructions on the [2019 Novel Coronavirus Resource Page](#)**.
 - i. LabCorp ordering codes are 2019 Novel Coronavirus (COVID-19), NAA; TEST: 139900.

6. ***Infectious disease public health actions:***

- a. Educate detainees to include the importance of hand washing and hand hygiene, covering coughs with the elbow instead of with hands, and requesting sick call if they feel ill.
 - i. [Illness Prevention and Patient Education](#) resources in multiple languages are available on SharePoint.
- b. See also [05-06-G-02 Infectious Disease Public Health Actions Guide: Isolation and Management of Detainees Exposed to Infectious Organisms](#).
- c. **Known exposure to a person with confirmed COVID-19**
 - i. Implement cohorting with restricted movement for detainees housed with the ill detainee or who have been in close contact¹ with the ill detainee for the duration of the most recent incubation period (14 days after most recent exposure to an ill detainee).
 - ii. Monitor cohorted detainees daily to observe for fever and symptoms of respiratory illness.
 - iii. Refer exposed detainees with new onset fever and/or respiratory illness to a medical provider for evaluation.
 - iv. Discontinue cohorting when 14-day incubation period completes with no new cases.
- d. **Exposure to a person with fever or symptoms being evaluated or under investigation for COVID-19 but not confirmed to have COVID-19**
 - i. Implement cohorting with restricted movement for detainees housed with the ill detainee or who have been in close contact¹ with the ill detainee for the duration of the most recent incubation period.

- ii. Monitor cohorted detainees daily to observe for fever and symptoms of respiratory illness.
- iii. Refer exposed detainees with new onset fever and/or respiratory illness to a medical provider for evaluation.
- iv. If the index patient is subsequently confirmed to have COVID-19, see section 5.b above.
- v. Discontinue cohorting if the index patient receives an alternate diagnosis that excludes COVID-19.
- vi. Any of the cohorted detainees with exposure risk should complete their initial 14-day monitoring period (i.e., for asymptomatic monitoring).
- e. Report cohorting through routine IHSC cohort reporting protocols.
- f. Document any asymptomatic and afebrile detainees under monitoring for COVID-19 on the [Lower Respiratory Illness Tracking Tool](#).
- g. Recommend to Field Office Director or designee that detainees cohorted due to high or medium exposure risk or known exposure to an ill person not be transferred or transported.
- i. See [IHSC Interim COVID-19 Risk Assessment](#) on the [2019 Novel Coronavirus Resource Page](#).
- h. If a cohorted detainee must be released in the U.S., notify the local health department including the intended address and telephone numbers of the detainee's intended destination.

¹**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)

Resources and references

- [2019 Novel Coronavirus Resource Page](#) on SharePoint
- [Illness Prevention and Patient Education](#) resources in multiple languages are available on SharePoint.
- [COVID-19 Questions and Responses](#) on SharePoint for submitting questions, receiving responses from IHSC subject matter experts, and viewing all questions and responses

IHSC Official Guidance

Guidance number	Guidance name	Type
05-02	Occupational Health Directive	Policy
05-02 G-04	Occupational Health Guide: Workforce Health	Guide
05-02 G-1	Occupational Health Guide: Bloodborne Pathogens and Other Potentially Infectious Materials	Guide
05-02 G-2	Occupational Health Guide: Personal Protective Equipment Program	Guide
05-02-G-03	Occupational Health Guide: Respiratory Protection Program	Guide
05-04	Environmental Health Directive	Policy
05-04 G-01	IHSC Environmental Health Guide	Guide
05-06	Infectious Disease Public Health Actions Directive	Policy
05-06 G-01	Infectious Disease Public Health Actions Guide: Contact and Outbreak Investigation Guide	Guide
05-06 G-02	Infectious Disease Public Health Actions Guide: Isolation and Management of Detainees Exposed to Infectious Organisms	Guide
05-06 G-03	Infectious Disease Public Health Actions Guide: Surveillance and Reporting	Guide

- [Infection Control: Novel Coronavirus 2019 \(COVID-19\) | CDC](#)
- [Interim Guidance: Healthcare Professionals 2019-nCoV | CDC](#) (including CDC website listing of geographic area(s) with widespread or sustained community transmission)
- [CDC | Coronavirus Disease 2019 \(COVID-19\)](#)
- [2019 Novel Coronavirus \(2019-nCoV\) | TDSHS](#)
- [nCOV2019 | CDPH](#)
- [Novel Coronavirus Outbreak 2020 | Washington State Department of Health](#)

- [ADHS - Highlighted Infectious Diseases for Arizona - Coronavirus Disease 2019 \(COVID-19\)](#)
- [Coronavirus | NYC Health](#)
- [2019 Novel \(New\) Coronavirus | NYDOH](#)
- [2019 Novel Coronavirus \(2019-nCoV\) | Florida Department of Health](#)
- [NJ Department of Health | Communicable Disease Service | COVID-2019 \(Novel Coronavirus\)](#)
- [Pennsylvania Department of Health | Coronavirus](#)
- [2019 Novel Coronavirus \(2019 nCoV\) | Frequently Asked Questions | IDPH](#)

Points of contact for questions

- [IHSC Staff: COVID-19 Questions and Responses](#) on SharePoint for submitting questions, receiving responses from IHSC subject matter experts, and viewing all questions and responses
 - Regional Infection Prevention Supervisory Nurses, PHSP Unit Senior Public Health Analyst, PHSP Unit Chief
- [Facilities without IHSC Medical Staffing](#): Assigned Field Medical Coordinators
- [Public health agencies: IHSC_InfectionPrevention@ice.dhs.gov](#)

Appendix A: Intake Screening Questions

Updated February 28, 2020

1. **Have you been in close contact with a person with laboratory-confirmed 2019 novel coronavirus or their respiratory secretions in the past 14 days?**
 - Last date you had contact with that person: mm/dd/yyyy**OR**
2. **What countries have you traveled from or through in the past two weeks?**
 - Check whether the detainee traveled from or through geographic area(s) with widespread or sustained community transmission*in the past 14 days?
 - ***Please see CDC website listing of geographic area(s) with widespread or sustained community transmission at <https://www.cdc.gov/coronavirus/2019-ncov/hcp/clinical-criteria.html>**
3. If yes to #1 **or** the detainee traveled from or through geographic area(s) with widespread or sustained community transmission*in the past 14 days? (#2):
 - **Have you had fever and/or respiratory illness with onset in the past 14 days?**
 - **If yes, what date did you first notice symptoms?: mm/dd/yyyy**
 - **If yes, implement standard, airborne, and contact precautions including eye protection**, isolate and refer to a medical provider, add Medical Hold, notify FHPM, IPO, or designee.
 - **If no, implement MONITORING**; house in single room (preferred) if available, implement daily checks for 14 days after initial DHS apprehension, add Medical Hold, notify FHPM, IPO, or designee.
4. If no travel from or through geographic area(s) with widespread or sustained community transmission* in the past 14 days AND no close contact with a person with laboratory-confirmed 2019 novel coronavirus or their respiratory secretions in the past 14 days?
 - ***Please see CDC website listing of international area(s) with sustained transmission at <https://www.cdc.gov/coronavirus/2019-ncov/hcp/clinical-criteria.html>**
 - Routine intake
 - If the initial DHS apprehension date (i.e., initial CBP or ICE encounter) documented in ENFORCE is ≥ 14 days prior, the detainee is outside the 14 day window and does not require monitoring for the epidemiologic risk of COVID-19 exposure
 - Facility Infection Prevention Officers and/or PHSP Unit staff can help confirm the date of initial DHS apprehension in ENFORCE

***Please see CDC website listing of international area(s) with sustained transmission at <https://www.cdc.gov/coronavirus/2019-ncov/hcp/clinical-criteria.html>**

From: Office of the Executive Associate Director for ERO
Sent: Sat, 11 Apr 2020 15:20:32 +0000
To: Undisclosed recipients:
Subject: UPDATED (Additional Attachments Added): ICE Detention Facilities COVID-19 Response Requirements [FO]
Attachments: ERO COVID-19 Response Requirements for Facilities 4.10.20.pdf, Attachment A.pdf, Attachment B.pdf, Attachment C.pdf, Attachment D.pdf, Attachment E.pdf, Attachment F.pdf, Attachment G.pdf, Attachment H.pdf, Attachment I.pdf, Attachment J.pdf, Attachment K.pdf



Enforcement and Removal Operations Office of the Executive Associate Director

To: Field Office Directors and Deputy Field Office Directors

The attached U.S. Immigration and Customs Enforcement (ICE) Enforcement and Removal Operations (ERO) Coronavirus Disease 2019 (COVID-19) Pandemic Response Requirements (PRR) sets forth expectations and assists ICE detention facility operators to sustain detention operations, while mitigating risk to the safety and well-being of detainees, staff, contractors, visitors, and stakeholders due to COVID-19.

These requirements must immediately be distributed to all detention facilities within your area of responsibility. Once distributed, please provide email confirmation to Mission Support Specialist (b)(6); (b)(7)(C) at (b)(6); (b)(7)(C) by **5:00 pm EDT Monday, April 13, 2020.**

*Tae D. Johnson
Deputy Executive Associate Director
Enforcement and Removal Operations*

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ERO

U.S. Immigration and Customs Enforcement Enforcement and Removal Operations

COVID-19 Pandemic Response Requirements



U.S. Immigration
and Customs
Enforcement

AMERICAN
OVERSIGHT

ERO COVID-19 Pandemic Response Requirements (Version 1.0, April 10, 2020)

1

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PURPOSE AND SCOPE

The U.S. Immigration and Customs Enforcement (ICE) Enforcement and Removal Operations (ERO) Coronavirus Disease 2019 (COVID-19) Pandemic Response Requirements (PRR) sets forth expectations and assists ICE detention facility operators to sustain detention operations, while mitigating risk to the safety and well-being of detainees, staff, contractors, visitors, and stakeholders due to COVID-19. Consistent with ICE's overall adjustments to its immigration enforcement posture,¹ the ERO PRR builds upon previously issued guidance and sets forth specific mandatory requirements expected to be adopted by all detention facilities housing ICE detainees, as well as best practices for such facilities, to ensure that detainees are appropriately housed and that available mitigation measures are implemented during this unprecedented public health crisis. The ERO PRR has been developed in consultation with the Centers for Disease Control and Prevention (CDC) and is a dynamic document that will be updated as additional/revised information and best practices become available.

INTRODUCTION

As the CDC has explained:

COVID-19 is a communicable disease caused by a novel (new) coronavirus, SARS-CoV-2, that was first identified as the cause of an outbreak of respiratory illness that began in Wuhan Hubei Province, People's Republic of China (China).

COVID-19 appears to spread easily and sustainably within communities. The virus is thought to transfer primarily by person-to-person contact through respiratory droplets produced when an infected person coughs or sneezes; it may transfer through contact with surfaces or objects contaminated with these droplets. There is also evidence of asymptomatic transmission, in which an individual infected with COVID-19 is capable of spreading the virus to others before exhibiting symptoms. The ease of transmission presents a risk of a surge in hospitalizations for COVID-19, which would reduce available hospital capacity. Such a surge has been identified as a likely contributing factor to the high mortality rate for COVID-19 cases in Italy and China.

Symptoms include fever, cough, and shortness of breath, and typically appear 2-14 days after exposure. Manifestations of severe disease include severe pneumonia, acute respiratory distress syndrome (ARDS), septic shock, and multi-organ failure. According to the [World Health Organization], approximately 3.4% of reported COVID-19 cases have resulted in death globally. This mortality rate is higher among older adults or those with compromised immune systems. Older adults and people who have severe chronic medical conditions like heart, lung or kidney disease are also at higher risk for more serious COVID-19 illness. Early data suggest older people are twice as likely to have serious COVID-19 illness.

¹ See, e.g., Attachment A, U.S. Immigration and Customs Enforcement, *Updated ICE statement on COVID-19* (Mar. 18, 2020), <https://www.ice.gov/news/releases/updated-ice-statement-covid-19>.

Given the seriousness and pervasiveness of COVID-19, ICE is taking necessary and prompt measures in response. ICE is providing guidance on the minimum measures required for facilities housing ICE detainees to implement to ensure consistent practices throughout its detention operations and the provision of medical care across the full spectrum of detention facilities to mitigate the spread of COVID-19. The ICE detention standards applicable to all facilities used to house ICE detainees have long required that each such facility have written plans that address the management of infectious and communicable diseases, including, but not limited to, testing, isolation, prevention, treatment, and education. Those requirements include reporting and collaboration with local or state health departments in accordance with state and local laws and recommendations.² The measures set forth in the PRR, allow ICE personnel and detention providers to properly discharge their obligations under those standards in light of the unique challenges posed by COVID-19.

OBJECTIVES

The ERO PRR is designed to establish consistency across ICE detention facilities by establishing mandatory requirements and best practices all detention facilities housing ICE detainees are expected to follow during the COVID-19 pandemic. Consistent with ICE detention standards, all facilities housing ICE detainees are required to have a COVID-19 mitigation plan that meets the following four objectives:

- To protect employees, contractors, detainees, visitors to the facility, and stakeholders from exposure to the virus;
- To maintain essential functions and services at the facility throughout the pendency of the pandemic;
- To reduce movement and limit interaction of detainees with others outside their assigned housing units, as well as staff and others, and to promote social distancing within housing units; and
- To establish means to monitor, cohort, quarantine, and isolate the sick from the well.³

² See, e.g., Attachment B, ICE National Detention Standards 2019, Standard 4.3, Medical Care, at II.D.2 (p. 114), https://www.ice.gov/doclib/detention-standards/2019/4_3.pdf; Attachment C, 2011 ICE Performance-Based National Detention Standards (PBNDS), Revised 2016, Standard 4.3, Part V.C.1 (p. 261), <https://www.ice.gov/doclib/detention-standards/2011/4-3.pdf>; Attachment D, 2008 ICE PBNDS, Standard 4-22, Medical Care, V.C.1 (pp. 5-6), https://www.ice.gov/doclib/dro/detention-standards/pdf/medical_care.pdf.

³ A *cohort* is a group of persons with a similar condition grouped or housed together for observation over a period of time. Isolation and quarantine are public health practices used to protect the public from exposure to individuals who have or may have a contagious disease. For purposes of this document, and as defined by the CDC, *quarantine* as the separation of a person or group of people reasonably believed to have been exposed to a communicable disease but not yet symptomatic, from others who have not been exposed, to prevent the possible spread of the communicable disease. For purposes of this document, and as defined by the CDC, *isolation* as the separation of a person or group of people known or reasonably

CONCEPT OF OPERATIONS

The ERO PRR is intended for use across ICE's entire detention network, applying to all facilities housing ICE detainees, including ICE-owned Service Processing Centers, facilities operated by private vendors, and facilities operated by local government agencies that have mixed populations of which ICE detainees comprise only a small fraction.

DEDICATED ICE DETENTION FACILITIES

All ICE dedicated detention facilities⁴ must:

- Comply with the provisions of their relevant ICE contract or service agreement.
- Comply with the ICE national detention standards applicable to the facility, generally the Performance-Based National Detention Standards 2011 (PBNDS 2011).
- Comply with the CDC's Interim Guidance on Management of Coronavirus Disease 2019 (COVID-19) in Correctional and Detention Facilities (Attachment E).
- Follow ICE's March 27, 2020 Memorandum to Detention Wardens and Superintendents on COVID-19 Action Plan Revision 1, and subsequent updates (Attachment F).
- Report all confirmed and suspected COVID-19 cases to the local ERO Field Office Director (or designee), Field Medical Coordinator, and local health department immediately.
- Notify both the local ERO Field Office Director (or designee) and the Field Medical Coordinator as soon as practicable, but in no case more than 12 hours after identifying any detainee who meets the CDC's identified populations potentially being at higher-risk for serious illness from COVID-19, including:
 - People aged 65 and older
 - People of all ages with underlying medical conditions, particularly if not well controlled, including:
 - People with chronic lung disease or moderate to severe asthma
 - People who have serious heart conditions
 - People who are immunocompromised
 - Many conditions can cause a person to be immunocompromised, including cancer treatment, smoking, bone marrow or organ transplantation, immune deficiencies, poorly controlled HIV or

believed to be infected with a communicable disease and potentially infectious from others to prevent the spread of the communicable disease.

⁴ Dedicated detention facilities are facilities that house only ICE detainees. Dedicated facilities may be ICE-owned Service Processing Centers, privately owned Contract Detention Facilities, or facilities operated by state or local governments that hold no other detention populations except ICE detainees.

AIDS, and prolonged use of corticosteroids and other immune weakening medications

- People with severe obesity (body mass index [BMI] of 40 or higher)
- People with diabetes
- People with chronic kidney disease undergoing dialysis
- People with liver disease

Notification shall be made via e-mail from the facility's Health Services Administrator (HSA) (or equivalent) and contain the following subject line for ease of identification: "Notification of COVID-19 High Risk Detainee (A-Number)." At a minimum the HSA will provide the following information:

- Detainee name
- Detention location
- Current medical issues as well as medications currently prescribed
- Facility medical Point of Contact (POC) and phone number

NON-DEDICATED ICE DETENTION FACILITIES

All non-dedicated detention facilities and local jails housing ICE detainees must:

- Comply with the provisions of their relevant ICE contract or service agreement.
- Comply with the ICE national detention standards applicable to the facility, generally the 2019 National Detention Standards.
- Comply with the CDC Interim Guidance on Management of Coronavirus Disease 2019 (COVID-19) in Correctional and Detention Facilities.
- Report all confirmed and suspected COVID-19 cases to the local ERO Field Office Director (or designee), Field Medical Coordinator, and local health department immediately.
- Notify both the ERO Field Office Director (or designee) and Field Medical Coordinator as soon as practicable, but in no case more than 12 hours after identifying any detainee who meets the CDC's identified populations potentially being at higher-risk for serious illness from COVID-19, including:
 - People aged 65 and older
 - People of all ages with underlying medical conditions, particularly if not well controlled, including:
 - People with chronic lung disease or moderate to severe asthma
 - People who have serious heart conditions
 - People who are immunocompromised
 - Many conditions can cause a person to be immunocompromised, including cancer treatment, smoking, bone marrow or organ transplantation, immune deficiencies, poorly controlled HIV or

AIDS, and prolonged use of corticosteroids and other immune weakening medications

- People with severe obesity (body mass index [BMI] of 40 or higher)
- People with diabetes
- People with chronic kidney disease undergoing dialysis
- People with liver disease

Notification should be made via e-mail from the facility's HSA (or equivalent) and should contain the following subject line for ease of identification: "Notification of COVID-19 High Risk Detainee (A-Number)." Other standardized means of communicating this information to ICE are acceptable. At a minimum the HSA will provide the following information:

- Detainee name
- Detention location
- Current medical issues as well as medications currently prescribed
- Facility medical POC and phone number

ALL FACILITIES HOUSING ICE DETAINEES

In addition to the specific measures listed above, all detention facilities housing ICE detainees must also comply with the following:

PREPAREDNESS

Administrators can plan and prepare for COVID-19 by ensuring that all persons in the facility know the symptoms of COVID-19 and how to respond if they develop symptoms. Other essential actions include developing contingency plans for reduced workforces due to absences, coordinating with public health and correctional partners, and communicating clearly with staff and detainees about these preparations and how they may temporarily alter daily life.

- **Develop information-sharing systems with partners.**
 - Identify points of contact in relevant state, local, tribal, and/or territorial public health department before cases develop.
 - Communicate with other correctional and detention facilities in the same geographic area to share information including disease surveillance and absenteeism patterns among staff.
- **Review existing pandemic, influenza, all-hazards, and disaster plans, and revise for COVID-19, and ensure that they meet the requirements of ICE's detention standards.**
- **Offer the seasonal influenza vaccine to all detained persons (existing populations and new intakes) and staff throughout the influenza season, where possible.**

➤ Staffing

- Review sick leave policies to ensure that staff can stay home when sick and determine which officials will have the authority to send symptomatic staff home. Staff who report for work with symptoms of COVID-19 must be sent home and advised to follow CDC-recommended steps for persons exhibiting COVID-19 symptoms.
- Staff who test positive for COVID-19 must inform their workplace and personal contacts immediately. If a staff member has a confirmed COVID-19 infection, the relevant employers will inform other staff of their possible exposure to COVID-19 in the workplace consistent with any legal limitations on the sharing of such information. Exposed employees must then self-monitor for symptoms (i.e., fever, cough, or shortness of breath).
- Identify staff whose duties would allow them to work from home and allow them to work from home in order to promote social distancing and further reduce the risk of COVID-19 transmission.
- Determine minimum levels of staff in all categories required for the facility to function safely.
- Follow the Public Health Recommendations for Community-Related Exposure.⁵

➤ Supplies

- Ensure that sufficient stocks of hygiene supplies (soap, hand sanitizer, tissues), personal protective equipment (PPE) (to include facemasks, N95 respirators, eye protection, disposable medical gloves, and disposable gowns/one-piece coveralls), and medical supplies (consistent with the healthcare capabilities of the facility) are on hand, and have a plan in place to restock as needed if COVID-19 transmission occurs within the facility.
- Note that shortages of N95 respirators are anticipated during the COVID-19 response. Based on local and regional situational analysis of PPE supplies, face masks should be used when the supply chain of N95 respirators cannot meet the demand.
- Follow COVID-19: Strategies for Optimizing the Supply of PPE.⁶
- Soiled PPE items should be disposed in leak-proof plastic bags that are tied at the top and not re-opened. Bags can be disposed of in the regular solid waste stream.
- Cloth face coverings should be worn by detainees and staff (when PPE supply is limited) to help slow the spread of COVID-19. Cloth face masks should:

⁵ Attachment G, Centers of Disease Control and Prevention, *Public Health Recommendations for Community-Related Exposure*, <https://www.cdc.gov/coronavirus/2019-ncov/php/public-health-recommendations.html> (last visited Apr. 9, 2020).

⁶ Attachment H, Centers for Disease Control and Prevention, *Strategies to Optimize the Supply of PPE and Equipment*, <https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/> (last visited Apr. 9, 2020).

- fit snugly but comfortably against the side of the face
- be secured with ties or ear loops where possible or securely tied
- include multiple layers of fabric
- allow for breathing without restriction
- be able to be laundered and machine dried without damage or change to shape.

➤ Hygiene

- Reinforce healthy hygiene practices and provide and restock hygiene supplies throughout the facility, including in bathrooms, food preparation and dining areas, intake areas, visitor entries and exits, visitation rooms, common areas, medical, and staff-restricted areas (e.g., break rooms).
- Require all persons within the facility to cover their mouth and nose with their elbow (or ideally with a tissue) rather than with their hand when they cough or sneeze, and to throw all tissues in the trash immediately after use. Provide detainees and staff no-cost access to tissues and no-touch receptacles for disposal.
- Require all persons within the facility to maintain good hand hygiene by regularly washing their hands with soap and water for at least 20 seconds, especially after coughing, sneezing, or blowing their nose; after using the bathroom; before eating or preparing food; before taking medication; and after touching garbage.
- Provide detainees and staff no-cost, unlimited access to supplies for hand cleansing, including liquid soap, running water, hand drying machines or disposable paper towels, and no-touch trash receptacles.
- Provide alcohol-based hand sanitizer with at least 60% alcohol where permissible based on security restrictions.
- Require all persons within the facility to avoid touching their eyes, nose, or mouth without cleaning their hands first.
- Post signage throughout the facility reminding detained persons and staff to practice good hand hygiene and cough etiquette (printable materials for community-based settings can be found on the [CDC website](https://www.cdc.gov/coronavirus/2019-ncov/community/organizations/cleaning-disinfection.html)). Signage must be in English and Spanish, as well as any other common languages for the detainee population at the facility.
- Prohibit sharing of eating utensils, dishes, and cups.
- Prohibit non-essential personal contact such as handshakes, hugs, and high-fives.

➤ Cleaning/Disinfecting Practices

- Adhere to CDC recommendations for cleaning and disinfection during the COVID-19 response.⁷
- Several times a day using household cleaners and Environmental Protection Agency-registered disinfectants, clean and disinfect surfaces and objects that are

⁷ Attachment I, Centers for Disease Control and Prevention, *Cleaning and Disinfection for Community Facilities*, <https://www.cdc.gov/coronavirus/2019-ncov/community/organizations/cleaning-disinfection.html> (last visited Apr. 9, 2020).

frequently touched, especially in common areas (e.g., doorknobs, light switches, sink handles, countertops, toilets, toilet handles, recreation equipment). The Environmental Protection Agency's (EPA) list of certified cleaning products is located [here](#).

- Staff should clean shared equipment several times per day and on a conclusion of use basis (e.g., radios, service weapons, keys, handcuffs).
- Ensure that transport vehicles are thoroughly cleaned after carrying a confirmed or suspected COVID-19 case.
- Facility leadership will ensure that there is adequate oversight and supervision of all individuals responsible for cleaning and disinfecting these areas.

CDC Recommended Cleaning Tips

Hard (Non-porous) Surfaces

- If surfaces are dirty, they should be cleaned using a detergent or soap and water prior to disinfection.
- For disinfection, most common EPA-registered household disinfectants should be effective.
 - A list of products that are EPA-approved for use against the virus that causes COVID-19 is available [here](#). Follow the manufacturer's instructions for all cleaning and disinfection products for concentration, application method and contact time, etc.
 - Additionally, diluted household bleach solutions (at least 1000ppm sodium hypochlorite) can be used if appropriate for the surface. Follow manufacturer's instructions for application, ensuring a contact time of at least 1 minute, and allowing proper ventilation during and after application. Check to ensure the product is not past its expiration date. Never mix household bleach with ammonia or any other cleanser. Unexpired household bleach will be effective against coronaviruses when properly diluted.
 - Prepare a bleach solution by mixing:
 - 5 tablespoons (1/3 cup) bleach per gallon of water or
 - 4 teaspoons bleach per quart of water

Soft (Porous) Surfaces

- For soft (porous) surfaces such as carpeted floor, rugs, and drapes, remove visible contamination if present and clean with appropriate cleaners indicated for use on these surfaces. After cleaning:
 - If the items can be laundered, launder items in accordance with the manufacturer's instructions using the warmest appropriate water setting for the items and then dry items completely.

- Otherwise, use products that are EPA-approved for use against the virus that causes COVID-19 and that are suitable for porous surfaces.⁸

Electronics

- For electronics such as tablets, touch screens, keyboards, remote controls, and ATM machines, remove visible contamination if present.
 - Follow the manufacturer's instructions for all cleaning and disinfection products.
 - Consider use of wipeable covers for electronics.
 - If no manufacturer guidance is available, consider the use of alcohol-based wipes or sprays containing at least 70% alcohol to disinfect touch screens. Dry surfaces thoroughly to avoid pooling of liquids.

Linens, Clothing, and Other Items That Go in the Laundry

- In order to minimize the possibility of dispersing virus through the air, do not shake dirty laundry.
- Wash items as appropriate in accordance with the manufacturer's instructions. If possible, launder items using the warmest appropriate water setting for the items and dry items completely. Dirty laundry that has been in contact with an ill person can be washed with other people's items.
- Clean and disinfect hampers or other carts for transporting laundry according to guidance above for hard or soft surfaces.

PREVENTION

Detention facilities can prevent introduction of COVID-19 from the community and reduce transmission if it is already inside by reinforcing good hygiene practices among incarcerated/detained persons, staff, and visitors (including increasing access to soap and paper towels), intensifying cleaning/disinfection practices, and implementing social distancing strategies.

Because many individuals infected with COVID-19 do not display symptoms, the virus could be present in facilities before cases are identified. Both good hygiene practices and social distancing are critical in preventing further transmission.

➤ Perform pre-intake screening for all staff and new entrants for symptoms of COVID-19.

Screening should take place before staff and new intakes enter the facility or just inside the facility, where practicable. For new admissions, this should occur before beginning the intake process, in order to identify and immediately isolate any detainee with symptoms before the individual comes in contact with others or is placed in

⁸ Attachment J, U.S. Environmental Protection Agency, *List N: Disinfectants for Use Against SARS-CoV-2*, <https://www.epa.gov/pesticide-registration/list-n-disinfectants-use-against-sars-cov-2> (last visited Apr. 9, 2020).

the general population. This should include temperature screening of all staff and new entrants, as well as a verbal symptoms check.

- Verbal screening for symptoms of COVID-19 and contact with COVID-19 cases should include the following questions based on Interim Guidance: Managing COVID-19 in Correctional/Detention Facilities:
 - Today or in the past 24 hours, have you had any of the following symptoms?
 - Fever, felt feverish, or had chills?
 - Cough?
 - Difficulty breathing?
 - In the past 14 days, have you had contact with a person known to be infected with COVID-19 where you were not wearing the recommended proper PPE?
- If staff have symptoms of COVID-19 (fever, cough, shortness of breath): they must be denied access to the facility.
- If any new intake has symptoms of COVID-19:
 - Require the individual to wear a face mask.
 - Ensure that staff interacting with the symptomatic individual wears recommended PPE.
 - Isolate the individual and refer to healthcare staff for further evaluation.
 - Facilities without onsite healthcare staff should contact their state, local, tribal, and/or territorial health department to coordinate effective isolation and necessary medical care.
- If an individual is a close contact of a known COVID-19 case or has traveled to an affected area (but has no COVID-19 symptoms), quarantine the individual and monitor for symptoms two times per day for 14 days.

➤ Visitation

- During suspended (social) or modified (legal) visitation programs, provide access to virtual visitation options where available. When not possible, verbally screen all visitors on entry for symptoms of COVID-19 and perform temperature checks, when possible. ICE continues to explore opportunities to enhance attorney access while legal visits are being impacted. For facilities at which immigration hearings are conducted or where detainees are otherwise held who have cases pending immigration proceedings, this may include:
 - Adding all immigration attorneys of record to the Talton Pro-bono platform.
 - Requiring facilities to establish a process for detainees/immigration attorneys to schedule appointments and facilitate the calls.
 - Leveraging technology (e.g., tablets, smartphones) to facilitate attorney/client communication.

- Working with the various detention contractors and telephone service providers to ensure that all detainees receive some number of free calls per week.
- Communicate with the public about any changes to facility operations, including visitation programs. Facilities are encouraged to prohibit or, at a minimum, significantly adopt restricted visitation programs, and to suspend all volunteer work assignments for detainees assigned to food service, and other assignments where applicable.
- **Where possible, restrict transfers of detained non-ICE populations to and from other jurisdictions and facilities unless necessary for medical evaluation, isolation/quarantine, clinical care, or extenuating security concerns.**
- **Consider suspending work release programs for inmates at shared facilities to reduce overall risk of introduction and transmission of COVID-19 into the facility.**
- **When feasible and consistent with security priorities, encourage staff to maintain a distance greater than six feet from an individual that appears feverish or ill and/or with respiratory symptoms while interviewing, escorting, or interacting in other ways, unless wearing PPE.**
- **Additional Measures to Facilitate Social Distancing**
 - Although strict social distancing may not be possible in congregate settings such as detention facilities, all facilities housing ICE detainees should implement the following measures to the extent practicable:
 - Efforts should be made to reduce the population to approximately 75% of capacity.
 - Where detainee populations are such that such cells are available, to the extent possible, house detainees in individual rooms.
 - Recommend that detainees sharing sleeping quarters sleep “head-to-foot.”
 - Extend recreation, law library, and meal hours and stagger detainee access to the same in order to limit the number of interactions between detainees from other housing units.
 - Staff and detainees should be directed to avoid congregating in groups of 10 or more, employing social distancing strategies at all times.
 - Whenever possible, all staff and detainees should maintain a distance of six feet from one another.
 - If practicable, beds in housing units should be rearranged to allow for sufficient separation during sleeping hours.

MANAGEMENT

If there has been a suspected COVID-19 case inside the facility (among incarcerated/detained persons, staff, or visitors who have recently been inside), begin implementing Management strategies while test results are pending. Essential Management strategies include placing cases and individuals with symptoms under medical isolation, quarantining their close contacts, and facilitating necessary medical care, while observing relevant infection control and environmental disinfection protocols and wearing recommended PPE.

ICE Custody Review for Potentially High-Risk Detainees

Upon being informed of a detainee who may potentially be at higher risk for serious illness from exposure to COVID-19, ERO will review the case to determine whether continued detention is appropriate.⁹ ICE will make such custody determinations on a case-by-case basis, pursuant to the applicable legal standards, with due consideration of the public health considerations implicated.

- **Considerable effort should be made to quarantine all new entrants for 14 days before they enter the general population.**
 - To do this, facilities should consider cohorting daily intakes; two days of new intakes, or multiple days on new intakes, in designated areas prior to placement into the general population. Given the significant variance in facility attributes and characteristics, cohorting options and capabilities will differ across the various detention facilities housing ICE detainees. ICE encourages all facilities to adopt the most effective cohorting methods practicable based on the individual facility characteristics taking into account the number new intakes anticipated per day.
- **For suspected or confirmed COVID-19 cases:**
 - Isolate the individual immediately in a separate environment from other individuals. Facilities should make every possible effort to isolate persons individually. Each isolated individual should be assigned his or her own housing space and bathroom where possible. Cohorting should only be practiced if there are no other available options. Only individuals who are laboratory-confirmed COVID-19 cases should be isolated as a cohort. Do not cohort confirmed cases with suspected cases or case contacts.
 - Ensure that the individual is always wearing a face mask (if it does not restrict breathing) when outside of the isolation space, and whenever another individual enters the isolation room. Masks should be changed at least daily, and when visibly soiled or wet.

⁹ Attachment K, Assistant Director Peter Berg, Enforcement and Removal Operations, *Updated Guidance: COVID-19 Detained Docket Review* (Apr. 4, 2020).

- If the number of confirmed cases exceeds the number of individual isolation spaces available in the facility, then ICE must be promptly notified so that transfer to other facilities, transfers to hospitals, or release can be coordinated immediately. Until such time as transfer or release is arranged, the facility must be especially mindful of cases that are at higher risk of severe illness from COVID-19. Ideally, ill detainees should not be cohorted with other infected individuals. If cohorting of ill detainees is unavoidable, make all possible accommodations until transfer occurs to prevent transmission of other infectious diseases to the higher-risk individual (For example, allocate more space for a higher-risk individual within a shared isolation room).
- Review the CDC's preferred method of medically isolating COVID-19 cases here depending on the space available in a particular facility. In order of preference, individuals under medical isolation should be housed:
 - Separately, in single cells with solid walls (i.e., not bars) 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 and a solid door that closes fully. Employ social distancing strategies related to housing in the Prevention section above.
 - As a cohort, in a large, well-ventilated cell with solid walls but without a solid door. Employ social distancing strategies related to housing in the Prevention section above.
 - As a cohort, in single cells without solid walls or solid doors (i.e., cells enclosed entirely with bars), preferably with an empty cell between occupied cells. (Although individuals are in single cells in this scenario, the airflow between cells essentially makes it a cohort arrangement in the context of COVID-19).
 - As a cohort, in multi-person cells without solid walls or solid doors (i.e., cells enclosed entirely with bars), preferably with an empty cell between occupied cells. Employ social distancing strategies related to housing in the Prevention section above.
- Maintain isolation until all the CDC criteria have been met:
 - The individual has been free from fever for 72 hours without the use of fever-reducing medications.
 - The individual's other symptoms have improved (e.g., cough, shortness of breath).
 - The individual has tested negative in at least two consecutive respiratory specimens collected at least 24 hours apart.
 - At least 7 days have passed since the date of the individual's first positive COVID-19 test and he or she has had no subsequent illness.

- Meals should be provided to COVID-19 cases in their isolation rooms. Isolated cases should throw disposable food service items in the trash in their isolation room. Non-disposable food service items should be handled with gloves and washed with hot water or in a dishwasher. Individuals handling used food service items must clean their hands after removing gloves.
- Laundry from a COVID-19 case can be washed with other individuals' laundry.
 - Individuals handling laundry from COVID-19 cases should wear disposable gloves, discard gloves after each use, and clean their hands after handling.
 - Do not shake dirty laundry. This will minimize the possibility of dispersing the virus through the air.
 - Launder items as appropriate in accordance with the manufacturer's instructions. If possible, launder items using the warmest appropriate water setting for the items and dry items completely.
 - Clean and disinfect clothes hampers according to guidance above for surfaces. If permissible, consider using a bag liner that is either disposable or can be laundered.

ATTACHMENTS

ATTACHMENT LETTER	DOCUMENT NAME AND CITATION
A	U.S. Immigration and Customs Enforcement, <i>Updated ICE statement on COVID-19</i> (Mar. 18, 2020), https://www.ice.gov/news/releases/updated-ice-statement-covid-19 .
B	ICE National Detention Standards 2019, Standard 4.3, Medical Care, https://www.ice.gov/doclib/detention-standards/2019/4_3.pdf .
C	2011 ICE Performance-Based National Detention Standards, Revised 2016, Standard 4.3, https://www.ice.gov/doclib/detention-standards/2011/4-3.pdf .
D	2008 ICE Performance-Based National Detention Standards, Standard 4-22, Medical Care, https://www.ice.gov/doclib/dro/detention-standards/pdf/medical_care.pdf .
E	Centers of Disease Control and Prevention, <i>Interim Guidance on Management of Coronavirus Disease 2019 (COVID-19) in Correctional and Detention Facilities</i> (Mar. 23, 2020), https://www.cdc.gov/coronavirus/2019-ncov/downloads/guidance-correctional-detention.pdf .
F	Memorandum from Executive Associate Director Enrique Lucero, Enforcement and Removal Operations, <i>Memorandum on Coronavirus 2019 (COVID-19) Action Plan, Revision 1</i> (Mar. 27, 2020).
G	Centers of Disease Control and Prevention, <i>Public Health Recommendations for Community-Related Exposure</i> , https://www.cdc.gov/coronavirus/2019-ncov/php/public-health-recommendations.html (last visited Apr. 9, 2020).
H	Centers for Disease Control and Prevention, <i>Strategies to Optimize the Supply of PPE and Equipment</i> , https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/ (last visited Apr. 9, 2020).
I	Centers for Disease Control and Prevention, <i>Cleaning and Disinfection for Community Facilities</i> , https://www.cdc.gov/coronavirus/2019-ncov/community/organizations/cleaning-disinfection.html (last visited Apr. 9, 2020).

J	U.S. Environmental Protection Agency, <i>List N: Disinfectants for Use Against SARS-CoV-2</i> , https://www.epa.gov/pesticide-registration/list-n-disinfectants-use-against-sars-cov-2 (last visited Apr. 9, 2020).
K	Assistant Director Peter Berg, Enforcement and Removal Operations, <i>Updated Guidance: COVID-19 Detained Docket Review</i> (Apr. 4, 2020).

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Updated ICE statement on COVID-19

Statement attributable U.S. Immigration and Customs Enforcement

To ensure the welfare and safety of the general public as well as officers and agents in light of the ongoing COVID-19 pandemic response, U.S. Immigration and Customs Enforcement (ICE) will temporarily adjust its enforcement posture beginning today, March 18, 2020. ICE's highest priorities are to promote life-saving and public safety activities.

ICE Enforcement and Removal Operations (ERO) will focus enforcement on public safety risks and individuals subject to mandatory detention based on criminal grounds. For those individuals who do not fall into those categories, ERO will exercise discretion to delay enforcement actions until after the crisis or utilize alternatives to detention, as appropriate.

Homeland Security Investigations will continue to carry out mission critical criminal investigations and enforcement operations as determined necessary to maintain public safety and national security. Examples include investigations into child exploitation, gangs, narcotics trafficking, human trafficking, human smuggling, and continued participation on the Joint Terrorism Task Force. This work will be conducted based on ability to coordinate and work with prosecutors from the Department of Justice and intake at both the U.S. Marshals Service and Bureau of Prisons.

Consistent with its sensitive locations policy, during the COVID-19 crisis, ICE will not carry out enforcement operations at or near health care facilities, such as hospitals, doctors' offices, accredited health clinics, and emergent or urgent care facilities, except in the most extraordinary of circumstances. Individuals should not avoid seeking medical care because they fear civil immigration enforcement.

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Last Reviewed/Updated: 04/03/2020

STANDARD 4.3

MEDICAL CARE

I. POLICY

All detainees shall have access to appropriate medical, dental, and mental health care, including emergency services. Each medical facility will strive for accreditation with National Commission on Correctional Health Care.

II. STANDARDS AND PROCEDURES

A. General

Every facility shall directly or contractually provide its detainee population with the following:

1. Initial medical, mental health and dental screening;
2. Medically necessary and appropriate medical, dental and mental health care and pharmaceutical services at no cost to the detainee;
3. Comprehensive, routine and preventive health care, as medically indicated;
4. Emergency care;
5. Specialty health care;
6. Timely responses to medical complaints;
7. Hospitalization as needed within the local community; and
8. Staff or professional language services necessary to allow for meaningful access for detainees with limited English proficiency (LEP), and effective communication for detainees with disabilities, during any medical or mental health appointment, sick call, treatment, or consultation.

The health care program and the medical facilities will be under the direction of a Health Services Administrator (HSA) and/or Clinical Medical Authority (CMA). When the HSA is not a physician, final clinical judgment shall rest with the facility's designated CMA.

Facilities will employ sufficient medical staff to perform basic exams and treatments for all detainees. The HSA will negotiate and keep current arrangements with nearby medical facilities or health care providers to provide required health care not available within the

facility. These arrangements will include appropriate custodial officers to transport and remain with the detainee for the duration of any off-site treatment or hospital admission.

B. Facilities

Adequate space and equipment will be furnished so that all detainees are provided basic health examination, treatment, and communication in private. Medical records will be kept separately from detainee records and stored in a securely locked area. All pharmaceuticals will be stored in a secure area and temperature controlled to ensure no alteration in potency.

C. Health Care Staff

Health care staff shall have a valid professional licensure and/or certification for the jurisdiction in which they practice and will perform duties within the scope of their clinical license. The following terms apply to health care staff referred to throughout this standard.

1. **Health Care Practitioner:** Defined as an individual who is licensed, certified, or credentialed by a state, territory, or other appropriate body to provide health care services within the scope and skills of the respective health care profession.
2. **Mental Health Provider:** Psychiatrist, clinical or counseling psychologist, physician, psychiatric nurse, clinical social worker, or any other mental health professional who, by virtue of their education, credentials, and experience, are permitted by law to evaluate and care for the mental health needs of patients.

D. Medical Screening (New Arrivals)

As soon as possible, but no later than 12 hours after arrival, all detainees shall receive, by a health care practitioner or a specially trained detention officer, an initial medical, dental and mental health screening and be asked for information regarding any known acute, emergent, or pertinent past or chronic medical conditions, including history of mental illness, particularly prior suicide attempts or current suicidal/homicidal ideation or intent, and any disabilities or impairments affecting major life activities. Any detainee responding in the affirmative shall be sent for evaluation to a qualified, licensed health care practitioner as quickly as possible, but no later than two working days. Detainees who appear upon arrival to raise urgent medical or mental health concerns shall receive priority in the intake screening process. For intra-system transfers, a health care practitioner will review each incoming detainee's health record or health summary within 12 hours of arrival, to ensure continuity of care.

Facilities shall have policies and procedures to ensure documentation of the initial health screening and assessment.

1. Tuberculosis

All new arrivals shall receive tuberculosis (TB) screening in accordance with the most current Centers for Disease Control and Prevention (CDC) guidelines, including, but not limited to, CDC Guidelines for Correctional Facilities, prior to being placed in general population. For detainees who have been in continuous law enforcement custody, symptom screening plus documented TB screening within one year of arrival may be accepted for intake screening purposes.

Detainees with symptoms suggestive of pulmonary TB disease and/or with suspected or confirmed TB disease based on historical, clinical and/or laboratory findings will be housed in an airborne infection isolation room with negative pressure ventilation and promptly evaluated for TB disease. Detainees with suspected pulmonary TB disease will remain in airborne infection isolation until determined by a health care practitioner to be noncontagious in accordance with CDC guidelines. All detainees with suspected or confirmed TB disease shall be evaluated for human immunodeficiency virus (HIV), and all detainees with HIV shall be evaluated for TB disease, which includes a chest x-ray. The CMA will consult with the local or state TB program on all aspects of health and public health care for detainees with suspected or confirmed TB disease, including testing, treatment, release from isolation, placement in general population, and public health actions.

2. Infectious and Communicable Diseases

The facility will have written plans that address the management of infectious and communicable diseases, including, but not limited to, testing, isolation, prevention, and education. This also includes reporting and collaboration with local or state health departments in accordance with state and local laws and recommendations.

E. Comprehensive Health Assessment

The facility will conduct and document a comprehensive health assessment, including a physical examination and mental health screening, on each detainee within 14 days of the detainee's arrival at the facility. Health assessments shall be performed by a physician, physician assistant, nurse practitioner, registered nurse (RN) (with documented initial and annual training provided by a physician), or other health care practitioner, as permitted by law. When a physical examination is not conducted by a provider, it must be reviewed by a provider. If there is documented evidence of a comprehensive health assessment within the previous 90 days, the health care practitioner may determine that a new assessment is not required.

F. Substance Dependence and Detoxification

During the initial screening, all detainees shall be evaluated for their use of or dependence on mood and mind-altering substances including alcohol, opiates, hypnotics, and sedatives.

Detainees reporting the use of such substances shall be evaluated for their degree of reliance and potential for withdrawal. The CMA shall establish guidelines for evaluation and treatment of new arrivals who require detoxification. If females are housed at the facility, guidelines will specifically address the treatment of pregnant women who are chemically dependent. Treatment and supportive measures shall be provided to permit withdrawal with minimal discomfort.

Where a detainee requires hospitalization, a physician's order will be obtained and ICE/ERO shall be notified. Detainees experiencing severe or life-threatening alcohol or drug withdrawal shall be immediately transferred to an emergency department for evaluation. Once evaluated, the detainee will be treated on-site if the facility is qualified to provide treatment and monitoring for withdrawal or transferred to an appropriate facility.

G. Translation, Interpretation, and Language Access for Detainees with Limited English Proficiency

Facilities shall provide appropriate interpretation and language services for LEP detainees related to medical and mental health care. When appropriate staff interpretation is not available, facilities will make use of professional interpretation services. Detainees shall not be used for interpretation services during any medical or mental health service. Interpretation and translation services by other detainees shall only be used in an emergency medical situation.

H. Dental Treatment

An initial dental screening exam shall be performed within 14 days of the detainee's arrival. If no on-site dentist is available, the initial dental screening may be performed by a physician, physician assistant, nurse practitioner, or registered nurse. Such non-dental clinicians shall be trained annually on how to conduct the exam by a dentist.

Detainees shall be afforded only authorized dental treatment, defined as follows:

1. Emergency dental treatment shall be provided for immediate relief of pain, trauma, and acute oral infection.
2. Routine dental treatment may be provided to detainees for whom dental treatment is inaccessible for prolonged periods because of detention for over six months. Routine dental treatment includes amalgam and composite restorations, prophylaxis, root canals, extractions, x-rays, the repair and adjustment of prosthetic appliances, and other procedures required to maintain the detainee's health.

I. Sick Call

The facility will have regularly scheduled times, in accordance with facility policy, when medical personnel are available to see detainees who have requested medical services, commonly known as sick call.

The facility will have a mechanism that allows detainees the opportunity to privately request health care services (including mental health and dental services) provided by a physician or other health care practitioner in a clinical setting. If necessary, detainees shall be provided assistance in filling out the request, especially detainees with a disability, or who are illiterate or LEP.

The facility shall have procedures to ensure that all request slips are received and triaged by the medical staff within 24 hours of receipt of the request. Request slips shall be provided in English and Spanish, at a minimum.

A health care practitioner will review the request and determine when the detainee will be seen based on the acuity of the problem and within a reasonable period of time.

All detainees, including those in Special Management Units, regardless of classification, will have access to sick call.

J. 24-Hour Emergency Medical and Mental Health Treatment

The facility will have a written plan for the delivery of 24-hour emergency medical and mental health care when no medical personnel are on duty at the facility, or when immediate outside medical attention is otherwise required.

K. First Aid and Medical Emergencies

The CMA will determine the availability and placement of first aid kits.

Detention staff and health care staff will be trained to respond to health-related emergencies within a 4-minute response time. This training will be provided by a responsible medical authority in cooperation with the facility and will include the following:

- a. The recognition of signs of potential health emergencies and the required response;
- b. The administration of first aid and cardiopulmonary resuscitation (CPR);
- c. The recognition of signs and symptoms of mental illness; and
- d. The facility's established plan and procedures for providing emergency medical care including, when required, the safe and secure transfer of detainees for appropriate hospital or other medical services.

If a detainee requires emergency medical care, the first responding officer will immediately take steps to contact a health care practitioner through established procedures.

L. Delivery of Medication

Medication will be distributed according to the specific instructions and procedures established by the health care provider. Health care providers and officers shall keep written records of all medication given to (or refused by) detainees.

Medication will not be delivered or administered by detainees. In facilities that are medically staffed 24 hours a day, a health care practitioner will distribute medication. In facilities that are not medically staffed 24 hours a day, medication may be distributed, consistent with state law and/or regulations, by detention officers who have received proper training, but only when medication must be delivered at a specific time when medical staff is not on duty. Distribution of medication by non-medical staff will be according to the specific instructions and procedures established by the CMA.

M. Special Needs

The facility will notify ICE/ERO of any detainee who requires close medical supervision, including chronic and convalescent care. The facility shall develop a written treatment plan, including access to health care and other treatment, and coordination with non-medical personnel as necessary.

The facility will notify ICE/ERO of any self-identified transgender detainees and coordinate care with ICE/ERO based on medical needs.

N. Bloodborne Pathogens

See also Standard 1.1 “Environmental Health and Safety” for additional information.

Information regarding infectious diseases shall be communicated on a regular basis to non-medical and medical staff, as well as detainees. Detainees exposed to potentially infectious bodily fluids (e.g., through needle sticks or bites) shall be afforded immediate medical assistance, and the incident shall be reported as soon as possible to the clinical director or designee and documented in the detainee’s medical file. All detainees shall be assumed to be infectious for bloodborne pathogens, and standard precautions are to be used at all times when caring for all detainees.

The facility shall establish a written plan to address exposure to bloodborne pathogens and post-exposure intervention, including prophylactic administration of medication, as appropriate and according to facility policies; the management of hepatitis A, B, and C; and the management of HIV infection, including reporting.

1. Hepatitis

A detainee may request hepatitis testing at any time.

2. HIV

A detainee may request HIV testing at any time. Facilities shall develop a written plan to ensure the highest degree of confidentiality regarding HIV status. Staff training shall emphasize the need for confidentiality, and procedures shall be established to limit access to health records to only authorized individuals and only when necessary.

The accurate diagnosis and medical management of HIV infection among detainees is important. An HIV diagnosis may be made only by a qualified health care practitioner, based on a medical history, current clinical evaluation of signs and symptoms, and laboratory studies.

3. Clinical Evaluation and Management

Medical personnel shall provide all detainees diagnosed with HIV or acquired immunodeficiency syndrome (AIDS) appropriate medical care consistent with national recommendations and guidelines disseminated through the U.S. Department of Health and Human Services agencies, including the CDC, and the Infectious Diseases Society of America. Medical and pharmacy personnel shall ensure that all Food and Drug Administration (FDA) approved medications currently approved for the treatment of HIV/AIDS are accessible. Medical and pharmacy personnel shall develop and implement distribution procedures to ensure timely and confidential access to medications.

