UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF NEW YORK
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HASSAN CHUNN; NEHEMIAH McBRIDE; AYMAN RABADI by his Next Friend Migdaliz Quinones; and JUSTIN RODRIGUEZ by his Next Friend Jacklyn Romanoff; ELODIA LOPEZ; and JAMES HAIR, individually and on behalf of all others similarly situated,

Petitioners,

-against-

WARDEN DEREK EDGE,

Respondent.

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Civil Action No.
20-CV-1590
(Kovner, J.)
(Mann, M.J.)

MEMORANDUM OF LAW IN OPPOSITION TO PETITIONERS' MOTIONS *IN LIMINE*

RICHARD P. DONOGHUE
United States Attorney
Counsel for Respondent
Eastern District of New York
271-A Cadman Plaza East, 7th Floor
Brooklyn, New York 11201

May 10, 2020

James R. Cho
Seth D. Eichenholtz
Joseph A. Marutollo
Paulina Stamatelos
Assistant United States Attorneys
(Of Counsel)

TABLE OF CONTENTS

PRELIMINARY STATEMENT

Upon learning of the first COVID-19 cases in the United States in January 2020, the Federal Bureau of Prisons ("BOP") immediately took action to prevent the introduction and spread of COVID-19 in BOP institutions across the nation, including at the Metropolitan Detention Center-Brooklyn ("MDC"). From January 2020 through the present, the BOP has been coordinating its COVID-19 efforts with subject-matter experts both internal and external to the agency, including implementing guidance and directives from the World Health Organization, the Centers for Disease Control and Prevention, the Office of Personnel Management, the Department of Justice, and the Office of the Vice President. As a result of BOP officials' round-the-clock efforts at MDC, COVID-19 has been effectively contained at the MDC. Indeed, largely as a result of these efforts, Petitioners cannot point to a single MDC inmate who has needed hospitalization in connection with the pandemic, or, for that matter, to a single inmate who suffered serious illness or even succumbed to COVID-19.

Despite BOP's extraordinary efforts in combatting COVID-19 at the MDC, Petitioners filed the instant action, baselessly charging that Respondent was deliberately indifferent to the safety of MDC's inmates. The petition was based on unfounded allegation, speculation, and hearsay. Likely knowing their petition was a factual and legal house of cards unlikely to withstand scrutiny, Petitioners sought to buttress their claims by hiring Dr. Homer Venters. After conducting a purported "inspection" of the MDC that predominantly involved speaking with a small group of inmates handpicked by Petitioners' counsel, Dr. Venters reflexively adopted the handpicked inmates' allegations without any scrutiny or examination of objective evidence. He then issued a declaration based on the unchallenged statements and unsurprisingly reached a conclusion mostly in accord with the petition.

Countering these allegations, Respondent submitted robust, factual evidence in the form of declarations from MDC staff, documents, and independent-minded experts who based their opinion on experience and medical guidance, which shows the true extent of MDC's strikingly successful efforts

to mitigate the risk of COVID-19 to inmates and staff alike.

Petitioners now find themselves on the eve of the first proceeding which will test the veracity of their arguments, faced with credible evidence that brings the allegation and speculation previously animating their claims to the point of collapse. In a desperate, last-ditch attempt to prevent Respondent from introducing the evidence fatal to Petitioners' claims, Petitioners bring the instant motions *in limine* seeking, for various reasons, preclusion of the very evidence that will demonstrate the efforts MDC has undertaken. First, Petitioners seek a sanction for supposed spoliation of evidence because MDC staff discarded written sick call requests after entering the information contained in these documents into the MDC's electronic medical records system. The requested sanction, unsurprisingly, is to preclude the Respondent from submitting evidence as to the adequacy of his COVID-19 response, which could essentially allow Petitioners to prevail despite such compelling evidence. As discussed in more detail below, there was no spoliation of evidence, there is no basis for a sanction here, and even if there were, such a disproportionate proposed sanction is not appropriate or proportional.

Additionally, as set forth below, Petitioners' motion *in limine* seeking to preclude the expert testimony of Ms. Asma Tekbali, M.P.H—an epidemiologist and infection preventionist currently working on the frontlines of combatting the COVID-19 pandemic in one of the nation's leading hospitals—should be swiftly rejected by the Court.

ARGUMENT

I. Petitioners' Desperate Motion To Preclude Objective Evidence Through An Unfounded "Spoliation" Sanction Must Be Denied

A. Background Regarding Sick Call Requests

MDC has a system in place whereby there exist several avenues through which an inmate can request an appointment with a medical provider, known as a "sick call." *See* Excerpt of Deposition of BOP Health Services Administrator Stacey Vasquez ("Vasquez Dep."), annexed to the Declaration of

Petitioners' counsel, Dkt. No. 72 ("Vasquez Dep.") 186-87. The preferred method for these requests is to file an electronic request through the inmate e-mail system using TRULINCS. *See* Excerpted Section of Inmate Handbook, annexed to the Declaration of Seth Eichenholtz, as Exhibit A at 23-24 (discussing episodic care and emergency medical treatment); *see* Vasquez Dep. 188. However, an inmate can make an oral request for sick call to any staff member (who make rounds every 30 minutes in all the units during this pandemic), or health care provider (who are currently making rounds twice daily in the quarantine and isolation units and at least once daily in the other units), or submit a written request on a sick call form. *See* Vasquez Dep. 48-49, 75, 187; *see also* Vasquez Declaration, Dkt. No. 80 ("Vasquez Decl.") 4-5. When health care providers make rounds, they also carry with them paper sick call requests to give to inmates if requested, and they collect sick call requests. *See* Vasquez Dep. 186-88. Once the health care provider receives the sick call request, the provider triages the sick call request and may examine an inmate immediately, if necessary. *See* Vasquez Dep. 186-90, 54. Otherwise, the health care provider enters the information contained in those forms into the BOP's medical records database in order to schedule the inmate for sick call. *See* Vasquez Dep. 187-90. The sick call schedule contains the inmate name and register number, and may include a brief synopsis about the inmate's complaint – in substance the information contained on the form. *See* Vasquez Dep. 188. The form is then discarded as the information lives in the medical records system.[1] *See* Vasquez Dep. 188-94. After the inmate is seen by medical staff, the information about the nature of the inmate's medical complaints is contained in an "encounter note" in the inmate's medical records moving forward. *See* Vasquez Dep.

[1] Health Services Administrator Vasquez noted that it is "not a good infectious disease practice" to prolong the retention of these paper documents, particularly to the extent the inmate writing the document claims to be infected with COVID-19. Vasquez. Tr. 196. Petitioners attempt to cast nefarious motives behind this common sense concern by calling it a "shifting" explanation of why records are not preserved. *See* Pet. Mot. at 9-11. Far from shifting, it is just *another* reason that MDC chooses not to keep the paper documents when the substance of the request is already preserved in its medical records system. Petitioners' hyperbolic characterization to the contrary rests on the unfounded assumption that there can be but one reason that these records are not maintained once the information is entered into the medical records system.

190-91.

B. Standard for a Motion for Spoliation Sanctions

Spoliation is commonly defined as "the destruction or significant alteration of evidence, or the failure to preserve property for another's use as evidence in pending or reasonably forseeable litigation." *West v. Goodyear Tire & Rubber Co.*, 167 F.3d 776, 779 (2d Cir. 1999); *see also Saul v. Tivoli Systems, Inc.*, 2001 U.S. Dist. LEXIS 9873 (S.D.N.Y. 2001). When a party requests an adverse inference charge based upon the spoliation of evidence, courts engage in a three-step process to analyze the legitimacy of the claim. *See, e.g., Residential Funding Corp. v. Degeorge Financial Corp.*, 306 F.3d 99, 107 (2d Cir. 2002). Specifically, the party must establish the following: "(1) the party *having control over the evidence* had an obligation to preserve it at the time it was destroyed; (2) the records were destroyed 'with a culpable state of mind'; and (3) the destroyed evidence was 'relevant' to the party's claim or defense such that a reasonable trier of fact could find that it would support that claim or defense." *Id.* at 107 (emphasis added) (citing *Byrnie v. Town of Cromwell*, 243 F.3d 93, 107 (2d Cir. 2001)). The burden of establishing these elements falls upon the party seeking the adverse inference charge. The party requesting sanctions has the burden of establishing the elements of spoliation by a preponderance of the evidence. *See, e.g., Distefano v. Law Offices of Barabra H. Kastos, PC*, No. 11-CV-2893 (PKC)(AKT), 2017 WL 1968278, at *17 (E.D.N.Y. May 10, 2017). Here, Petitioners have the burden of establishing each of the three elements required for a sanction. They can establish none.

C. Petitioners Cannot Establish a Duty to Preserve Written Sick Call Reports When the Information is Preserved in the Medical Records System

At the outset, courts must first determine whether the party against whom the adverse inference charge is sought was under an affirmative duty to preserve the evidence in question. *See Shaffer v. RWP Group, Inc.*, 169 F.R.D. 19, 24 (E.D.N.Y. 1996) (quotations omitted); *Barsoum v. NYC Housing Authority*, 2001 U.S. Dist. LEXIS 3814, at *6 (S.D.N.Y. 2001); *Henkel Corp. v. Polyglass USA, Inc.*,

194 F.R.D. 454, 2000 U.S. Dist. LEXIS 9423 (E.D.N.Y. 2000). The duty to preserve such evidence begins when litigation is "pending or reasonably foreseeable." *Micron Technology, Inc. v. Rambus,* Inc., 645 F.3d 1311, 1321 (Fed. Cir. 2011) (citing *Silvestri v. General Motors Corp.*, 271 F.3d 583, 590 (4th Cir. 2001) and *West v. Goodyear Tire & Rubber Co.*, 167 F.3d 776, 779 (2d Cir. 1999)). This is a flexible fact-specific standard that allows the court to exercise the discretion necessary to confront the myriad factual situations inherent in the spoliation inquiry. *Id.* A duty to preserve documents is not triggered from the mere existence of a potential claim. *Id.* (citing *Trask–Morton v. Motel 6 Operating L.P.*, 534 F.3d 672, 681–82 (7th Cir. 2008)).

As part of this inquiry as to whether a duty exists, the Court must determine the relevant scope of the party's obligation to preserve evidence. *Zubulake v. USB Warburg, LLC,* 220 F.R.D. 212, 217 (S.D.N.Y. 2003). As the Court noted in *Zubulake*, "[m]ust [an entity,] upon recognizing the threat of litigation, preserve every shred of paper, every e-mail or electronic document, and every backup tape? The answer is clearly, 'no.'" *Id.* at 271. Also, courts have held that spoliation sanctions are not warranted where, as here, the information is stored in other places. *Raymond v. City of New York*, 15 Civ. 6885 (LTS)(SLC), 2020 WL 1067482, at *10 (S.D.N.Y. Mar. 5, 2020) (citing *GenOn Mid-Atlantic, LLC v. Stone & Webster, Inc.*, 282 F.R.D. 346, 359 (S.D.N.Y. 2012); *Paluch v. Dawson*, No. 06 Civ. 01751, 2009 WL 3287395, at *3 (E.D. Pa. Oct. 13, 2019)).

In their motion, Petitioners focus only on the date any obligation to preserve documents is triggered, and wholly fail to grapple with the issue of whether the paper sick call requests at issue are part of a reasonable scope of the duty to preserve when the substantive information contained in those forms is entered into the medical records system. *See* Pl. Mot. at 12-13. As discussed earlier, the underlying written requests are disposed of because they are duplicative, unnecessary to maintain, and as part of infection control methods. Under these circumstances, Petitioners cannot establish that

Respondent had a duty to preserve the written records because the substance of the information contained in these documents is stored in the medical records system.

D. Petitioners Cannot Establish That Any Failure to Preserve Records Was Done With a Culpable State of Mind

And even assuming Respondent was under an obligation to preserve these written requests (which he was not, as evident by Respondent's full compliance with Court orders in this matter), Petitioners cannot show that Respondent acted with a "sufficiently culpable state of mind" when MDC personnel continued to engage in the established routine of preserving written sick call information by entering the information from the form into the medical records system, not by preserving the requests in document form. Showing such a state of mind is an essential element of a motion for sanctions. *Caltenco v. GH Food Inc.*, 2018 WL 1788147, at *5 (citing *Estate of Jackson v. Cty. of Suffolk*, 12 Civ. 1455 (JFB) (AKT), 2014 WL 1342957, at *11 (Mar. 31, 2014), *R&R adopted*, 12 Civ. 1455 (JFB) (AKT), 2014 WL 3513403 (E.D.N.Y. July 15, 2014)). While negligence can suffice to meet such a standard, the finding of such culpability is extremely fact specific because "failures to produce or preserve can occur 'along a continuum of fault—ranging from innocence through the degrees of negligence to intentionality.'" *Id.* (quoting *Wandering Dago Inc. v. New York State Office of Gen. Servs.*, No. 13 Civ. 1053 (MAD), 2015 WL 3453321, at *11 (N.D.N.Y. May 29, 2015)).

Here, Respondent has fully complied with the Court order regarding production of sick call requests, and voluntarily expanded that production since. In accordance with the Court's order, Respondent disclosed 888 electronic sick call documents to the Petitioners. Further, once Petitioners raised—for the first time—the specific concern about preservation of the paper sick call requests *in addition to* the data already in the inmate's medical records during an April 25 conference before Judge

Mann,[2] MDC has preserved each and every properly submitted written sick call request.[3] Finally, MDC *voluntarily* agreed, at Petitioners' request, to produce paper sick call records, which included all written requests from April 25 through May 9.[4] In fully responding to the Court's discovery order and expanding the production after the order, Respondent showed diligence, not negligence.

Further, Petitioners argue Respondent has a culpable state of mind because MDC did not change their practice of disposing of written sick call documents after entering the substance of the information into the medical record system when they knew inmates might have less ability to file sick call requests electronically.[5] This limitation, they posit, should have resulted in MDC automatically changing its sick call processing to preserve the documents associated with written requests. However, it is completely understandable that against the backdrop of producing all electronic sick call reports in compliance with the Court's order, and managing to do so while also addressing the urgent matters that arise at MDC during a global health emergency, MDC did not consider changing its written sick call

[2] During that conference, Judge Mann stated: "I'm not going to opine now, whether or not the failure to preserve previously, you know, given the circumstances under which the Bureau of Prisons is operating, I'm not saying that that's spoliation of evidence but going forward, it certainly would be a better practice for the Bureau of Prisons, the MDC, to retain those written documents." Tr. Apr. 25, 2020 Hearing at 48:12-15.

[3] Petitioners argue that they failed to more aggressively pursue production of these written forms during an earlier conference on April 13 because they assumed that inmates could only request sick call through an electronic system (Pt. Motion, p. 7), but that argument is undermined by the transcript of the April 13 proceedings before the Court upon which they rely in their motion. During that conference, counsel for the Respondent made clear that there are occasionally written sick call requests, and those requests may not be preserved after entered into the medical records system. Counsel explained that inmates who wanted to request sick call "can make an oral request to a BOP staff member, they can get a staff member **a hard copy piece of paper requesting sick call** or they can also submit a request electronically using the Trulincs system." Transcript of the April 13, 2020 Conference, p. 23 (emphasis added). Counsel later expanded on the retention of written requests, stating that "those requests are then sent to the medical unit to schedule but what happens beyond that it **may be maintained or it may not be maintained**. The important thing is that the inmate gets seen by a medical professional. I think that's what the BOP's primary concern is." *Id*. at p. 25 (emphasis added). Petitioners did not during that conference demand that MDC start to maintain the documents and the Court only ordered the production of electronic requests because it was assumed that those requests would be simplest to obtain from a centralized source. *Id*. at 25.

[4] Notwithstanding the above, Respondent will endeavor to search for, and produce, any supplemental paper sick call requests between April 1 and April 24 prior to the May 12 hearing.

[5] It is important to note that this phase of the response started on April 1, *after* the start of this litigation. April 1 Declaration of Associate Warden Melinda King, ECF Docket No. 21.

processing practice solely for litigation purposes and where it knew the information is already preserved in its medical records system.

Under these circumstances, where there is absolutely no evidence of negligence, bad faith, or gross negligence, Petitioners cannot establish a "culpable state of mind." *Singh v. Penske Truck Leasing Co., L.P.*, No. 13 Civ. 1860 (VSB)(GWG), 2015 WL 802994, at *5 (S.D.N.Y Feb. 26, 2015).

E. Petitioners Cannot Show Relevance or Prejudice

Petitioners also cannot show that these sick call requests are relevant and that the documents' loss is prejudicial to their claims. Where the moving party acted only negligently, relevance is established when a party "sets forth with any degree of specificity, the materials which would have been helpful in prosecuting [their] claims. Relevance cannot be established solely on the basis of conjecture. Nor can a finding of relevance be grounded solely on the basis that some evidence in the custody of key witnesses no longer exists." *Alter v. Rocky Point School Dist.*, No. 13-CV-1100 (JS)(AKT), 2014 WL 4966119, at *11-12 (E.D.N.Y. Sept. 30, 2014). Prejudice is established where spoliation *substantially* denies a party the ability to support or defend their claim. *Pension Comm. of the Univ. of Montreal Pension Plan v. Banc of Am. Sec.*, 685 F. Supp. 2d 456, 479 (S.D.N.Y. 2010).

Here, the proffered reason behind Petitioners' need for sick call records is to ascertain the kinds of medical complaints that inmates had and whether those complaints evidenced Petitioners' allegations that COVID-19 was a greater issue at MDC than shown in the number of inmates who actually tested positive for the disease. Respondent's robust production in response to this order already provides Petitioners a sense of the kind and number of complaints that were made to MDC compared to the numbers of inmates tested. Under these circumstances where Petitioners can rely on the existing production to obtain the information needed, spoliation sanctions are not permitted. *See Raymond*, 2020 WL 1067482, at *10; *Managed Care Solutions, Inc. v. Essent Healthcare, Inc.*, 736 F. Supp. 2d 1317, 1327 (S.D. Fl. 2010) (denying motion for sanctions because "the allegedly spoliated evidence is not

crucial to the plaintiff's claims because the plaintiff would still be able to prove its case through additional already obtained evidence.")

When determining whether Petitioners are prejudiced by a failure to retain the fraction of requests that were in written form but ultimately entered into the MDC medical records system, it must be emphasized that MDC produced 888 electronic sick call requests for the period of March 13-April 13, 2020, a period of approximately 5 weeks – or approximately 178 electronic requests per week. By comparison, for the week of April 24 through May 1, there were only 36 written sick call requests, and this during a time where Petitioners allege that there is an increase in use of written sick call requests. This strongly suggests that written sick call requests comprised only a small fraction of inmate sick call requests for MDC, even after the April 1 implementation of Phase V of the COVID-19 response. Further, Petitioners offer no basis to believe that the information originally contained in the sick call reports is not preserved in the MDC's medical records system. Under these facts, Petitioners cannot possibly show prejudice and relevance in any missing written sick call reports

Petitioners claim they are prejudiced because they are "no longer able to establish with accuracy how many people reported symptoms of COVID-19 and requested medical care for those symptoms during the time period at issue" (Pt. Mot., p. 17), but indeed that was never possible to begin with given privacy issues and time constraints – inmates can use various methods to request care, including verbal requests to staff, which may be reflected only in their individual medical records.[6] The Court, however, recognized that it is unrealistic to expect MDC to search for and preserve every sick call request in every

[6] Notably, sick call requests are of limited value to this end in that they do not indicate MDC medical staff's response to the request, the results of an objective medical exam that gives greater insight into the inmate's actual medical condition, nor the individual's ultimate diagnosis. The full details of both the inmate medical complaint and the staff's response is contained in the inmate medical records for each encounter with MDC medical staff. To the extent that limited information is important, it remains preserved, along with the information contained in inmates' medical records.

form when it ordered the disclosure of only the electronic sick call records. April 14, 2020 Order, ECF Docket No. 43, pp. 3-4.

Given the disclosure of all relevant electronic records (which were quite voluminous), and the additional, good faith productions made since, Petitioners cannot show prejudice and relevance merely because they will not be able to consider prior to the preliminary injunction hearing some of the sick call requests made by some inmates in written form.

F. Even if a Spoliation Sanction Were Warranted—and it is not—Petitioners are not Entitled to the Relief They Seek

Petitioners seek a sanction wholly disproportional to the consequence of the allegedly spoliated evidence. Despite the voluminous information about sick call requests already available to Petitioners, they argue that Respondent must be precluded from offering *any* evidence to counter their baseless allegation that MDC does not have an adequate sick call response system. Pt. Mot., pp. 23-24. Such a drastic sanction is akin to precluding Respondent from presenting any substantive defense on the issue of providing medical care to inmates, and would unjustly prejudice Respondent. *See Schmid v. Milwaukee Elec. Tool Corp*., 13 F.3d 76, 79 (3d Cir. 1994) (holding that the court should impose "the least onerous sanction corresponding to the willfulness of the destructive act and the prejudice suffered by the victim"). Dispositive sanctions require a showing of "'willfulness, bad faith, or fault on the part of the sanctioned party.'" *Dahoda v. John Deere Co*., 216 F. App'x 124, 125, 2007 WL 491846, at *1 (2d Cir. 2007) (quoting *West v. Goodyear Tire & Rubber Co.*, 167 F.3d 776, 779 (2d Cir. 1999)). Petitioners have not made such a showing here and are not entitled to any sanction, let alone one that would serve to preclude Respondent from presenting his case at the May 12 hearing.

II. Petitioners' Motion to Exclude Respondent's Epidemiology and Infection Preventionist Expert is Without Merit

A. Federal Standards for the Admission of Expert Testimony

The admissibility of expert testimony is governed by Rule 702 of the Federal Rules of Evidence, which states that:

> A witness who is qualified as an expert by knowledge, skill, experience, training, or education may testify in the form of an opinion or otherwise if:
> (a) the expert's scientific, technical, or other specialized knowledge will help the trier of fact to understand the evidence or to determine a fact in issue;
> (b) the testimony is based on sufficient facts or data;
> (c) the testimony is the product of reliable principles and methods; and
> (d) the expert has reliably applied the principles and methods to the facts of the case.

Fed. R. Evid. 702. Under Rule 702, a court must first determine "whether the expert is qualified to testify." *Zaremba v. General Motors Corp.*, 360 F.3d 355, 360 (2d Cir. 2004). The Second Circuit "has interpreted this qualification liberally." *Thomas v. YRC Inc.*, No. 16 Civ. 6105, 2018 WL 919998, at *6 (S.D.N.Y. Feb. 14, 2018) (citing cases); *Cedar Petrochemicals, Inc. v. Dongbu Hannong Chemical Co.*, 769 F. Supp. 2d 269, 283 (S.D.N.Y. 2011) ("An expert should not be required to satisfy an overly narrow test of his own qualifications.").

Once the qualification threshold is met, the judge's task is to "ensure that an expert's testimony both rests on a reliable foundation and is relevant to the task at hand." *Daubert v. Merrell Dow Pharmaceuticals, Inc.*, 509 U.S. 579, 597 (1993). Specifically, in determining admissibility under *Daubert*, judges are charged with a gate-keeping function pursuant to Rule 702 whereby they must determine (1) whether the theory or methodology underlying the testimony is reliable and (2) whether the expert's theory or methodology is relevant in that it "fits" the facts of the case. *See Daubert*, 509 U.S. at 590-91. The judge's "gate keeping" obligation applies not only to "scientific" testimony but to "technical" and "other specialized" knowledge as well. *Kumho Tire v. Carmichael*, 526 U.S. 137, 141 (1999).

"A review of the case law after *Daubert* shows that the rejection of expert testimony is the exception rather than the rule." *Schoolcraft v. City of New York*, No. 10 Civ. 6005, 2015 WL 6444620, at *1 (S.D.N.Y. Oct. 23, 2015) (quoting Advisory Committee Notes to the 2000 Amendments to Fed. R. Evid. 702). As the *Daubert* court explained, "the traditional and appropriate means of attacking shaky but admissible evidence" are not exclusion, but rather "[v]igorous cross-examination, presentation of contrary evidence, and careful instruction on the burden of proof." 509 U.S. at 596 n. 10. "Doubts about the usefulness of an expert's testimony should be resolved in favor of admissibility." *Marmol v. Biro Mfg. Co.*, No. 93-CV-2659, 1997 WL 88854, at *4 (E.D.N.Y. Feb. 24, 1997) (Johnson, J.) (citations omitted).

B. Ms. Tekbali is Qualified to Testify as an Expert Witness

Contrary to Petitioners' flippant description of Ms. Tekbali (Pl. Mot. 1, 20), Ms. Tekbali has a deep background in epidemiology and infection prevention. *See Curriculum Vitae* of Asma Tekbali, bearing Bates No. 113 annexed to the Declaration of Seth Eichenholtz, as Exhibit B ("Tekbali 113"). The court considers the "totality of a witness's background when evaluating the witness's qualifications to testify as an expert." *Rosco, Inc. v. Mirror Lite Co.*, 506 F. Supp. 2d 137, 144-45 (E.D.N.Y. 2007). After obtaining a Bachelor of Science degree in Biology, English, and Chemistry from Texas Woman's University, Ms. Tekbali obtained a Certificate in Epidemiology and Population Health from the Mailman School of Public Health at Columbia University, and a Masters in Public Health focusing on Global Health and Bioethics from New York University. *See* Tekbali 113. Ms. Tekbali has also completed a Post-Baccalaureate Research Training Program at the Human Genome Sequencing Center at Baylor College of Medicine. *Id.*

Ms. Tekbali, moreover, has had significant practical experience as an epidemiologist and infection preventionist, including on the frontlines of the current COVID-19 pandemic.

An infection preventionist is considered to be a hospital epidemiologist. *See* Declaration of Asma Tekbali, annexed hereto, ¶ 4. Epidemiologists focus primarily on the patterns and statistics of diseases, how infections can be spread, and investigating outbreaks. Tekbali Decl. ¶ 3. Infection preventionists do all of the above in a hospital setting to improve the quality of patient care and maintain the safety of hospital staff. *Id.* ¶4. There is a deeper clinical aspect for infection preventionists; they are the authority for physicians and nurses when it comes to isolating patients or performing tests. Tekbali Decl. *Id.* It is not uncommon for infection preventionists to be involved in clinical care and to engage directly with patients. *Id.* Furthermore, infection preventionists are heavily involved in nearly every aspect of hospital safety, including food preparation and linen services. *Id.*

Ms. Tekbali currently works at Lenox Hill Hospital/Northwell Health as an epidemiologist focused on infection prevention. *See* Tekbali 113. Ms. Tekbali's previous work experiences include working as a laboratory test developer at a prominent clinical diagnostic laboratory in New York, as a diagnostic laboratory scientist at a genetic testing laboratory, and as a lead microbiologist for a county government. *See id.*

Prior to the COVID-19 pandemic reaching New York City, Ms. Tekbali was involved in Lenox Hill Hospital's emergency management plan in anticipation of the pandemic. Tekbali Decl. ¶ 5. To date, Ms. Tekbali's Northwell Health employer is believed to have treated the most COVID-19 patients in the world. *Id.* Ms. Tekbali has been on the frontlines of COVID-19 at the very epicenter of the pandemic, and has the current and relevant experience when it comes to the prevention of COVID-19. Tekbali Decl. *Id.* ¶ 6. She has consulted on many patient cases related to homeless shelters, group homes, and nursing homes. *Id.* ¶ 9.

Ms. Tekbali and her colleagues in the epidemiology department make the final determination on all infection control matters within the hospital. *Id.* ¶ 7. Physicians are required to speak with Ms.

Tekbali for guidance on patient isolation, testing, and safe discharge. *Id.* Along with her colleagues, Ms. Tekbali's decision holds authority over the physician's decision. *Id.* ¶ 7.

Additionally, as an infection preventionist, the scope of Ms. Tekbali's work goes beyond statistical analysis of the hospital's infections. *Id.* ¶ 10. Ms. Tekbali is closely involved in the clinical management of a patient, and often has the opportunity to speak directly to patients alongside their providers. *Id.* Medical providers often call Ms. Tekbali directly to consult on a testing decision based on a patient's symptom presentation. *Id.* ¶ 11. For example, Ms. Tekbali advises a physician on whether symptoms are consistent with tuberculosis. *Id.* Furthermore, if patients show symptoms consistent with an infectious disease that their provider has not noticed, Ms. Tekbali looks through their medical records and provides a recommendation on isolation and what tests to order. *Id.* A patient may need guidance on isolation practices, mask usage, or have questions about laboratory testing; these patients frequently request to speak directly with Ms. Tekbali. *Id.* ¶ 10. Ms. Tekbali also consults with and advises a diverse group of departments at the hospital, including food services, linen services, sanitation, and engineering on infection control matters. *Id.* ¶ 8.

Further, Northwell has published more research on COVID-19 than any institution in the world. *Id.* ¶ 12. Indeed, Ms. Tekbali has been published on epidemiological issues related to COVID-19 in a leading, peer-reviewed journal in the field, the AMERICAN JOURNAL OF OBSTETRICS & GYNECOLOGY. Tekbali Decl. ¶ 12, Tekbali 113. The AMERICAN JOURNAL OF OBSTETRICS is ranked second out of 183 obstetrics & gynecology journals,[7] with one of the highest impact factors of 6.120 in 2018-19.[8] Tekbali Decl. ¶ 12.[9]

[7] *See* https://www.scimagojr.com/journalrank.php?category=2729.

[8] *See* https://academic-accelerator.com/Impact-Factor-IF/American-Journal-of-Obstetrics-and-Gynecology.

[9] In contrast, it does not appear that Petitioners' expert has published any peer-reviewed articles in connection with COVID-19.

Ms. Tekbali's educational background, work experience, and publication experience thus amply qualifies her to provide an expert opinion as an epidemiologist and infection preventionist in this case. *See Allstate Ins. Co. v. Gonyo*, No. 8:07-cv-1011, 2009 WL 1212482, at *4 (N.D.N.Y. Apr. 30, 2009) ("[T]he text of Rule 702 expressly contemplates that an expert may be qualified on the basis of experience" (quoting Advisory Committee Notes to the 2000 Amendments to Fed. R. Evid. 702)); *see also Kumho Tire Co.*, 526 U.S. at 152 (noting that expert testimony may be based on professional studies or personal experience).

