

Washington State Penitentiary

COVID-19 Response

DATE: March 7, 2022

TO: All WSP Incarcerated Individuals



FROM: Rob Jackson, WSP Superintendent
Steve Barker, Assoc. Superintendent, COVID-19 Incident Command

SUBJECT: COVID-19 Questions/Concerns Q&A

In February 2022 many of you were asked if you had questions and concerns about how DOC is handling the pandemic, and we also recognized the need for CDC information to be provided to you. That information was made available to you on March 2, 2022. In the spirit of transparency, we have collected your most asked questions and provided answers below. Thank you for your patience while we developed this information, it consists of local, clinical and DOC Headquarters' input.

- **Provide the statistics on false positive/negative results and the accuracy rate of tests.**

PCR Tests (polymerase chain reaction): This works by identifying specific genes in the COVID-19 virus RNA present in the nasal swab sample. According to available data, the PCR test will result positive in a patient that is infected with COVID-19 approximately 97-98% of the time. Although rare, false negatives occur if it's too early or too late in the disease process, and if the quality or the amount of viral RNA present in the sample is not sufficient.

The PCR test will result negative in a patient that is not infected with COVID-19 approximately 98% of the time. False positives are extremely rare. This is especially true during an outbreak when there is a large portion of a population with COVID-19 and a high probability of getting infected.

BD Veritor Rapid Antigen (rapid test): This works by identifying the COVID-19 antigens in the nasal swab sample. According to available data, 84% of symptomatic patients who tested positive from a PCR test mentioned above, also tested positive with the BD Veritor Rapid Antigen Test. The remaining 16% were patients that tested positive for COVID-19 on a nasal swab PCR but were negative on the rapid antigen test, known as false negatives. This means that a minority of patients who have symptoms but test negative on the rapid antigen test would test positive on the PCR test. Patients who had symptoms of COVID-19 but tested negative on nasal swab PCR test, known as true negatives, 100% were also negative on the BD Veritor Rapid Antigen Test. There were no known patients who had symptoms that had a negative nasal swab PCR test and a positive rapid antigen test, known as false positives.

In summary, although the rapid test might miss some patients who really have COVID-19 according to the PCR test (false negatives), it would be extremely rare that the rapid test would result positive on patients that have a negative PCR test (false positives). As mentioned before, in the setting of an outbreak, the likelihood of a positive rapid test being a true positive is much higher. This is also why patients with symptoms and a negative test need to be medically isolated and re-tested, as they might become positive on the following days as more viral particles become detectable in the nares. The data above is for symptomatic patients, we still don't have enough data on the performance of the BD Veritor Rapid Antigen Test on asymptomatic patients.

Another important point to consider is that after someone recovers from COVID-19, the PCR test might continue to be positive, since it can detect very small amounts of viral particles even if the patient is

asymptomatic and not contagious anymore. Hence, we switch to rapid testing patients for 90 days after infection due to the potential for persistent positive PCR testing. During this period, if the rapid test changes from negative to positive, it could mean re-infection and the need for medical isolation.

- **What are the protocols around changing PPE between testing's?**

The current guidance for PPE follows recommendations by the Department of Health and CDC. For healthcare providers collecting specimens or working within six feet of patients suspected to be infected with COVID-19, recommended PPE includes N95 mask, eye protection, gloves and a gown. Gloves should be changed between each patient tested and include proper hand hygiene. The rest of PPE can stay on unless it comes in contact with a patient. Healthcare providers should wear a face mask at all times while in the healthcare facility.

- **What are the specifics on quarantine/medical isolation protocols in congregate settings from DOH/CDC, and why the protocols are different for staff?**

Per DOH/CDC guidelines for medical isolation, patients with confirmed COVID-19 who are without fever and have improving symptoms can have medical isolation lifted after 10 days. With high transmissibility of the current COVID-19 variant in a congregate living setting, DOC guidelines indicate that isolation can be lifted after 10 days for a fully-vaccinated patient, and after 14 days for patients not fully vaccinated – provided they both have negative rapid test prior to lifting isolation. Due to critical staff shortages, we followed CDC guidance and temporarily changed medical isolation protocol for staff, so they can return after five days of isolation. However, the DOC has taken additional precautions and requires a negative rapid test prior to return to work, as well as strict masking guidelines. Staff with a close contact must frequently rapid test during the 10 days after exposure and are given strict masking guidance. When critical staffing shortages resolve, the protocols for staff will return to that of general population.