Any detainee with confirmed or suspected TB disease shall also be evaluated for possible HIV infection, and any detainee with HIV shall be evaluated for TB disease.

Medical and pharmacy personnel shall ensure the facility maintains access to adequate supplies of FDA-approved medications for the treatment of HIV/AIDS to ensure that newly admitted detainees are able to continue with their treatment without interruption. Upon release, detainees currently receiving anti-HIV therapy and other drugs shall receive up to a 30-day supply of their medications as medically appropriate.

When current symptoms suggest HIV infection, the following procedures shall be implemented.

- a. Clinical evaluation shall determine the medical need for isolation, but HIV infection cannot be the sole reason for isolation. Segregation of HIV-positive detainees is not necessary for public health purposes. Detainees with HIV shall not be separated from the general population, either pending a test result or after a test report, unless clinical evaluation reveals a medical need for isolation.
- b. Following a clinical evaluation, if a detainee manifests symptoms requiring treatment beyond the facility's capability, a qualified health care practitioner shall recommend the detainee's transfer to a local hospital or other appropriate facility

for further medical testing, final diagnosis, and acute treatment, as needed, and consistent with local and national standards.

- c. New HIV-positive diagnoses must be reported to government bodies according to state and local laws and requirements; the HSA is responsible for ensuring that all applicable state requirements are met.

O. Informed Consent

The facility health care practitioner will obtain specific signed and dated consent forms from all detainees before any medical examination or treatment, except in emergency circumstances. Prior to the administration of psychotropic medications, a separate documented informed consent, that includes a description of the medications side effects, shall be obtained.

As a rule, medical treatment shall not be administered against the detainee's will. If a detainee refuses treatment, ICE/ERO will be consulted in determining whether forced treatment will be administered, unless the situation is an emergency. In emergency situations or those that place other detainees or staff at risk of exposure to infectious agents, the facility shall take appropriate emergency measures and notify ICE/ERO as soon as possible.

If the detainee refuses to consent to treatment, medical staff will explain the medical risks to the detainee of declining treatment and make reasonable efforts to convince the detainee to voluntarily accept treatment in a language or manner that the detainee understands. Medical staff will document their treatment efforts and the refusal of treatment in the detainee's medical record. A detainee refusing examination or treatment may be segregated from the general population when recommended by the medical staff. Forced treatment is prohibited unless there is a valid court order authorizing involuntary medical treatment.

P. Confidentiality and Release of Medical Records

All medical personnel, and in particular those who have access to medical records, shall protect the privacy of detainees' medical information to the maximum extent possible while permitting the exchange of health information required to fulfill program responsibilities and to provide for the well-being of detainees.

Detainees and their representatives shall be allowed to request and receive medical records pursuant to facility policy, which shall be communicated to the detainee in the facility handbook. Detainees and their representatives may also request medical records through the detainee's designated ICE officer or the ICE Freedom of Information Act (FOIA) process as described in the National Detainee Handbook.

Detainees who indicate that they wish to obtain copies of their medical records shall be provided with any appropriate forms. The facility will provide the detainee with assistance

in making the written request (if needed) and will assist in transmitting the request to the appropriate office or person.

Following the release of health information, the written authorization shall be retained in the health record, and a copy placed in the detainee's detention file or maintained in a retrievable electronic format.

Q. Transfer and Release of Detainees

1. Medical/Psychiatric Alert

When a health care practitioner determines that a detainee's medical or psychiatric condition requires either clearance by the medical staff prior to release or transfer to another facility, or requires medical escort during removal or transfer, the facility shall notify ICE/ERO in writing.

2. Notification of Transfers, Releases, and Removals

Medical personnel will be given advance notice prior to the release, transfer, or removal of a detainee, so that they may provide for any medical needs associated with the transfer or release.

3. Transfer of Medical Information

- a. When a detainee is transferred to another detention facility, the sending facility shall ensure that a medical transfer summary accompanies the detainee. Upon request of the receiving facility, the sending facility shall transmit a copy of the full medical record within five business days or sooner if determined by the receiving facility to be a medically urgent matter.
- b. Upon removal or release from ICE/ERO custody, the detainee shall be provided medication (in quantities specified below), referrals to community-based providers as medically appropriate, and a detailed medical care summary. This summary should include instructions that the detainee can understand and health history that would be meaningful to future medical providers. The summary shall include, at a minimum, the following items:
 - 1) Patient identification;
 - 2) Tuberculosis (TB) screening results (including results date) and current TB status if TB disease is suspected or confirmed;
 - 3) Current mental, dental, and physical health status, including all significant health issues, and highlighting any potential unstable issues or conditions which require urgent follow-up;

- 4) Current medications, with instructions for dose, frequency, etc., with specific instructions for medications that must be administered en route;
- 5) Any past hospitalizations or major surgical procedures;
- 6) Recent test results, as appropriate;
- 7) Known allergies;
- 8) Any pending medical or mental health evaluations, tests, procedures, or treatments for a serious medical condition scheduled for the detainee at the sending facility. In the case of patients with communicable disease and/or other serious medical needs, detainees being released from ICE/ERO custody are given a list of community resources, at a minimum;
- 9) Copies of any relevant documents as appropriate;
- 10) Printed instructions on how to obtain the complete medical record; and
- 11) The name and contact information of the transferring medical official.

4. Medications

The facility shall ensure that, at a minimum, a seven-day supply of medication (or, in the case of TB medications, 15 days; and in the case of HIV/AIDS medications, 30 days) accompanies the detainee upon transfer from the facility, as ordered by the prescribing authority.

Upon removal or release from ICE custody, the detainee shall receive up to a 30-day supply of medication as ordered by the prescribing authority and a medical care summary. If a detainee is on prescribed narcotics, the clinical health authority shall make a determination regarding continuation, based on assessment of the detainee.

R. Medical Experimentation and Research

Detainees shall not be used in any medical, pharmaceutical, or cosmetic experiments or research.

This will not preclude an individual detainee from receiving a medical treatment or procedure not generally available, but determined medically necessary by the CMA, such as medications and clinical trials. The administration of such investigational therapies shall follow relevant FDA or other national protocols and will be administered only with written consent from the detainee, which should be retained in the detainee's medical record. The facility shall notify ICE/ERO of all such situations.

S. Mental Health Program

1. Details

The facility shall have a mental health program, approved by the appropriate medical authority, that provides:

- a. Assistance with intake screening for mental health concerns;
- b. Referral as needed for evaluation, diagnosis, treatment and monitoring of mental illness by a qualified mental health care provider;
- c. Sufficient capacity to provide crisis intervention and management of acute mental health episodes;
- d. Transfer to licensed mental health facilities of detainees whose mental health needs exceed the capabilities of the facility; and
- e. Professional consultation for and assistance with the suicide prevention program.

2. Referrals and Treatment

Based on the intake screening, the comprehensive health assessment, medical documentation, or subsequent observations by detention staff or medical personnel, a detainee may be referred for mental health treatment or evaluation. Any detainee referred for mental health treatment shall be triaged for any emergency needs and receive an evaluation by a qualified mental health provider no later than seven days after the referral. The provider shall develop an overall treatment/management plan. If the detainee's mental illness or developmental or intellectual disability needs exceed the treatment capability of the facility, a referral for an outside mental health facility shall be initiated and the facility shall notify ICE/ERO in a timely manner. Any detainee prescribed psychiatric medications must be regularly evaluated by a duly licensed and appropriate medical professional to ensure proper treatment and dosage.

3. Involuntary Administration of Psychotropic Medication

Involuntary administration of psychotropic medication to detainees shall comply with established guidelines and applicable laws, and shall be performed only pursuant to the specific, written, and detailed authorization of a physician. Absent a declared medical emergency, before psychotropic medication is involuntarily administered, the HSA shall contact ICE/ERO to facilitate a request for a court order.

4. Serious Mental Illness

The following non-exhaustive categories of conditions should be considered to constitute a serious mental illness:

- a. conditions that a qualified medical provider has determined to meet the criteria for a “serious mental disorder or condition” pursuant to applicable ICE policies, including:
 - 1) A mental disorder that is causing serious limitations in communication, memory, or general mental and/or intellectual functioning (e.g., communicating, conducting activities of daily life, social skills); or a severe medical condition(s) (e.g., traumatic brain injury or dementia) that is significantly impairing mental function; or
 - 2) One or more of the following active psychiatric symptoms and/or behaviors: severe disorganization, active hallucinations or delusions, mania, catatonia, severe depressive symptoms, suicidal ideation and/or behavior, marked anxiety or impulsivity; or
 - 3) Significant symptoms of one of the following:
 - i. Psychosis or Psychotic Disorder;
 - ii. Bipolar Disorder;
 - iii. Schizophrenia or Schizoaffective Disorder;
 - iv. Major Depressive Disorder with Psychotic Features;
 - v. Dementia and/or a Neurocognitive Disorder; or
 - vi. Intellectual Development Disorder (moderate, severe, or profound);
 - 4) Any ongoing or recurrent conditions that have required a recent or prolonged hospitalization, typically for greater than 14 days, or a recent and prolonged stay in the medical clinic of a detention or correctional facility, typically for greater than 30 days;
 - 5) Any condition that would preclude the detainee from being housed, typically for greater than 30 days, in a non-restrictive setting (such as a general population housing unit, as opposed to a special management unit or a medical clinic); and
 - 6) Any other mental illness determined to be serious by IHSC.

T. Referrals for Sexual Abuse Victims or Abusers

If any security or medical intake screening or classification assessment indicates that a detainee has experienced prior sexual victimization or perpetrated sexual abuse, staff shall, as appropriate, ensure that the detainee is immediately referred to a qualified medical

practitioner or mental health provider for a medical and/or mental health evaluation and follow-up as appropriate.

When a referral for medical follow-up is initiated, the detainee shall receive a health evaluation no later than two working days from the date of assessment. When a referral for mental health follow-up is initiated, the detainee shall receive a mental health evaluation no later than 72 hours after the referral.

For the purposes of this section, a “qualified medical practitioner” or “qualified mental health practitioner” means a health or mental health professional, respectively, who in addition to being qualified to evaluate and care for patients within the scope of his or her professional practice, has successfully completed specialized training for treating sexual abuse victims.

U. Women’s Medical Care

Female detainees shall receive routine, age appropriate gynecological and obstetrical health care, consistent with recognized community and clinical guidelines for women’s health services.

1. Initial Assessment

All initial health assessments of female detainees shall be conducted by a qualified health care practitioner. In addition to the criteria listed on the health assessment form, the evaluation shall inquire about and perform the following:

- a. Pregnancy test for detainees aged 18-56 and deliver to the detainee and document the results;
- b. If the detainee is currently nursing (breastfeeding);
- c. Use of contraception;
- d. Reproductive history (number of pregnancies, number of live births, number of spontaneous/elective abortions, pregnancy complications, etc.);
- e. Menstrual cycle;
- f. History of breast and gynecological problems;
- g. Family history of breast and gynecological problems; and
- h. Any history of physical or sexual victimization and when the incident occurred.

A pelvic and breast examination, pap test, baseline mammography and sexually transmitted disease (STD) testing shall be offered and provided as deemed appropriate or necessary by a health care practitioner.

2. Preventive Services

Contraception

Upon request, appropriately trained medical personnel within their scope of practice shall provide detainees with non-directive (impartial) advice and consultation about family planning and contraception, and where medically appropriate, prescribe and dispense medical contraception.

3. Pregnancy

Upon confirmation by health care practitioner that a detainee is pregnant, the detainee shall be provided close medical supervision. Pregnant detainees shall have access to prenatal and specialized care, and comprehensive counseling on topics including, but not limited to, nutrition, exercise, complications of pregnancy, prenatal vitamins, labor and delivery, postpartum care, lactation, family planning, abortion services and parenting skills.

The facility administrator shall ensure that ICE/ERO is notified as soon as practicable of any pregnant detainee, but no later than 72 hours after such determination.

A health care practitioner will identify any special needs (e.g., diet, housing, and other accommodations such as the provision of additional pillows) and inform all necessary security staff and facility authorities. If a pregnant detainee has been identified as high risk, the detainee shall be referred to a physician specializing in high risk pregnancies.

All chemically dependent pregnant detainees (e.g., detainees dependent on substances including alcohol, sedatives/hypnotics, anxiolytics, and opioids) are considered high risk and referred to qualified physician capable of addressing their needs immediately.

a. Abortion Access

In the event continued detention is necessary and appropriate, and consistent with the practice of ICE/ERO's federal partners, if the life of the mother would be endangered by carrying a fetus to term, or in the case of rape or incest, ICE/ERO will assume the costs associated with a female detainee's decision to terminate a pregnancy.

- 1) In this instance, or in a situation where a female detainee opts to fund the termination of her pregnancy, ICE/ERO will arrange for transportation at no cost to the detainee for the medical appointment and, if requested by the detainee, for access to religious counseling, and non-directive (impartial)

medical resources and social counseling, to include outside social services or women's community resources groups.

- 2) If a detainee requests to terminate her pregnancy, it will be documented in the detainee's medical records. The detainee's statement should be signed personally by the detainee and include clear language of the detainee's intent.

4.3 Medical Care

I. Purpose and Scope

This detention standard ensures that detainees have access to appropriate and necessary medical, dental and mental health care, including emergency services.

This detention standard applies to the following types of facilities housing ICE/ERO detainees:

- Service Processing Centers (SPCs);
- Contract Detention Facilities (CDFs); and
- State or local government facilities used by ERO through Intergovernmental Service Agreements (IGSAs) to hold detainees for more than 72 hours.

Procedures in italics are specifically required for SPCs, CDFs, and Dedicated IGSA facilities. Non-dedicated IGSA facilities must conform to these procedures or adopt, adapt or establish alternatives, provided they meet or exceed the intent represented by these procedures.

For all types of facilities, procedures that appear in italics with a marked (**) on the page indicate optimum levels of compliance for this standard.

Various terms used in this standard may be defined in standard “7.5 Definitions.”

II. Expected Outcomes

The expected outcomes of this detention standard are as follows (specific requirements are defined in “V. Expected Practices”).

1. Detainees shall have access to a continuum of health care services, including screening, prevention, health education, diagnosis and treatment.

***Medical facilities within the detention facility shall achieve and maintain current accreditation*

with the National Commission on Correctional Health Care (NCCHC), and shall maintain compliance with those standards.

2. The facility shall have a mental health staffing component on call to respond to the needs of the detainee population 24 hours a day, seven days a week.
3. The facility shall provide communication assistance to detainees with disabilities and detainees who are limited in their English proficiency (LEP). The facility will provide detainees with disabilities with effective communication, which may include the provision of auxiliary aids, such as readers, materials in Braille, audio recordings, telephone handset amplifiers, telephones compatible with hearing aids, telecommunications devices for deaf persons (TTYs), interpreters, and note-takers, as needed. The facility will also provide detainees who are LEP with language assistance, including bilingual staff or professional interpretation and translation services, to provide them with meaningful access to its programs and activities.

All written materials provided to detainees shall generally be translated into Spanish. Where practicable, provisions for written translation shall be made for other significant segments of the population with limited English proficiency.

Oral interpretation or assistance shall be provided to any detainee who speaks another language in which written material has not been translated or who is illiterate.

Newly-admitted detainees shall be informed orally or in a manner in which the detainee understands about how to access, appeal or communicate concerns about health services.

4. Detainees shall be able to request health services on a daily basis and shall receive timely follow-up.
5. Detainees shall receive continuity of care from

time of admission to time of transfer, release or removal. Detainees, who have received medical care, released from custody or removed shall receive a discharge plan, a summary of medical records, any medically necessary medication and referrals to community-based providers as medically-appropriate.

6. A detainee who is determined to require health care beyond facility resources shall be transferred in a timely manner to an appropriate facility. A written list of referral sources, including emergency and routine care, shall be maintained and updated annually.
7. A transportation system shall provide timely access to health care services that are not available at the facility. Procedures for use of this transportation system shall include: a) prioritization of medical needs; b) urgency (such as the use of an ambulance instead of standard transportation); c) transfer of medical information and medications; and d) safety and security concerns of all persons.
8. A detainee who requires close, chronic or convalescent medical supervision shall be treated in accordance with a written treatment plan conforming to accepted medical practices for the condition in question, approved by a licensed physician, dentist or mental health practitioner.
9. Twenty-four hour emergency medical and mental health services shall be available to all detainees.
10. Centers for Disease Control and Prevention (CDC) guidelines for the prevention and control of infectious and communicable diseases shall be followed.
11. Occupational Safety and Health Administration (OSHA) and applicable state guidelines for managing bio-hazardous waste and decontaminating medical and dental equipment shall be followed.
12. Detainees with chronic conditions shall receive

care and treatment, as needed, that includes monitoring of medications, diagnostic testing and chronic care clinics.

13. The facility administrator shall notify ICE/ERO, in writing, of any detainee whose medical or mental health needs require special consideration in such matters as housing, transfer or transportation.
14. Each detainee shall receive a comprehensive medical, dental and mental health intake screening as soon as possible, but no later than 12 hours after arrival at each detention facility. Detainees who appear upon arrival to raise urgent medical or mental health concerns shall receive priority in the intake screening process.
15. Each detainee shall receive a comprehensive health assessment, including a physical examination and mental health screening, by a qualified, licensed health care professional no later than 14 days after entering into ICE custody or arrival at facility. For the purposes of the comprehensive medical examination, a qualified licensed health provider includes the following: physicians, physician assistants, nurses, nurse practitioners, or others who by virtue of their education, credentials and experience are permitted by law to evaluate and care for patients.
16. Qualified, licensed health care professionals shall classify each detainee on the basis of medical and mental health needs. Detainees shall be referred for evaluation, diagnosis, treatment and stabilization as medically indicated.
17. At no time shall a pregnant detainee be restrained, absent truly extraordinary circumstances that render restraints absolutely necessary.
18. Detainees experiencing severe, life-threatening intoxication or withdrawal symptoms shall be transferred immediately for either on-site or off-site emergency department evaluation.

19. Pharmaceuticals and non-prescription medicines shall be secured, stored and inventoried.
20. Prescriptions and medications shall be ordered, dispensed and administered in a timely manner and as prescribed by a licensed health care professional. This shall be conducted in a manner that seeks to preserve the privacy and personal health information of detainees.
21. Health care services shall be provided by a sufficient number of appropriately trained and qualified personnel, whose duties are governed by thorough and detailed job descriptions and who are licensed, certified, credentialed and/or registered in compliance with applicable state and federal requirements.
22. Detention and health care personnel shall be trained initially and annually in the proper use of emergency medical equipment and shall respond to health-related emergency situations.
23. Information about each detainee's health status shall be treated as confidential, and health records shall be maintained in accordance with accepted standards separately from other detainee detention files and be accessible only in accordance with written procedures and applicable laws. Health record files on each detainee shall be well organized, available to all practitioners and properly maintained and safeguarded.
24. Informed consent standards shall be observed and adequately documented. Staff shall make reasonable efforts to ensure that detainees understand their medical condition and care.
25. Medical and mental health interviews, screenings, appraisals, examinations, procedures and administration of medication shall be conducted in settings that respect detainees' privacy in accordance with safe and/orderly operations of the facility.
26. A detainee's request to see a health care provider of the same gender should be considered; when not feasible, a same-gender chaperone shall be provided. When care is provided by a health care provider of the opposite gender, a detainee shall be provided a same-gender chaperone upon the detainee's request.
27. Detainees in Special Management Units (SMUs) shall have access to the same or equivalent health care services as detainees in the general population, as specified in standard "2.12 Special Management Units."
28. ***Adequate space and staffing for the use of services of the ICE Tele-Health Systems, inclusive of tele-radiology (ITSP) and tele-medicine, shall be provided.*
29. All detainees shall receive medical and mental health screenings, interventions and treatments for gender-based abuse and/or violence, including sexual assault and domestic violence.
30. This standard and the implementation of this standard will be subject to internal review and a quality assurance system in order to ensure the standard of care in all facilities is high.

III. Standards Affected

This detention standard replaces "Medical Care" dated 12/2/2008.

IV. References

- American Correctional Association, *Performance-based Standards for Adult Local Detention Facilities*, 4th Edition: 4-ALDF-2A-15, 4C-01 through 4C-31, 4C-34 through 4C-41, 4D-01 through 4D-21, 4D-23 through 4D-28, 2A-45, 7D-25.
- American College of Obstetricians and Gynecologists, *Guidelines for Women's Health Care* (3rd edition. 2007); "Special Issues in Women's Health" (2005).
- American Public Health Association *Standards for*

*Health Services in Correctional Institutions,
Health Services for Women.*

Centers for Disease Control and Prevention website, www.cdc.gov (for the most current guidelines and recommendations on tuberculosis case management and control, HIV management, health care acquired infections, infection control, influenza management, respiratory protection, infectious diseases of public health significance, emerging infectious diseases, and correctional health)

United States Department of Health and Human Services, HIV Clinical Guidelines Portal, <http://aidsinfo.nih.gov/Guidelines/default.aspx> (for the most current national guidelines on HIV Management)

Infectious Diseases Society of America, <http://www.idsociety.org/Content.aspx?id=9088> (for the most current infectious diseases practice guidelines prepared or endorsed by the Infectious Diseases Society of America)

National Commission on Correctional Health Care, *Standards for Health Services in Jails* (2014).

Exec. Order 13166.

ICE/ERO *Performance-based National Detention Standards 2011*:

- “1.2 Environmental Health and Safety,” particularly in regard to storing, inventorying and handling needles and other sharp instruments; standard precautions to prevent contact with blood and other body fluids; sanitation and cleaning to prevent and control infectious diseases; and disposing of hazardous and infectious waste;
- “2.11 Sexual Abuse and Assault Prevention and Intervention”;
- “4.2 Hunger Strikes”;
- “4.6 Significant Self-harm and Suicide Prevention and Intervention”;

- “4.7 Terminal Illness, Advance Directives and Death.”

ICE Health Service Corps (IHSC) *Policies and Procedures Manual*.

The Joint Commission.

www.flu.gov

www.aids.gov

“*Standards to Prevent, Detect, and Respond to Sexual Abuse and Assault in Confinement Facilities*,” 79 Fed. Reg. 13100 (Mar. 7, 2014).

V. Expected Practices

A. General

Every facility shall directly or contractually provide its detainee population with the following:

1. Initial medical, mental health and dental screening;
2. Medically necessary and appropriate medical, dental and mental health care and pharmaceutical services;
3. Comprehensive, routine and preventive health care, as medically indicated;
4. Emergency care;
5. Specialty health care;
6. Timely responses to medical complaints; and
7. Hospitalization as needed within the local community.
8. Staff or professional language services necessary for detainees with limited English proficiency (LEP) during any medical or mental health appointment, sick call, treatment, or consultation.

***Medical facilities within the detention facility shall achieve and maintain current accreditation with the National Commission on Correctional Health Care (NCCCHC), and shall maintain compliance with those standards.*

B. Designation of Authority

A designated health services administrator (HSA) or the equivalent in non-IHSC staffed detention facilities shall have overall responsibility for health care services pursuant to a written agreement, contract or job description. The HSA is a physician or health care professional and shall be identified to detainees.

The designated clinical medical authority (CMA) at the facility shall have overall responsibility for medical clinical care pursuant to a written agreement, contract or job description. The CMA shall be a medical doctor (MD) or doctor of osteopathy (DO). The CMA may designate a clinically trained professional to have medical decision making authority in the event that the CMA is unavailable.

When the HSA is other than a physician, final clinical judgment shall rest with the facility's designated CMA. In no event shall clinical decisions be made by non-clinicians.

The HSA shall be authorized and responsible for making decisions about the deployment of health resources and the day-to-day operations of the health services program. The CMA together with the HSA establishes the processes and procedures necessary to meet the medical standards outlined herein.

All facilities shall provide medical staff and sufficient support personnel to meet these standards. A staffing plan will be reviewed at least annually which identifies the positions needed to perform the required services.

Health care personnel perform duties within their scope of practice for which they are credentialed by training, licensure, certification, job descriptions, and/or written standing or direct orders by personnel authorized by law to give such orders.

The facility administrator, in collaboration with the CMA and HSA, negotiates and maintains arrangements with nearby medical facilities or health

care providers to provide required health care not available within the facility, as well as identifying custodial officers to transport and remain with detainees for the duration of any off-site treatment or hospital admission.

C. Communicable Disease and Infection Control

1. General

Each facility shall have written plans that address the management of infectious and communicable diseases, including screening, prevention, education, identification, monitoring and surveillance, immunization (when applicable), treatment, follow-up, isolation (when indicated) and reporting to local, state and federal agencies.

Plans shall include:

- a. coordination with local public health authorities;
- b. ongoing education for staff and detainees;
- c. control, treatment and prevention strategies;
- d. protection of detainee confidentiality;
- e. media relations, in coordination with the local Public Affairs Officer (PAO);
- f. procedures for the identification, surveillance, immunization, follow-up and isolation of patients;
- g. hand hygiene
- h. management of infectious diseases and reporting them to local and/or state health departments in accordance with established guidelines and applicable laws; and
- i. management of bio-hazardous waste and decontamination of medical and dental equipment that complies with applicable laws and standard "1.2 Environmental Health and Safety."

Facilities shall comply with current and future plans implemented by federal, state or local authorities addressing specific public health issues including

communicable disease reporting requirements. Infectious and communicable disease control activities shall be reviewed and discussed in the quarterly administrative meetings as described in Section V.DD of this detention standard. Designated medical staff shall report to the IHSC Public Health, Safety, and Preparedness Unit all detainees diagnosed with a communicable disease of public health significance.

2. Tuberculosis (TB) Management

As indicated in this standard below in section “J. Medical and Mental Health Screening of New Arrivals,” screening for TB is initiated at intake and in accordance with Center for Disease Control and Prevention (CDC) guidelines.

All new arrivals shall receive TB screening within 12 hours of intake and in accordance with CDC guidelines (www.cdc.gov/tb). For detainees that have been in continuous law enforcement custody, symptom screening plus documented TB screening within one year of arrival may be accepted for intake screening purposes.

Annual or periodic TB testing shall be implemented in accordance with CDC guidelines; annual TB screening method should be appropriately selected with consideration given to the initial screening method conducted or documented during intake.

Detainees with symptoms suggestive of TB, or with suspected or confirmed active TB disease based on clinical and/or laboratory findings, shall be placed in a functional airborne infection isolation room with negative pressure ventilation and be promptly evaluated for TB disease. Patients with suspected active TB shall remain in airborne infection isolation until determined by a qualified provider to be noncontagious in accordance with CDC guidelines.

For all patients with confirmed and suspected active tuberculosis, designated medical staff shall:

- a. Report all cases to local and/or state health departments within one working day of meeting reporting criteria and in accordance with

established guidelines and applicable laws, identified by the custodial agency and the detainee’s identifying number of that agency (ICE detainees are reported as being in ICE custody and are identified by their alien numbers).

- b. Report all detainees with suspected or confirmed TB to the ICE Health Service Corps (IHSC), Public Health, Safety, and Preparedness Unit within one working day of initial identification with suspected or confirmed TB disease.

Reporting shall include names, aliases, date of birth, alien number, case status/classification, available diagnostic and lab results, treatment status (including drugs and dosages), treatment start date, a summary case report, and a point of contact and telephone number for follow-up.

- c. Promptly report any movement of TB patients, including hospitalizations, facility transfers, releases, or removals/deportations to the local and/or state health department and the IHSC Public Health, Safety, and Preparedness Unit.

When treatment is indicated, multi-drug, anti-TB therapy shall be administered using directly observed therapy (DOT) in accordance with American Thoracic Society (ATS) and CDC guidelines. For patients with drug-resistant or multi-drug-resistant TB, the state or local health department shall be consulted to establish a customized treatment regimen and treatment plan. Patients receiving anti-TB therapy shall be provided with a 15 day supply of medications and appropriate education when transferred, released or deported, in an effort to prevent interruptions in treatment until care is continued in another location.

Treatment for latent TB infection (LTBI) shall not be initiated unless active TB disease is ruled out.

Designated medical staff shall coordinate with the IHSC Epidemiology Unit and the local and/or state health department to facilitate an international referral and continuity of therapy. Designated

medical staff shall collaborate with the local and/or state health department on tuberculosis and other communicable diseases of public health significance.

3. Significant Communicable Disease

Designated medical staff shall notify the IHSC Public Health, Safety, and Preparedness Unit of any ICE detainee with a significant communicable disease and of any contact or outbreak investigations involving ICE detainees exposed to a significant communicable disease without known immunity. Significant communicable diseases include, but are not limited to, varicella (chicken pox), measles, mumps, pertussis (whooping cough), and typhoid.

4. Bloodborne Pathogens

Infection control awareness shall be communicated on a regular basis to correctional and medical staff, as well as detainees. Detainees exposed to potentially infectious body fluids (e.g., through needle sticks or bites) shall be afforded immediate medical assistance, and the incident shall be reported as soon as possible to the clinical director or designee and documented in the medical file. All detainees shall be assumed to be infectious for bloodborne pathogens, and standard precautions are to be used at all times when caring for all detainees.

Each facility shall establish a written plan to address exposure to bloodborne pathogens; the management of hepatitis A, B, and C; and the management of HIV infection, including reporting.

a. Hepatitis

A detainee may request hepatitis testing at any time during detention

b. HIV

A detainee may request HIV testing at any time during detention. Persons who must feed, escort, directly supervise, interview or conduct routine office work with HIV patients are not considered at risk of infection. However, persons regularly exposed to blood are at risk. Facilities shall develop a written plan to ensure the highest

degree of confidentiality regarding HIV status and medical condition. Staff training must emphasize the need for confidentiality, and procedures must be in place to limit access to health records to only authorized individuals and only when necessary.

The accurate diagnosis and medical management of HIV infection among detainees shall be promoted. An HIV diagnosis may be made only by a licensed health care provider, based on a medical history, current clinical evaluation of signs and symptoms and laboratory studies.

c. Clinical Evaluation and Management

Medical personnel shall provide all detainees diagnosed with HIV/AIDS medical care consistent with national recommendations and guidelines disseminated through the U.S. Department of Health and Human Services, the CDC, and the Infectious Diseases Society of America. Medical and pharmacy personnel shall ensure that all Food and Drug Administration (FDA) medications currently approved for the treatment of HIV/AIDS are accessible. Medical and pharmacy personnel shall develop and implement distribution procedures to ensure timely and confidential access to medications.

Many of these guidelines are available through the following links:

<http://aidsinfo.nih.gov/Guidelines/default.aspx>
<http://www.cdc.gov/hiv/resources/guidelines/index.htm#treatment>
<http://www.idsociety.org/Content.aspx?id=9088>

Medical and pharmacy personnel shall ensure the facility maintains access to adequate supplies of FDA-approved medications for the treatment of HIV/AIDS to ensure newly admitted detainees shall be able to continue with their treatments without interruption. Upon release, detainees currently receiving highly active antiretroviral therapy and other drugs shall receive up to a 30-

day supply of their medications as medically appropriate.

When current symptoms are suggestive of HIV infection, the following procedures shall be implemented.

- 1) Clinical evaluation shall determine the medical need for isolation.

Detainees with HIV shall not be separated from the general population, either pending a test result or after a test report, unless clinical evaluation reveals a medical need for isolation. Segregation of HIV-positive detainees is not necessary for public health purposes.

- 2) Following a clinical evaluation, if a detainee manifests symptoms requiring treatment beyond the facility's capability, the provider shall recommend the detainee's transfer to a local hospital or other appropriate facility for further medical testing, final diagnosis and acute treatment as needed, consistent with local operating procedures.
- 3) Any detainee with active tuberculosis shall also be evaluated for possible HIV infection.
- 4) New HIV-positive diagnoses must be reported to government bodies according to state and local laws and requirements; the HSA is responsible for ensuring that all applicable state requirements are met.

The "Standard Precautions" section of standard "1.2 Environmental Health and Safety" provides more detailed information.

D. Notifying Detainees about Health Care Services

In accordance with standard "6.1 Detainee Handbook," the facility shall provide each detainee, upon admittance, a copy of the detainee handbook and local supplement, in which procedures for access to health care services are explained.

Health care practitioners should explain any rules about mandatory reporting and other limits to confidentiality in their interactions with detainees. Informed consent shall be obtained prior to providing treatment (absent medical emergencies). Consent forms and refusals shall be documented and placed in the detainee's medical file.

In accordance with the section on Orientation in standard "2.1 Admission and Release," access to health care services, the sick call and medical grievance processes shall be included in the orientation curriculum for newly admitted detainees.

E. Translation and Language Access for Detainees with Limited English Proficiency

Facilities shall provide appropriate interpretation and language services for LEP detainees related to medical and mental health care. Where appropriate staff interpretation is not available, facilities will make use of professional interpretation services. Detainees shall not be used for interpretation services during any medical or mental health service. Interpretation and translation services by other detainees shall only be provided in an emergency medical situation.

Facilities shall post signs in medical intake areas in English, Spanish, and languages spoken by other significant segments of the facility's detainee population listing what language assistance is available during any medical or mental health treatment, diagnostic test, or evaluation.

F. Facilities

1. Examination and Treatment Area

Adequate space and equipment shall be furnished in all facilities so that all detainees may be provided basic health examinations and treatment in private while ensuring safety.

A holding/waiting area shall be located in the medical facility under the direct supervision of custodial officers. A detainee toilet and drinking

fountain shall be accessible from the holding/waiting area.

2. Medical Records

Medical records shall be kept separate from detainee detention records and stored in a securely locked area within the medical unit.

3. Medical Housing

If there is a specific area, separate from other housing areas, where detainees are admitted for health observation and care under the supervision and direction of health care personnel, consideration shall be given to the detainee's age, gender, medical requirements and custody classification and the following minimum standards shall be met:

a. Care

- 1) Physician at the facility or on call 24 hours per day;
- 2) Qualified health care personnel on duty 24 hours per day when patients are present;
- 3) Staff members within sight or sound of all patients;
- 4) Maintenance of a separate medical housing record distinct from the complete medical record; and
- 5) Compliance with all established guidelines and applicable laws.

Detainees in medical housing shall have access to other services such as telephone, legal access and materials, consistent with their medical conditions.

Prior to placing a detainee with a mental illness in medical housing, a determination shall be made by a medical or mental health professional that placement in medical housing is medically necessary.

b. Wash Basins, Bathing Facilities and Toilets

- 1) Detainees shall have access to operable

washbasins with hot and cold running water at a minimum ratio of 1 for every 12 detainees, unless state or local building codes specify a different ratio.

- 2) Sufficient bathing facilities shall be provided to allow detainees to bathe daily, and sufficient bathing facilities shall be physically accessible for detainees with disabilities, as required by the applicable accessibility standard. Water shall be thermostatically controlled to temperatures ranging from 100 F to 120 F degrees.
- 3) Detainees shall have access to operable toilets and hand-washing facilities 24 hours per day and shall be permitted to use toilet facilities without staff assistance. Unless state or local building or health codes specify otherwise:
 - a) toilets shall be provided at a minimum ratio of 1 to every 12 detainees in male facilities and 1 for every 8 in female facilities, and
 - b) all housing units with three or more detainees shall have a minimum of two toilets.

G. Pharmaceutical Management

Each detention facility shall have and comply with written policy and procedures for the management of pharmaceuticals, to include:

1. a formulary of all prescription and nonprescription medicines stocked or routinely procured from outside sources;
2. identification of a method for promptly approving and obtaining medicines not on the formulary;
3. prescription practices, including requirements that medications are prescribed only when clinically indicated, and that prescriptions are reviewed before being renewed;
4. procurement, receipt, distribution, storage, dispensing, administration and disposal of

medications;

5. secure storage and disposal and perpetual inventory of all controlled substances (DEA Schedule II-V), syringes, and needles;
6. medicine administration error reports to be kept for all administration errors;
7. all staff responsible for administering or having access to pharmaceuticals to be trained on medication management before beginning duty;
8. all pharmaceuticals to be stored in a secure area with the following features:
 - a. a secure perimeter;
 - b. access limited to authorized medical staff (never detainees);
 - c. solid walls from floor to ceiling and a solid ceiling;
 - d. a solid core entrance door with a high security lock (with no other access); and
 - e. a secure medication storage area;
9. administration and management in accordance with state and federal law;
10. supervision by properly licensed personnel;
11. administration of medications by properly licensed, credentialed, trained personnel under the supervision of the health services administrator (HSA), clinical medical authority (CMA), both; and
12. documentation of accountability for administering or distributing medications in a timely manner, and according to licensed provider orders.

H. Nonprescription Medications

The facility administrator and HSA shall jointly approve any nonprescription medications that are available to detainees outside of health services (e.g., sold in commissary, distributed by housing officers, etc.), and shall jointly review the list, on an annual

basis at a minimum.

I. Medical Personnel

All health care staff must be verifiably licensed, certified, credentialed, and/or registered in compliance with applicable state and federal requirements. Copies of the documents must be maintained on site and readily available for review. A restricted license does not meet this requirement.

J. Medical and Mental Health Screening of New Arrivals

As soon as possible, but no later than 12 hours after arrival, all detainees shall receive, by a health care provider or a specially trained detention officer, an initial medical, dental and mental health screening and be asked for information regarding any known acute or emergent medical conditions. Any detainee responding in the affirmative shall be sent for evaluation to a qualified, licensed health care provider as quickly as possible, but in no later than two working days. Detainees who appear upon arrival to raise urgent medical or mental health concerns shall receive priority in the intake screening process. For intrasystem transfers, a qualified health care professional will review each incoming detainee's health record or health summary within 12 hours of arrival, to ensure continuity of care.

For LEP individuals, interpretation for the screening will be conducted by facility staff with appropriate language capabilities or through professional interpretation services, as described in Section E of this standard ("Translation and Language Access for Detainees with Limited English Proficiency").

If screening is performed by a detention officer, the facility shall maintain documentation of the officer's special training, and the officer shall have available for reference the training syllabus, to include education on patient confidentiality of disclosed information.

The screening shall inquire into the following:

1. any past history of serious infectious or communicable illness, and any treatment or symptoms;
2. history of physical and mental illness;
3. pain assessment;
4. current and past medication;
5. allergies;
6. past surgical procedures;
7. symptoms of active TB or previous TB treatment;
8. dental care history;
9. use of alcohol, tobacco and other drugs, including an assessment for risk of potential withdrawal;
10. possibility of pregnancy;
11. other relevant health problems identified by the CMA responsible for screening inquiry;
12. observation of behavior, including state of consciousness, mental status, appearance, conduct, tremor, sweating;
13. history of suicide attempts or current suicidal/homicidal ideation or intent;
14. observation of body deformities and other physical abnormalities;
15. inquire into a transgender detainee's gender self-identification and history of transition-related care, when a detainee self-identifies as transgender;
16. past hospitalizations;
17. chronic illness (including, but not limited to, hypertension and diabetes);
18. dietary needs; and
19. any history of physical or sexual victimization or perpetrated sexual abuse, and when the incident occurred.

Where there is a clinically significant finding as a result of the initial screening, an immediate referral shall be initiated and the detainee shall receive a health assessment no later than two working days from the initial screening.

For further information and guidance, see standard "2.1 Admission and Release."

Initial screenings shall be conducted in settings that respect detainees' privacy and include observation and interview questions related to the detainee's potential suicide risk and mental health. For further information, see standard "4.6 Significant Self-harm and Suicide Prevention and Intervention."

If, at any time during the screening process, there is an indication of need of, or a request for, mental health services, the HSA must be notified within 24 hours. The CMA, HSA or other qualified licensed health care provider shall ensure a full mental health evaluation, if indicated. Mental health evaluations must be conducted within the timeframes prescribed in "O. Mental Health Program" of this standard.

All facilities shall have policies and procedures in place to ensure documentation of the initial health screening and assessment.

The health intake screening shall be conducted using the IHSC Intake Screening Form (IHSC 795A) or equivalent and shall be completed prior to the detainee's placement in a housing unit. The Intake Screening Form attached as Appendix 4.3.A mirrors form IHSC 795A and may be used by facilities to ensure compliance with screening requirements in these standards.

Upon completion of the In-Processing Health Screening form, the detention officer shall immediately notify medical staff when one or more positive responses are documented. Medical staff will then assess priority for treatment (e.g. urgent, today or routine).

Limited-English proficient detainees and detainees who are hearing impaired shall be provided

interpretation or translation services or other assistance as needed for medical care activities.

Language assistance may be provided by another medical staff member competent in the language or by a professional service, such as a telephone interpretation service.

K. Substance Dependence and Detoxification

All detainees shall be evaluated through an initial screening for use of and/or dependence on mood- and mind-altering substances, alcohol, opiates, hypnotics, sedatives, etc. Detainees who report the use of such substances shall be evaluated for their degree of reliance on and potential for withdrawal from the substance.

The CMA shall establish guidelines for evaluation and treatment of new arrivals who require detoxification.

Detainees experiencing severe or life-threatening intoxication or withdrawal shall be transferred immediately to an emergency department for evaluation.

Once evaluated, the detainee will be referred to an appropriate facility qualified to provide treatment and monitoring for withdrawal, or treated on-site if the facility is staffed with qualified personnel and equipment to provide appropriate care.

L. Privacy and Chaperones

1. Medical Privacy

Medical and mental health interviews, screenings, appraisals, examinations, procedures, and administration of medication shall be conducted in settings that respect detainees' privacy.

2. Same-Gender Providers and Chaperones

A detainee's request to see a health care provider of the same gender should be considered; when not feasible, a same-gender chaperone shall be provided.

When care is provided by a health care provider of the opposite gender, a detainee shall be provided a same-gender chaperone upon the detainee's request.

A same-gender chaperone shall be provided, even in the absence of a request by the detainee, when a medical encounter involves a physical examination of sensitive body parts, to include breast, genital, or rectal examinations, by a provider of the opposite gender.

Only medical personnel may serve as chaperones during medical encounters and examinations.

M. Comprehensive Health Assessment

Each facility's health care provider shall conduct a comprehensive health assessment, including a physical examination and mental health screening, on each detainee within 14 days of the detainee's arrival unless more immediate attention is required due to an acute or identifiable chronic condition. Physical examinations shall be performed by a physician, physician assistant, nurse practitioner, RN (with documented training provided by a physician) or other health care practitioner as permitted by law.

Facility medical personnel are encouraged to use the form "Physical Examination/Health Appraisal" attached as Appendix 4.3.B when conducting the comprehensive health assessment.

If documentation exists of such a health assessment within the previous 90 days, the facility health care provider upon review may determine that a new appraisal is not required.

The CMA shall be responsible for review of all comprehensive health assessments to assess the priority for treatment.

Detainees diagnosed with a communicable disease shall be isolated according to national standards of medical practice and procedures.

N. Medical/Psychiatric Alerts and Holds

Where a detainee has a serious medical or mental

health condition or otherwise requires special or close medical care, medical staff shall complete a Medical/Psychiatric Alert form (IHSC-834) or equivalent, and file the form in the detainee's medical record. Where medical staff furthermore determine the condition to be serious enough to require medical clearance of the detainee prior to transfer or removal, medical staff shall also place a medical hold on the detainee using the Medical/Psychiatric Alert form (IHSC-834) or equivalent, which serves to prevent ICE from transferring or removing the detainee without the prior clearance of medical staff at the facility. The facility administrator shall receive notice of all medical/psychiatric alerts or holds, and shall be responsible for notifying ICE/ERO of any medical alerts or holds placed on a detainee that is to be transferred.

Potential health conditions meriting the completion of a Medical/Psychiatric Alert form may include, but are not limited to:

1. medical conditions requiring ongoing therapy, such as:
 - a. active TB
 - b. infectious diseases
 - c. chronic conditions
2. mental health conditions requiring ongoing therapy, such as:
 - a. suicidal behavior or tendencies
3. ongoing physical therapy
4. pregnancy

O. Mental Health Program

1. Mental Health Services Required

Each facility shall have an in-house or contractual mental health program, approved by the appropriate medical authority that provides:

- a. intake screening Form IHSC 795A (or equivalent)

for mental health concerns;

- b. referral as needed for evaluation, diagnosis, treatment and monitoring of mental illness by a competent mental health professional.
- c. crisis intervention and management of acute mental health episodes;
- d. transfer to licensed mental health facilities of detainees whose mental health needs exceed the capabilities of the facility; and
- e. a suicide prevention program.

2. Mental Health Provider

The term “mental health provider” includes psychiatrists, physicians, psychologists, clinical social workers and other appropriately licensed independent mental health practitioners

3. Mental Health Evaluation

Based on intake screening, the comprehensive health assessment, medical documentation, or subsequent observations by detention staff or medical personnel, any detainee referred for mental health treatment shall receive an evaluation by a qualified health care provider no later than 72 hours after the referral, or sooner if necessary. If the practitioner is not a mental health provider and further referral is necessary, the detainee will be evaluated by a mental health provider within the next business day.

Such evaluation and screenings shall include:

- a. reason for referral;
- b. history of any mental health treatment or evaluation;
- c. history of illicit drug/alcohol use or abuse or treatment for such;
- d. history of suicide attempts;
- e. current suicidal/homicidal ideation or intent;
- f. current use of any medication;
- g. estimate of current intellectual function;

- h. mental health screening, to include prior history physical, sexual or emotional abuse;
- i. impact of any pertinent physical condition, such as head trauma;
- j. recommend actions for any appropriate treatment, including but not limited to the following:
 - 1) remain in general population with psychotropic medication and counseling,
 - 2) “short-stay” unit or infirmary,
 - 3) Special Management Unit, or
 - 4) community hospitalization; and
- k. recommending and/or implementing a treatment plan, including recommendations concerning transfer, housing, voluntary work and other program participation.

4. Referrals and Treatment

Any detainee referred for mental health treatment shall receive an evaluation by a qualified health care provider no later than 72 hours after the referral, or sooner if necessary. If the practitioner is not a mental health provider and further referral is necessary, the detainee will be evaluated by a mental health provider within the next business day.

The provider shall develop an overall treatment/management plan.

If the detainee’s mental illness or developmental or intellectual disability needs exceed the treatment capability of the facility, a referral for an outside mental health facility may be initiated.

Any detainee prescribed psychiatric medications must be regularly evaluated by a duly-licensed and appropriate medical professional, at least once a month, to ensure proper treatment and dosage;

5. Medical Isolation

The CMA may authorize medical isolation for a detainee who is at high risk for violent behavior

because of a mental health condition. The CMA shall be responsible for the daily reassessment of the need for continued medical isolation to ensure the health and safety of the detainee.

Medical isolation shall not be used as a punitive measure.

6. Involuntary Administration of Psychotropic Medication

Involuntary administration of psychotropic medication to detainees shall comply with established guidelines and applicable laws, and shall be performed only pursuant to the specific, written and detailed authorization of a physician. Absent declared medical emergency, before psychotropic medication is involuntarily administered, it is required that the HSA contact ERO management, who shall then contact respective ICE Office of Chief Counsel to facilitate a request for a court order to involuntarily medicate the detainee.

Prior to involuntarily administering psychotropic medication, absent a declared medical emergency, the authorizing physician shall:

- a. review the medical record of the detainee and conduct a medical examination;
- b. specify the reasons for and duration of therapy, and whether the detainee has been asked if he/she would consent to such medication;
- c. specify the medication to be administered, the dosage and the possible side effects of the medication;
- d. document that less restrictive intervention options have been exercised without success;
- e. detail how medication is to be administered;
- f. monitor the detainee for adverse reactions and side effects; and
- g. prepare treatment plans for less restrictive alternatives as soon as possible.

Also see section “Z: Informed Consent and

Involuntary Treatment” later in this detention standard.

P. Referrals for Sexual Abuse Victims or Abusers

If any security or medical intake screening or classification assessment indicates that a detainee has experienced prior sexual victimization or perpetrated sexual abuse, staff shall, as appropriate, ensure that the detainee is immediately referred to a qualified medical or mental health practitioner for medical and/or mental health follow-up as appropriate.

When a referral for medical follow-up is initiated, the detainee shall receive a health evaluation no later than two working days from the date of assessment. When a referral for mental health follow-up is initiated, the detainee shall receive a mental health evaluation no later than 72 hours after the referral.

For the purposes of this section, a “qualified medical practitioner” or “qualified mental health practitioner” means a health or mental health professional, respectively, who in addition to being qualified to evaluate and care for patients within the scope of his/her professional practice, has successfully completed specialized training for treating sexual abuse victims.

Q. Annual Health Examinations

Any detainee in ICE custody for more than one year continuously shall receive health examinations on an annual basis. Such examinations may occur more frequently for certain individuals, depending on their medical history and/or health conditions. Detainees shall have access to age- and gender-appropriate exams annually, including re-screening for TB.

R. Dental Treatment

An initial dental screening shall be performed within 14 days of the detainee’s arrival. The initial dental screening may be performed by a dentist or a properly trained qualified health provider.

1. Emergency dental treatment shall be provided for immediate relief of pain, trauma and acute oral infection.
2. Routine dental treatment may be provided to detainees in ICE custody for whom dental treatment is inaccessible for prolonged periods because of detention for over six months, including amalgam and composite restorations, prophylaxis, root canals, extractions, x-rays, the repair and adjustment of prosthetic appliances and other procedures required to maintain the detainee’s health. Dental exams and treatment shall be performed only by licensed dental personnel.

S. Sick Call

Each facility shall have a sick call procedure that allows detainees the unrestricted opportunity to freely request health care services (including mental health and dental services) provided by a physician or other qualified medical staff in a clinical setting. This procedure shall include:

1. clearly written policies and procedures;
2. sick call process shall be communicated in writing and verbally to detainees during their orientation;
3. regularly scheduled “sick call” times shall be established and communicated to detainees;
4. an established procedure shall be in place at all facilities to ensure that all sick call requests are received and triaged by appropriate medical personnel within 24 hours after a detainee submits the request. All written sick call requests shall be date and time stamped and filed in the detainee’s medical record. Medical personnel shall review the request slips and determine when the detainee shall be seen based on acuity of the problem. In an urgent situation, the housing unit officer shall notify medical personnel immediately.

If the procedure requires a written request slip, such

slips shall be provided in English and the most common languages spoken by the detainee population of that facility. Limited-English proficient detainees and detainees who are hearing impaired shall be provided interpretation/translation services or other assistance as needed to complete a request slip.

All detainees, including those in SMUs, regardless of classification, shall have access to sick call. See standard “2.12 Special Management Units” for details.

All facilities shall maintain a permanent record of all sick call requests.

T. Emergency Medical Services and First Aid

1. Each facility shall have a written emergency services plan for delivery of 24-hour emergency health care. This plan shall be prepared in consultation with the facility’s CMA or the HSA, and must include the following:
 - a. an on-call physician, dentist and mental health professional, or designee, that are available 24 hours per day;
 - b. a list of telephone numbers for local ambulances and hospital services available to all staff;
 - c. an automatic external defibrillator (AED) shall be maintained for use at each facility and accessible to staff;
 - d. all detention and medical staff shall receive cardio pulmonary resuscitation (CPR, AED), and emergency first aid training annually;
 - e. detention and health care personnel shall be trained annually to respond to health-related situations within four minutes; and
 - f. security procedures that ensure the immediate transfer of detainees for emergency medical care.
2. The health services administrator ensures that medical staff have training and competency in implementing the facility’s emergency health care plan appropriate for each staff’s scope of practice or position. The facility administrator ensures that non-medical staff have appropriate training and competency in implementing the facility’s emergency plan appropriate for each staff’s position. Training and competency assessment shall include the following areas:
 - a. recognizing of signs of potential health emergencies and the required responses;
 - b. administering first aid, AED and cardiopulmonary resuscitation (CPR);
 - c. obtaining emergency medical assistance through the facility plan and its required procedures;
 - d. recognizing signs and symptoms of mental illness and suicide risk; and
 - e. the facility’s established plan and procedures for providing emergency medical care including, when required, the safe and secure transfer of detainees for appropriate hospital or other medical services, including by ambulance when indicated. The plan must provide for expedited entrance to and exit from the facility.
3. When a non-medical employee is unsure whether emergency care is required, he/she shall immediately notify medical personnel to make the determination.
4. Medical and safety equipment shall be available and maintained, and staff shall be trained in proper use of the equipment.
5. The facility administrator, in consultation with the designee for environmental health and safety, determines the number, contents, and placement of first aid kits, and establishes protocols for monthly inspections of first aid kits.