Although Petitioners argue that Ms. Tekbali is not qualified to provide opinions "regarding appropriate medical care for COVID-19 and infectious disease prevention in correctional settings" and as an expert on "appropriate medical care," those assertions necessarily fail. *See* Pl. Mot. at 21-22. Petitioners squarely ignore Ms. Tekbali's significant experience as an epidemiologist working on the forefront of combatting the COVID-19 outbreak at one of our nation's leading medical hospitals. *See* Tekbali 1, 113; *Point Productions A.G. v. Sony Music Entertainment, Inc.*, No. 93 Civ. 4001, 2004 WL 345551, at *4-5 (S.D.NY. Feb. 23, 2004) (denying motion to preclude testimony of expert whose "credentials relate almost entirely to his work and professional experiences"). In her current role at Lenox Hill Hospital/Northwell Health, Ms. Tekbali focuses on overseeing the COVID-19 guidance, including advising providers on proper utilization of personal protective equipment, monitoring infections, reporting outbreaks, and appropriately isolating patients to stop the spread. *See* Tekbali 1, 113. Indeed, Ms. Tekbali is deeply versed in issues related to the COVID-19 pandemic and is overwhelmingly qualified to opine on that topic. Ms. Tekbali is certainly qualified to reach conclusions on how incarcerated individuals should be housed and how their movements should be restricted from an infection control standpoint. Indeed, Ms. Tekbali's profession calls for the ability to adapt guidance for a facility's unique capabilities. Tekbali Decl. ¶ 9.

Petitioners' argument, moreover, that Ms. Tekbali cannot opine on whether MDC was taking appropriate steps to contain the spread of COVID-19 because she lacks expertise in "correctional settings" is nonsensical. *See* Pl. Mot. at 21-22. An expert need not possess "specialized knowledge" in every subcategory of information that touches on her opinions. *See Packard v. City of New York*, No. 15 Civ. 7130, 2020 WL 1479016, at *3-*4 (S.D.N.Y. Mar. 25, 2020). Indeed, courts have consistently denied motions to preclude expert testimony, reasoning that such specialized knowledge is not a necessary qualification. *See, e.g.*, *Packard*, 2020 WL 1479016, at *3-*4 (holding that an expert witness lacking particular knowledge pertaining to training of NYPD officers could nevertheless offer his opinion regarding the effect that the provision of training to police officers can be expected to have on their actions); *Washington v. Kellwood Co.*, 105 F. Supp. 3d 293, 308–09 (S.D.N.Y. 2015) (holding that a witness with expertise in business valuation need not have specific expertise in the apparel industry in order to testify to the valuation of an apparel-related enterprise). Here, Ms. Tekbali is qualified to offer her opinion in this case because, as discussed above, she has significant experience and a strong educational background as an epidemiologist, and has worked directly and published on COVID-19 related issues. Ms. Tekbali need not have any specialized knowledge on correctional settings to be able to opine on COVID-19 issues at MDC. Rather, her experience as an epidemiologist working on COVID-19 issues amount to all of the "specialized knowledge" necessary to qualify her as an expert here. *See Packard*, 2020 WL 1479016, at *3-4.

Ultimately, Petitioners' contentions regarding Ms. Tekbali's qualifications and expertise fail because they all go to the weight of the evidence and are a subject for cross-examination, not admissibility. *See, e.g., Daubert*, 509 U.S. at 596 ("Vigorous cross examination, presentation of contrary evidence, and careful instruction on the burden of proof are the traditional and appropriate means of attacking [allegedly] shaky but admissible evidence."); *McCullock v. H.B. Fuller Co.*, 61 F.3d

1038, 1044 (2d Cir. 1995) ("Disputes as to the strength of [the expert's] credentials, faults in his use of differential etiology as a methodology, or lack of textual authority for his opinion, go to the weight, not the admissibility, of his testimony."). The only appropriate remedies are thus a "vigorous cross-examination" and "the presentation of contrary evidence" in court—not preclusion. *See, e.g.*, *Thomas v. YRC Inc.*, No. 16 Civ. 6105, 2018 WL 919998, at *6 (S.D.N.Y. Feb. 14, 2018) (denying motion to preclude expert testimony because "[g]iven that the rejection of expert testimony is the exception rather than the rule, 'vigorous cross-examination' and 'the presentation of contrary evidence' are the appropriate remedies for plaintiff's concerns regarding [defendant's expert's], not preclusion").

C. Ms. Tekbali's Methodologies Are Reliable and Will Assist the Court in Reaching a Decision

Ms. Tekbali's opinion is rooted in a thorough review of the record, reliable principles of epidemiology, and specific guidance from the Centers for Disease and Control and Prevention ("CDC") and the NYC Department of Health regarding COVID-19. Ms. Tekbali's testimony will assist the Court in interpreting the testimony of various witnesses and declarants, including Dr. Venters. Indeed, Respondent intends to offer into evidence Ms. Tekbali's expert report (which is already attached to Respondent's opposition to Petitioners' motion for a preliminary injunction) to further assist the Court in its assessment regarding MDC's protocol and practice in containing the disease.

Petitioners mischaracterize Ms. Tekbali's methodology by stating that her report is "devoted to restatements of website information from the CDC or the NYC Department of Health." *See* Pl. Mot. at 21. But it is hardly surprising that Ms. Tekbali, a trained epidemiologist and infection preventionist, would reference and discuss specific guidance from the CDC and NYC Department of Health in reaching her conclusions regarding MDC's practices regarding COVID-19. *See* Tekbali 2-7. Indeed, Dr. Venters's failure to do the same in his report does not make Ms. Tekbali's report deficient. Moreover, these sources form the basis of a reliable methodology because they are "of a type reasonably

relied on by" epidemiologists working on COVID-19 issues and in her field. *See Packard*, 2020 WL 1479016, at *4 (expert's opinion and methodology reliable where it was not based on "traditional scientific methods" because it was based on data "of a type reasonably relied on by experts in various disciplines of social sciences").

Petitioners' criticism of Ms. Tekbali's methodology on the basis that "she lacks a factual basis for reaching conclusions about actual practice at the facility" is also fatally flawed. *See* Pl. Mot. at 24-25. That contention, as well as the arguments regarding Ms. Tekbali's reliance on CDC and NYC Department of Health guidance on COVID-19, are improperly raised in their motion to preclude, because those argument address the *weight* of Ms. Tekbali's testimony. Petitioners' remedy is cross-examination of Ms. Tekbali or the presentation of contrary evidence in Court—not preclusion of Ms. Tekbali's entire testimony. *See e.g.*, *Daubert*, 509 U.S. at 596 ("Vigorous cross examination, presentation of contrary evidence, and careful instruction on the burden of proof are the traditional and appropriate means of attacking [allegedly] shaky but admissible evidence."). The Court should thus allow Ms. Tekbali to testify regarding her opinion in this case.

D. Ms. Tekbali's Opinions are Relevant to the Case and Will Assist the Court in Reaching a Decision

Ms. Tekbali has offered relevant opinions regarding the protocols and practices pertaining to the prevention of the spread of COVID-19 at MDC. There can be no dispute that Ms. Tekbali's testimony on the steps taken at MDC to prevent the spread of COVID-19 is relevant to Petitioners' claim regarding the alleged conditions and spread of COVID-19 at MDC. Indeed, Respondent would be deeply prejudiced if Ms. Tekbali is not permitted to opine on the steps taken at MDC, as that defense is essential to Respondent's defense of this case.

Moreover, Ms. Tekbali's specialized expertise in combatting the COVID-19 outbreak and minimizing the spread of infection will be helpful to the Court. Ms. Tekbali's analysis evaluates the

recommended guidance regarding preventing the spread of COVID-19 and the policies and practices in place at MDC. Ms. Tekbali's analysis is relevant to many of the central issues in this case, and she should be permitted to testify. Petitioners concede as much. Petitioners nowhere contest the relevance of Ms. Tekbali's testimony, or the extent to which her testimony will aid the Court. *See* Pl. Mot. at 20-25. Petitioners, rather, are challenging the weight of Ms. Tekbali's testimony—arguments improperly raised in a motion to preclude, and best addressed only through cross-examination or the admission of evidence in Court. *See e.g.*, *Daubert*, 509 U.S. at 596. The Court should thus allow Ms. Tekbali to testify and introduce relevant and helpful evidence in this case.

Finally, even if, *arguendo*, the Court were inclined to preclude Ms. Tekbali (which it should not, for the reasons described above), since the Court will be the trier of fact, the Court should defer ruling on the application until after it has heard the expert testimony at trial. As stated in *Astra Aktiebolag v. Andrx Pharmaceuticals, Inc.*, 222 F.Supp.2d 423, 485-486 (S.D.N.Y. 2002) (citing *Colon v. Bic USA, Inc.*, 199 F. Supp. 2d 53, 71 (S.D.N.Y. 2001):

> [The party's] *Daubert* challenges were raised just prior to trial and this trial was conducted as a bench trial, the court elected to hear the *Daubert* proof during the trial itself . . . . Although courts often hold pretrial evidentiary hearings in the context of Rule 104(a) rulings on the admissibility of expert testimony, "[n]othing in *Daubert*, or any other Supreme Court or Second Circuit case, mandates that the district court hold a *Daubert* hearing before ruling on the admissibility of expert testimony."

See also Leith v. Lufthansa German Airlines, 1995 WL 699708, at *1 (N.D. Ill.) ("Waiting until trial to deal with both issues, admissibility and causation, does not carry with it the possible contamination of the fact-finding process, as there will be no jury and the court will hear the issue once in any event.").

CONCLUSION

Accordingly, for the reasons set forth above, Petitioners' motion *in liminie* should be denied, and Respondent granted such further relief as the Court deems just and proper.

Dated: Brooklyn, New York
May 10, 2020

RICHARD P. DONOGHUE

United States Attorney
Counsel for Respondent
Eastern District of New York
271-A Cadman Plaza East, 7th Fl.
Brooklyn, New York 11201

By: /s/
James R. Cho
Seth D. Eichenholtz
Joseph A. Marutollo
Paulina Stamatelos
Assistant U.S. Attorneys
Attorneys for Respondent
(718) 254-6519/7036/6288/6198
james.cho@usdoj.gov
seth.eichenholtz@usdoj.gov
joseph.marutollo@usdoj.gov
pauline.stamatelos@usdoj.gov

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF NEW YORK

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HASSAN CHUNN; NEHEMIAH McBRIDE; AYMAN RABADI by his Next Friend Migdaliz Quinones; and JUSTIN RODRIGUEZ by his Next Friend Jacklyn Romanoff; ELODIA LOPEZ; and JAMES HAIR, individually and on behalf of all others similarly situated,

Petitioners,

-against-

WARDEN DEREK EDGE,

Respondent.

----------x

Civil Action No. 20-CV-1590 (Kovner, J.) (Mann, M.J.)

Seth D. Eichenholtz, an attorney duly admitted to practice in the Eastern District of New York, declares pursuant to 28 U.S.C. § 1746, under penalty of perjury, that the following is true and correct:

1. I am an Assistant United States Attorney, of counsel to Richard P. Donoghue, United States Attorney, Eastern District of New York, attorney for Respondent. I am familiar with the facts in the instant case.

2. Attached hereto as Exhibit A is a relevant section of the Metropolitan Detention Center in Brooklyn, New York (MDC)'s Inmate Handbook.

3. Attached hereto as Exhibit B is the curriculum vitae of expert witness Asma Tekbali.

4. Attached hereto as Exhibit C is the report of expert witness Asma Tekbali.

5. Attached hereto as Exhibit D is a transcript of proceedings on April 13, 2020 before the Honorable Rachel Kovner and Roanne L. Mann.

Dated: Brooklyn, New York
May 10, 2020

RICHARD P. DONOGHUE
United States Attorney

By: /s/

Seth D. Eichenholtz
Assistant U.S. Attorney
(718) 254-7036
Seth.Eichenholtz@usdoj.gov

Exhibit A

INMATE ADMISSION & ORIENTATION HANDBOOK

UPDATED: January 25, 2019

programs or work related functions. Additionally, bedside visits and funeral trips may be authorized for inmates with custody levels below maximum. All expenses will be borne by the inmate, except for the first eight hours of each day that the employee is on duty. There are occasions based on a determination that the perceived danger to BOP staff during the proposed visit is too great, or the security concerns about the individual inmate outweigh the need to visit the community.

Furloughs
A furlough is an authorized absence from an institution by an inmate who is not under the escort of a staff member, a U.S. Marshal, other Federal or State agent. Furloughs are a privilege, not a right, and are only granted when clearly in the public interest and for the furtherance of a legitimate correctional goal. An inmate who meets the eligibility requirements may submit an application for furlough to staff for approval.

Central Inmate Monitoring System
The Central Inmate Monitoring System (CIMS) is a method for the Agency to monitor and control the transfer, temporary release, and participation in community activities of inmates who pose special management considerations. Designation as a CIMS case does not, in and of itself, prevent an inmate from participating in community activities. All inmates who are designated as CIMS cases will be notified by their Case Manager.

Marriages
If an inmate wishes to be married while incarcerated, the Warden may authorize the inmate to do so under certain conditions. All expenses of the marriage will be paid by the inmate. If an inmate requests permission to marry he/she must:

- Have a letter from the intended spouse which verifies their intention to marry.
- Demonstrate legal eligibility to marry.
- Be mentally competent.
- The marriage must not present a security risk to the institution.

Marriage procedures are detailed in local Institution Supplement’s.

Barber Shop
Haircuts are authorized on the housing units in the area designated by the Unit Manager, and permitted during the hours of 8:00 a.m. to 2:30 p.m.

Medical Services
The BOP inmate health care delivery system includes local ambulatory clinics as well as major medical centers. Locally, emergency medical care is available 24 hours a day in all BOP facilities. BOP clinical staff typically covers the day and evening shifts and community emergency personnel meet emergency needs when BOP clinical staff is not on-site.

Health services typically include episodic visits for new or recurring medical or dental symptoms through a sick call system, chronic care management for chronic and infectious diseases through enrollment in chronic care clinics for regular care, routine dental care, medical and dental emergency care for injuries and sudden illness, age-appropriate preventive care to promote optimal health and functional status, restorative care to promote achievable functional status, long-term care and end-of-life care.

Sick Call System

For episodic care, inmates must sign up for sick call. This is accomplished by sending an email to the BRO/Inmatetosickcall box for medical and the BRO/Inmatetodental box for dental sick call. Clinical and dental staff will screen the inmate's complaint, give a future appointment based on the nature of the health complaint and enter the appointment date on the "callout" sheet. Inmate sick call emails are triaged on Monday, Tuesday, Thursday, and Friday. Inmates who become ill suddenly will notify their work supervisor or Unit Officer to call the Health Services Unit to arrange an evaluation. Inmates requesting health services will be charged a co-payment fee of $2.00 unless staff determines they are indigent and not subject to a co-payment fee.

Inmates in detention or segregation who are unable to utilize the electronic sick call sign up will access sick call by submitting a written request for evaluation or by verbally asking for a sick call appointment when the Health Services clinician makes daily rounds in the secured unit.

Emergency Medical Treatment
All emergencies or injuries receive priority for treatment. Appropriate medical care will be provided by institution clinical staff or by community emergency personnel after regular Health Services Unit operating hours when institution clinicians are not on-site. Clinicians covering evenings, weekends and holidays provide treatment for acute medical problems and directly observed pill lines.

Medication Administration (Pill Line)
Controlled medications are administered at regularly scheduled times of the day and evening in the Unit known as the "pill line." Clinical staff delivers controlled medications to inmates in detention or segregation units during established pill line times.

On-the-job Injuries
Inmates injured while performing an assigned duty, must immediately report this injury to their work supervisor. The work supervisor reports the injury to the institution Safety Manager who completes mandatory occupational injury documentation. The inmate must be evaluated by clinical staff and an injury report completed for inclusion in the inmate's health record under the Occupational Medicine section of BEMR.

Inmates who suffer a work-related injury may be eligible for compensation if the injury prevents the inmate from performing his or her usual work duties. However, the inmate may be disqualified from eligibility for lost-time wages or compensation if he or she fails to report a work injury promptly to the supervisor.

CONTACT WITH THE COMMUNITY AND PUBLIC

Correspondence
In most cases, inmates are permitted to correspond with the public, family members, and
others without prior approval. All outgoing general mail must remain unsealed and deposited in the general mailbox on the housing unit. General mail is inspected and/or read by staff. The outgoing envelope must have the inmate's committed name, register number, and complete institution return address in the upper left hand corner. Example:

Metropolitan Detention Center
Inmate Name and Register Number
P. O. Box 329002

Exhibit B

ASMA TEKBALI

225 E. 86th St., Apt. 305, New York, New York 10028 | (469) 363-8559 | asma.tekbali@gmail.com

Education

Master of Public Health: **Global Health, Bioethics** **May 2019**
New York University **New York, NY**
Relevant coursework includes Data-Driven Decision Making, Social Determinants of Health, Biostatistics, Healthcare Policy & Management. Member of Healthcare Consulting Organization. **GPA: 3.75**

Certificate: **Epidemiology & Population Health** **2017**
Columbia University-Mailman School of Public Health **New York, NY**

Post-Baccalaureate Research Training Program **2015**
Baylor College of Medicine-Human Genome Sequencing Center **Houston, TX**
Performed independent research while completing coursework alongside PhD students in the department of human genetics

Bachelor of Science: **Biology, English & Chemistry** **2007-2011**
Texas Woman's University **Denton, TX**

Work History

Epidemiologist: Infection Preventionist **August 2019 – Current**
Lenox Hill Hospital/Northwell Health **New York, NY**
- Oversee COVID-19 pandemic guidance for nurses, physicians, and other medical support staff
- Investigate disease outbreaks within hospital system and report to government entities
- Develop and implement isolation protocols
- Analyze and collect infectious disease-related data through laboratory tests

Laboratory Test Developer **Oct 2016 – Jan 2019**
Sema4 Genomics - Clinical Diagnostic Laboratory, Mount Sinai Joint-Venture **New York, NY**
- Performed validation testing for product development of innovative newborn screening kit for multi-billion dollar growth market
- Streamlined automation processes by developing procedures, methods, and controls for six genetic disorders
- Collaborated with physicians, technologists, and vendors to optimize department communication and improve workflow
- Developed program for efficient sample tracking that has been adopted and utilized throughout the company
- Executed key analyses and tests including Next Generation Sequencing (NGS) and non-invasive prenatal testing

Diagnostic Laboratory Scientist **Jul 2015 - Jul 2016**
Genesis Genetics - Preimplantation Genetic Testing Laboratory **Houston, TX**
- Performed complex DNA amplification of various cell-types and collaborated with embryologists to optimize DNA quality
- Achieved exceptional individual turnaround time per sample at 2.2 days to process and report results to client
- Facilitated Clinical Laboratory Improvement Amendments (CLIA) certification of laboratory
- Analyzed and interpreted sequencing results for patient reports; recommended whether embryos were safe for IVF transfer

Lead Microbiologist **Jan 2013 - Jan 2014**
Dallas County Department of Health and Human Services **Dallas, TX**
- Engaged in highly critical containment of bioterrorism agents including *E.coli* 0157, Salmonella species, and *Y.pestis*
- Executed rapid detection of *N.gonorrheae* via rRNA amplification, and tagged DNA/RNA hybridization
- Conducted genetic typing of Influenza clinical samples using RT-PCR in collaboration with Centers for Disease Control
- Collaborated with epidemiologists to meet the growing public health needs of Dallas Fort-Worth

Publications

1. A. Tekbali, et al. (2020). "Pregnant versus non-pregnant SARS-CoV-2 and COVID-19 Hospital Admissions: The first 4 weeks in New York". *American Journal of Obstetrics.*
2. Matthew J. Blitz, Amos Grünebaum, Asma Tekbali (2020). "Intensive Care Unit Admissions for Pregnant and Non-Pregnant Women with COVID-19". *American Journal of Obstetrics.* **Accepted for publication on 5/4/20**

Exhibit C

Asma Tekbali, M.P.H.
225 E 86th St. Apt. 305
New York, New York 10028
(646) 265-2108
atekbali@northwell.edu

May 7, 2020

James Cho
Assistant U.S. Attorney
U.S. Attorney's Office
Eastern District of New York
271 Cadman Plaza East
Brooklyn, N.Y. 11201

Re: Chunn v. Edge, Case No. 20-cv-1590 (E.D.N.Y.)

Dear Mr. Cho,

I was asked to provide an expert opinion and analysis on this case as an epidemiologist and infection preventionist. My background is primarily in microbiology, having previously worked in diagnostic testing for infectious diseases at the Dallas County Department of Health. My role as a public health microbiologist provided me with the unique experience of laboratory test analysis alongside epidemiological methods. I graduated from New York University's College of Global Public Health in 2019 and have been employed as an infection preventionist in the Epidemiology Department of Lenox Hill Hospital, Northwell Health, in New York City since August 2019. Lenox Hill has a total of 431 staffed beds and treats approximately 163,000 patients per year and has more than 680 medical personnel on staff.

As an epidemiologist, I have been on the forefront of combatting the COVID-19 outbreak and minimizing the spread of infections. During the current COVID-19 pandemic, Lenox Hill has treated and discharged over 1000 COVID-19 patients. My role at Lenox Hill Hospital entails advising providers on proper PPE utilization, monitoring hospital acquired infections, reporting outbreaks to government entities, and preventing the spread of infection by isolating patients appropriately.

The COVID-19 pandemic has caused my role to evolve significantly as our department became the center of the hospital's response plan. I have contributed to the planning and construction of new designated "COVID-19" units, helped to develop hospital-wide policy on isolation and testing protocols consistent with CDC guidelines and the latest in scientific research into COVID-19, and supported staff on preventing transmission of the virus through education. My team and I consult with physicians on whether a patient is low or high suspicion for COVID-19, and whether cohorting patients is appropriate. With PPE supplies dwindling and changing constantly, I have also helped to develop plans to extend the use of various items, including N95 masks and protective gowns.

In connection with this case, I have reviewed the following documents: the Amended Petition, the deposition transcript of Dr. Homer Venters, the deposition transcript of Stacey

Vasquez, Dr. Homer Venters' facility evaluation, and the declarations of Lt. Cmdr. D. Jordan, Ayman Rabadi and Justin Rodriguez. I also reviewed applicable city, state and CDC guidelines, including CDC guidelines as they relate to "Correctional and Detention Facilities" (https://www.cdc.gov/coronavirus/2019-ncov/community/correction-detention/index.html).

I set forth the following opinions based on my training, research and experience in the field of public health and epidemiology:

Page 24 of the petition states that inmates are at "higher risk for developing acute symptoms than if they were in the community, because the MDC lacks the medical resources to care for symptomatic inmates." According to the CDC, over 80% of patients present with mild symptoms, with an overall case fatality rate of 2.3%. *See* Interim Clinical Guidance for Management of Patients with Confirmed Coronavirus Disease (COVID-19) (https://www.cdc.gov/coronavirus/2019-ncov/hcp/clinical-guidance-management-patients.html) (Exhibit 1). Since most people will develop mild symptoms and can recover without medical intervention, the CDC suggests that individuals need not get tested and should simply quarantine and self-monitor their symptoms. Per CDC guidance, decisions to test are based on clinical presentation and provider's discretion. There are virtually no clinical interventions for patients who present with mild symptoms. Asymptomatic patients are not prioritized for testing per CDC guidelines. *See* Evaluating and Testing Persons for Coronavirus Disease 2019 (COVID-19) (https://www.cdc.gov/coronavirus/2019-ncov/hcp/clinical-criteria.html) (Exhibit 2).

Since different facilities use different testing platforms, it is difficult to obtain reliable statistics on testing sensitivity and specificity. Some symptomatic patients consistently test negative. If patients have symptoms that are consistent with COVID-19, testing will not change their clinical management. According to the NYC Department of Health, an individual with symptoms consistent with COVID-19 will be advised to isolate with either a negative or positive test result. *See* FAQ About 2019 Novel Coronavirus and COVID-19 for Health Care Providers (https://www1.nyc.gov/assets/doh/downloads/pdf/imm/covid-19-provider-faqs.pdf) (Exhibit 3).

On page 23 of the petition, meal preparation is listed as a risk for inmates contracting COVID-19. According to the CDC, there is no evidence to support transmission of COVID-19 associated with food. *See* Food Safety and Coronavirus Disease 2019 (COVID-19) (https://www.cdc.gov/foodsafety/newsletter/food-safety-and-Coronavirus.html) (Exhibit 4). When hand sanitizer is not available, the CDC notes that handwashing with soap and water is just as effective.

On page 27 of the petition, inmate James Hair is noted to be of significant risk due to his multiple sclerosis (MS). The National MS Society's website states that there is no increased risk of individuals contracting COVID-19 due to MS. *See* https://www.nationalmssociety.org/coronavirus-covid-19-information/multiple-sclerosis-and-coronavirus#section-0) (Exhibit 5). It also states that there are no special PPE requirements for individuals who have MS.

The petition notes that inmates have not received gloves or sanitizer, but the CDC does not advise individuals to wear gloves in lieu of hand hygiene. In fact, some literature suggests

that gloves help to spread the virus as people are less conscious of hand hygiene while wearing gloves.

I have reviewed Dr. Venters' deposition transcript and there are many areas he has discussed that do not represent current standard infection control practices as it relates to the COVID-19 pandemic.

On page 81 of his transcript, he suggested that patients use N95 masks, which is unheard of and has never been indicated by any public health entity or expert. He further states that this is the clinical standard he has used previously. However patients would need to be individually fit tested and the facility would need to have a variety of sizes available. There is little utility in providing a patient with an N95, as they are primarily used to protect the wearer from exposure to small particles. N95s are reserved for airborne viruses such as tuberculosis and measles. While COVID-19 is transmitted via respiratory droplet, an N95 is indicated for providers only since the virus can remain in the air for a few seconds after a patient coughs directly in a provider's face (this happens quite often). As per CDC guidelines N95 masks are reserved for health care professionals and first-responders, and N95 masks are not needed outside the healthcare setting. *See* Personal Protective Equipment: Questions and Answers (https://www.cdc.gov/coronavirus/2019-ncov/hcp/respirator-use-faq.html) (Exhibit 6).

On page 104 of his transcript, Dr. Venters recommends cohorting high-risk detainees together. Cohorting is not necessary. The best intervention for higher risk inmates is to limit their contact with other inmates, as the MDC has been doing with all inmates, not just high-risk inmates. With proper hand hygiene and universal masking within the facility, there is no need to cohort.

Other points of note from the transcript:

- Temperature screening is the standard used by hospitals and many other healthcare facilities, including Lenox Hill Hospital, to triage patients. While some patients who are COVID-19 positive do not present with a high fever, screening for fevers as the standard protocol and has been deemed adequate since 83%-99% of COVID-19 patients present with a fever, according to the CDC. Exhibit 1.

- The "forensic" cleaning staff he references does not require N95s. As per the CDC, they are at low risk. *See* Cleaning and Disinfection for Community Facilities (https://www.cdc.gov/coronavirus/2019-ncov/community/organizations/cleaning-disinfection.html) (Exhibit 7). There is low risk of exposure for those who are cleaning surfaces outside of designated COVID-19 units. If they are handling waste and items from a known or suspected COVID-19 patient, gloves and gowns are indicated.

- The following issues are consistent with the problems facing the rest of the country: lack of testing availability, lack of PPE, and overall poor surveillance. Surveillance refers to lack of wide-spread testing. Since only symptomatic

individuals meet the criteria for testing, it is hard to know how many people actually have the virus. Exhibit 2. This is not unique to the prison system during this pandemic.

- Dr. Venters mentioned that non-urgent patients required daily examinations. Having gone through the virus personally and advised medical staff at my facility, this is not the standard of care.

- Negative pressure is not required for COVID-19 because this is not an airborne virus. At our hospital, we do not use negative pressure rooms. Patients are placed on enhanced droplet and contact precautions, not airborne precautions.

- Booties and foot covers were never required as PPE. We do not allow providers to wear this type of PPE to care for patients.

- Dr. Venters stated that pregnant women are in the high-risk category. Again, this is not true based on my own published research and CDC guidelines. Special care should be taken, but they are not at risk for severe illness or death.

The MDC's procedures for preventing the spread of COVID-19 is consistent with CDC guidance and within the standard of care. Current CDC guidelines state that providers are to use their judgment to determine whether a patient has signs and symptoms of COVID-19. While testing is a factor in this decision, providers at many facilities, including my own, assume a patient has COVID-19 if their symptoms are consistent with the virus, despite a negative test result or no test results at all. These symptoms include fever, acute respiratory illness, shaking with chills, muscle pain, new loss of taste or smell, sore throat, or headache. Symptoms may appear 2-14 days after exposure.

Recent CDC guidance for infection control measures states that facilities should actively screen for fever and symptoms before individuals enter a healthcare facility. As Ms. Vasquez stated on page 38 of her transcript, inmates in the quarantine and isolation units are screened for fevers and symptoms twice per day. This screening protocol is in line with guidance from the CDC and the current standard of care, since 83%-99% of individuals infected with COVID-19 present with a fever. *See* Exhibit 1.

Ms. Vasquez also stated that all new inmates are required to quarantine for 14 days prior to joining the general population. These inmates are monitored for symptoms. This is considered to be "source control" or "active screening" and is utilized to prevent transmission of the virus from asymptomatic or pre-symptomatic individuals. Further source control, as outlined in Ms. Vasquez's transcript on page 58, includes inmates and providers wearing standard surgical masks to prevent respiratory droplets from spreading between individuals.

Ms. Vasquez further mentions that inmates who show symptoms consistent with COVID-19 are immediately isolated in designated isolation units. On page 62, the isolation protocol is outlined. Standard protocol within my own facility states that patients are to be isolated as soon as they are suspected of having COVID-19; they are considered "rule out" patients at this point,

with a test pending, or based on symptoms alone. Patients who test positive or are presumed positive based on their clinical presentations are able to be cohorted in a double room.

The MDC's practice has been to isolate an inmate who has tested positive for COVID-19 and the inmate's cellmate, if symptomatic. The MDC would consider the cellmate presumptively positive. The MDC's practice is consistent with CDC guidelines and the standard of care in the community.

The MDC's practice of presuming inmates positive is consistent with the standard of care given the CDC's guidance limiting the use of widespread testing. Put another way, MDC's practice of presuming inmates as positive rather than testing all symptomatic inmates -- given the limited number of tests available both in the community and at the MDC -- is entirely consistent with CDC guidelines and the standard of care. For example, roommates of those who have tested positive are considered exposed and potentially infected. The roommates are to remain isolated unless they remain asymptomatic for 14 days or have tested negative. Either testing or non-test based strategy is an acceptable practice.

I would like to clarify an important aspect of transmission. This virus is transmitted primarily via respiratory droplet; meaning the virus can be caught when an individual is in close proximity to an infected person and gets their droplets into the mouth, nose, or eyes. There was the suggestion that the virus could be airborne in several areas (example, page 74 of Vasquez's transcript). It is unlikely that the virus would be airborne and travel from the top tier of the isolation unit to inmates in the bottom tier. Further, airborne isolation rooms with negative pressure are only utilized for aerosolizing procedures. *See* Summary for Healthcare Facilities: Strategies for Optimizing the Supply of N95 Respirators during the COVID-19 Response (https://www.cdc.gov/coronavirus/2019-ncov/hcp/checklist-n95-strategy.html) (Exhibit 8). Furthermore, the frequency at which surgical masks are given to inmates (once a week, page 74) is in line with many healthcare facilities' guidance. There is a PPE shortage for the entire nation, and prior to getting a new shipment in, our staff was also advised to wear the same surgical mask for a week (or until visibly soiled).