- **Why are we operating in cohorts if the DOC makes the entire side/unit reset, then run as tiers instead of cohorts?**

Cohorting is one of several mitigation strategies designed to decrease the rate of transmission within a unit by dividing the population in groups to isolate possible spread. It is only one of many strategies. Unfortunately, although cohorting is often very effective to get units off quarantine faster, there can still be transmission within a unit or between cohorts due to shared airspace. Therefore, when there is a new positive patient, quarantine timelines need to be reset in the unit amongst patients who share these areas.

- **If we are positive, why aren't we sent to medical isolation for five days, and if exposed, why must we go into quarantine instead of daily testing?**

Unfortunately, congregate-living settings such as a prison unit are much higher risk for transmission compared to other settings. This is mainly due to the increased number of individuals in a very limited space, the limited ventilation, and the increased transmissibility of the COVID-19 variant. Per CDC guidance, isolation in congregate living settings should not be less than 10 days, otherwise remaining residents would be placed at an increased risk of getting infected.

When a patient has been exposed to a person with COVID-19, it is crucial that the exposed patient is placed on quarantine. Daily testing could be helpful, but would not be enough to prevent transmissions, because patients can become contagious two days prior to a positive test. This exposes other individuals and contributes to the spread in the unit. Daily testing would mitigate or decrease risk but does not replace of the need to quarantine.

- **Can headquarters come out with a medical waiver for us to sign to accept the risks of developing COVID-19 to avoid quarantine?**

Since COVID-19 is infectious and can spread to others, it is not the same as signing a refusal for care. Individuals can refuse care for themselves and choose to take risks, but the decision not to quarantine not only affects the individual choosing to quarantine, but it also impacts those around them. Other residents

may have risk factors for developing severe COVID-19, may not have made the same decision and may not want to take that risk.

- **Why are symptomatic individuals getting more privileges than those without symptoms that are put on continuous quarantine? After negative tests I am still on quarantine, but people who tested positive are getting to go to yard.**

There is an important difference between being symptomatic and having tested positive for COVID-19. Once a patient has tested positive for COVID-19 and is placed in an area where everyone in the unit also has tested positive for COVID-19, there is no longer the need to prevent transmission in that unit, so people can have more opportunities to share spaces.

When a patient is symptomatic and the result is negative for COVID-19, the patient would not be able to go to the medical-isolation unit with positive individuals, because we cannot expose them to COVID-19 without knowing that they already have the virus. This symptomatic patient would not be able to stay on his previous unit either. Any symptomatic patient must be placed on medical isolation to protect asymptomatic individuals. Hence, being symptomatic but having a negative COVID-19 test would cause a separate, potentially more restrictive kind of medical isolation until COVID-19 is confirmed or ruled out with repeat testing.

As mentioned above, another issue with quarantine is that whenever there's a new positive, the clock resets for the unit in question. That's why cohorting and other measures aim to limit the spread so quarantine can be lifted sooner. Again, people who test positive and go to a medical-isolation unit no longer need to be protected from each other and they can have more time in the shared spaces.

DOC continues to review and update COVID-19 protocols and operational capabilities for facilities on outbreak to make allowances for outdoor time and minimize restrictive measures as much as possible.

- **Who is making the decision to keep us quarantined for so long?**

The spread of COVID-19 determines how long folks are in quarantine. DOC is following CDC guidance and working to get folks out of quarantine as quickly as possible based on the ongoing cases of COVID-19. The better individuals mask, socially distance, cohort, wash hands and report symptoms, the less transmission occurs, and the faster units come off quarantine. Many DOC facilities have successfully come off quarantine and outbreak status. The Omicron variant of COVID-19 is more transmissible than prior variants and the most recent surge had a large impact on folks in and out of prison.