6. Victims of sexual abuse shall have timely access to emergency medical treatment and crisis intervention services in accordance with standard “2.11 Sexual Abuse and Assault, Prevention and Intervention.”

U. Delivery of Medication

Distribution of medication (including over the counter) shall be performed in accordance with specific instructions and procedures established by the HSA in consultation with the CMA. Written records of all prescribed medication given to or refused by detainees shall be maintained.

1. If prescribed medication must be delivered at a time when medical staff is not on duty, the medication may be distributed by detention officers, where it is permitted by state law to do so, who have received proper training by the HSA or designee.
2. The facility shall maintain documentation of the training given any officer required to distribute medication, and the officer shall have available for reference the training syllabus or other guide or protocol provided by the health authority.
3. Detainees may not deliver or administer medications to other detainees.
4. All prescribed medications and medically necessary treatments shall be provided to detainees on schedule and without interruption, absent exigent circumstances.
5. Detainees who arrive at a detention facility with prescribed medications or who report being on such medications, shall be evaluated by a qualified health care professional as soon as possible, but not later than 24 hours after arrival, and provisions shall be made to secure medically necessary medications.
6. Detainees shall not be charged for any medical services to include pharmaceuticals dispensed by medical personnel

V. Health Education and Wellness Information

Qualified health care personnel shall provide detainees health education and wellness information on topics including, but not limited to, the following:

1. dangers of self-medication;
2. personal and hand hygiene and dental care;
3. prevention of communicable diseases;
4. smoking cessation;
5. self-care for chronic conditions; and
6. benefits of physical fitness.

W. Special Needs and Close Medical Supervision

Consistent with Standard 4.8 “Disability Identification, Assessment, and Accommodation” and the IHSC Detainee Covered Services Package, detainees will be provided medical prosthetic devices or other impairment aids, such as eyeglasses, hearing aids, or wheelchairs.

When a detainee requires close medical supervision, including chronic and convalescent care, a written treatment plan, including access to health care and other care and supervision personnel, shall be developed and approved by the appropriate qualified licensed health care provider, in consultation with the patient, with periodic review. Likewise, staff responsible for such matters as housing and program assignments and disciplinary measures shall consult with the responsible qualified licensed health care provider or health services administrator.

Exercise areas shall be available to meet exercise and physical therapy requirements of individual detainee treatment plans.

Transgender detainees who were already receiving hormone therapy when taken into ICE custody shall have continued access. All transgender detainees shall

have access to mental health care, and other transgender-related health care and medication based on medical need. Treatment shall follow accepted guidelines regarding medically necessary transition-related care.

For special needs related to female detainees, see standard “4.4 Medical Care (Women).

X. Notifications of Detainees with Serious Illnesses and Other Specified Conditions

The facility administrator and clinical medical authority shall ensure that the Field Office Director is notified as soon as practicable of any detainee housed at the facility who is determined to have a serious physical or mental illness or to be pregnant, or have medical complications related to advanced age, but no later than 72 hours after such determination. The written notification shall become part of the detainee’s health record file.

1. Serious Physical Illness

For purposes of this subsection only, the following non-exhaustive categories of medical conditions may be considered to constitute serious physical illness –

- any terminal illness;
- active cancer, including but not limited to aliens undergoing chemotherapy;
- Acquired Immuno- Deficiency Syndrome (AIDS) or diagnosed HIV-positive conditions requiring medication;
- multi-drug-resistant (MDR) or extensively drug-resistant (XDR) tuberculosis disease;
- any condition that requires dialysis;
- any condition that requires tube-feedings, mechanical ventilation, an implanted cardiac device, or an oxygen tank;

- any chronic deteriorating condition requiring multiple medications, to include progressive immune-suppressive conditions;
- any active condition that has caused repeated loss of consciousness;
- any condition that requires an imminent medical procedure or other medical intervention to prevent deterioration;
- any condition or infirmity that requires continuous or near-continuous medical care, such as those who are bedbound or incapable of caring for themselves; or any ongoing or recurrent conditions that have required a recent or prolonged hospitalization, typically for greater than 14 days, or a recent and prolonged stay in the medical clinic of a detention or correctional facility, typically for greater than 30 days;
- conditions requiring frequent care that is beyond the medical capabilities of detention facilities where the alien may be housed;
- any condition that would preclude the alien from being housed, typically for greater than 30 days, in a non-restrictive setting (such as a general population housing unit, as opposed to a special management unit or a medical clinic); or
- any other physical illness determined to be serious by facility medical personnel or by IHSC.

2. Serious Mental Illness

For the purposes of this section, the following non-exhaustive categories of conditions should be considered to constitute a serious mental illness:

(a) conditions that a qualified medical provider has determined to meet the criteria for a “serious mental disorder or condition” pursuant to applicable ICE policies, including:

- a mental disorder that is causing serious limitations in communication, memory, or general mental and/or intellectual functioning (e.g. communicating, conducting activities of daily life, social skills); or a severe medical condition(s) (e.g. traumatic brain injury or dementia) that is significantly impairing mental function; or
- one or more of the following active psychiatric symptoms and/or behavior: severe disorganization, active hallucinations or delusions, mania, catatonia, severe depressive symptoms, suicidal ideation and/or behavior, marked anxiety of impulsivity.
- significant symptoms of one of the following:
 - Psychosis or Psychotic Disorder;
 - Bipolar Disorder;
 - Schizophrenia or Schizoaffective Disorder;
 - Major Depressive Disorder with Psychotic Features;
 - Dementia and/or a Neurocognitive Disorder; or
 - Intellectual Development Disorder (moderate, severe, or profound).

b) any ongoing or recurrent conditions that have required a recent or prolonged hospitalization, typically for greater than 14 days, or a recent and prolonged stay in the medical clinic of a detention or correctional facility, typically for greater than 30 days;

c) any condition that would preclude the alien from being housed, typically for greater than 30 days, in a non-restrictive setting (such as a general population housing unit, as opposed to a special management unit or a medical clinic);

d) any other mental illness determined to be serious by IHSC.

3. Pregnancy

The notification requirement in this section applies to all women who have been medically certified as pregnant, regardless of the stage of the pregnancy.

Y. Restraints

Restraints for medical or mental health purposes may be authorized only by the facility’s CMA or designee, after determining that less restrictive measures are not appropriate. In the absence of the CMA, qualified medical personnel may apply restraints upon declaring a medical emergency. Within one-hour of initiation of emergency restraints or seclusion, qualified medical staff shall notify and obtain an order from the CMA or designee.

- a. The facility shall have written procedures that specify:
- 1) the conditions under which restraints may be applied;
 - 2) the types of restraints to be used;
 - 3) the proper use, application and medical monitoring of restraints;
 - 4) requirements for documentation, including efforts to use less restrictive alternatives; and
 - 5) after-incident review.

The use of restraints requires documented approval and guidance from the CMA. Record-keeping and reporting requirements regarding the medical approval to use restraints shall be consistent with other provisions within these standards, including documentation in the detainee’s A-file, detention

and medical file.

Z. Continuity of Care

The facility HSA must ensure that a plan is developed that provides for continuity of medical care in the event of a change in detention placement or status.

The detainee's medical needs shall be taken into account prior to any transfer of the detainee to another facility. Alternatives to transfer shall be considered, taking into account the disruption that a transfer will cause to a detainee receiving medical care. Upon transfer to another facility, the medical provider shall prepare and provide a Medical Transfer Summary as required by "C. Responsibilities of the Health Care Provider at the Sending Facility," found in Standard 7.4 "Detainee Transfers." In addition, the medical provider shall ensure that at least 7 day (or, in the case of TB medications, 15 day and in the case of HIV/AIDS medications, 30 day) supply of medication shall accompany the detainee as ordered by the prescribing authority.

Upon removal or release from ICE custody, the detainee shall receive up to a 30 day supply of medication as ordered by the prescribing authority and a detailed medical care summary as described in "BB. Medical Records" of this standard. If a detainee is on prescribed narcotics, the clinical health authority shall make a determination regarding continuation, based on assessment of the detainee. The HSA must ensure that a continuity of treatment care plan is developed and a written copy provided to the detainee prior to removal.

AA. Informed Consent and Involuntary Treatment

Involuntary treatment is a decision made only by medical staff under strict legal restrictions. When a detainee refuses medical treatment, and the licensed healthcare provider determines that a medical emergency exists, the physician may authorize involuntary medical treatment. Prior to any contemplated action involving non-emergent

involuntary medical treatment, respective ICE Office of Chief Counsel shall be consulted.

1. Upon admission at the facility, documented informed consent shall be obtained for the provision of health care services.
2. All examinations, treatments, and procedures are governed by informed consent practices applicable in the jurisdiction.
3. A separate documented informed consent is required for invasive procedures, including surgeries, invasive diagnostic tests, and dental extractions.
4. Prior to the administration of psychotropic medications, a separate documented informed consent, that includes a description of the medication's side effects, shall be obtained.
5. If a consent form is not available in a language the detainee understands, professional interpretation services will be provided as described in Section E ("Translation and Language Access for Detainees with Limited English Proficiency") and documented on the form.
6. If a detainee refuses treatment and the CMA or designee determines that treatment is necessary, ICE/ERO shall be consulted in determining whether involuntary treatment shall be pursued.
7. If the detainee refuses to consent to treatment, medical staff shall make reasonable efforts to explain to the detainee the necessity for and propriety of the recommended treatment.
8. Medical staff shall ensure that the detainee's questions regarding the treatment are answered by appropriate medical personnel.
9. Medical staff shall explain the medical risks if treatment is declined and shall document their treatment efforts and refusal of treatment in the detainee's medical record. Detainees will be asked to sign a translated form that indicates that they have refused treatment.

10. The clinical medical authority and facility administrator shall look into refusals of treatment to ensure that such refusals are not the result of miscommunication or misunderstanding.
11. Facilities should make efforts to involve trusted individuals such as clergy or family members should a detainee refuse treatment.
12. A detainee who refuses examination or treatment may be segregated from the general population when such segregation is determined medically necessary by the CMA. Segregation shall only be for medical reasons that are documented in the medical record, and may not be used for punitive purposes. Such segregation shall only occur after a determination by a component mental health professional has taken place that shows the segregation shall not adversely affect the detainee's mental health.
13. In the event of a hunger strike, see standard "4.2 Hunger Strikes."

Standard "4.7 Terminal Illness, Advance Directives and Death" provides details regarding living wills and advance directives, organ donations and do not resuscitate (DNR) orders.

BB. Medical Records

1. Health Record File

The HSA shall maintain a complete health record on each detainee that is:

- a. Organized uniformly in accordance with appropriate accrediting body standards;
- b. Available to all practitioners and used by them for health care documentation; and
- c. Properly maintained and safeguarded in a securely locked area within the medical unit.

2. Confidentiality and Release of Medical Records

All medical providers, as well as detention officers and staff shall protect the privacy of detainees' medical information in accordance with established

guidelines and applicable laws. These protections apply, not only to records maintained on paper, but also to electronic records where they are used. Staff training must emphasize the need for confidentiality and procedures must be in place to limit access to health records to only authorized individuals and only when necessary.

Information about a detainee's health status and a detainee's health record is confidential, and the active medical record shall be maintained separately from other detention records and be accessible in accordance with applicable laws and regulations.

The HSA shall provide the facility administrator and designated staff information that is necessary as follows:

- a. to preserve the health and safety of the detainee, other detainees, staff or any other person;
- b. for administrative and detention decisions such as housing, voluntary work assignments, security and transport; or
- c. for management purposes such as audits and inspections.

When information is covered by the Privacy Act, specific legal restrictions govern the release of medical information or records.

Detainees who indicate they wish to obtain copies of their medical records shall be provided with the appropriate request form. ICE/ERO, or the facility administrator, shall provide limited-English proficient detainees and detainees who are hearing impaired with interpretation or translation services or other assistance as needed to make the written request, and shall assist in transmitting the request to the facility HSA.

Upon his/her request, while in detention, a detainee or his/her designated representative shall receive information from their medical records. Copies of health records shall be released by the HSA directly to a detainee or their designee, at no cost to the detainee, within a reasonable timeframe after receipt

by the HSA of a written authorization from the detainee.

A written request may serve as authorization for the release of health information, as long as it includes the following information, and meets any other requirements of the HSA:

- a. address of the facility to release the information;
- b. name of the individual or institution to receive the information;
- c. detainee's full name, A-number (or other facility identification number), date of birth and nationality;
- d. specific information to be released with inclusive dates of treatment; and
- e. detainee's signature and date.

Following the release of health information, the written authorization shall be retained in the health record.

Detainees are to be informed that if they are released or removed from custody prior to laboratory results being evaluated, the results shall be made available by contacting the detention facility and providing a release of information consent.

3. Inactive Health Record Files

Inactive health record files shall be retained as permanent records in compliance with locally established procedures and the legal requirements of the jurisdiction.

4. Transfer and Release of Detainees

ICE/ERO and the HSA shall be notified when detainees are to be transferred or released. Detainees shall be transferred, released or removed, with proper medication to ensure continuity of care throughout the transfer and subsequent intake process, release or removal (see "W. Continuity of Care," above). Those detainees who are currently placed in a medical hold status must be evaluated and cleared by a licensed independent practitioner

(LIP) prior to transfer or removal. In addition, the CMA or designee must inform the facility administrator in writing if the detainee's medical or psychiatric condition requires a medical escort during removal or transfer.

- a. **Notification of Medical/Psychiatric Alerts or Holds**
Upon receiving notification that a detainee is to be transferred, appropriate medical staff at the sending facility shall notify the facility administrator of any medical/psychiatric alerts or holds that have been assigned to the detainee, as reflected in the detainee's medical records. The facility administrator shall be responsible for providing notice to ICE/ERO of any medical alerts or holds placed on a detainee that is to be transferred.
- b. **Notification of Transfers, Releases and Removals**
The HSA shall be given advance notice by ICE/ERO prior to the release, transfer or removal of a detainee, so that medical staff may determine and provide for any medical needs associated with the transfer, release or removal.
- c. **Transfer of Medical Information**
 - 1) When a detainee is transferred to another detention facility, the sending facility shall ensure that a Medical Transfer Summary accompanies the detainee, as required in "C. Responsibilities of the Health Care Provider at the Sending Facility" found in Standard 7.4 "Detainee Transfers." Upon request of the receiving facility, the sending facility shall transmit a copy of the full medical record within 5 business days, and sooner than that if determined by the receiving facility to be a medically urgent matter.
 - 2) Upon removal or release from ICE custody, the detainee shall be provided medication, referrals to community-based providers as medically appropriate, and a detailed medical care summary. This summary should include

instructions that the detainee can understand and health history that would be meaningful to future medical providers. The summary shall include, at a minimum, the following items:

- a) patient identification;
- b) tuberculosis (TB) screening results (including results date) and current TB status if TB disease is suspected or confirmed;
- c) current mental, dental, and physical health status, including all significant health issues, and highlighting any potential unstable issues or conditions which require urgent follow-up;
- d) current medications, with instructions for dose, frequency, etc., with specific instructions for medications that must be administered en route;
- e) any past hospitalizations or major surgical procedures;
- f) recent test results, as appropriate;
- g) known allergies;
- h) any pending medical or mental health evaluations, tests, procedures, or treatments for a serious medical condition scheduled for the detainee at the sending facility. In the case of patients with communicable disease and/or other serious medical needs, detainees being released from ICE custody are given a list of community resources, at a minimum;
- i) copies of any relevant documents as appropriate;
- j) printed instructions on how to obtain the complete medical record; and
- k) the name and contact information of the transferring medical official.

The IHSC Form 849 or equivalent, or the Medical Transfer Summary attached as Appendix 4.3.C, which mirrors IHSC Form 849, may be used by facilities to ensure compliance with these standards.

CC. Terminal Illness or Death of a Detainee

Procedures to be followed in the event of a detainee's terminal illness or death are in standard "4.7 Terminal Illness, Advance Directives and Death." The standard also addresses detainee organ donations.

DD. Medical Experimentation

Detainees shall not participate in medical, pharmaceutical or cosmetic research while under the care of ICE.

This stipulation does not preclude the use of approved clinical trials that may be warranted for a specific inmate's diagnosis or treatment when recommended and approved by the clinical medical director. Such measures require documented informed consent.

EE. Administration of the Medical Department

1. Quarterly Administrative Meetings

The HSA shall convene a meeting quarterly at minimum, and include other facility and medical staff as appropriate. The meeting agenda shall include, at minimum, the following:

- a. an account of the effectiveness of the facility's health care program;
- b. discussions of health environment factors that may need improvement;
- c. review and discussion of communicable disease and infectious control activities;
- d. changes effected since the previous meetings; and
- e. recommended corrective actions, as necessary.

Minutes of each meeting shall be recorded and kept on file.

2. Health Care Internal Review and Quality Assurance

The HSA shall implement a system of internal review and quality assurance. The system shall include:

- a. participation in a multidisciplinary quality improvement committee;
- b. collection, trending and analysis of data along with planning, interventions and reassessments;
- c. evaluation of defined data;
- d. analysis of the need for ongoing education and training;
- e. on-site monitoring of health service outcomes on a regular basis through the following measures:
 - 1) chart reviews by the responsible physician or his/her designee, including investigation of complaints and quality of health records;
 - 2) review of practices for prescribing and administering medication;
 - 3) systematic investigation of complaints and grievances;
 - 4) monitoring of corrective action plans;
 - 5) reviewing all deaths, suicide attempts and illness outbreaks;
 - 6) developing and implementing corrective-action plans to address and resolve identified problems and concerns;
 - 7) reevaluating problems or concerns, to determine whether the corrective measures have achieved and sustained the desired results;
 - 8) incorporating findings of internal review activities into the organization's educational and training activities;
 - 9) maintaining appropriate records of internal

review activities; and

- 10) ensuring records of internal review activities comply with legal requirements on confidentiality of records.

3. Peer Review

The HSA shall implement an intra-organizational, external peer review program for all independently licensed medical professionals. Reviews shall be conducted at least annually.

FF. Examinations by Independent Medical Service Providers and Experts

On occasion, medical and/or mental health examinations by a practitioner or expert not associated with ICE or the facility may provide a detainee with information useful in administrative proceedings.

If a detainee seeks an independent medical or mental health examination, the detainee or his/her legal representative shall submit to the Field Office Director a written request that details the reasons for such an examination. Ordinarily, the Field Office Director shall approve the request for independent examination, as long as such examination shall not present an unreasonable security risk. Requests for independent examinations shall be responded to as quickly as practicable. If a request is denied, the Field Office Director shall advise the requester in writing of the rationale.

Neither ICE/ERO nor the facility shall assume any costs of the examination, which will be at the detainee's expense. The facility shall provide a location for the examination but no medical equipment or supplies and the examination must be arranged and conducted in a manner consistent with maintaining the security and good order of the facility.

GG. Tele-Health Systems

***The facility, when equipped with appropriate technology and adequate space, shall provide for the*

use of services of the ICE Tele-Health Systems, inclusive of tele-radiology (ITSP), tele-psychiatry and tele-medicine.

1. The cost of the equipment, equipment maintenance, staff training and credentialing (as outlined in the contract), arrangements for x-ray interpretation and administration by a credentialed radiologist; and data transmission to and from the detention facility, shall be provided by the facility and charged directly to ICE.
2. The facility administrator shall coordinate with the ITSP to ensure adequate space is provided for the equipment, connectivity is available, and electrical services are installed.
3. Immediate 24-hour access, seven days a week, to equipment for service and maintenance by ITSP technicians shall be granted.
4. A qualified tele-health coordinator shall be appointed and available for training by the ITSP. Qualified, licensed and credentialed medical staff shall be available to provide tele-health services as guided by state and federal requirements and restrictions.

Medical Forms:

- **Appendix 4.3.A: Intake Screening**
- **Appendix 4.3.B: Physical Examination/Health Appraisal**
- **Appendix 4.3.C: Medical Transfer Summary**

INTAKE SCREENING

Identification

Patient was identified by (check 2 sources): ☐ Wrist Band ☐ Picture ☐ Verbally ☐ ID Badge ☐ Other:		
Chaperone Present? ☐ Yes ☐ No If yes, give chaperone name:		
Date of arrival at facility:	Time of arrival:	Time of initial screening:
If transferred from another facility, did medical transfer summary accompany the patient? ☐ Yes ☐ No ☐ Not Applicable		
Was the Pre-Screening Note reviewed? ☐ Yes ☐ No		

Subjective

Communication Assessment:

What language do you speak? ☐ English ☐ Spanish ☐ Other:
Interpreter provided? ☐ Yes ☐ No If yes, name or INT number:
If No, patient speaks: ☐ English fluently ☐ Provider fluent in patient's native language ☐ No interpreter available at this time
Do you have any difficulty with: ☐ Hearing ☐ Speech ☐ Vision Check if yes. If yes, what accommodation do you need to help you read, communicate, or navigate the facility?

Disability Screening:

Do you have any difficulty with walking, standing, or climbing stairs? ☐ Yes ☐ No If yes, explain:
Do you have any difficulty reading or writing? ☐ Yes ☐ No If yes, explain:
What was the highest grade completed in school?
Do you have any difficulty understanding directions? ☐ Yes ☐ No If yes, explain:

Medical Screening:

How do you feel today? (Explain in his/her own words)			
Are you currently having any pain? ☐ Yes ☐ No If yes, complete pain assessment below			
a. Character of pain:	b. Location:	c. Duration:	d. Intensity: (0-10 pain scale)
e. What relieves pain or makes it worse?			
Do you have any current or past medical problems? ☐ Yes ☐ No If yes, explain:			

Last Name:	First Name:
A#:	Country of Origin:
Date of Arrival:	DOB:
Facility:	Sex:

Medical Screening (continued)

Are you currently or in the past year have you taken any medication on a regular basis, including over the counter and herbal? ☐ Yes ☐ No If yes, list medications:
Do you have your medications with you? ☐ Yes ☐ No If yes, list medications and disposition:
Do you have any allergies to medication or food? ☐ Yes ☐ No If yes, list all:
Are you now or have you ever been treated by a doctor for a medical condition to include hospitalizations, surgeries, infectious or communicable diseases? ☐ Yes ☐ No If yes, explain:
Do you now or have you ever had Tuberculosis (TB)? ☐ Yes ☐ No
In the past 2 months, have you experienced any of the following signs or symptoms continuously for more than 2 weeks: Cough? ☐ Yes ☐ No Coughing up blood? ☐ Yes ☐ No Chest pain? ☐ Yes ☐ No Loss of appetite? ☐ Yes ☐ No Fever, chills, or night sweats for no known reason? ☐ Yes ☐ No Unexplained weight loss? ☐ Yes ☐ No
Symptom screening with positive responses(s) is concerning for active TB: ☐ Yes ☐ No If yes, explain:
Referred to provider for further evaluation. ☐ Yes ☐ No
Have you had any recent sudden changes with your vision or hearing? ☐ Yes ☐ No If yes, explain:
Do you have any specific dietary needs? ☐ Yes ☐ No If yes, explain:
Have you traveled outside of the US within the past 30 days? ☐ Yes ☐ No If so, where?
Have you ever had or have you ever been vaccinated against Chicken Pox? ☐ Yes ☐ No ☐ Admits prior infection

LGBT Screening

Are you gay, lesbian, bisexual, transgender, intersex or gender non-conforming? ☐ Yes ☐ No
If transgender, what is your gender self-identification?

Last Name:	First Name:
A#:	Country of Origin:
Date of Arrival:	DOB:
Facility:	Sex:

Female Patient Only

Are you pregnant? ☐ Yes ☐ No ☐ Not Applicable If yes, date of last menstrual period:

Are you currently breastfeeding? ☐ Yes ☐ No If yes, when is the last day you breastfed?

Have you had unprotected sexual intercourse in the past 5 days? ☐ Yes ☐ No

If yes, would you like to speak to a medical provider about emergency contraception to prevent a possible pregnancy? ☐ Yes ☐ No

If yes, contact a medical provider immediately for guidance.

Oral Screening

Are you having any significant dental problems? ☐ Yes ☐ No If yes, explain:

Do you have dentures, partials, braces, etc? ☐ Yes ☐ No If yes, do you have these items with you?

Mental Health Screening

Have you ever been diagnosed with mental illnesses or mental health conditions? ☐ Yes ☐ No If yes, what illness?

Have you ever received counseling, medication or hospitalization for mental health problems (to include outpatient treatment)?

☐ Yes ☐ No If yes, explain.

Refer for follow-up and appropriate treatment as necessary.

Do you have a history of self-injurious behavior? ☐ Yes ☐ No If yes: ☐ Cutting ☐ Self-mutilation ☐ Other

Most recent **If yes, refer for follow-up and appropriate treatment as necessary.**

Have you ever tried to kill or harm yourself? ☐ Yes ☐ No If yes, when did the attempt occur?

Method: ☐ Gun ☐ Hanging ☐ Cutting skin ☐ Pills ☐ Other

If attempt was within the last 90 days, make referral to mental health immediately.

Are you currently thinking about killing or harming yourself? ☐ Yes ☐ No **If yes, make referral to mental health immediately.**

Do you have a history of assaulting or attacking others? ☐ Yes ☐ No

Do you know of someone in this facility whom you wish to attack or harm? ☐ Yes ☐ No

If yes, who is this person? **If yes, make referral to mental health immediately.**

Do you now or have you ever heard voices that other people don't hear, seen things or people that others don't see, or felt others were trying to harm you for no logical or apparent reason? ☐ Yes ☐ No If yes, explain:

Last Name:

First Name:

A#:

Country of Origin:

Date of Arrival:

DOB:

Facility:

Sex:

Sexual Abuse and Assault Screening

Have you been a victim of physical or sexual abuse or assault? ☐ Yes ☐ No If yes, explain:

If yes, refer for medical or mental health evaluation as appropriate.

Do you feel that you are in danger of being physically or sexually assaulted while you are in custody? ☐ Yes ☐ No If yes, explain:

If yes, refer for follow-up and appropriate treatment as necessary.

Have you ever sexually assaulted or abused another person? ☐ Yes ☐ No If yes, explain:

If yes, refer for medical or mental health evaluation as appropriate.

Trauma History Screening

Have you had a physical or emotional trauma due to abuse or victimization? ☐ Yes ☐ No

Have you ever experienced, witnessed or been confronted with an event that involved actual or threatened death or serious injury (can include domestic violence, sexual assault, robbery, natural disaster, war, serious illness, terrorism). ☐ Yes ☐ No

If yes, answer the following:

- | | | | | |
|---|-----------------------------|-------------------------------|-----------------------------------|----------------------------------|
| • Was your response to this event intense fear, helplessness or horror? | ☐ No | ☐ Some | ☐ Moderate | ☐ Extreme |
| • Has this experience caused significant distress or impairment in your life? | ☐ No | ☐ Some | ☐ Moderate | ☐ Extreme |
| • Has it affected your interpersonal relationships, work or other areas? | ☐ No | ☐ Some | ☐ Moderate | ☐ Extreme |
| • Is this experience currently causing significant distress or impairment in your life? | ☐ No | ☐ Some | ☐ Moderate | ☐ Extreme |

If the patient experienced any of the above, refer for follow-up and appropriate treatment as necessary.

Cultural/Religious Assessment

Is there anything important to know about your religious or cultural beliefs that are of concern to you while in detention? ☐ Yes ☐ No
If yes, explain:

Substance Use/Abuse Screening

Have you ever been treated for drug and/or alcohol problems? ☐ Yes ☐ No

Have you ever suffered withdrawal symptoms from drug and/or alcohol use? ☐ Yes ☐ No

Are you able to stop using drugs or alcohol if you want? ☐ Yes ☐ No

Have you ever blacked out or experienced memory loss from drinking or drug use? ☐ Yes ☐ No

Have drug or alcohol use negatively impacted your life (family, work, relationships, criminal charges)? ☐ Yes ☐ No

If yes to any of the above questions, explain:

Refer for follow-up and appropriate treatment as necessary.

Last Name:

First Name:

A#:

Country of Origin:

Date of Arrival:

DOB:

Facility:

Sex:

Substance Use/Abuse Screening (continued)

In the past three months, have you used tobacco, alcohol, illegal drugs, or misused prescription drugs? ☐ Yes ☐ No

If yes, complete the following (refer for follow-up and appropriate treatment as necessary).

Substance Used/Route of Use	Date of Last Use	Amount/Quantity Last Used

Objective

Patient does not appear to have abnormal physical, mental, and/or emotional characteristics. ☐ Yes ☐ No

Patient does not appear to have barriers to communication. ☐ Yes ☐ No

Patient is oriented to: Person ☐ Yes ☐ No Place ☐ Yes ☐ No Time ☐ Yes ☐ No

If you observe any of the following, check the appropriate box and document findings below:

Appearance: ☐ Sweating ☐ Shaking/tremors ☐ Anxious ☐ Disheveled ☐ Ill appearance

Findings:

Behavior: ☐ Disorderly ☐ Appropriate ☐ Insensible ☐ Agitation ☐ Inability to focus/concentrate Findings:

State of Consciousness: ☐ Alert ☐ Responsive ☐ Lethargic

Findings:

Ease of Movement: ☐ Body deformities ☐ Gait

Findings:

Breathing: ☐ Persistent cough ☐ Hyperventilation

Findings:

Skin: ☐ Lesions ☐ Jaundice ☐ Rashes ☐ Infestations ☐ Nits (lice) ☐ Bruises ☐ Scars ☐

☐ Tattoos Needle Marks or Indications of Drug Use Findings:

Developmental or Physical Disabilities: ☐ Developmental Delay ☐ Para/quadruplegia ☐ Stroke ☐ Amputation ☐ Cardiac condition

Findings:

Assistive Devices: ☐ Glasses/Contacts ☐ Hearing aid(s) ☐ Denture(s)/Partial(s) ☐ Orthopedic brace ☐ Prosthetic ☐ Cane

Findings:

☐ None Observed

Comments/Other Findings:

Vital Signs

T _____ P _____ Resp _____ BP _____ HT _____ WT _____ HCG Results: ☐ Pos ☐ Neg ☐ N/A

Last Name:

First Name:

A#:

Country of Origin:

Date of Arrival:

DOB:

Facility:

Sex:

Assessment

Initial Medical Screening:

- ☐ No findings requiring referral
- ☐ Findings requiring referral identified. See disposition below.
- ☐ List all findings:

Plan

Disposition:

- ☐ General population
- ☐ General population with referral for: ☐ Medical ☐ Mental health care
- ☐ Isolation until medically evaluated
- ☐ Referral for immediate: ☐ Medical ☐ Mental health ☐ Dental care

Details of referral:

Care/Intervention/Follow-up:

- ☐ Physical examination/Health Assessment will be performed within 14 days.
- ☐ Physical exam will be scheduled for patient.
- ☐ Tuberculin Skin Test (TST) administered ☐ Left forearm ☐ Right forearm
- ☐ Chest X-Ray (CXR) completed with appropriate shielding
- ☐ TST or CXR not needed. Transfer Summary accompanying patient documents negative screening within timeframe allowed by policy.
- ☐ The following care/treatment was provided during this Intake Screening.

Last Name:

First Name:

A#:

Country of Origin:

Date of Arrival:

DOB:

Facility:

Sex:

Patient Education:

☐ Tuberculosis screening and need for tuberculin skin test (TST) or chest x-ray (CXR) explained to patient prior to performance.
☐ Access to medical, dental, and mental health care explained to patient as well as grievance process.
☐ Given the Dealing with Stress brochure in _____ language.
☐ Given the Medical Orientation brochure in _____ language.
☐ Given the Health Information brochures in _____ language.
☐ Patient verbalized understanding of teaching or instruction provided.
☐ Patient was asked if he or she had any additional questions and all questions were addressed.
☐ Female ONLY: Educated and provided brochure describing female medical and mental health services related to pregnancy, terminated/miscarried pregnancies, contraception, family planning and age-appropriate gynecological health care.
☐ Other education provided:

Provider's Signature_____
Stamp / Printed Name_____
Date_____
Time_____
Reviewer's Signature_____
Stamp / Printed Name_____
Date_____
Time

Last Name:	First Name:
A#:	Country of Origin:
Date of Arrival:	DOB:
Facility:	Sex:

Physical Examination/Health Appraisal

Patient was identified by (check 2 sources): ☐ Wrist Band, ☐ Picture, ☐ Verbally, ☐ ID Badge, ☐ Other _____
Chaperone Present? ☐ Yes ☐ No If yes, give chaperone name: _____

Communication Assessment:

What language do you speak? ☐ English, ☐ Spanish, ☐ Other: _____

Interpreter provided? ☐ Yes ☐ No If yes, Name or INT#: _____

Detainee speaks ☐ English Fluently; ☐ Provider fluent in patient's native language; ☐ No interpreter available at this time

Do you have any difficulty with ☐ hearing, ☐ speech or ☐ vision? Check if Yes.

If yes, what accommodations, do you need to help you read, communicate, or navigate the facility? _____

Subjective:

Current Significant Medical Problems	Date Problem began	Current Status

Current Medications including OTC and Herbal:

Name	Dose	Route	Frequency

Allergies:

Medications/Food/Environmental: List All: _____ \

Pain Assessment

Are you currently in pain? ☐ Yes ☐ No If yes, pain began when? _____ Intensity: (0/10 scale) _____

Character of Pain: _____ Location: _____

Duration: _____

Has anything you have done or tried in the past relieved the pain or made it worse? ☐ Yes ☐ No

If yes, explain _____

Last Name:	First Name:
A#:	Country of Origin:
Date of Arrival:	DOB:
Facility:	Sex:

Physical Examination/Health Appraisal (con't)

Disability

Do you have any difficulty with walking, standing, or climbing stairs? ☐ Yes ☐ No

If yes, do you use a wheelchair, walker, cane or crutches? _____

Have you ever had an injury to your head or brain which resulted in the loss of consciousness and/or recurring headaches, dizziness, confusion or memory loss? ☐ Yes ☐ No If yes, when was the injury? mm/yyyy _____

Can you read? ☐ Yes ☐ No If yes, in which language? _____ Do you have difficulty reading? ☐ Yes ☐ No

Can you write? ☐ Yes ☐ No If yes, in which language? _____ Do you have difficulty writing? ☐ Yes ☐ No

What was the highest grade you completed in school? _____

Do you have difficulty understanding directions? ☐ Yes ☐ No

If yes, does someone normally assist you with any regular tasks of daily living? _____

Medical History

Has a medical professional ever diagnosed you with any of the following?

☐ Yes ☐ No Asthma	☐ Yes ☐ No Cardiovascular disease	☐ Yes ☐ No Tuberculosis	Comment: **Type
☐ Yes ☐ No Cancer	☐ Yes ☐ No Kidney Disease	☐ Yes ☐ No Stroke	
☐ Yes ☐ No HIV	☐ Yes ☐ No Hyperlipidemia	☐ Yes ☐ No Hepatitis**	
☐ Yes ☐ No Seizures	☐ Yes ☐ No Diabetes	☐ Yes ☐ No Sexually Transmitted Infections**	
☐ Yes ☐ No Hypertension ☐ Yes ☐ No Sickle Cell Anemia			
Varicella ☐ Yes ☐ No ☐ Admits to prior infection ☐ Admits being vaccinated ☐ History denied at physical exam			
Other _____			

Surgical/Hospitalization History:

Surgery or reason for hospitalization	When (mm/yyyy)

Dental

Do you have any significant dental problems? ☐ No, ☐ Cavity, ☐ Broken tooth, ☐ Infection, ☐ Broken jaw, ☐ Other _____

Do you have any dental prosthesis? ☐ None, ☐ Full upper denture, ☐ Full lower denture, ☐ partial denture upper, ☐ partial denture lower, ☐ braces, ☐ retainer

Last Name:	First Name:
A#:	Country of Origin:
Date of Arrival:	DOB:
Facility:	Sex:

Physical Examination/Health Appraisal (con't)

Family History

Asthma ☐ Yes ☐ No Hypertension ☐ Yes ☐ No Diabetes ☐ Yes ☐ No Cardiovascular Disease ☐ Yes ☐ No
Cancer ☐ Yes ☐ No Tuberculosis ☐ Yes ☐ No Stroke ☐ Yes ☐ No Other: _____
Breast or gynecological problems ☐ Yes ☐ No

Female Only

OB History:

Have you ever been pregnant? ☐ No ☐ Yes #Pregnancies _____ #C-Sections _____
#Live Births _____ #Full Term _____ #Pre-Term _____ #Abortions _____ #Miscarriages _____ #Living _____
Are you pregnant? ☐ No ☐ Yes
Are you currently receiving prenatal care? ☐ No ☐ Yes Where? _____
Have you ever been told that you had a 'high risk' pregnancy? If yes, what was the reason?

Are you currently breast feeding? ☐ No ☐ Yes
If yes, how old is the nursing child? _____ When was the last time you breast fed? (mm/dd/yyyy) _____

GYN History:

When was the first day of your LMP? _____ If more than 30 days, why?

Do you have a history of breast or gynecological problems? ☐ No ☐ Yes Explain _____
Do you use birth control? ☐ No ☐ Yes What type? _____ When was the last time you used it? _____
When was your last PAP smear? _____ If known, results _____

Sexual Abuse and Assault/Vulnerabilities

Have you ever been a victim of physical abuse? ☐ No ☐ Yes
Have you ever been a victim of sexual abuse or assault? ☐ No ☐ Yes
If yes, refer patient for medical evaluation in two working days or for mental health evaluation in 72 hours.

Are you gay/ lesbian, bisexual, transgender, intersex or gender non- conforming? ☐ Yes ☐ No
If transgender, what gender do you identify with _____

Do you believe you are vulnerable to sexual abuse or assault in ICE custody? ☐ Yes ☐ No If yes, why? _____
If yes, implement treatment plan.

Have you ever been involved in an incident where you sexually abused others? ☐ Yes ☐ No
If yes, refer patient for medical evaluation in two working days or for mental health evaluation in 72 hours.

Mental Health

Do you have a history of:
Manic episodes ☐ Yes ☐ No Depression ☐ Yes ☐ No Psychotropic medications ☐ Yes ☐ No
Severe anxiety ☐ Yes ☐ No Psychosis ☐ Yes ☐ No Violence towards others ☐ Yes ☐ No
Suicide attempts/gestures ☐ Yes ☐ No

Are you currently having any mental health issues? ☐ Yes ☐ No If yes, explain problem and date problem began _____

Last Name:	First Name:
A#:	Country of Origin:
Date of Arrival:	DOB:
Facility:	Sex:

Physical Examination/Health Appraisal (con't)

Social History

Drug Use History:

Have you used drugs other than those for medical reasons in the past 12 months? ☐ No ☐ Yes If yes, what?

PCP ☐ No ☐ Yes Ketamine ☐ No ☐ Yes Marijuana ☐ No ☐ Yes Prescription Opiates ☐ No ☐ Yes

LSD ☐ No ☐ Yes Ecstasy ☐ No ☐ Yes Methamphetamine ☐ No ☐ Yes

Heroin ☐ No ☐ Yes Route: Injected ☐ No ☐ Yes Intranasal ☐ No ☐ Yes Smoked ☐ No ☐ Yes

Cocaine ☐ No ☐ Yes Route: Injected ☐ No ☐ Yes Intranasal ☐ No ☐ Yes Smoked ☐ No ☐ Yes

When did you last use? _____ Are you having any withdrawal symptoms? ☐ No ☐ Yes If yes, which apply?

☐ Nausea ☐ Vomiting ☐ Diarrhea ☐ Chills ☐ Sweating ☐ Insomnia ☐ Aches & pains ☐ Anxiety

Have you ever gone through withdrawal from drugs? ☐ No ☐ Yes If yes, when? _____

Are you currently in a drug treatment program? ☐ No ☐ Yes If yes, Name of program? _____

Type of Program: ☐ Detox ☐ Methadone ☐ Residential Treatment ☐ Outpatient ☐ 12 Step ☐ Other

Alcohol Use History:

Do you drink alcohol? ☐ No ☐ Yes If yes, type? ☐ Beer ☐ Malt liquor ☐ Wine ☐ Liquor

How often do you drink? ☐ Daily ☐ Weekly ☐ Monthly ☐ Rarely

How much do you drink when you drink? _____

Do you notice over time that you need to drink more for the same effect? ☐ No ☐ Yes

When was your last drink? _____

Are you having any withdrawal symptoms? ☐ No ☐ Yes If yes, which apply? ☐ Headache ☐ Fever ☐ Nausea

☐ Vomiting ☐ Insomnia ☐ Tremor ☐ Hallucinations ☐ Convulsions

Have you ever gone through alcohol withdrawal in the past? ☐ No ☐ Yes How long ago? _____

Have you ever been in treatment for alcohol use? ☐ No ☐ Yes If yes, when? _____

What type of program? ☐ Outpatient ☐ Inpatient

Have you ever been convicted for driving under the influence of alcohol? ☐ No ☐ Yes If yes, when? _____

Tobacco History:

Have you ever used tobacco products? ☐ No ☐ Yes If yes, please answer the following questions:

Do you currently use tobacco products? ☐ No ☐ Yes If yes, what type of products? ☐ Cigarettes ☐ Cigar ☐ Pipe ☐ Chewing tobacco

How long have you used tobacco products? _____ How frequently did/do you use tobacco? _____

When did you last use tobacco products? _____

Are you having any withdrawal symptoms from not using tobacco? ☐ No ☐ Yes If yes, what symptoms are you experiencing?

☐ Cravings ☐ Irritation ☐ Anger ☐ Increased Appetite ☐ Weight Gain ☐ Concentration Problems ☐ Restlessness ☐ Insomnia

☐ Anxiety

Preventative Medicine/Screening History

Have you had screening for cancer? ☐ Yes ☐ No When? (mm/yyyy) _____

What type screening & results if known? _____

Have you had a mammogram? ☐ Yes ☐ No When? (mm/yyyy) _____ Results, if known _____

Have you had a pap smear? ☐ Yes ☐ No When? (mm/yyyy) _____ Results, if known _____

Last Name:	First Name:
A#:	Country of Origin:
Date of Arrival:	DOB:
Facility:	Sex:

Physical Examination/Health Appraisal (con't)

OBJECTIVE:

Vital Signs

T _____ P _____ R _____ BP _____ HT _____ WT _____
 Visual Acuity (Snellen): Left _____ Right _____ Both _____
 Hearing: ☐ Grossly intact ☐ Other _____

General Physical Examination

	R = Refused	NE = Not Evaluated	
General	R	NE	Findings:
ENT	R	NE	Findings:
Dental	R	NE	Findings:
Neurological	R	NE	Findings:
Cardiac	R	NE	Findings:
Pulmonary	R	NE	Findings:
Gastrointestinal	R	NE	Findings:
Genitourinary	R	NE	Findings:
Extremities	R	NE	Findings:
Skin	R	NE	Findings:
Comments/Other Findings:			

Mental Status Examination

Orientation	Alert ☐ No ☐ Yes Oriented to person ☐ No ☐ Yes Place ☐ No ☐ Yes Time ☐ No ☐ Yes
Perceptions/ Thought Content	Perceptual disturbances? ☐ No ☐ Yes If yes, ☐ Auditory hallucinations ☐ Visual hallucinations ☐ Delusions
Appearance	☐ Appropriately dressed ☐ well groomed; ☐ Disheveled; ☐ Other
Posture	☐ Erect; ☐ Stooped; ☐ Slouched; ☐ Other
Gait/Walk	☐ Steady; ☐ Shuffle; ☐ Limp; ☐ Other
Movement	☐ Appropriate; ☐ Tics; ☐ Repetitive; ☐ Rigid; ☐ Agitated; ☐ Slow; ☐ Other
Mood	☐ Appropriate; ☐ Labile; ☐ Relaxed; ☐ Happy; ☐ Calm; ☐ Distressed; ☐ Angry; ☐ Agitated; ☐ Sad/Depressed; ☐ Fearful/Anxious; ☐ Irritable; ☐ Other
Attitude	☐ Cooperative; ☐ Uncooperative; ☐ Threatening; ☐ Evasive
Speech	☐ Coherent; ☐ Incoherent; ☐ Pressured; ☐ Average speed; ☐ Rapid; ☐ Slow; ☐ Slurred; ☐ Mumbled; ☐ Talkative; ☐ Loud; ☐ Soft; ☐ Other
Intelligence	☐ Appears normal; ☐ Appears developmentally delayed
Insight	☐ Good; ☐ Impaired
Comments:	

Last Name:	First Name:
A#:	Country of Origin:
Date of Arrival:	DOB:
Facility:	Sex:

Physical Examination/Health Appraisal (con't)

Assessment:

___ Physical exam/health appraisal shows no significant medical, mental health or dental issues currently.

___ Physical exam/health appraisal shows the following significant issues:

Plan:

Treatment including medications: _____

Immunizations, Injections, Imaging, Labs: _____

Referrals: _____

Other

Preventative Medicine/Patient Education:

___ Given the Staying Healthy brochure in the _____ language.

___ Verbally given instruction on dental hygiene.

___ Provided with instruction appropriate to patient's health needs.

___ Patient verbalized understanding of teaching or instructions provided.

___ Patient was asked if he/she had any additional questions, and any questions were addressed.

___ Patient was instructed to return to medical clinic as needed.

___ Patient was instructed to return to clinic for appointment.

___ Health Assessment was rescheduled until [_____] to provide sign language interpreter for health assessment.

___ Health Assessment was rescheduled until [_____] to provide foreign language interpreter for health assessment.

___ Other: _____

Last Name:	First Name:
A#:	Country of Origin:
Date of Arrival:	DOB:
Facility:	Sex:

MEDICAL TRANSFER SUMMARY

Last Name:	First Name:
A#:	Country of Origin:
Date of Arrival at Sending Facility:	DOB:
Sending Facility:	Sex:

1. General Information:

Cleared for Travel by Ground Transportation: ☐ Yes ☐ No Date of Departure: _____
Cleared for Travel by Air Transportation: ☐ Yes ☐ No Final Destination, if known: _____
Reason for Transfer: ☐ Custody ☐ Medical Medical Escort required: ☐ Yes ☐ No If yes, type: ☐ Medical ☐ Psychiatric

2. Current Medical, Dental, and/or Mental Health Diagnoses/Problems:

URGENT

3. Allergies: _____

4. Current Prescribed Medications: List All (Name, Dosage, Directions in layman's terms)

Check off Medication Required for Care en Route

Medication	Dose	# Sent	Route	Instructions for use (include proper time for administration)	Stop Date
☐					
☐					
☐					
☐					
☐					
☐					
☐					

5. TB Clearance Status for Transfer or Transportation

Screening Modality (Check all that apply and document below): ☐ CXR ☐ TST ☐ IGRA ☐ Symptom Screen

CXR: Date: _____

TB Screening: ☐ Negative, not consistent w/TB ☐ Positive, consistent w/TB

TST: Administered Date: _____ **TST** Read Date: _____ Results: _____ mm induration

IGRA: Collection Date: _____ Results: ☐ Positive ☐ Negative ☐ Indeterminate

Symptom Screening Date: _____ Results: ☐ Positive ☐ Negative

Is the patient being treated for TB? ☐ No ☐ Yes, select options: ☐ Cleared for general detention population
☐ Not cleared for general detention population
☐ Being treated for TB, see attached TB Case Management documentation

Medical Transfer Summary (con't)

6. Healthcare Follow-Up:

Recent (within 6 months) Test Results: _____

Recent (within 6 months) Hospitalizations/Surgeries: _____

Recommended Future Lab Work: _____

Pending Specialty Appointment (s): _____

Recommended Specialty Appointment (s): _____

Requires Immediate Follow Up: _____

7. Special Needs Affecting Transportation: -- Use Standard Infection Control Precautions for all patients --

Are there any medical, dental, or mental health condition that restricts the length of time the patient can be on travel status? ☐ Yes ☐ No

Reason(s) and maximum length of travel time: _____

Does the patient have any special needs that escorting staff should be aware of? ☐ Yes ☐ No

If so, what? _____

Equipment provided by: ☐ Medical Authority ☐ Other _____ Equipment owned by: ☐ Medical Authority ☐ Other _____

Patient will keep equipment upon arrival at destination? ☐ Yes ☐ No

Is there any medical equipment required to accompany the patient during travel? ☐ Yes ☐ No

If so, what? _____

Are any special precautions required during transport? ☐ Yes ☐ No

Precautions needed for the patient: _____

Precautions needed for the escorting staff: _____

8. Additional Comments (Mark through if no comments are made): Attach additional pages or medical records as needed

9. Release from custody: Attach ☐ Instructions for Requesting Complete Medical Records ☐ Community Resource Information, if applicable

Sending Facility Point of Contact: _____

Sending Facility Contact Number: _____

Completed by Provider Printed Name

Date

Time

Provider Signature

Last Name:	First Name:
A#:	Country of Origin:
Date of Arrival at Sending Facility:	DOB:
Sending Facility:	Sex:

ICE/DRO DETENTION STANDARD

MEDICAL CARE

I. PURPOSE AND SCOPE. This Detention Standard ensures that detainees have access to emergent, urgent, or non-emergent medical, dental, and mental health care that are within the scope of services provided by the DIHS, so that their health care needs are met in a timely and efficient manner.

This Detention Standard applies to the following types of facilities housing DRO detainees:

- Service Processing Centers (SPCs);
- Contract Detention Facilities (CDFs); and
- State or local government facilities used by DRO through Intergovernmental Service Agreements (IGSAs) to hold detainees for more than 72 hours.

Procedures in italics are specifically required for SPCs and CDFs. IGSAs must conform to these procedures or adopt, adapt or establish alternatives, provided they meet or exceed the intent represented by these procedures.

Some terms used in this document may be defined in the separate **Definitions** Standard.

II. EXPECTED OUTCOMES. The expected outcomes of this Detention Standard are:

1. Detainees will have access to a continuum of health care services, including prevention, health education, diagnosis, and treatment.
2. Health care needs will be met in a timely and efficient manner.
3. Newly admitted detainees will be informed, orally and in writing, about how to access health services.
4. Detainees will be able to initiate requests for health services on a daily basis.
5. Detainees will receive timely follow-up to their health care requests.
6. Detainees will have continuity of care from admission to transfer, discharge, or removal, including referral to community-based providers when indicated.
7. A detainee who needs health care beyond facility resources will be transferred in a timely manner to an appropriate facility where care is available. A written list of referral sources, including emergency and routine care, will be maintained as necessary and updated at minimum annually.
8. A transportation system will be available that ensures timely access to health care services that are only available outside the facility, including: prioritization of medical need, urgency (such as the use of ambulance instead of standard transportation) and transfer of medical information.
9. A detainee who requires close, chronic or convalescent medical supervision will be treated in accordance with a written plan approved by licensed physician, dentist, or mental health practitioner that includes directions to health care providers and other involved medical personnel.