Ms. Vasquez also mentions the criteria for discontinuing medical isolation on page 81. This criteria, 7 days after symptom onset and 72 hours without fever (without the use of antipyretics), is guidance from the New York State Department of Health that our facility uses as well. *See* Health Advisory: Discontinuation of Isolation for Patients with COVID-19 Who Are Hospitalized or in Nursing Homes, Adult Care Homes, or Other Congregate Settings with Vulnerable Residents (https://coronavirus.health.ny.gov/system/files/documents/2020/04/doh-covid-19-discontinuing-isolation-hospital-congregate-setting.pdf) (Exhibit 9).

Declaration of Ayman Rabadi

- Mr. Rabadi states on page 3, paragraph 12, that he is locked in his cell 24 hours a day, save for 30 minutes 3 times per week. It is my understanding that inmates are now allowed out of their cell for one hour, instead of 30 minutes. This is the current standard for isolation to prevent the spread of the virus. This is an appropriate measure to prevent the spread, as recommended by the NYC Department of Health (DOH). *See* COVID-19:

Guidance for Congregate Settings (https://www1.nyc.gov/assets/doh/downloads/pdf/imm/guidance-for-congregate-settings-covid19.pdf) (Exhibit 10).

- On page 3, paragraph 15, there is a complaint about the reuse of masks and lack of gloves. Currently, gloves are not recommended as PPE for non-medical staff. The CDC recommends hand washing and covering the mouth and nose. *See* How to Protect Yourself & Others (https://www.cdc.gov/coronavirus/2019-ncov/prevent-getting-sick/prevention.html) (Exhibit 11). Since masks are in limited supply, the CDC states that masks can be reused until soiled or broken. Inmates are said to receive one mask per week, which is appropriate given the frequency of use (3 times per week for approximately one hour).

Declaration of Justin Rodriguez

The declaration of Justin Rodriguez states that he did not receive any medical care during his illness. His symptoms presented as mild with the loss of smell and taste, chills, and shortness of breath. As mentioned previously in this report, individuals with mild symptoms do not require medical care. Since he tested positive for antibodies upon his release, it is assumed he previously was infected with the virus and recovered without complication.

I have reviewed the deposition transcript of Associate Warden Milinda King. On page 27, lines 24 and 25, she states that inmates receive two different types of soap, liquid and bars of soap. The liquid soap is available on units at all times, and bars of soap are given biweekly, or at the request of the inmate. Both types of soap are acceptable to prevent the spread of COVID-19, according to the CDC. *See* Handwashing at Home, at Play, and Out and About (https://www.cdc.gov/handwashing/pdf/handwashing-poster.pdf) (Exhibit 12).

It is my opinion that MDC is taking appropriate steps to prevent the spread of COVID-19, and this opinion is further supported by the declaration of Lt. Cmdr. Jordan.

• On page 5, paragraph 14, she writes that newly arriving inmates are screened for symptoms and exposure risk factors. This is consistent with the standard of care, and is similar to the process outlined by the CDC for source control by triaging patients for signs and symptoms of COVID-19. *See* Interim Infection Prevention and Control Recommendations for Patients with Suspected or Confirmed Coronavirus Disease 2019 (COVID-19) in Healthcare Settings (https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html) (Exhibit 13). Further precaution is taken (beyond recommendation) by quarantining asymptomatic inmates for 14 days. The same process is done for symptomatic inmates who have known exposure to the virus. The NYC Department of Health advises correctional facilities to isolate inmates with "covid-like illness" from residents who are not yet symptomatic. *See* Exhibit 10. Such measures are being taken at MDC.

• Since isolation spaces are limited, the CDC suggests that measures be taken to prevent the spread of the virus. Such measures are outlined on pages 9-10, paragraph 29: all staff must

wear PPE and inmates who are isolated are required to wear a surgical mask to prevent the spread of respiratory droplets, which is the primary mode in which the virus is transmitted.

• The process for self-monitoring for inmates is discussed on page 11, paragraph 35. This is consistent with the standard of care and CDC guidelines. Individuals are advised to keep track of their symptoms and separate themselves from others. *See* What to Do If You Are Sick (https://www.cdc.gov/coronavirus/2019-ncov/if-you-are-sick/steps-when-sick.html) (Exhibit 14).

• Symptomatic inmates are evaluated by medical providers (page 11, paragraph 36), and the decision to isolate and test is per the healthcare provider's discretion.

• Steps to reduce movement within MDC have been taken, as outlined on pages 5-6, paragraphs 15 and 16 of the declaration. Staggered bathing and time out of their cells have been implemented in addition to limited inmate gatherings (page 7). This is consistent with NYC DOH's recommendations for congregate settings. *See* Exhibit 10.

Recently, the New York State Department of Health conducted a survey on newly admitted COVID-19 patients from 113 hospitals. It evaluated the risk factors for COVID-19 hospitalization based on location. This data was presented during a Weekly Healthcare Provider COVID-19 Update on May 7th. It found that individuals who reside in jail or prison have a less than 1% risk for hospitalization, which was the lowest risk group in the survey. (https://coronavirus.health.ny.gov/weekly-health-provider-webinar starting at 14:48)

To conclude, it is my opinion that MDC is following proper infection control protocols that are adequate and in line with the standard of care and CDC guidance. The CDC's epidemiologic risk classification notes that transmission risk is low when both provider and patient are wearing masks or are able to social distance, as respiratory droplets are unlikely to travel further than 6 feet. *See, e.g.*, Interim U.S. Guidance for Risk Assessment and Public Health Management of Healthcare Personnel with Potential Exposure in a Healthcare Setting to Patients with Coronavirus Disease 2019 (COVID-19) (https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-risk-assesment-hcp.html) (Exhibit 15).

If additional, relevant material become available, I reserve the right to supplement this report. Pursuant to the provisions of 28 U.S.C. § 1746, I declare under penalty of perjury that the foregoing is true and correct to the best of my information, knowledge, and belief

Sincerely,

Asma Tekbali

Asma Tekbali, M.P.H.

Tekbali Exhibit 1

Centers for Disease Control and Prevention

Coronavirus Disease 2019 (COVID-19)

Interim Clinical Guidance for Management of Patients with Confirmed Coronavirus Disease (COVID-19)

Summary of Recent Changes

Revisions were made on April 3, 2020, to reflect the following:

- New information about asymptomatic and pre-symptomatic infections
- Non-steroidal anti-inflammatory drugs, angiotensin-converting enzyme inhibitors, and angiotensin receptor blockers and risk of infection or infection severity
- Information about COVID-19 and potential for SARS-CoV-2 reinfection
- Possibility of infection with both SARS-CoV-2 and other respiratory viruses
- Additional laboratory and imaging findings in COVID-19
- Updated guidelines from the World Health Organization and the Surviving Sepsis Campaign
- Inclusion of new resource: Information for Clinicians on Therapeutic Options for COVID-19 Patients
- Inclusion of National Institutes of Health: Coronavirus Disease 2019 (COVID-19) Treatment Guidelines

This interim guidance is for clinicians caring for patients with confirmed infection with severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2), the virus that causes coronavirus disease 2019 (COVID-19). CDC will update this interim guidance as more information becomes available.

The National Institutes of Health recently published guidelines on prophylaxis use, testing, and management of COVID-19 patients. For more information, please visit: National Institutes of Health: Coronavirus Disease 2019 (COVID-19) Treatment Guidelines . The recommendations in the guidelines were based on scientific evidence and expert opinion and will be updated as more data becomes available.

Clinical Presentation

Incubation period

The incubation period for COVID-19 is thought to extend to 14 days, with a median time of 4-5 days from exposure to symptoms onset.[1-3] One study reported that 97.5% of persons with COVID-19 who develop symptoms will do so within 11.5 days of SARS-CoV-2 infection.[3]

Presentation

The signs and symptoms of COVID-19 present at illness onset vary, but over the course of the disease, most persons with COVID-19 will experience the following[1,4-9]:

- Fever (83–99%)
- Cough (59–82%)
- Fatigue (44–70%)
- Anorexia (40–84%)
- Shortness of breath (31–40%)
- Sputum production (28–33%)
- Myalgias (11–35%)

Atypical presentations have been described, and older adults and persons with medical comorbidities may have delayed presentation of fever and respiratory symptoms.[10,11] In one study of 1,099 hospitalized patients, fever was present in only 44% at hospital admission but later developed in 89% during hospitalization.[1] Headache, confusion, rhinorrhea, sore throat, hemoptysis, vomiting, and diarrhea have been reported but are less common (<10%).[1,4-6] Some persons with COVID-19 have experienced gastrointestinal symptoms such as diarrhea and nausea prior to developing fever and lower respiratory tract signs and symptoms.[9] Anosmia or ageusia preceeding the onset of respiratory symptoms has been anecdotally reported[12], but more information is needed to understand its role in identifying COVID-19.

Several studies have reported that the signs and symptoms of COVID-19 in children are similar to adults and are usually milder compared to adults.[13-17] For more information on the clinical presentation and course among children, see Information for Pediatric Healthcare Providers.

Asymptomatic and Pre-Symptomatic Infection

Several studies have documented SARS-CoV-2 infection in patients who never develop symptoms (asymptomatic) and in patients not yet symptomatic (pre-symptomatic).[14,16,18-28] Since asymptomatic persons are not routinely tested, the prevalence of asymptomatic infection and detection of pre-symptomatic infection is not well understood. One study found that as many as 13% of RT-PCR-confirmed cases of SARS-CoV-2 infection in children were asymptomatic.[14] Another study of skilled nursing facility residents infected with SARS-CoV-2 from a healthcare worker demonstrated that half were asymptomatic or pre-symptomatic at the time of contact tracing evaluation and testing.[26] Patients may have abnormalities on chest imaging before the onset of symptoms.[20,21] Some data suggest that pre-symptomatic infection tended to be detected in younger individuals and was less likely to be associated with viral pneumonia.[20,21]

Asymptomatic and Pre-Symptomatic Transmission

Epidemiologic studies have documented SARS-CoV-2 transmission during the pre-symptomatic incubation period[20,29-31], and asymptomatic transmission has been suggested in other reports.[22,23,32] Virologic studies have also detected SARS-CoV-2 with RT-PCR low cycle thresholds, indicating larger quantities of viral RNA, and cultured viable virus among persons with asymptomatic and pre-symptomatic SARS-CoV-2 infection.[19,24,26,33] The exact degree of SARS-CoV-2 viral RNA shedding that confers risk of transmission is not yet clear. Risk of transmission is thought to be greatest when patients are symptomatic since viral shedding is greatest at the time of symptom onset and declines over the course of several days to weeks.[33-36] However, the proportion of SARS-CoV-2 transmission in the population due to asymptomatic or pre-symptomatic infection compared to symptomatic infection is unclear.[37]

Clinical Course

Illness Severity

The largest cohort of >44,000 persons with COVID-19 from China showed that illness severity can range from mild to critical[38]:

- Mild to moderate (mild symptoms up to mild pneumonia): 81%
- Severe (dyspnea, hypoxia, or >50% lung involvement on imaging): 14%
- Critical (respiratory failure, shock, or multiorgan system dysfunction): 5%

In this study, all deaths occurred among patients with critical illness and the overall case fatality rate was 2.3%.[38] The case fatality rate among patients with critical disease was 49%.[38] Among children in China, illness severity was lower with 94% having asymptomatic, mild or moderate disease, 5% having severe disease, and <1% having critical disease.[14] Among U.S. COVID-19 cases with known disposition, the proportion of persons who were hospitalized was 19%.[39] The proportion of persons with COVID-19 admitted to the intensive care unit (ICU) was 6%.[39]

Clinical Progression

Among patients who developed severe disease, the medium time to dyspnea ranged from 5 to 8 days, the median time to acute respiratory distress syndrome (ARDS) ranged from 8 to 12 days, and the median time to ICU admission ranged from 10 to 12 days.[5,6,10,11] Clinicians should be aware of the potential for some patients to rapidly deteriorate one week after illness onset. Among all hospitalized patients, a range of 26% to 32% of patients were admitted to the ICU.[6,8,11] Among all patients, a

range of 3% to 17% developed ARDS compared to a range of 20% to 42% for hospitalized patients and 67% to 85% for patients admitted to the ICU.[1,4-6,8,11] Mortality among patients admitted to the ICU ranges from 39% to 72% depending on the study.[5,8,10,11] The median length of hospitalization among survivors was 10 to 13 days.[1,6,8]

Risk Factors for Severe Illness

Age is a strong risk factor for severe illness, complications, and death.[1,6,8,10,11,38-41] Among more than 44,000 confirmed cases of COVID-19 in China, the case fatality rate was highest among older persons: ≥80 years: 14.8%, 70–79 years: 8.0%, 60–69 years: 3.6%, 50–59 years: 1.3%, 40–49 years: 0.4%, <40 years: 0.2%.[38,42] Early U.S. epidemiologic data suggests that the case fatality was highest in persons aged ≥85 years (range 10%–27%), followed by 3%–11% for ages 65–84 years, 1%–3% for ages 55–64 years, and <1% for ages 0–54 years.[39]

Patients in China with no reported underlying medical conditions had an overall case fatality of 0.9%, but case fatality was higher for patients with comorbidities: 10.5% for those with cardiovascular disease, 7.3% for diabetes, and approximately 6% each for chronic respiratory disease, hypertension, and cancer.[42] Heart disease, hypertension, prior stroke, diabetes, chronic lung disease, and chronic kidney disease have all been associated with increased illness severity and adverse outcomes.[1,6,10,11,38,42,43] Accounting for differences in age and prevalence of underlying condition, mortality associated with COVID-19 in the United States was similar to China.[39,40,44]

Medications

It has been hypothesized that angiotensin-converting enzyme (ACE) inhibitors or angiotensin receptor blockers (ARBs) may increase the risk of SARS-CoV-2 infection and COVID-19 severity.[45] ACE inhibitors and ARBs increase the expression of angiotensin-converting enzyme 2 (ACE2). SARS-CoV-2 uses the ACE2 receptor to enter into the host cell. There are no data to suggest a link between ACE inhibitors or ARBs with worse COVID-19 outcomes. The American Heart Association (AHA), the Heart Failure Society of America (HFSA), and the American College of Cardiology (ACC) released a statement recommending continuation of these drugs for patients already receiving them for heart failure, hypertension, or ischemic heart disease.[46]

It has also been hypothesized that non-steroidal anti-inflammatory drugs (NSAIDs) may worsen COVID-19. Currently, there are no data suggesting an association between COVID-19 clinical outcomes and NSAID use. More information can be found at Healthcare Professionals: Frequently Asked Questions and Answers.

Reinfection

There are no data concerning the possibility of re-infection with SARS-CoV-2 after recovery from COVID-19. Viral RNA shedding declines with resolution of symptoms, and may continue for days to weeks.[11,33,34] However, the detection of RNA during convalescence does not necessarily indicate the presence of viable infectious virus. Clinical recovery has been correlated with the detection of IgM and IgG antibodies which signal the development of immunity.[36,47-49]

Viral Testing

Diagnosis of COVID-19 requires detection of SARS-CoV-2 RNA by reverse transcription polymerase chain reaction (RT-PCR). Detection of SARS-CoV-2 viral RNA is better in nasopharynx samples compared to throat samples.[33,50] Lower respiratory samples may have better yield than upper respiratory samples.[33,50]. SARS-CoV-2 RNA has also been detected in stool and blood.[13,34,47,51] Detection of SARS-CoV-2 RNA in blood may be a marker of severe illness.[52] Viral RNA shedding may persist over longer periods among older persons and those who had severe illness requiring hospitalization. (median range of viral shedding among hospitalized patients 12–20 days).[11,33-36]

Infection with both SARS-CoV-2 and with other respiratory viruses has been reported, and detection of another respiratory pathogen does not rule out COVID-19.[53]

For more information about testing and specimen collection, handling and storage, visit Evaluating and Testing Persons for Coronavirus Disease 2019 (COVID-19) and Frequently Asked Questions on COVID-19 Testing at Laboratories.

Laboratory and Radiographic Findings

Laboratory Findings

Lymphopenia is the most common lab finding in COVID-19 and is found in as many as 83% of hospitalized patients.[1,5] Lymphopenia, neutrophilia, elevated serum alanine aminotransferase and aspartate aminotransferase levels, elevated lactate dehydrogenase, high CRP, and high ferritin levels may be associated with greater illness severity.[1,5,6,8,11,54] Elevated D-dimer and lymphopenia have been associated with mortality.[8,11] Procalcitonin is typically normal on admission, but may increase among those admitted to the ICU.[4-6] Patients with critical illness had high plasma levels of inflammatory makers, suggesting potential immune dysregulation.[5,55]

Radiographic Findings

Chest radiographs of patients with COVID-19 typically demonstrate bilateral air-space consolidation, though patients may have unremarkable chest radiographs early in the disease.[1,5,56] Chest CT images from patients with COVID-19 typically demonstrate bilateral, peripheral ground glass opacities.[4,8,38,56-65] Because this chest CT imaging pattern is non-specific and overlaps with other infections, the diagnostic value of chest CT imaging for COVID-19 may be low and dependent upon interpretations from individual radiologists.[57,66] One study found that 56% of patients who presented within 2 days of diagnosis had a normal CT[58]. Conversely, other studies have also identified chest CT abnormalities in patients prior to the detection of SARS-CoV-2 RNA.[56,67] Given the variability in chest imaging findings, chest radiograph or CT alone is not recommended for the diagnosis of COVID-19. The American College of Radiology also does not recommend CT for screening or as a first-line test for diagnosis of COVID-19. (See American College of Radiology Recommendations).

Clinical Management and Treatment

Mild to Moderate Disease

Patients with a mild clinical presentation (absence of viral pneumonia and hypoxia) may not initially require hospitalization, and many patients will be able to manage their illness at home. The decision to monitor a patient in the inpatient or outpatient setting should be made on a case-by-case basis. This decision will depend on the clinical presentation, requirement for supportive care, potential risk factors for severe disease, and the ability of the patient to self-isolate at home. Patients with risk factors for severe illness (see People Who Are at Higher Risk for Severe Illness) should be monitored closely given the possible risk of progression to severe illness in the second week after symptom onset.[5,6,10,11]

For information regarding infection prevention and control recommendations, please see Interim Infection Prevention and Control Recommendations for Patients with Confirmed Coronavirus Disease 2019 (COVID-19) or Persons Under Investigation for COVID-19 in Healthcare Settings.

Severe Disease

Some patients with COVID-19 will have severe disease requiring hospitalization for management. No specific treatment for COVID-19 is currently FDA approved. Corticosteroids have been widely used in hospitalized patients with severe illness in China[6,8,10,11]; however, the benefit of corticosteroid use cannot be determined based upon uncontrolled observational data. By contrast, patients with MERS-CoV or influenza who were given corticosteroids were more likely to have prolonged viral replication, receive mechanical ventilation, and have higher mortality.[68-72] Therefore, corticosteroids should be avoided unless indicated for other reasons, such as management of chronic obstructive pulmonary disease exacerbation or septic shock. More information can be found at Healthcare Professionals: Frequently Asked Questions and Answers.

Inpatient management revolves around the supportive management of the most common complications of severe COVID-19: pneumonia, hypoxemic respiratory failure/ARDS, sepsis and septic shock, cardiomyopathy and arrhythmia, acute kidney injury, and complications from prolonged hospitalization including secondary bacterial infections, thromboembolism, gastrointestinal bleeding, and critical illness polyneuropathy/myopathy.[1,4-6,10,11,38,73-76]

The Infectious Diseases Society of America has released guidelines on the treatment and management of patients with COVID-19. For more information, please visit: Infectious Diseases Society of America Guidelines on the Treatment and Management of Patients with COVID-19 Infection.

The World Health Organization and the Surviving Sepsis Campaign have both released comprehensive guidelines for the inpatient management of patients with COVID-19, including those who are critically ill. For more information visit: Interim Guidance on Clinical management of severe acute respiratory infection when novel coronavirus (nCoV) infection is suspected (WHO) and Surviving Sepsis Campaign: Guidelines on the Management of Critically Ill Adults with Coronavirus Disease 2019 (COVID-19) .

For more information on the management of children, see Information for Pediatric Healthcare Providers and the Surviving Sepsis Campaign International Guidelines for the Management of Septic Shock and Sepsis-Associated Organ Dysfunction in Children.

Investigational Therapeutics

No FDA-approved drugs have demonstrated safety and efficacy in randomized controlled trials for patients with COVID-19. Use of investigational therapies for treatment of COVID-19 should ideally be done in the context of enrollment in randomized controlled trials. Several clinical trials are underway testing multiple drugs with in-vitro antiviral activity against SARS-CoV-2 and/or immunomodulatory effects that may have clinical benefit. For the latest information, see Information for Clinicians on Therapeutic Options for COVID-19 Patients. For the information on registered trials in the U.S., see ClinicalTrials.gov.

Discontinuation of Transmission-Based Precautions or Home Isolation

Patients who have clinically recovered and are able to discharge from the hospital but who have not been cleared from their Transmission-Based Precautions may continue isolation at their place of residence until cleared. For recommendations on discontinuation of Transmission-Based Precautions or home isolation for patients who have recovered from COVID-19 illness, please see: Interim Guidance for Discontinuation of Transmission-Based Precautions and Disposition of Hospitalized Patients with COVID-19, Interim Guidance for Discontinuation of In-Home Isolation for Patients with COVID-19, and Discontinuation of In-Home Isolation for Immunocompromised Persons with COVID-19.

Additional resources:

- Information for Pediatric Healthcare Providers
- Evaluating and Testing Persons for Coronavirus Disease 2019 (COVID-19)
- Frequently Asked Questions on COVID-19 Testing at Laboratories
- Healthcare Professionals: Frequently Asked Questions and Answers
- Interim Infection Prevention and Control Recommendations for Patients with Suspected or Confirmed Coronavirus Disease 2019 (COVID-19) or in Healthcare Settings
- World Health Organization. Interim Guidance on Clinical management of severe acute respiratory infection when novel coronavirus (nCoV) infection is suspected
- Surviving Sepsis Campaign: Guidelines on the Management of Critically Ill Adults with Coronavirus Disease 2019 (COVID-19)
- Surviving Sepsis Campaign: International Guidelines for Management of Sepsis and Septic Shock: 2016
- Surviving Sepsis Campaign International Guidelines for the Management of Septic Shock and Sepsis-Associated Organ Dysfunction in Children
- Diagnosis and Treatment of Adults with Community-acquired Pneumonia. An Official Clinical Practice Guideline of the American Thoracic Society and Infectious Diseases Society of America
- ACR Recommendations for the use of Chest Radiography and Computed Tomography (CT) for Suspected COVID-19 Infection
- Infectious Diseases Society of America Guidelines on the Treatment and Management of Patients with COVID-19 Infection
- National Institutes of Health: Coronavirus Disease 2019 (COVID-19) Treatment Guidelines

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Page last reviewed: April 6, 2020

Tekbali Exhibit 2

Centers for Disease Control and Prevention
CDC 24/7: Saving Lives, Protecting People™

Coronavirus Disease 2019 (COVID-19)

Evaluating and Testing Persons for Coronavirus Disease 2019 (COVID-19)

CDC guidance for COVID-19 may be adapted by state and local health departments to respond to rapidly changing local circumstances.

Summary of Recent Changes

Revisions were made on May 3, 2020 to reflect the following:

- Updated recommendations for testing, specimen collection, and reporting patients and reporting positive test results
- Specification of testing priorities

Revisions were made on April 27, 2020 to reflect the following:

- Updated priorities for testing patients with suspected COVID-19 infection

Revisions were made on March 24, 2020 to reflect the following:

- Updated priorities for testing patients with suspected COVID-19 infection

Revisions were made on March 9, 2020, to reflect the following:

- Reorganized the Criteria to Guide Evaluation and Laboratory Testing for COVID-19 section

Revisions were made on March 4, 2020, to reflect the following:

- Criteria for evaluation of persons for testing for COVID-19 were expanded to include a wider group of symptomatic patients.

CDC Health Advisory

Update and Interim Guidance on Outbreak of Coronavirus Disease 2019 (COVID-19)

CDC continues to closely monitor an outbreak of respiratory illness caused by COVID-19 that was initially detected in Wuhan City, Hubei Province, China. This HAN Update provides a situational update and guidance to state and local health departments and health care providers.

No vaccine for COVID-19 is currently available; however, vaccine trials are in progress . The National Institutes of Health recently published guidelines on prophylaxis use, testing, and management of COVID-19 patients. For more information, please visit: National Institutes of Health: Coronavirus Disease 2019 (COVID-19) Treatment Guidelines .

The CDC clinical criteria for considering testing for COVID-19 have been developed based on what is known about COVID-19 and are subject to change as additional information becomes available.

Contact your local or state health department

Healthcare providers should **immediately** notify their local or state health department in the event of the identification of a PUI for COVID-19. When working with your local or state health department check their available hours.

PRIORITIES FOR COVID-19 TESTING

(Nucleic Acid or Antigen)

High Priority

- Hospitalized patients **with** symptoms
- Healthcare facility workers, workers in congregate living settings, and first responders **with** symptoms
- Residents in long-term care facilities or other congregate living settings, including prisons and shelters, **with** symptoms

Priority

- Persons **with** symptoms of potential COVID-19 infection, including: fever, cough, shortness of breath, chills, muscle pain, new loss of taste or smell, vomiting or diarrhea, and/or sore throat.
- Persons **without** symptoms who are prioritized by health departments or clinicians, for any reason, including but not limited to: public health monitoring, sentinel surveillance, or screening of other asymptomatic individuals according to state and local plans.

Clinicians considering diagnostic testing of people with possible COVID-19 should continue to work with their local and state health departments to coordinate testing through public health laboratories , or work with commercial or clinical laboratories using diagnostic tests authorized for emergency use by the U.S. Food and Drug Administration.

Clinicians should use their judgment to determine if a patient has signs and symptoms compatible with COVID-19 and whether the patient should be tested. Asymptomatic infection with SARS-CoV-2, the virus that causes COVID-19, has been reported. Most patients with confirmed COVID-19 have developed fever[1] and/or symptoms of acute respiratory illness (e.g., cough, difficulty breathing) but some people may present with other symptoms as well. Other considerations that may guide testing are epidemiologic factors such as the occurrence of local community transmission of COVID-19 in a jurisdiction. Clinicians are encouraged to test for other causes of respiratory illness.

Other considerations that may guide testing are epidemiologic factors such as known exposure to an individual who has tested positive for SARS-CoV-2, and the occurrence of local community transmission or transmission within a specific setting/facility (e.g., nursing homes) of COVID-19. Clinicians are strongly encouraged to test for other causes of respiratory illness, for example influenza, in addition to testing for SARS-CoV-2. Another population in which to prioritize testing of minimally symptomatic and even asymptomatic persons are long-term care facility residents, especially in facilities where one or more other residents have been diagnosed with symptomatic or asymptomatic COVID-19.

SARS-CoV-2 can cause asymptomatic, pre-symptomatic, and minimally symptomatic infections, leading to viral shedding that may result in transmission to others who are particularly vulnerable to severe disease and death. Even mild signs and symptoms (e.g., sore throat) of COVID-19 should be evaluated among potentially exposed healthcare personnel, due to their extensive and close contact[2] with vulnerable patients in healthcare settings. Additional information is available in CDC's Interim U.S. Guidance for Risk Assessment and Public Health Management of Healthcare Personnel with Potential Exposure in a Healthcare Setting to Patients with Coronavirus Disease 2019 (COVID-19).

Recommendations for Viral Testing, Specimen Collection, and Reporting

Updated May 3, 2020

Clinicians should immediately implement recommended infection prevention and control practices, including use of recommended personal protective equipment (PPE) if a patient is suspected of having COVID-19. They should also notify infection control personnel at their healthcare facility if a patient is classified as a Patient Under Investigation (PUI) for COVID-19.

For diagnostic testing for COVID-19 see the Interim Guidelines for Collecting, Handling, and Testing Clinical Specimens from PUIs for COVID-19 and Biosafety FAQs for handling and processing specimens from possible cases and PUIs.

Clinicians should report positive test results to their local or state health department only.

Recommendations for Antibody Testing

Updated May 5, 2020

CDC does not recommend using antibody testing to diagnose acute infection. It is recommended to use a viral (nucleic acid or antigen) test to diagnose acute infection.

Additional Resources:

- Nasal (Anterior Nasal) Specimen Collection for SARS-CoV-2 Diagnostic Testing [1 page]
- Guidance – Proposed Use of Point-of-Care (POC) Testing Platforms for SARS-CoV-2 (COVID-19) [2 pages]
- State health department after-hours contact list
- Directory of Local Health Departments
- World Health Organization (WHO) Coronavirus
- WHO guidance on clinical management of severe acute respiratory infection when COVID-19 is suspected
- NIH Coronavirus Disease 2019 (COVID-19) and Treatment Guidelines
- CMS Guidelines
- FAQs on Diagnostic Testing from the FDA

Footnotes

[1]Fever may be subjective or confirmed

[2]Close contact is defined as—

a) being within approximately 6 feet (2 meters) of a COVID-19 case; 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)

Additional information is available in CDC's Interim Infection Prevention and Control Recommendations for Patients with Confirmed COVID-19 or Persons Under Investigation for COVID-19 in Healthcare Settings.

Page last reviewed: May 5, 2020
Content source: National Center for Immunization and Respiratory Diseases (NCIRD), Division of Viral Diseases

Tekbali Exhibit 3

FAQ About 2019 Novel Coronavirus and COVID-19 for Health Care Providers

For updated information and guidance on the outbreak, including guidance on testing and managing patients who have suspected or confirmed coronavirus disease 2019 (COVID-19), visit the provider web pages from the New York City Health Department and U.S. Centers for Disease Control and Prevention (CDC).

About 2019 Novel Coronavirus and COVID-19 Respiratory Disease

What are the 2019 novel coronavirus and COVID-19?

A novel coronavirus — one not previously identified in humans — was first identified in December 2019 in Wuhan, Hubei Province, China. The virus, officially named severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) causes a respiratory disease called coronavirus disease 2019 (COVID-19) and is spread person to person. The COVID-19 outbreak has now become a pandemic, which means that it is spreading person to person in multiple parts of the world, including the United States. For the most recent tally of persons diagnosed with COVID-19 in New York City, visit nyc.gov/health/coronavirus.

How does the 2019 coronavirus disease spread?

There is increasing understanding of how this newly identified virus spreads. Most spread appears to occur from person to person via respiratory droplets, primarily through close contact (within about 6 feet) with a person with COVID-19. Close contact includes those persons who reside or provide care in the same household of the ill person or are an intimate partner of the ill person. Detectable levels of viral RNA appear to be highest right after onset of illness and then decline as the illness progresses and symptoms improve. Viral RNA levels are also higher among persons who are more severely ill. These findings suggest there is a greater risk of transmission from symptomatic persons, and during the early stages of a person's illness. Transmission from persons who are asymptomatic and pre-symptomatic has been increasingly reported. Further studies and data from clinical settings are needed to fully understand transmission.

What is the guidance on wearing face coverings in public?

The CDC and the NYC Health Department recommend wearing cloth face coverings in public where physical distancing is difficult to maintain to slow the spread and transmission of the virus. Cloth face coverings should cover the mouth and nose, fit snugly against the side of the face, include multiple layers of fabric and should not interfere with breathing. You should still stand 6 feet away from people in public. Face coverings do not protect the wearer but rather help prevent the spread of the virus from the wearer to others. This component for minimizing transmission, is particularly important in light of asymptomatic and pre-symptomatic transmission.

Can persons with COVID-19 shed the virus before or after showing symptoms?

The onset and duration of viral shedding and period of infectiousness for COVID-19 are not fully known. It is possible that SARS-CoV-2 RNA may be detectable in the upper or lower respiratory tract for weeks after illness onset, similar to what is seen with infection with MERS-CoV and SARS-CoV. However, detection of viral RNA does not necessarily mean that infectious virus is present. Asymptomatic infection resulting in transmission of infection with

SARS-CoV-2 has been reported. Similarly, pre-symptomatic transmission has been reported. Existing literature regarding SARS-CoV-2 suggest that the incubation period may range from two to 14 days, but the mean is about five to six days.

What is known regarding re-infection after initial infection?

There is not yet any evidence of re-infection with SARS-CoV-2 after an initial infection. A positive test result using a molecular assay (e.g., rtPCR) weeks after infection provides evidence of the presence of viral RNA. For most patients, it should not be interpreted as an ongoing or new infection as viral shedding may continue for weeks following the initial infection.

How long does SARS-CoV-2 survive on surfaces?

Reports that describe the detection of viral RNA should be interpreted with caution. Refer to studies that report on the presence of viable virus. How long any virus can survive on a surface depends on several factors, including:

- The characteristics of the virus itself
- The type of surface
- Environmental conditions, including temperature, humidity and exposure to sunlight
- Cleaning products used

Studies have reported that viable SARS-CoV-2 can survive on copper for up to four hours, on cardboard for up to 24 hours and on plastic and steel for up to three days. Of note, this was determined under experimental conditions and does not necessarily occur outside of a laboratory-controlled setting. The half-life of viral particles was approximately 5.6 hours on stainless steel, 6.8 hours on plastic and less than 4 hours on cardboard. This highlights the importance of appropriate cleaning and decontamination of the environment in certain settings (see Infection Prevention and Control section). Person-to-person spread is thought to be the most important driver of transmission.

If I am a New York State certified health care worker and want to help facilities that need more staff, what should I do?

Join the New York City Medical Reserve Corps (NYC MRC). Volunteers are needed now to assist with the overwhelming demands on the NYC health care system. The NYC MRC is a community-based corps of over 9,000 medical and nonmedical volunteers with a mission to strengthen public health, improve emergency response capabilities and build community resilience in NYC. NYC MRC is managed under the NYC Department of Health and Mental Hygiene (Health Department) and has served as a valuable staffing resource for emergency response and nonemergency public health and community resilience activities in NYC since its inception in 2004. NYC MRC volunteers represent a variety of professions, including physicians, physician assistants, nurse practitioners, registered nurses, medical students, as well as other health care professionals and nonmedical volunteers.

NYC MRC can mobilize volunteers for nonemergency public health or community resilience activities and rapidly deploy volunteers for emergency response operations. NYC MRC can recruit and select volunteers for assignments based on many criteria, such as profession, languages spoken and home address. To volunteer and become a member of the NYC MRC, visit nyc.gov/health/mrc.

The New York State Department of Health (NYSDOH) is also recruiting medical volunteers.

Where can I find the most recent NYC COVID-19 data?

Surveillance data on the COVID-19 pandemic impact in NYC are updated each day with data from the preceding day. Data include the number of persons with confirmed COVID-19 and persons seeking care at NYC emergency departments (EDs) for influenza-like illness as well as the number hospitalized for influenza-like illness and pneumonia for persons over 18 years of age. Expanded data are available regarding confirmed and probable deaths by race/ethnicity.

Note that the data likely do not reflect the true number of people with COVID-19 in NYC because of limited testing and therefore may overrepresent the proportion of COVID-19 cases in NYC requiring hospitalization.

Back to Table of Contents

Preparing to Manage Patients with Possible or Confirmed COVID-19

How can an outpatient practice best prepare to manage persons with possible or confirmed COVID-19?

Outpatient health care settings should implement a continuum of infection control measures before patient arrival, upon arrival, throughout the patient's visit and until the patient's room is cleaned and disinfected. Have systems to rapidly identify patients and visitors who might have COVID-19 and take steps to prevent them from potentially infecting others. It is particularly important to protect individuals at increased risk for adverse outcomes from COVID-19 (e.g., older persons, persons with disabilities and persons with comorbid conditions). The following are recommended during the current period of widespread community transmission:

1. Strongly discourage persons who have a mild or moderate disease consistent with COVID-19-like illness (fever, cough, shortness of breath, sore throat, loss of sense of smell or taste) and who do not require medical care from leaving their homes. This minimizes risk of transmission to others, especially health care workers.
2. Implement measures to prevent unnecessary in-person health care visits by patients with mild to moderate illness.

3. Consider contacting patients in advance of their appointment by phone, text or other methods.
4. Consider placing signage and greeters at entry points to screen persons seeking care and visitors by asking if they have a COVID-19-like illness.
5. Post signage in multiple languages instructing patients at entry points to immediately report fever or other symptoms of COVID-19-like illness (e.g., new cough, shortness of breath, loss of the sense of smell or taste or sore throat). Posters can be downloaded from NYC Health Department's coronavirus webpage.
6. Triage personnel should have a supply of face masks, hand sanitizer and tissues for all patients.

How can hospitals best prepare for receiving and managing persons with possible or confirmed COVID-19?

At this point, hospitals should prioritize urgent and emergent patient care and procedures to protect patients, expand capacity and conserve supply of personal protective equipment (PPE).

CDC has several resources on its Health Care Facilities page including:

- Steps Health Care Facilities Can Take
- Interim Guidance for Health Care Facilities
- Interim Additional Guidance for Outpatient and Ambulatory Care Settings
- Considerations for Pharmacies
- Dental Settings
- Strategies to Prevent the Spread of COVID-19 in Long-Term Care Facilities
- Interim Guidance for Outpatient Hemodialysis Facilities

Also visit the Greater New York Hospital Association (GNYHA) website.

Back to Table of Contents

Self-Monitoring, Quarantine, Isolation and Having Contact With a Person With COVID-19

What is the difference between quarantine and isolation?

Isolation and quarantine are different. These two terms are not interchangeable. Isolation refers to the separation of sick people with a contagious disease from people who are not sick.

Quarantine refers to the separation of asymptomatic people who were exposed to a contagious disease to see if they become sick. The NYC Health Department is not issuing either mandatory isolation or quarantine orders for persons with COVID-19. People who are sick with possible or confirmed COVID-19 need to self-isolate at home: "If you are sick, stay home." Refer to the question **Should I tell my patient who has possible or confirmed COVID-19 to isolate themselves at home while they are sick?** below for details.

What is self-monitoring?

To help prevent further spread of COVID-19, all New Yorkers should **self-monitor** daily. The virus causing COVID-19 is now spreading rapidly in NYC and all New Yorkers should assume that they have been exposed to COVID-19, and self-monitor accordingly. Self-monitoring is an important tool to help people recognize when they are becoming sick so they can self-isolate at home and avoid infecting others. New Yorkers should self-monitor every day for the onset of any of the following new symptoms that cannot be attributed to another preexisting condition (e.g., asthma, emphysema):

- Fever (temperature 100.4 degrees F or 38.0 degrees C or greater) or begin to feel warm
- Cough
- Shortness of breath
- Loss of sense of smell or taste
- Sore throat

Note: In children, fever with sore throat may be due to conditions other than COVID-19 (e.g., strep throat) and parents/guardians should be instructed to consult a health care provider to rule out other etiologies.

During this time of widespread transmission, NYC health care providers should assume that anyone who has developed these symptoms has COVID-19. Refer to **Should I tell my patient who has possible or confirmed COVID-19 to isolate themselves at home while they are sick?** below.

Should I tell my patient who has possible or confirmed COVID-19 to isolate themselves at home while they are sick?

Yes. Persons with either of the following:

1. A positive test result for COVID-19 using a molecular assay (e.g., rtPCR)
2. Any subjective or measured fever (100.4 degrees F or 38.0 degrees C or greater), new cough, shortness of breath, loss of sense of smell or taste or sore throat that is not due to an underlying or known medical condition (such as asthma or emphysema)

Should be directed to self-isolate by staying home until all the following are true:

- It has been at least seven days since their symptoms started.
- If they never had fever OR they have not had a fever for the prior three days without use of antipyretics.

- Their overall illness has improved for at least three days.

Remind patients that even when they feel better, they should stay home as much as possible and only go out (with a face covering) for essential supplies like groceries or medications, or to seek medical care.

For those with only loss of smell or taste, they should isolate for seven days since symptom(s) onset, regardless of whether there is any improvement.

Examples:

- Fever begins on March 1 and lasts until March 3. Remain isolated until March 8 (seven days from beginning of symptoms).
- Cough begins on March 1 and does not begin to significantly improve until March 8, which is also your last day of fever. Remain isolated until March 11 (three days from fever ending and symptom improvement).

For asymptomatic individuals with a positive molecular assay (i.e., rtPCR) test result, they should stay home for seven days from when specimen that tested positive was collected.

Upon completion, persons can return to their normal activities within the context of current NYS or NYC executive orders.

Note: Health care workers and other staff employed by a facility regulated by the NYSDOH (e.g., an Article 28 facility) or a jurisdiction outside of NYC should check with their employer before returning to work, as the employer may have a different policy regarding COVID-19.

See additional guidance for people at risk for more severe disease from COVID-19 or who may require emergency medical attention: **Who is at risk for severe disease and what should I do if a patient who is at home with possible or confirmed COVID-19 develops severe symptoms?**

What should I tell patients who had contact with someone with known or suspected COVID-19?

All New Yorkers, especially those who have had close contact with a person with possible or confirmed COVID-19, should **self-monitor** for the onset of a new illness (see **What is self-monitoring?**). Close contact includes residing with or providing care to someone in the household of the ill person or being an intimate partner of the ill person. Close contacts should **monitor** their health *at all times*, but particularly for 14 days starting from the last time there was close contact with the person while they were ill (see **What is self-monitoring?**). If a close contact develops illness consistent with COVID-19 they should be advised to **self-isolate**. Refer to guidance described in **Should I tell my patient who has possible or confirmed COVID-19 to isolate themselves at home while they are sick?**

Asymptomatic people who may have had contact with someone with COVID-19 do not need testing for SARS-CoV-2.

Back to Table of Contents

Clinical Management of Patients with Possible or Confirmed COVID-19

What is COVID-19-like illness?

COVID-19-like illness is described as new onset of **any** of the following that cannot be attributed to an underlying or previously recognized condition:

- Subjective fever or measured fever (temperature of 100.4 degrees F or 38.0 degrees C or greater)
- Cough
- Shortness of breath
- Loss of sense of smell or taste
- Sore throat

In children, fever with sore throat may be attributable to conditions other than COVID-19 (e.g., strep throat) and parent/guardian should be instructed to consult a health care provider to rule out other etiologies.

What is the difference between a confirmed and a possible case of COVID-19?

A confirmed case of COVID-19 is defined as an ill person with a positive laboratory test for COVID-19. A possible case of COVID-19 is defined as a person with COVID-19-like illness during a period of widespread COVID-19 transmission for whom testing was not performed.

How should I treat a patient with possible or confirmed COVID-19?

- Currently, medical care for COVID-19 is supportive.
- Corticosteroids should be avoided unless they are indicated for other reasons (e.g., COPD exacerbation, septic shock, ARDS).
- Treament guidelines were issued by the National Institutes of Health (NIH) and can be accessed on their **website.** The guidance will be updated frequently as published data and other authoritative information becomes available.
- The antiviral remdesivir is being studied in Phase 2 and Phase 3 clinical trials. Compassionate use of the drug by the manufacturer, Gilead, is no longer available. Clinicians interested participating in remdesivir trials can directly reach out to the National Institutes of Health (NIH) or Gilead. In addition, see CDC's current Clinical Guidance. Off-label use of drugs without clinical efficacy data should be discouraged.
- Azithromycin and hydroxychloroquine are not recommended for management of non-hospitalized people with COVID-19-like illness**.** The NIH recommends against

using this combination of medications for COVID-19 outside the context of a clinical trial. Reserve therapeutic agents, such as azithromycin and hydroxychloroquine, for patients who will benefit from their indicated use. Antibiotics are indicated when there is suspicion of concurrent bacterial pneumonia. As mandated by New York State Executive Order 202.10, "no pharmacist shall dispense hydroxychloroquine or chloroquine except when written as prescribed for [a Food and Drug Administration (FDA)]-approved indication or as part of a state-approved clinical trial related to COVID-19 for a patient who has tested positive for COVID-19, with such test results documented as part of the prescription". No other experimental or prophylactic use shall be permitted, and any permitted prescription is limited to one 14-day prescription with no refills.

Are non-respiratory symptoms, such as diarrhea, chills/rigors, myalgias, nausea, or vomiting suggestive of COVID-19?

COVID-19-like illness is defined as new fever, shortness of breath, cough, or sore throat. Patients with COVID-19-like illness may also present with other symptoms including loss of sense of smell or taste, myalgias, or diarrhea.

What is the duration of illness in non-hospitalized patients with mild to moderate illness?

The report of the WHO-China Joint Mission approximated that the median time from onset to clinical recovery for mild cases is two weeks. They also reported that the median duration is approximately three to six weeks for patients with severe or critical disease.

Would a person with diarrhea, cough or rhinorrhea, even improving, be allowed to return to work, if they don't have fever for at least 72 hours and it has been at least seven days from illness onset?

Use clinical judgment in advising patients with non-respiratory symptoms after seven days. A cough after a respiratory viral infection can last for several weeks after an infection. If it has been at least seven days since onset of symptoms, 72 hours since last fever (without antipyretics) and respiratory symptoms (including cough) are improving, you do not need to continue to self-isolate if there is a residual cough or rhinorrhea. If diarrhea is a persistent symptom, the patient should not return to work until the diarrhea has resolved for at least 48 hours.

Who is at risk for severe disease and what should I do if a patient who is at home with possible or confirmed COVID-19 develops severe symptoms?

People 50 years of age or older, and especially those 65 years of age or older, or who have other health conditions — including lung disease, moderate to severe asthma, heart disease, a

weakened immune system, obesity, diabetes, kidney disease liver disease, or cancer — may be at risk for more severe disease and death from COVID-19. Monitor these patients more closely and advise them to contact a provider if they develop symptoms that worsen or do not go away after three to four days.

Advise patients with **underlying medical conditions or other risk factors** for severe COVID-19 illness who experience COVID-19 symptoms to seek medical care before symptoms become severe.

Counsel patients with severe symptoms of any type — including trouble breathing, chest pain, alteration in mental status or cyanosis — to not delay seeking care. They should contact their provider immediately or **call 911** and alert the operator that they have or may have COVID-19.

If their symptoms do not require urgent care but do need to be evaluated, advise them to call their health care provider to discuss next steps.

Patients who do not have a health care provider can call 844-NYC-4NYC (844-692-4692) to discuss COVID-19 symptoms and receive medical advice and assistance, regardless of their immigration status or ability to pay.

Are there neurological effects of infection with the virus that causes COVID-19?

There is increasing evidence that the virus that causes COVID-19 may cause impairment of the nervous system. About one-third of COVID-19 patients in one study from Wuhan were reported to have neurological system involvement. The following neurological symptoms or conditions have been reported most frequently in association with COVID-19: headache, loss of sense of smell or taste or paresthesia. Less common reported conditions include encephalopathy, ataxia, stroke, trigeminal neuralgia or seizures.

What is the risk to pregnant people with COVID-19?

It is not currently known if pregnant people have a greater chance of getting sick or having more serious illness from COVID-19 than the general public. Pregnancy can sometimes weaken a person's immune system, increasing their risk of some infections. With viruses from the same family as COVID-19, and other viral respiratory infections such as influenza, pregnant people have had a higher risk of developing severe illness. It is always important for pregnant people to protect themselves from viral respiratory infections. For more information, visit the CDC's webpage on COVID-19 and pregnancy.

Does COVID-19 during pregnancy hurt the fetus?

It is not currently known if there is any risk to the fetus of a pregnant person who has COVID-19. There have been a small number of problems reported (e.g., preterm birth) in babies born to people who tested positive for COVID-19 during pregnancy. However, it is not clear that

these outcomes were related to the birth parent's infection. To date, there have been a small number of studies of infants born to birth parents with COVID-19 who have tested negative for the COVID-19 virus. There have also been a very small number on infants who tested positive for the virus shortly after birth but it is unknown if transmission happened before or after birth. The virus was also not found in samples of amniotic fluid or breastmilk.

Should individuals with COVID-19-like illness avoid non-steroidal anti-inflammatories (NSAIDS) or ACE inhibitors?

At this time, there are no reliable data to support claims that the use of NSAIDs may contribute to poorer outcomes in persons with COVID-19. Additionally, the American College of Cardiology (ACC) released the followng statement:

> "Currently there are no experimental or clinical data demonstrating beneficial or adverse outcomes with background use of angiotensin-converting enzyme (ACE) inhibitors, angiotensin-receptor blockers (ARBs) or other renin-angiotensin-aldosterone system (RAAS) antagonists in COVID-19 or among COVID-19 patients with a history of cardiovascular disease treated with such agents. The Heart Failure Society of America (HFSA), ACC, and American Heart Association (AHA) recommend continuation of RAAS antagonists for those patients who are currently prescribed such agents for indications for which these agents are known to be beneficial, such as heart failure, hypertension, or ischemic heart disease."

What do I do when I discharge, or send home, a person with confirmed or possible COVID-19?

When preparing to discharge patients with confirmed or possible COVID-19 from the emergency or inpatient unit, or send them home from an outpatient health care facility, instruct them to self-isolate at home (see **Should I tell my patient who has possible or confirmed COVID-19 to isolate themselves at home while they are sick?** for details) and remind their household contacts to self-monitor (see above) The NYC Health Department does not require a negative COVID-19 test to release a patient from a health care facility or to have them return to work or school following self-isolation. If the patient is a health care worker, refer to the sections below which contain questions specific to health care workers: Guidance for NYC Health Care Workers in Health Care Facilities Not Regulated by the New York State Department of Health or Who Work in a Jurisdiction Outside of NYC; and Information for Health Care Workers in Health Care Facilities Regulated by the New York State Department of Health.

Persons who have to travel using public transportation should be advised to use physical distancing (maintain a distance of 6 feet or more from other people), advise them to wear a face covering and cover their mouth and nose with a tissue or sleeve when sneezing or coughing. They should not use their hands to cover their sneeze or cough.

How do I determine when to discontinue COVID-19 isolation and transmission-based precautions (e.g., droplet and isolation) for a person with confirmed or possible COVID-19?

COVID-19 isolation and transmission-based precautions for most persons with possible or confirmed COVID-19 can be discontinued when it has been:

- At least seven days after symptom onset AND;
- If they ever had fever, they have been fever-free for at least three days without antipyretics AND;
- Their overall illness has improved

Where can I find updated information for providers on COVID-19?

The NYC Health Department's response is evolving rapidly. Visit the Department's provider webpage and the CDC provider webpage for updated information on testing and clinical guidance.

Consider signing up for the NYC Health Department Health Alert Network (HAN). The HAN contains public health information for medical providers, including:

- Up-to-date health alert information, delivered to your inbox and archived on the web
- An online document library on public health topics

Visit the HAN webpage to learn more and to subscribe to the HAN.

Back to Table of Contents

Testing and Reporting

What should I tell patients who are worried or want to be tested for COVID-19?

Do NOT test non-hospitalized patients for COVID-19 during this period of widespread community transmission. Patients who can be safely managed at home should therefore be strongly advised to do so. Tell patients who are not hospitalized and who try to get tested that testing can lead to:

- Possible transmission of COVID-19 to others, especially health care workers, during travel and clinic visits.
- Worsening of the shortage of medical equipment, tests and other resources that others in the hospital need more.
- Increased risk that they might get infected if they do not already have COVID-19 while traveling or visiting a medical clinic.
- A positive or negative test result in a person who is thought to have COVID-19 will likely not change their medical management.
- A false negative result in a patient with COVID-19 could lead them to unnecessarily expose others.

For most people, whether they test positive or negative will not change what they should do

— stay home and isolate if they have symptoms. A positive test result will not change that advice. See NYC Health Advisory #8: Do not test non-hospitalized patients and preserve PPE.

How can I test for the virus that causes COVID-19?

During this period of widespread transmission, the NYC Health Department strongly recommends against testing persons with mild or moderate illness who can be safely managed at home, unless a diagnosis may impact patient management. This means that testing should be focused on the most ill or vulnerable persons that have been admitted to the hospital. Not testing persons with mild or moderate illness may prevent exposure to health care workers, patients and the public and reduce the demand for PPE and laboratory test-related supplies that are in short supply. Whenever possible, test for common causes of respiratory illness (e.g., influenza) before testing for COVID-19. COVID-19 testing is not indicated for persons who are asymptomatic. Several commercial and hospital-based laboratories are now offering COVID-19 testing using a molecular assay (e.g., rtPCR). In most cases, these tests will be conducted at no cost to the patient, per a New York State directive.

How can I request testing at the NYC Public Health Lab (PHL) for the virus that causes COVID-19?

The NYC Health Department's PHL will only accept preapproved specimens for hospitalized patients with severe acute lower respiratory illness (e.g., pneumonia). To obtain approval for PHL testing, contact the NYC Health Department Coronavirus Testing Call Center by calling the Provider Access Line (PAL) at 866-692-3641. If testing is approved, the clinical team should transfer patient specimens to the hospital's central laboratory and also provide the hospital's central laboratory with the unique identification number provided by the Call Center. The hospital's central laboratory should submit the necessary laboratory requisition online through PHL's eOrder. The hospital's central laboratory should then call back the PAL with the eOrder number and the unique identification number provided by the Call Center to arrange courier transportation of the specimen to PHL (the hospital can also arrange for its own courier to PHL). If you do not already have an eOrder account, visit the PHL webpage for more information.

What specimens should I collect for testing at PHL?

If the NYC Health Department approves testing at PHL, the preferred specimen combination for testing is:

- One nasopharyngeal (NP) swab.
- One nasal swab (anterior nares) may be self-collected by patient with healthcare personnel supervision. Guidance for specimen self-collection can be found here.
- One saliva specimen self-collected by patient with healthcare personnel supervision.

At this time, we ask for all three specimens to be collected whenever possible. If data from three-site collection indicate that the clinical sensitivity of nasal swab and/or saliva specimens is

commensurate to NP swab specimens, we will advise that NP swabs are no longer necessary. Once sensitivity is confirmed, patients may be able to self-collect these specimens, reducing the need for direct collection of specimens for testing by healthcare workers and the associated PPE required for such collection.

Additional acceptable specimen types include:

- One NP swab and one oropharyngeal (OP) swab in the same viral transport medium collection tube (NP/OP swab).
- One lower respiratory tract specimen if patient is able to produce and/or hospitalized (sputum or tracheal aspirate) and submit to the clinical laboratory at your facility.

Additional details can be found on the PHL webpage.

How will PHL test results be reported to me?

All PHL test reports will be delivered by fax to the submitting laboratory. The report will also be available in eOrder. Providers should contact their hospital's central laboratory for test results. **The NYC Health Department will not report back results to patients on behalf of providers.**

Should providers report possible or confirmed COVID-19 cases to the NYC Health Department?

All positive test results will be sent directly from the laboratory to the NYC Health Department.

What do I tell my patient who has possible or confirmed COVID-19?

Any patient with laboratory confirmed COVID-19 or a COVID-19-like illness should be advised to self-isolate at home (for details, see **Should I tell my patient who has possible or confirmed COVID-19 to isolate themselves at home while they are sick?**). The NYC Health Department is not contacting individuals with confirmed COVID-19. Additional guidance can be found at nyc.gov/health/coronavirus.

Should a hospital notify patients if a health care worker has been exposed to COVID-19?

The NYC Health Department is not requiring hospitals to notify patients potentially exposed to COVID-19 by a health care worker. There is widespread community transmission and patients could have been exposed in the hospital or community. However, the hospital can issue their own notification letters if they would like.

I suspect my patient has COVID-19, but their test for the disease came back negative. What does this mean?

If a patient for whom the clinical suspicion of COVID-19 is high has a negative COVID-19 test result, the test result may be inaccurate. If there is reason to suspect an inpatient has COVID-

19 despite a negative test result, consider retesting and continuing infection control practices appropriate for COVID-19. Outpatients with symptoms consistent with COVID-19 should not be tested. They should self-isolate at home (for details, see Should I tell my patient who has possible or confirmed COVID-19 to isolate themselves at home while they are sick?). A negative test does not rule out COVID-19 in an individual with symptoms.

What can you tell me about the new serologic assays for COVID-19 that I have seen advertised?

Health care providers and clinical laboratories are cautioned that most SARS-CoV-2 serology tests marketed currently to health care providers and clinical laboratories have not been validated and are of questionable reliability. Sensitivities, specificities and predictive values of these serology test kits have not been evaluated. It is a provider's and laboratory director's responsibility that all testing performed in a practice or clinical laboratory is in compliance with applicable regulations. The Infectious Disease Society of America has released a summary document describing the state of SARS-CoV-2 serologic tests.

What considerations are there for using serology tests to determine immunity or to diagnose current or previous infections with SARS-CoV-2?

Although there is interest in identifying individuals who may be immune to SARS-CoV-2 due to previous infection, significant voids remain in our scientific understanding of the pathophysiology of SARS-CoV-2 which make interpreting serologic assays challenging for clinical and public health practice. Given the current lack of evidence that detection of SARS-CoV-2 antibody on any serologic test is indicative of durable immunity, it should not be used for that purpose. Serologic tests should not be used to diagnose acute or prior SARS-CoV-2 infection. They may produce false negative or false positive results, the consequences of which include providing patients incorrect guidance on preventive interventions like physical distancing or protective equipment. Serologic tests do not have a role in diagnosing acute infection in symptomatic individuals since antibody responses to infection may take days to weeks to be detectable. A negative serology would, therefore, not exclude SARS-CoV-2 infection in a patient with recent exposure to the virus. Cross-reactivity of antibody to other common coronavirus proteins may also occur, so a positive serology may either reflect infection with SARS-CoV-2 or past infection with other human coronaviruses.

Back to Table of Contents

Infection Prevention and Control

Do I need to manage patients with possible or confirmed COVID-19 in an airborne infection isolation room (AIIR)?

As per the newest CDC guidance, patients can be managed with droplet precautions. This means that patients can be evaluated in a private examination room with the door closed. An AIIR is no longer required by the CDC unless the patient will be undergoing an aerosol-generating procedure (the CDC does not consider the collection of an NP or OP swab an aerosol-generating procedure).

If a private exam room is not readily available, ensure that the patient is not allowed to wait among other patients seeking care. Identify a separate space that allows the patient to be separated from others by at least 6 feet, with easy access to respiratory hygiene supplies (e.g., tissues, trash can, hand sanitizer). In some settings, patients might opt to wait in a personal vehicle or outside the health care facility where they can be contacted by mobile phone when it is their turn to be evaluated.

What PPE is recommended while caring for someone with possible or confirmed COVID-19?

As per the newest CDC guidance, patients can be managed with droplet precautions. The safety of health care workers is a top priority for the NYC Health Department. As we gain more understanding of COVID-19, our guidance will evolve. The use of standard, contact and droplet precautions with eye protection is appropriate when caring for patients who have possible or confirmed COVID-19. PPE should include a face mask (procedure or surgical mask) and gown and gloves and eye protection (goggles or face shield).

This means the NYC Health Department recommends that health care workers do not need to use a fit-tested N95 respirator or powered air purifying respirator (PAPR), and that patients can be evaluated in a private examination room with the door closed.

However, an N95 respirator or PAPR should be used during aerosol-generating procedures (e.g., intubation, suctioning, nebulizer therapy, some high flow oxygenation strategies) and when caring for patients with severe illness requiring intensive care.

What should outpatient providers do to protect themselves and their patients if they do not have access to appropriate PPE recommended by the NYC Health Department (as described above), or a separate room to examine a patient with suspected or confirmed COVID-19?

If a facility is not able to implement droplet precautions using PPE as defined in the previous question, and a provider decided that testing for COVID-19 will change management, arrange transport to a facility that can safely evaluate the patient. If the provider or clinic already has a system in place to transfer a patient to another facility, use that system. Inform the receiving facility before notifying the transport entity.

Where can I find information on how to conserve PPE?

Rapidly diminishing supplies of PPE are being reported. Supplies of PPE must be reserved for high-risk procedures due to potential supply chain constraints. Ample studies indicate the safety of droplet precautions which may also help prevent the complete exhaustion of fit-tested N95 respirators and PAPRs; higher-level PPE will continue to be needed to protect

health care workers during critical and medically necessary aerosol-generating procedures (e.g., intubation, suctioning) throughout the course of this outbreak. The NYSDOH and NYC Health Department are monitoring the need and supply of PPE among health care providers and will advise of any updates as needed.

What strategies are there to optimize the supply of PPE?

To manage shortages or the complete lack of PPE supplies, facilities should use a variety of interventions to work within the contingency and crisis capacity scenarios. General interventions to minimize the need for PPE may include:

- Implement telemedicine options whenever possible.
- Install physical barriers (e.g., glass or plastic windows) at reception areas to limit contact between triage personnel and potentially infectious patients.
- Restrict the number of health care workers entering rooms with COVID-19 patients and bundle care activities.
- Use PPE recommended by the NYC Health Department for caring for patients with COVID-19.
- Educate and train staff on correct PPE use and appropriate donning and doffing procedures.

Contingency and crisis strategies have been developed by the NYC Health Department and the CDC. Refer to the guidance listed below.

For goggles or face shields, face masks and gowns:

- Refer to CDC's guidance on strategies for contingency and crisis capacity for eye protection.
- Refer to CDC's guidance on how to optimize gowns supply during contingency and surge capacity.
- Refer to CDCs guidance on how to optimize facemasks supplies following contingency and surge capacity strategies.