10. Detainees will have access to specified 24-hour emergency medical, dental, and mental health services.
11. Minimum requirements for medical housing units will be met.
12. Female detainees will undergo pregnancy testing and pregnancy management services.
13. Screening, prevention and control measures will be utilized to assist in prevention and management of infectious and communicable diseases.
14. Biohazardous waste will be managed and medical and dental equipment decontaminated in accordance with standard medical practices and in compliance with applicable laws.
15. Detainees with chronic conditions will receive care and treatment for conditions where non-treatment would result in negative outcomes or permanent disability as determined by the clinical medical authority.
16. The facility administrator will develop a plan to ensure that ICE is notified in writing of any detainee whose special medical or mental health needs require special consideration in such matters as housing, transfer, or transportation.
17. Detainees will have access to emergency and specified routine dental care provided under direction and supervision of a licensed dentist.
18. Detainees will be provided health education and wellness information.
19. Each newly admitted detainee, including transfers, will receive a documented medical, dental, and mental health screening upon intake and, within 14 days of arrival, a comprehensive health appraisal by qualified personnel in a private setting as practicable to ensure safety.
20. Detainees with suspected or known mental health concerns will be referred as needed for evaluation, diagnosis, treatment, and stabilization
21. Mental health crisis intervention services will be identified and available for detainees who experience acute mental health episodes.
22. Restraints for medical or mental health purposes will be authorized only by the facility's clinical medical authority, in accordance with the requirements specified in this Detention Standard.
23. Prior to placement in a non-detention facility or special unit within the facility specifically designated for the care of the severely mentally ill or developmentally disabled, a detainee shall be afforded due process in compliance with applicable laws.
24. Medical and dental orthoses or prostheses and other aids to impairment are supplied in a timely manner when the health of the detainee would otherwise be adversely affected, as determined by the responsible physician or dentist.
25. Detoxification from alcohol, opiates, hypnotics, other stimulants, and sedatives is done only under medical supervision in accordance with applicable laws.
26. Pharmaceuticals and nonprescription medicines will be secured, stored and inventoried.
27. Prescriptions and medications will be ordered, dispensed, and administered in a timely and sufficient manner as prescribed by a health care professional.

28. Health care services will be administered by the health administrative authority, and clinical decisions will be the sole province of the clinical medical authority.
29. Health care services will be provided by a sufficient number of appropriately trained and qualified personnel, whose duties are governed by thorough and detailed job descriptions and who are verifiable licensed, certified, credentialed, and/or registered in compliance with applicable state and federal requirements.
30. Detention and health care personnel will be trained, initially and annually, to respond to health-related emergency situations within four minutes and in the proper use of emergency medical equipment
31. Information about each detainee's health status will be treated as confidential, and health records will be maintained in accordance with accepted standards separately from other detainee detention files and be accessible only in accordance with written procedures and applicable laws. Health record files on each detainee will be well organized, available to all practitioners, and properly maintained and safeguarded.
32. Informed consent standards will be observed and adequately documented. Staff will make reasonable efforts to ensure that detainees understand their medical condition and care.
33. Medical and mental health interviews, screenings, appraisals, examinations, and procedures will be conducted in settings that respect detainees' privacy in accordance with safe and orderly operations of the facility.
34. Detainees will be provided same sex chaperones as appropriate or as requested.
35. When a detainee is transferred to another facility, the transferring facility will send a completed medical transfer summary and other medical documentation as appropriate to the receiving facility.
36. Detainees in Special Management Units will have access to the same health care services as detainees in the general population.
37. Non-English speaking detainees and/or detainees who are deaf and/or hard at hearing will be provided interpretation/translation services or other assistance as needed for medical care activities.
38. Detainees with special needs, including physical or developmental disabilities, will be evaluated and given the appropriate care and communication their situation requires.

III. DIRECTIVES AFFECTED. This Detention Standard replaces **Medical Care** dated 9/12/2008.

IV. REFERENCES

American Correctional Association 4th Edition Standards for Adult Detention Facilities: 4-ALDF-2A-15, 4C-01 through 4C-31, 4C-34 through 4C-41, 4D-01 through 4D-21, 4D-23 through 4D-28, 2A-45, 7D-25.

Detention Standard on **Environmental Health and Safety**, particularly in regard to:

- Storing, inventorying, and handling needles and other sharp instruments,

- Standard precautions to prevent contact with blood and other body fluids,
- Sanitation and cleaning to prevent and control infectious diseases, and
- Disposing of hazardous and infectious waste.

Detention Standard on **Sexual Abuse and Assault Prevention and Intervention.**

Detention Standard on **Suicide Prevention and Intervention.**

Detention Standard on **Hunger Strikes.**

Detention Standard on **Terminal Illness, Advance Directives, and Death.**

United States Public Health Service (USPHS) Division of Immigration Health Services (DIHS) Policies and Procedures Manual.

National Commission on Correctional Health Care (NCCHC), Standards for Health Services in Jails .

The Joint Commission (TJC)

http://www.cdc.gov/tb/pubs/mmwr/Maj_guide/Correctional.htm/ (for CDC guidelines on prevention and control of tuberculosis in correctional and detention facilities).

V. EXPECTED PRACTICES

A. General

Every facility shall directly or contractually provide its detainee population:

- Initial medical, mental health, and dental screening,
- Primary medical and dental care,
- Emergency care,
- Specialty health care,
- Timely responses,
- Mental health care, and
- Hospitalization as needed within the local community
- Identification of a health administrative authority and a clinical medical authority within the facility.

B. Designation of Authority

A designated administrative health authority shall have overall responsibility for health care services pursuant to a written agreement, contract, or job description. The administrative health authority is a physician, health services administrator, or health agency. When the administrative health authority is other than a physician, final clinical judgment shall rest with the facility's designated clinical medical authority.

In no event should clinical decisions be made by non-clinicians.

The administrative health authority shall be authorized and responsible for making decisions about the deployment of health resources and the day-to-day operations of the health services program.

A designated clinical medical authority shall have overall responsibility for medical clinical care pursuant to a written agreement, contract, or job description. The clinical medical authority is a physician, licensed independent practitioner, or other clinically trained professional designated by a physician to have final medical decision-making authority. In the event that the clinical medical authority is not a licensed physician, the clinical medical authority must establish a physician-level collaboration for purposes of medical management and professional collaboration. The clinical medical authority together with the administrative health authority establishes the processes and procedures necessary to meet the medical standards outlined herein.

All facilities shall provide a medical staff and sufficient support personnel to meet these Standards. A staffing plan, which is reviewed at least annually by the administrative health authority, identifies the positions needed to perform the required services.

Health care personnel perform duties for which they are credentialed by training, licensure, certification, job descriptions, and/or written standing or direct orders by personnel authorized by law to give such orders.

The facility administrator, in collaboration with the clinical medical authority and administrative health authority, negotiates and maintains arrangements with nearby medical facilities or health care providers to provide required health care not available within the facility, as well as identifying custodial officers to transport and remain with detainees for the duration of any off-site treatment or hospital admission.

C. Communicable Disease and Infection Control

1. General

Each facility shall have written plans that address the management of infectious and communicable diseases, including prevention, education, identification, surveillance, immunization (when applicable), treatment, follow-up, isolation (when indicated), and reporting to local, state, and federal agencies.

Plans shall include:

- Coordination with public health authorities;
- Ongoing education for staff and detainees;
- Control, treatment and prevention strategies;
- Protection of individual confidentiality;
- Media relations;
- Procedures for the identification, surveillance, immunization, follow-up and isolation of patients;
- Manage infectious diseases and report them to local and/or state health departments in accordance with established guidelines and applicable laws; and

- Management of biohazardous waste and decontamination of medical and dental equipment that complies with applicable laws and Detention Standard on **Environmental Health and Safety**.

Facilities shall comply with current and future plans implemented by federal, state or local authorities addressing specific public health issues including communicable disease reporting requirements. Infectious and communicable disease control activities shall be reviewed and discussed with ICE in the Quarterly Administrative Meetings required later in this Detention Standard.

2. Additional Requirements Regarding Tuberculosis (TB)

As indicated below in the section on **Medical Screening of New Arrivals**, screening for tuberculosis is initiated at intake and in accordance with Center for Disease Control and Prevention (CDC) guidelines.

All new arrivals shall receive TB screening within 12 hours of intake and using methods in accordance with CDC guidelines for non-minimal risk detention facilities [symptom screening plus at least one of the following: tuberculin skin test (TST), chest radiography, or QuantiFERON-TB Gold or In-tube test (QFT)]; for CDC guidelines on prevention and control of TB in correctional and detention settings, see http://www.cdc.gov/tb/pubs/mmwr/Maj_guide/Correctional.htm/.

Detainees will receive TB testing every 12 months.

Detainees with symptoms suggestive of TB shall be placed in a functional airborne infection isolation room with negative pressure ventilation and promptly evaluated for TB disease. If TB screening is negative and the detainee is asymptomatic, the detainee will be allowed to join the general population.

Suspected and confirmed active TB patients shall be placed in a functional airborne infection isolation room with negative pressure ventilation (on- or off-site) until determined by a qualified provider to be noninfectious in accordance with CDC guidelines for non-minimal risk detention facilities.

For all **confirmed and suspected** active tuberculosis cases, designated medical staff shall report:

- All cases to local and/or state health departments within one working day of meeting reporting criteria and in accordance with established guidelines and applicable laws, identified by the custodial agency and the detainee's identifying number of that agency (i.e., ICE detainees are reported as being in ICE custody and identified by their alien numbers).
- All cases to the ICE HQ Epidemiology Unit within one working day.

Reporting shall include names, aliases, date of birth, alien number, case status/classification, available diagnostic and lab results, treatment status including drugs and dosages, treatment start date, a point of contact and telephone number for follow-up, and provision of medication administration records (MARs).

- Any movement of TB patients, including hospitalizations, facility transfers, releases, or removals/deportations to the local and/or state health department and the ICE HQ Epidemiology Unit.

When treatment is indicated, multi-drug, anti-TB therapy will be administered using Directly Observed Therapy (DOT) in accordance with American Thoracic Society (ATS) and CDC guidelines. For patients with drug-resistant or multi-drug-resistant TB, the state or local health department will be consulted to establish a customized treatment regimen and treatment plan. Patients receiving anti-TB therapy will be provided with at least a two week supply of medications and appropriate education when transferred, released, or deported, in an effort to prevent interruptions in treatment until care is continued in another location.

Treatment for latent TB infection (LTBI) shall not be initiated unless active TB disease is ruled-out.

Designated medical staff shall coordinate with the ICE Epidemiology Program and the local and/or state health department to facilitate an international referral and continuity of therapy. Designated medical staff shall collaborate with the local and/or state health department on tuberculosis and other communicable disease contact investigations.

Designated medical staff shall report to the ICE Epidemiology Unit all cases of nationally notifiable infectious diseases as per the CDC list located at the following link: <http://www.cdc.gov/ncphi/diss/nndss/phs/infdis.htm>.

Designated medical staff also shall report to the ICE Epidemiology Unit all cases of Varicella, (herpes zoster [shingles], chicken pox).

3. Varicella

Designated medical staff shall notify the ICE HQ Epidemiology Unit of any varicella cases among ICE detainees and of any ICE detainees exposed to active varicella without a history of prior varicella or varicella immunization.

4. Bloodborne Pathogens

Infection control awareness shall be communicated on a regular basis to correctional and medical staff as well as detainees. A detainee may request HIV testing at any time during detention. Persons, who must feed, escort, directly supervise, interview or conduct routine office work with HIV patients are not considered at risk of infection; however, persons regularly exposed to blood are at risk. Facilities must develop a plan to ensure the highest degree of confidentiality regarding HIV status and medical condition. Staff training must emphasize the need for confidentiality and procedures must be in place to limit access to health records to only authorized individuals and only when necessary.

The accurate diagnosis and medical management of HIV infection among detainees shall be promoted. An HIV diagnosis may be made only by a licensed physician, based on a medical history, current clinical evaluation of signs and symptoms, and laboratory studies.

a. Clinical Evaluation

When current symptoms are suggestive of HIV infection, the following shall be implemented:

- Clinical evaluation shall determine the medical need for isolation.

The health authority shall not recommend to ICE/DRO that the detainee be separated from the general population, either pending a test result or after a test report, unless clinical evaluation reveals a medical need for isolation. Segregation of HIV-positive detainees is not necessary for public health purposes.

- Following a clinical evaluation, if a detainee manifests symptoms requiring treatment beyond the facility's capability, the provider shall recommend the detainee's transfer to a hospital, or other appropriate facility, for further medical testing, final diagnosis, and acute treatment as needed, consistent with local operational procedures.
- Any detainee with active tuberculosis should also be evaluated for possible HIV infection.
- HIV positive detainees should be hospitalized until any acute treatment deemed necessary is completed.

When the attending physician determines that a detainee is in remission from his or her illness and/or no longer requires off-site care, he or she shall be returned to the detention facility. The physician shall recommend whether the detainee should be housed in the general population or in another location for medical purposes.

- An HIV positive diagnosis must be reported to government bodies according to state and federal requirements. Reports of AIDS, and not HIV infection, are required by the CDC. State laws differ considerably, and the administrative health authority is responsible for ensuring that all applicable state requirements are met.

b. Exposure

Detainee's exposure to potentially infectious body fluids, such as through needle sticks or bites shall be afforded immediate medical assistance, and the incident shall be reported as soon as possible to the clinical director or designee.

Each facility shall establish a plan to address exposure to bloodborne pathogens, including reporting.

c. Precautions

All detainees should be assumed to be infectious for blood-borne pathogens, and standard precautions are to be used at all times when caring for all detainees.

The **Standard Precautions** section of the Detention Standard on **Environmental Health and Safety** provides more detailed information.

D. Notifying Detainees about Health Care Services

In accordance with the Detention Standard on **Detainee Handbook**, the facility shall provide each detainee, upon admittance, a copy of the detainee handbook and local supplement, in which procedures for access to health care services are explained.

In accordance with the section on **Orientation** in the Detention Standard on **Admission and Release**, access to health care services, sick call and a medical grievance process shall be included in the orientation curriculum for newly admitted detainees.

E. Facilities

1. Examination and Treatment Area

Adequate space and equipment shall be furnished in all facilities so that all detainees may be provided basic health examinations and treatment in private while ensuring safety.

A holding/waiting area shall be located at the entrance to the medical facility that is under the direct supervision of custodial officers. A detainee toilet and drinking fountain shall be accessible from the holding/waiting area.

2. Medical Records

Medical records shall be kept separate from detainee detention records and stored in a securely locked area within the medical unit.

3. Medical Housing

If there is a specific area, separate from other housing areas, where detainees are admitted for health observation and care under the supervision and direction of health care personnel, the following minimum standards shall be met:

a. Care

- Clearly defined scope of care services available;
- Physician on call or available 24 hours per day;
- Health care personnel are on duty 24 hours per day when patients are present;
- All patients within sight or sound of a staff member;
- Housing record that is a separate and distinct section of the complete medical record; and
- Compliance with all established guidelines and applicable laws.

Facilities are expected to provide detainees in medical housing access to other services such as telephone, legal access and materials consistent with their medical condition.

b. Wash Basins, Bathing Facilities, and Toilets

- Detainees have access to operable washbasins with hot and cold running water at a minimum ratio of one for every 12 detainees, unless state or local building codes specify a different ratio.

- Sufficient bathing facilities are provided to allow detainees to bathe daily, and at least one is configured and equipped to accommodate detainees with physical impairments or who need assistance to bathe. Water is thermostatically controlled to temperatures ranging from 100 F to 120 F degrees.
- Detainees have access to operable toilets and hand-washing facilities 24 hours per day and are able to use toilet facilities without staff assistance. Unless state or local building or health codes specify otherwise:
 - Toilets are provided at a minimum ratio of one to every 12 detainees in male facilities and one for every 8 in female facilities.
 - All housing units with three or more detainees have a minimum of two toilets.

F. Pharmaceutical Management

Each facility shall have written policy and procedures for the management of pharmaceuticals that include:

- A formulary of all prescription and nonprescription medicines stocked or routinely procured from outside sources.
- A method for promptly approving and obtaining medicines not on the formulary should be identified.
- Prescription practices, including requirements that medications are prescribed only when clinically indicated, and that prescriptions are reviewed before being renewed.
- Procurement, receipt, distribution, storage, dispensing, administration and disposal of medications.
- Secure storage and disposal and perpetual inventory of all controlled substances (DEA Schedule II-V), syringes and needles.
- Medicine administration error reports shall be kept for all administration errors.
- All staff responsible for administering or having access to pharmaceuticals will be trained on medication management before beginning duty.
- All pharmaceuticals shall be stored in a secure area with the following features:
 - A secure perimeter;
 - Access limited to authorized medical staff (never detainees);
 - Solid walls from floor to ceiling and a solid ceiling;
 - A solid core entrance door with a high security lock (with no other access); and

- A secure medication storage area.
- Administration and management in accordance with state and federal law
- Supervision by properly licensed personnel
- Administration of medications by properly trained personnel under the supervision of the health services administrator, or equivalent
- Accountability for administering or distributing medications in a timely manner and according to licensed provider orders

G. Nonprescription Medications

The facility administrator and administrative health authority shall jointly approve any nonprescription medications that are available to detainees outside of health services (sold in commissary, distributed by housing officers, etc.), and they shall jointly review the list annually.

H. Medical Personnel

All health care staff must be verifiably licensed, certified, credentialed, and/or registered in compliance with applicable state and federal requirements

I. Medical Screening of New Arrivals

1. Medical Screening

Initial medical, dental, and mental health screening shall be done within 12 hours of arrival by a health care provider or a detention officer specially trained to perform this function.

If screening is performed by a detention officer, the facility shall maintain documentation of the officer's special training, and the officer shall have available for reference the training syllabus, to include education on patient confidentiality of disclosed information.

The screening shall inquire into the following:

- Any past history of serious infectious or communicable illness, and any treatment or symptoms;
- Current illness and health problems, including communicable diseases;
- Pain assessment;
- Current and past medication;
- Allergies;
- Past surgical procedures;
- Symptoms of active TB or previous TB treatment;
- Dental problems;
- Use of alcohol and other drugs;
- Possibility of pregnancy;

- Other health programs designated by the responsible clinical medical authority;
- Observation of behavior, including state of consciousness, mental status, appearance, conduct, tremor, sweating;
- History of suicide attempts or current suicidal/homicidal ideation or intent;
- Observation of body deformities and other physical abnormalities;
- Questions and an assessment regarding past or recent sexual victimization.

For further information, see the Detention Standard on **Admission and Release**.

Screening shall include observation and interview items related to the detainee's potential suicide risk and possible mental disabilities, including mental illness. For further information, see the Detention Standard on **Suicide Prevention and Intervention**.

If at any time during the screening process there is an indication of need, or request for, mental health services, the health authority must be notified within 24 hours. The clinical medical authority will ensure a full mental health evaluation if indicated. See the section on **Mental Health Program** below.

Medical and mental health interviews and examinations shall be conducted in settings that respect detainees' privacy.

All facilities shall have policies and procedures to ensure the initial health screening and assessment is documented.

- The In Processing Health Screening form I-795A or medical facility equivalent will be completed during the in-processing and prior to the detainee's placement in a housing unit.
- The health intake screening shall be conducted using form **I-795A or an equivalent**. Upon completion, the In-Processing Health Screening form shall be forwarded to the facility medical staff for appropriate action.

The clinical medical authority shall be responsible for review of all health screening forms within 24 hours or next business day to assess the priority for treatment (for example, Urgent, Today, or Routine).

For other facilities that do not use the ICE/DRO In-Processing Health Screening form, ICE/DRO Medical must approve any substitute form.

Non-English speaking detainees and detainees who are deaf or hard of hearing will be provided interpretation or translation services or other assistance as needed for medical care activities.

- Language assistance may be provided by another staff member competent in the language or by a professional service, such as a telephone translation service.

2. Substance Dependence and Detoxification

All detainees shall be evaluated through the initial screening for their use of or dependence on mood and mind-altering substances, alcohol, opiates, hypnotics,

sedatives, etc. Detainees who report the use of such substances shall be evaluated for their degree of reliance on and potential for withdrawal.

The clinical medical authority shall establish guidelines for evaluation and treatment of new arrivals who require detoxification. Treatment and supportive measures shall permit withdrawal with minimal physiological and physical discomfort.

Detoxification shall be done only at facilities qualified to do so in accordance with established guidelines and applicable laws.

J. Health Appraisal

Each facility's health care provider shall conduct a health appraisal including a physical examination on each detainee within 14 days of the detainee's arrival unless more immediate attention is required due to an acute or identifiable chronic condition, in accordance with the most recent ACA Adult Local Detention Facility standards for Health Appraisals. If there is documentation of one within the previous 90 days, the facility health care provider upon review may determine that a new appraisal is not required.

Medical, dental, and mental health interviews, examinations, and procedures shall be conducted in settings that respect detainees' privacy.

Detainees will be provided same sex chaperones as appropriate or as requested.

The clinical medical authority shall be responsible for review of all health appraisals to assess the priority for treatment.

Detainees diagnosed with a communicable disease shall be isolated according to national standards of medical practice and procedures.

K. Mental Health Program

1. Mental Health Services Required

Each facility shall have an in-house or contractual mental health program, approved by the appropriate medical authority, that provides:

- Intake screening (see DIHS Form 795A or equivalent) for mental health problems will include:
- Referral as needed for evaluation, diagnosis, treatment, and monitoring of mental illness;
- Crisis intervention and management of acute mental health episodes;
- Transfer to licensed mental health facilities of detainees whose mental health needs exceed the capabilities of the facility; and
- Suicide prevention program.

2. Mental Health Provider

The term "mental health provider" includes a psychiatrist, physician, psychologist, clinical social worker, or other appropriately licensed independent mental health practitioner.

3. Mental Health Evaluation

Based on intake screening, medical documentation or subsequent observations by detention staff or medical personnel, the administrative health authority shall immediately refer any detainee with mental health needs to a mental health provider for a mental health evaluation.

Such evaluation and screenings shall include:

- Reason for referral;
- History of any mental health treatment or evaluation;
- History of illicit drug/alcohol use or abuse or treatment for such;
- History of suicide attempts;
- Current suicidal/homicidal ideation or intent;
- Current use of any medication;
- Estimate of current intellectual function;
- Mental health screening should include prior history physical, sexual, or emotional abuse; and
- Impact of any pertinent physical condition, such as head trauma;.
- Recommend any appropriate treatment, for example:
 - Remain in general population with psychotropic medication and counseling,
 - “Short-stay” unit or infirmary,
 - Special Management Unit, or
 - Community hospitalization.
- Recommend and/or implement a treatment plan, including recommendations concerning transfer, housing, voluntary work, and other program participation.

4. Referrals and Treatment

Any detainee referred for mental health treatment shall receive a comprehensive evaluation by a licensed mental health provider as clinically necessary, but no later than 14 days of the referral.

The provider shall develop an overall treatment/management plan that may include transfer to a mental health facility if the detainee’s mental illness or developmental disability needs exceed the treatment capability of the facility.

The health administrative authority/clinical medical authority shall ensure due process in compliance with applicable laws.

5. Medical Isolation

The clinical medical authority may place in medical isolation a detainee who is at high risk for violent behavior because of a mental health condition. The clinical medical authority must provide for reassessment on a daily basis the need for continued medical isolation for the health and safety of the detainee.

6. Restraints

Restraints for medical or mental health purposes may be authorized only by the facility's clinical medical authority, after reaching the conclusion that less restrictive measures are not appropriate. The facility shall have written procedures that specify:

- The conditions under which restraints may be applied;
- The types of restraints to be used;
- The proper use, application, and monitoring of restraints;
- Requirements for documentation, including efforts to use less restrictive alternatives; and
- After-incident review.

7. Involuntary Administration of Psychotropic Medications

Involuntary administration of psychotropic medications to detainees shall comply with established guidelines and applicable laws and only pursuant to the specific, written and detailed authorization of a physician. When psychotropic medication is involuntarily administered, it is required that the administrative health authority contact DRO Management, who shall contact respective DHS/ICE Chief Counsel. The authorizing physician shall:

- Review the medical record of the detainee and conduct a medical examination;
- Specify the reasons for and duration of therapy and whether the detainee has been asked if he or she would consent to such medication;
- Specify the medication to be administered, the dosage, and the possible side effects of the medication;
- Document that less restrictive intervention options have been exercised without success;
- Detail how the medication is to be administered;
- Monitor the detainee for adverse reactions and side effects; and
- Prepare treatment plans for less restrictive alternatives as soon as possible.

Also see the section on Informed Consent and Involuntary Treatment later in this Detention Standard.

L. Annual Health Examinations

The clinical medical authority or health administrative authority (or their equivalents) may determine that detainees not covered below in the section on **Special Needs and Close Medical Supervision** are to be scheduled for annual medical examinations.

A detainee that is in ICE custody for over a year shall receive health examinations on an annual basis. Such examinations may occur more frequently for certain individuals, depending on their medical history or health conditions. Detainees shall have access to age and gender appropriate exams annually, including rescreening for tuberculosis.

M. Dental Treatment

An initial dental screening exam shall be performed within 14 days of the detainee's arrival. If no on-site dentist is available, the initial dental screening may be performed by a physician, physician assistant, nurse practitioner, registered dental hygienist, or registered nurse.

- **Emergency dental treatment** shall be provided for immediate relief of pain, trauma and acute oral infection.
- **Routine dental treatment** may be provided to detainees in ICE custody for whom dental treatment is inaccessible for prolonged periods because of detention for over six (6) months, including amalgam and composite restorations, prophylaxis, root canals, extractions, x-rays, the repair and adjustment of prosthetic appliances and other procedures required to maintain the detainee's health.

N. Sick Call

Each facility shall have a sick call procedure that allows detainees the unrestricted opportunity to freely request health care services (including mental health and dental services) provided by a physician or other qualified medical staff in a clinical setting. This procedure shall include:

- Clearly written policies and procedures;
- Sick call process will be communicated in writing and verbally to detainees during their orientation;
- Regularly scheduled "sick call" times will be established and communicated to detainees;
- All facilities must have an established procedure in place to ensure that all sick call requests are received and triaged by appropriate medical personnel within 48 hours after the detainee submits the request. In an urgent situation, the housing unit officer shall notify medical personnel immediately.

If the procedure uses a written request slip, they shall be provided in English and the most common languages spoken by the detainee population of that facility. Non-English speaking detainees and detainees who are deaf or hard of hearing will be provided interpretation/translation services as needed or other assistance as needed to complete a request slip.

Medical personnel shall review the request slips and determine when the detainee will be seen.

All detainees, including those in Special Management Units, regardless of classification, shall have access to sick call. See the Detention Standard on **Special Management Units** for details.

All facilities shall maintain a permanent record of all sick call requests.

O. Emergency Medical Services and First Aid

Each facility shall have a written emergency services plan for the delivery of 24-hour emergency health care.

A plan shall be prepared in consultation with the facility's clinical medical authority or the administrative health authority. The plan will include the following:

- An on-call physician, dentist, and mental health professional, or designee, that are available 24 hours per day;
- A list of telephone numbers for local ambulances and hospital services available to all staff;
- An automatic external defibrillator (AED) will be maintained for use at each facility and accessible to staff.
- All detention staff shall receive cardio pulmonary resuscitation (CPR, AED) , and emergency first aid training annually;
- Detention and health care personnel will be trained annually to respond to health-related situations within four (4) minutes;
- Security procedures that ensure the immediate transfer of detainees for emergency medical care.

The training shall be provided by a responsible medical authority in cooperation with the facility administrator and shall include:

1. Recognizing of signs of potential health emergencies and the required responses;
2. Administering first aid, AED, and cardiopulmonary resuscitation (CPR);
3. Obtaining emergency medical assistance through the facility plan and its required procedures;
4. Recognizing signs and symptoms of mental illness and suicide risk;
5. The facility's established plan and procedures for providing emergency medical care including, when required, the safe and secure transfer of detainees for appropriate hospital or other medical services, including by ambulance when indicated. The plan must provide for expedited entrance to and exit from the facility.

When an employee is unsure whether emergency care is required, he or she shall immediately notify medical personnel to make the determination.

Medical and safety equipment shall be available and maintained, and staff shall be trained in proper use of the equipment.

In each detention facility, the designated health authority and facility administrator shall determine the contents, number, location(s), use protocols, and procedures for monthly inspections of first aid kits.

P. Delivery of Medication

Distribution of medication shall be in accordance with specific instructions and procedures established by the administrative health authority. Written records of all medication given to detainees shall be maintained.

- If medication must be delivered at a specific time when medical staff is not on duty, it may be distributed by detention officers who have received proper training by the administrative health authority.
- The facility shall maintain documentation of the training given any officer required to distribute medication, and the officer shall have available for reference the training syllabus or other guide or protocol provided by the health authority.
- Detainees may not deliver or administer medications to other detainees.

Q. Health Education and Wellness Information

The health authority shall provide detainees health education and wellness information on such topics as dangers of self-medication, personal hygiene and dental care, prevention of communicable diseases, smoking cessation, self-care for chronic conditions, and the benefits of physical fitness.

R. Special Needs and Close Medical Supervision

The health administrative authority for each facility must have a plan to notify ICE for any detainee with special needs. The written notification must become part of the detainee's health record file.

When a detainee requires close medical supervision, including chronic and convalescent care, a written treatment plan that includes access to health care and other personnel regarding care and supervision, shall be developed and approved by the appropriate physician, dentist, or mental health practitioner, in consultation with the patient, with periodic review. The written treatment plan will conform to NCCHC and TJC requirements. Likewise, staff responsible for such matters as housing and program assignments, and disciplinary measures shall consult with the responsible clinician, clinical director, or health services administrator.

Female detainees shall have access to pregnancy testing and pregnancy management services that include routine prenatal care, addiction management, comprehensive counseling and assistance, nutrition, and postpartum follow-up.

Detainees shall have access to age and gender-appropriate examinations.

Durable medical equipment shall be provided as determined by the responsible physician or dentist in conjunction with the health care authorization process.

Exercise areas will be available to meet exercise and physical therapy requirements of individual detainee treatment plans.

S. Continuity of Care

The facility administrative health authority must ensure that a plan is developed that provides for continuity of medical care in the event of a change in detention placement or status.

The detainee's medical needs shall be taken into account prior to any transfer of the detainee to another facility and alternatives to transfer shall be considered, taking into account the disruption that a transfer will cause to a detainee receiving medical care (see ICE/DRO National Detention Standard on **Transfer of Detainees**, Section II-A). Upon transfer to another facility or release, the medical provider shall ensure that all relevant medical records and at least 7 days' (or, in the case of TB medications, 15 days') supply of medication shall accompany the detainee.

T. Informed Consent and Involuntary Treatment

As a rule, medical treatment shall not be administered against a detainee's will.

- Upon admission at the facility, documented informed consent will be obtained for the provision of health care services.
- For any additional procedure, a separate documented informed consent will be obtained.
- Informed consent standards of the jurisdiction shall be observed, and consent forms shall either be in a language understood by the detainee or translation assistance shall be provided and documented on the form.
- If a detainee refuses treatment and the clinical medical authority determines that the treatment is necessary, ICE/DRO shall be consulted in determining whether involuntary treatment shall be pursued.
- If the detainee refuses to consent to treatment, medical staff shall make reasonable efforts to convince the detainee to voluntarily accept treatment.
- Medical staff shall explain the medical risks if treatment is declined and shall document their treatment efforts and the refusal of treatment in the detainee's medical record.
- When determined to be medically necessary by the clinical medical authority, a detainee who refuses examination or treatment may be segregated from the general population. Such segregation shall only be for medical reasons that are documented in the medical record and may not be used for punitive purposes.
- Involuntary treatment is a decision made only by medical staff under strict legal restrictions. Prior to any contemplated action involving involuntary medical treatment, DHS / ICE respective Chief Counsel will be consulted.
- In the event of a hunger strike, see the Detention Standard on **Hunger Strikes**.

The Detention Standard on **Terminal Illness, Advance Directives, and Death** provides details regarding living wills and advance directives, organ donations, and "do-not-resuscitate" orders.

U. Medical Records

1. Health Record File

The administrative health authority shall maintain a complete health record on each detainee that is:

- Organized uniformly in accordance with recognized medical records standards;
- Available to all practitioners and used by them for health care documentation;
- Properly maintained and safeguarded in a securely locked area within the medical unit.

2. Confidentiality and Release of Medical Records

All medical providers shall protect the privacy of detainees' medical information in accordance with established guidelines and applicable laws. These protections apply, not only to records maintained on paper, but also to electronic records where they are used. Staff training must emphasize the need for confidentiality and procedures must be in place to limit access to health records to only authorized individuals and only when necessary.

Information about a detainee's health status and a detainee's health record is confidential, and the active medical record shall be maintained separately from other detention records and be accessible in accordance with applicable laws and regulations.

The administrative health authority shall provide the facility administrator and designated staff information that is necessary:

- To preserve the health and safety of the detainee, other detainees, staff, or any other person.
- For administrative and detention decisions such as housing, voluntary work assignments, security, and transport.
- For management purposes such as audits and inspections.

When information is covered by the Privacy Act, specific legal restrictions govern the release of medical information or records.

Copies of health records shall be released by the administrative health authority directly to a detainee or their designee, at no cost to the detainee, upon receipt by the administrative health authority of a written authorization from the detainee that complies with the Health Insurance Portability and Accountability Act (HIPAA).

While in detention, a detainee, or their designated representative, shall receive requested information from their medical records. Upon request, medical record information will be released within a reasonable timeframe after receipt of an authorization.

A written request may serve as authorization for the release of health information, as long as it includes the following (and meets any other requirements of the administrative health authority):

- Address of the facility to release the information;
- Name of the individual or institution to receive the information;

- Detainee's full name, A-number (or other facility identification number), date of birth and nationality;
- Specific information to be released with inclusive dates of treatment; and
- Detainee's signature and date.

Following the release of health information, the written authorization shall be retained in the health record.

Detainees who indicate they wish to obtain copies of their medical records shall be provided with the appropriate request form. ICE/DRO, or the facility administrator, shall provide non-English speaking detainees and detainees who are deaf or hard of hearing with interpretation or translation services or other assistance as needed to make the written request and assist in transmitting the request to the facility administrative health authority.

3. Inactive Health Record Files

Inactive health record files shall be retained as permanent records in compliance with locally established procedures and the legal requirements of the jurisdiction.

4. Transfer and Release of Detainees

ICE/DRO and the administrative health authority shall be notified when detainees are to be transferred or released. Detainees should be transferred with proper medication to ensure continuity of care throughout the transfer and subsequent intake process. (See Section S – Continuity of care)

a. Medical/Psychiatric Alert. Medical staff shall notify the facility administrator in writing, when they determine that a detainee's medical or psychiatric condition requires:

- Clearance by the medical staff prior to release or transfer, or
- Medical escort during removal, deportation, or transfer.

b. Notification of Transfers, Releases, and Removals. The administrative health authority shall be given advance notice prior to the release, transfer, or removal of a detainee, so that medical staff may determine and provide for any medical needs associated with the transfer or release.

c. Transfer of Health Records. A summary of the detainee's medical care (transfer summary) shall be marked "CONFIDENTIAL MEDICAL RECORDS" and shall accompany the detainee who is being transferred. This includes detainees who are being transferred into or out of ICE custody. Full copies of the medical records or parts thereof must be made immediately available upon the request of the receiving facility's administrative health authority or clinical medical authority. Other requirements for the transfer of records are contained in the Detention Standard on **Transfers of Detainees**.

V. Terminal Illness, Fatal Injury, or Death of a Detainee

Procedures to be followed in the event of a detainee's terminal illness, fatal injury, or death are in the Detention Standard on **Terminal Illness, Advance Directives, and Death**. The Detention Standard also addresses detainee organ donations.

W. Medical Experimentation

Detainees will not participate in medical, pharmaceutical or cosmetic research while under the care of ICE detention facilities.

This does not preclude the use of approved clinical trials that may be warranted for a specific inmate's diagnosis or treatment when recommended and approved by the clinical medical director. Such measures require documented informed consent.

X. Administration of the Medical Department

1. Quarterly Administrative Meetings

The administrative health authority shall convene a meeting at least quarterly and include other facility and medical staff as appropriate.

The meeting agenda shall include, at a minimum:

- An account of the effectiveness of the facility health care program;
- Discussions of health environment factors that may need improvement;
- Review and discussion of communicable disease and infectious control activities;
- Changes effected since the previous meetings; and
- Recommended corrective actions, as necessary.

Minutes of each meeting shall be recorded and kept on file.

2. Health Care Internal Review and Quality Assurance

The administrative health authority shall implement a system of internal review and quality assurance. Elements of the system shall include:

- Participating in a multidisciplinary quality improvement committee.
- Collecting, trending, and analysis of data along with planning, interventions, and reassessments.
- Evaluating defined data.
- Analyze the need for ongoing education and training.
- On-site monitoring of health service outcomes on a regular basis through:
 1. Chart reviews by the responsible physician or his or her designee, including investigation of complaints and quality of health records.
 2. Review of prescribing practices and administration of medication practices.
 3. Systematic investigation of complaints and grievances.
 4. Monitoring of corrective action plans.
 5. Reviewing all deaths, suicide attempts, and illness outbreaks.
 6. Developing and implementing corrective action plans to address and resolve identified problems and concerns.
 7. Reevaluating problems or concerns to determine whether the corrective measures have achieved and sustained the desired results.

8. Incorporating findings of internal review activities into the organization's educational and training activities.
9. Maintaining appropriate records of internal review activities.
10. Ensuring records of internal review activities comply with legal requirements on confidentiality of records.

3. Peer Review

The administrative health authority shall implement an intra-organizational, external peer review program for all independently licensed medical professionals. Reviews are conducted at least every two years.

Y. Examinations by Independent Medical Service Providers and Experts

On occasion, medical and/or mental health examinations by a practitioner or expert not associated with ICE/DRO or the facility may provide a detainee with information useful in administrative proceedings.

If a detainee seeks an independent medical or mental health examination, the detainee or his or her legal representative shall submit to the Field Office Director a written request that details the reasons for such an examination. Ordinarily, the Field Office Director shall approve the request for independent examination, as long as it would not present an unreasonable security risk. Requests for independent examinations shall be answered as quickly as practicable. If a request is denied, the Field Office Director shall advise the requester in writing of the rationale.

Neither ICE/DRO nor the facility may assume any costs of the examination, which shall be at the detainee's expense. The facility shall provide a location for the examination but no medical equipment or supplies, and the examination must be arranged and conducted in a manner consistent with security and good order.

Z. Medical Grievance Process

See **Grievance System** Detention Standard.

Standard Approved:

(b)(6); (b)(7)(C)

12/5/2008

(b)(6); (b)(7)(C)

Date

**Director
Office of Detention and Removal Operations**

Interim Guidance on Management of Coronavirus Disease 2019 (COVID-19) in Correctional and Detention Facilities

This interim guidance is based on what is currently known about the transmission and severity of coronavirus disease 2019 (COVID-19) as of **March 23, 2020**.

The US Centers for Disease Control and Prevention (CDC) will update this guidance as needed and as additional information becomes available. Please check the following CDC website periodically for updated interim guidance: <https://www.cdc.gov/coronavirus/2019-ncov/index.html>.

This document provides interim guidance specific for correctional facilities and detention centers during the outbreak of COVID-19, to ensure continuation of essential public services and protection of the health and safety of incarcerated and detained persons, staff, and visitors. Recommendations may need to be revised as more information becomes available.

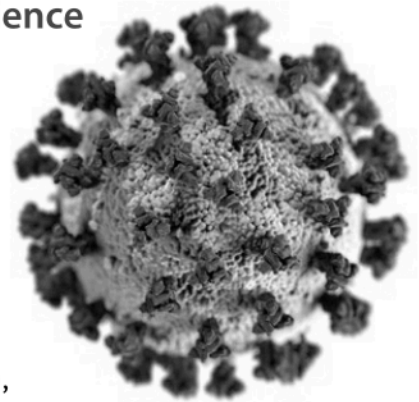
In this guidance

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- Operational Preparedness
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- Clinical Care of COVID-19 Cases
- Recommended PPE and PPE Training for Staff and Incarcerated/Detained Persons
- Verbal Screening and Temperature Check Protocols for Incarcerated/Detained Persons, Staff, and Visitors

Who is the intended audience for this guidance?

This document is intended to provide guiding principles for healthcare and non-healthcare administrators of correctional and detention facilities (including but not limited to federal and state prisons, local jails, and detention centers), law enforcement agencies that have custodial authority for detained populations (i.e., US Immigration and Customs Enforcement and US Marshals Service), and their respective health departments, to assist in preparing for potential introduction, spread, and mitigation of COVID-19 in their facilities. In general, the document uses terminology referring to correctional environments but can also be applied to civil and pre-trial detention settings.

This guidance will not necessarily address every possible custodial setting and may not use legal terminology specific to individual agencies' authorities or processes. **The guidance may need to be adapted based on individual facilities' physical space, staffing, population, operations, and other resources and conditions.** Facilities should contact CDC or their state, local, territorial, and/or tribal public health department if they need assistance in applying these principles or addressing topics that are not specifically covered in this guidance.



cdc.gov/coronavirus

Why is this guidance being issued?

Correctional and detention facilities can include custody, housing, education, recreation, healthcare, food service, and workplace components in a single physical setting. The integration of these components presents unique challenges for control of COVID-19 transmission among incarcerated/detained persons, staff, and visitors. Consistent application of specific preparation, prevention, and management measures can help reduce the risk of transmission and severe disease from COVID-19.

- Incarcerated/detained persons live, work, eat, study, and recreate within congregate environments, heightening the potential for COVID-19 to spread once introduced.
- In most cases, incarcerated/detained persons are not permitted to leave the facility.
- There are many opportunities for COVID-19 to be introduced into a correctional or detention facility, including daily staff ingress and egress; transfer of incarcerated/detained persons between facilities and systems, to court appearances, and to outside medical visits; and visits from family, legal representatives, and other community members. Some settings, particularly jails and detention centers, have high turnover, admitting new entrants daily who may have been exposed to COVID-19 in the surrounding community or other regions.
- Persons incarcerated/detained in a particular facility often come from a variety of locations, increasing the potential to introduce COVID-19 from different geographic areas.
- Options for medical isolation of COVID-19 cases are limited and vary depending on the type and size of facility, as well as the current level of available capacity, which is partly based on medical isolation needs for other conditions.
- Adequate levels of custody and healthcare staffing must be maintained to ensure safe operation of the facility, and options to practice social distancing through work alternatives such as working from home or reduced/alternate schedules are limited for many staff roles.
- Correctional and detention facilities can be complex, multi-employer settings that include government and private employers. Each is organizationally distinct and responsible for its own operational, personnel, and occupational health protocols and may be prohibited from issuing guidance or providing services to other employers or their staff within the same setting. Similarly, correctional and detention facilities may house individuals from multiple law enforcement agencies or jurisdictions subject to different policies and procedures.
- Incarcerated/detained persons and staff may have medical conditions that increase their risk of severe disease from COVID-19.
- Because limited outside information is available to many incarcerated/detained persons, unease and misinformation regarding the potential for COVID-19 spread may be high, potentially creating security and morale challenges.
- The ability of incarcerated/detained persons to exercise disease prevention measures (e.g., frequent handwashing) may be limited and is determined by the supplies provided in the facility and by security considerations. Many facilities restrict access to soap and paper towels and prohibit alcohol-based hand sanitizer and many disinfectants.
- Incarcerated persons may hesitate to report symptoms of COVID-19 or seek medical care due to co-pay requirements and fear of isolation.

CDC has issued separate COVID-19 guidance addressing healthcare infection control and clinical care of COVID-19 cases as well as close contacts of cases in community-based settings. Where relevant, community-focused guidance documents are referenced in this document and should be monitored regularly for updates, but they may require adaptation for correctional and detention settings.

This guidance document provides additional recommended best practices specifically for correctional and detention facilities. **At this time, different facility types (e.g., prison vs. jail) and sizes are not differentiated. Administrators and agencies should adapt these guiding principles to the specific needs of their facility.**

What topics does this guidance include?

The guidance below includes detailed recommendations on the following topics related to COVID-19 in correctional and detention settings:

- ✓ Operational and communications preparations for COVID-19
- ✓ Enhanced cleaning/disinfecting and hygiene practices
- ✓ Social distancing strategies to increase space between individuals in the facility
- ✓ How to limit transmission from visitors
- ✓ Infection control, including recommended personal protective equipment (PPE) and potential alternatives during PPE shortages
- ✓ Verbal screening and temperature check protocols for incoming incarcerated/detained individuals, staff, and visitors
- ✓ Medical isolation of confirmed and suspected cases and quarantine of contacts, including considerations for cohorting when individual spaces are limited
- ✓ Healthcare evaluation for suspected cases, including testing for COVID-19
- ✓ Clinical care for confirmed and suspected cases
- ✓ Considerations for persons at higher risk of severe disease from COVID-19

Definitions of Commonly Used Terms

Close contact of a COVID-19 case—In the context of COVID-19, an individual is considered a close contact if they a) have been within approximately 6 feet of a COVID-19 case for a prolonged period of time or b) 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).

Cohorting—Cohorting refers to the practice of isolating multiple laboratory-confirmed COVID-19 cases together as a group, or quarantining close contacts of a particular case together as a group. Ideally, cases should be isolated individually, and close contacts should be quarantined individually. However, some correctional facilities and detention centers do not have enough individual cells to do so and must consider cohorting as an alternative. See [Quarantine](#) and [Medical Isolation](#) sections below for specific details about ways to implement cohorting to minimize the risk of disease spread and adverse health outcomes.

Community transmission of COVID-19—Community transmission of COVID-19 occurs when individuals acquire the disease through contact with someone in their local community, rather than through travel to an affected location. Once community transmission is identified in a particular area, correctional facilities and detention centers are more likely to start seeing cases inside their walls. Facilities should consult with local public health departments if assistance is needed in determining how to define “local community” in the context of COVID-19 spread. However, because all states have reported cases, all facilities should be vigilant for introduction into their populations.

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

Incarcerated/detained persons—For the purpose of this document, “incarcerated/detained persons” refers to persons held in a prison, jail, detention center, or other custodial setting where these guidelines are generally applicable. The term includes those who have been sentenced (i.e., in prisons) as well as those held for pre-trial (i.e., jails) or civil purposes (i.e., detention centers). Although this guidance does not specifically reference individuals in every type of custodial setting (e.g., juvenile facilities, community confinement facilities), facility administrators can adapt this guidance to apply to their specific circumstances as needed.

Medical Isolation—Medical isolation refers to confining a confirmed or suspected COVID-19 case (ideally to a single cell with solid walls and a solid door that closes), to prevent contact with others and to reduce the risk of transmission. Medical isolation ends when the individual meets pre-established clinical and/or testing criteria for release from isolation, in consultation with clinical providers and public health officials (detailed in guidance [below](#)). In this context, isolation does NOT refer to punitive isolation for behavioral infractions within the custodial setting. Staff are encouraged to use the term “medical isolation” to avoid confusion.

Quarantine—Quarantine refers to the practice of confining individuals who have had close contact with a COVID-19 case to determine whether they develop symptoms of the disease. Quarantine for COVID-19 should last for a period of 14 days. Ideally, each quarantined individual would be quarantined in a single cell with solid walls and a solid door that closes. If symptoms develop during the 14-day period, the individual should be placed under [medical isolation](#) and evaluated for COVID-19. If symptoms do not develop, movement restrictions can be lifted, and the individual can return to their previous residency status within the facility.

Social Distancing—Social distancing is the practice of increasing the space between individuals and decreasing the frequency of contact to reduce the risk of spreading a disease (ideally to maintain at least 6 feet between all individuals, even those who are asymptomatic). Social distancing strategies can be applied on an individual level (e.g., avoiding physical contact), a group level (e.g., canceling group activities where individuals will be in close contact), and an operational level (e.g., rearranging chairs in the dining hall to increase distance between them). Although social distancing is challenging to practice in correctional and detention environments, it is a cornerstone of reducing transmission of respiratory diseases such as COVID-19. Additional information about social distancing, including information on its use to reduce the spread of other viral illnesses, is available in this [CDC publication](#).

Staff—In this document, “staff” refers to all public sector employees as well as those working for a private contractor within a correctional facility (e.g., private healthcare or food service). Except where noted, “staff” does not distinguish between healthcare, custody, and other types of staff including private facility operators.

Symptoms—[Symptoms of COVID-19](#) include fever, cough, and shortness of breath. Like other respiratory infections, COVID-19 can vary in severity from mild to severe. When severe, pneumonia, respiratory failure, and death are possible. COVID-19 is a novel disease, therefore the full range of signs and symptoms, the clinical course of the disease, and the individuals and populations most at risk for disease and complications are not yet fully understood. Monitor the [CDC website](#) for updates on these topics.

Facilities with Limited Onsite Healthcare Services

Although many large facilities such as prisons and some jails usually employ onsite healthcare staff and have the capacity to evaluate incarcerated/detained persons for potential illness within a dedicated healthcare space, many smaller facilities do not. Some of these facilities have access to on-call healthcare staff or providers who visit the facility every few days. Others have neither onsite healthcare capacity nor onsite medical isolation/quarantine space and must transfer ill patients to other correctional or detention facilities or local hospitals for evaluation and care.

The majority of the guidance below is designed to be applied to any correctional or detention facility, either as written or with modifications based on a facility's individual structure and resources. However, topics related to healthcare evaluation and clinical care of confirmed and suspected COVID-19 cases and their close contacts may not apply directly to facilities with limited or no onsite healthcare services. It will be especially important for these types of facilities to coordinate closely with their state, local, tribal, and/or territorial health department when they encounter confirmed or suspected cases among incarcerated/detained persons or staff, in order to ensure effective medical isolation and quarantine, necessary medical evaluation and care, and medical transfer if needed. The guidance makes note of strategies tailored to facilities without onsite healthcare where possible.

Note that all staff in any sized facility, regardless of the presence of onsite healthcare services, should observe guidance on recommended PPE in order to ensure their own safety when interacting with confirmed and suspected COVID-19 cases. Facilities should make contingency plans for the likely event of PPE shortages during the COVID-19 pandemic.

COVID-19 Guidance for Correctional Facilities

Guidance for correctional and detention facilities is organized into 3 sections: Operational Preparedness, Prevention, and Management of COVID-19. Recommendations across these sections can be applied simultaneously based on the progress of the outbreak in a particular facility and the surrounding community.

- **Operational Preparedness.** This guidance is intended to help facilities prepare for potential COVID-19 transmission in the facility. Strategies focus on operational and communications planning and personnel practices.
- **Prevention.** This guidance is intended to help facilities prevent spread of COVID-19 from outside the facility to inside. Strategies focus on reinforcing hygiene practices, intensifying cleaning and disinfection of the facility, screening (new intakes, visitors, and staff), continued communication with incarcerated/detained persons and staff, and social distancing measures (increasing distance between individuals).
- **Management.** This guidance is intended to help facilities clinically manage confirmed and suspected COVID-19 cases inside the facility and prevent further transmission. Strategies include medical isolation and care of incarcerated/detained persons with symptoms (including considerations for cohorting), quarantine of cases' close contacts, restricting movement in and out of the facility, infection control practices for individuals interacting with cases and quarantined contacts or contaminated items, intensified social distancing, and cleaning and disinfecting areas visited by cases.