For N95 respirators:

- NYC Health Department strategies to conserve respiratory PPE.
- CDC recommends that N95s that have exceeded their manufacturer-designated shelf life should be used only as outlined in the Strategies for Optimizing the Supply of N95 Respirators.
- More information about the use of expired respirators when supplies are low can be found on the CDC website as well as guidance on what to check to make sure they are still good.
- Refer to CDC's detailed guidance on how to optimize N95 respirator supplies including contingency and crisis strategies.

On March 14, 2020, the Occupational Safety and Health Administration (OSHA) released Temporary Enforcement Guidance: Health Care Respiratory Protection Annual Fit-Testing for N95 Filtering Facepieces During the COVID-19 Outbreak. A fit test is required for anyone

wearing a respirator to protect against COVID-19. Annual fit test can be temporarily suspended if the employee has already been fit tested to that respirator.

Can I get masks and other supplies from the emergency stockpile?

Currently, PPE in the NYC stockpile that is available to health care facilities and providers in NYC includes N95 respirators, N95 respirators that are labelled expired, face masks, eye protection (goggles and face shields), gloves and isolation gowns. Due to the overwhelming demand for supplies, severe shortages in the supply chain, and limited stockpiled resources, requests for PPE will be prioritized based on the facility type and stratified by the type of patient care provided. At this time, only requests from hospitals, emergency medical services (EMS), nursing homes, dialysis centers, groups homes licensed by the NYS Office for Persons With Developmental Disabilities (OPWDD), visiting nurses providing essential care to suspected or known COVID-19 patients, and home health aides caring for persons with suspected or confirmed COVID will be considered. Supplies are prioritized for health care providers and facilities that are providing direct patient care in inpatient settings or in specific settings whose staff cannot maintain 6 feet of separation from a patient.

If you are:

- A hospital, you may request N95s, face masks, eye protection, isolation gowns and gloves.
- A nursing home, you may request face masks; if you have ventilator patients, you may request N95s, goggles, face shields, gloves and isolation gowns.
- An EMS provider, you may request N95s, face masks, eye protection, isolation gowns and gloves.
- A dialysis center, you may request face masks.

Facilities should contact their respective associations to make a request from the stockpile. Unfortunately, at this time, if you do not fall into one of these facility types, your request will be denied.

Are there recommendations on reusing/sanitizing PPE such as N95 masks?

Providers can refer to the NYC Health Department website for guidance on decontamination strategies for N95 respirators and strategies for reuse and extended use of PPE during the COVID-19 pandemic.

When can I discontinue isolation precautions for a patient with possible or confirmed COVID-19?

The NYC Health Department advises that isolation precautions can be discontinued for hospitalized and residential patients after at least seven days from their symptom onset and at least 72 hours after their fever has ended without fever-reducing medicines and their symptoms have improved.

The NYSDOH may have differing recommendations, and NYSDOH-regulated facilities should refer to them for guidance.

Back to Table of Contents

Cleaning Health Care Facilities and Ambulances

After a person with suspected or confirmed COVID-19 exits an exam room, what is the recommended cleaning and down-time before the room can be returned to routine use?

If no aerosol-generating procedure was performed, an exam room can immediately be cleansed using routine cleaning and disinfection procedures (e.g., using cleaners and water to pre-clean surfaces prior to applying an EPA-registered, hospital-grade disinfectant). Focus on frequently touched surfaces or objects for appropriate contact times as indicated on the product's label and use products which are appropriate for SARS-CoV-2 in health care settings. Cleaning staff should use gown and gloves; if there is a risk of splash, include mask and eye protection.

Refer to the List N of Disinfectants for Use Against SARS-CoV-2 on the EPA website for EPA-registered disinfectants that have qualified under EPA's emerging viral pathogens program for use against SARS-CoV-2.

If an aerosol-generating procedure was performed in a non-AIIR, it is reasonable to wait two hours, an amount of time that is commonly used for pathogens spread by the airborne route (e.g., measles, tuberculosis). The room should undergo appropriate cleaning and surface disinfection before it is returned to routine use. Anyone entering a room before two hours after a patient exits should use appropriate PPE as determined by your facility.

What is the recommendation for environmental cleaning products in clinical settings?

Routine cleaning and disinfection procedures are appropriate for SARS-CoV-2 in health care settings, including patient-care areas in which aerosol-generating procedures are performed. Clean frequently touched, non-porous surfaces and objects with cleansers and water prior to applying an EPA-registered, hospital-grade disinfectant that is effective against coronaviruses. Refer to the product label for appropriate contact time. Refer to the List N of Disinfectants for Use Against SARS-CoV-2 on the EPA website for EPA-registered disinfectants that have qualified under EPA's emerging viral pathogens program for use against SARS-CoV-2.

How should standard medical waste (e.g., sputum cup) from a patient suspected or confirmed to be infected with SARS-CoV-2 be handled?

The SARS-CoV-2 virus is not a Category A infectious substance. Waste contaminated with

SARS-CoV-2 should be treated routinely as regulated medical waste. If your contract waste company is applying stricter criteria, the facility should address the issue directly with the contractor.

- Management of laundry, food service utensils and medical waste should also be performed in accordance with routine procedures.
- Use PPE, such as puncture-resistant gloves and face or eye protection to prevent worker exposure to medical waste, including sharps and other items that can cause injuries or exposures to infectious materials.

Regulated medical waste information is available in:

- CDC's guidelines for environmental infection control in health care facilities
- CDC's interim infection prevention and control recommendations for hospitalized patients with MERS
- OSHA's general MERS infection prevention and control recommendations

If a person with suspected or confirmed COVID-19 is transported in an ambulance, what is the cleaning procedure and down-time recommendation before that ambulance is allowed back into service?

When no aerosol-generating procedure was performed, routine disinfection procedures for ambulances are recommended. Any waste generated is not considered Category A waste. Use disposable or dedicated patient-care equipment (e.g., blood pressure cuffs). If common use of equipment for multiple patients is unavoidable, clean and disinfect such equipment before use on another patient according to the equipment and disinfectant manufacturers' instructions for use.

If an aerosol-generating procedure was performed the current down-time recommendation is to take an ambulance that was used to transport a patient with suspected COVID-19 out of service for two hours, consistent with the recommendation for airborne pathogens such as measles or tuberculosis. Alternatively, determine when the ambulance is safe to use again by using the ambulance manufacturer's guidance to determine when the vehicle's passenger compartment air changes per hour will remove 99.9% of airborne contaminants.

For additional information, see CDC guidance: Interim Guidance for Emergency Medical Services (EMS) Systems and 911 Public Safety Answering Points (PSAPs) for COVID-19 in the United States.

Back to Table of Contents

Guidance for NYC Health Care Workers in Health Care Facilities Not Regulated by the New York State Department of Health or Who Work in a Jurisdiction Outside of NYC

Which facilities are/are not regulated by New York State?

New York State regulates Article 28 facilities; Article 28 facilities include hospitals, nursing homes, acute care clinics, and diagnostic and treatment facilities. Article 28 status can be checked at: https://health.data.ny.gov/Health/Health-Facility-General-Information/vn5v-hh5r.

What self-monitoring steps are recommended for health care workers?

Because COVID-19 is spreading in the community, health care workers are at risk of exposure to COVID-19 in both the workplace and the community. Therefore, the NYC Health Department is asking ALL health care workers, regardless of whether they have had a known SARS-CoV-2 exposure, to self-monitor by taking their temperature twice daily and assessing themselves for COVID-19-like illness. **If a health care worker develops COVID-19-like illness, they should NOT report to work. If onset occurs while working, they should immediately leave the patient care area and isolate themselves from other people.**

What should I recommend to an asymptomatic health care worker who tests positive for COVID-19?

Given current shortages in PPE, collection swabs, viral transport media and testing reagents, **do not test asymptomatic and/or exposed health care workers**. However, if testing is done against public health recommendations, asymptomatic health care workers who have a positive test result for COVID-19 should not go to work. The health care worker should monitor their health at home for COVID-19-like illness for a total of seven days from the date of specimen collection. If the health care worker remains symptom-free, they may return to work after the seven days. If the health care worker develops COVID-19-like illness during the seven-day self-monitoring period, they will need to self-isolate for an additional seven days from symptom onset and until they have been afebrile for 72 hours off antipyretics before they return to work. Refer to NYC Health Department guidance online for details on COVID-19-like illness and guidance on self-isolation specific to health care workers.

What if a health care worker develops COVID-19-like illness while not at work?

Health care workers with COVID-19-like illness should stay home and immediately notify their supervisor. Visit the NYC Health Department COVID-19 webpage for more information. At the completion of self-isolation (see Should I tell my patient who has possible or confirmed COVID-19 to isolate themselves at home while they are sick?), health care workers should check with their employer before returning to work. Refer to NYC Health Department guidance online for details on COVID-19-like illness and guidance on self-isolation specific to health care workers.

Do facilities need to report to the NYC Health Department any health care worker with possible of confirmed COVID-19?

No, facilities do not need to report to the NYC Health Department any health care workers

with possible or probable COVID-19. Health care workers who are ill should self-isolate (see

Self-Monitoring, Quarantine, Isolation and Having Contact With a Person With COVID-19 for details).

Do facilities need to report to the NYC Health Department any health care worker with exposure to a COVID-19 case?

No, facilities do not need to report health care workers who have had an exposure to a COVID-19 case to the NYC Health Department. All health care workers should be instructed to self-monitor for 14 days after the exposure.

Should facilities notify patients who may have been exposed to COVID-19 while at their facility?

Facilities may consider notifying patients and other health care workers who were in **close contact** with a health care worker or hospital roommate with confirmed COVID-19; however, no personal identifiers should be released.

Can the NYC Health Department tell us if any of our recent patients or health care workers were exposed to or diagnosed with COVID-19 outside of our facility?

No, the NYC Health Department is unable to release test results.

Does a health care worker with COVID-19-like illness need to get tested?

No, the NYC Health Department does not recommend testing at this time for anyone, including health care workers, who have mild or moderate illness. However, individual facilities may have differing policies for whether to test a health care worker who may have COVID-19. Testing of health care workers who do not meet PHL criteria should be done using a commercial or hospital-based laboratory.

Can health care workers who have had exposure to a known COVID-19 be with their family?

Yes. Health care workers should practice physical distancing and monitor their temperature two times per day (every morning and evening) with one being immediately before starting a shift. Only if/when they develop COVID-19-like illness should they isolate themselves immediately from other people to the extent possible in the household (for details, see

Self-Monitoring, Quarantine, Isolation and Having Contact With a Person With COVID-19).

When can a health care worker with possible or confirmed COVID-19 return to work?

The NYC Health Department does not need to give clearance, nor does it require a negative test, to allow a health care worker to return to work. Refer to the NYC Health Department

COVID-19 webpage for additional information.

Health care workers and other staff employed by a facility regulated by the NYSDOH (e.g., an Article 28 Facility) or a jurisdiction outside of NYC should check with their employer before returning to work as the employer may have a different policy regarding COVID-19.

How will we be notified of patients who were evaluated at our facility, then subsequently diagnosed with COVID-19 elsewhere?

Due to high volume, the NYC Health Department will not be able to conduct case investigations for all confirmed cases, so you will no longer receive updates regarding possible exposures from patients or staff at your facility.

What is considered a high-risk exposure for a health care worker?

High-risk exposures include:

1) An unmasked provider having prolonged close contact (less than 6 feet for more than a few minutes) with an unmasked confirmed COVID-19 patient
2) A provider not wearing eye protection while present for an aerosol-generating procedure (e.g., cardiopulmonary resuscitation, intubation, extubation, bronchoscopy, nebulizer therapy, sputum induction)
3) A health care worker present for an aerosol-generating procedure while not wearing a respirator

Do we need to furlough (send home) health care workers who have had a high-risk exposure?

No, in the context of widespread community transmission of COVID-19, ALL health care workers should self-monitor for illness consistent with COVID-19 because all health care workers are at risk of unrecognized exposures. See NYC Health Department Guidance for additional information.

Instead, health care workers with a high-risk exposure to a patient with confirmed COVID-19 should take extra care to monitor their health but can keep working. **There is no requirement for 14-day quarantine of health care workers with high-risk exposures**. They should self-monitor at least twice daily for subjective fever or measured temperature of 100.4 degrees F or 38 degrees C or greater, cough, shortness of breath, loss of smell or taste or sore throat, as well as new onset of low acuity symptoms that may be associated with early signs of infection with COVID-19, including muscle aches, malaise (feeling tired or run down), runny nose or stuffiness or congestion.

Timing of these checks should be at least eight hours apart with one check immediately before each health care shift. If any of these symptoms develop then the health care worker should **not** come to work. If symptoms develop at work, the health care worker should immediately leave the patient care area, isolate themselves and notify their supervisor (for details, see

Self-Monitoring, Quarantine, Isolation and Having Contact With a Person With COVID-19). See

NYC Health Department Guidance for additional information.

Back to Table of Contents

Information for Health Care Workers in Health Care Facilities Regulated by the New York State Department of Health

Health care facilities and workers regulated by the NYSDOH are encouraged to reach out to their employer or the NYSDOH for the most recent and comprehensive guidance. Guidance is changing, and the answers provided below may not be current.

How do I contact the NYSDOH or a NYS Local Health Department (LHD)?

NYS LHD contact information is available online. Providers who are unable to reach the LHD can contact the NYSDOH Bureau of Communicable Disease Control at 518-473-4439 during business hours or the NYSDOH Public Health Duty Officer at 866-881-2809 evenings, weekends and holidays.

If a health care worker from a facility that is regulated by the NYSDOH is positive for COVID-19, when can they come back to work?

Health care workers who work at a facility regulated by the NYSDOH should check with their employer.

Do all symptomatic health care workers who work at a facility that is regulated by the NYSDOH need to be tested if exposed to a known COVID-19 case?

Health care workers who work at a facility regulated by the NYSDOH should check with their employer.

Do facilities regulated by the NYSDOH need to report any symptomatic health care workers who have had exposure to a COVID-19 case?

Article 28 facilities should report these exposures to New York State Department of Health.

Should a facility that is regulated by the NYSDOH contact patients who came in contact with a suspected or positive COVID-19 health care worker while they were symptomatic?

Article 28 facilities must follow NYSDOH guidance.

Can the NYC Health Department tell us if any of our recent patients or health care workers were exposed to or diagnosed with COVID-19 outside of our facility?

The NYC Health Department is unable to release test results, unless the results are related to the care of the patient. If so (and results are known), we can provide test results to the provider or facility responsible for care.

Do I work at an Article 28 Facility?

Facilities can look up their Article 28 status at the following link: https://health.data.ny.gov/Health/Health-Facility-General-Information/vn5v-hh5r.

Back to Table of Contents

Visitors to Hospitalized Persons with Suspected or Confirmed COVID-19

On April 10, 2020, the NYSDOH suspended all visitations to hospitals in the State of New York except for patient support persons, or family members and/or legal representatives of patients in imminent end-of-life situations.

Hospitals are required to permit a patient support person at the patient bedside for:

- Patients in labor and delivery (one support person)
- Pediatric patients (one or two support people, depending on circumstances)
- Patients for whom a support person has been determined to be essential to the care of the patient (medically necessary) including patients with intellectual and/or developmental disabilities and patients with cognitive impairments including dementia (two support people)
- Patients in imminent end-of-life circumstances (two support people)

Back to Table of Contents

Patient Mental Health

How do I help a patient who seems overwhelmed or distressed about being tested for, diagnosed with or otherwise affected by COVID-19?

Emotional reactions to stressful situations such as this emerging health crisis are expected. Remind patients that feeling sad, anxious, overwhelmed or having trouble sleeping or other symptoms of distress is normal. If symptoms become worse, last longer than a month or if

someone struggles to participate in their usual daily activities, encourage them to reach out for support and help. People in NYC can call NYC Well at 888-NYC WELL (888 692-9355), or text "WELL" to 65173, for access to a confidential help line that is staffed 24 hours a day, seven days a week, by trained counselors who can provide brief supportive therapy, crisis counseling and connections to behavioral health treatment and support in over 200 languages. Trained counselors will listen to the caller's concerns, explore coping and other available supports and offer referrals to community resources for follow-up care and support.

Back to Table of Contents

Telehealth

Where can I find general information about telehealth?

You can refer to the National Consortium of Telehealth Resource Centers web site, "COVID-19 Telehealth Toolkit" and the Special Edition Medicaid Update entitled "Comprehensive Guidance Regarding Use of Telehealth including Telephonic Services During the COVID-10 State of Emergency".

For Medicaid Fee-for-Service telehealth/telephonic coverage and policy questions, call the Medicaid Office of Insurance Programs, Division of Program Development and Management, at 518-473-2160 or email Telehealth.Policy@health.ny.gov.

Where can I find information about Medicaid and telehealth reimbursement?

For comprehensive guidance on telehealth, telephone communications and reimbursement for Medicaid, refer to the NYS DOH Medicaid Update website and visit "COVID-19 Special Edition Publications".

Back to Table of Contents

More Information

- NYC COVID-19 Information for Providers
- NYC Guidance for Colleges and Universities
- CDC COVID-19 Information for Health Care Professionals
- Sign up for health alerts from the NYC Health Department
- Sign up for alerts from the CDC

Back to Table of Contents

The NYC Health Department may change recommendations as the situation evolves. **4.29.20**

Tekbali Exhibit 4

Centers for Disease Control and Prevention

Food Safety

Food Safety and Coronavirus Disease 2019 (COVID-19)

Coronaviruses are generally thought to be spread from person-to-person through respiratory droplets. Currently there is no evidence to support transmission of COVID-19 associated with food. Before preparing or eating food, it is important to always wash your hands with soap and water for 20 seconds for general food safety. Throughout the day, wash your hands after blowing your nose, coughing or sneezing, or going to the bathroom.

It may be possible that a person can get COVID-19 by touching a surface or object that has the virus on it and then touching their own mouth, nose, or possibly their eyes, but this is not thought to be the main way the virus spreads.

In general, because of poor survivability of these coronaviruses on surfaces, there is likely very low risk of spread from food products or packaging that are shipped over a period of days or weeks at ambient, refrigerated, or frozen temperatures.

You should always handle and prepare food safely, including keeping raw meat separate from other foods, refrigerating perishable foods, and cooking meat to the right temperature to kill harmful germs. See CDC's Food Safety site for more information.

For more information on COVID-19, visit CDC's FAQ page.

For more information on COVID-19 and food, see FAQ pages from the U.S. Food and Drug Administration and the U.S. Department of Agriculture.

Page last reviewed: March 23, 2020

Tekbali Exhibit 5

Multiple Sclerosis & Coronavirus

Living with a chronic disease brings special considerations. Learn more about risk factors, ways to stay well, and specific recommendations.

No one should face MS alone. Support the National MS Society COVID-19 Response Fund to meet the urgent needs of the MS community during this crisis.

Donate Today

In this article

Coronavirus Risk for People Living with Multiple Sclerosis (MS)

MS itself does not increase the risk of getting COVID-19. However, certain factors associated with your MS may increase your risk for complications:

- Chronic medical conditions, such as lung disease, heart disease, diabetes, cancer, smoking and asthma
- Significantly restricted mobility, such as needing to spend most of your day seated or in bed
- Age 65 or older
- Possibly taking certain disease modifying therapies that deplete immune system cells
- Severe obesity or BMI higher than 40
- Living in a long-term care facility

Sometimes, the body's response to infections, including COVID-19, may cause a temporary worsening of MS symptoms. Typically, these symptoms settle down once the infection clears up. If you are experiencing new MS symptoms or have any concerns about any of your MS symptoms, please contact your MS healthcare provider.

Protecting Yourself from Coronavirus

The Centers for Disease Control and Prevention (CDC) provides recommendations on how to prevent the spread of COVID-19 and what to do if you show symptoms.

Working and Coronavirus (COVID-19)

MS Healthcare Providers

Healthcare providers who treat people living with MS can find additional information in our Professional Resource Center.

Healthcare Workers Who Have MS

- There is no increased risk of you getting COVID-19 because you have MS.
- If you are concerned about your risk of getting COVID-19 because of the DMT you take, please contact your MS provider for advice.
- There are no special personal protective equipment (PPE) instructions for people with MS. You should follow the same precautions as other healthcare workers. If you are concerned about your risk due to your DMT, please contact your MS provider for advice.

Employee Rights
There are many protections that could be available to you if your employer is not being flexible with work from home options or workplace accommodations. Visit our employment resources page to learn more or contact an MS Navigator to discuss your individual rights and options.

Children with MS

There is no specific advice for children with MS; they should follow the advice above for all people with MS. The CDC has specific recommendations for children and COVID-19.

Pregnancy

At this time there is no specific advice for women with MS who are pregnant. There is general information on COVID-19 and pregnancy on the CDC website.

Additional Resources

- COVID-19 Studies Recruiting People with MS
- Centers for Disease Control and Prevention
- World Health Organization

MS Treatment Guidelines During Coronavirus

Expert advice about disease modifying therapies, tips on social distancing, relapses for those living with MS during the Coronavirus pandemic.

Learn More

Suspected COVID-19 and MS

Keep up to date on topics such as: Affects of Covid-19 with those affected by MS, Covid-19 registries for those with MS, and Covid-19 and relapses.

Learn More

En Español

Learn More

En Español

Estamos observando de cerca la situación del coronavirus (COVID-19) y tomando decisiones sobre la mejor manera de actuar en esta situación sin precedente.

Aprende Más

Participants & Volunteers

For the safety of the MS community and all our communities — we've stopped gathering in person for now. Contact Fundraising Support for event related questions or [illegible] website. [illegible] more about [illegible] opportunities.

The National MS Society is Here to Help

Need More Information?

We Are Here

Our MS Navigators help identify solutions and provide access to the resources you are looking for. Call 1-800-344-4867 or contact us online.

Contact Us

ASK AN MS EXPERT

Weekly Webinars

The Ask an MS Expert weekly webinar series is an opportunity to learn more about multiple sclerosis from top MS experts.

Learn More

Hidden Link

Tekbali Exhibit 6

Centers for Disease Control and Prevention

Coronavirus Disease 2019 (COVID-19)

Personal Protective Equipment: Questions and Answers

Updated March 14, 2020

This document is intended to address frequently asked questions about personal protective equipment (PPE).

Gowns

- What testing and standards should I consider when looking for CDC-recommended protective clothing? +
- What type of gown is recommended for patients with suspected or confirmed COVID-19? +
- What types of gowns are available for healthcare personnel to protect from COVID-19? +
- What is the difference between gowns and coveralls? +
- How do I put on (don) and take off (doff) my gown? +
- Is it acceptable for emergency medical services to wear coveralls as an alternative to gowns when COVID-19 is suspected in a patient needing emergency transport? +

Gloves

- What type of glove is recommended to care for suspected or confirmed COVID-19 patients in healthcare settings? +
- What standards should be considered when choosing gloves? +
- Is double gloving necessary when caring for suspected or confirmed COVID-19 patients in healthcare settings? +
- Are extended length gloves necessary when caring for suspected or confirmed COVID-19 patients in healthcare settings? +
- How do I put on (don) or take off (doff) my gloves? +

Footnotes

[1]ASTM D6319-Standard Specification for Nitrile Examination Gloves for Medical Applications

[2]ASTM D3578 Standard Specification for Rubber Examination Gloves

[3]ASTM D5250 Standard Specification for Poly(vinyl chloride) Gloves for Medical Application

[4]ASTMD 6977 Standard Specification for Polychloroprene Examination Gloves for Medical Application

Respirators

- Should I wear a respirator in public? +

Should I wear a respirator in public? +

What is a respirator? +

What is an N95 filtering facepiece respirator (FFR)? +

What makes N95 respirators different from facemasks (sometimes called a surgical mask)? +

What is a Surgical N95 respirator and who needs to wear it?

- A surgical N95 (also referred as a medical respirator) is recommended only for use by healthcare personnel (HCP) who need protection from both airborne and fluid hazards (e.g., splashes, sprays). These respirators are not used or needed outside of healthcare settings. In times of shortage, only HCP who are working in a sterile field or who may be exposed to high velocity splashes, sprays, or splatters of blood or body fluids should wear these respirators, such as in operative or procedural settings. Most HCP caring for confirmed or suspected COVID-19 patients should not need to use surgical N95 respirators and can use standard N95 respirators.
- If a surgical N95 is not available for use in operative or procedural settings, then an unvalved N95 respirator may be used with a faceshield to help block high velocity streams of blood and body fluids.

My employees complain that Surgical N95 respirators are hot and uncomfortable - what can I do? +

My N95 respirator has an exhalation valve, is that okay? +

How can I tell if a respirator is NIOSH-approved? +

How do I know if a respirator is falsely advertising NIOSH-approval? +

How do I know if my respirator is expired? +

What do I do with an expired respirator? +

What methods should healthcare facilities consider in order to avoid unintentional loss of PPE during COVID-19? +

Page last reviewed: March 14, 2020

Tekbali Exhibit 7

Centers for Disease Control and Prevention

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

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. Reusable (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
- Find Answers to Common Cleaning and Disinfection Questions

Page last reviewed: April 1, 2020

Tekbali Exhibit 8

Centers for Disease Control and Prevention

Coronavirus Disease 2019 (COVID-19)

Summary for Healthcare Facilities: Strategies for Optimizing the Supply of N95 Respirators during the COVID-19 Response

Related Pages

N95 Respirator Summary

Stockpiled N95 Respirators

Decontamination & Reuse of Filtering Facepiece Respirators

This summary is intended to help healthcare facilities optimize supplies of disposable N95 filtering facepiece respirators when there is limited supply during the COVID-19 pandemic. The strategies are categorized in a continuum of care and further organized according to the hierarchy of controls, as defined below.

Printer-Friendly Version [PDF – 647 KB]

Conventional Capacity Strategies (should be incorporated into everyday practices)

Engineering Controls
Place patients with suspected or confirmed COVID-19 in an airborne infection isolation room (AIIR) for aerosol generating procedures
Use physical barriers such as glass or plastic windows at reception areas, curtains between patients, etc.
Properly maintain ventilation systems to provide air movement from a clean to contaminated flow direction

Administrative Controls
Limit the number of patients going to hospitals or outpatient settings by screening patients for acute respiratory illness prior to non-urgent care or elective visits
Exclude all HCP not directly involved in patient care (e.g., dietary, housekeeping employees)
Reduce face-to-face HCP encounters with patients (e.g., bundling activities, use of video monitoring)
Exclude visitors to patients with known or suspected COVID-19
Implement source control: Identify and assess patients who may be ill with or who may have been exposed to a patient with known COVID-19 and recommend they use facemasks until they can be placed in an AIIR or private room.
Cohort patients: Group together patients who are infected with the same organism to confine their care to one area
Cohort HCP: Assign designated teams of HCP to provide care for all patients with suspected or confirmed COVID-19

Administrative Controls
Use telemedicine to screen and manage patients using technologies and referral networks to reduce the influx of patients to healthcare facilities
Train HCP on indications for use of N95 respirators
Train HCP on use of N95 respirators (i.e., proper use, fit, donning and doffing, etc.)
Implement just-in-time fit testing: Plan for larger scale evaluation, training, and fit testing of employees when necessary during a pandemic
Limit respirators during training: Determine which HCP do and do not need to be in a respiratory protection program and, when possible, allow limited re-use of respirators by individual HCP for training and then fit testing
Implement qualitative fit testing to assess adequacy of a respirator fit to minimize destruction of N95 respirator used in fit testing and allow for limited re-use by HCP

Personal Protective Equipment: Respiratory Protection
Use surgical N95 respirators only for HCP who need protection from both airborne and fluid hazards (e.g., splashes, sprays). If needed but unavailable, use faceshield over standard N95 respirator.
Use alternatives to N95 respirators where feasible (e.g., other disposable filtering facepiece respirators, elastomeric respirators with appropriate filters or cartridges, powered air purifying respirators)

Contingency Capacity Strategies (during expected shortages)

Administrative Controls
Decrease length of hospital stay for medically stable patients with COVID-19 who cannot be discharged to home for social reasons by identifying alternative non-hospital housing
Temporarily suspend annual fit testing per interim guidance from OSHA

Personal Protective Equipment and Respiratory Protection
Use N95 respirators beyond the manufacturer-designated shelf life for training and fit testing
Extend the use of N95 respirators by wearing the same N95 for repeated close contact encounters with several different patients, without removing the respirator per recommended guidance on implementation of extended use

Crisis Strategies (during known shortages)

When N95 Supplies are Running Low

Personal Protective Equipment: and Respiratory Protection and Facemasks
Use respirators as identified by CDC as performing adequately for healthcare delivery beyond the manufacturer-designated shelf life
Use respirators approved under standards used in other countries that are similar to NIOSH-approved respirators
Implement limited re-use of N95 respirators by one HCP for multiple encounters with different patients, but remove it after each encounter. See additional guidance on potential methods for decontamination.

Personal Protective Equipment: and Respiratory Protection and Facemasks
Use additional respirators identified by CDC as NOT performing adequately for healthcare delivery beyond the manufacturer-designated shelf life
Prioritize the use of N95 respirators and facemasks by activity type with and without masking symptomatic patients

When No Respirators Are Left

Administrative Controls
Exclude HCP at higher risk for severe illness from COVID-19 such as those of older age, those with chronic medical conditions, or those who may be pregnant from contact with known or suspected COVID-19 patients
Designate convalescent HCP for provision of care to known or suspected COVID-19 patients (those who have clinically recovered from COVID-19 and may have some protective immunity) to preferentially provide care)

Engineering Controls
Use an expedient patient isolation room for risk-reduction
Use a ventilated headboard to decrease risk of HCP exposure to a patient-generated aerosol

Page last reviewed: April 16, 2020

Tekbali Exhibit 9

NEW YORK STATE OF OPPORTUNITY. Department of Health

ANDREW M. CUOMO
Governor

HOWARD A. ZUCKER, M.D., J.D.
Commissioner

SALLY DRESLIN, M.S., R.N.
Executive Deputy Commissioner

DATE: April 19, 2020

TO: Hospitals, Nursing Homes, Adult Care Homes, and Other Congregate Settings Where Populations Vulnerable to COVID-19 Reside

FROM: NYS Department of Health (NYSDOH) Bureau of Healthcare Associated Infections (BHAI)

Health Advisory: Discontinuation of Isolation for Patients with COVID-19 Who Are Hospitalized or in Nursing Homes, Adult Care Homes, or Other Congregate Settings with Vulnerable Residents

Please distribute immediately to:
Administrators, Infection Preventionists, Medical Directors, and Nursing Directors

Recent guidance allows for discontinuation of isolation for patients with COVID-19 when they meet the following conditions:

- 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.

However, hospitalized patients or older adults may have longer periods of infectivity, and hospitals, nursing homes, adult care facilities, and certain other congregate living facilities, are settings with highly vulnerable patients and residents. Therefore, for patients who are admitted to or remain in these settings, NYSDOH recommends discontinuation of transmission-based precautions for patients with COVID-19, when they meet the following more stringent conditions:

- Non-test-based strategy:
  - At least 3 days (72 hours) have passed since recovery, defined as resolution of fever (greater than or equal to 100.0) without the use of fever-reducing medications; **AND**
  - Improvement in respiratory symptoms (e.g., cough, shortness of breath); **AND**
  - At least **14 days** have passed since symptoms attributed to COVID-19 first appeared.
    - For patients who were asymptomatic at the time of their first positive test and remain asymptomatic, at least 14 days have passed since the first positive test.

- Test-based strategy: If testing is available to a facility through in-house or commercial means, the following test-based strategy may also be considered.
  - Lack of fever (greater than and equal to 100.0), without 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 tests

conducted on recommended specimens (nasopharyngeal, nasal and oropharyngeal, or nasal and saliva), collected greater than or equal to 24 hours apart.
- For patients who were asymptomatic at the time of their first positive test and remain asymptomatic, testing for release from isolation may begin a minimum of 7 days from the first positive test.

These recommendations also apply to persons suspected of having COVID-19. The test-based strategy is strongly preferred for severely immunocompromised patients (e.g. treated with immunosuppressive drugs, stem cell or solid organ transplant recipients, inherited immunodeficiency, or poorly controlled HIV). If the test strategy is not used for individuals severely immunocompromised, the case should be discussed with the local health department or with NYSDOH.

Patients who remain in, or are admitted, to a nursing home, adult care facility, or other congregate living facility with vulnerable residents, and meet criteria for discontinuation of transmission-based precautions using the non-test-based strategy but who remain symptomatic, such as with a persistent cough, should be: (1) placed in a single room or be cohorted with other recovering residents who had confirmed COVID-19; (2) remain in their room; and (3) wear a facemask when caregivers enter the room.

General questions or comments about this advisory can be sent to covidhospitaldtcinfo@health.ny.gov, covidnursinghomeinfo@health.ny.gov, covidadultcareinfo@health.ny.gov, or icp@health.ny.gov.

Tekbali Exhibit 10

COVID-19: Guidance for Congregate Settings

For general information on coronavirus disease 2019 (COVID-19), including how to guard against stigma, visit nyc.gov/health/coronavirus or cdc.gov/covid19. For real-time updates, text "COVID" to 692-692. Message and data rates may apply.

1. Introduction

A congregate setting is an environment where a number of people reside, meet or gather in close proximity for either a limited or extended period of time. Examples include homeless shelters, assisted living facilities, group homes, prisons, detention centers, schools and workplaces. The New York State Department of Health has issued specific guidance and requirements for nursing homes and adult care facilities specific to COVID-19 that do not apply to other congregate settings. Visit coronavirus.health.ny.gov for the latest information.

How does COVID-19 spread?

- The virus is most likely to spread to people who are in close contact (within about 6 feet) with an infected person. The virus is in droplets that are sprayed when a person coughs or sneezes, and possibly when they talk. Staying 6 feet away helps protect you from that spray.
- Scientists disagree on how long COVID-19 lives on surfaces, but it can live on surfaces that people frequently touch. The virus can then be spread if someone touches their eyes, nose or mouth with unwashed hands that have virus on them.
- Scientists now believe that people who have no symptoms can spread the virus. However, people who are experiencing symptoms (for example, coughing or sore throat) are probably more likely to transmit the virus to others.

Who is at higher risk of getting COVID-19 or of having severe illness?

- People who are at most risk of severe illness are people 50 years of age or older and people who have other health conditions, including:
    - Lung disease
    - Moderate to severe asthma
    - Heart disease
    - A weakened immune system
    - Obesity
    - Diabetes
    - Kidney disease
    - Liver disease
    - Cancer

  While currently there is no data to suggest pregnant people are more likely to be infected by the virus that causes COVID-19, they should be monitored closely. Pregnant people can get very sick if infected by some viruses. People with regular close contact with someone who has or could have COVID-19 are also at higher risk of getting COVID-19, such as people who live in the same home, caretakers who work in the home or current sexual partners.

For COVID-19 planning and response purposes, NYC will use the following definition for COVID-19-like illness (CLI):

- Fever (temperature of 100.4 degrees F or 38 degrees C or greater)
- Cough
- Shortness of breath (difficulty breathing)
- Sore throat

To date, most people with CLI have not been tested for COVID-19. People with CLI should be considered contagious.

2. COVID-19 in Congregate Settings

Managing the spread of COVID-19 in congregate settings presents special challenges. The best way to prevent an outbreak of COVID-19 in your facility is to implement policies and practices that:

- Enable people to stay 6 feet apart
- Allow rapid identification of CLI among residents
- Isolate residents with CLI from residents who are not yet symptomatic
- Promote frequent hand washing with soap and water among residents and staff
- Ensure adequate supplies for staff and residents to practice healthy hygiene
- Direct staff to stay home if sick

Every facility is different, and you know your facility best. Tailor this guide to your circumstances. The more aggressive you can be in your prevention and intervention measures, the more likely you will be able to reduce transmission in your facility. The goals of this document are to help congregate setting facilities:

- Implement measures to prevent the spread of existing CLI and COVID-19
- Identify clear steps to take regarding dining and cleaning
- Implement policies on room isolation and monitoring symptoms of ill residents
- Give guidance to staff on how they should be caring for residents with CLI and COVID-19

3. Preventive Measures to Reduce the Spread of COVID-19

Post signage

- Place signs visible to all staff, residents and any visitors to stay home or in their rooms if they are sick. Signs in multiple languages can be found on nyc.gov/coronavirus.
- Place *Cover Your Cough* and *Wash your Hands* posters in visible locations around your facility. Posters can be found in multiple languages on nyc.gov/coronavirus.
- Place clear signage outside all isolation areas for staff and residents to properly identify these areas to reduce intermingling of symptomatic and non-symptomatic individuals.

Educate staff and residents

- Ensure staff and residents know the symptoms of CLI and how to report CLI at the first signs of illness.

- Reduce face-to-face interactions with residents. Interact remotely, including by phone, email, intercom or video if available. Deliver written information by sliding written material under someone's door.

Screenings

- Screen staff, residents and others for CLI at all entrances to the facility.
- Screen by asking if they have any of the following symptoms:
    - Subjective fever ("feels feverish")
    - New (within seven days) cough, shortness of breath or sore throat

  A "yes" answer to any of these should be considered CLI. Have a plan to immediately isolate any resident with CLI and make arrangements for appropriate shelter; others should not enter the facility.

Reduce movement within the facility

- Eliminate visitors or restrict only to essential visitors. Inform families or caregivers. Provide alternate ways for residents to stay in touch with their families, such as by phone or video.
- Close common spaces. Suspend all group programming, classes or any activity that involves groups of residents.
- Review vendor and supply processes; prohibit non-essential vendors from delivering to the facility. Direct vendors to drop supplies outside. Plan for supply shortages.
- Strongly discourage residents from leaving the facility, except for supervised smoking breaks. For smokers, where possible, work with the resident's mental health or primary care provider to secure nicotine replacement therapy (NRT) to help eliminate nicotine withdrawal and the desire to leave their room to smoke.
- Limit interaction in common spaces, including hallways, by staggering any required movement of residents.
- Create a staggered bathing schedule to limit the number of people using the facilities at the same time.

Provide adequate supplies for staff and residents to practice healthy hygiene

- Deliver supplies to residents with CLI including fluids, tissues, and plastic bags for the proper disposal of used tissues.
- Stock bathrooms and other sinks consistently with soap and drying materials.
- Provide alcohol-based hand sanitizers that contain at least 60% alcohol (if that is an option at your facility) at key points within the facility, including registration desks, entrances/exits and eating areas.
- Position a trash can near the exit inside any resident room or area designated for people with CLI to make it easy for staff and residents to discard items.

4. Standard Facility Operations: Dinning and Cleaning

Dining and meals

- Close dining rooms. Deliver meals to resident rooms. If you need additional staff to be able to provide room service, develop a staffing plan.
- If closing shared dining areas is absolutely not possible, stagger eating times and increase space between tables, so diners remain 6 feet apart.
- Close kitchens to residents. Develop alternatives to between-meal access depending on your services. If necessary, suspend certain services and communicate to residents that changes are being made to protect them.

Cleaning and disinfecting

Routine cleaning of surfaces using appropriate cleaning and disinfection methods can help to prevent the spread of COVID-19. There is no need to do any cleaning beyond the routine cleaning, even if there was someone in your facility with COVID-19.

- Clean and disinfect high-touch surfaces regularly. Frequently touched surfaces and objects can vary by location. Examples include doorknobs, light switches, handrails, kitchen appliances, counters, drawer pulls, tables, sinks, faucet and toilet handles, drinking fountains, elevator buttons, push plates, phones, keys and remote controls.

- Clean by removing any visible dirt and grime before using disinfectants. Disinfectants remove most germs and are most effective on clean surfaces or objects. Coronaviruses are relatively easy to kill with most disinfectants. When using cleaning and disinfecting products, always read and follow the manufacturer's directions (e.g., application method, contact time).

- For clothing, towels, linens and other items that go in the laundry: Wash at the warmest possible setting with your usual detergent and then dry completely. Avoid "hugging" laundry before washing it to avoid self-contamination. Do not shake dirty laundry before washing to avoid spreading virus or other dirt and bacteria through the air. Dirty laundry from an ill person can be washed with other people's items.

- Any bathroom in use by a resident with CLI should be cleaned and disinfected after each use ideally by the person with CLI. If this is not possible, the caregiver should wait as long as possible after use by an ill person to clean and disinfect the high-touch surfaces.

5. Rooming, Isolation and Monitoring Symptoms of Residents with CLI

Create more space in sleeping arrangements for all residents

- Increase spacing so beds are at least 6 feet apart.
- Put fewer residents within a dorm or unit. Convert common spaces to sleeping areas to spread people out.
- Arrange beds so that individuals lay head-to-toe (or toe-to-toe) or create barriers between beds using items such as foot lockers, dresser or curtains.

- Avoid housing older adults, people with underlying medical conditions or people with disabilities in the same room as people with symptoms.
- Where possible, keep elderly residents and people with behavioral health conditions in familiar surroundings and minimize confusion and behavioral challenges.

Isolate ill residents. Keep those with CLI apart from those who are not ill.
It is critical to develop and implement plans to isolate (separate) residents with CLI from residents without symptoms.

- If residents share a room and one has CLI, separate them. If both residents in a shared room have CLI, they can remain in the room together. Strategies to accomplish this separation include:
    - If there are large shared sleeping areas, designate one area for residents with CLI and one area for those without symptoms.
    - If your building has sleeping areas with multiple floors, designate one floor for residents with CLI and one floor for residents with symptoms.
    - If you have multiple buildings, designate one building for residents with CLI and one building for residents without symptoms.
- Prepare to move residents around the building or to different facilities.
- Designate a bathroom for people with CLI and a bathroom for those without symptoms.
- Monitor resident health and move residents immediately into the areas designated for CLI at first sign of illness.
- Residents with CLI can be removed from isolation (separation) from other residents when **all** of the following are true:
    - It has been **at least** seven days since the resident's symptoms started.
    - The resident never had fever or the resident has not had a fever for the prior three days without use of fever-reducing drugs such as Tylenol or ibuprofen.
    - The resident's overall illness has improved.

Monitor symptoms of residents and when to refer for medical care

- Routine outpatient COVID-19 testing is not needed. If a resident has CLI, the resident should be assumed to have COVID-19.
- Do not transfer a resident to the hospital for evaluation for mild or moderate illness for testing or treatment. However, if severe symptoms occur, medical care should be sought as they can signal life-threatening illness.
- Residents who are able to self-monitor should monitor their own symptoms. In cases where staff must assist residents in monitoring symptoms, they should do so from six feet away.
- Visit nyc.gov/health/coronavirus for the list of risk factors that increase risk for severe illness; residents with CLI and who have these risk factors may require closer monitoring.
- Staff should continuously assess whether residents develop more severe illness. Staff should refer residents to the hospital if they have any of the following:
    - Trouble breathing
    - Persistent pain or pressure in the chest
    - New confusion or inability to stay awake

- Bluish lips or face

This list is not all inclusive. If you have any concern about a medical emergency, consult provider immediately, or call **911**.

6. Instructions for Staff Caring for Residents with CLI

Interacting with a resident with CLI

- All residents with CLI should be isolated.
- Identify and limit the number of staff interacting with isolated residents.
- Maintain social distancing as much as possible. Complete caregiver tasks from 6 feet away or more. Leave food or medication outside a door or 6 feet away from the ill person.
- If you need to be within 6 feet, wear a face covering (any well-secured paper or cloth that covers your nose and mouth) and disposable gloves as available when you enter the room where the ill individual is isolated. When you have physical contact with the ill individual (e.g., helping to bathroom, bathing, changing clothes) cover your clothing with a gown (washable or disposable), if available. Whenever leaving the bedroom, carefully remove the gloves, face covering and gown, put the disposable items in a trash can and the washable items in a plastic bag until ready to be washed, and wash your hands with soap and water for at least 20 seconds.
- If no gloves or face covering are available, limit close contact with the person and if possible, have the individual cover their mouth with a tissue or cloth. Provide a plastic bag for the direct disposal of the tissue after use.
- Bundle tasks that require close contact together to limit encounters with the ill person.

Help with basic needs

- Make sure you can help the person adhere to instructions for medication and care, and provide support for getting groceries, prescriptions and other personal needs.

Limit the resident with CLI to one room

- Only people who are providing care for the resident with CLI should enter the room or designated area.
- Assign a separate bathroom, if available. If the bathroom is shared, clean and disinfect after each use. Focus on frequently touched surfaces (door handles, sinks, paper towel dispenser, hand dryer, etc.).

Promote frequent hand washing

- All residents and staff should wash hands often and thoroughly with soap and water for at least 20 seconds. Use an alcohol-based hand sanitizer if soap and water are not available. Do not touch eyes, nose or mouth with unwashed hands. Always wash hands before and after going into the residents' bedrooms.

Avoid sharing common items

- You should not share dishes, drinking glasses, cups, eating utensils, towels, bedding or other personal items. After the person uses these items, you should wash them thoroughly.

Monitor the ill individual's symptoms

- If they are getting sicker, notify someone at the facility or call their health care provider to arrange to have them seen. Make sure the provider is aware the person has or may have COVID-19 so that they can put appropriate infection-control measures in place.

Monitor yourself

- Caregivers and others in close contact with the person should monitor their own health for signs or symptoms of fever, a new cough, new shortness of breath or new sore throat. If that occurs, the caregiver will need to be isolated.

7. Mental Health Response

- Some facilities provide mental health services ranging from full-service on-site services to evaluation of community clients and referral to off-site providers. Have plans in place plans for patients who regularly receive mental health services.

- If a client or resident must be isolated because of CLI or confirmed COVID-19, consider alternative arrangements such as video conferencing for continuity of regular services.

- Implement procedures to identify and update at least weekly the mental health resources (for example providers, pharmacies) that are available.

- Review and update provider contracts, and emergency medical protocols and procedures, including transporting persons to inpatient mental health facilities, if necessary, and evaluation of clients and residents for other medical needs. (See Section 6, Instructions for Staff Caring for Residents with CLI).

- When transport of a client or resident is necessary, implement procedures to ensure notification of all receiving facilities before the transport takes place.

8. Considerations for Residents who use Drugs

- Be aware that social distancing recommendations may increase the risk of fatal overdose for residents who use drugs and are now using drugs alone.
    - Facility staff should increase safety checks and always carry naloxone.
    - Naloxone should be accessible to all residents.
    - For information on how to access naloxone, visit nyc.gov/naloxone.
- Be aware that residents who use drugs are at risk for withdrawal; they may seek to prevent symptoms by maintaining drug use, and may seek to exit the facility more often than other residents.
- Support residents to obtain sterile syringes. Sterile syringes can be obtained from Syringe Service Programs (SSPs) and pharmacies participating in the expanded syringe access program (ESAP). For information on syringe access, visit health.ny.gov/syringes.

- Social distancing means that parks and other places where people typically use drugs may be harder to access safely. As a result, residents might be more likely to use drugs in the facility.
    - Work with residents to develop an overdose safety plan including being aware of changes in tolerance; having someone check on them after they have used; using one drug at a time; and using a little bit at a time.
- Establish bathroom safety protocols, including:
    - Check bathrooms in common spaces for possible overdoses
    - Ensure bathrooms are accessible by staff in case of emergency (consider access to key or entry code; if door opens inward, entry may be blocked if resident is supine)
    - Install a sharps container for syringe disposal. Sharps containers can be obtained from Syringe Service Programs. To find your local SSP, visit health.ny.gov/syringes
- Provide residents who use drugs with information about medication for opioid use disorder (MOUD). Call 888-NYC-WELL (888-692-9355) for more information.

People who use drugs and are in isolation

- Residents who use drugs and are isolated due to CLI are at increased risk of fatal overdose.
- Residents who are isolated might experience withdrawal symptoms.
    - Residents who are not currently receiving MOUD should consider starting buprenorphine.
    - Residents who are currently prescribed methadone should contact their clinic to ask about options for home delivery.
    - Residents who are currently prescribed sublingual buprenorphine should contact their provider and pharmacy to ensure ongoing access to medication.
    - Residents who are currently prescribed buprenorphine via injection or those receiving naltrexone via injection will need support to transition to an alternative medication.
    - To learn more about medications for addiction treatment via telehealth, visit oasas.ny.gov/medication-assisted-treatment-telehealth or call Health + Hospitals' virtual buprenorphine clinic at 212-562-2665.
- Residents who use drugs and are in isolation due to CLI may be most vulnerable to mental health issues such as depression and anxiety. Facilities should have a plan to provide support and referrals consistent with social distancing practices. Call 888-NYC-WELL (888-692-9355) for more information.

9. Continuity of Operations and Guidance to Staff

- Staff should continually monitor themselves for CLI. If they develop CLI at home, they should not come to work until after the full course of their illness.
- Any staff who develops symptoms of CLI at the facility should leave immediately and return home for the full course of their illness. They should wear a face covering (any well- secured paper or cloth that covers their nose and mouth) and avoid other people as much as possible. They should walk to their destination if they can and avoid crowded public transportation.
- If any staff develops CLI, they should stay home until **all** of the following are true:
    - It has been **at least** seven days since the staff's symptoms started.

    - The staff member has never had a fever or has not had a fever for three days without the use of fever-reducing drugs such as Tylenol or ibuprofen.
    - The staff's other symptoms have improved.
- Anticipate and plan for staffing challenges
    - Expect that many staff will be ill and furloughed until no longer a risk to others.
    - Expect additional staffing shortages due to changes in child care needs when day care programs and schools are closed.
    - Telecommuting may be an option for some.
- Anticipate and plan for shortages as supply chains are affected; pre-order essentials to maintain adequate reserves.
- Partners during routine operations will be affected similarly. Facility operations may need to adjust to challenges felt in associated programs, organizations and agencies.

The NYC Health Department may change recommendations as the situation evolves. 4.8.20

Tekbali Exhibit 11

Centers for Disease Control and Prevention

Coronavirus Disease 2019 (COVID-19)

How to Protect Yourself & Others

Older adults and people who have severe underlying medical conditions like heart or lung disease or diabetes seem to be at higher risk for developing serious complications from COVID-19 illness. More information on Are you at higher risk for serious illness?

Know how it spreads

- There is currently no vaccine to prevent coronavirus disease 2019 (COVID-19).
- **The best way to prevent illness is to avoid being exposed to this virus.**
- The virus is thought to spread mainly from person-to-person.
  - Between people who are in close contact with one another (within about 6 feet).
  - Through respiratory droplets produced when an infected person coughs, sneezes or talks.
  - These droplets can land in the mouths or noses of people who are nearby or possibly be inhaled into the lungs.
  - Some recent studies have suggested that COVID-19 may be spread by people who are not showing symptoms.

Everyone Should

Wash your hands often

- Wash your hands often with soap and water for at least 20 seconds especially after you have been in a public place, or after blowing your nose, coughing, or sneezing.
- If soap and water are not readily available, **use a hand sanitizer that contains at least 60% alcohol**. Cover all surfaces of your hands and rub them together until they feel dry.
- **Avoid touching your eyes, nose, and mouth** with unwashed hands.

Avoid close contact

- **Avoid close contact with people who are sick, even inside your home.** If possible, maintain 6 feet between the person who is sick and other household members.
- **Put distance between yourself and other people outside of your home**.
  - Remember that some people without symptoms may be able to spread virus.
  - Stay at least 6 feet (about 2 arms' length) from other people.
  - Do not gather in groups.
  - Stay out of crowded places and avoid mass gatherings.
  - Keeping distance from others is especially important for people who are at higher risk of getting very sick.

Cover your mouth and nose with a cloth face cover when around

others

- You could spread COVID-19 to others even if you do not feel sick.
- Everyone should wear a cloth face cover when they have to go out in public, for example to the grocery store or to pick up other necessities.
  - Cloth face coverings should not be placed on young children under age 2, anyone who has trouble breathing, or is unconscious, incapacitated or otherwise unable to remove the mask without assistance.
- The cloth face cover is meant to protect other people in case you are infected.
- Do NOT use a facemask meant for a healthcare worker.
- Continue to keep about 6 feet between yourself and others. The cloth face cover is not a substitute for social distancing.

Cover coughs and sneezes

- **If you are in a private setting and do not have on your cloth face covering, remember to always cover your mouth and nose** with a tissue when you cough or sneeze or use the inside of your elbow.
- **Throw used tissues** in the trash.
- Immediately **wash your hands** with soap and water for at least 20 seconds. If soap and water are not readily available, clean your hands with a hand sanitizer that contains at least 60% alcohol.

Clean and disinfect

- **Clean AND disinfect** frequently touched surfaces **daily**. This includes tables, doorknobs, light switches, countertops, handles, desks, phones, keyboards, toilets, faucets, and sinks.
- **If surfaces are dirty, clean them.** Use detergent or soap and water prior to disinfection.
- **Then, use a household disinfectant.** Most common EPA-registered household disinfectants will work.

Handwashing Resources

Handwashing tips

Hand Hygiene in Healthcare Settings

More information

Symptoms

What to do if you are sick

If someone in your house gets sick

Travelers

Individuals, schools, events, businesses and more

Healthcare Professionals

Frequently asked questions

6 Steps to Prevent COVID-19

6 Steps to Prevent COVID-19 (ASL Version)

ASL Video Series: What You Need to Know About Handwashing

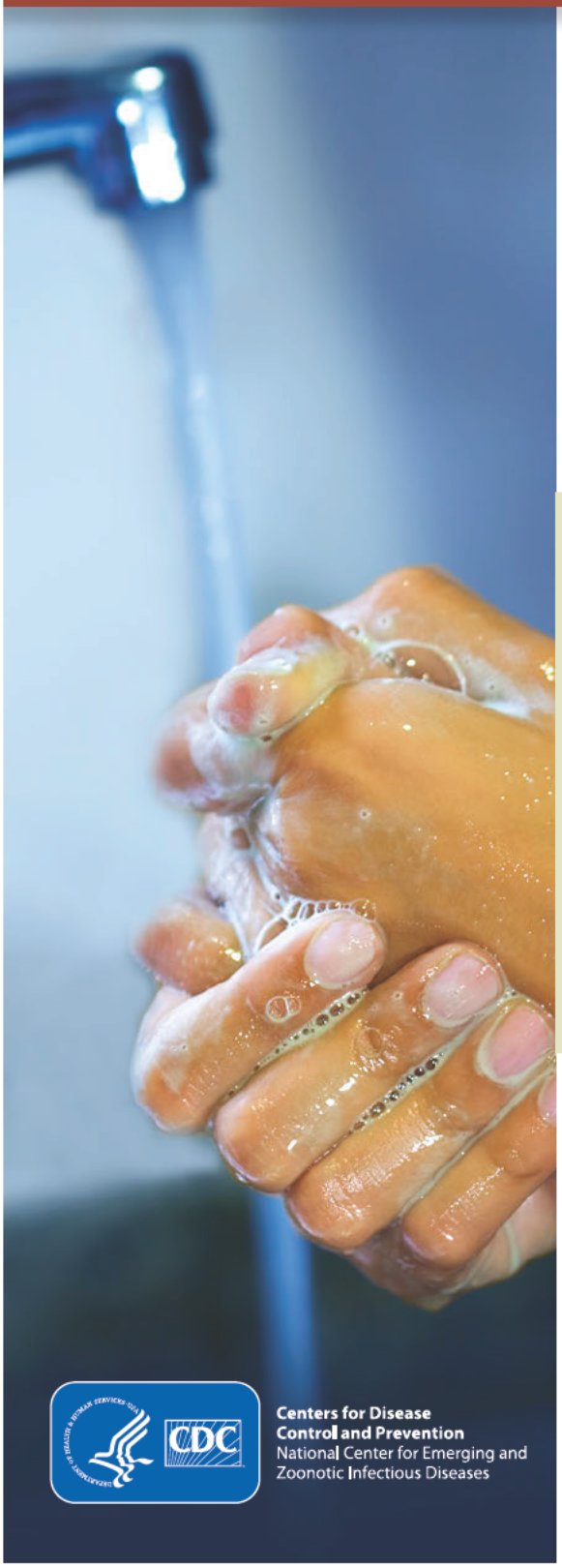
Social Distancing (ASL Video)

Page last reviewed: April 24, 2020

Tekbali 84

Tekbali Exhibit 12

Handwashing
at Home, at Play, and Out and About



Centers for Disease Control and Prevention
National Center for Emerging and Zoonotic Infectious Diseases

Germs are everywhere! They can get onto your hands and items you touch throughout the day. Washing hands at key times with soap and water is one of the most important steps you can take to get rid of germs and avoid spreading germs to those around you.

How can washing your hands keep you healthy?

Germs can get into the body through our eyes, nose, and mouth and make us sick. Handwashing with soap removes germs from hands and helps prevent sickness. Studies have shown that handwashing can prevent 1 in 3 diarrhea-related sicknesses and 1 in 5 respiratory infections, such as a cold or the flu.

Handwashing helps prevent infections for these reasons:

People often touch their eyes, nose, and mouth without realizing it, introducing germs into their bodies.

Germs from unwashed hands may get into foods and drinks when people prepare or consume them. Germs can grow in some types of foods or drinks and make people sick.

Germs from unwashed hands can be transferred to other objects, such as door knobs, tables, or toys, and then transferred to another person's hands.

What is the right way to wash your hands?

1. Wet your hands with clean running water (warm or cold) and apply soap.
2. Lather your hands by rubbing them together with the soap.
3. Scrub all surfaces of your hands, including the palms, backs, fingers, between your fingers, and under your nails. Keep scrubbing for at least 20 seconds. Need a timer? Hum the "Happy Birthday" song twice.
4. Rinse your hands under clean, running water.
5. Dry your hands using a clean towel or air dry them.

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When should you wash your hands?

Handwashing at any time of the day can help get rid of germs, but there are key times when it's most important to wash your hands.

- Before, during, and after preparing food
- Before eating food
- Before and after caring for someone who is sick
- Before and after treating a cut or wound
- After using the bathroom, changing diapers, or cleaning up a child who has used the bathroom
- After blowing your nose, coughing, or sneezing
- After touching an animal, animal food or treats, animal cages, or animal feces (poop)
- After touching garbage
- If your hands are visibly dirty or greasy

What type of soap should you use?

You can use bar soap or liquid soap to wash your hands. Many public places provide liquid soap because it's easier and cleaner to share with others. Studies have not found any added health benefit from using soaps containing antibacterial ingredients when compared with plain soap. Both are equally effective in getting rid of germs. If soap and water are not available, use an alcohol-based hand sanitizer that contains at least 60% alcohol.

How does handwashing help fight antibiotic resistance?

Antibiotic resistance occurs when bacteria resist the effects of an antibiotic – that is, germs are not killed and they continue to grow. Sicknesses caused by antibiotic-resistant bacteria can be harder to treat. Simply using antibiotics creates resistance, so avoiding infections in the first place reduces the amount of antibiotics that have to be used and reduces the likelihood that resistance will develop during treatment. Handwashing helps prevent many sicknesses, meaning less use of antibiotics.

Studies have shown that handwashing can prevent

1 in 3

diarrhea-related sicknesses and

1 in 5

respiratory infections, such as a cold or the flu.

For more information and a video demonstration of how to wash your hands, visit the CDC handwashing website:

www.cdc.gov/handwashing

Tekbali Exhibit 13

Centers for Disease Control and Prevention

Coronavirus Disease 2019 (COVID-19)

Interim Infection Prevention and Control Recommendations for Patients with Suspected or Confirmed Coronavirus Disease 2019 (COVID-19) in Healthcare Settings

Update April 13, 2020

Summary of Changes to the Guidance

Below are changes to the guidance as of April 13, 2020:

- To address asymptomatic and pre-symptomatic transmission, implement source control for everyone entering a healthcare facility (e.g., healthcare personnel, patients, visitors), regardless of symptoms.
  - This action is recommended to help prevent transmission from infected individuals who may or may not have symptoms of COVID-19.
  - Cloth face coverings are not considered PPE because their capability to protect healthcare personnel (HCP) is unknown. Facemasks, if available, should be reserved for HCP.
  - For visitors and patients, a cloth face covering may be appropriate. If a visitor or patient arrives to the healthcare facility without a cloth face covering, a facemask may be used for source control if supplies are available.
- Actively screen everyone for fever and symptoms of COVID-19 before they enter the healthcare facility.
- As community transmission intensifies within a region, healthcare facilities could consider foregoing contact tracing for exposures in a healthcare setting in favor of universal source control for HCP and screening for fever and symptoms before every shift.
- Added links to updated guidance for:
  - Strategies to Optimize the Supply of PPE and other Equipment
  - Interim Guidance for Discontinuation of Transmission-Based Precautions and Disposition of Hospitalized Patients with COVID-19
  - Interim Guidance on Criteria for Return to Work for Healthcare Personnel with Confirmed or Suspected COVID-19.
  - Strategies to Mitigate Staffing Shortages

Key Concepts in This Guidance

- **Reduce facility risk.** Cancel elective procedures, use telemedicine when possible, limit points of entry and manage visitors, screen everyone entering the facility for COVID-19 symptoms, implement source control for everyone entering the facility, regardless of symptoms.
- **Isolate symptomatic patients as soon as possible.** Set up separate, well-ventilated triage areas, place patients with suspected or confirmed COVID-19 in private rooms with the door closed and with private bathrooms (as possible). Reserve AIIRs for patients with COVID-19 undergoing aerosol generating procedures and for care of patients with pathogens transmitted by the airborne route (e.g., tuberculosis, measles, varicella).
- **Protect healthcare personnel.** Emphasize hand hygiene, install barriers to limit contact with patients at triage, cohort patients with COVID-19, limit the numbers of staff providing their care, prioritize respirators for aerosol generating procedures.