Operational Preparedness

Administrators can plan and prepare for COVID-19 by ensuring that all persons in the facility know the symptoms of COVID-19 and how to respond if they develop symptoms. Other essential actions include developing contingency plans for reduced workforces due to absences, coordinating with public health and correctional partners, and communicating clearly with staff and incarcerated/detained persons about these preparations and how they may temporarily alter daily life.

Communication & Coordination

✓ **Develop information-sharing systems with partners.**

- Identify points of contact in relevant state, local, tribal, and/or territorial public health departments before cases develop. Actively engage with the health department to understand in advance which entity has jurisdiction to implement public health control measures for COVID-19 in a particular correctional or detention facility.
- Create and test communications plans to disseminate critical information to incarcerated/detained persons, staff, contractors, vendors, and visitors as the pandemic progresses.

- Communicate with other correctional facilities in the same geographic area to share information including disease surveillance and absenteeism patterns among staff.
 - Where possible, put plans in place with other jurisdictions to prevent confirmed and suspected COVID-19 cases and their close contacts from being transferred between jurisdictions and facilities unless necessary for medical evaluation, medical isolation/quarantine, clinical care, extenuating security concerns, or to prevent overcrowding.
 - Stay informed about updates to CDC guidance via the CDC COVID-19 website as more information becomes known.
- ✓ **Review existing pandemic flu, all-hazards, and disaster plans, and revise for COVID-19.**
- Ensure that physical locations (dedicated housing areas and bathrooms) have been identified to isolate confirmed COVID-19 cases and individuals displaying COVID-19 symptoms, and to quarantine known close contacts of cases. (Medical isolation and quarantine locations should be separate). The plan should include contingencies for multiple locations if numerous cases and/or contacts are identified and require medical isolation or quarantine simultaneously. See Medical Isolation and Quarantine sections below for details regarding individual medical isolation and quarantine locations (preferred) vs. cohorting.
 - Facilities without onsite healthcare capacity should make a plan for how they will ensure that suspected COVID-19 cases will be isolated, evaluated, tested (if indicated), and provided necessary medical care.
 - Make a list of possible social distancing strategies that could be implemented as needed at different stages of transmission intensity.
 - Designate officials who will be authorized to make decisions about escalating or de-escalating response efforts as the epidemiologic context changes.
- ✓ **Coordinate with local law enforcement and court officials.**
- Identify lawful alternatives to in-person court appearances, such as virtual court, as a social distancing measure to reduce the risk of COVID-19 transmission.
 - Explore strategies to prevent over-crowding of correctional and detention facilities during a community outbreak.
- ✓ **Post signage throughout the facility communicating the following:**
- **For all:** symptoms of COVID-19 and hand hygiene instructions
 - **For incarcerated/detained persons:** report symptoms to staff
 - **For staff:** stay at home when sick; if symptoms develop while on duty, leave the facility as soon as possible and follow CDC-recommended steps for persons who are ill with COVID-19 symptoms including self-isolating at home, contacting their healthcare provider as soon as possible to determine whether they need to be evaluated and tested, and contacting their supervisor.
 - Ensure that signage is understandable for non-English speaking persons and those with low literacy, and make necessary accommodations for those with cognitive or intellectual disabilities and those who are deaf, blind, or low-vision.

Personnel Practices

- ✓ **Review the sick leave policies of each employer that operates in the facility.**
- Review policies to ensure that they actively encourage staff to stay home when sick.
 - If these policies do not encourage staff to stay home when sick, discuss with the contract company.
 - Determine which officials will have the authority to send symptomatic staff home.

- ✓ **Identify staff whose duties would allow them to work from home. Where possible, allowing staff to work from home can be an effective social distancing strategy to reduce the risk of COVID-19 transmission.**
 - Discuss work from home options with these staff and determine whether they have the supplies and technological equipment required to do so.
 - Put systems in place to implement work from home programs (e.g., time tracking, etc.).
- ✓ **Plan for staff absences.** Staff should stay home when they are sick, or they may need to stay home to care for a sick household member or care for children in the event of school and childcare dismissals.
 - Allow staff to work from home when possible, within the scope of their duties.
 - Identify critical job functions and plan for alternative coverage by cross-training staff where possible.
 - Determine minimum levels of staff in all categories required for the facility to function safely. If possible, develop a plan to secure additional staff if absenteeism due to COVID-19 threatens to bring staffing to minimum levels.
 - Consider increasing keep on person (KOP) medication orders to cover 30 days in case of healthcare staff shortages.
- ✓ **Consider offering revised duties to staff who are at higher risk of severe illness with COVID-19.** Persons at higher risk may include older adults and persons of any age with serious underlying medical conditions including lung disease, heart disease, and diabetes. See CDC's website for a complete list, and check regularly for updates as more data become available to inform this issue.
 - Facility administrators should consult with their occupational health providers to determine whether it would be allowable to reassign duties for specific staff members to reduce their likelihood of exposure to COVID-19.
- ✓ **Offer the seasonal influenza vaccine to all incarcerated/detained persons (existing population and new intakes) and staff throughout the influenza season.** Symptoms of COVID-19 are similar to those of influenza. Preventing influenza cases in a facility can speed the detection of COVID-19 cases and reduce pressure on healthcare resources.
- ✓ **Reference the Occupational Safety and Health Administration website for recommendations regarding worker health.**
- ✓ **Review CDC's guidance for businesses and employers** to identify any additional strategies the facility can use within its role as an employer.

Operations & Supplies

- ✓ **Ensure that sufficient stocks of hygiene supplies, cleaning supplies, PPE, and medical supplies (consistent with the healthcare capabilities of the facility) are on hand and available, and have a plan in place to restock as needed if COVID-19 transmission occurs within the facility.**
 - Standard medical supplies for daily clinic needs
 - Tissues
 - Liquid soap when possible. If bar soap must be used, ensure that it does not irritate the skin and thereby discourage frequent hand washing.
 - Hand drying supplies
 - Alcohol-based hand sanitizer containing at least 60% alcohol (where permissible based on security restrictions)
 - Cleaning supplies, including EPA-registered disinfectants effective against the virus that causes COVID-19

- Recommended PPE (facemasks, N95 respirators, eye protection, disposable medical gloves, and disposable gowns/one-piece coveralls). See [PPE section](#) and [Table 1](#) for more detailed information, including recommendations for extending the life of all PPE categories in the event of shortages, and when face masks are acceptable alternatives to N95s.
- Sterile viral transport media and sterile swabs [to collect nasopharyngeal specimens](#) if COVID-19 testing is indicated
- ✓ **Make contingency plans for the probable event of PPE shortages during the COVID-19 pandemic, particularly for non-healthcare workers.**
 - See CDC guidance [optimizing PPE supplies](#).
- ✓ **Consider relaxing restrictions on allowing alcohol-based hand sanitizer in the secure setting where security concerns allow.** If soap and water are not available, [CDC recommends](#) cleaning hands with an alcohol-based hand sanitizer that contains at least 60% alcohol. Consider allowing staff to carry individual-sized bottles for their personal hand hygiene while on duty.
- ✓ **Provide a no-cost supply of soap to incarcerated/detained persons, sufficient to allow frequent hand washing.** (See [Hygiene](#) section below for additional detail regarding recommended frequency and protocol for hand washing.)
 - Provide liquid soap where possible. If bar soap must be used, ensure that it does not irritate the skin and thereby discourage frequent hand washing.
- ✓ **If not already in place, employers operating within the facility should establish a [respiratory protection program](#) as appropriate, to ensure that staff and incarcerated/detained persons are fit tested for any respiratory protection they will need within the scope of their responsibilities.**
- ✓ **Ensure that staff and incarcerated/detained persons are trained to correctly don, doff, and dispose of PPE that they will need to use within the scope of their responsibilities.** See [Table 1](#) for recommended PPE for incarcerated/detained persons and staff with varying levels of contact with COVID-19 cases or their close contacts.

Prevention

Cases of COVID-19 have been documented in all 50 US states. Correctional and detention facilities can prevent introduction of COVID-19 from the community and reduce transmission if it is already inside by reinforcing good hygiene practices among incarcerated/detained persons, staff, and visitors (including increasing access to soap and paper towels), intensifying cleaning/disinfection practices, and implementing social distancing strategies.

Because many individuals infected with COVID-19 do not display symptoms, the virus could be present in facilities before cases are identified. Both good hygiene practices and social distancing are critical in preventing further transmission.

Operations

- ✓ **Stay in communication with partners about your facility's current situation.**
 - State, local, territorial, and/or tribal health departments
 - Other correctional facilities
- ✓ **Communicate with the public about any changes to facility operations, including visitation programs.**

- ✓ **Restrict transfers of incarcerated/detained persons to and from other jurisdictions and facilities unless necessary for medical evaluation, medical isolation/quarantine, clinical care, extenuating security concerns, or to prevent overcrowding.**
 - Strongly consider postponing non-urgent outside medical visits.
 - If a transfer is absolutely necessary, perform verbal screening and a temperature check as outlined in the [Screening](#) section below, before the individual leaves the facility. If an individual does not clear the screening process, delay the transfer and follow the [protocol for a suspected COVID-19 case](#)—including putting a face mask on the individual, immediately placing them under medical isolation, and evaluating them for possible COVID-19 testing. If the transfer must still occur, ensure that the receiving facility has capacity to properly isolate the individual upon arrival. Ensure that staff transporting the individual wear recommended PPE (see [Table 1](#)) and that the transport vehicle is [cleaned](#) thoroughly after transport.
- ✓ **Implement lawful alternatives to in-person court appearances where permissible.**
- ✓ **Where relevant, consider suspending co-pays for incarcerated/detained persons seeking medical evaluation for respiratory symptoms.**
- ✓ **Limit the number of operational entrances and exits to the facility.**

Cleaning and Disinfecting Practices

- ✓ **Even if COVID-19 cases have not yet been identified inside the facility or in the surrounding community, begin implementing intensified cleaning and disinfecting procedures according to the recommendations below. These measures may prevent spread of COVID-19 if introduced.**
- ✓ **Adhere to [CDC recommendations for cleaning and disinfection during the COVID-19 response](#).** Monitor these recommendations for updates.
 - Several times per day, clean and disinfect surfaces and objects that are frequently touched, especially in common areas. Such surfaces may include objects/surfaces not ordinarily cleaned daily (e.g., doorknobs, light switches, sink handles, countertops, toilets, toilet handles, recreation equipment, kiosks, and telephones).
 - Staff should clean shared equipment several times per day and on a conclusion of use basis (e.g., radios, service weapons, keys, handcuffs).
 - Use household cleaners and [EPA-registered disinfectants effective against the virus that causes COVID-19](#) as appropriate for the surface, following label instructions. This may require lifting restrictions on undiluted disinfectants.
 - Labels contain instructions for safe and effective use of the cleaning product, including precautions that should be taken when applying the product, such as wearing gloves and making sure there is good ventilation during use.
- ✓ **Consider increasing the number of staff and/or incarcerated/detained persons trained and responsible for cleaning common areas to ensure continual cleaning of these areas throughout the day.**
- ✓ **Ensure adequate supplies to support intensified cleaning and disinfection practices, and have a plan in place to restock rapidly if needed.**

Hygiene

- ✓ **Reinforce healthy hygiene practices, and provide and continually restock hygiene supplies throughout the facility, including in bathrooms, food preparation and dining areas, intake areas, visitor entries and exits, visitation rooms and waiting rooms, common areas, medical, and staff-restricted areas (e.g., break rooms).**
- ✓ **Encourage all persons in the facility to take the following actions to protect themselves and others from COVID-19. Post signage throughout the facility, and communicate this information verbally on a regular basis.** Sample signage and other communications materials are available on the CDC website. Ensure that materials can be understood by non-English speakers and those with low literacy, and make necessary accommodations for those with cognitive or intellectual disabilities and those who are deaf, blind, or low-vision.
 - **Practice good cough etiquette:** Cover your mouth and nose with your elbow (or ideally with a tissue) rather than with your hand when you cough or sneeze, and throw all tissues in the trash immediately after use.
 - **Practice good hand hygiene:** Regularly wash your hands with soap and water for at least 20 seconds, especially after coughing, sneezing, or blowing your nose; after using the bathroom; before eating or preparing food; before taking medication; and after touching garbage.
 - **Avoid touching your eyes, nose, or mouth without cleaning your hands first.**
 - **Avoid sharing eating utensils, dishes, and cups.**
 - **Avoid non-essential physical contact.**
- ✓ **Provide incarcerated/detained persons and staff no-cost access to:**
 - **Soap**—Provide liquid soap where possible. If bar soap must be used, ensure that it does not irritate the skin, as this would discourage frequent hand washing.
 - **Running water, and hand drying machines or disposable paper towels for hand washing**
 - **Tissues** and no-touch trash receptacles for disposal
- ✓ **Provide alcohol-based hand sanitizer with at least 60% alcohol where permissible based on security restrictions.** Consider allowing staff to carry individual-sized bottles to maintain hand hygiene.
- ✓ **Communicate that sharing drugs and drug preparation equipment can spread COVID-19 due to potential contamination of shared items and close contact between individuals.**

Prevention Practices for Incarcerated/Detained Persons

- ✓ **Perform pre-intake screening and temperature checks for all new entrants. Screening should take place in the sallyport, before beginning the intake process,** in order to identify and immediately place individuals with symptoms under medical isolation. See Screening section below for the wording of screening questions and a recommended procedure to safely perform a temperature check. Staff performing temperature checks should wear recommended PPE (see PPE section below).
 - **If an individual has symptoms of COVID-19** (fever, cough, shortness of breath):
 - Require the individual to wear a face mask.
 - Ensure that staff who have direct contact with the symptomatic individual wear recommended PPE.
 - Place the individual under medical isolation (ideally in a room near the screening location, rather than transporting the ill individual through the facility), and refer to healthcare staff for further evaluation. (See Infection Control and Clinical Care sections below.)
 - Facilities without onsite healthcare staff should contact their state, local, tribal, and/or territorial health department to coordinate effective medical isolation and necessary medical care.

- **If an individual is a close contact of a known COVID-19 case (but has no COVID-19 symptoms):**

- Quarantine the individual and monitor for symptoms two times per day for 14 days. (See Quarantine section below.)
- Facilities without onsite healthcare staff should contact their state, local, tribal, and/or territorial health department to coordinate effective quarantine and necessary medical care.

- ✓ **Implement social distancing strategies to increase the physical space between incarcerated/detained persons (ideally 6 feet between all individuals, regardless of the presence of symptoms).** Strategies will need to be tailored to the individual space in the facility and the needs of the population and staff. Not all strategies will be feasible in all facilities. Example strategies with varying levels of intensity include:

- **Common areas:**

- Enforce increased space between individuals in holding cells, as well as in lines and waiting areas such as intake (e.g., remove every other chair in a waiting area)

- **Recreation:**

- Choose recreation spaces where individuals can spread out
- Stagger time in recreation spaces
- Restrict recreation space usage to a single housing unit per space (where feasible)

- **Meals:**

- Stagger meals
- Rearrange seating in the dining hall so that there is more space between individuals (e.g., remove every other chair and use only one side of the table)
- Provide meals inside housing units or cells

- **Group activities:**

- Limit the size of group activities
- Increase space between individuals during group activities
- Suspend group programs where participants are likely to be in closer contact than they are in their housing environment
- Consider alternatives to existing group activities, in outdoor areas or other areas where individuals can spread out

- **Housing:**

- If space allows, reassign bunks to provide more space between individuals, ideally 6 feet or more in all directions. (Ensure that bunks are cleaned thoroughly if assigned to a new occupant.)
- Arrange bunks so that individuals sleep head to foot to increase the distance between them
- Rearrange scheduled movements to minimize mixing of individuals from different housing areas

- **Medical:**

- If possible, designate a room near each housing unit to evaluate individuals with COVID-19 symptoms, rather than having them walk through the facility to be evaluated in the medical unit. If this is not feasible, consider staggering sick call.
- Designate a room near the intake area to evaluate new entrants who are flagged by the intake screening process for COVID-19 symptoms or case contact, before they move to other parts of the facility.

- ✓ **Communicate clearly and frequently with incarcerated/detained persons about changes to their daily routine and how they can contribute to risk reduction.**
- ✓ **Note that if group activities are discontinued, it will be important to identify alternative forms of activity to support the mental health of incarcerated/detained persons.**
- ✓ **Consider suspending work release programs and other programs that involve movement of incarcerated/detained individuals in and out of the facility.**
- ✓ **Provide up-to-date information about COVID-19 to incarcerated/detained persons on a regular basis, including:**
 - Symptoms of COVID-19 and its health risks
 - Reminders to report COVID-19 symptoms to staff at the first sign of illness
- ✓ **Consider having healthcare staff perform rounds on a regular basis to answer questions about COVID-19.**

Prevention Practices for Staff

- ✓ **Remind staff to stay at home if they are sick.** Ensure that staff are aware that they will not be able to enter the facility if they have symptoms of COVID-19, and that they will be expected to leave the facility as soon as possible if they develop symptoms while on duty.
- ✓ **Perform verbal screening (for COVID-19 symptoms and close contact with cases) and temperature checks for all staff daily on entry.** See Screening section below for wording of screening questions and a recommended procedure to safely perform temperature checks.
 - In very small facilities with only a few staff, consider self-monitoring or virtual monitoring (e.g., reporting to a central authority via phone).
 - Send staff home who do not clear the screening process, and advise them to follow CDC-recommended steps for persons who are ill with COVID-19 symptoms.
- ✓ **Provide staff with up-to-date information about COVID-19 and about facility policies on a regular basis, including:**
 - Symptoms of COVID-19 and its health risks
 - Employers' sick leave policy
 - **If staff develop a fever, cough, or shortness of breath while at work:** immediately put on a face mask, inform supervisor, leave the facility, and follow CDC-recommended steps for persons who are ill with COVID-19 symptoms.
 - **If staff test positive for COVID-19:** inform workplace and personal contacts immediately, and do not return to work until a decision to discontinue home medical isolation precautions is made. Monitor CDC guidance on discontinuing home isolation regularly as circumstances evolve rapidly.
 - **If a staff member is identified as a close contact of a COVID-19 case (either within the facility or in the community):** self-quarantine at home for 14 days and return to work if symptoms do not develop. If symptoms do develop, follow CDC-recommended steps for persons who are ill with COVID-19 symptoms.
- ✓ **If a staff member has a confirmed COVID-19 infection, the relevant employers should inform other staff about their possible exposure to COVID-19 in the workplace, but should maintain confidentiality as required by the Americans with Disabilities Act.**
 - Employees who are close contacts of the case should then self-monitor for symptoms (i.e., fever, cough, or shortness of breath).

- ✓ **When feasible and consistent with security priorities, encourage staff to maintain a distance of 6 feet or more from an individual with respiratory symptoms while interviewing, escorting, or interacting in other ways.**
- ✓ **Ask staff to keep interactions with individuals with respiratory symptoms as brief as possible.**

Prevention Practices for Visitors

- ✓ **If possible, communicate with potential visitors to discourage contact visits in the interest of their own health and the health of their family members and friends inside the facility.**
- ✓ **Perform verbal screening (for COVID-19 symptoms and close contact with cases) and temperature checks for all visitors and volunteers on entry.** See [Screening](#) section below for wording of screening questions and a recommended procedure to safely perform temperature checks.
 - Staff performing temperature checks should wear [recommended PPE](#).
 - Exclude visitors and volunteers who do not clear the screening process or who decline screening.
- ✓ **Provide alcohol-based hand sanitizer with at least 60% alcohol in visitor entrances, exits, and waiting areas.**
- ✓ **Provide visitors and volunteers with information to prepare them for screening.**
 - Instruct visitors to postpone their visit if they have symptoms of respiratory illness.
 - If possible, inform potential visitors and volunteers before they travel to the facility that they should expect to be screened for COVID-19 (including a temperature check), and will be unable to enter the facility if they do not clear the screening process or if they decline screening.
 - Display [signage](#) outside visiting areas explaining the COVID-19 screening and temperature check process. Ensure that materials are understandable for non-English speakers and those with low literacy.
- ✓ **Promote non-contact visits:**
 - Encourage incarcerated/detained persons to limit contact visits in the interest of their own health and the health of their visitors.
 - Consider reducing or temporarily eliminating the cost of phone calls for incarcerated/detained persons.
 - Consider increasing incarcerated/detained persons' telephone privileges to promote mental health and reduce exposure from direct contact with community visitors.
- ✓ **Consider suspending or modifying visitation programs, if legally permissible. For example, provide access to virtual visitation options where available.**
 - If moving to virtual visitation, clean electronic surfaces regularly. (See [Cleaning](#) guidance below for instructions on cleaning electronic surfaces.)
 - Inform potential visitors of changes to, or suspension of, visitation programs.
 - Clearly communicate any visitation program changes to incarcerated/detained persons, along with the reasons for them (including protecting their health and their family and community members' health).
 - If suspending contact visits, provide alternate means (e.g., phone or video visitation) for incarcerated/detained individuals to engage with legal representatives, clergy, and other individuals with whom they have legal right to consult.

NOTE: Suspending visitation would be done in the interest of incarcerated/detained persons' physical health and the health of the general public. However, visitation is important to maintain mental health.

If visitation is suspended, facilities should explore alternative ways for incarcerated/detained persons to communicate with their families, friends, and other visitors in a way that is not financially burdensome for them. See above suggestions for promoting non-contact visits.

- ✓ **Restrict non-essential vendors, volunteers, and tours from entering the facility.**

Management

If there has been a suspected COVID-19 case inside the facility (among incarcerated/detained persons, staff, or visitors who have recently been inside), begin implementing Management strategies while test results are pending. Essential Management strategies include placing cases and individuals with symptoms under medical isolation, quarantining their close contacts, and facilitating necessary medical care, while observing relevant infection control and environmental disinfection protocols and wearing recommended PPE.

Operations

- ✓ **Implement alternate work arrangements deemed feasible in the Operational Preparedness section.**
- ✓ **Suspend all transfers of incarcerated/detained persons to and from other jurisdictions and facilities (including work release where relevant), unless necessary for medical evaluation, medical isolation/quarantine, care, extenuating security concerns, or to prevent overcrowding.**
 - If a transfer is absolutely necessary, perform verbal screening and a temperature check as outlined in the Screening section below, before the individual leaves the facility. If an individual does not clear the screening process, delay the transfer and follow the protocol for a suspected COVID-19 case—including putting a face mask on the individual, immediately placing them under medical isolation, and evaluating them for possible COVID-19 testing. If the transfer must still occur, ensure that the receiving facility has capacity to appropriately isolate the individual upon arrival. Ensure that staff transporting the individual wear recommended PPE (see Table 1) and that the transport vehicle is cleaned thoroughly after transport.
- ✓ **If possible, consider quarantining all new intakes for 14 days before they enter the facility's general population (SEPARATELY from other individuals who are quarantined due to contact with a COVID-19 case).** Subsequently in this document, this practice is referred to as **routine intake quarantine**.
- ✓ **When possible, arrange lawful alternatives to in-person court appearances.**
- ✓ **Incorporate screening for COVID-19 symptoms and a temperature check into release planning.**
 - Screen all releasing individuals for COVID-19 symptoms and perform a temperature check. (See Screening section below.)
 - If an individual does not clear the screening process, follow the protocol for a suspected COVID-19 case—including putting a face mask on the individual, immediately placing them under medical isolation, and evaluating them for possible COVID-19 testing.
 - If the individual is released before the recommended medical isolation period is complete, discuss release of the individual with state, local, tribal, and/or territorial health departments to ensure safe medical transport and continued shelter and medical care, as part of release planning. Make direct linkages to community resources to ensure proper medical isolation and access to medical care.
 - Before releasing an incarcerated/detained individual with COVID-19 symptoms to a community-based facility, such as a homeless shelter, contact the facility's staff to ensure adequate time for them to prepare to continue medical isolation, or contact local public health to explore alternate housing options.

✓ **Coordinate with state, local, tribal, and/or territorial health departments.**

- When a COVID-19 case is suspected, work with public health to determine action. See Medical Isolation section below.
- When a COVID-19 case is suspected or confirmed, work with public health to identify close contacts who should be placed under quarantine. See Quarantine section below.
- Facilities with limited onsite medical isolation, quarantine, and/or healthcare services should coordinate closely with state, local, tribal, and/or territorial health departments when they encounter a confirmed or suspected case, in order to ensure effective medical isolation or quarantine, necessary medical evaluation and care, and medical transfer if needed. See Facilities with Limited Onsite Healthcare Services section.

Hygiene

- ✓ **Continue to ensure that hand hygiene supplies are well-stocked in all areas of the facility.** (See above.)
- ✓ **Continue to emphasize practicing good hand hygiene and cough etiquette.** (See above.)

Cleaning and Disinfecting Practices

- ✓ **Continue adhering to recommended cleaning and disinfection procedures for the facility at large.** (See above.)
- ✓ **Reference specific cleaning and disinfection procedures for areas where a COVID-19 case has spent time (below).**

Medical Isolation of Confirmed or Suspected COVID-19 Cases

NOTE: Some recommendations below apply primarily to facilities with onsite healthcare capacity. Facilities with Limited Onsite Healthcare Services, or without sufficient space to implement effective medical isolation, should coordinate with local public health officials to ensure that COVID-19 cases will be appropriately isolated, evaluated, tested (if indicated), and given care.

- ✓ **As soon as an individual develops symptoms of COVID-19, they should wear a face mask (if it does not restrict breathing) and should be immediately placed under medical isolation in a separate environment from other individuals.**
- ✓ **Keep the individual's movement outside the medical isolation space to an absolute minimum.**
 - Provide medical care to cases inside the medical isolation space. See Infection Control and Clinical Care sections for additional details.
 - Serve meals to cases inside the medical isolation space.
 - Exclude the individual from all group activities.
 - Assign the isolated individual a dedicated bathroom when possible.
- ✓ **Ensure that the individual is wearing a face mask at all times when outside of the medical isolation space, and whenever another individual enters.** Provide clean masks as needed. Masks should be changed at least daily, and when visibly soiled or wet.
- ✓ **Facilities should make every possible effort to place suspected and confirmed COVID-19 cases under medical isolation individually. Each isolated individual should be assigned their own housing space and bathroom where possible.** Cohorting should only be practiced if there are no other available options.

- If cohorting is necessary:
 - **Only individuals who are laboratory confirmed COVID-19 cases should be placed under medical isolation as a cohort. Do not cohort confirmed cases with suspected cases or case contacts.**
 - Unless no other options exist, do not house COVID-19 cases with individuals who have an undiagnosed respiratory infection.
 - Ensure that cohorted cases wear face masks at all times.

✓ **In order of preference, individuals under medical isolation should be housed:**

- Separately, in single cells with solid walls (i.e., not bars) 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 and a solid door that closes fully. Employ social distancing strategies related to housing in the Prevention section above.
- As a cohort, in a large, well-ventilated cell with solid walls but without a solid door. Employ social distancing strategies related to housing in the Prevention section above.
- As a cohort, in single cells without solid walls or solid doors (i.e., cells enclosed entirely with bars), preferably with an empty cell between occupied cells. (Although individuals are in single cells in this scenario, the airflow between cells essentially makes it a cohort arrangement in the context of COVID-19.)
- As a cohort, in multi-person cells without solid walls or solid doors (i.e., cells enclosed entirely with bars), preferably with an empty cell between occupied cells. Employ social distancing strategies related to housing in the Prevention section above.
- Safely transfer individual(s) to another facility with available medical isolation capacity in one of the above arrangements
(NOTE—Transfer should be avoided due to the potential to introduce infection to another facility; proceed only if no other options are available.)

If the ideal choice does not exist in a facility, use the next best alternative.

✓ **If the number of confirmed cases exceeds the number of individual medical isolation spaces available in the facility, be especially mindful of cases who are at higher risk of severe illness from COVID-19.** Ideally, they should not be cohorted with other infected individuals. If cohorting is unavoidable, make all possible accommodations to prevent transmission of other infectious diseases to the higher-risk individual. (For example, allocate more space for a higher-risk individual within a shared medical isolation space.)

- Persons at higher risk may include older adults and persons of any age with serious underlying medical conditions such as lung disease, heart disease, and diabetes. See CDC's website for a complete list, and check regularly for updates as more data become available to inform this issue.
- Note that incarcerated/detained populations have higher prevalence of infectious and chronic diseases and are in poorer health than the general population, even at younger ages.

✓ **Custody staff should be designated to monitor these individuals exclusively where possible.** These staff should wear recommended PPE as appropriate for their level of contact with the individual under medical isolation (see PPE section below) and should limit their own movement between different parts of the facility to the extent possible.

✓ **Minimize transfer of COVID-19 cases between spaces within the healthcare unit.**

- ✓ **Provide individuals under medical isolation with tissues and, if permissible, a lined no-touch trash receptacle.** 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. If soap and water are not available, clean hands with an alcohol-based hand sanitizer that contains at least 60% alcohol (where security concerns permit). Ensure that hand washing supplies are continually restocked.
- ✓ **Maintain medical isolation until all the following criteria have been met. Monitor the CDC website for updates to these criteria.**

For individuals who will be tested to determine if they are still contagious:

 - The individual has been free from fever for at least 72 hours without the use of fever-reducing medications **AND**
 - The individual's other symptoms have improved (e.g., cough, shortness of breath) **AND**
 - The individual has tested negative in at least two consecutive respiratory specimens collected at least 24 hours apart

For individuals who will NOT be tested to determine if they are still contagious:

 - The individual has been free from fever for at least 72 hours without the use of fever-reducing medications **AND**
 - The individual's other symptoms have improved (e.g., cough, shortness of breath) **AND**
 - At least 7 days have passed since the first symptoms appeared

For individuals who had a confirmed positive COVID-19 test but never showed symptoms:

 - At least 7 days have passed since the date of the individual's first positive COVID-19 test **AND**
 - The individual has had no subsequent illness
- ✓ **Restrict cases from leaving the facility while under medical isolation precautions, unless released from custody or if a transfer is necessary for medical care, infection control, lack of medical isolation space, or extenuating security concerns.**
 - If an incarcerated/detained individual who is a COVID-19 case is released from custody during their medical isolation period, contact public health to arrange for safe transport and continuation of necessary medical care and medical isolation as part of release planning.

Cleaning Spaces where COVID-19 Cases Spent Time

Thoroughly clean and disinfect all areas where the confirmed or suspected COVID-19 case spent time. Note—these protocols apply to suspected cases as well as confirmed cases, to ensure adequate disinfection in the event that the suspected case does, in fact, have COVID-19. Refer to the Definitions section for the distinction between confirmed and suspected cases.

- Close off areas used by the infected individual. If possible, open outside doors and windows to increase air circulation in the area. Wait as long as practical, up to 24 hours under the poorest air exchange conditions (consult CDC Guidelines for Environmental Infection Control in Health-Care Facilities for wait time based on different ventilation conditions), before beginning to clean and disinfect, to minimize potential for exposure to respiratory droplets.
- Clean and disinfect all areas (e.g., cells, bathrooms, and common areas) used by the infected individual, focusing especially on frequently touched surfaces (see list above in Prevention section).

✓ **Hard (non-porous) surface cleaning and disinfection**

- If surfaces are dirty, they should be cleaned using a detergent or soap and water prior to disinfection.
- For disinfection, most common EPA-registered household disinfectants should be effective. Choose cleaning products based on security requirements within the facility.
 - Consult a list of products that are EPA-approved for use against the virus that causes COVID-19. Follow the manufacturer's instructions for all cleaning and disinfection products (e.g., concentration, application method and contact time, etc.).
 - Diluted household bleach solutions can be used if appropriate for the surface. Follow the manufacturer's instructions for application and proper ventilation, and check to ensure the product is not past its expiration date. Never mix household bleach with ammonia or any other cleanser. Unexpired household bleach will be effective against coronaviruses when properly diluted. Prepare a bleach solution by mixing:
 - 5 tablespoons (1/3rd cup) bleach per gallon of water or
 - 4 teaspoons bleach per quart of water

✓ **Soft (porous) surface cleaning and disinfection**

- For soft (porous) surfaces such as carpeted floors and rugs, remove visible contamination if present and clean with appropriate cleaners indicated for use on these surfaces. After cleaning:
 - If the items can be laundered, launder items in accordance with the manufacturer's instructions using the warmest appropriate water setting for the items and then dry items completely.
 - Otherwise, use products that are EPA-approved for use against the virus that causes COVID-19 and are suitable for porous surfaces.

✓ **Electronics cleaning and disinfection**

- For electronics such as tablets, touch screens, keyboards, and remote controls, remove visible contamination if present.
 - Follow the manufacturer's instructions for all cleaning and disinfection products.
 - Consider use of wipeable covers for electronics.
 - If no manufacturer guidance is available, consider the use of alcohol-based wipes or spray containing at least 70% alcohol to disinfect touch screens. Dry surfaces thoroughly to avoid pooling of liquids.

Additional information on cleaning and disinfection of communal facilities such can be found on [CDC's website](#).

✓ **Ensure that staff and incarcerated/detained persons performing cleaning wear recommended PPE.** (See [PPE](#) section below.)

✓ **Food service items.** Cases under medical isolation should throw disposable food service items in the trash in their medical isolation room. Non-disposable food service items should be handled with gloves and washed with hot water or in a dishwasher. Individuals handling used food service items should clean their hands after removing gloves.

✓ **Laundry from a COVID-19 cases can be washed with other individuals' laundry.**

- Individuals handling laundry from COVID-19 cases should wear disposable gloves, discard after each use, and clean their hands after.
- Do not shake dirty laundry. This will minimize the possibility of dispersing virus through the air.
- Launder items as appropriate in accordance with the manufacturer's instructions. If possible, launder items using the warmest appropriate water setting for the items and dry items completely.

- Clean and disinfect clothes hampers according to guidance above for surfaces. If permissible, consider using a bag liner that is either disposable or can be laundered.
- ✓ **Consult cleaning recommendations above to ensure that transport vehicles are thoroughly cleaned after carrying a confirmed or suspected COVID-19 case.**

Quarantining Close Contacts of COVID-19 Cases

NOTE: Some recommendations below apply primarily to facilities with onsite healthcare capacity. Facilities without onsite healthcare capacity, or without sufficient space to implement effective quarantine, should coordinate with local public health officials to ensure that close contacts of COVID-19 cases will be effectively quarantined and medically monitored.

- ✓ **Incarcerated/detained persons who are close contacts of a confirmed or suspected COVID-19 case (whether the case is another incarcerated/detained person, staff member, or visitor) should be placed under quarantine for 14 days (see CDC guidelines).**
 - If an individual is quarantined due to contact with a suspected case who is subsequently tested for COVID-19 and receives a negative result, the quarantined individual should be released from quarantine restrictions.
- ✓ **In the context of COVID-19, an individual (incarcerated/detained person or staff) is considered a close contact if they:**
 - Have been within approximately 6 feet of a COVID-19 case for a prolonged period of time OR
 - Have had direct contact with infectious secretions of 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).

- ✓ **Keep a quarantined individual's movement outside the quarantine space to an absolute minimum.**
 - Provide medical evaluation and care inside or near the quarantine space when possible.
 - Serve meals inside the quarantine space.
 - Exclude the quarantined individual from all group activities.
 - Assign the quarantined individual a dedicated bathroom when possible.
- ✓ **Facilities should make every possible effort to quarantine close contacts of COVID-19 cases individually.** Cohorting multiple quarantined close contacts of a COVID-19 case could transmit COVID-19 from those who are infected to those who are uninfected. Cohorting should only be practiced if there are no other available options.
 - If cohorting of close contacts under quarantine is absolutely necessary, symptoms of all individuals should be monitored closely, and individuals with symptoms of COVID-19 should be placed under medical isolation immediately.
 - If an entire housing unit is under 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.
 - Some facilities may choose to quarantine all new intakes for 14 days before moving them to the facility's general population as a general rule (not because they were exposed to a COVID-19 case). Under this scenario, avoid mixing individuals quarantined due to exposure to a COVID-19 case with individuals undergoing routine intake quarantine.

- If at all possible, do not add more individuals to an existing quarantine cohort after the 14-day quarantine clock has started.
 - ✓ **If the number of quarantined individuals exceeds the number of individual quarantine spaces available in the facility, be especially mindful of those who are at higher risk of severe illness from COVID-19.** Ideally, they should not be cohorted with other quarantined individuals. If cohorting is unavoidable, make all possible accommodations to reduce exposure risk for the higher-risk individuals. (For example, intensify social distancing strategies for higher-risk individuals.)
 - ✓ **In order of preference, multiple quarantined individuals should be housed:**
 - Separately, in single cells with solid walls (i.e., not bars) 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 (i.e., cells enclosed entirely with bars), preferably with an empty cell between occupied cells creating at least 6 feet of space between individuals. (Although individuals are in single cells in this scenario, the airflow between cells essentially makes it a cohort arrangement in the context of COVID-19.)
 - As a cohort, in multi-person cells without solid walls or solid doors (i.e., cells enclosed entirely with bars), preferably with an empty cell between occupied cells. Employ social distancing strategies related to housing in the Prevention section to maintain at least 6 feet of space between individuals housed in the same cell.
 - As a cohort, in individuals' regularly assigned housing unit but with no movement outside the unit (if an entire housing unit has been exposed). Employ social distancing strategies related to housing in the Prevention section above to maintain at least 6 feet of space between individuals.
 - Safely transfer to another facility with capacity to quarantine in one of the above arrangements
- (NOTE—Transfer should be avoided due to the potential to introduce infection to another facility; proceed only if no other options are available.)
- ✓ **Quarantined individuals should wear face masks if feasible based on local supply, as source control, under the following circumstances** (see PPE section and Table 1):
 - If cohorted, quarantined individuals should wear face masks at all times (to prevent transmission from infected to uninfected individuals).
 - If quarantined separately, individuals should wear face masks whenever a non-quarantined individual enters the quarantine space.
 - All quarantined individuals should wear a face mask if they must leave the quarantine space for any reason.
 - Asymptomatic individuals under routine intake quarantine (with no known exposure to a COVID-19 case) do not need to wear face masks.
 - ✓ **Staff who have close contact with quarantined individuals should wear recommended PPE if feasible based on local supply, feasibility, and safety within the scope of their duties** (see PPE section and Table 1).
 - Staff supervising asymptomatic incarcerated/detained persons under routine intake quarantine (with no known exposure to a COVID-19 case) do not need to wear PPE.

- ✓ **Quarantined individuals should be monitored for COVID-19 symptoms twice per day, including temperature checks.**
 - If an individual develops symptoms, they should be moved to medical isolation immediately and further evaluated. (See [Medical Isolation](#) section above.)
 - See [Screening](#) section for a procedure to perform temperature checks safely on asymptomatic close contacts of COVID-19 cases.
- ✓ **If an individual who is part of a quarantined cohort becomes symptomatic:**
 - **If the individual is tested for COVID-19 and tests positive:** the 14-day quarantine clock for the remainder of the cohort must be reset to 0.
 - **If the individual is tested for COVID-19 and tests negative:** the 14-day quarantine clock for this individual and the remainder of the cohort does not need to be reset. This individual can return from medical isolation to the quarantined cohort for the remainder of the quarantine period.
 - **If the individual is not tested for COVID-19:** the 14-day quarantine clock for the remainder of the cohort must be reset to 0.
- ✓ **Restrict quarantined individuals from leaving the facility (including transfers to other facilities) during the 14-day quarantine period, unless released from custody or a transfer is necessary for medical care, infection control, lack of quarantine space, or extenuating security concerns.**
- ✓ **Quarantined individuals can be released from quarantine restrictions if they have not developed symptoms during the 14-day quarantine period.**
- ✓ **Meals should be provided to quarantined individuals in their quarantine spaces.** Individuals under quarantine should throw disposable food service items in the trash. Non-disposable food service items should be handled with gloves and washed with hot water or in a dishwasher. Individuals handling used food service items should clean their hands after removing gloves.
- ✓ **Laundry from quarantined individuals can be washed with other individuals' laundry.**
 - Individuals handling laundry from quarantined persons should wear disposable gloves, discard after each use, and clean their hands after.
 - Do not shake dirty laundry. This will minimize the possibility of dispersing virus through the air.
 - Launder items as appropriate in accordance with the manufacturer's instructions. If possible, launder items using the warmest appropriate water setting for the items and dry items completely.
 - Clean and disinfect clothes hampers according to guidance above for surfaces. If permissible, consider using a bag liner that is either disposable or can be laundered.

Management of Incarcerated/Detained Persons with COVID-19 Symptoms

NOTE: Some recommendations below apply primarily to facilities with onsite healthcare capacity. Facilities without onsite healthcare capacity or without sufficient space for medical isolation should coordinate with local public health officials to ensure that suspected COVID-19 cases will be effectively isolated, evaluated, tested (if indicated), and given care.

- ✓ **If possible, designate a room near each housing unit for healthcare staff to evaluate individuals with COVID-19 symptoms, rather than having them walk through the facility to be evaluated in the medical unit.**
- ✓ **Incarcerated/detained individuals with COVID-19 symptoms should wear a face mask and should be placed under medical isolation immediately. Discontinue the use of a face mask if it inhibits breathing. See [Medical Isolation](#) section above.**

- ✓ **Medical staff should evaluate symptomatic individuals to determine whether COVID-19 testing is indicated.** Refer to CDC guidelines for information on [evaluation](#) and [testing](#). See [Infection Control](#) and [Clinical Care](#) sections below as well.
- ✓ **If testing is indicated (or if medical staff need clarification on when testing is indicated), contact the state, local, tribal, and/or territorial health department. Work with public health or private labs as available to access testing supplies or services.**
 - o If the COVID-19 test is positive, continue medical isolation. (See [Medical Isolation](#) section above.)
 - o If the COVID-19 test is negative, return the individual to their prior housing assignment unless they require further medical assessment or care.

Management Strategies for Incarcerated/Detained Persons without COVID-19 Symptoms

- ✓ **Provide clear information to incarcerated/detained persons about the presence of COVID-19 cases within the facility, and the need to increase social distancing and maintain hygiene precautions.**
 - o Consider having healthcare staff perform regular rounds to answer questions about COVID-19.
 - o Ensure that information is provided in a manner that can be understood by non-English speaking individuals and those with low literacy, and make necessary accommodations for those with cognitive or intellectual disabilities and those who are deaf, blind, or low-vision.
- ✓ **Implement daily temperature checks in housing units where COVID-19 cases have been identified, especially if there is concern that incarcerated/detained individuals are not notifying staff of symptoms.** See [Screening](#) section for a procedure to safely perform a temperature check.
- ✓ **Consider additional options to intensify [social distancing](#) within the facility.**

Management Strategies for Staff

- ✓ **Provide clear information to staff about the presence of COVID-19 cases within the facility, and the need to enforce social distancing and encourage hygiene precautions.**
 - o Consider having healthcare staff perform regular rounds to answer questions about COVID-19 from staff.
- ✓ **Staff identified as close contacts of a COVID-19 case should self-quarantine at home for 14 days and may return to work if symptoms do not develop.**
 - o See [above](#) for definition of a close contact.
 - o Refer to [CDC guidelines](#) for further recommendations regarding home quarantine for staff.

Infection Control

Infection control guidance below is applicable to all types of correctional facilities. Individual facilities should assess their unique needs based on the types of exposure staff and incarcerated/detained persons may have with confirmed or suspected COVID-19 cases.

- ✓ **All individuals who have the potential for direct or indirect exposure to COVID-19 cases or infectious materials (including body substances; contaminated medical supplies, devices, and equipment; contaminated environmental surfaces; or contaminated air) should follow infection control practices outlined in the [CDC Interim Infection Prevention and Control Recommendations for Patients with Suspected or Confirmed Coronavirus Disease 2019 \(COVID-19\) in Healthcare Settings](#). Monitor these guidelines regularly for updates.**

- Implement the above guidance as fully as possible within the correctional/detention context. Some of the specific language may not apply directly to healthcare settings within correctional facilities and detention centers, or to facilities without onsite healthcare capacity, and may need to be adapted to reflect facility operations and custody needs.
- Note that these recommendations apply to staff as well as to incarcerated/detained individuals who may come in contact with contaminated materials during the course of their work placement in the facility (e.g., cleaning).
- ✓ **Staff should exercise caution when in contact with individuals showing symptoms of a respiratory infection.** Contact should be minimized to the extent possible until the infected individual is wearing a face mask. If COVID-19 is suspected, staff should wear recommended PPE (see [PPE](#) section).
- ✓ **Refer to [PPE](#) section to determine recommended PPE for individuals persons in contact with confirmed COVID-19 cases, contacts, and potentially contaminated items.**

Clinical Care of COVID-19 Cases

- ✓ **Facilities should ensure that incarcerated/detained individuals receive medical evaluation and treatment at the first signs of COVID-19 symptoms.**
 - If a facility is not able to provide such evaluation and treatment, a plan should be in place to safely transfer the individual to another facility or local hospital.
 - The initial medical evaluation should determine whether a symptomatic individual is at [higher risk for severe illness from COVID-19](#). Persons at higher risk may include older adults and persons of any age with serious underlying medical conditions such as lung disease, heart disease, and diabetes. See [CDC's website](#) for a complete list, and check regularly for updates as more data become available to inform this issue.
- ✓ **Staff evaluating and providing care for confirmed or suspected COVID-19 cases should follow the [CDC Interim Clinical Guidance for Management of Patients with Confirmed Coronavirus Disease \(COVID-19\)](#) and monitor the guidance website regularly for updates to these recommendations.**
- ✓ **Healthcare staff should evaluate persons with respiratory symptoms or contact with a COVID-19 case in a separate room, with the door closed if possible, while wearing [recommended PPE](#) and ensuring that the suspected case is wearing a face mask.**
 - If possible, designate a room near each housing unit to evaluate individuals with COVID-19 symptoms, rather than having them walk through the facility to be evaluated in the medical unit.
- ✓ **Clinicians are strongly encouraged to test for other causes of respiratory illness (e.g., influenza).**
- ✓ **The facility should have a plan in place to safely transfer persons with severe illness from COVID-19 to a local hospital if they require care beyond what the facility is able to provide.**
- ✓ **When evaluating and treating persons with symptoms of COVID-19 who do not speak English, using a language line or provide a trained interpreter when possible.**

Recommended PPE and PPE Training for Staff and Incarcerated/Detained Persons

- ✓ **Ensure that all staff (healthcare and non-healthcare) and incarcerated/detained persons who will have contact with infectious materials in their work placements have been trained to correctly don, doff, and dispose of PPE relevant to the level of contact they will have with confirmed and suspected COVID-19 cases.**

- Ensure that staff and incarcerated/detained persons who require respiratory protection (e.g., N95s) for their work responsibilities have been medically cleared, trained, and fit-tested in the context of an employer's respiratory protection program.
- For PPE training materials and posters, please visit the CDC website on Protecting Healthcare Personnel.
- ✓ **Ensure that all staff are trained to perform hand hygiene after removing PPE.**
- ✓ **If administrators anticipate that incarcerated/detained persons will request unnecessary PPE, consider providing training on the different types of PPE that are needed for differing degrees of contact with COVID-19 cases and contacts, and the reasons for those differences (see Table 1). Monitor linked CDC guidelines in Table 1 for updates to recommended PPE.**
- ✓ **Keep recommended PPE near the spaces in the facility where it could be needed, to facilitate quick access in an emergency.**
- ✓ **Recommended PPE for incarcerated/detained individuals and staff in a correctional facility** will vary based on the type of contact they have with COVID-19 cases and their contacts (see Table 1). Each type of recommended PPE is defined below. **As above, note that PPE shortages are anticipated in every category during the COVID-19 response.**
 - **N95 respirator**

See below for guidance on when face masks are acceptable alternatives for N95s. N95 respirators should be prioritized when staff anticipate contact with infectious aerosols from a COVID-19 case.

 - **Face mask**
 - **Eye protection**—goggles or disposable face shield that fully covers the front and sides of the face
 - **A single pair of disposable patient examination gloves**

Gloves should be changed if they become torn or heavily contaminated.

 - **Disposable medical isolation gown or single-use/disposable coveralls, when feasible**
 - If custody staff are unable to wear a disposable gown or coveralls because it limits access to their duty belt and gear, ensure that duty belt and gear are disinfected after close contact with the individual. Clean and disinfect duty belt and gear prior to reuse using a household cleaning spray or wipe, according to the product label.
 - If there are shortages of gowns, they should be prioritized for aerosol-generating procedures, care activities where splashes and sprays are anticipated, and high-contact patient care activities that provide opportunities for transfer of pathogens to the hands and clothing of staff.
- ✓ **Note that shortages of all PPE categories are anticipated during the COVID-19 response, particularly for non-healthcare workers. Guidance for optimizing the supply of each category can be found on CDC's website:**
 - **Guidance in the event of a shortage of N95 respirators**
 - Based on local and regional situational analysis of PPE supplies, **face masks are an acceptable alternative when the supply chain of respirators cannot meet the demand**. During this time, available respirators should be prioritized for staff engaging in activities that would expose them to respiratory aerosols, which pose the highest exposure risk.
 - **Guidance in the event of a shortage of face masks**
 - **Guidance in the event of a shortage of eye protection**
 - **Guidance in the event of a shortage of gowns/coveralls**

Table 1. Recommended Personal Protective Equipment (PPE) for Incarcerated/Detained Persons and Staff in a Correctional Facility during the COVID-19 Response

Classification of Individual Wearing PPE	N95 respirator	Face mask	Eye Protection	Gloves	Gown/Coveralls
Incarcerated/Detained Persons					
Asymptomatic incarcerated/detained persons (under quarantine as close contacts of a COVID-19 case*)	Apply face masks for source control as feasible based on local supply, especially if housed as a cohort				
Incarcerated/detained persons who are confirmed or suspected COVID-19 cases, or showing symptoms of COVID-19	–	✓	–	–	–
Incarcerated/detained persons in a work placement handling laundry or used food service items from a COVID-19 case or case contact	–	–	–	✓	✓
Incarcerated/detained persons in a work placement cleaning areas where a COVID-19 case has spent time	Additional PPE may be needed based on the product label. See CDC guidelines for more details.			✓	✓
Staff					
Staff having direct contact with asymptomatic incarcerated/detained persons under quarantine as close contacts of a COVID-19 case* (but not performing temperature checks or providing medical care)	–	Face mask, eye protection, and gloves as local supply and scope of duties allow.			–
Staff performing temperature checks on any group of people (staff, visitors, or incarcerated/detained persons), or providing medical care to asymptomatic quarantined persons	–	✓	✓	✓	✓
Staff having direct contact with (including transport) or offering medical care to confirmed or suspected COVID-19 cases (see CDC infection control guidelines)	✓**		✓	✓	✓
Staff present during a procedure on a confirmed or suspected COVID-19 case that may generate respiratory aerosols (see CDC infection control guidelines)	✓	–	✓	✓	✓
Staff handling laundry or used food service items from a COVID-19 case or case contact	–	–	–	✓	✓
Staff cleaning an area where a COVID-19 case has spent time	Additional PPE may be needed based on the product label. See CDC guidelines for more details.			✓	✓

* If a facility chooses to routinely quarantine all new intakes (without symptoms or known exposure to a COVID-19 case) before integrating into the facility's general population, face masks are not necessary.