Background

This interim guidance has been updated based on currently available information about COVID-19 and the current situation in the United States, which includes community transmission, infections identified in healthcare personnel (HCP), and shortages of facemasks, N95 filtering facepiece respirators (FFRs) (commonly known as N95 respirators), eye protection, gloves, and gowns.

Mode of transmission: Current data suggest person-to-person transmission most commonly happens during close exposure to a person infected with the virus that causes COVID-19, primarily via respiratory droplets produced when the infected person speaks, coughs, or sneezes. Droplets can land in the mouths, noses, or eyes of people who are nearby or possibly be inhaled into the lungs of those within close proximity. Transmission also might occur through contact with contaminated surfaces followed by self-delivery to the eyes, nose, or mouth. The contribution of small respirable particles, sometimes called aerosols or droplet nuclei, to close proximity transmission is currently uncertain. However, airborne transmission from person-to-person over long distances is unlikely. Recent experience with outbreaks in nursing homes has reinforced that residents with COVID-19 frequently do not report typical symptoms such as fever or respiratory symptoms; some may not report any symptoms. Unrecognized asymptomatic and pre-symptomatic infections likely contribute to transmission in these and other healthcare settings. Source control, which involves having the infected person wear a cloth face covering or facemask over their mouth and nose to contain their respiratory secretions, might help reduce the risk of transmission of SARS CoV-2 from both symptomatic and asymptomatic people.

This guidance is applicable to all U.S. healthcare settings. This guidance is not intended for non-healthcare settings (e.g., schools) OR for persons outside of healthcare settings. For recommendations regarding clinical management, air or ground medical transport, or laboratory settings, refer to the main CDC COVID-19 website.

Shortage of personal protective equipment: Controlling exposures to sources of occupational infections is a fundamental method of protecting HCP. Traditionally, a hierarchy of controls has been used as a means of determining how to implement feasible and effective control solutions. The hierarchy ranks controls according to their reliability and effectiveness and includes engineering controls, administrative controls, and ends with personal protective equipment (PPE). PPE is the least effective control because it involves a high level of worker involvement and is highly dependent on proper fit and correct, consistent use.

Major distributors in the United States have reported shortages of PPE, including N95 respirators, facemasks, eye protection, gowns, and gloves. Healthcare facilities are responsible for protecting their HCP from exposure to pathogens, including by providing appropriate PPE.

In times of shortages, alternatives to N95s should be considered, including powered air-purifying respirators (PAPRs), other classes of disposable FFRs, elastomeric half-mask, and full facepiece air-purifying respirators where feasible. Special care should be taken to ensure that respirators are reserved for situations where respiratory protection is most important, such as performance of aerosol generating procedures on patients with suspected or confirmed COVID-19 or provision of care to patients with other infections for which respiratory protection is strongly indicated (e.g., tuberculosis, measles, varicella).

The anticipated timeline for return to routine levels of PPE is not yet known. Information about strategies to optimize the current supply of N95 respirators, including the use of devices that provide higher levels of respiratory protection (e.g., powered air-purifying respirators [PAPRs]) when N95s are in limited supply and a companion summary list to help healthcare facilities prioritize the implementation of the strategies, is available. Strategies to optimize the supply of other PPE and equipment, including tools to calculate the burn rate of PPE are also available.

Capacity across the healthcare continuum: Use of N95 or higher-level respirators are recommended for HCP who have been medically cleared, trained, and fit tested, in the context of a facility's respiratory protection program. However, the majority of nursing homes and outpatient clinics, including hemodialysis facilities, do not have respiratory protection programs nor have they fit tested HCP, making use of respirators currently unachievable. Without an alternative, this can lead to transfer of patients with known or suspected COVID-19 to another facility (e.g., acute care hospital) for evaluation and care. In areas with community transmission, acute care facilities could be quickly overwhelmed by transfers of patients who have only mild illness and do not require hospitalization. To address potential for an increased number of patients seeking healthcare, guidance for establishing Alternate Care Sites has been created.

Many of the recommendations described in this guidance (e.g., triage procedures, source control) should already be part of an infection control program designed to prevent transmission of seasonal respiratory infections. As it might be challenging to distinguish COVID-19 from other respiratory infections, interventions will need to be applied broadly and not limited to patients with confirmed COVID-19.

patients with confirmed COVID-19.

This guidance is applicable to all U.S. healthcare settings. **This guidance is not intended for non-healthcare settings (e.g., schools) OR for persons outside of healthcare settings.** For recommendations regarding clinical management, air or ground medical transport, or laboratory settings, refer to the main CDC COVID-19 website.

Definitions:

Healthcare Personnel (HCP): HCP include, but are not limited to, emergency medical service personnel, nurses, nursing assistants, physicians, technicians, therapists, phlebotomists, pharmacists, students and trainees, contractual staff not employed by the healthcare facility, and persons not directly involved in patient care, but who could be exposed to infectious agents that can be transmitted in the healthcare setting (e.g., clerical, dietary, environmental services, laundry, security, engineering and facilities management, administrative, billing, and volunteer personnel).

Cloth face covering: Textile (cloth) covers that are intended to keep the person wearing one from spreading respiratory secretions when talking, sneezing, or coughing. They are not PPE and it is uncertain whether cloth face coverings protect the wearer. Guidance on design, use, and maintenance of cloth face coverings is available.

Facemask: Facemasks are PPE and are often referred to as surgical masks or procedure masks. Use facemasks according to product labeling and local, state, and federal requirements. FDA-cleared surgical masks are designed to protect against splashes and sprays and are prioritized for use when such exposures are anticipated, including surgical procedures. Facemasks that are not regulated by FDA, such as some procedure masks, which are typically used for isolation purposes, may not provide protection against splashes and sprays.

Respirator: A respirator is a personal protective device that is worn on the face, covers at least the nose and mouth, and is used to reduce the wearer's risk of inhaling hazardous airborne particles (including dust particles and infectious agents), gases, or vapors. Respirators are certified by the CDC/NIOSH, including those intended for use in healthcare. Refer to the Appendix for a summary of different types of respirators.

Recommendations

1. Minimize Chance for Exposures

Ensure facility policies and practices are in place to minimize exposures to respiratory pathogens including SARS-CoV-2, the virus that causes COVID-19. Measures should be implemented before patient arrival, upon arrival, throughout the duration of the patient's visit, and until the patient's room is cleaned and disinfected. It is particularly important to protect individuals at increased risk for adverse outcomes from COVID-19 (e.g., older individuals with comorbid conditions), including HCP who are in a recognized risk category.

- **Universal Source Control**

Continued community transmission has increased the number of individuals potentially exposed to and infectious with SARS-CoV-2. Fever and symptom screening have proven to be relatively ineffective in identifying all infected individuals, including HCP. Symptom screening also will not identify individuals who are infected but otherwise asymptomatic or pre-symptomatic; additional interventions are needed to limit the unrecognized introduction of SARS-CoV-2 into healthcare settings by these individuals. As part of aggressive source control measures, healthcare facilities should consider implementing policies requiring everyone entering the facility to wear a cloth face covering (if tolerated) while in the building, regardless of symptoms. This approach is consistent with a recommendation to the general public advising them to wear a cloth face covering whenever they must leave their home.

- **Patient and Visitors**

Patients and visitors should, ideally, be wearing their own cloth face covering upon arrival to the facility. If not, they should be offered a facemask or cloth face covering as supplies allow, which should be worn while they are in the facility (if tolerated). They should also be instructed that if they must touch or adjust their cloth face covering they should perform hand hygiene immediately before and after. Facemasks and cloth face coverings should not be placed on young children under age 2, anyone who has trouble breathing, or anyone who is unconscious, incapacitated or otherwise unable to remove the mask without assistance. Patients may remove their cloth face covering when in their rooms but should put them back on when leaving their room or when others (e.g., HCP, visitors) enter the room. Screening for symptoms and appropriate triage, evaluation, and isolation of individuals who report symptoms should still occur

evaluation, and isolation of individuals who report symptoms should still occur.

- **Healthcare Personnel**

As part of source control efforts, HCP should wear a facemask at all times while they are in the healthcare facility. When available, facemasks are generally preferred over cloth face coverings for HCP as facemasks offer both source control and protection for the wearer against exposure to splashes and sprays of infectious material from others. **If there are anticipated shortages of facemasks, facemasks should be prioritized for HCP and then for patients with symptoms of COVID-19 (as supply allows). Cloth face coverings should NOT be worn instead of a respirator or facemask if more than source control is required.**

Some HCP whose job duties do not require PPE (e.g., clerical personnel) might continue to wear their cloth face covering for source control while in the healthcare facility. Other HCP (e.g., nurses, physicians) might wear their cloth face covering for part of the day when not engaged in direct patient care activities, only switching to a respirator or facemask when PPE is required. To avoid risking self-contamination, HCP should consider continuing to wear their respirator or facemask (extended use) instead of intermittently switching back to their cloth face covering. Of note, N95s with an exhaust valve might not provide source control. HCP should remove their respirator or facemask and put on their cloth face covering when leaving the facility at the end of their shift. They should also be instructed that if they must touch or adjust their facemask or cloth face covering they should perform hand hygiene immediately before and after.

HCP should have received job-specific training on PPE and demonstrated competency with selection and proper use (e.g., putting on and removing without self-contamination).

Because cloth face coverings can become saturated with respiratory secretions, care should be taken to prevent self-contamination. They should be changed if they become soiled, damp, or hard to breathe through, laundered regularly (e.g., daily and when soiled), and, hand hygiene should be performed immediately before and after any contact with the cloth face covering. Facilities should also provide training about when, how, and where cloth face coverings can be used (e.g., frequency of laundering, guidance on when to replace, circumstances when they can be worn in the facility, importance of hand hygiene to prevent contamination).

- **Before Arrival**
  - When scheduling appointments for routine medical care (e.g., annual physical, elective surgery), instruct patients to call ahead and discuss the need to reschedule their appointment if they develop fever or symptoms of COVID-19 on the day they are scheduled to be seen. Advise them that they should put on their own cloth face covering, regardless of symptoms, before entering the facility.
  - When scheduling appointments for patients requesting evaluation for possible COVID-19, use nurse-directed triage protocols to determine if an appointment is necessary or if the patient can be managed from home.
    - If the patient must come in for an appointment, instruct them to call beforehand to inform triage personnel that they have symptoms of COVID-19 and to take appropriate preventive actions (e.g., follow triage procedures, put on their own cloth face covering prior to entry and throughout their visit or, if a cloth face covering cannot be tolerated, hold a tissue against their mouth and nose to contain respiratory secretions).
  - If a patient is arriving via transport by emergency medical services (EMS), EMS personnel should contact the receiving emergency department (ED) or healthcare facility and follow previously agreed upon local or regional transport protocols. This will allow the healthcare facility to prepare for receipt of the patient.
- **Upon Arrival and During the Visit**
  - Limit and monitor points of entry to the facility.
  - Advise patients and visitors entering the facility, regardless of symptoms, to put on a cloth face covering or facemask before entering the building and await screening for fever and symptoms of COVID-19.
  - Take steps to ensure everyone adheres to respiratory hygiene and cough etiquette, hand hygiene, and all patients follow triage procedures throughout the duration of the visit.
    - Post visual alerts (e.g., signs, posters) at the entrance and in strategic places (e.g., waiting areas, elevators, cafeterias) to provide instructions (in appropriate languages) about hand hygiene and respiratory hygiene and cough etiquette. Instructions should include wearing a cloth face covering or facemask for source control, and how and when to perform hand hygiene.
    - Provide supplies for respiratory hygiene and cough etiquette, including alcohol-based hand rub (ABHR) with 60-95% alcohol, tissues, and no-touch receptacles for disposal, at healthcare facility entrances, waiting rooms, and patient check-ins.
    - Install physical barriers (e.g., glass or plastic windows) at reception areas to limit close contact between triage personnel and potentially infectious patients.
    - Consider establishing triage stations outside the facility to screen individuals before they enter.

- Consider establishing triage stations outside the facility to screen individuals before they enter.
  - Ensure rapid, safe triage and isolation of patients with symptoms of suspected COVID-19 or other respiratory infection (e.g., fever, cough).
    - Ensure triage personnel who will be taking vitals and assessing patients wear a respirator (or facemask if respirators are not available), eye protection, and gloves for the primary evaluation of all patients presenting for care until COVID-19 is deemed unlikely.
    - Prioritize triage of patients with symptoms of suspected COVID-19.
    - Triage personnel should have a supply of facemasks or cloth face coverings; these should be provided to all patients who are not wearing their own cloth face covering at check-in, assuming a sufficient supply exists.
    - Ensure that, at the time of patient check-in, all patients are asked about the presence of fever, symptoms of COVID-19, or contact with patients with possible COVID-19.
    - Isolate patients with symptoms of COVID-19 in an examination room with the door closed. If an examination room is not readily available ensure the patient is not allowed to wait among other patients seeking care.
      - Identify a separate, well-ventilated space that allows waiting patients to be separated by 6 or more feet, with easy access to respiratory hygiene supplies.
      - In some settings, patients might opt to wait in a personal vehicle or outside the healthcare facility where they can be contacted by mobile phone when it is their turn to be evaluated.
      - Incorporate questions about new onset of COVID-19 symptoms into daily assessments of all admitted patients. Monitor for and evaluate all new fevers and symptoms consistent with COVID-19 among patients. Place any patient with unexplained fever or symptoms of COVID-19 on appropriate Transmission-Based Precautions and evaluate.
      - Prioritize patients with suspected COVID-19 who require admission to a hospital or congregate care setting (e.g., nursing home) for testing.
- **Additional Strategies to Minimize Chances for Exposure:**
  - Implement alternatives to face-to-face triage and visits.
  - Learn more about how healthcare facilities can Prepare for Community Transmission
  - Designate an area at the facility (e.g., an ancillary building or temporary structure) or identify a location in the area to be a "respiratory virus evaluation center" where patients with fever or COVID-19 symptoms can seek evaluation and care.
  - Cancel group healthcare activities (e.g., group therapy, recreational activities).
  - Postpone elective procedures, surgeries, and non-urgent outpatient visits.

2. Adhere to Standard and Transmission-Based Precautions

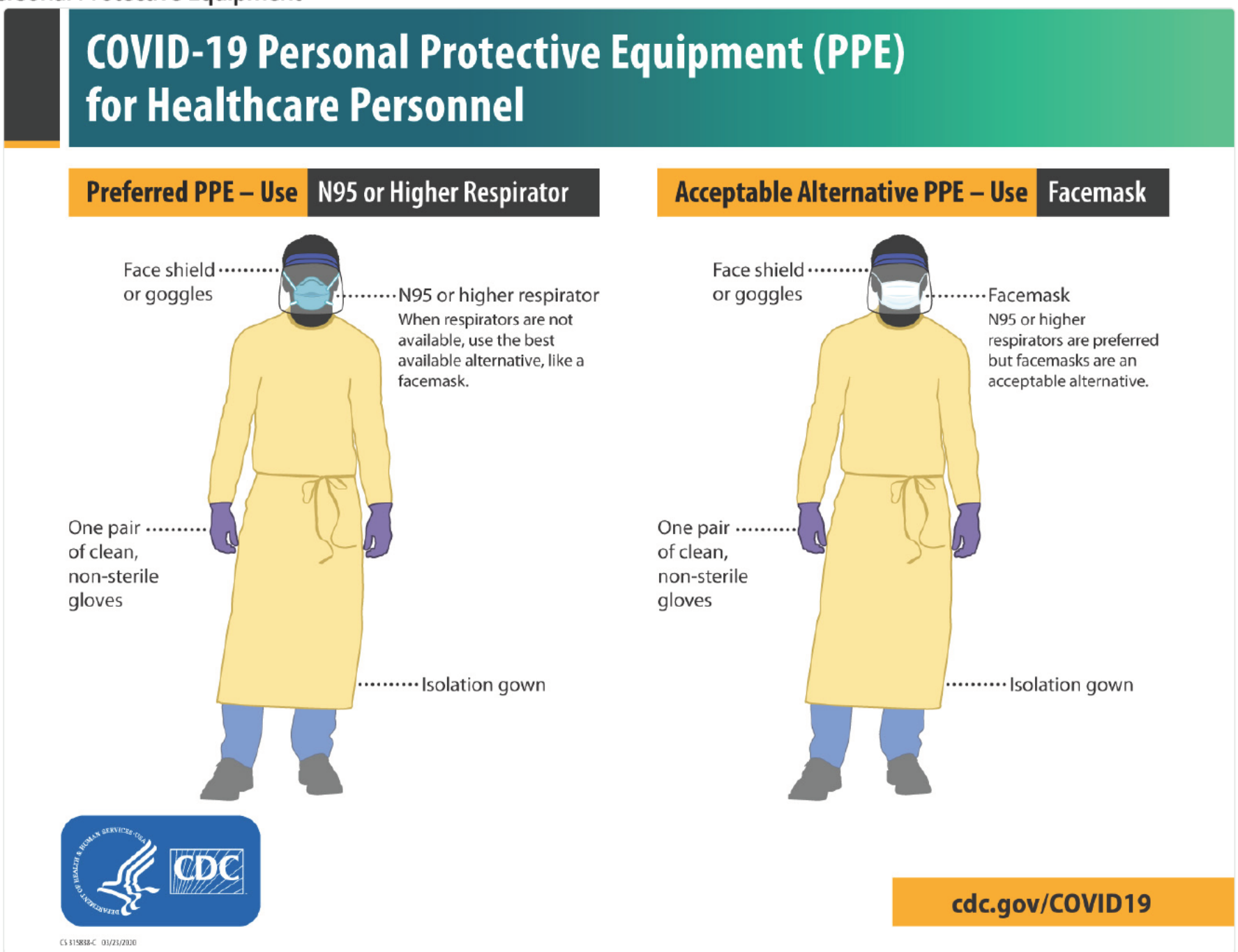
Standard Precautions assume that every person is potentially infected or colonized with a pathogen that could be transmitted in the healthcare setting. Elements of Standard Precautions that apply to patients with respiratory infections, including COVID-19, are summarized below. Attention should be paid to training and proper donning (putting on), doffing (taking off), and disposal of any PPE. This document does not emphasize all aspects of Standard Precautions (e.g., injection safety) that are required for all patient care; the full description is provided in the Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings.

HCP (see Section 5 for measures for non-HCP visitors) **who enter the room of a patient with known or suspected COVID-19 should adhere to Standard Precautions and use a respirator (or facemask if a respirator is not available), gown, gloves, and eye protection.** When available, respirators (instead of facemasks) are preferred; they should be prioritized for situations where respiratory protection is most important and the care of patients with pathogens requiring Airborne Precautions (e.g., tuberculosis, measles, varicella). Information about the recommended duration of Transmission-Based Precautions is available in the Interim Guidance for Discontinuation of Transmission-Based Precautions and Disposition of Hospitalized Patients with COVID-19

- **Hand Hygiene**
  - HCP should perform hand hygiene before and after all patient contact, contact with potentially infectious material, and before putting on and after removing PPE, including gloves. Hand hygiene after removing PPE is particularly important to remove any pathogens that might have been transferred to bare hands during the removal process.
  - HCP should perform hand hygiene by using ABHR with 60-95% alcohol or washing hands with soap and water for at least 20 seconds. If hands are visibly soiled, use soap and water before returning to ABHR.

- Healthcare facilities should ensure that hand hygiene supplies are readily available to all personnel in every care location.

- **Personal Protective Equipment**



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Employers should select appropriate PPE and provide it to HCP in accordance with OSHA PPE standards (29 CFR 1910 Subpart I) . HCP must receive training on and demonstrate an understanding of:

- when to use PPE
- what PPE is necessary
- how to properly don, use, and doff PPE in a manner to prevent self-contamination
- how to properly dispose of or disinfect and maintain PPE
- the limitations of PPE.

Any reusable PPE must be properly cleaned, decontaminated, and maintained after and between uses. Facilities should have policies and procedures describing a recommended sequence for safely donning and doffing PPE. The PPE recommended when caring for a patient with known or suspected COVID-19 includes:

- **Respirator or Facemask** ***(Cloth face coverings are NOT PPE and should not be worn for the care of patients with known or suspected COVID-19 or other situations where a respirator or facemask is warranted)***
  - Put on an N95 respirator (or higher level respirator) or facemask (if a respirator is not available) before entry into the patient room or care area, if not already wearing one as part of extended use or reuse strategies to optimize PPE supply. Higher level respirators include other disposable filtering facepiece respirators, PAPRs, or elastomeric respirators.
  - N95 respirators or respirators that offer a higher level of protection should be used instead of a facemask when performing or present for an aerosol generating procedure (See Section 4). See appendix for respirator definition. Disposable respirators and facemasks should be removed and discarded after exiting the patient's room or care

area and closing the door unless implementing extended use or reuse. Perform hand hygiene after removing the respirator or facemask.
        - If reusable respirators (e.g., powered air-purifying respirators [PAPRs]) are used, they must be cleaned and disinfected according to manufacturer's reprocessing instructions prior to re-use.
    - When the supply chain is restored, facilities with a respiratory protection program should return to use of respirators for patients with known or suspected COVID-19. Those that do not currently have a respiratory protection program, but care for patients with pathogens for which a respirator is recommended, should implement a respiratory protection program.
- **Eye Protection**
    - Put on eye protection (i.e., goggles or a disposable face shield that covers the front and sides of the face) upon entry to the patient room or care area, if not already wearing as part of extended use or reuse strategies to optimize PPE supply. Personal eyeglasses and contact lenses are NOT considered adequate eye protection.
    - Remove eye protection before leaving the patient room or care area.
    - Reusable eye protection (e.g., goggles) must be cleaned and disinfected according to manufacturer's reprocessing instructions prior to re-use. Disposable eye protection should be discarded after use unless following protocols for extended use or reuse.
- **Gloves**
    - Put on clean, non-sterile gloves upon entry into the patient room or care area.
        - Change gloves if they become torn or heavily contaminated.
    - Remove and discard gloves when leaving the patient room or care area, and immediately perform hand hygiene.
- **Gowns**
    - Put on a clean isolation gown upon entry into the patient room or area. Change the gown if it becomes soiled. Remove and discard the gown in a dedicated container for waste or linen before leaving the patient room or care area. Disposable gowns should be discarded after use. Cloth gowns should be laundered after each use.
    - If there are shortages of gowns, they should be prioritized for:
        - aerosol generating procedures
        - care activities where splashes and sprays are anticipated
        - high-contact patient care activities that provide opportunities for transfer of pathogens to the hands and clothing of HCP. Examples include:
            - dressing
            - bathing/showering
            - transferring
            - providing hygiene
            - changing linens
            - changing briefs or assisting with toileting
            - device care or use
            - wound care
    - Additional strategies for optimizing supply of gowns are available.
- Facilities should work with their health department and healthcare coalition to address shortages of PPE.

3. Patient Placement

- For patients with COVID-19 or other respiratory infections, evaluate need for hospitalization. If hospitalization is not medically necessary, home care is preferable if the individual's situation allows.
- If admitted, place a patient with known or suspected COVID-19 in a single-person room with the door closed. The patient should have a dedicated bathroom.
    - Airborne Infection Isolation Rooms (AIIRs) (See definition of AIIR in appendix) should be reserved for patients who will be undergoing aerosol generating procedures (See Aerosol Generating Procedures Section)
- As a measure to limit HCP exposure and conserve PPE, facilities could consider designating entire units within the facility, with dedicated HCP, to care for patients with known or suspected COVID-19. Dedicated means that HCP are assigned to care only for these patients during their shift.
    - Determine how staffing needs will be met as the number of patients with known or suspected COVID-19 increases and HCP become ill and are excluded from work.

    - It might not be possible to distinguish patients who have COVID-19 from patients with other respiratory viruses. As such, patients with different respiratory pathogens might be housed on the same unit. However, only patients with the same respiratory pathogen may be housed in the same room. For example, a patient with COVID-19 should ideally not be housed in the same room as a patient with an undiagnosed respiratory infection.
- Limit transport and movement of the patient outside of the room to medically essential purposes.
    - Consider providing portable x-ray equipment in patient cohort areas to reduce the need for patient transport.
- To the extent possible, patients with known or suspected COVID-19 should be housed in the same room for the duration of their stay in the facility (e.g., minimize room transfers).
- Patients should wear a facemask or cloth face covering to contain secretions during transport. If patients cannot tolerate a facemask or cloth face covering or one is not available, they should use tissues to cover their mouth and nose while out of their room.
- Personnel entering the room should use PPE as described above.
- Whenever possible, perform procedures/tests in the patient's room.
- Once the patient has been discharged or transferred, HCP, including environmental services personnel, should refrain from entering the vacated room until sufficient time has elapsed for enough air changes to remove potentially infectious particles (more information on clearance rates under differing ventilation conditions is available). After this time has elapsed, the room should undergo appropriate cleaning and surface disinfection before it is returned to routine use.

4. Take Precautions When Performing Aerosol Generating Procedures (AGPs)

- Some procedures performed on patients with known or suspected COVID-19 could generate infectious aerosols. Procedures that pose such risk should be performed cautiously and avoided if possible.
- If performed, the following should occur:
    - HCP in the room should wear an N95 or higher-level respirator such as disposable filtering facepiece respirators, PAPRs, and elastomeric respirators, eye protection, gloves, and a gown.
    - The number of HCP present during the procedure should be limited to only those essential for patient care and procedure support. Visitors should not be present for the procedure.
    - AGPs should ideally take place in an AIIR.
    - Clean and disinfect procedure room surfaces promptly as described in the section on environmental infection control below.

5. Collection of Diagnostic Respiratory Specimens

- When collecting diagnostic respiratory specimens (e.g., nasopharyngeal swab) from a patient with possible COVID-19, the following should occur:
    - Specimen collection should be performed in a normal examination room with the door closed.
    - HCP in the room should wear an N95 or higher-level respirator (or facemask if a respirator is not available), eye protection, gloves, and a gown.
        - If respirators are not readily available, they should be prioritized for other procedures at higher risk for producing infectious aerosols (e.g., intubation), instead of for collecting nasopharyngeal swabs.
    - The number of HCP present during the procedure should be limited to only those essential for patient care and procedure support. Visitors should not be present for specimen collection.
    - Clean and disinfect procedure room surfaces promptly as described in the section on environmental infection control below.

6. Manage Visitor Access and Movement Within the Facility

- Limit visitors to the facility to only those essential for the patient's physical or emotional well-being and care (e.g., care partners).
- Encourage use of alternative mechanisms for patient and visitor interactions such as video-call applications on cell phones or tablets.
- Limit points of entry to the facility and visitation hours to allow screening of all potential visitors.

- Actively assess all visitors for fever and COVID-19 symptoms upon entry to the facility. If fever or COVID-19 symptoms are present, the visitor should not be allowed entry into the facility.
- Establish procedures for monitoring, managing, and training all visitors, which should include:
  - All visitors should be instructed to wear a facemask or cloth face covering at all times while in the facility, perform frequent hand hygiene, and restrict their visit to the patient's room or other area designated by the facility.
  - Informing visitors about appropriate PPE use according to current facility visitor policy.
- If visitation to patients with COVID-19 occurs, visits should be scheduled and controlled to allow for the following:
  - Facilities should evaluate risk to the health of the visitor (e.g., visitor might have underlying illness putting them at higher risk for COVID-19) and ability to comply with precautions.
  - Facilities should provide instruction, before visitors enter patients' rooms, on hand hygiene, limiting surfaces touched, and use of PPE according to current facility policy while in the patient's room.
  - Visitors should not be present during AGPs or other procedures.
  - Visitors should be instructed to only visit the patient room. They should not go to other locations in the facility.

7. Implement Engineering Controls

- Design and install engineering controls to reduce or eliminate exposures by shielding HCP and other patients from infected individuals. Examples of engineering controls include:
  - physical barriers or partitions to guide patients through triage areas
  - curtains between patients in shared areas
  - air-handling systems (with appropriate directionality, filtration, exchange rate, etc.) that are properly installed and maintained

8. Monitor and Manage Healthcare Personnel

- Facilities and organizations providing healthcare should implement sick leave policies for HCP that are non-punitive, flexible, and consistent with public health guidance.

- As part of routine practice, HCP should be asked to regularly monitor themselves for fever and symptoms of COVID-19.
  - HCP should be reminded to stay home when they are ill.
  - If HCP develop fever ($T \geq 100.0^{o}F$) or symptoms consistent with COVID-19* while at work they should keep their cloth face covering or facemask on, inform their supervisor, and leave the workplace.
- Screen all HCP at the beginning of their shift for fever and symptoms consistent with COVID-19*
  - Actively take their temperature and document absence of symptoms consistent with COVID-19*. If they are ill, have them keep their cloth face covering or facemask on and leave the workplace.
  - *Fever is either measured temperature $\geq 100.0^{o}F$ or subjective fever. Note that fever may be intermittent or may not be present in some individuals, such as those who are elderly, immunosuppressed, or taking certain medications (e.g., NSAIDs). Clinical judgement should be used to guide testing of individuals in such situations. Respiratory symptoms consistent with COVID-19 are cough, shortness of breath, and sore throat. Medical evaluation may be warranted for lower temperatures ($<100.0^{o}F$) or other symptoms (e.g., muscle aches, nausea, vomiting, diarrhea, abdominal pain headache, runny nose, fatigue) based on assessment by occupational health. Additional information about clinical presentation of patients with COVID-19 is available.
- HCP with suspected COVID-19 should be prioritized for testing.

- Information about when HCP with confirmed or suspected COVID-19 may return to work is available in the Interim Guidance on Criteria for Return to Work for Healthcare Personnel with Confirmed or Suspected COVID-19.

- As community transmission intensifies within a region, benefits of formal contact tracing for exposures in healthcare settings might be limited unless residing in a community that is not yet affected by COVID-19. Healthcare facilities should consider foregoing contact tracing in favor of universal source control for HCP and screening for fever and symptoms before every shift.

- As the COVID-19 pandemic progresses, staffing shortages will likely occur due to HCP exposures, illness, or need to care for family members at home. Healthcare facilities must be prepared for potential staffing shortages and have plans and

processes in place to mitigate these, including providing resources to assist HCP with anxiety and stress. Strategies to mitigate staffing shortages are available.

9. Train and Educate Healthcare Personnel

- Provide HCP with job- or task-specific education and training on preventing transmission of infectious agents, including refresher training.
- Ensure that HCP are educated, trained, and have practiced the appropriate use of PPE prior to caring for a patient, including attention to correct use of PPE and prevention of contamination of clothing, skin, and the environment during the process of removing such equipment.