** A NIOSH-approved N95 is preferred. However, based on local and regional situational analysis of PPE supplies, face masks are an acceptable alternative when the supply chain of respirators cannot meet the demand. During this time, available respirators should be prioritized for procedures that are likely to generate respiratory aerosols, which would pose the highest exposure risk to staff.

Verbal Screening and Temperature Check Protocols for Incarcerated/Detained Persons, Staff, and Visitors

The guidance above recommends verbal screening and temperature checks for incarcerated/detained persons, staff, volunteers, and visitors who enter correctional and detention facilities, as well as incarcerated/detained persons who are transferred to another facility or released from custody. Below, verbal screening questions for COVID-19 symptoms and contact with known cases, and a safe temperature check procedure are detailed.

✓ **Verbal screening for symptoms of COVID-19 and contact with COVID-19 cases should include the following questions:**

- *Today or in the past 24 hours, have you had any of the following symptoms?*
 - *Fever, felt feverish, or had chills?*
 - *Cough?*
 - *Difficulty breathing?*
- *In the past 14 days, have you had contact with a person known to be infected with the novel coronavirus (COVID-19)?*

✓ **The following is a protocol to safely check an individual's temperature:**

- Perform hand hygiene
- Put on a face mask, eye protection (goggles or disposable face shield that fully covers the front and sides of the face), gown/coveralls, and a single pair of disposable gloves
- Check individual's temperature
- **If performing a temperature check on multiple individuals, ensure that a clean pair of gloves is used for each individual and that the thermometer has been thoroughly cleaned in between each check.** If disposable or non-contact thermometers are used and the screener did not have physical contact with an individual, gloves do not need to be changed before the next check. If non-contact thermometers are used, they should be cleaned routinely as recommended by CDC for infection control.
- Remove and discard PPE
- Perform hand hygiene

U.S. Department of Homeland Security
500 12th Street, SW
Washington, D.C. 20536



U.S. Immigration and Customs Enforcement

March 27, 2020

MEMORANDUM FOR: Detention Wardens and Superintendents

THROUGH: Field Office Directors

FROM: Enrique M. Lucero
Executive Associate Director
Enforcement and Removal Operations

SUBJECT: Memorandum on Coronavirus Disease 2019 (COVID-19)
Action Plan, Revision 1

(b)(6); (b)(7)(C)

Background:

U.S. Immigration and Customs Enforcement (ICE) continues to monitor the spread of Coronavirus Disease 2019 (COVID-19) and to work in conjunction with select U.S. Department of Homeland Security (DHS) Component leadership and the Acting Secretary to implement a mitigation strategy.

To ensure a unified and preventative response, the ICE Enforcement and Removal Operations (ERO), ICE Health Service Corps (IHSC), Custody Management Division, and Field Operations are providing the following guidance. The combination of a dense and highly transient detained population presents unique challenges for ICE efforts to mitigate the risk of infection and transmission. Consequently, these measures were developed to reduce exposure to COVID-19, protect the detained population, and optimize employee health and availability for duty.

This memorandum only applies to IHSC-staffed and non-IHSC-staffed, ICE-dedicated facilities. For intergovernmental partners and non-dedicated facilities, ICE defers to local, state, tribal, territorial, and federal public health policies and authorities, including adherence with state laws on communicable disease reporting, but recommends actions contained in this memorandum be considered as best practices. Questions and concerns related to the following Action Plan can be addressed to [\(b\)\(6\); \(b\)\(7\)\(C\)@ice.dhs.gov](mailto:(b)(6); (b)(7)(C)@ice.dhs.gov).

Please see the recently-issued Centers for Disease Control and Prevention (CDC) Interim Guidance: Managing COVID-19 in Correctional/Detention Facilities for additional information.

Action Plan:

STAFF HIRING: Wardens and facility staff should continue to meet any personnel staffing plan and staffing criteria outlined in the Performance Work Statement (PWS) and terms and conditions of their negotiated contract or agreement for medical staff and guard services. Facilities are expected to be appropriately staffed to meet established work schedules, rest periods, and to ensure the delivery of detainee medical and mental health care as it relates to the continually evolving impact of COVID-19.

LOGISTICS: Wardens and Facility Administrators should assess their inventories of food, medicine, cleaning supplies, personal protective equipment (PPE), and facility operational practices, and consistently maintain services and supplies to assure the safety, security, health, and well-being of ICE detainees. Facilities should have updated pandemic plans and policies as well as established quarantine and/or isolation areas within their facilities in the event they are needed. Alcohol-based hand sanitizer with at least 60 percent alcohol should be available in visitor entrances, exits, and waiting areas. In addition, alcohol-based hand sanitizer should be made available to staff and detainees in the secure setting to the maximum extent possible.

SOCIAL VISITATION/TELEPHONIC COMMUNICATION: As of March 13, 2020, social visits to/with ICE detainees at all detention facilities are suspended until further notice in order to mitigate the potential introduction of COVID-19 into the facilities. ICE recognizes the considerable impact of suspending personal visitation, and requests maximizing detainee use of teleconferencing, video visitation (e.g., Skype, FaceTime), email, and/or tablets, with extended hours where possible.

Detention facilities should make a timely effort to identify indigence in the detainee population. A detainee is considered “indigent” if he/she has less than \$15.00 in his/her account for ten days. These detainees must be afforded the same telephone access and related privileges as other detainees. Each facility must ensure all detainees are able to make calls to the ICE-provided list of free legal service providers and consulates at no charge to the detainee or the receiving party, and that indigent detainees may request a call to immediate family or others in personal or family emergencies or on an as-needed basis to maintain community ties.

LEGAL VISITS: Detainee access to legal representatives remains a paramount requirement and should be accommodated to the maximum extent practicable. Legal visitation must continue unless determined to pose a risk to the safety and security of the facility.

Non-contact legal visitation (e.g., Skype or teleconference) should be offered first to limit exposure to ICE detainees, but in person contact should be permitted if determined essential by the legal representative. Prior to the in-person visit, the legal representative must undergo the same screening required for staff entry into the facility. The ultimate legal visit approving authority lies with the Warden or Facility Administrator; however, the facility should notify its local Field Office Director as soon as possible of any denied legal visits.

LEGAL RIGHTS GROUP PRESENTATIONS: Government-sponsored Legal Orientation Programs (LOPs), carried out by the Department of Justice Executive Office for Immigration Review (EOIR) and authorized by congressional appropriations, currently operate at a limited

number of detention sites, and may continue to conduct detainee presentations. No more than four LOP presenters may be allowed in the facility at any time and must undergo the same screening required for staff entry into the facility. Non-LOP legal rights group presentations offered by volunteers are suspended until further notice.

STAFF-DETAINEE COMMUNICATION VISITS: Field Office Directors should remain aware that detainees may experience increased feelings of fear and confusion during this time. Regular communication with staff is particularly important. Detainees should have frequent opportunities for informal contact with facility managerial and supervisory staff and with ERO field office staff.

Field Office Directors should monitor both facility staff and ERO officers to ensure they continue to interact with detainees. ICE staff-detainee communication may be conducted in-person (with appropriate risk reduction protocols to protect ERO officers, detainees, and facility staff) or through non-contact visitation using videoconferencing, phone calls, e-mail, or other communication services.

CONTRACTORS: Contractors performing essential services or maintenance on essential systems in ICE detention facilities must continue to be provided facility access and must undergo the same screening required for staff entry into the facility. Examples of essential services include medical and mental health services, telephone access, cleaning, laundry, waste disposal, and critical infrastructure repairs.

Facility annual inspections by the ICE inspections contractor, The Nakamoto Group, are suspended for 30 days from the issuance date of this memorandum.

VOLUNTEERS: Volunteer visits to ICE detention facilities are suspended until further notice unless approved by the Assistant Directors for Field Operations and Custody Management. The only exception is the facility Chaplain, who may continue to offer availability for individual and group pastoral care but must undergo the same screening required for staff entry into the facility. Other volunteers, contractors, and community groups that augment and enhance the religious program are suspended until further notice to reduce the risk of possible transmission of COVID-19 to detainees.

TOURS: Facility tours are suspended until further notice, excluding Members of Congress, Congressional Member Delegations (CODELs), and Congressional Staff Delegations (STAFFDELS) who will not be prevented from accessing facilities for the purpose of conducting oversight. To safeguard visitors, detainees, ICE and facility staff, congressional visitors may be subject to special screening procedures congruent with staff facility entry screening. Congressional visitors should be advised of standard hygiene practices to help prevent the spread of disease (i.e., washing hands, avoiding close contact) and should be made aware of available hand washing stations within the facility.

STAFF TRAINING: All ERO in-person staff training related to the ICE detention standards or facility compliance is suspended until further notice, including conferences, Contracting Officer Representative (COR) training, and Field Office Compliance Training. Wardens and Facility Administrators will determine the training schedule for facility staff. All staff licenses and certifications shall be maintained.

SCREENING OF FACILITY STAFF: Enhanced health screening of both ICE and facility staff should be implemented by ICE detention facilities in geographic areas with “sustained community transmission.” These geographical areas are determined by the CDC and information is available at:

<https://www.cdc.gov/coronavirus/2019-ncov/cases-in-us.html>. Health screening includes self-reporting symptoms associated with COVID-19 infection and a temperature check.

Wardens and Facility Administrators in those geographical areas should collaborate with their Health Services Administrator to designate a trained staff member available on all shifts to conduct verbal screening and record temperature checks. It is not required that the trained staff member be medical personnel; however, the staff member must have documented training and protect the privacy of those being screened.

Verbal screening for symptoms of COVID-19 and contact with COVID-19 cases should include the following questions based on Interim Guidance: Managing COVID-19 in Correctional/Detention Facilities:

- Today or in the past 24 hours, have you had any of the following symptoms?
 - Fever, felt feverish, or had chills?
 - Cough?
 - Difficulty breathing?
- In the past 14 days, have you had contact with a person known to be infected with COVID-19 where you were not wearing the recommended proper personal protective equipment (PPE)?

The following is a protocol to safely check an individual’s temperature:

- Perform hand hygiene.
- Put on a face mask, eye protection (goggles or disposable face shield that fully covers the front and sides of the face), gowns/coveralls, and a single pair of disposable gloves.
- Check the individual’s temperature.
- If performing a temperature check on multiple individuals, ensure that a clean pair of gloves is used for each individual and that the thermometer has been thoroughly cleaned in between each check.
- If disposable or non-contact thermometers are used and the screener did not have physical contact with an individual, gloves do not need to be changed before the next check. If non-contact thermometers are used, they should be cleaned routinely as recommended by CDC for infection control.
- Remove and discard PPE.
- Perform hand hygiene.

Staff who do not clear the screening process, or refuse the enhanced health screening must be denied entry and advised to follow CDC-recommended steps for persons who are sick with COVID-19 symptoms.

If PPE supply is limited, consider other PPE strategies based on CDC Guidance | Strategies for Optimizing the Supply of PPE.

If staff register a temperature greater than or equal to 100.4 degrees (Fahrenheit), they should be denied entry to the facility and placed on leave per the employer's administrative policies.

DETAINEE SCREENING: IHSC developed guidance for IHSC-staffed facilities to assist in the risk assessment and management of detained individuals with potential exposure to COVID-19, and guidance was disseminated to non IHSC-staffed ICE detention facilities for potential adoption of this guidance at their respective sites. This guidance addresses intake medical screenings, monitoring, encounters, laboratory testing, and public health actions. The CDC remains the authoritative source for information on how to protect individuals and reduce exposure to COVID-19. ICE continues to encourage facilities to follow CDC guidelines and those of their state and local health departments for non IHSC-staffed ICE detention facilities.

ICE requests that Wardens and Facility Administrators ensure ICE detainees are provided guidance and education in a language that they fully comprehend regarding basic hygiene and measures to maintain health. Links for detainee/patient education resources, in a variety of languages, are maintained in the IHSC guidance and information on the CDC website.

MODIFIED OPERATIONS: Wardens and Facility Administrators should implement modified operations to maximize social distancing in facilities, as much as practicable. For example, Wardens and Facility Administrators should consider staggered mealtimes and recreation times in order to limit congregate gatherings. All community service projects are suspended until further notice.

CONSIDERATIONS FOR DETAINEE RELEASE: Upon notification of a detainee's pending release, a qualified health care provider will conduct a temperature screening:

- Temperature checks will be completed no more than 12 hours prior to facility departure and documented in the detainee medical record and transfer summary.
- Temperature checks must be completed and documented prior to providing ICE with transfer summary documents.

When considering the release of detainees into the United States with confirmed or suspected COVID-19, the following must be addressed for detainees exposed to an individual with confirmed or suspected COVID-19 or detainees under monitoring for having epidemiologic risk of exposure to COVID-19:

- If the detainee will be released prior to completion of the recommended medical isolation, cohorting, or monitoring period, the state or local health department in the facility jurisdiction should be notified of the detainee's release:
 - The health department should be provided with the detainee's name, intended address, email address, and all available telephone numbers.
- Facilitate safe transport, continued shelter, and medical care, as part of release planning:
 - Provide information regarding any potential community resources to promote continuity of care.
 - Attempt to facilitate transportation coordination through a family or friend.

- Advise the detainee to avoid public transportation, commercial ride sharing (e.g., Uber, Lyft), and taxis.
- Provide the detainee the CDC's *What To Do if You Are Sick* fact sheet.

If this guidance creates any contractual issues, please contact your respective Contracting Officer Representative.



Centers for Disease Control and Prevention
CDC 24/7: Saving Lives, Protecting People™

Coronavirus Disease 2019 (COVID-19)

Public Health Recommendations for Community-Related Exposure

The following updates CDC guidance for definitions and management of contacts of persons with COVID-19 contained in "Public Health Recommendations after Travel from Areas with Potential Risk of Exposure to Coronavirus Disease 2019 (COVID-19)." Separate guidance is available for travelers and health care workers. See also [Guidance for essential workers](#).

Public health recommendations have been updated to accommodate new scientific evidence, evolving epidemiology and the need to simplify risk stratification. New recommendations are based on:

- Growing evidence of transmission risk from infected persons without symptoms or before the onset of recognized symptoms;
- Increased community transmission in many parts of the country;
- A need to communicate effectively to the general public and to simplify implementation for public health authorities;
- Limitations in access to COVID-19 testing and increasing number of cases diagnosed clinically
- Continued focus on reducing transmission through social distancing of individuals in affected areas

Summary of Changes:

- Changed risk strata descriptions – levels of risk have been reduced to simplify communications and implementation
- Changed period of exposure risk from "onset of symptoms" to "48 hours before symptom onset"
- Added the definition of a contact to include exposure to a laboratory confirmed case as well as a clinically compatible case in regions with widespread ongoing transmission
- Removed "no risk" category and replaced with unknown risk to acknowledge that all persons in the United States are at some risk of COVID-19 given the increases in community spread throughout the United States.

Current guidance based on community exposure, for asymptomatic persons exposed to persons with known or suspected COVID-19 or possible COVID-19

Travelers, health care workers and critical infrastructure workers should follow guidance that include special consideration for these groups. CDC's recommendations for community-related exposures are provided below. Individuals should always follow guidance of the state and local authorities.

Person	Exposure to	Recommended Precautions for the Public

• Household member • Intimate partner • Individual providing care in a household without using recommended infection control precautions • Individual who has had close contact (< 6 feet)** for a prolonged period of time ***	• Person with symptomatic COVID-19 during period from 48 hours before symptoms onset until meets criteria for discontinuing home isolation (can be a laboratory-confirmed disease or a clinically compatible illness in a state or territory with widespread community transmission)	• Stay home until 14 days after last exposure and maintain social distance (at least 6 feet) from others at all times • Self-monitor for symptoms ◦ Check temperature twice a day ◦ Watch for fever*, cough, or shortness of breath • Avoid contact with people at higher risk for severe illness (unless they live in the same home and had same exposure) • Follow CDC guidance if symptoms develop
All U.S. residents, other than those with a known risk exposure	• Possible unrecognized COVID-19 exposures in U.S. communities	• Be alert for symptoms ◦ Watch for fever*, cough, or shortness of breath ◦ Take temperature if symptoms develop • Practice social distancing ◦ Maintain 6 feet of distance from others ◦ Stay out of crowded places • Follow CDC guidance if symptoms develop

*For the purpose of this guidance, fever is defined as subjective fever (feeling feverish) or a measured temperature of 100.4°F (38°C) or higher. Note that fever may be intermittent or may not be present in some people, such as those who are elderly, immunosuppressed, or taking certain medications (e.g., NSAIDs).

** Data are limited to define of close contact. Factors to consider when defining close contact include proximity, the duration of exposure (e.g., longer exposure time likely increases exposure risk), whether the individual has symptoms (e.g., coughing likely increases exposure risk) and whether the individual was wearing a facemask (which can efficiently block respiratory secretions from contaminating others and the environment).

***Data are insufficient to precisely define the duration of time that constitutes a prolonged exposure. Recommendations vary on the length of time of exposure from 10 minutes or more to 30 minutes or more. In healthcare settings, it is reasonable to define a prolonged exposure as any exposure greater than a few minutes because the contact is someone who is ill. Brief interactions are less likely to result in transmission; however, symptoms and the type of interaction (e.g., did the person cough directly into the face of the individual) remain important.

Integration of these definitions and actions into communications and actions of public health authorities can be guided by CDC's "Implementation of Mitigation Strategies for Communities with Local COVID-19 Transmission" 

Page last reviewed: March 30, 2020

Content source: National Center for Immunization and Respiratory Diseases (NCIRD), Division of Viral Diseases



Coronavirus Disease 2019 (COVID-19)

Strategies to Optimize the Supply of PPE and Equipment

Personal protective equipment (PPE) is used every day by healthcare personnel (HCP) to protect themselves, patients, and others when providing care. PPE helps protect HCP from potentially infectious patients and materials, toxic medications, and other potentially dangerous substances used in healthcare delivery.

PPE shortages are currently posing a tremendous challenge to the US healthcare system because of the COVID-19 pandemic. Healthcare facilities are having difficulty accessing the needed PPE and are having to identify alternate ways to provide patient care.

CDC's optimization strategies for PPE offer options for use when PPE supplies are stressed, running low, or absent. Contingency strategies can help stretch PPE supplies when shortages are anticipated, for example if facilities have sufficient supplies now but are likely to run out soon. Crisis strategies can be considered during severe PPE shortages and should be used with the contingency options to help stretch available supplies for the most critical needs. As PPE availability returns to normal, healthcare facilities should promptly resume standard practices.

Eye Protection

Isolation Gowns

Facemasks

N95 Respirators

Decontamination and Reuse of Filtering Facepiece Respirators

Ventilators

Key Concepts

HCP and facilities—along with their healthcare coalitions, local and state health departments, and local and state partners—will have to work together to develop strategies that identify and extend PPE supplies, so that recommended PPE will be available when needed most. When using PPE optimization strategies, training on PPE use, including proper donning and doffing procedures, must be provided to HCP before they carry out patient care activities.

- All U.S. healthcare facilities should begin using PPE contingency strategies now.
 - Maximize use of engineering controls, such as barriers and maintained ventilation systems, and administrative controls, such as altering work practices to minimize patient contacts.
 - Cancel elective and non-urgent procedures/appointments.
 - Reserve PPE for HCP and replace PPE normally used for source control with other barrier precautions such as tissues.
 - Use re-usable PPE that can be reprocessed.
 - Use PPE beyond the manufacturer-designated shelf life for training.

- Consider allowing HCP to extend use of respirators, facemasks, and eye protection, beyond a single patient contact.
- U.S. healthcare facilities experiencing PPE shortages may need to consider crisis capacity strategies, which must be carefully planned before implementation. The effectiveness of crisis strategies is uncertain and they may pose a risk for transmission between HCP and patients.
 - Consider using intact PPE that is beyond the manufacturer-designated shelf life for patient care activities.
 - Carefully prioritize PPE use for selected care activities. This could include reserving sterile gowns and gloves for urgent sterile patient procedures, such as surgery, and reserving respirators for aerosol-generating procedures and patient care with airborne transmitted disease risks, like tuberculosis, measles, and varicella.
 - If no commercial PPE is available, carefully consider if alternative approaches will reduce the risk of HCP exposure and are safe for patient care.
- As PPE becomes available, healthcare facilities should promptly resume standard practices.

Guidance

Personal Protective Equipment Burn Rate Calculator

Using PPE

Emergency Use Authorization (EUA) of Respiratory Protective Devices

On February 4, 2020, the HHS Secretary declared that circumstances exist to justify the authorization of emergency use of additional respiratory protective devices in healthcare settings during the COVID-19 outbreak. The FDA is providing frequent updates for manufacturers, facilities, and local/state jurisdictions about Emergency Use Authorizations (EUA) for respirators and other types of personal protective equipment. The FDA has issued EUAs to authorize all NIOSH approved particulate-filtering air purifying respirators (APRs) [\[link\]](#) to be used in healthcare settings, including all NIOSH approved filtering facepiece respirators, elastomeric APRs, powered air purifying respirators, expired NIOSH-approved filtering facepiece respirators, and respirators that have been decontaminated pursuant to the terms and conditions of an authorized decontamination system. The authorized decontamination systems are listed on the FDA EUA website. In addition, non-NIOSH-approved disposable filtering facepiece respirators within the context of the posted EUA [\[link\]](#) are permitted for use as well.

Page last reviewed: April 3, 2020

Content source: National Center for Immunization and Respiratory Diseases (NCIRD), Division of Viral Diseases



Centers for Disease Control and Prevention
CDC 24/7: Saving Lives, Protecting People™

Coronavirus Disease 2019 (COVID-19)

Cleaning and Disinfection for Community Facilities

Interim Recommendations for U.S. Community Facilities with Suspected/Confirmed Coronavirus Disease 2019 (COVID-19)

Summary of Recent Changes

Revisions made on 4/1/2020:

- Added guidance on the timing of disinfection after a suspected/confirmed COVID-19 case

Revisions made on 3/26/2020:

- Updated guidance for cleaning and disinfection of soft (porous) surfaces
- Updated links to EPA-registered disinfectant list
- Added guidance for disinfection of electronics
- Updated core disinfection/cleaning guidance

Background

There is much to learn about the novel coronavirus (SARS-CoV-2) that causes coronavirus disease 2019 (COVID-19). Based on what is currently known about the virus and about similar coronaviruses that cause SARS and MERS, spread from person-to-person happens most frequently among close contacts (within about 6 feet). This type of transmission occurs via respiratory droplets, but disease transmission via infectious aerosols is currently uncertain. Transmission of SARS-CoV-2 to persons from surfaces contaminated with the virus has not been documented. Transmission of coronavirus in general occurs much more commonly through respiratory droplets than through fomites. Current evidence suggests that SARS-CoV-2 may remain viable for hours to days on surfaces made from a variety of materials. Cleaning of visibly dirty surfaces followed by disinfection is a best practice measure for prevention of COVID-19 and other viral respiratory illnesses in community settings.

It is unknown how long the air inside a room occupied by someone with confirmed COVID-19 remains potentially infectious. Facilities will need to consider factors such as the size of the room and the ventilation system design (including flowrate [air changes per hour] and location of supply and exhaust vents) when deciding how long to close off rooms or areas used by ill persons before beginning disinfection. Taking measures to improve ventilation in an area or room where someone was ill or suspected to be ill with COVID-19 will help shorten the time it takes respiratory droplets to be removed from the air.

Purpose

This guidance provides recommendations on the cleaning and disinfection of rooms or areas occupied by those with suspected or with confirmed COVID-19. It is aimed at limiting the survival of SARS-CoV-2 in key environments. These recommendations will be updated if additional information becomes available.

These guidelines are focused on community, non-healthcare facilities such as schools, institutions of higher education, offices, daycare centers, businesses, and community centers that do, and do not, house persons overnight. These guidelines are not meant for cleaning staff in healthcare facilities or repatriation sites, households, or for others for whom specific guidance already exists.

Definitions

- *Community facilities* such as schools, daycare centers, and businesses comprise most non-healthcare settings that are visited by the general public outside of a household.
- *Cleaning* refers to the removal of dirt and impurities, including germs, from surfaces. Cleaning alone does not kill germs. But by removing the germs, it decreases their number and therefore any risk of spreading infection.
- *Disinfecting* works by using chemicals, for example EPA-registered disinfectants, to kill germs on surfaces. This process does not necessarily clean dirty surfaces or remove germs. But killing germs remaining on a surface after cleaning further reduces any risk of spreading infection.

Cleaning and Disinfection After Persons Suspected/Confirmed to Have COVID-19 Have Been in the Facility

Timing and location of cleaning and disinfection of surfaces

- At a school, daycare center, office, or other facility that does not house people overnight:
 - Close off areas visited by the ill persons. Open outside doors and windows and use ventilating fans to increase air circulation in the area. Wait 24 hours or as long as practical before beginning cleaning and disinfection.
 - Cleaning staff should clean and disinfect all areas such as offices, bathrooms, common areas, shared electronic equipment like tablets, touch screens, keyboards, remote controls, and ATM machines used by the ill persons, focusing especially on frequently touched surfaces.
- At a facility that does house people overnight:
 - Follow Interim Guidance for US Institutions of Higher Education on working with state and local health officials to isolate ill persons and provide temporary housing as needed.
 - Close off areas visited by the ill persons. Open outside doors and windows and use ventilating fans to increase air circulation in the area. Wait 24 hours or as long as practical before beginning cleaning and disinfection.
 - In areas where ill persons are being housed in isolation, follow Interim Guidance for Environmental Cleaning and Disinfection for U.S. Households with Suspected or Confirmed Coronavirus Disease 2019. This includes focusing on cleaning and disinfecting common areas where staff/others providing services may come into contact with ill persons but reducing cleaning and disinfection of bedrooms/bathrooms used by ill persons to as-needed.
 - In areas where ill persons have visited or used, continue routine cleaning and disinfection as in this guidance.
- If it has been more than 7 days since the person with suspected/confirmed COVID-19 visited or used the facility, additional cleaning and disinfection is not necessary.

How to Clean and Disinfect

Hard (Non-porous) Surfaces

- If surfaces are dirty, they should be cleaned using a detergent or soap and water prior to disinfection.
- For disinfection, most common EPA-registered household disinfectants should be effective.

- A list of products that are EPA-approved for use against the virus that causes COVID-19 is available [here](#)   . Follow the manufacturer's instructions for all cleaning and disinfection products for concentration, application method and contact time, etc.
- Additionally, diluted household bleach solutions (at least 1000ppm sodium hypochlorite) can be used if appropriate for the surface. Follow manufacturer's instructions for application, ensuring a contact time of at least 1 minute, and allowing proper ventilation during and after application. Check to ensure the product is not past its expiration date. Never mix household bleach with ammonia or any other cleanser. Unexpired household bleach will be effective against coronaviruses when properly diluted.
 - Prepare a bleach solution by mixing:
 - 5 tablespoons (1/3 cup) bleach per gallon of water or
 - 4 teaspoons bleach per quart of water

Soft (Porous) Surfaces

- For soft (porous) surfaces such as carpeted floor, rugs, and drapes, remove visible contamination if present and clean with appropriate cleaners indicated for use on these surfaces. After cleaning:
 - If the items can be laundered, launder items in accordance with the manufacturer's instructions using the warmest appropriate water setting for the items and then dry items completely.
 - Otherwise, use products that are EPA-approved for use against the virus that causes COVID-19   and that are suitable for porous surfaces

Electronics

- For electronics such as tablets, touch screens, keyboards, remote controls, and ATM machines, remove visible contamination if present.
 - Follow the manufacturer's instructions for all cleaning and disinfection products.
 - Consider use of wipeable covers for electronics.
 - If no manufacturer guidance is available, consider the use of alcohol-based wipes or sprays containing at least 70% alcohol to disinfect touch screens. Dry surfaces thoroughly to avoid pooling of liquids.

Linens, Clothing, and Other Items That Go in the Laundry

- In order to minimize the possibility of dispersing virus through the air, do not shake dirty laundry.
- Wash items as appropriate in accordance with the manufacturer's instructions. If possible, launder items using the warmest appropriate water setting for the items and dry items completely. Dirty laundry that has been in contact with an ill person can be washed with other people's items.
- Clean and disinfect hampers or other carts for transporting laundry according to guidance above for hard or soft surfaces.

Personal Protective Equipment (PPE) and Hand Hygiene:

- The risk of exposure to cleaning staff is inherently low. Cleaning staff should wear disposable gloves and gowns for all tasks in the cleaning process, including handling trash.
 - Gloves and gowns should be compatible with the disinfectant products being used.
 - Additional PPE might be required based on the cleaning/disinfectant products being used and whether there is a risk of splash.
 - Gloves and gowns should be removed carefully to avoid contamination of the wearer and the surrounding area. Be sure to clean hands after removing gloves.

- If gowns are not available, coveralls, aprons or work uniforms can be worn during cleaning and disinfecting. Reuseable (washable) clothing should be laundered afterwards. Clean hands after handling dirty laundry.
- Gloves should be removed after cleaning a room or area occupied by ill persons. Clean hands immediately after gloves are removed.
- Cleaning staff should immediately report breaches in PPE such as a tear in gloves or any other potential exposures to their supervisor.
- Cleaning staff and others should clean hands often, including immediately after removing gloves and after contact with an ill person, by washing hands with soap and water for 20 seconds. If soap and water are not available and hands are not visibly dirty, an alcohol-based hand sanitizer that contains at least 60% alcohol may be used. However, if hands are visibly dirty, always wash hands with soap and water.
- Follow normal preventive actions while at work and home, including cleaning hands and avoiding touching eyes, nose, or mouth with unwashed hands.
 - Additional key times to clean hands include:
 - After blowing one's nose, coughing, or sneezing
 - After using the restroom
 - Before eating or preparing food
 - After contact with animals or pets
 - Before and after providing routine care for another person who needs assistance such as a child

Additional Considerations for Employers:

- Employers should work with their local and state health departments to ensure appropriate local protocols and guidelines, such as updated/additional guidance for cleaning and disinfection, are followed, including for identification of new potential cases of COVID-19.
- Employers should educate staff and workers performing cleaning, laundry, and trash pick-up activities to recognize the symptoms of COVID-19 and provide instructions on what to do if they develop symptoms within 14 days after their last possible exposure to the virus. At a minimum, any staff should immediately notify their supervisor and the local health department if they develop symptoms of COVID-19. The health department will provide guidance on what actions need to be taken.
- Employers should develop policies for worker protection and provide training to all cleaning staff on site prior to providing cleaning tasks. Training should include when to use PPE, what PPE is necessary, how to properly don (put on), use, and doff (take off) PPE, and how to properly dispose of PPE.
- Employers must ensure workers are trained on the hazards of the cleaning chemicals used in the workplace in accordance with OSHA's Hazard Communication standard (29 CFR 1910.1200 [↗](#)).
- Employers must comply with OSHA's standards on Bloodborne Pathogens (29 CFR 1910.1030 [↗](#)), including proper disposal of regulated waste, and PPE (29 CFR 1910.132 [↗](#)).

Additional Resources

- OSHA COVID-19 Website [↗](#)
- CDC Home Care Guidance
- CDC COVID-19 Environmental Cleaning and Disinfection Guidance for Households
- CDC Home Care Guidance for People with Pets

Page last reviewed: April 1, 2020

Content source: National Center for Immunization and Respiratory Diseases (NCIRD), Division of Viral Diseases

An official website of the United States government.

We've made some changes to EPA.gov. If the information you are looking for is not here, you may be able to find it on the EPA Web Archive or the January 19, 2017 Web Snapshot.

Close



List N: Disinfectants for Use Against SARS-CoV-2

Other COVID-19 Resources

- [EPA's Coronavirus Site](#)
- [CDC's Coronavirus Disease 2019 Site](#)
- [CDC's Cleaning and Disinfection Recommendations for COVID-19](#)
- [NPIC's COVID-19 Virus Factsheet](#)

All products on this list meet EPA's criteria for use against SARS-CoV-2, the virus that causes COVID-19.

Finding a Product

The easiest way to find a product on this list is to enter **the first two sets of its EPA registration number** into the search bar below.

For example, if EPA Reg. No. 12345-12 is on List N, you can buy EPA Reg. No. 12345-12-2567 and know you're getting an equivalent product. You can find this number by looking for the EPA Reg. No. on the product label.

Using Other Products

If you can't find a product on this list to use against SARS-CoV-2, look at a different product's label to confirm it has an EPA registration number and that human coronavirus is listed as a target pathogen.

Follow the Label

When using an EPA-registered disinfectant, **follow the label directions** for safe, effective use. Make sure to follow the contact time, which is the amount of time the surface should be visibly wet, listed in the table below.

These products are for use on surfaces, not humans.

Additional Resources

- [Still have questions? See our FAQs about this list.](#)
- [My company has a product it would like included on this list](#)

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

List N was last updated on April 2, 2020.

Search:

[Export to PDF](#)

Show entries

List N: Products with Emerging Viral Pathogens AND Human Coronavirus claims for use against SARS-CoV-2

EPA Registration Number	Active Ingredient (s)	Product Name	Company	Follow the disinfection directions and preparation for the following virus	Contact Time (in minutes)	Formulation Type	Surface Types for Use	Use Site	Emerging Viral Pathogen Claim?
84683-3	Thymol	Benefect Botanical Daily Cleaner Disinfectant Spray	Cleanwell LLC	Rhinovirus	10	RTU	Hard nonporous	Healthcare; Institutional; Residential	Yes

<u>EPA Registration Number</u>	<u>Active Ingredient (s)</u>	<u>Product Name</u>	<u>Company</u>	<u>Follow the disinfection directions and preparation for the following virus</u>	<u>Contact Time (in minutes)</u>	<u>Formulation Type</u>	<u>Surface Types for Use</u>	<u>Use Site</u>	<u>Emerging Viral Pathogen Claim?</u>
88897-2	Quaternary ammonium; Isopropanol; Ethanol	Panther Disinfectant	Maxill Inc	Adenovirus; Feline calicivirus	3	RTU	Hard nonporous	Healthcare; Institutional	Yes
42048-4	L-Lactic Acid	Sani-Cide EX3 (10X) RTU	Celeste Industries Corp	Feline calicivirus	10	RTU	Hard nonporous	Institutional	Yes
66171-7	Quaternary ammonium; Glutaraldehyde	Synergize	Preserve International	Feline calicivirus	10	Dilutable	Hard nonporous	Institutional	Yes
85837-4	Hydrogen peroxide	Proxi Home General Disinfectant Cleaner Spray	Innovasource LLC	Rhinovirus	10	RTU	Hard nonporous	Healthcare; Institutional; Residential	Yes
498-179	Quaternary ammonium; Ethanol	Champion Sprayon Spray Disinfectant Formula 3	Chase Products Co	Rhinovirus	10	RTU	Hard nonporous	Healthcare; Institutional; Residential	Yes
1839-236	Quaternary ammonium	SC-5:128N	Stepan Company	Rotavirus	5	Dilutable	Hard nonporous	Healthcare; Institutional; Residential	Yes
70385-6	Quaternary ammonium	QGC	Prorestore Products	Feline calicivirus	10	Dilutable	Hard nonporous	Healthcare; Institutional; Residential	Yes
1043-87	Phenolic	Vesphene II se	Steris Corporation	Adenovirus	10	Dilutable	Hard nonporous	Healthcare; Institutional	Yes
1043-91	Phenolic	LpH®	Steris Corporation	Adenovirus	10	Dilutable	Hard nonporous	Institutional	Yes
1839-100	Quaternary ammonium	Veterinarian Type Disinfectant	Stepan Company	Feline calicivirus; norovirus	10	Dilutable	Hard nonporous	Residential	Yes
4091-20	Quaternary ammonium	Phoenix 2	W.M. Barr & Company Inc	Rotavirus; Feline calicivirus; Rhinovirus	5	RTU	Hard nonporous	Healthcare; Institutional; Residential	Yes
44446-67	Phenolic; Ethanol	Concept Hospital Disinfectant Deodorant	Quest Specialty Corp	Rhinovirus; Canine hepatitis virus	10	RTU	Hard nonporous	Healthcare; Institutional; Residential	Yes
45745-11	Hydrogen peroxide	HP2O2	Midlab	Rotavirus; Norovirus; Rhinovirus	5	Dilutable	Hard nonporous	Healthcare; Institutional	Yes
56392-8	Sodium hypochlorite	Dispatch	Clorox Professional Products Company	Adenovirus	1	Towelette	Hard nonporous	Healthcare; Institutional; Residential	Yes
65402-9	Peroxyacetic acid; Hydrogen Peroxide	VigorOx 15/10 Antimicrobial Agent	PeroxyChem LLC	Feline calicivirus	5	Dilutable	Hard nonporous	Healthcare; Institutional	Yes
67619-40	Sodium hypochlorite	TNT	Clorox Professional Products Company	Murine norovirus	1	RTU	Hard nonporous	Healthcare; Institutional; Residential	Yes
70060-19	Sodium chlorite; Sodium dischloroisocyanurate dihydrate	Aseptrol S10-Tab	BASF Corporation	Feline calicivirus	10	Solid	Hard nonporous	Healthcare; Institutional; Residential	Yes

<u>EPA Registration Number</u>	<u>Active Ingredient (s)</u>	<u>Product Name</u>	<u>Company</u>	<u>Follow the disinfection directions and preparation for the following virus</u>	<u>Contact Time (in minutes)</u>	<u>Formulation Type</u>	<u>Surface Types for Use</u>	<u>Use Site</u>	<u>Emerging Viral Pathogen Claim?</u>
70144-4	Quaternary ammonium; Ethanol	Opti-cide Max Wipes	Micro-Scientific LLC	Rotavirus	1	Wipe	Hard nonporous	Healthcare; Institutional; Residential	Yes
70271-13	Sodium hypochlorite	Pure Bright Germicidal Ultra Bleach	KIK International LLC	Adenovirus; Rotavirus; Canine parvovirus; Feline panleukopenia virus; Hepatitis A virus; Norovirus; Poliovirus; Rhinovirus	5	Dilutable	Hard nonporous	Healthcare; Institutional; Residential	Yes
70271-31	Sodium hypochlorite	Nova	KIK International LLC	Rhinovirus	10	Dilutable	Hard nonporous	Healthcare; Institutional; Residential	Yes
777-131	Hypochlorous acid	Cousteau	Reckitt Benckiser	Rhinovirus	10	RTU	Hard nonporous	Healthcare; Institutional; Residential	Yes
82972-1	Chlorine dioxide; Quaternary ammonium	Vital Oxide	Vital Solutions LLC	Adenovirus; Canine parvovirus	10	RTU	Hard nonporous	Healthcare; Institutional; Residential	Yes
84198-1	Hydrogen peroxide	Peroxy HDOX	Earth Laboratories Inc	Norovirus	5	Dilutable	Hard nonporous	Healthcare; Institutional	Yes
84683-4	Thymol	Benefect Botanical Daily Cleaner Disinfectant Towelette	Cleanwell LLC	Rhinovirus	10	Wipe	Hard nonporous	Healthcare; Institutional; Residential	Yes

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LAST UPDATED ON APRIL 2, 2020

From: [Berg, Peter B](#)
To: [REDACTED]
Cc: [REDACTED]
Subject: Updated Guidance: COVID-19 Detained Docket Review-- Effective Immediately
Date: Saturday, April 4, 2020 5:17:40 PM

UPDATE: Please see the updated guidance below. The previous version of this guidance is rescinded.

This message is sent from Peter B. Berg, (a)Assistant Director, Field Operations

To: Field Office Directors and Deputy Field Office Directors
Subject: COVID-19 Detained Docket Review

Background:

U.S. Immigration and Customs Enforcement (ICE) has taken a number of significant and proactive measures in response to the Coronavirus Disease 2019 (COVID-19) pandemic, in order to mitigate the spread of COVID-19 to aliens detained in its custody, its workforce, and stakeholders at its detention facilities. As more becomes known about the virus, ERO will continue to update its practices and guidance in this regard. General ICE COVID-19 guidance is available [here](#) and will be updated and supplemented on an ongoing basis.

On March 18, 2020, you were directed to review the cases of aliens detained in your area of responsibility who were over the age of 70 or pregnant to determine whether continued detention was appropriate. The Centers for Disease Control and Prevention (CDC) has developed a [list](#) of categories of individuals identified as potentially being at higher-risk for serious illness from COVID-19. Expanding on that list, ERO has identified the following categories of cases that should be reviewed to re-assess custody:

- Pregnant detainees or those having delivered in the last two weeks
- Detainees over 60 years old
- Detainees of any age having chronic illnesses which would make them immune-compromised, including but not limited to:
 - Blood Disorders
 - Chronic Kidney Disease
 - Compromised immune system (e.g., ongoing treatment such as chemotherapy or radiation, received an organ or bone marrow transplant, taking high doses of corticosteroids or other immunosuppressant medications)
 - Endocrine disorders

- Metabolic disorders
- Heart disease
- Lung disease
- Neurological and neurologic and neurodevelopment conditions

As part of your ongoing application of the CDC's Interim Guidance on Management of Coronavirus Disease 2019 (COVID-19) in Correctional and Detention Facilities (available [here](#)), please identify all cases within your AOR that meet any of the criteria above and validate that list with assistance from IHSC or your Field Medical Coordinator to ensure the conditions listed are still present and do result in the detainee potentially having a higher risk for serious illness from COVID-19. After identifying a case as meeting any of the above criteria, you should review the case to determine whether continued detention remains appropriate in light of the COVID-19 pandemic.

The presence of one of the factors listed above should be considered a significant discretionary factor weighing in favor of release. To be clear, however, it may not always be determinative. Field offices must remain cognizant of the requirements of mandatory detention. Section 236(c) of the Immigration and Nationality Act (INA) mandates the detention of certain categories of criminal and terrorist aliens during the pendency of removal proceedings. Such aliens may not be released in the exercise of discretion during the pendency of removal proceedings even if potentially higher-risk for serious illness from COVID-19. INA § 236(c); 8 C.F.R. § 236.1(c)(1)(i). Such aliens may only be released following a final order issued by an immigration judge, the Board of Immigration Appeals, or a federal court granting the alien relief, dismissing proceedings, or terminating proceedings. Similarly, pursuant to section 241(a)(2), certain criminal and terrorist aliens subject to a final order of removal may not be released during the 90-day removal period even if potentially higher-risk for serious illness from COVID-19. INA § 241(a)(2). For alien's subject to discretionary detention under section 236(a), please remember that release is prohibited, even if the alien is potentially higher-risk for serious illness from COVID-19, if such release would pose a danger to property or persons. 8 C.F.R. § 236.1(c)(8).

When reviewing cases of alien's subject to discretionary detention under 236(a), the following must be completed:

- **Cases involving any arrests or convictions for any crimes that involve risk to the public regardless of the date of arrest or conviction must be reviewed and approved by a Deputy Field Office Director (DFOD) or higher before a determination is made to release.**
 - Examples of crimes that involve a risk to the public include any crime that: involves any form of violence, driving while intoxicated, threatening behaviors, terroristic threats, stalking, domestic violence, harm to a child, or any form of assault or battery. This list is not intended to be

comprehensive. If there is any doubt whether a crime involves risk to the public, consult with your Office of the Principal Legal Advisor (OPLA) field location and your respective Deputy Assistant Director for Domestic Operations before a custody redetermination is completed.

- You may consider the age of an arrest or conviction as a mitigating or an aggravating factor, but the age of an arrest or a conviction does not automatically outweigh public safety concerns.

With regard to arriving aliens and certain other aliens eligible for consideration of parole from custody, under current circumstances and absent significant adverse factors, the fact that an alien is potentially higher-risk for serious illness from COVID-19, may form the basis for a determination that “continued detention is not in the public interest,” justify release under 8 C.F.R. § 212.5(b) (5).

For other aliens for whom there is discretion to release, field offices remain responsible for articulating individualized custody determinations, taking into consideration the totality of the circumstances presented in the case. The fact that an alien is potentially higher-risk for serious illness from COVID-19 should be considered a factor weighing in favor of release. You may also consider alternatives to detention consistent with ICE ATD policies, if ATD is determined to sufficiently mitigate the risk of flight.

Any releases attributed to reviews of COVID-19 susceptibility shall be documented in the ENFORCE Alien Removal Module (EARM) under Special Class - COVID-19 Chronic Care Release. As previously communicated, these individuals should be placed on ATD if possible.

Please contact your local OPLA field location should you have any questions or concerns regarding your authority to release in any individual case.

For any questions on this guidance, please contact your respective Deputy Assistant Director for Domestic Operations.

Limitation on the Applicability of this Guidance. This message is intended to provide internal guidance to the operational components of U.S. Immigration and Customs Enforcement. It does not, is not intended to, shall not be construed to, and may not be relied upon to create any rights, substantive or procedural, enforceable at law by any person in any matter, civil or criminal.

From: Office of the Executive Associate Director for ERO
Sent: Tue, 24 Mar 2020 21:41:56 +0000
To: Undisclosed recipients:
Subject: CDC Interim Guidance on Management of COVID-19 for Correctional and Detention Facilities [FO]



Enforcement and Removal Operations Office of the Executive Associate Director

To: All ERO Personnel

In our continued efforts to provide the ERO workforce the most current and relevant information regarding COVID-19, I would like to share [Interim Guidance on Management of COVID-19 for Correctional and Detention Facilities](#) from the Centers for Disease Control and Prevention (CDC).

Please keep in mind that this situation is fluid and we will continue to share information as it becomes available. Your health is paramount; remain vigilant and stay safe.

Enrique M. Lucero
Executive Associate Director
Enforcement and Removal Operations

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From: ERO Assistant Directors
Sent: Sat, 21 Mar 2020 20:25:26 +0000
To: Undisclosed recipients:
Subject: COVID-19 Response Plan and Best Practices [CMD]
Attachments: COVID-19 Response Plan Facility Memorandum.pdf, ICE Guidance For Detention Facilities.docx



Enforcement and Removal Operations Assistant Director for Custody Management

To: Field Office Directors and Deputy Field Office Directors

The combination of a dense and highly transient detained population places ICE facilities at a higher risk of infection and transmission. To ensure a unified preventative response to COVID-19, the ICE Office Enforcement and Removal Operations (ERO), ICE Health Service Corps (IHSC), Custody Management Division, and Field Operations are providing the attached guidance which includes both a Facility Response Plan and Best Practices for Detention Facilities in managing COVID-19. These measures were developed to reduce exposure, protect the detained population, and ensure staff remain healthy and available for duty. Please share with your stakeholders as appropriate.

(b)(6); (b)(7)(C)

Acting ERO Assistant Director, Custody Management

This message was sent in concurrence with AD Field Operations.

This message expires one year from the date it was sent, pursuant to ERO policy.

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U.S. Immigration
and Customs
Enforcement

March 20, 2020

MEMORANDUM FOR: Detention Wardens and Superintendents

THROUGH: Field Office Directors

FROM: Enrique M. Lucero (b)(6); (b)(7)(C)
Executive Associate Director
Enforcement and Removal Operations

SUBJECT: Memorandum on Novel Coronavirus (COVID-19) Action Plan

Background:

U.S. Immigration and Customs Enforcement (ICE) is monitoring the increase of the Novel (new) Coronavirus (COVID-19) and continues to work in conjunction with select Component leaders and the Acting Secretary to implement a mitigation strategy.

To ensure a unified preventative response, the ICE Enforcement and Removal Operations (ERO), ICE Health Service Corps (IHSC), Custody Management Division, and Field Operations are providing the following guidance. The combination of a dense and highly transient detained population places ICE facilities at a higher risk of infection and transmission. Consequently, these measures were developed to reduce exposure to COVID-19, protect the detained population, and ensure staff remain healthy and available for duty.

This memorandum only applies to ICE-dedicated facilities. For intergovernmental partners and non-dedicated facilities, ICE defers to local, state, tribal, territorial, and federal public health policies and authorities, including adherence with state laws on communicable disease reporting. Questions and concerns related to the following Action Plan can be addressed to:

(b)(6); (b)(7)(C) @ice.dhs.gov.

Action Plan:

STAFF HIRING: Wardens and facility staff should continue to meet any personnel staffing plan and staffing criteria outlined in the Performance Work Statement (PWS) and terms and conditions of their negotiated contract or agreement for medical staff and guard services. Facilities are expected to be appropriately staffed to meet established work schedules, contact and work relief, rest periods, and starting and stopping work, to include ensuring the delivery of detainee medical and mental health care as it relates to the continually evolving impact of COVID-19.

LOGISTICS: Wardens and Facility Administrators should assess their inventories of food, medicines, cleaning supplies, personal protective equipment (PPE), and facility operational practices to have sufficient services and supplies at all times to assure the safety, security, health, and wellbeing of ICE detainees. Facilities should have updated pandemic plans and policies and have established quarantine and/or isolation areas within their facilities in case they are needed.

SOCIAL VISITATION: As of March 13, 2020, social visits to/with ICE detainees at all detention facilities are suspended until further notice in order to mitigate the potential transmission of COVID-19. ICE recognizes the considerable impact of suspending personal visitation, and requests service providers that currently offer teleconferencing, video visitation (e.g., Skype, Facetime), email and/or tablets to detainees, increase use of these communication services, with extended hours where possible.

Detention facilities should make a timely effort to identify indigence in the detainee population to ensure indigent detainees are afforded the same telephone access and telephone-related privileges as other detainees. A detainee is considered “indigent” if he/she has less than \$15.00 in his/her account for 10 days. Each facility must ensure all detainees are able to make calls to the ICE-provided list of free legal service providers and consulate at no charge to the detainee or the receiving party, and that indigent detainees may request a call to immediate family or others in personal or family emergencies or on an as-needed basis to maintain community ties.

LEGAL VISITS: Detainee access to legal counsel remains a paramount requirement and should be accommodated to the maximum extent practicable. Unless and until it is determined to pose a risk to the safety and security of the facility, legal visitation will continue.

Non-contact legal visitation (e.g., Skype or teleconference) should be offered first to limit exposure to ICE detainees, but if the attorney believes the legal visit requires contact, the facility should permit the visit. For in-person visits to occur, the attorney must undergo screening using the same procedures as staff. ICE will require all legal visitors to provide and wear PPE (e.g., gloves, N-95 masks, and eye protection) while visiting any facility. Visitors may also be required to go through similar testing as employees of the detention facility. The overall authority to approve legal visits lies with the Warden or Facility Administrator; however, the facility should notify its local Field Office Director as soon as possible of any denied legal visits.

LEGAL RIGHTS GROUP PRESENTATIONS: Government-sponsored Legal Orientation Programs (LOPs) carried out by the Department of Justice Executive Office of Immigration Review (EOIR) and authorized by congressional appropriations currently operate at a limited number of detention sites and may continue to make presentations to detainees. No more than four LOP presenters may be allowed in the facility at any time and they will need to undergo screening using the same procedures as staff. ICE will require all legal visitors to provide and wear PPE (e.g., gloves, N-95 masks, and eye protection) while visiting any facility. Non-LOP legal rights group presentations offered by volunteers are suspended until further notice.

STAFF-DETAINEE COMMUNICATION VISITS: Detainees should continue to have frequent opportunities for informal contact with facility managerial and supervisory staff and

with ERO field office staff. Regular communication is particularly important at a time when feelings of fear and confusion are experienced by many detainees.

Field Office Directors should monitor that both facility staff and ERO officers continue to interact with detainees. ICE staff-detainee communication may be conducted in-person (with appropriate PPE to protect ERO officers, detainees, and facility staff) or through non-contact visitation using videoconferencing, phone calls, e-mail, or other communication services.

ICE staff-detainee communication contact visits to remotely located detention facilities requiring ERO officers to fly or take public transportation as part of the route are suspended until further notice. Essential services include, for example, medical and mental health services, telephone access, cleaning, laundry, waste disposal, and critical infrastructure repairs.

CONTRACTORS: Contractors performing essential services or maintenance on essential systems in ICE detention facilities must continue to be provided facility access, and should be screened prior to entry by the same screening procedures used for staff. Examples of essential services include medical and mental health services, telephone access, cleaning, laundry, waste disposal, and critical infrastructure repairs.

Facility annual inspections by the ICE inspections contractor, The Nakamoto Group, are suspended for 30 days from the issuance date of this memorandum.

VOLUNTEERS: Volunteer visits to ICE detention facilities are suspended until further notice unless approved by the Assistant Directors for Field Operations and Custody Management. The exception to this suspension is the Chaplain who, if a volunteer, should continue to be available to provide pastoral care and counseling to detainees who request it, both through group programs and individual services. To conduct counseling or in-person services, the Chaplain must undergo screening using the same procedures as staff. Other volunteers, contractors, and community groups that augment and enhance the religious program are suspended until further notice to reduce the risk of possible transmission of COVID-19 to detainees.

TOURS: Facility tours are suspended until further notice, excluding Members of Congress, Congressional Member Delegations (CODELs), and Congressional Staff Delegations Delegations (STAFFDELS) who will not be prevented from accessing facilities for the purpose of conducting oversight. To safeguard visitors, detainees, ICE and facility staff, congressional visitors may be subject to special screening procedures, including undergoing testing similar to that administered to facility employees. Congressional visitors may also be required to wear protective equipment and should be advised of standard hygiene practices to help prevent the spread of disease (i.e., washing hands and avoiding close contact) and should be made aware of available washrooms within the facility.

STAFF TRAINING: All ERO in-person staff training related to the ICE detention standards or facility compliance is suspended until further notice, to include conferences, Contracting Officer Representative (COR) training, and Field Office Compliance Training.

Wardens and Facility Administrators will determine the training schedule for facility staff.

All staff licenses and certifications are required to be up to date.

SCREENING OF FACILITY STAFF: Enhanced health screening of both ICE and facility staff should be implemented by ICE detention facilities in areas with “sustained community transmission.” “Sustained community transmission” is determined by the Centers for Disease Control and Prevention (CDC) and information is available on [this resource page](https://www.cdc.gov/coronavirus/2019-ncov/cases-in-us.html): <https://www.cdc.gov/coronavirus/2019-ncov/cases-in-us.html>. Such screening includes self-reporting and temperature checks.

Wardens and Facility Administrators in those areas should work with their Health Services Administrator to designate a qualified health care professional to be available on all shifts to administer and record temperature checks. The health care professionals should take care to protect the privacy of each person being screened. Employees performing the screening must have appropriate PPE, to include the N-95 respirator, face shield/goggles, gloves, and a gown.

Given the public health emergency, staff who refuse the enhanced health screening should be denied entry to the facility. If staff register an oral temperature of greater than or equal to 100.4 degrees (Fahrenheit), they should be denied entry to the facility and placed on Weather and Safety leave.

DETAINEE SCREENING: IHSC developed guidance for IHSC-staffed facilities to help in the risk assessment and management of detained individuals with potential exposure to COVID-19, and this guidance was disseminated to ICE detention facilities for possible adoption at their sites. Version 6.0, issued March 6, 2020, addresses intake medical screenings, monitoring, encounters, laboratory testing, and public health actions. The CDC remains the authoritative source for information about how to protect individuals and reduce exposure to the virus. ICE continues to encourage facilities to follow CDC guidelines as well as those of their state and local health departments.

ICE requests that Wardens and Facility Administrators ensure ICE detainees are given guidance and educated in a language that they fully understand on basic hygiene measures to keep themselves healthy. Links for detainee/patient education resources in multiple languages are included in the IHSC guidance and information on the CDC website.

MODIFIED OPERATIONS: Wardens and Facility Administrators should implement modified operations to maximize social distancing in our facilities, as much as practicable. For example, Wardens and Facility Administrators should consider staggered mealtimes and staggered recreation times in order to limit congregate gatherings.

Any community service projects should also be suspended until further notice. Anyone entering the facility should be advised of standard hygiene practices to help prevent the spread of disease (i.e., washing hands and avoiding close contact) and should be made aware of available washrooms within the facility.

Anyone seeking to enter an ICE detention facility should be subject to additional, enhanced screening procedures.

If this guidance creates any contractual issues, please reach out to your respective Contracting Officer.



U.S. Immigration and Customs Enforcement

for Detention Facilities

Detention facilities are complex, multi-employer settings that include government and private employers. Each is organizationally distinct and responsible for its own operational, personnel, and occupational health protocols and may be prohibited from issuing guidance or providing services to other employers or their staff within the same setting. In addition, detention facilities may house individuals from multiple law enforcement agencies or jurisdictions with differing policies and procedures.

There are many opportunities for COVID-19 to be introduced into a detention facility, including daily staff ingress and egress; transfer of detained persons between facilities and systems, to court appearances, and outside medical visits; and visits from family, legal counsel, and other community members. Some settings, particularly jails and detention centers, have high turnover, admitting new entrants daily who may have been exposed to COVID-19 in the surrounding community.

Symptoms of COVID-19 include fever, cough, and shortness of breath. Like other lower respiratory infections, COVID-19 can vary in severity from mild to severe. When severe, pneumonia, respiratory failure, and even death are possible. COVID-19 is a novel disease, therefore the full range of signs and symptoms, the clinical course of the disease, and the individuals and populations most at risk for disease and complications are not yet fully understood. Monitor the **CDC website** for updates on these topics.

The following serves as guidelines or best practices that all detention facilities should follow and focus on preparedness, prevention, and management.

Preparedness. This guidance is intended to help facilities prepare for COVID-19 transmission in the facility and focus on operational and communications planning, reinforcing hygiene practices, intensifying cleaning and disinfection of the facility, and monitoring for potential cases.

1) Develop information-sharing systems with partners.

- Identify points of contact in relevant state, local, tribal, and/or territorial public health department before cases develop.
- Communicate with other correctional and detention facilities in the same geographic area to share information including disease surveillance and absenteeism patterns among staff.

2) Review existing pandemic flu, all-hazards, and disaster plans, and revise for COVID-19.

- Ensure that physical locations (dedicated housing areas and bathrooms) have been identified to isolate confirmed COVID-19 cases and individuals displaying COVID-19 symptoms, and to quarantine known close contacts of confirmed cases.



U.S. Immigration and Customs Enforcement : for Detention Facilities

(Isolation and quarantine locations should be separate.) The plan should include contingencies for multiple locations if numerous cases and/or contacts are identified and require isolation or quarantine simultaneously.

- Facilities without onsite healthcare capacity should plan for how they will ensure that suspected COVID-19 cases will be isolated, evaluated, tested (if indicated), and provided necessary medical care.

3) Offer the seasonal influenza vaccine to all detained persons (existing population and new intakes) and staff throughout the influenza season.

4) Staffing:

- Review sick leave policies to ensure that staff can stay home when sick and determine which officials will have the authority to send symptomatic staff home. Staff who report for work with symptoms of COVID-19 should be sent home and advised to follow [CDC-recommended steps for persons who are ill with COVID-19 symptoms](#).
- Staff who test positive for COVID-19 should inform their workplace and personal contacts immediately. If a staff member has a confirmed COVID-19 infection, the relevant employers should inform other staff of their possible exposure to COVID-19 in the workplace but maintain confidentiality as required by the Americans with Disabilities Act (ADA). Exposed employees should then self-monitor for [symptoms](#) (i.e., fever, cough, or shortness of breath).
- Identify staff whose duties would allow them to work from home. This is an effective social distancing strategy to reduce the risk of COVID-19 transmission.
- Determine minimum levels of staff in all categories required for the facility to function safely.

5) Supplies: Ensure that sufficient stocks of hygiene supplies (soap, hand sanitizer, tissues), personal protective equipment (PPE) (to include facemasks, N95 respirators, eye protection, disposable medical gloves, and disposable gowns/one-piece coveralls), and medical supplies (consistent with the healthcare capabilities of the facility) are on hand, and have a plan in place to restock as needed if COVID-19 transmission occurs within the facility.

- Note that shortages of N95 respirators are anticipated during the COVID-19 response. Based on local and regional situational analysis of PPE supplies, face masks should be used when the supply chain of respirators cannot meet the demand.



U.S. Immigration and Customs Enforcement : for Detention Facilities

- Soiled PPE items should be disposed in leak-proof plastic bags that are tied at the top and not re-opened. Bags can be disposed of in the regular solid waste stream.

6) **Cleaning/Disinfecting Practices:** Adhere to CDC recommendations for cleaning and disinfection during the COVID-19 response.

- Several times a day using household cleaners and EPA-registered disinfectants, clean and disinfect surfaces and objects that are frequently touched, especially in common areas (e.g., doorknobs, light switches, sink handles, countertops, toilets, toilet handles, recreation equipment).
- Staff should clean shared equipment several times per day and on a conclusion of use basis (e.g., radios, service weapons, keys, handcuffs).
- Ensure that transport vehicles are thoroughly cleaned after carrying a confirmed or suspected COVID-19 case.

7) **Hygiene:** Reinforce healthy hygiene practices and provide and restock (as feasible) hygiene supplies throughout the facility, including in bathrooms, food preparation and dining areas, intake areas, visitor entries and exits, visitation rooms, common areas, medical, and staff-restricted areas (e.g., break rooms).

- Encourage all persons within the facility to cover their mouth and nose with their elbow (or ideally with a tissue) rather than with their hand when they cough or sneeze, and to throw all tissues in the trash immediately after use. Provide detained persons and staff no-cost access to tissues, and no-touch receptacles for disposal.
- Encourage all persons within the facility to maintain good hand hygiene by regularly washing their hands with soap and water for at least 20 seconds, especially after coughing, sneezing, or blowing their nose; after using the bathroom; before eating or preparing food; before taking medication; and after touching garbage.
- Provide detained persons and staff no-cost, unlimited access to supplies for hand cleansing, including liquid soap, running water, hand drying machines or disposable paper towels, and no-touch trash receptacles.
- Provide alcohol-based hand sanitizer with at least 60% alcohol where permissible based on security restrictions.
- Encourage all persons within the facility to avoid touching their eyes, nose, or mouth without cleaning their hands first.



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- Post signage throughout the facility reminding detained persons and staff to practice good hand hygiene and cough etiquette (printable materials for community-based settings can be found on the [CDC website](#)).
- Discourage sharing of eating utensils, dishes, and cups.
- Discourage non-essential personal contact such as handshakes, hugs, and high-fives.

Prevention. This guidance is intended to help facilities prevent spread of COVID-19 from outside the facility to inside. Social distancing is critical by increasing the space between individuals and decrease the frequency of contact to reduce the risk of spreading a disease. Additional information about social distancing, including information on its use to reduce the spread of other viral illnesses, is available in this [CDC publication](#).

1) Perform pre-intake screening for all new entrants for symptoms of COVID-19.

Ideally, screening should take place before new intakes enter the facility or just inside the facility, before beginning the intake process, in order to identify and immediately isolate any individuals with symptoms. This includes temperature screening of all new entrants.

- **If an individual has symptoms of COVID-19** (fever, cough, shortness of breath):
 - Require the individual to wear a face mask.
 - Ensure that staff interacting with the symptomatic individual at a distance of <6 feet wear recommended PPE.
 - Isolate the individual and refer to healthcare staff for further evaluation.
 - Facilities without onsite healthcare staff should contact their state, local, tribal, and/or territorial health department to coordinate effective isolation and necessary medical care.
- **If an individual is a close contact of a known COVID-19 case or has traveled to an affected area (but has no COVID-19 symptoms):**
 - Quarantine the individual and monitor for symptoms two times per day for 14 days.

2) Visitations:

- Suspend or modify visitation programs, if legally permissible, and provide access to virtual visitation options where available. If suspension of visitations is not



U.S. Immigration and Customs Enforcement : for Detention Facilities

possible, verbally screen all visitors and volunteers on entry for symptoms of COVID-19 and perform temperature checks.

- Communicate with the public about any changes to facility operations, including visitation programs. Most facilities should have restricted or prohibited visitation programs.

3) Restrict transfers of detained persons to and from other jurisdictions and facilities unless necessary for medical evaluation, isolation/quarantine, clinical care, or extenuating security concerns.

4) Implement virtual court appearances where permissible.

5) Consider social distancing options to increase the physical space between detained persons and to limit interactions in large group settings. Strategies will need to be tailored to the individual space in the facility and the needs of the population and staff. Not all strategies will be feasible in all facilities. Example strategies with varying levels of intensity include:

- Enforce increased space between individuals in holding cells, as well as in lines and waiting spaces
- Stagger time in recreation spaces
- Stagger meals, and rearrange seating in the dining hall so that there is more space between individuals
- Limit the size of group activities
- Increase space between individuals during group activities
- If space allows, reassign bunks to provide more space between individuals, ideally ≥ 6 feet in all directions. (Ensure that bunks are cleaned thoroughly if assigned to a new occupant.)
- Arrange bunks so that detained persons sleep head to foot to increase distance.
- Suspend group programs where participants are likely to be in close contact.
- Rearrange scheduled movements to minimize mixing of individuals from different housing areas.
- Provide meals inside housing units.
- Restrict recreation space usage to a single housing unit per space (where feasible).



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- If possible, designate a room near each housing unit to evaluate sick individuals rather than having them walk through the facility to be evaluated in the medical unit. If this is not feasible, consider staggering sick call.

- 6) Consider suspending work release programs.
- 7) When feasible and consistent with security priorities, encourage staff to maintain a distance of 6 feet from an individual with respiratory symptoms while interviewing, escorting, or interacting in other ways.

Management. This guidance is intended to help facilities clinically manage confirmed and suspected COVID-19 cases and their close contacts inside the facility and prevent further transmission.

- 1) Suspend all transfers of detained persons to and from other jurisdictions and facilities (including work release), unless necessary for medical evaluation, isolation/quarantine, care, or extenuating security concerns.
- 2) Consider quarantining all new entrants for 14 days before they enter the general population.
 - For suspected or confirmed COVID-19 cases:
 - Ensure that the individual is wearing a face mask at all times when outside of the isolation space, and whenever another individual enters the isolation room. Masks should be changed at least daily, and when visibly soiled or wet.
 - Isolate the individual immediately in a separate environment from other individuals. Facilities should make every possible effort to isolate persons individually. Each isolated individual should be assigned their own housing space and bathroom where possible. Cohorting should only be practiced if there are no other available options. **Only individuals who are laboratory confirmed COVID-19 cases should be isolated as a cohort. Do not cohort confirmed cases with suspected cases or case contacts.**
- 3) If the number of confirmed cases exceeds the number of individual isolation spaces available in the facility, be especially mindful of cases who are at higher risk of severe illness from COVID-19. Ideally, they should not be cohorted with other infected individuals. If cohorting is unavoidable, make all possible accommodations to prevent transmission of other infectious diseases to the higher-risk individual. (For example, allocate more space for a higher-risk individual within a shared isolation room.)
- 4) Custody staff should be designated to monitor these individuals exclusively where possible. These staff should wear recommended PPE when interacting with infected individuals and should limit their movement between different parts of the facility to the extent possible.



U.S. Immigration and Customs Enforcement

for Detention Facilities

5) Maintain isolation until all the following criteria have been met:

- The individual has been free from fever for 72 hours without the use of fever-reducing medications
- The individual's other symptoms have improved (e.g., cough, shortness of breath)
- The individual has tested negative in at least two consecutive respiratory specimens collected at least 24 hours apart
- At least 7 days have passed since the date of the individual's first positive COVID-19 test and has had no subsequent illness.

6) Thoroughly clean and disinfect all areas where the infected individual spent time. (e.g., cells, bathrooms, and common areas) used by the infected individual, focusing especially on frequently touched surfaces. A list of products that are EPA-approved for use against the virus that causes COVID-19 is available [here](#). Follow the manufacturer's instructions for all cleaning and disinfection products (e.g., concentration, application method and contact time, etc.).

7) Meals should be provided to COVID-19 cases in their isolation rooms. Isolated cases should throw disposable food service items in the trash in their isolation room. Non-disposable food service items should be handled with gloves and washed with hot water or in a dishwasher. Individuals handling used food service items should clean their hands after removing gloves.

8) Laundry from a COVID-19 case can be washed with other individuals' laundry.

- Individuals handling laundry from COVID-19 cases should wear disposable gloves, discard after each use, and clean their hands after.
- Do not shake dirty laundry. This will minimize the possibility of dispersing virus through the air.

From: Office of the Executive Associate Director for ERO
Sent: Fri, 10 Apr 2020 21:30:58 +0000
To: Undisclosed recipients:
Subject: ICE Detention Facilities COVID-19 Response Requirements [FO]
Attachments: ERO COVID-19 Response Requirements for Facilities 4.10.20.pdf



Enforcement and Removal Operations Office of the Executive Associate Director

To: Field Office Directors and Deputy Field Office Directors

The attached U.S. Immigration and Customs Enforcement (ICE) Enforcement and Removal Operations (ERO) Coronavirus Disease 2019 (COVID-19) Pandemic Response Requirements (PRR) sets forth expectations and assists ICE detention facility operators to sustain detention operations, while mitigating risk to the safety and well-being of detainees, staff, contractors, visitors, and stakeholders due to COVID-19.

These requirements must immediately be distributed to all detention facilities within your area of responsibility. Once distributed, please provide email confirmation to Mission Support Specialist (b)(6); (b)(7)(C) at (b)(6); (b)(7)(C), by **5:00 pm EDT Monday, April 13, 2020.**

Tae D. Johnson
Deputy Executive Associate Director
Enforcement and Removal Operations

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ERO

U.S. Immigration and Customs Enforcement Enforcement and Removal Operations

COVID-19 Pandemic Response Requirements



**U.S. Immigration
and Customs
Enforcement**

AMERICAN
OVERSIGHT

ERO COVID-19 Pandemic Response Requirements (Version 1.0, April 10, 2020)

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PURPOSE AND SCOPE

The U.S. Immigration and Customs Enforcement (ICE) Enforcement and Removal Operations (ERO) Coronavirus Disease 2019 (COVID-19) Pandemic Response Requirements (PRR) sets forth expectations and assists ICE detention facility operators to sustain detention operations, while mitigating risk to the safety and well-being of detainees, staff, contractors, visitors, and stakeholders due to COVID-19. Consistent with ICE's overall adjustments to its immigration enforcement posture,¹ the ERO PRR builds upon previously issued guidance and sets forth specific mandatory requirements expected to be adopted by all detention facilities housing ICE detainees, as well as best practices for such facilities, to ensure that detainees are appropriately housed and that available mitigation measures are implemented during this unprecedented public health crisis. The ERO PRR has been developed in consultation with the Centers for Disease Control and Prevention (CDC) and is a dynamic document that will be updated as additional/revised information and best practices become available.

INTRODUCTION

As the CDC has explained:

COVID-19 is a communicable disease caused by a novel (new) coronavirus, SARS-CoV-2, that was first identified as the cause of an outbreak of respiratory illness that began in Wuhan Hubei Province, People's Republic of China (China).

COVID-19 appears to spread easily and sustainably within communities. The virus is thought to transfer primarily by person-to-person contact through respiratory droplets produced when an infected person coughs or sneezes; it may transfer through contact with surfaces or objects contaminated with these droplets. There is also evidence of asymptomatic transmission, in which an individual infected with COVID-19 is capable of spreading the virus to others before exhibiting symptoms. The ease of transmission presents a risk of a surge in hospitalizations for COVID-19, which would reduce available hospital capacity. Such a surge has been identified as a likely contributing factor to the high mortality rate for COVID-19 cases in Italy and China.

Symptoms include fever, cough, and shortness of breath, and typically appear 2-14 days after exposure. Manifestations of severe disease include severe pneumonia, acute respiratory distress syndrome (ARDS), septic shock, and multi-organ failure. According to the [World Health Organization], approximately 3.4% of reported COVID-19 cases have resulted in death globally. This mortality rate is higher among older adults or those with compromised immune systems. Older adults and people who have severe chronic medical conditions like heart, lung or kidney disease are also at higher risk for more serious COVID-19 illness. Early data suggest older people are twice as likely to have serious COVID-19 illness.

¹ See, e.g., Attachment A, U.S. Immigration and Customs Enforcement, *Updated ICE statement on COVID-19* (Mar. 18, 2020), <https://www.ice.gov/news/releases/updated-ice-statement-covid-19>.

Given the seriousness and pervasiveness of COVID-19, ICE is taking necessary and prompt measures in response. ICE is providing guidance on the minimum measures required for facilities housing ICE detainees to implement to ensure consistent practices throughout its detention operations and the provision of medical care across the full spectrum of detention facilities to mitigate the spread of COVID-19. The ICE detention standards applicable to all facilities used to house ICE detainees have long required that each such facility have written plans that address the management of infectious and communicable diseases, including, but not limited to, testing, isolation, prevention, treatment, and education. Those requirements include reporting and collaboration with local or state health departments in accordance with state and local laws and recommendations.² The measures set forth in the PRR, allow ICE personnel and detention providers to properly discharge their obligations under those standards in light of the unique challenges posed by COVID-19.

OBJECTIVES

The ERO PRR is designed to establish consistency across ICE detention facilities by establishing mandatory requirements and best practices all detention facilities housing ICE detainees are expected to follow during the COVID-19 pandemic. Consistent with ICE detention standards, all facilities housing ICE detainees are required to have a COVID-19 mitigation plan that meets the following four objectives:

- To protect employees, contractors, detainees, visitors to the facility, and stakeholders from exposure to the virus;
- To maintain essential functions and services at the facility throughout the pendency of the pandemic;
- To reduce movement and limit interaction of detainees with others outside their assigned housing units, as well as staff and others, and to promote social distancing within housing units; and
- To establish means to monitor, cohort, quarantine, and isolate the sick from the well.³

² See, e.g., Attachment B, ICE National Detention Standards 2019, Standard 4.3, Medical Care, at II.D.2 (p. 114), https://www.ice.gov/doclib/detention-standards/2019/4_3.pdf; Attachment C, 2011 ICE Performance-Based National Detention Standards (PBNDS), Revised 2016, Standard 4.3, Part V.C.1 (p. 261), <https://www.ice.gov/doclib/detention-standards/2011/4-3.pdf>; Attachment D, 2008 ICE PBNDS, Standard 4-22, Medical Care, V.C.1 (pp. 5-6), https://www.ice.gov/doclib/dro/detention-standards/pdf/medical_care.pdf.

³ A *cohort* is a group of persons with a similar condition grouped or housed together for observation over a period of time. Isolation and quarantine are public health practices used to protect the public from exposure to individuals who have or may have a contagious disease. For purposes of this document, and as defined by the CDC, *quarantine* as the separation of a person or group of people reasonably believed to have been exposed to a communicable disease but not yet symptomatic, from others who have not been exposed, to prevent the possible spread of the communicable disease. For purposes of this document, and as defined by the CDC, *isolation* as the separation of a person or group of people known or reasonably

CONCEPT OF OPERATIONS

The ERO PRR is intended for use across ICE's entire detention network, applying to all facilities housing ICE detainees, including ICE-owned Service Processing Centers, facilities operated by private vendors, and facilities operated by local government agencies that have mixed populations of which ICE detainees comprise only a small fraction.

DEDICATED ICE DETENTION FACILITIES

All ICE dedicated detention facilities⁴ must:

- Comply with the provisions of their relevant ICE contract or service agreement.
- Comply with the ICE national detention standards applicable to the facility, generally the Performance-Based National Detention Standards 2011 (PBNDS 2011).
- Comply with the CDC's Interim Guidance on Management of Coronavirus Disease 2019 (COVID-19) in Correctional and Detention Facilities (Attachment E).
- Follow ICE's March 27, 2020 Memorandum to Detention Wardens and Superintendents on COVID-19 Action Plan Revision 1, and subsequent updates (Attachment F).
- Report all confirmed and suspected COVID-19 cases to the local ERO Field Office Director (or designee), Field Medical Coordinator, and local health department immediately.
- Notify both the local ERO Field Office Director (or designee) and the Field Medical Coordinator as soon as practicable, but in no case more than 12 hours after identifying any detainee who meets the CDC's identified populations potentially being at higher-risk for serious illness from COVID-19, including:
 - People aged 65 and older
 - People of all ages with underlying medical conditions, particularly if not well controlled, including:
 - People with chronic lung disease or moderate to severe asthma
 - People who have serious heart conditions
 - People who are immunocompromised
 - Many conditions can cause a person to be immunocompromised, including cancer treatment, smoking, bone marrow or organ transplantation, immune deficiencies, poorly controlled HIV or

believed to be infected with a communicable disease and potentially infectious from others to prevent the spread of the communicable disease.

⁴ Dedicated detention facilities are facilities that house only ICE detainees. Dedicated facilities may be ICE-owned Service Processing Centers, privately owned Contract Detention Facilities, or facilities operated by state or local governments that hold no other detention populations except ICE detainees.

AIDS, and prolonged use of corticosteroids and other immune weakening medications

- People with severe obesity (body mass index [BMI] of 40 or higher)
- People with diabetes
- People with chronic kidney disease undergoing dialysis
- People with liver disease

Notification shall be made via e-mail from the facility's Health Services Administrator (HSA) (or equivalent) and contain the following subject line for ease of identification: "Notification of COVID-19 High Risk Detainee (A-Number)." At a minimum the HSA will provide the following information:

- Detainee name
- Detention location
- Current medical issues as well as medications currently prescribed
- Facility medical Point of Contact (POC) and phone number

NON-DEDICATED ICE DETENTION FACILITIES

All non-dedicated detention facilities and local jails housing ICE detainees must:

- Comply with the provisions of their relevant ICE contract or service agreement.
- Comply with the ICE national detention standards applicable to the facility, generally the 2019 National Detention Standards.
- Comply with the CDC Interim Guidance on Management of Coronavirus Disease 2019 (COVID-19) in Correctional and Detention Facilities.
- Report all confirmed and suspected COVID-19 cases to the local ERO Field Office Director (or designee), Field Medical Coordinator, and local health department immediately.
- Notify both the ERO Field Office Director (or designee) and Field Medical Coordinator as soon as practicable, but in no case more than 12 hours after identifying any detainee who meets the CDC's identified populations potentially being at higher-risk for serious illness from COVID-19, including:
 - People aged 65 and older
 - People of all ages with underlying medical conditions, particularly if not well controlled, including:
 - People with chronic lung disease or moderate to severe asthma
 - People who have serious heart conditions
 - People who are immunocompromised
 - Many conditions can cause a person to be immunocompromised, including cancer treatment, smoking, bone marrow or organ transplantation, immune deficiencies, poorly controlled HIV or

AIDS, and prolonged use of corticosteroids and other immune weakening medications

- People with severe obesity (body mass index [BMI] of 40 or higher)
- People with diabetes
- People with chronic kidney disease undergoing dialysis
- People with liver disease

Notification should be made via e-mail from the facility's HSA (or equivalent) and should contain the following subject line for ease of identification: "Notification of COVID-19 High Risk Detainee (A-Number)." Other standardized means of communicating this information to ICE are acceptable. At a minimum the HSA will provide the following information:

- Detainee name
- Detention location
- Current medical issues as well as medications currently prescribed
- Facility medical POC and phone number

ALL FACILITIES HOUSING ICE DETAINEES

In addition to the specific measures listed above, all detention facilities housing ICE detainees must also comply with the following:

PREPAREDNESS

Administrators can plan and prepare for COVID-19 by ensuring that all persons in the facility know the symptoms of COVID-19 and how to respond if they develop symptoms. Other essential actions include developing contingency plans for reduced workforces due to absences, coordinating with public health and correctional partners, and communicating clearly with staff and detainees about these preparations and how they may temporarily alter daily life.

- **Develop information-sharing systems with partners.**
 - Identify points of contact in relevant state, local, tribal, and/or territorial public health department before cases develop.
 - Communicate with other correctional and detention facilities in the same geographic area to share information including disease surveillance and absenteeism patterns among staff.
- **Review existing pandemic, influenza, all-hazards, and disaster plans, and revise for COVID-19, and ensure that they meet the requirements of ICE's detention standards.**
- **Offer the seasonal influenza vaccine to all detained persons (existing populations and new intakes) and staff throughout the influenza season, where possible.**

➤ Staffing

- Review sick leave policies to ensure that staff can stay home when sick and determine which officials will have the authority to send symptomatic staff home. Staff who report for work with symptoms of COVID-19 must be sent home and advised to follow CDC-recommended steps for persons exhibiting COVID-19 symptoms.
- Staff who test positive for COVID-19 must inform their workplace and personal contacts immediately. If a staff member has a confirmed COVID-19 infection, the relevant employers will inform other staff of their possible exposure to COVID-19 in the workplace consistent with any legal limitations on the sharing of such information. Exposed employees must then self-monitor for symptoms (i.e., fever, cough, or shortness of breath).
- Identify staff whose duties would allow them to work from home and allow them to work from home in order to promote social distancing and further reduce the risk of COVID-19 transmission.
- Determine minimum levels of staff in all categories required for the facility to function safely.
- Follow the Public Health Recommendations for Community-Related Exposure.⁵

➤ Supplies

- Ensure that sufficient stocks of hygiene supplies (soap, hand sanitizer, tissues), personal protective equipment (PPE) (to include facemasks, N95 respirators, eye protection, disposable medical gloves, and disposable gowns/one-piece coveralls), and medical supplies (consistent with the healthcare capabilities of the facility) are on hand, and have a plan in place to restock as needed if COVID-19 transmission occurs within the facility.
- Note that shortages of N95 respirators are anticipated during the COVID-19 response. Based on local and regional situational analysis of PPE supplies, face masks should be used when the supply chain of N95 respirators cannot meet the demand.
- Follow COVID-19: Strategies for Optimizing the Supply of PPE.⁶
- Soiled PPE items should be disposed in leak-proof plastic bags that are tied at the top and not re-opened. Bags can be disposed of in the regular solid waste stream.
- Cloth face coverings should be worn by detainees and staff (when PPE supply is limited) to help slow the spread of COVID-19. Cloth face masks should:

⁵ Attachment G, Centers of Disease Control and Prevention, *Public Health Recommendations for Community-Related Exposure*, <https://www.cdc.gov/coronavirus/2019-ncov/php/public-health-recommendations.html> (last visited Apr. 9, 2020).

⁶ Attachment H, Centers for Disease Control and Prevention, *Strategies to Optimize the Supply of PPE and Equipment*, <https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/> (last visited Apr. 9, 2020).

- fit snugly but comfortably against the side of the face
- be secured with ties or ear loops where possible or securely tied
- include multiple layers of fabric
- allow for breathing without restriction
- be able to be laundered and machine dried without damage or change to shape.

➤ **Hygiene**

- Reinforce healthy hygiene practices and provide and restock hygiene supplies throughout the facility, including in bathrooms, food preparation and dining areas, intake areas, visitor entries and exits, visitation rooms, common areas, medical, and staff-restricted areas (e.g., break rooms).
- Require all persons within the facility to cover their mouth and nose with their elbow (or ideally with a tissue) rather than with their hand when they cough or sneeze, and to throw all tissues in the trash immediately after use. Provide detainees and staff no-cost access to tissues and no-touch receptacles for disposal.
- Require all persons within the facility to maintain good hand hygiene by regularly washing their hands with soap and water for at least 20 seconds, especially after coughing, sneezing, or blowing their nose; after using the bathroom; before eating or preparing food; before taking medication; and after touching garbage.
- Provide detainees and staff no-cost, unlimited access to supplies for hand cleansing, including liquid soap, running water, hand drying machines or disposable paper towels, and no-touch trash receptacles.
- Provide alcohol-based hand sanitizer with at least 60% alcohol where permissible based on security restrictions.
- Require all persons within the facility to avoid touching their eyes, nose, or mouth without cleaning their hands first.
- Post signage throughout the facility reminding detained persons and staff to practice good hand hygiene and cough etiquette (printable materials for community-based settings can be found on the [CDC website](https://www.cdc.gov/coronavirus/2019-ncov/community/organizations/cleaning-disinfection.html)). Signage must be in English and Spanish, as well as any other common languages for the detainee population at the facility.
- Prohibit sharing of eating utensils, dishes, and cups.
- Prohibit non-essential personal contact such as handshakes, hugs, and high-fives.

➤ **Cleaning/Disinfecting Practices**

- Adhere to CDC recommendations for cleaning and disinfection during the COVID-19 response.⁷
- Several times a day using household cleaners and Environmental Protection Agency-registered disinfectants, clean and disinfect surfaces and objects that are

⁷ Attachment I, Centers for Disease Control and Prevention, *Cleaning and Disinfection for Community Facilities*, <https://www.cdc.gov/coronavirus/2019-ncov/community/organizations/cleaning-disinfection.html> (last visited Apr. 9, 2020).

frequently touched, especially in common areas (e.g., doorknobs, light switches, sink handles, countertops, toilets, toilet handles, recreation equipment). The Environmental Protection Agency's (EPA) list of certified cleaning products is located [here](#).

- Staff should clean shared equipment several times per day and on a conclusion of use basis (e.g., radios, service weapons, keys, handcuffs).
- Ensure that transport vehicles are thoroughly cleaned after carrying a confirmed or suspected COVID-19 case.
- Facility leadership will ensure that there is adequate oversight and supervision of all individuals responsible for cleaning and disinfecting these areas.

CDC Recommended Cleaning Tips

Hard (Non-porous) Surfaces

- If surfaces are dirty, they should be cleaned using a detergent or soap and water prior to disinfection.
- For disinfection, most common EPA-registered household disinfectants should be effective.
 - A list of products that are EPA-approved for use against the virus that causes COVID-19 is available [here](#). Follow the manufacturer's instructions for all cleaning and disinfection products for concentration, application method and contact time, etc.
 - Additionally, diluted household bleach solutions (at least 1000ppm sodium hypochlorite) can be used if appropriate for the surface. Follow manufacturer's instructions for application, ensuring a contact time of at least 1 minute, and allowing proper ventilation during and after application. Check to ensure the product is not past its expiration date. Never mix household bleach with ammonia or any other cleanser. Unexpired household bleach will be effective against coronaviruses when properly diluted.
 - Prepare a bleach solution by mixing:
 - 5 tablespoons (1/3 cup) bleach per gallon of water or
 - 4 teaspoons bleach per quart of water

Soft (Porous) Surfaces

- For soft (porous) surfaces such as carpeted floor, rugs, and drapes, remove visible contamination if present and clean with appropriate cleaners indicated for use on these surfaces. After cleaning:
 - If the items can be laundered, launder items in accordance with the manufacturer's instructions using the warmest appropriate water setting for the items and then dry items completely.

- Otherwise, use products that are EPA-approved for use against the virus that causes COVID-19 and that are suitable for porous surfaces.⁸

Electronics

- For electronics such as tablets, touch screens, keyboards, remote controls, and ATM machines, remove visible contamination if present.
 - Follow the manufacturer's instructions for all cleaning and disinfection products.
 - Consider use of wipeable covers for electronics.
 - If no manufacturer guidance is available, consider the use of alcohol-based wipes or sprays containing at least 70% alcohol to disinfect touch screens. Dry surfaces thoroughly to avoid pooling of liquids.

Linens, Clothing, and Other Items That Go in the Laundry

- In order to minimize the possibility of dispersing virus through the air, do not shake dirty laundry.
- Wash items as appropriate in accordance with the manufacturer's instructions. If possible, launder items using the warmest appropriate water setting for the items and dry items completely. Dirty laundry that has been in contact with an ill person can be washed with other people's items.
- Clean and disinfect hampers or other carts for transporting laundry according to guidance above for hard or soft surfaces.

PREVENTION

Detention facilities can prevent introduction of COVID-19 from the community and reduce transmission if it is already inside by reinforcing good hygiene practices among incarcerated/detained persons, staff, and visitors (including increasing access to soap and paper towels), intensifying cleaning/disinfection practices, and implementing social distancing strategies.

Because many individuals infected with COVID-19 do not display symptoms, the virus could be present in facilities before cases are identified. Both good hygiene practices and social distancing are critical in preventing further transmission.

➤ Perform pre-intake screening for all staff and new entrants for symptoms of COVID-19.

Screening should take place before staff and new intakes enter the facility or just inside the facility, where practicable. For new admissions, this should occur before beginning the intake process, in order to identify and immediately isolate any detainee with symptoms before the individual comes in contact with others or is placed in

⁸ Attachment J, U.S. Environmental Protection Agency, *List N: Disinfectants for Use Against SARS-CoV-2*, <https://www.epa.gov/pesticide-registration/list-n-disinfectants-use-against-sars-cov-2> (last visited Apr. 9, 2020).

the general population. This should include temperature screening of all staff and new entrants, as well as a verbal symptoms check.

- Verbal screening for symptoms of COVID-19 and contact with COVID-19 cases should include the following questions based on Interim Guidance: Managing COVID-19 in Correctional/Detention Facilities:
 - Today or in the past 24 hours, have you had any of the following symptoms?
 - Fever, felt feverish, or had chills?
 - Cough?
 - Difficulty breathing?
 - In the past 14 days, have you had contact with a person known to be infected with COVID-19 where you were not wearing the recommended proper PPE?
- If staff have symptoms of COVID-19 (fever, cough, shortness of breath): they must be denied access to the facility.
- If any new intake has symptoms of COVID-19:
 - Require the individual to wear a face mask.
 - Ensure that staff interacting with the symptomatic individual wears recommended PPE.
 - Isolate the individual and refer to healthcare staff for further evaluation.
 - Facilities without onsite healthcare staff should contact their state, local, tribal, and/or territorial health department to coordinate effective isolation and necessary medical care.
- If an individual is a close contact of a known COVID-19 case or has traveled to an affected area (but has no COVID-19 symptoms), quarantine the individual and monitor for symptoms two times per day for 14 days.

➤ Visitation

- During suspended (social) or modified (legal) visitation programs, provide access to virtual visitation options where available. When not possible, verbally screen all visitors on entry for symptoms of COVID-19 and perform temperature checks, when possible. ICE continues to explore opportunities to enhance attorney access while legal visits are being impacted. For facilities at which immigration hearings are conducted or where detainees are otherwise held who have cases pending immigration proceedings, this may include:
 - Adding all immigration attorneys of record to the Talton Pro-bono platform.
 - Requiring facilities to establish a process for detainees/immigration attorneys to schedule appointments and facilitate the calls.
 - Leveraging technology (e.g., tablets, smartphones) to facilitate attorney/client communication.

- Working with the various detention contractors and telephone service providers to ensure that all detainees receive some number of free calls per week.
- Communicate with the public about any changes to facility operations, including visitation programs. Facilities are encouraged to prohibit or, at a minimum, significantly adopt restricted visitation programs, and to suspend all volunteer work assignments for detainees assigned to food service, and other assignments where applicable.
- **Where possible, restrict transfers of detained non-ICE populations to and from other jurisdictions and facilities unless necessary for medical evaluation, isolation/quarantine, clinical care, or extenuating security concerns.**
- **Consider suspending work release programs for inmates at shared facilities to reduce overall risk of introduction and transmission of COVID-19 into the facility.**
- **When feasible and consistent with security priorities, encourage staff to maintain a distance greater than six feet from an individual that appears feverish or ill and/or with respiratory symptoms while interviewing, escorting, or interacting in other ways, unless wearing PPE.**
- **Additional Measures to Facilitate Social Distancing**
 - Although strict social distancing may not be possible in congregate settings such as detention facilities, all facilities housing ICE detainees should implement the following measures to the extent practicable:
 - Efforts should be made to reduce the population to approximately 75% of capacity.
 - Where detainee populations are such that such cells are available, to the extent possible, house detainees in individual rooms.
 - Recommend that detainees sharing sleeping quarters sleep “head-to-foot.”
 - Extend recreation, law library, and meal hours and stagger detainee access to the same in order to limit the number of interactions between detainees from other housing units.
 - Staff and detainees should be directed to avoid congregating in groups of 10 or more, employing social distancing strategies at all times.
 - Whenever possible, all staff and detainees should maintain a distance of six feet from one another.
 - If practicable, beds in housing units should be rearranged to allow for sufficient separation during sleeping hours.

MANAGEMENT

If there has been a suspected COVID-19 case inside the facility (among incarcerated/detained persons, staff, or visitors who have recently been inside), begin implementing Management strategies while test results are pending. Essential Management strategies include placing cases and individuals with symptoms under medical isolation, quarantining their close contacts, and facilitating necessary medical care, while observing relevant infection control and environmental disinfection protocols and wearing recommended PPE.

ICE Custody Review for Potentially High-Risk Detainees

Upon being informed of a detainee who may potentially be at higher risk for serious illness from exposure to COVID-19, ERO will review the case to determine whether continued detention is appropriate.⁹ ICE will make such custody determinations on a case-by-case basis, pursuant to the applicable legal standards, with due consideration of the public health considerations implicated.

- **Considerable effort should be made to quarantine all new entrants for 14 days before they enter the general population.**
 - To do this, facilities should consider cohorting daily intakes; two days of new intakes, or multiple days on new intakes, in designated areas prior to placement into the general population. Given the significant variance in facility attributes and characteristics, cohorting options and capabilities will differ across the various detention facilities housing ICE detainees. ICE encourages all facilities to adopt the most effective cohorting methods practicable based on the individual facility characteristics taking into account the number new intakes anticipated per day.
- **For suspected or confirmed COVID-19 cases:**
 - Isolate the individual immediately in a separate environment from other individuals. Facilities should make every possible effort to isolate persons individually. Each isolated individual should be assigned his or her own housing space and bathroom where possible. Cohorting should only be practiced if there are no other available options. Only individuals who are laboratory-confirmed COVID-19 cases should be isolated as a cohort. Do not cohort confirmed cases with suspected cases or case contacts.
 - Ensure that the individual is always wearing a face mask (if it does not restrict breathing) when outside of the isolation space, and whenever another individual enters the isolation room. Masks should be changed at least daily, and when visibly soiled or wet.

⁹ Attachment K, Assistant Director Peter Berg, Enforcement and Removal Operations, *Updated Guidance: COVID-19 Detained Docket Review* (Apr. 4, 2020).

- If the number of confirmed cases exceeds the number of individual isolation spaces available in the facility, then ICE must be promptly notified so that transfer to other facilities, transfers to hospitals, or release can be coordinated immediately. Until such time as transfer or release is arranged, the facility must be especially mindful of cases that are at higher risk of severe illness from COVID-19. Ideally, ill detainees should not be cohorted with other infected individuals. If cohorting of ill detainees is unavoidable, make all possible accommodations until transfer occurs to prevent transmission of other infectious diseases to the higher-risk individual (For example, allocate more space for a higher-risk individual within a shared isolation room).
- Review the CDC's preferred method of medically isolating COVID-19 cases here depending on the space available in a particular facility. In order of preference, individuals under medical isolation should be housed:
 - Separately, in single cells with solid walls (i.e., not bars) 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 and a solid door that closes fully. Employ social distancing strategies related to housing in the Prevention section above.
 - As a cohort, in a large, well-ventilated cell with solid walls but without a solid door. Employ social distancing strategies related to housing in the Prevention section above.
 - As a cohort, in single cells without solid walls or solid doors (i.e., cells enclosed entirely with bars), preferably with an empty cell between occupied cells. (Although individuals are in single cells in this scenario, the airflow between cells essentially makes it a cohort arrangement in the context of COVID-19).
 - As a cohort, in multi-person cells without solid walls or solid doors (i.e., cells enclosed entirely with bars), preferably with an empty cell between occupied cells. Employ social distancing strategies related to housing in the Prevention section above.
- Maintain isolation until all the CDC criteria have been met:
 - The individual has been free from fever for 72 hours without the use of fever-reducing medications.
 - The individual's other symptoms have improved (e.g., cough, shortness of breath).
 - The individual has tested negative in at least two consecutive respiratory specimens collected at least 24 hours apart.
 - At least 7 days have passed since the date of the individual's first positive COVID-19 test and he or she has had no subsequent illness.

- Meals should be provided to COVID-19 cases in their isolation rooms. Isolated cases should throw disposable food service items in the trash in their isolation room. Non-disposable food service items should be handled with gloves and washed with hot water or in a dishwasher. Individuals handling used food service items must clean their hands after removing gloves.
- Laundry from a COVID-19 case can be washed with other individuals' laundry.
 - Individuals handling laundry from COVID-19 cases should wear disposable gloves, discard gloves after each use, and clean their hands after handling.
 - Do not shake dirty laundry. This will minimize the possibility of dispersing the virus through the air.
 - Launder items as appropriate in accordance with the manufacturer's instructions. If possible, launder items using the warmest appropriate water setting for the items and dry items completely.
 - Clean and disinfect clothes hampers according to guidance above for surfaces. If permissible, consider using a bag liner that is either disposable or can be laundered.

ATTACHMENTS

ATTACHMENT LETTER	DOCUMENT NAME AND CITATION
A	U.S. Immigration and Customs Enforcement, <i>Updated ICE statement on COVID-19</i> (Mar. 18, 2020), https://www.ice.gov/news/releases/updated-ice-statement-covid-19 .
B	ICE National Detention Standards 2019, Standard 4.3, Medical Care, https://www.ice.gov/doclib/detention-standards/2019/4_3.pdf .
C	2011 ICE Performance-Based National Detention Standards, Revised 2016, Standard 4.3, https://www.ice.gov/doclib/detention-standards/2011/4-3.pdf .
D	2008 ICE Performance-Based National Detention Standards, Standard 4-22, Medical Care, https://www.ice.gov/doclib/dro/detention-standards/pdf/medical_care.pdf .
E	Centers of Disease Control and Prevention, <i>Interim Guidance on Management of Coronavirus Disease 2019 (COVID-19) in Correctional and Detention Facilities</i> (Mar. 23, 2020), https://www.cdc.gov/coronavirus/2019-ncov/downloads/guidance-correctional-detention.pdf .
F	Memorandum from Executive Associate Director Enrique Lucero, Enforcement and Removal Operations, <i>Memorandum on Coronavirus 2019 (COVID-19) Action Plan, Revision 1</i> (Mar. 27, 2020).
G	Centers of Disease Control and Prevention, <i>Public Health Recommendations for Community-Related Exposure</i> , https://www.cdc.gov/coronavirus/2019-ncov/php/public-health-recommendations.html (last visited Apr. 9, 2020).
H	Centers for Disease Control and Prevention, <i>Strategies to Optimize the Supply of PPE and Equipment</i> , https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/ (last visited Apr. 9, 2020).
I	Centers for Disease Control and Prevention, <i>Cleaning and Disinfection for Community Facilities</i> , https://www.cdc.gov/coronavirus/2019-ncov/community/organizations/cleaning-disinfection.html (last visited Apr. 9, 2020).

J	U.S. Environmental Protection Agency, <i>List N: Disinfectants for Use Against SARS-CoV-2</i> , https://www.epa.gov/pesticide-registration/list-n-disinfectants-use-against-sars-cov-2 (last visited Apr. 9, 2020).
K	Assistant Director Peter Berg, Enforcement and Removal Operations, <i>Updated Guidance: COVID-19 Detained Docket Review</i> (Apr. 4, 2020).



Interim Reference Sheet on 2019-Novel Coronavirus (COVID-19): Detainee Care

ICE Health Service Corps (IHSC)

Version 8.0, March 28, 2020

WHAT'S NEW

Version 8.0

- Added language to address that there is no centralized listing of areas in the US with ongoing or sustained community transmission. State and local health departments may have listings of case counts in their jurisdictions and may be referenced to assess whether the detainee had been in a US community with ongoing or sustained community transmission of COVID-19 in the past 14 days.
- Revised recommendation for observation of detainees under monitoring or cohorting
- Added a section with recommendation to the Field Office Director or designee with considerations for domestic release and movement of detainees for medically necessary continuity of care
- Added information on reporting staff with confirmed COVID-19 to local health departments for public health investigations and interventions and to avert threats to public health and safety
- Added links to [Dental Care - Prioritizing Care and Staying Safe](#)
- Moved information on documentation in the [Lower Respiratory Illness Tracking Tool](#) and on documentation in the [Cohort Tracker](#) to a separate section on REPORTING

Version 7.0

- Recommendations to reduce the risk of transmission now link to a separate [Reducing the Risk of COVID-19 Transmission](#) document on the [2019 Novel Coronavirus Resource Page](#). This document includes strategies for optimizing personal protective equipment (PPE)

Situation Summary

The CDC is closely monitoring an outbreak caused by a novel (new) coronavirus (COVID-19). The situation is evolving and expanding with community transmission occurring in multiple countries including the United States. For the most current information, check the CDC

information pages at <https://www.cdc.gov/coronavirus/2019-ncov/index.html> frequently for updates.

CDC interim guidance for health care professionals, including clinical criteria, is available at <https://www.cdc.gov/coronavirus/2019-nCoV/clinical-criteria.html>.

ICE Health Service Corps Recommendations

- *Note: recommendations will be updated if and as necessary to address the evolving public health situation. See also [2019 Novel Coronavirus Resource Page](#) including [Reducing the Risk of COVID-19 Transmission](#) and [Dental Care - Prioritizing Care and Staying Safe](#)*

1. *During intake medical screening:*

- Ask all detainees if they have had close contact¹ with a person with laboratory-confirmed COVID-19 in the past 14 days**
- Ask all detainees what countries they have traveled from or through in the past two weeks**
 - Check whether these countries include geographic area(s) with widespread or sustained community transmission.*
 - *Please see CDC website listing of geographic area(s) with widespread or sustained community transmission at <https://www.cdc.gov/coronavirus/2019-ncov/hcp/clinical-criteria.html>.**
 - There is no centralized listing of areas in the US with ongoing or sustained community transmission. State and local health departments may have listings of case counts in their jurisdictions and may be referenced to assess whether the detainee had been in a US community with ongoing or sustained community transmission of COVID-19 in the past 14 days.
 - If the detainee responded yes to 1a and/or the detainee traveled from or through geographic area(s) with widespread or sustained community transmission* in the past 14 days (1b), assess for fever and symptoms of respiratory illness.**
 - If the detainee has a fever and/or symptoms of respiratory illness, refer to ISOLATION below.
 - If the detainee does not have fever or respiratory illness, refer to MONITORING, below.
 - For IHSC-staffed medical clinics, add a Global Alert / Medical Alert in the electronic health record that states, “*Epidemiologic risk of possible COVID-19 exposure. The last reported date of possible exposure was mm/dd/yyyy.*”
Click [here](#) for the eCW guide for adding a Global Alert.
- If the detainee has fever and/or symptoms or respiratory illness and has not traveled from or through area(s) with sustained community transmission* in the past 14 days and if they have not had close contact¹ with a person with laboratory-confirmed

- COVID-19 or their respiratory secretions in the past 14 days → refer to a medical provider (see ENCOUNTER below).
- d. Educate all detainees to include the importance of hand washing and hand hygiene, covering coughs with the elbow instead of with hands, and requesting sick call if they feel ill.
 - i. Illness Prevention and Patient Education resources in multiple languages are available on the 2019 Novel Coronavirus Resource Page.

2. MONITORING of detainees with exposure risk who do not present with fever or symptoms:

- a. See also Coronavirus Disease 2019 (COVID-19) - Housing of Asymptomatic Detainees.
- b. For detainees with travel history from or through geographic area(s) with sustained community transmission* in the past 14 days and/or detainees who have had close contact¹ with a person with laboratory-confirmed COVID-19 in the past 14 days who do not present with fever or symptoms of respiratory illness → monitor for 14 days after initial DHS apprehension
 - i. ***Please see CDC website listing of international area(s) with sustained transmission at <https://www.cdc.gov/coronavirus/2019-ncov/hcp/clinical-criteria.html>.**
 - ii. There is no centralized listing of areas in the US with ongoing or sustained community transmission. State and local health departments may have listings of case counts in their jurisdictions and may be referenced to assess whether the detainee had been in a US community with ongoing or sustained community transmission of COVID-19 in the past 14 days.
- c. House detainees under monitoring in a single cell room if available or as a cohort for 14 days after initial DHS apprehension.
- d. Refer also to appendix A, Intake Screening Questions and Intake Screening and Early Management Algorithm on the 2019 Novel Coronavirus Resource Page.
- e. Visit dorms daily and remind detainees that medical services are available.
 - i. Educate patients to report if they feel ill or feverish.
 - ii. Remind custody staff to report any patients they are concerned about, with special attention to those who might have fever, cough, or shortness of breath.
 - iii. Promote access to care through sick call and urgent care services.
 - iv. Provide frequent patient education via town halls and similar dorm visits to reinforce detainee knowledge about how to access care.
- f. If detainee is housed in a facility without IHSC medical staffing, medical staff should notify their assigned IHSC Field Medical Coordinator.
- g. Request a medical alert in following usual protocols stating that “the detainee is under observation through mm/dd/yyyy due to recent travel from or through geographic area(s) with widespread or sustained community transmission” Release the medical alert at the completion of the 14-day monitoring period.

- h. See REPORTING below.
- i. For monitoring of asymptomatic detainees, it is not necessary to contact the local health department.

3. ***ENCOUNTER. During sick call, health assessment, or other clinical encounter in which a detainee presents with or complains of fever and/or respiratory illness, or is observed with signs of fever and/or respiratory illness:***

- a. Ask all detainees what countries they have traveled from or through in the past two weeks.
 - i. Check whether these countries include international area(s) with sustained transmission.*
 - ii. ***Please see CDC website listing of international area(s) with sustained transmission at <https://www.cdc.gov/coronavirus/2019-ncov/hcp/clinical-criteria.html>.**
 - iii. There is no centralized listing of areas in the US with ongoing or sustained community transmission. State and local health departments may have listings of case counts in their jurisdictions and may be referenced to assess whether the detainee had been in a US community with ongoing or sustained community transmission of COVID-19 in the past 14 days.
- b. **If the detainee has traveled from or through area(s) with sustained community transmission* in the past 14 days, or if they have had close contact¹ with a person with laboratory-confirmed COVID-19 or their respiratory secretions in the past 14 days**
 - i. → refer to ISOLATION below.
- c. If the detainee has not traveled from or through area(s) with sustained community transmission* in the past 14 days and if they have not had close contact¹ with a person with laboratory-confirmed COVID-19 or their respiratory secretions in the past 14 days then
 - i. → Providers should use their judgment to determine if a patient has signs and symptoms compatible with COVID-19 and whether the patient should be tested. Decisions on which patients receive testing should be based on the epidemiology of COVID-19, as well as the clinical course of illness. Providers are strongly encouraged to test for other causes of respiratory illness, including infections such as influenza.
 - ii. See [Reducing the Risk of COVID-19 Transmission](#) and [Dental Care - Prioritizing Care and Staying Safe](#)
 - iii. See SPECIMEN COLLECTION AND LABORATORY TESTING below.
- d. Educate detainees to include the importance of hand washing and hand hygiene, covering coughs with the elbow instead of with hands, and requesting sick call if they feel ill.
 - i. [Illness Prevention and Patient Education](#) resources in multiple languages are available on the [2019 Novel Coronavirus Resource Page](#).

4. ISOLATION and management of detainees with fever and/or symptoms of respiratory illness and who have traveled from or through geographic area(s) with widespread or sustained community transmission at in the past 14 days or have had close contact¹ with a person with laboratory-confirmed COVID-19 or their respiratory secretions in the past 14 days:

- a. See [Coronavirus Disease 2019 \(COVID-19\) | Housing Symptomatic Detainees](#)
- b. See [Reducing the Risk of COVID-19 Transmission and Dental Care - Prioritizing Care and Staying Safe](#)
- c. Place a tight-fitting surgical mask on the detainee.
- d. Promptly consult with a medical provider, preferably the Clinical Director or designee.
- e. Place the detainee in a private medical housing room, ideally in an airborne infection isolation room if available. If no single occupancy medical housing unit room is available, placement in other areas of the facility may be utilized to house the ill detainee separately from the general detention population.
- f. Call the local and/or state health department for notification and guidance.
- g. Laboratory testing for COVID-19 is now available through commercial laboratories including LabCorp and through local and/or state health departments.
 - i. See SPECIMEN COLLECTION AND LABORTORY TESTING below.
 - ii. Report positive test results for COVID-19 promptly to the local or state health department
- h. If the detainee has underlying illness or is acutely ill, or symptoms do not resolve, consult with the Regional Clinical Director, and/or Infectious Disease program.
- i. If the detainee is referred to a local hospital, call the hospital in advance to notify of the recent relevant travel history and respiratory symptoms and to coordinate how manage the detainee safely.
- j. Promptly notify the facility's staff responsible for infection prevention and control (e.g., in IHSC facilities, notify the Infection Prevention Officer, or the Facility Healthcare Program Manager (if the facility does not have an Infection Prevention Officer position); if the Infection Prevention Officer or Facility Healthcare Program Manager is not available, IHSC staff should notify the Infection Prevention Group at [#IHSC_PHSP_IPO@ice.dhs.gov](#).
- k. Facilities without IHSC medical staffing should notify their assigned Field Medical Coordinator.
- l. IHSC Infection Prevention Officers, Facility Healthcare Program Managers, Field Medical Coordinators, or designees should notify the Regional Infection Prevention Supervisory Nurse immediately.
- m. Detainees isolated for respiratory illness and who have epidemiologic risk for COVID-19 exposure should wear a tight-fitting surgical mask when outside of the isolation room.
- n. See REPORTING below.

- o. The contagious period for COVID-19 is still undetermined.
 - i. If the detainee tests positive for COVID-19 and fever and symptoms have resolved, consult with the Infectious Disease Program and/or local health department regarding appropriate release from isolation.
 - ii. If the detainee tests negative for COVID-19, had high or medium exposure risk, and fever and symptoms have resolved, release from isolation after completion of the 14-day monitoring period after initial DHS apprehension.
 - iii. If the detainee tests negative for COVID-19 and fever and/or symptoms persist, consult with the Regional Clinical Director and/or Infectious Disease Program
- p. Educate detainees to include the importance of hand washing and hand hygiene, covering coughs with the elbow instead of with hands, and requesting sick call if they feel ill.
 - i. Illness Prevention and Patient Education resources in multiple languages are available on the 2019 Novel Coronavirus Resource Page.

5. ***SPECIMEN COLLECTION AND LABORATORY TESTING for COVID-19***

- a. Laboratory testing for COVID-19 is available through commercial laboratories including LabCorp and through local and/or state health departments.
- b. See **Specimen Collection instructions on the 2019 Novel Coronavirus Resource Page**.
 - i. LabCorp ordering codes are 2019 Novel Coronavirus (COVID-19), NAA; TEST: 139900.

6. ***Infectious disease public health actions:***

- a. Educate detainees to include the importance of hand washing and hand hygiene, covering coughs with the elbow instead of with hands, and requesting sick call if they feel ill.
 - i. Illness Prevention and Patient Education resources in multiple languages are available on SharePoint.
- b. See also 05-06-G-02 Infectious Disease Public Health Actions Guide: Isolation and Management of Detainees Exposed to Infectious Organisms.
- c. **Known exposure to a person with confirmed COVID-19**
 - i. Implement cohorting with restricted movement for detainees housed with the ill detainee or who have been in close contact¹ with the ill detainee for the duration of the most recent incubation period (14 days after most recent exposure to an ill detainee).
 - ii. See also MONITORING above. Monitor cohorted detainees daily to observe for fever and symptoms of respiratory illness.
 - iii. Refer exposed detainees with new onset fever and/or respiratory illness to a medical provider for evaluation.
 - iv. Discontinue cohorting when 14-day incubation period completes with no new cases.

- d. **Exposure to a person with fever or symptoms being evaluated or under investigation for COVID-19 but not confirmed to have COVID-19**
 - i. Implement cohorting with restricted movement for detainees housed with the ill detainee or who have been in close contact¹ with the ill detainee for the duration of the most recent incubation period.
 - ii. Monitor cohorted detainees daily to observe for fever and symptoms of respiratory illness.
 - iii. Refer exposed detainees with new onset fever and/or respiratory illness to a medical provider for evaluation.
 - iv. If the index patient is subsequently confirmed to have COVID-19, see ***Known exposure to a person with confirmed COVID-19*** above.
 - v. Discontinue cohorting if the index patient receives an alternate diagnosis that excludes COVID-19.
 - vi. Any of the cohorted detainees with exposure risk should complete their initial 14-day monitoring period (i.e., for asymptomatic monitoring).
- e. Visit dorms daily and remind detainees that medical services are available.
 - i. Educate patients to report if they feel ill or feverish.
 - ii. Remind custody staff to report any patients they are concerned about, with special attention to those who might have fever, cough, or shortness of breath.
 - iii. Promote access to care through sick call and urgent care services.
 - iv. *Provide frequent patient education via town halls and similar dorm visits to reinforce detainee knowledge about how to access care.*

7. Recommendations to Field Office Director or Designee Regarding Detainee Release and Special Circumstance Movement

- a. Recommend all detainees being released be given the fact sheets *Steps to help prevent the spread of COVID-19 if you are sick* and *Stop the spread of germs*.
- b. Recommend the following considerations if decisions are made to release in the U.S. detainees with confirmed or suspected COVID-19, detainees exposed to a person with confirmed or suspected COVID-19, or detainees under monitoring for having epidemiologic risk of exposure to COVID-19:
 - i. If the detainee will be released before the recommended medical isolation, cohorting, or monitoring period is complete, discuss release of the individual with state or local health department
 - Provide the health department with the detainee's name, intended address, email address, and all available telephone numbers
 - ii. Facilitate safe transport, continued shelter, and medical care, as part of release planning.
 - Make direct linkages to community resources to ensure proper medical isolation and access to medical care if needed.
 - Coordinate with the detainee for a family member or friend to provide transportation

- Advise the detainee to avoid public transportation, commercial ride sharing (e.g., Uber, Lyft), and taxis
- iii. Give the detainee the CDC's *What To Do if You Are Sick* fact sheet (see [2019 Novel Coronavirus Resource Page | Illness Prevention Patient Education](#))
- c. Detainees under isolation, cohorting, or monitoring should be permitted to attend other medically necessary appointments with advance coordination with the receiving facility
- d. Detainees under isolation, cohorting, or monitoring should not be restricted from movement to facilitate a medically- or behaviorally-necessary placement
- e. If a detainee under isolation, cohorting, or monitoring must be moved to another facility; the receiving facility must be notified of the monitoring, cohorting, isolation end dates
- f. Recommend to Field Office Director or designee that detainees cohorted due to exposure risk or known exposure to an ill person not be transferred or transported unless medically necessary.
- i. See [IHSC Interim COVID-19 Risk Assessment](#) on the [2019 Novel Coronavirus Resource Page](#).

8. **REPORTING**

- a. Document any ill detainee who is suspected of having COVID-19 on the [Lower Respiratory Illness Tracking Tool](#).
- b. Document any asymptomatic detainee under monitoring with HIGH or MEDIUM exposure risk on the [Lower Respiratory Illness Tracking Tool](#) (see [Coronavirus Disease 2019 \(COVID-19\) - Housing of Asymptomatic Detainees](#)).
- c. Document cohorting and detainees under monitoring with LOW exposure risk through routine IHSC cohort reporting protocols using the [Cohort Tracker](#).
- d. Any employee known to have a positive test result for COVID-19 must be promptly reported to the local or state health department in accordance with local or state public health laws and permissible exemptions under the Health Insurance Portability and Accountability Act (HIPAA) requiring notifications to public health departments for conducting investigations and interventions and to avert a serious threat to public health and safety. Reported must include the employee's name, date of birth, address, phone number, and testing location.

¹**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)

If such contact occurs while not wearing recommended personal protective equipment or PPE (e.g., gowns, gloves, NIOSH-certified disposable N95 respirator, eye protection), criteria for PUI consideration are met.

Resources and references

- [2019 Novel Coronavirus Resource Page](#) on SharePoint
- [Reducing the Risk of COVID-19 Transmission](#)
- [Illness Prevention and Patient Education](#) resources in multiple languages are available on SharePoint.
- [COVID-19 Questions and Responses](#) on SharePoint for submitting questions, receiving responses from IHSC subject matter experts, and viewing all questions and responses

IHSC Official Guidance

Guidance number	Guidance name	Type
05-02	Occupational Health Directive	Policy
05-02 G-04	Occupational Health Guide: Workforce Health	Guide
05-02 G-1	Occupational Health Guide: Bloodborne Pathogens and Other Potentially Infectious Materials	Guide
05-02 G-2	Occupational Health Guide: Personal Protective Equipment Program	Guide
05-02-G-03	Occupational Health Guide: Respiratory Protection Program	Guide
05-04	Environmental Health Directive	Policy
05-04 G-01	IHSC Environmental Health Guide	Guide
05-06	Infectious Disease Public Health Actions Directive	Policy
05-06 G-01	Infectious Disease Public Health Actions Guide: Contact and Outbreak Investigation Guide	Guide
05-06 G-02	Infectious Disease Public Health Actions Guide: Isolation and Management of Detainees Exposed to Infectious Organisms	Guide

Guidance number	Guidance name	Type
05-06 G-03	Infectious Disease Public Health Actions Guide: Surveillance and Reporting	Guide

- [Infection Control: Novel Coronavirus 2019 \(COVID-19\) | CDC](#)
- [Interim Guidance: Healthcare Professionals 2019-nCoV | CDC \(including CDC website listing of geographic area\(s\) with widespread or sustained community transmission\)](#)
- [Resources for Correctional and Detention Facilities | CDC](#)
- [CDC | Coronavirus Disease 2019 \(COVID-19\)](#)
- [2019 Novel Coronavirus \(2019-nCoV\) | TDSHS](#)
- [nCOV2019 | CDPH](#)
- [Novel Coronavirus Outbreak 2020 | Washington State Department of Health](#)
- [ADHS - Highlighted Infectious Diseases for Arizona - Coronavirus Disease 2019 \(COVID-19\)](#)
- [Coronavirus | NYC Health](#)
- [2019 Novel \(New\) Coronavirus | NYDOH](#)
- [2019 Novel Coronavirus \(2019-nCoV\) | Florida Department of Health](#)
- [NJ Department of Health | Communicable Disease Service | COVID-2019 \(Novel Coronavirus\)](#)
- [Pennsylvania Department of Health | Coronavirus](#)
- [2019 Novel Coronavirus \(2019 nCoV\) | Frequently Asked Questions | IDPH](#)

Points of contact for questions

- [IHSC Staff: COVID-19 Questions and Responses](#) on SharePoint for submitting questions, receiving responses from IHSC subject matter experts, and viewing all questions and responses
 - Regional Infection Prevention Supervisory Nurses, PHSP Unit Senior Public Health Analyst, PHSP Unit Chief
- [Facilities without IHSC Medical Staffing](#): Assigned Field Medical Coordinators
- [Public health agencies: IHSC](#) InfectionPrevention@ice.dhs.gov

Appendix A: Intake Screening Questions

Updated March 11, 2020

1. **Have you been in close contact with a person with laboratory-confirmed 2019 novel coronavirus or their respiratory secretions in the past 14 days?**
 - Last date you had contact with that person: mm/dd/yyyy**OR**
2. **What countries have you traveled from or through in the past two weeks?**
 - Check whether the detainee traveled from or through geographic area(s) with widespread or sustained community transmission*in the past 14 days?
 - ***Please see CDC website listing of geographic area(s) with widespread or sustained community transmission at <https://www.cdc.gov/coronavirus/2019-ncov/hcp/clinical-criteria.html>**
3. If yes to #1 **or** the detainee traveled from or through geographic area(s) with widespread or sustained community transmission*in the past 14 days? (#2):
 - **Have you had fever and/or respiratory illness with onset in the past 14 days?**
 - **If yes, what date did you first notice symptoms?: mm/dd/yyyy**
 - **If yes, isolate and refer to a medical provider, add Medical Hold, notify FHPM, IPO, or designee.**
 - See Reducing the Risk of COVID-19 Transmission
 - **If no, implement MONITORING;** house in single room (preferred) if available, implement daily checks for 14 days after initial DHS apprehension, add Medical Hold, notify FHPM, IPO, or designee.
4. If no travel from or through geographic area(s) with widespread or sustained community transmission* in the past 14 days AND no close contact with a person with laboratory-confirmed 2019 novel coronavirus or their respiratory secretions in the past 14 days?
 - ***Please see CDC website listing of international area(s) with sustained transmission at <https://www.cdc.gov/coronavirus/2019-ncov/hcp/clinical-criteria.html>**
 - Routine intake
 - If the initial DHS apprehension date (i.e., initial CBP or ICE encounter) documented in ENFORCE is ≥ 14 days prior, the detainee is outside the 14 day window and does not require monitoring for the epidemiologic risk of COVID-19 exposure
 - Facility Infection Prevention Officers and/or PHSP Unit staff can help confirm the date of initial DHS apprehension in ENFORCE

***Please see CDC website listing of international area(s) with sustained transmission at <https://www.cdc.gov/coronavirus/2019-ncov/hcp/clinical-criteria.html>**



Interim Reference Sheet on 2019-Novel Coronavirus (COVID-19): Detainee Care

Version 9.0, April 1, 2020

Key changes

Version 9.0

- Discontinued the following actions as part of our COVID-19 response due to CDC's guidance for ALL international travelers to *stay home for 14 days from the time you returned home* from international travel and due to widespread, ongoing transmission in the U.S.
 - Asking detainees during intake if they have traveled from or through specific countries in the past 14 days
 - 14-day monitoring of asymptomatic, afebrile detainees that have traveled from or through specific countries in the past 14 days
 - Documenting individual asymptomatic, afebrile detainees that have traveled from or through specific countries in the past 14 days in the Lower Respiratory Illness Tracker
- Added information about contagiousness and releasing transmission-based precautions
- The following actions shall continue:
 - Intake screening to identify detainees with fever and/or symptoms of respiratory illness
 - Asking detainees during intake if they have had exposure to a person with COVID-19 in the past 14 days.
 - Cohorting as a group of people exposed to a person with suspected or confirmed COVID-19 and tracking cohorted units on the [Cohort Tracker](#).
 - Documenting individual detainees in isolation with fever and/or symptoms of respiratory illness in the [Lower Respiratory Illness Tracking Tool](#).
- Added information to recommend to the Field Office Director or Designee and/or Facility Administrator to consider housing newly arriving detainees separately for 14 days before releasing to the general population.

Version 8.0

- Revised recommendation for observation of detainees under monitoring or cohorting
- Added a section with recommendation to the Field Office Director or designee with considerations for domestic release and movement of detainees for medically necessary continuity of care
- Added information on reporting staff with confirmed COVID-19 to local health departments for public health investigations and interventions and to avert threats to public health and safety
- Added links to [Dental Care - Prioritizing Care and Staying Safe](#)
Moved information on documentation in the [Lower Respiratory Illness Tracking Tool](#) and on documentation in the [Cohort Tracker](#) to a separate section on REPORTING

Situation Summary

The CDC is closely monitoring an outbreak caused by a novel (new) coronavirus (COVID-19). The situation is evolving and expanding with community transmission occurring in multiple countries including the United States. For the most current information, check the CDC information pages at <https://www.cdc.gov/coronavirus/2019-ncov/index.html> frequently for updates. CDC interim guidance for health care professionals, including clinical criteria, is available at <https://www.cdc.gov/coronavirus/2019-nCoV/clinical-criteria.html>.

ICE Health Service Corps Recommendations

- *Note: recommendations will be updated if and as necessary to address the evolving public health situation. See also [2019 Novel Coronavirus Resource Page](#) including [Reducing the Risk of COVID-19 Transmission](#) and [Dental Care - Prioritizing Care and Staying Safe](#)*

1. *During intake medical screening:*

- a. **Ask all detainees if they have had close contact¹ with a person with laboratory-confirmed COVID-19 in the past 14 days**
 - i. **If the detainee responded yes to 1a),** assess for fever and symptoms of respiratory illness.
 - If the detainee has a fever and/or symptoms of respiratory illness, refer to ISOLATION below.
 - If the detainee does not have fever or respiratory illness, refer to EXPOSURE-BASED COHORTING, below.
 - b. If the detainee has fever and/or symptoms or respiratory illness and if they have not had close contact¹ with a person with laboratory-confirmed COVID-19 or their respiratory secretions in the past 14 days → refer to a medical provider (see ENCOUNTER below).
 - c. Educate all detainees to include the importance of hand washing and hand hygiene, covering coughs with the elbow instead of with hands, and requesting sick call if they feel ill.
 - i. [Illness Prevention and Patient Education](#) resources in multiple languages are available on the [2019 Novel Coronavirus Resource Page](#).

2. **ENCOUNTER. During sick call, health assessment, or other clinical encounter in which a detainee presents with or complains of fever and/or respiratory illness, or is observed with signs of fever and/or respiratory illness:**

- a. **If the detainee had close contact¹ with a person with laboratory-confirmed COVID-19 or their respiratory secretions in the past 14 days**
 - i. → refer to ISOLATION below.
 - b. If the detainee has not had close contact¹ with a person with laboratory-confirmed COVID-19 or their respiratory secretions in the past 14 days, then

- i. → Providers should use their judgment to determine if a patient has signs and symptoms compatible with COVID-19 and whether the patient should be isolated and tested. Decisions on which patients receive testing should be based on the epidemiology of COVID-19, as well as the clinical course of illness. Providers are strongly encouraged to test for other causes of respiratory illness, including infections such as influenza.
- ii. See [Reducing the Risk of COVID-19 Transmission](#) and [Dental Care - Prioritizing Care and Staying Safe](#)
- iii. See SPECIMEN COLLECTION AND LABORATORY TESTING below.
- c. Educate detainees to include the importance of hand washing and hand hygiene, covering coughs with the elbow instead of with hands, and requesting sick call if they feel ill.
 - i. [Illness Prevention and Patient Education](#) resources in multiple languages are available on the [2019 Novel Coronavirus Resource Page](#).

3. *ISOLATION and management of detainees with fever and/or symptoms of respiratory illness and who are suspected or confirmed to have COVID-19:*

- a. See [Coronavirus Disease 2019 \(COVID-19\) | Housing Symptomatic Detainees](#)
- b. See [Reducing the Risk of COVID-19 Transmission](#) and [Dental Care - Prioritizing Care and Staying Safe](#).
- c. Place a tight-fitting surgical mask on the detainee.
- d. Promptly consult with a medical provider, preferably the Clinical Director or designee.
- e. Place the detainee in a private medical housing room, ideally in an airborne infection isolation room if available. If no single occupancy medical housing unit room is available, placement in other areas of the facility may be utilized to house the ill detainee separately from the general detention population.
- f. Call the local and/or state health department for notification and guidance.
- g. Laboratory testing for COVID-19 is now available through commercial laboratories including LabCorp and through local and/or state health departments.
 - i. See SPECIMEN COLLECTION AND LABORTORY TESTING below.
 - ii. Report positive test results for COVID-19 promptly to the local or state health department
- h. If the detainee has underlying illness or is acutely ill, or symptoms do not resolve, consult with the Regional Clinical Director, and/or Infectious Disease program.
- i. If the detainee is referred to a local hospital, call the hospital in advance to notify of the recent relevant travel history and respiratory symptoms and to coordinate how manage the detainee safely.
- j. Promptly notify the facility's staff responsible for infection prevention and control (e.g., in IHSC facilities, notify the Infection Prevention Officer, or the Facility Healthcare Program Manager (if the facility does not have an Infection Prevention Officer position); if the Infection Prevention Officer or Facility Healthcare Program

- Manager is not available, IHSC staff should notify the Infection Prevention Group at #IHSC_PHSP_IPO@ice.dhs.gov.
- k. Facilities without IHSC medical staffing should notify their assigned Field Medical Coordinator.
 - l. IHSC Infection Prevention Officers, Facility Healthcare Program Managers, Field Medical Coordinators, or designees should notify the Regional Infection Prevention Supervisory Nurse immediately.
 - m. Detainees isolated for respiratory illness and who have epidemiologic risk for COVID-19 exposure should wear a tight-fitting surgical mask when outside of the isolation room.
 - n. See REPORTING below.
 - o. The contagious period for COVID-19 is still uncertain.
 - i. A person with COVID-19 is thought to be contagious starting 48 hours before symptom onset
 - ii. The decision to discontinue Transmission-Based Precautions should be made using a test-based strategy or a non-test-based strategy (i.e., time-since-illness-onset and time-since-recovery strategy). Meeting criteria for discontinuation of Transmission-Based Precautions is not a prerequisite for discharge.
 - **Test-based strategy (preferred if the patient is immunocompromised)**
 - Resolution of fever without the use of fever-reducing medications **and**
 - Improvement in respiratory symptoms (e.g., cough, shortness of breath), **and**
 - Negative results of an FDA Emergency Use Authorized COVID-19 molecular assay for detection of SARS-CoV-2 RNA from at least two consecutive nasopharyngeal swab specimens collected ≥ 24 hours apart (total of two negative specimens). See Interim Guidelines for Collecting, Handling, and Testing Clinical Specimens for 2019 Novel Coronavirus.
 - **Non-test-based strategy**
 - At least 3 days (72 hours) have passed *since recovery* defined as resolution of fever without *the* use of fever-reducing medications **and** improvement in respiratory symptoms (e.g., cough, shortness of breath); **and**,
 - At least 7 days have *passed since symptoms first appeared*
 - iii. If the detainee tests negative for COVID-19 and fever and/or symptoms persist, consult with the Regional Clinical Director and/or Infectious Disease Program
 - p. Educate detainees to include the importance of hand washing and hand hygiene, covering coughs with the elbow instead of with hands, and requesting sick call if they feel ill.
 - i. Illness Prevention and Patient Education resources in multiple languages are available on the 2019 Novel Coronavirus Resource Page.

4. SPECIMEN COLLECTION AND LABORATORY TESTING for COVID-19

- a. Laboratory testing for COVID-19 is available through commercial laboratories including LabCorp and through local and/or state health departments.
- b. See **Specimen Collection instructions on the 2019 Novel Coronavirus Resource Page**.
 - i. LabCorp ordering codes are 2019 Novel Coronavirus (COVID-19), NAA; TEST: 139900.

5. INFECTIOUS DISEASE PUBLIC HEALTH ACTIONS

- a. Educate detainees to include the importance of hand washing and hand hygiene, covering coughs with the elbow instead of with hands, and requesting sick call if they feel ill.
 - i. Illness Prevention and Patient Education resources in multiple languages are available on SharePoint.
- b. See also 05-06-G-02 Infectious Disease Public Health Actions Guide: Isolation and Management of Detainees Exposed to Infectious Organisms.

6. EXPOSURE-BASED COHORTING

- a. **Known exposure to a person with suspected or confirmed COVID-19**
 - i. Implement cohorting with restricted movement for detainees housed with the ill detainee or who have been in close contact¹ with the ill person for the duration of the most recent incubation period (14 days after most recent exposure to an ill person).
 - ii. Refer exposed detainees with new onset fever and/or respiratory illness to a medical provider for evaluation.
 - iii. Discontinue cohorting when 14-day incubation period completes with no new cases.
- b. **Exposure to a person with fever or symptoms being evaluated or under investigation for COVID-19 but not confirmed to have COVID-19**
 - i. Implement cohorting with restricted movement for detainees housed with the ill detainee or who have been in close contact¹ with the ill person for the duration of the most recent incubation period.
 - ii. Refer exposed detainees with new onset fever and/or respiratory illness to a medical provider for evaluation.
 - iii. If the index patient is subsequently confirmed to have COVID-19, see ***Known exposure to a person with confirmed COVID-19*** above.
 - iv. Discontinue cohorting if the index patient receives an alternate diagnosis that excludes COVID-19.
 - v. Any of the cohorted detainees with exposure risk should complete their initial 14-day monitoring period (i.e., for asymptomatic monitoring).

- c. **Visit dorms daily and remind detainees that medical services are available.**
 - i. Educate patients to report if they feel ill or feverish.
 - ii. Remind custody staff to report any patients they are concerned about, with special attention to those who might have fever, cough, or shortness of breath.
 - iii. Promote access to care through sick call and urgent care services.
 - iv. *Provide frequent patient education via town halls and similar dorm visits to reinforce detainee knowledge about how to access care.*

7. *Recommendations to the Field Office Director or Designee and the Facility Administrator or Warden for routine intake cohorting*

- a. Consider housing separately from GP all new intakes for 14 days before they enter the facility's general population (SEPARATELY from other individuals who are cohorted due to contact with a COVID-19 case).
- b. This could be individual housing or as a routine intake cohort.
- c. If housed as a routine intake cohort, consider allowing each individual to be moved to the general population after 14 days if no fever or symptoms.
- d. If any person in the routine intake cohort does develop fever or symptoms, the cohort status would be changed to an *exposure-based cohort*
- e. Routine intake cohorts do not require tracking or reporting

8. *Recommendations to the Field Office Director or Designee Regarding Detainee Release and Special Circumstance Movement*

- a. Recommend all detainees being released be given the fact sheets *Steps to help prevent the spread of COVID-19 if you are sick* and *Stop the spread of germs*.
- b. Recommend the following considerations if decisions are made to release in the U.S. detainees with confirmed or suspected COVID-19 and detainees exposed to a person with confirmed or suspected COVID-19:
 - i. If the detainee will be released before the recommended medical isolation or cohorting period is complete, discuss release of the individual with state or local health department
 - Provide the health department with the detainee's name, intended address, email address, and all available telephone numbers
 - ii. Facilitate safe transport, continued shelter, and medical care, as part of release planning.
 - Make direct linkages to community resources to ensure proper medical isolation and access to medical care if needed.
 - Coordinate with the detainee for a family member or friend to provide transportation
 - Advise the detainee to avoid public transportation, commercial ride sharing (e.g., Uber, Lyft), and taxis

- iii. Give the detainee the CDC's *What To Do if You Are Sick* fact sheet (see [2019 Novel Coronavirus Resource Page | Illness Prevention Patient Education](#))
- c. Detainees under isolation or cohorting should be permitted to attend other medically necessary appointments with advance coordination with the receiving facility
- d. Detainees under isolation or cohorting should not be restricted from movement to facilitate a medically- or behaviorally-necessary placement
- e. If a detainee under isolation or cohorting must be moved to another facility; the receiving facility must be notified of the isolation or cohorting end dates
- f. Recommend to Field Office Director or designee that detainees cohorted due to exposure to an ill person not be transferred or transported unless medically necessary.
 - i. See [IHSC Interim COVID-19 Risk Assessment](#) on the [2019 Novel Coronavirus Resource Page](#).

9. **REPORTING**

- a. Document any ill detainee who is suspected of having COVID-19 on the [Lower Respiratory Illness Tracking Tool](#).
- b. Document exposure-based cohorting through routine IHSC cohort reporting protocols using the [Cohort Tracker](#).
- c. Any employee known to have a positive test result for COVID-19 must be promptly reported to the local or state health department in accordance with local or state public health laws and permissible exemptions under the Health Insurance Portability and Accountability Act (HIPAA) requiring notifications to public health departments for conducting investigations and interventions and to avert a serious threat to public health and safety. Reported must include the employee's name, date of birth, address, phone number, and testing location.

¹**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)

If such contact occurs while not wearing recommended personal protective equipment or PPE (e.g., gowns, gloves, NIOSH-certified disposable N95 respirator, eye protection), criteria for PUI consideration are met.

Resources and references

- [2019 Novel Coronavirus Resource Page](#) on SharePoint
- [Reducing the Risk of COVID-19 Transmission](#)
- [Illness Prevention and Patient Education](#) resources in multiple languages are available on SharePoint.
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IHSC Official Guidance

Guidance number	Guidance name	Type
05-02	Occupational Health Directive	Policy
05-02 G-04	Occupational Health Guide: Workforce Health	Guide
05-02 G-1	Occupational Health Guide: Bloodborne Pathogens and Other Potentially Infectious Materials	Guide
05-02 G-2	Occupational Health Guide: Personal Protective Equipment Program	Guide
05-02-G-03	Occupational Health Guide: Respiratory Protection Program	Guide
05-04	Environmental Health Directive	Policy
05-04 G-01	IHSC Environmental Health Guide	Guide
05-06	Infectious Disease Public Health Actions Directive	Policy
05-06 G-01	Infectious Disease Public Health Actions Guide: Contact and Outbreak Investigation Guide	Guide
05-06 G-02	Infectious Disease Public Health Actions Guide: Isolation and Management of Detainees Exposed to Infectious Organisms	Guide

Guidance number	Guidance name	Type
05-06 G-03	Infectious Disease Public Health Actions Guide: Surveillance and Reporting	Guide

- [Infection Control: Novel Coronavirus 2019 \(COVID-19\) | CDC](#)
- [Interim Guidance: Healthcare Professionals 2019-nCoV | CDC \(including CDC website listing of geographic area\(s\) with widespread or sustained community transmission\)](#)
- [Resources for Correctional and Detention Facilities | CDC](#)
- [CDC | Coronavirus Disease 2019 \(COVID-19\)](#)
- [2019 Novel Coronavirus \(2019-nCoV\) | TDSHS](#)
- [nCOV2019 | CDPH](#)
- [Novel Coronavirus Outbreak 2020 | Washington State Department of Health](#)
- [ADHS - Highlighted Infectious Diseases for Arizona - Coronavirus Disease 2019 \(COVID-19\)](#)
- [Coronavirus | NYC Health](#)
- [2019 Novel \(New\) Coronavirus | NYDOH](#)
- [2019 Novel Coronavirus \(2019-nCoV\) | Florida Department of Health](#)
- [NJ Department of Health | Communicable Disease Service | COVID-2019 \(Novel Coronavirus\)](#)
- [Pennsylvania Department of Health | Coronavirus](#)
- [2019 Novel Coronavirus \(2019 nCoV\) | Frequently Asked Questions | IDPH](#)

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Appendix A: Intake Screening Questions

Updated April 1, 2020

1. **Have you been in close contact with a person with laboratory-confirmed 2019 novel coronavirus or their respiratory secretions in the past 14 days?**
 - Last date you had contact with that person: mm/dd/yyyy
2. If yes to #1:
 - **Have you had fever and/or respiratory illness with onset in the past 14 days?**
 - **If yes, what date did you first notice symptoms?: mm/dd/yyyy**
 - **If yes**, isolate and refer to a medical provider, add Medical Hold, notify FHPM, IPO, or designee.
 - See [Reducing the Risk of COVID-19 Transmission](#)
 - **If no, implement EXPOSURE-BASED COHORTING**; house in single room (preferred) if available, implement daily checks for 14 days after initial DHS apprehension, add Medical Hold, notify FHPM, IPO, or designee.
3. If no travel from or through geographic area(s) with widespread or sustained community transmission* in the past 14 days AND no close contact with a person with laboratory-confirmed 2019 novel coronavirus or their respiratory secretions in the past 14 days?
 - ***Please see CDC website listing of international area(s) with sustained transmission at <https://www.cdc.gov/coronavirus/2019-ncov/hcp/clinical-criteria.html>**
 - Routine intake
 - If the initial DHS apprehension date (i.e., initial CBP or ICE encounter) documented in ENFORCE is ≥ 14 days prior, the detainee is outside the 14 day window and does not require monitoring for the epidemiologic risk of COVID-19 exposure
 - Facility Infection Prevention Officers and/or PHSP Unit staff can help confirm the date of initial DHS apprehension in ENFORCE

***Please see CDC website listing of international area(s) with sustained transmission at <https://www.cdc.gov/coronavirus/2019-ncov/hcp/clinical-criteria.html>**



Interim Reference Sheet on 2019-Novel Coronavirus (COVID-19): Detainee Care
Version 9.1, April 6, 2020

Key changes

Version 9.1

- Corrected errors in Appendix A
- Added information that detainees that meet criteria for discontinuation of transmission-based precautions can be housed in general population.

Version 9.0

- Discontinued the following actions as part of our COVID-19 response due to CDC's guidance for ALL international travelers to *stay home for 14 days from the time you returned home* from international travel and due to widespread, ongoing transmission in the U.S.
 - Asking detainees during intake if they have traveled from or through specific countries in the past 14 days
 - 14-day monitoring of asymptomatic, afebrile detainees that have traveled from or through specific countries in the past 14 days
 - Documenting individual asymptomatic, afebrile detainees that have traveled from or through specific countries in the past 14 days in the Lower Respiratory Illness Tracker
- Added information about contagiousness and releasing transmission-based precautions
- The following actions shall continue:
 - Intake screening to identify detainees with fever and/or symptoms of respiratory illness
 - Asking detainees during intake if they have had exposure to a person with COVID-19 in the past 14 days.
 - Cohorting as a group of people exposed to a person with suspected or confirmed COVID-19 and tracking cohorted units on the [Cohort Tracker](#).
 - Documenting individual detainees in isolation with fever and/or symptoms of respiratory illness in the [Lower Respiratory Illness Tracking Tool](#).
- Added information to recommend to the Field Office Director or Designee and/or Facility Administrator to consider housing newly arriving detainees separately for 14 days before

Situation Summary

The CDC is closely monitoring an outbreak caused by a novel (new) coronavirus (COVID-19). The situation is evolving and expanding with community transmission occurring in multiple countries including the United States. For the most current information, check the CDC information pages at <https://www.cdc.gov/coronavirus/2019-ncov/index.html> frequently for updates. CDC interim guidance for health care professionals, including clinical criteria, is available at <https://www.cdc.gov/coronavirus/2019-nCoV/clinical-criteria.html>.

ICE Health Service Corps Recommendations

- *Note: recommendations will be updated if and as necessary to address the evolving public health situation. See also [2019 Novel Coronavirus Resource Page](#) including [Reducing the Risk of COVID-19 Transmission](#) and [Dental Care - Prioritizing Care and Staying Safe](#)*

1. *During intake medical screening:*

- a. **Ask all detainees if they have had close contact¹ with a person with laboratory-confirmed COVID-19 in the past 14 days**
 - i. **If the detainee responded yes to 1a),** assess for fever and symptoms of respiratory illness.
 - If the detainee has a fever and/or symptoms of respiratory illness, refer to ISOLATION below.
 - If the detainee does not have fever or respiratory illness, refer to EXPOSURE-BASED COHORTING, below.
 - b. If the detainee has fever and/or symptoms or respiratory illness and if they have not had close contact¹ with a person with laboratory-confirmed COVID-19 or their respiratory secretions in the past 14 days → refer to a medical provider (see ENCOUNTER below).
 - c. Educate all detainees to include the importance of hand washing and hand hygiene, covering coughs with the elbow instead of with hands, and requesting sick call if they feel ill.
 - i. [Illness Prevention and Patient Education](#) resources in multiple languages are available on the [2019 Novel Coronavirus Resource Page](#).

2. *ENCOUNTER. During sick call, health assessment, or other clinical encounter in which a detainee presents with or complains of fever and/or respiratory illness, or is observed with signs of fever and/or respiratory illness:*

- a. **If the detainee had close contact¹ with a person with laboratory-confirmed COVID-19 or their respiratory secretions in the past 14 days**
 - i. → refer to ISOLATION below.
 - b. If the detainee has not had close contact¹ with a person with laboratory-confirmed COVID-19 or their respiratory secretions in the past 14 days, then

- i. → Providers should use their judgment to determine if a patient has signs and symptoms compatible with COVID-19 and whether the patient should be isolated and tested. Decisions on which patients receive testing should be based on the epidemiology of COVID-19, as well as the clinical course of illness. Providers are strongly encouraged to test for other causes of respiratory illness, including infections such as influenza.
- ii. See [Reducing the Risk of COVID-19 Transmission](#) and [Dental Care - Prioritizing Care and Staying Safe](#)
- iii. See SPECIMEN COLLECTION AND LABORATORY TESTING below.
- c. Educate detainees to include the importance of hand washing and hand hygiene, covering coughs with the elbow instead of with hands, and requesting sick call if they feel ill.
 - i. [Illness Prevention and Patient Education](#) resources in multiple languages are available on the [2019 Novel Coronavirus Resource Page](#).

3. *ISOLATION and management of detainees with fever and/or symptoms of respiratory illness and who are suspected or confirmed to have COVID-19:*

- a. See [Coronavirus Disease 2019 \(COVID-19\) | Housing Symptomatic Detainees](#)
- b. See [Reducing the Risk of COVID-19 Transmission](#) and [Dental Care - Prioritizing Care and Staying Safe](#).
- c. Place a tight-fitting surgical mask on the detainee.
- d. Promptly consult with a medical provider, preferably the Clinical Director or designee.
- e. Place the detainee in a private medical housing room, ideally in an airborne infection isolation room if available. If no single occupancy medical housing unit room is available, placement in other areas of the facility may be utilized to house the ill detainee separately from the general detention population.
- f. Call the local and/or state health department for notification and guidance.
- g. Laboratory testing for COVID-19 is now available through commercial laboratories including LabCorp and through local and/or state health departments.
 - i. See SPECIMEN COLLECTION AND LABORATORY TESTING below.
 - ii. Report positive test results for COVID-19 promptly to the local or state health department
- h. If the detainee has underlying illness or is acutely ill, or symptoms do not resolve, consult with the Regional Clinical Director, and/or Infectious Disease program.
- i. If the detainee is referred to a local hospital, call the hospital in advance to notify of the recent relevant travel history and respiratory symptoms and to coordinate how manage the detainee safely.
- j. Promptly notify the facility's staff responsible for infection prevention and control (e.g., in IHSC facilities, notify the Infection Prevention Officer, or the Facility Healthcare Program Manager (if the facility does not have an Infection Prevention Officer position); if the Infection Prevention Officer or Facility Healthcare Program

- Manager is not available, IHSC staff should notify the Infection Prevention Group at [#IHSC_PHSP_IPO@ice.dhs.gov](mailto:IHSC_PHSP_IPO@ice.dhs.gov).
- k. Facilities without IHSC medical staffing should notify their assigned Field Medical Coordinator.
 - l. IHSC Infection Prevention Officers, Facility Healthcare Program Managers, Field Medical Coordinators, or designees should notify the Regional Infection Prevention Supervisory Nurse immediately.
 - m. Detainees isolated for respiratory illness and who have epidemiologic risk for COVID-19 exposure should wear a tight-fitting surgical mask when outside of the isolation room.
 - n. See REPORTING below.
 - o. The contagious period for COVID-19 is still uncertain.
 - i. A person with COVID-19 is thought to be contagious starting 48 hours before symptom onset
 - ii. The decision to discontinue [Transmission-Based Precautions](#) should be made using a test-based strategy or a non-test-based strategy (i.e., time-since-illness-onset and time-since-recovery strategy).
 - iii. Detainees that meet criteria for discontinuation of transmission-based precautions can be housed in general population.
 - **Test-based strategy (preferred if the patient is immunocompromised)**
 - Resolution of fever without the use of fever-reducing medications **and**
 - Improvement in respiratory symptoms (e.g., cough, shortness of breath), **and**
 - Negative results of an FDA Emergency Use Authorized COVID-19 molecular assay for detection of SARS-CoV-2 RNA from at least two consecutive nasopharyngeal swab specimens collected ≥ 24 hours apart (total of two negative specimens). See [Interim Guidelines for Collecting, Handling, and Testing Clinical Specimens for 2019 Novel Coronavirus](#).
 - **Non-test-based strategy**
 - At least 3 days (72 hours) have passed *since recovery* defined as resolution of fever without *the* use of fever-reducing medications **and** improvement in respiratory symptoms (e.g., cough, shortness of breath); **and**,
 - At least 7 days have *passed since symptoms first appeared*
 - iv. If the detainee tests negative for COVID-19 and fever and/or symptoms persist, consult with the Regional Clinical Director and/or Infectious Disease Program
 - p. Educate detainees to include the importance of hand washing and hand hygiene, covering coughs with the elbow instead of with hands, and requesting sick call if they feel ill.
 - i. [Illness Prevention and Patient Education](#) resources in multiple languages are available on the [2019 Novel Coronavirus Resource Page](#).

4. SPECIMEN COLLECTION AND LABORATORY TESTING for COVID-19

- a. Laboratory testing for COVID-19 is available through commercial laboratories including LabCorp and through local and/or state health departments.
- b. See **Specimen Collection instructions on the 2019 Novel Coronavirus Resource Page**.
 - i. LabCorp ordering codes are 2019 Novel Coronavirus (COVID-19), NAA; TEST: 139900.

5. INFECTIOUS DISEASE PUBLIC HEALTH ACTIONS

- a. Educate detainees to include the importance of hand washing and hand hygiene, covering coughs with the elbow instead of with hands, and requesting sick call if they feel ill.
 - i. Illness Prevention and Patient Education resources in multiple languages are available on SharePoint.
- b. See also 05-06-G-02 Infectious Disease Public Health Actions Guide: Isolation and Management of Detainees Exposed to Infectious Organisms.

6. EXPOSURE-BASED COHORTING

- a. **Known exposure to a person with suspected or confirmed COVID-19**
 - i. Implement cohorting with restricted movement for detainees housed with the ill detainee or who have been in close contact¹ with the ill person for the duration of the most recent incubation period (14 days after most recent exposure to an ill person).
 - ii. Refer exposed detainees with new onset fever and/or respiratory illness to a medical provider for evaluation.
 - iii. Discontinue cohorting when 14-day incubation period completes with no new cases.
- b. **Exposure to a person with fever or symptoms being evaluated or under investigation for COVID-19 but not confirmed to have COVID-19**
 - i. Implement cohorting with restricted movement for detainees housed with the ill detainee or who have been in close contact¹ with the ill person for the duration of the most recent incubation period.
 - ii. Refer exposed detainees with new onset fever and/or respiratory illness to a medical provider for evaluation.
 - iii. If the index patient is subsequently confirmed to have COVID-19, see ***Known exposure to a person with confirmed COVID-19*** above.
 - iv. Discontinue cohorting if the index patient receives an alternate diagnosis that excludes COVID-19.
 - v. Any of the cohorted detainees with exposure risk should complete their initial 14-day monitoring period (i.e., for asymptomatic monitoring).

- c. **Visit dorms daily and remind detainees that medical services are available.**
 - i. Educate patients to report if they feel ill or feverish.
 - ii. Remind custody staff to report any patients they are concerned about, with special attention to those who might have fever, cough, or shortness of breath.
 - iii. Promote access to care through sick call and urgent care services.
 - iv. *Provide frequent patient education via town halls and similar dorm visits to reinforce detainee knowledge about how to access care.*

7. *Recommendations to the Field Office Director or Designee and the Facility Administrator or Warden for routine intake cohorting*

- a. Consider housing separately from GP all new intakes for 14 days before they enter the facility's general population (SEPARATELY from other individuals who are cohorted due to contact with a COVID-19 case).
- b. This could be individual housing or as a routine intake cohort.
- c. If housed as a routine intake cohort, consider allowing each individual to be moved to the general population after 14 days if no fever or symptoms.
- d. If any person in the routine intake cohort does develop fever or symptoms, the cohort status would be changed to an *exposure-based cohort*
- e. Routine intake cohorts do not require tracking or reporting

8. *Recommendations to the Field Office Director or Designee Regarding Detainee Release and Special Circumstance Movement*

- a. Recommend all detainees being released be given the fact sheets *Steps to help prevent the spread of COVID-19 if you are sick* and *Stop the spread of germs*.
- b. Recommend the following considerations if decisions are made to release in the U.S. detainees with confirmed or suspected COVID-19 and detainees exposed to a person with confirmed or suspected COVID-19:
 - i. If the detainee will be released before the recommended medical isolation or cohorting period is complete, discuss release of the individual with state or local health department
 - Provide the health department with the detainee's name, intended address, email address, and all available telephone numbers
 - ii. Facilitate safe transport, continued shelter, and medical care, as part of release planning.
 - Make direct linkages to community resources to ensure proper medical isolation and access to medical care if needed.
 - Coordinate with the detainee for a family member or friend to provide transportation
 - Advise the detainee to avoid public transportation, commercial ride sharing (e.g., Uber, Lyft), and taxis

- iii. Give the detainee the CDC's *What To Do if You Are Sick* fact sheet (see [2019 Novel Coronavirus Resource Page | Illness Prevention Patient Education](#))
- c. Detainees under isolation or cohorting should be permitted to attend other medically necessary appointments with advance coordination with the receiving facility
- d. Detainees under isolation or cohorting should not be restricted from movement to facilitate a medically- or behaviorally-necessary placement
- e. If a detainee under isolation or cohorting must be moved to another facility; the receiving facility must be notified of the isolation or cohorting end dates
- f. Recommend to Field Office Director or designee that detainees cohorted due to exposure to an ill person not be transferred or transported unless medically necessary.
 - i. See [IHSC Interim COVID-19 Risk Assessment](#) on the [2019 Novel Coronavirus Resource Page](#).

9. **REPORTING**

- a. Document any ill detainee who is suspected of having COVID-19 on the [Lower Respiratory Illness Tracking Tool](#).
- b. Document exposure-based cohorting through routine IHSC cohort reporting protocols using the [Cohort Tracker](#).
- c. Any employee known to have a positive test result for COVID-19 must be promptly reported to the local or state health department in accordance with local or state public health laws and permissible exemptions under the Health Insurance Portability and Accountability Act (HIPAA) requiring notifications to public health departments for conducting investigations and interventions and to avert a serious threat to public health and safety. Reported must include the employee's name, date of birth, address, phone number, and testing location.

¹**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)

If such contact occurs while not wearing recommended personal protective equipment or PPE (e.g., gowns, gloves, NIOSH-certified disposable N95 respirator, eye protection), criteria for PUI consideration are met.

Resources and references

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Appendix A: Intake Screening Questions

Updated April 6, 2020

1. **Have you been in close contact with a person with laboratory-confirmed 2019 novel coronavirus or their respiratory secretions in the past 14 days?**
 - Last date you had contact with that person: mm/dd/yyyy
2. If yes to #1:
 - **Have you had fever and/or respiratory illness with onset in the past 14 days?**
 - **If yes, what date did you first notice symptoms?: mm/dd/yyyy**
 - **If yes**, isolate and refer to a medical provider, add Medical Hold, notify FHPM, IPO, or designee.
 - See [Reducing the Risk of COVID-19 Transmission](#)
 - **If no, implement EXPOSURE-BASED COHORTING;** house in single room (preferred) if available, implement daily checks for 14 days after initial DHS apprehension, add Medical Hold, notify FHPM, IPO, or designee.
3. If no fever, respiratory illness, or close contact with a person with laboratory-confirmed 2019 novel coronavirus or their respiratory secretions in the past 14 days.
 - Routine intake