10. Implement Environmental Infection Control

- Dedicated medical equipment should be used when caring for patients with known or suspected COVID-19.
  - All non-dedicated, non-disposable medical equipment used for patient care should be cleaned and disinfected according to manufacturer's instructions and facility policies.
- Ensure that environmental cleaning and disinfection procedures are followed consistently and correctly.
- Routine cleaning and disinfection procedures (e.g., using cleaners and water to pre-clean surfaces prior to applying an EPA-registered, hospital-grade disinfectant to frequently touched surfaces or objects for appropriate contact times as indicated on the product's label) are appropriate for SARS-CoV-2 in healthcare settings, including those patient-care areas in which aerosol generating procedures are performed.
  - Refer to List N on the EPA website for EPA-registered disinfectants that have qualified under EPA's emerging viral pathogens program for use against SARS-CoV-2.
- Management of laundry, food service utensils, and medical waste should also be performed in accordance with routine procedures.
- Additional information about recommended practices for terminal cleaning of rooms and PPE to be worn by environmental services personnel is available in the Healthcare Infection Prevention and Control FAQs for COVID-19

11. Establish Reporting within and between Healthcare Facilities and to Public Health Authorities

- Implement mechanisms and policies that promote situational awareness for facility staff including infection control, healthcare epidemiology, facility leadership, occupational health, clinical laboratory, and frontline staff about patients with known or suspected COVID-19 and facility plans for response.
- Communicate and collaborate with public health authorities.
  - Facilities should designate specific persons within the healthcare facility who are responsible for communication with public health officials and dissemination of information to HCP.
  - Communicate information about patients with known or suspected COVID-19 to appropriate personnel before transferring them to other departments in the facility (e.g., radiology) and to other healthcare facilities.

12. Appendix: Additional Information about Airborne Infection Isolation Rooms, Respirators and Facemasks

Information about Airborne Infection Isolation Rooms (AIIRs):

- AIIRs are single-patient rooms at negative pressure relative to the surrounding areas, and with a minimum of 6 air changes per hour (12 air changes per hour are recommended for new construction or renovation).
- Air from these rooms should be exhausted directly to the outside or be filtered through a high-efficiency particulate air (HEPA) filter directly before recirculation.
- Room doors should be kept closed except when entering or leaving the room, and entry and exit should be minimized.
- Facilities should monitor and document the proper negative-pressure function of these rooms.

Information about Respirators:

- A respirator is a personal protective device that is worn on the face, covers at least the nose and mouth, and is used to reduce the wearer's risk of inhaling hazardous airborne particles (including dust particles and infectious agents), gases, or vapors. Respirators are certified by the CDC/NIOSH, including those intended for use in healthcare.
- Respirator use must be in the context of a complete respiratory protection program in accordance with OSHA Respiratory Protection standard (29 CFR 1910.134). HCP should be medically cleared and fit tested if using respirators with tight-fitting facepieces (e.g., a NIOSH-approved N95 respirator) and trained in the proper use of respirators, safe removal and disposal, and medical contraindications to respirator use.
- NIOSH information about respirators
- OSHA Respiratory Protection eToo
- Strategies for Optimizing the Supply of N-95 Respirators

Filtering Facepiece Respirators (FFR) including N95 Respirators

- A commonly used respirator in healthcare settings is a filtering facepiece respirator (commonly referred to as an N95). FFRs are disposable half facepiece respirators that filter out particles.
- To work properly, FFRs must be worn throughout the period of exposure and be specially fitted for each person who wears one. This is called "fit testing" and is usually done in a workplace where respirators are used.
- Three key factors for an N95 respirator to be effective
- FFR users should also perform a user seal check to ensure proper fit each time an FFR is used.
- Learn more about how to perform a user seal check
- For more information on how to perform a user seal check: Click here

NIOSH-approved N95 respirators list

- PAPRs have a battery-powered blower that pulls air through attached filters, canisters, or cartridges. They provide protection against gases, vapors, or particles, when equipped with the appropriate cartridge, canister, or filter.
- Loose-fitting PAPRs do not require fit testing and can be used with facial hair.
- A list of NIOSH-approved PAPRs is located on the NIOSH Certified Equipment List.

Information about Facemasks:

- If worn properly, a facemask helps block respiratory secretions produced by the wearer from contaminating other persons and surfaces (often called source control).
- Surgical facemasks are cleared by the U.S. Food and Drug Administration (FDA) for use as medical devices. Facemasks should be used once and then thrown away in the trash.

Page last reviewed: April 12, 2020

Tekbali Exhibit 14

Centers for Disease Control and Prevention

Coronavirus Disease 2019 (COVID-19)

What to Do If You Are Sick

If you have a fever, cough or other symptoms, you might have COVID-19. Most people have mild illness and are able to recover at home. If you think you may have been exposed to COVID-19, contact your healthcare provider immediately.

- Keep track of your symptoms.
- **If you have an emergency warning sign (including trouble breathing),** get medical attention right away.

Self-Checker

A guide to help you make decisions and seek appropriate medical care

Steps to help prevent the spread of COVID-19 if you are sick

Follow the steps below: If you are sick with COVID-19 or think you might have COVID-19, follow the steps below to care for yourself and to help protect other people in your home and community.

Stay home except to get medical care

- **Stay home.** Most people with COVID-19 have mild illness and can recover at home without medical care. Do not leave your home, except to get medical care. Do not visit public areas.
- **Take care of yourself.** Get rest and stay hydrated. Take over-the-counter medicines, such as acetaminophen, to help you feel better.
- **Stay in touch with your doctor.** Call before you get medical care. Be sure to get care if you have trouble breathing, or have any other emergency warning signs, or if you think it is an emergency.
- **Avoid public transportation**, ride-sharing, or taxis.

Separate yourself from other people

As much as possible, stay in a specific room and away from other people and pets in your home. If possible, you should use a separate bathroom. If you need to be around other people or animals in or outside of the home, wear a cloth face covering.

- Additional guidance is available for those living in close quarters and shared housing.
- See COVID-19 and Animals if you have questions about pets.

Monitor your symptoms

- **Symptoms of COVID-19 include fever, cough, and shortness of breath but other symptoms may be present as well.** Trouble breathing is a more serious symptom that means you should get medical attention.
- **Follow care instructions from your healthcare provider and local health department.** Your local health authorities may give instructions on checking your symptoms and reporting information.

When to Seek Medical Attention

If you have any of these **emergency warning signs*** for COVID-19 get **medical attention immediately:**

- Trouble breathing
- Persistent pain or pressure in the chest
- New confusion or inability to arouse
- Bluish lips or face

*This list is not all possible symptoms. Please call your medical provider for any other symptoms that are severe or concerning to you.

Call 911 if you have a medical emergency: Notify the operator that you have, or think you might have, COVID-19. If possible, put on a cloth face covering before medical help arrives.

Call ahead before visiting your doctor

- **Call ahead.** Many medical visits for routine care are being postponed or done by phone or telemedicine.
- **If you have a medical appointment that cannot be postponed, call your doctor's office,** and tell them you have or may have COVID-19. This will help the office protect themselves and other patients.

If you are sick wear a cloth covering over your nose and mouth

- **You should wear a** cloth face covering, **over your nose and mouth** if you must be around other people or animals, including pets (even at home)
- You don't need to wear the cloth face covering if you are alone. If you can't put on a cloth face covering (because of trouble breathing, for example), cover your coughs and sneezes in some other way. Try to stay at least 6 feet away from other people. This will help protect the people around you.
- Cloth face coverings should not be placed on young children under age 2 years, anyone who has trouble breathing, or anyone who is not able to remove the covering without help.

Note: During the COVID-19 pandemic, medical grade facemasks are reserved for healthcare workers and some first responders. You may need to make a cloth face covering using a scarf or bandana.

Cover your coughs and sneezes

- **Cover your mouth and nose** with a tissue when you cough or sneeze.
- **Throw away used tissues** in a lined trash can.
- **Immediately wash your hands** with soap and water for at least 20 seconds. If soap and water are not available, clean your hands with an alcohol-based hand sanitizer that contains at least 60% alcohol.

Clean your hands often

- **Wash your hands** often with soap and water for at least 20 seconds. This is especially important after blowing your nose, coughing, or sneezing; going to the bathroom; and before eating or preparing food.
- **Use hand sanitizer** if soap and water are not available. Use an alcohol-based hand sanitizer with at least 60% alcohol, covering all surfaces of your hands and rubbing them together until they feel dry.
- **Soap and water** are the best option, especially if hands are visibly dirty.
- **Avoid touching** your eyes, nose, and mouth with unwashed hands

- **Avoid touching** your eyes, nose, and mouth with unwashed hands.
- Handwashing Tips

Avoid sharing personal household items

- **Do not share** dishes, drinking glasses, cups, eating utensils, towels, or bedding with other people in your home.
- **Wash these items thoroughly after using them** with soap and water or put in the dishwasher.

Clean all "high-touch" surfaces everyday

- **Clean and disinfect** high-touch surfaces in your "sick room" and bathroom; wear disposable gloves. Let someone else clean and disinfect surfaces in common areas, but you should clean your bedroom and bathroom, if possible.
- **If a caregiver or other person needs to clean and disinfect** a sick person's bedroom or bathroom, they should do so on an as-needed basis. The caregiver/other person should wear a mask and disposable gloves prior to cleaning. They should wait as long as possible after the person who is sick has used the bathroom before coming in to clean and use the bathroom.

High-touch surfaces include phones, remote controls, counters, tabletops, doorknobs, bathroom fixtures, toilets, keyboards, tablets, and bedside tables.

- **Clean and disinfect areas that may have blood, stool, or body fluids on them**.
- **Use household cleaners and disinfectants.** Clean the area or item with soap and water or another detergent if it is dirty. Then, use a household disinfectant.
    - Be sure to follow the instructions on the label to ensure safe and effective use of the product. Many products recommend keeping the surface wet for several minutes to ensure germs are killed. Many also recommend precautions such as wearing gloves and making sure you have good ventilation during use of the product.
    - Most EPA-registered household disinfectants should be effective. A full list of disinfectants can be found here .
    - Complete Disinfection Guidance

How to discontinue home isolation

People with COVID-19 who have stayed home (home isolated) can leave home under the following conditions**:

- **If you have not had a test** to determine if you are still contagious, you can leave home after these three things have happened:
    - You have had no fever for at least 72 hours (that is three full days of no fever **without** the use of medicine that reduces fevers)
      AND
    - other symptoms have improved (for example, when your cough or shortness of breath have improved)
      AND
    - at least 10 days have passed since your symptoms first appeared
- **If you have had a test** to determine if you are still contagious, you can leave home after these three things have happened:

- You no longer have a fever **(without** the use of medicine that reduces fevers)
  AND
- other symptoms have improved (for example, when your cough or shortness of breath have improved)
  AND
- you received two negative tests in a row, at least 24 hours apart. Your doctor will follow CDC guidelines.

People who DID NOT have COVID-19 symptoms, but tested positive and have stayed home (home isolated) can leave home under the following conditions**:

- **If you have not had a test** to determine if you are still contagious, you can leave home after these two things have happened:
  - At least 10 days have passed since the date of your first positive test
    AND
  - you continue to have no symptoms (no cough or shortness of breath) since the test.
- **If you have had a test** to determine if you are still contagious, you can leave home after:
  - You received two negative tests in a row, at least 24 hours apart. Your doctor will follow CDC guidelines.

Note: if you develop symptoms, follow guidance above for people with COVID19 symptoms.

In all cases, **follow the guidance of your doctor and local health department. The decision to stop home isolation should be made in consultation with your healthcare provider and state and local health departments. Some people, for example those with conditions that weaken their immune system, might continue to shed virus even after they recover.

Find more information on when to end home isolation.

For any additional questions about your care, contact your healthcare provider or state or local health department.

For healthcare professionals

There is no specific antiviral treatment recommended for COVID-19. People with COVID-19 should receive supportive care to help relieve symptoms. For severe cases, treatment should include care to support vital organ functions.

- Evaluating and Testing Patients for COVID-19
- Infection Prevention and Control in Healthcare Settings
- Discontinuing Isolation Guidance

Print Resources

Caring for yourself at home: 10 things to manage your health

What you can do if you have possible or confirmed COVID-19:

- English [1 page]
- Spanish
- Chi...

- Chinese
- Vietnamese
- Korean

More information

Travelers	Businesses
Households	Healthcare Professionals
People Who Need Extra Precautions	Health Departments
People Who Are Sick	Laboratories
Caregivers	ASL Video Series: Use the Coronavirus Self Checker
Schools	

Page last reviewed: May 6, 2020

Tekbali Exhibit 15

Centers for Disease Control and Prevention

Coronavirus Disease 2019 (COVID-19)

Interim U.S. Guidance for Risk Assessment and Public Health Management of Healthcare Personnel with Potential Exposure in a Healthcare Setting to Patients with Coronavirus Disease 2019 (COVID-19)

April 15, 2020

Summary of Recent Changes

Update: This Interim Guidance was updated and archived on April 12, 2020. Updates were made to align with revisions to the public health recommendations for community-related exposure to COVID-19, which changed the period of exposure risk from "onset of symptoms" to "48 hours before symptom onset."

Given the ongoing transmission of COVID-19 in communities across the United States and the role that asymptomatic and pre-symptomatic individuals with COVID-19 play in transmission, the feasibility and benefits of formal contact tracing for exposures in healthcare settings are likely limited and **this guidance is being archived. No further updates are planned.**

Healthcare facilities should consider foregoing contact tracing for exposures in a healthcare setting in favor of universal source control for healthcare personnel (HCP) and screening for fever and symptoms of COVID-19 before every shift. Additional infection prevention and control recommendations, including more details about universal source control in healthcare settings are available.

Background

Coronaviruses are a large family of viruses that are common in humans and in many different species of animals, including camels, cattle, cats, and bats. Rarely, animal coronaviruses can infect people and then spread between people such as with SARS-CoV, MERS-CoV, and now with SARS-CoV-2.

Published and early reports suggest spread from person-to-person most frequently happens during close exposure to a person infected with COVID-19. Person-to-person spread appears to occur similar to other respiratory viruses, mainly via respiratory droplets produced when an infected person speaks, coughs, or sneezes. These droplets can land in the mouths, noses, or eyes of people who are nearby or possibly be inhaled into the lungs. Although not likely to be the predominant mode of transmission, it is not clear the extent to which touching a surface contaminated with the virus and then touching the mouth, nose, or eyes contributes to transmission. Recent experience with outbreaks in nursing homes has reinforced that residents and HCP with COVID-19 frequently do not report typical symptoms such as fever or respiratory symptoms and some may not report any symptoms. Unrecognized asymptomatic and pre-symptomatic infections likely contribute to transmission in these and other healthcare settings.

Purpose

This interim guidance is intended to assist with assessment of risk, monitoring, and work restriction decisions for HCP with potential exposure to COVID-19. Separate guidance is available for travelers and exposures in U.S. communities. Because of their often extensive and close contact with vulnerable individuals in healthcare settings, a conservative approach to HCP monitoring and restriction from work was taken to quickly identify early symptoms and prevent transmission from potentially contagious HCP to patients, HCP, and visitors. The signs and symptoms* described in this guidance are broader than those described when assessing exposures for individuals not working in healthcare. Healthcare facilities should have a low threshold for evaluating symptoms and testing symptomatic HCP, particularly those who fall into the *high-* and *medium- risk* categories described in this guidance.

categories described in this guidance.

This guidance is based on currently available data about COVID-19. Recommendations regarding which HCP are restricted from work may not anticipate every potential scenario and will change if indicated by new information.

Healthcare facilities, in consultation with public health authorities, should use clinical judgement as well as the principles outlined in this guidance to assign risk and determine need for work restrictions. CDC remains available for further consultation by calling the Emergency Operations Center at 770-488-7100. This cautious approach will be refined and updated as more information becomes available and as response needs change in the United States.

Other Resources

Public Health Recommendations after Travel-Associated COVID-19 Exposure

Public Health Recommendations for Community-Related Exposure

Criteria for Return to Work for Healthcare Personnel with Confirmed or Suspected COVID-19 (Interim Guidance)

Strategies to Mitigate Healthcare Personnel Staffing Shortages

Interim Infection Prevention and Control Recommendations for Patients with Suspected or Confirmed Coronavirus Disease (COVID-19) in a Healthcare Setting.

I. Definitions Used in this Guidance

Self-monitoring means HCP should monitor themselves for fever by taking their temperature twice a day and remain alert for symptoms of COVID-19 (e.g., cough, shortness of breath, sore throat, myalgias, malaise)*. Anyone on self-monitoring should be provided a plan for whom to contact if they develop fever or respiratory symptoms during the self-monitoring period to determine whether medical evaluation is needed.

Active monitoring means that the state or local public health authority assumes responsibility for establishing regular communication with potentially exposed people to assess for the presence of fever or symptoms of COVID-19 (e.g., cough, shortness of breath, sore throat, myalgias, malaise)*. For HCP with high- or medium-risk exposures, CDC recommends this communication occurs at least once each day. The mode of communication can be determined by the state or local public health authority and may include telephone calls or any electronic or internet-based means of communication.

For HCP, active monitoring can be delegated by the health department to the HCP's healthcare facility occupational health or infection control program, if both the health department and the facility are in agreement. Note, inter-jurisdictional coordination will be needed if HCP live in a different local health jurisdiction than where the healthcare facility is located.

Self-Monitoring with delegated supervision in a healthcare setting means HCP perform self-monitoring with oversight by their healthcare facility's occupational health or infection control program in coordination with the health department of jurisdiction, if both the health department and the facility are in agreement. On days HCP are scheduled to work, healthcare facilities could consider measuring temperature and assessing symptoms prior to starting work. Alternatively, a facility may consider having HCP report temperature and absence of symptoms to occupational health prior to starting work. Modes of communication may include telephone calls or any electronic or internet-based means of communication.

Occupational health or infection control personnel should establish points of contact between the organization, the self-monitoring personnel, and the local or state health departments of authority in the location where self-monitoring personnel will be during the self-monitoring period. This communication should result in agreement on a plan for medical evaluation of personnel who develop fever or symptoms of COVID-19 (e.g., cough, shortness of breath, sore throat, myalgias, malaise)* during the self-monitoring period. The plan should include instructions for notifying occupational health and the local public health authority, and transportation arrangements to a designated hospital, if medically necessary, with advance notice if fever or symptoms of COVID-19 occur. The supervising organization should remain in contact with HCP through the self-monitoring period to manage self-monitoring activities and provide timely and appropriate follow-up if symptoms occur in a HCP. Note, inter-jurisdictional coordination will be needed if HCP live in a different local health jurisdiction than where the healthcare facility is located.

Close contact for healthcare exposures is defined as follows: a) being within approximately 6 feet (2 meters) of a person with COVID-19 for a prolonged period of time (such as caring for or visiting the patient; or sitting within 6 feet of the patient in a

healthcare waiting area or room); or b) having unprotected direct contact with infectious secretions or excretions of the patient (e.g., being coughed on, touching used tissues with a bare hand).

Data are limited for definitions of close contact. Factors for consideration include the duration of exposure (e.g., longer exposure time likely increases exposure risk), clinical symptoms of the patient (e.g., coughing likely increases exposure risk) and whether the patient was wearing a cloth face covering or facemask (which helps block respiratory secretions from contaminating others and the environment), PPE used by personnel, and whether aerosol generating procedures were performed.

Data are insufficient to precisely define the duration of time that constitutes a prolonged exposure. However, until more is known about transmission risks, it is reasonable to consider an exposure greater than a few minutes as a prolonged exposure. Brief interactions are less likely to result in transmission; however, clinical symptoms of the patient and type of interaction (e.g., did the patient cough directly into the face of the HCP) remain important. Recommendations will be updated as more information becomes available.

Risk stratification can be made in consultation with public health authorities. Examples of brief interactions include: briefly entering the patient room without having direct contact with the patient or their secretions/excretions, brief conversation at a triage desk with a patient who was not wearing a cloth face covering or facemask. See Table 1 for more detailed information.

Healthcare Personnel: For the purposes of this document, HCP refers to all paid and unpaid persons serving in healthcare settings who have the potential for direct or indirect exposure to patients or infectious materials, including body substances; contaminated medical supplies, devices, and equipment; contaminated environmental surfaces; or contaminated air. For this document, HCP does not include clinical laboratory personnel.

II. Defining Exposure Risk Category

While body fluids other than respiratory secretions have not been clearly implicated in transmission of COVID-19, unprotected contact with other body fluids, including blood, stool, vomit, and urine, might put HCP at risk of COVID-19.

Table 1 describes possible scenarios that can be used to assist with risk assessment. These scenarios do not cover all potential exposure scenarios and should not replace an individual assessment of risk for the purpose of clinical decision making or individualized public health management. Any public health decisions that place restrictions on an individual's or group's movements or impose specific monitoring requirements should be based on an assessment of risk for the individual or group. Healthcare facilities, in consultation with public health authorities should use the concepts outlined in this guidance along with clinical judgement to assign risk and determine need for work restrictions.

For this guidance *high-risk* exposures refer to HCP who have had prolonged close contact with patients with COVID-19 (beginning 48 hours before onset of symptoms) who were not wearing a cloth face covering or facemask while HCP nose and mouth were exposed to material potentially infectious with the virus causing COVID-19. Being present in the room for procedures that generate aerosols or during which respiratory secretions are likely to be poorly controlled (e.g., cardiopulmonary resuscitation, intubation, extubation, bronchoscopy, nebulizer therapy, sputum induction) on patients with COVID-19 (beginning 48 hours before onset of symptoms) when the healthcare providers' eyes, nose, or mouth were not protected, is also considered *high-risk*.

Medium-risk exposures generally include HCP who had prolonged close contact with patients with COVID-19 (beginning 48 hours before onset of symptoms) who were wearing a cloth face covering or facemask while HCP nose and mouth were exposed to material potentially infectious with the virus causing COVID-19. Some *low-risk* exposures are considered *medium-risk* depending on the type of care activity performed. For example, HCP who were wearing a gown, gloves, eye protection and a facemask (instead of a respirator) during an aerosol generating procedure would be considered to have a medium-risk exposure. If an AGP had not been performed, they would have been considered *low-risk*. See Table 1 for additional examples.

Low-risk exposures generally refer to brief interactions with patients with COVID-19 (beginning 48 hours before onset of symptoms) or prolonged close contact with patients (beginning 48 hours before onset of symptoms) who were wearing a cloth face covering or facemask for source control while HCP were wearing a facemask or respirator. Use of eye protection in addition to a facemask or respirator would further lower the risk of exposure.

Proper adherence to currently recommended infection control practices, including all recommended PPE, should protect HCP having prolonged close contact with patients infected with COVID-19. However, to account for any inconsistencies in use or adherence that could result in unrecognized exposures, HCP should still perform self-monitoring with delegated supervision.

HCP with no direct patient contact and no entry into active patient management areas who adhere to routine safety precautions do not have a risk of exposure to COVID-19 (i.e., they have *no identifiable risk*).

Currently, this guidance applies to HCP with potential exposure in a healthcare setting to patients with confirmed COVID-19. However, HCP exposures could involve a person under investigation (PUI) who is awaiting testing. Implementation of monitoring and work restrictions described in this guidance could be applied to HCP exposed to a PUI if test results for the PUI are not expected to return within 48 to 72 hours. A record of HCP exposed to a PUI should be maintained and HCP should be encouraged to perform self- monitoring while awaiting test results. If the results will be delayed more than 72 hours or the patient is positive for COVID-19, then the monitoring and work restrictions described in this document should be followed.

Table 1: Epidemiologic Risk Classification[1] for Asymptomatic Healthcare Personnel Following Exposure to Patients with Coronavirus Disease 2019 (COVID-19) or their Secretions/Excretions in a Healthcare Setting, and their Associated Monitoring and Work Restriction Recommendations

The highest risk exposure category that applies to each person should be used to guide monitoring and work restrictions.

Note: While respirators confer a higher level of protection than facemasks and are recommended when caring for patients with COVID-19, facemasks still confer some level of protection to HCP, which was factored into our assessment of risk.

Epidemiologic risk factors	Exposure category	Recommended Monitoring for COVID-19 *(until 14 days after last potential exposure)*	Work Restrictions for Asymptomatic HCP
Prolonged close contact with a patient with COVID-19 (beginning 48 hours before symptom onset) who was wearing a cloth face covering or facemask (i.e., source control)			
HCP PPE: None	Medium	Active	Exclude from work for 14 days after last exposure
HCP PPE: Not wearing a facemask or respirator	Medium	Active	Exclude from work for 14 days after last exposure
HCP PPE: Not wearing eye protection	Low	Self with delegated supervision	None
HCP PPE: Not wearing gown or gloves[a]	Low	Self with delegated supervision	None
HCP PPE: Wearing all recommended PPE (except wearing a facemask instead of a respirator)	Low	Self with delegated supervision	None
Prolonged close contact with a patient with COVID-19 (beginning 48 hours before symptom onset) who was not wearing a cloth face covering or facemask (i.e., no source control)			
HCP PPE: None	High	Active	Exclude from work for 14 days after last exposure
HCP PPE: Not wearing a facemask or respirator	High	Active	Exclude from work for 14 days after last exposure
HCP PPE: Not wearing eye protection[b]	Medium	Active	Exclude from work for 14 days after last exposure
HCP PPE: Not wearing gown or gloves[a,b]	Low	Self with delegated supervision	None

Epidemiologic risk factors	Exposure category	Recommended Monitoring for COVID-19 *(until 14 days after last potential exposure)*	Work Restrictions for Asymptomatic HCP
HCP PPE: Wearing all recommended PPE (except wearing a facemask instead of a respirator)[b]	Low	Self with delegated supervision	None

HCP=healthcare personnel; PPE=personal protective equipment

[a]The risk category for these rows would be elevated by one level if HCP had extensive body contact with the patients (e.g., rolling the patient).

[b]The risk category for these rows would be elevated by one level if HCP performed or were present for a procedure likely to generate higher concentrations of respiratory secretions or aerosols (e.g., cardiopulmonary resuscitation, intubation, extubation, bronchoscopy, nebulizer therapy, sputum induction). For example, HCP who were wearing a gown, gloves, eye protection and a facemask (instead of a respirator) during an aerosol generating procedure would be considered to have a medium-risk exposure.

Additional Scenarios:

- Refer to the footnotes above for scenarios that would elevate the risk level for exposed HCP. For example, HCP who were wearing a gown, gloves, eye protection, and a facemask (instead of a respirator) during an aerosol generating procedure would be considered to have a medium-risk exposure.
- Proper adherence to currently recommended infection control practices, including all recommended PPE, should protect HCP having prolonged close contact with patients with COVID-19. However, to account for any inconsistencies in use or adherence that could result in unrecognized exposures, HCP should still perform self-monitoring with delegated supervision.
- HCP not using all recommended PPE who have only brief interactions with a patient regardless of whether patient was wearing a cloth face covering or facemask are considered low-risk. Examples of brief interactions include: brief conversation at a triage desk; briefly entering a patient room but not having direct contact with the patient or the patient's secretions/excretions; entering the patient room immediately after the patient was discharged.
- HCP who walk by a patient or who have no direct contact with the patient or their secretions/excretions and no entry into the patient room are considered to have no identifiable risk.

III. Recommendations for Monitoring Based on COVID-19 Exposure Risk

HCP in any of the risk exposure categories who develop signs or symptoms compatible with COVID-19 must contact their established point of contact (public health authorities or their facility's occupational health program) for medical evaluation prior to returning to work

1. ***High- or Medium-risk*** **Exposure Category**
   HCP in the *high- or medium-risk* category should undergo active monitoring, including restriction from work in any healthcare setting until 14 days after their last exposure. If they develop any fever (measured temperature ≥100.0°F* or subjective fever) OR symptoms consistent with COVID-19 (e.g., cough, shortness of breath, sore throat, myalgias, malaise)* they should immediately self-isolate (separate themselves from others) and notify their local or state public health authority and healthcare facility promptly so that they can coordinate consultation and referral to a healthcare provider for further evaluation.
2. ***Low-risk*** **Exposure Category**
   HCP in the *low-risk* category should perform self-monitoring with delegated supervision until 14 days after the last potential exposure. Asymptomatic HCP in this category are not restricted from work. They should check their temperature twice daily and remain alert for symptoms consistent with COVID-19 (e.g., cough, shortness of breath, sore throat, myalgias, malaise)*. They should ensure they are afebrile and asymptomatic before leaving home and reporting for work. If they do not have fever or symptoms consistent with COVID-19 they may report to work. If they develop fever (measured temperature ≥ 100.0 °F* or subjective fever) OR symptoms consistent with COVID-19 they should immediately self-isolate (separate themselves from others) and notify their local or state public health

authority or healthcare facility promptly so that they can coordinate consultation and referral to a healthcare provider for further evaluation.

On days HCP are scheduled to work, healthcare facilities could consider measuring temperature and assessing symptoms prior to starting work. Alternatively, facilities could consider having HCP report temperature and symptoms to occupational health prior to starting work. Modes of communication may include telephone calls or any electronic or internet-based means of communication.

3. **HCP who Adhere to All Recommended Infection Prevention and Control Practices**
   Proper adherence to currently recommended infection control practices, including all recommended PPE, should protect HCP having prolonged close contact with patients infected with COVID-19. However, to account for any inconsistencies in use or adherence that could result in unrecognized exposures, HCP should still perform self-monitoring with delegated supervision as described under the low-risk exposure category.
4. ***No Identifiable risk* Exposure Category**
   HCP in the *no identifiable risk* category do not require monitoring or restriction from work.
5. **Community or travel-associated exposures**
   HCP with community- or travel-associated exposures to COVID-19 should inform their facility's occupational health program that they have had a community or travel-associated exposure. Decisions about restriction from work should be made in consultation with the occupational health program. HCP who develop signs or symptoms compatible with COVID-19 should contact their established point of contact (public health authorities or their facility's occupational health program) for medical evaluation prior to returning to work.

Additional Considerations and Recommendations:

While contact tracing and risk assessment, with appropriate implementation of HCP work restrictions, of potentially exposed HCP remains the recommended strategy for identifying and reducing the risk of transmission of COVID-19 to HCP, patients, and others, it is not practical or achievable in all situations. Community transmission of COVID-19 in the United States has been reported in multiple areas. This development means some recommended actions (e.g., contact tracing and risk assessment of all potentially exposed HCP) are impractical for implementation by healthcare facilities. In the setting of community transmission, all HCP are at some risk for exposure to COVID-19, whether in the workplace or in the community. Devoting resources to contact tracing and retrospective risk assessment could divert resources from other important infection prevention and control activities. Facilities should shift emphasis to more routine practices, which include asking HCP to report recognized exposures, regularly monitor themselves for fever and symptoms of COVID-19, use facemasks or cloth face coverings for source control, and not report to work when ill. Facilities should develop a plan for how they will screen for symptoms and evaluate ill HCP. This could include having HCP report absence of fever and symptoms prior to starting work each day.

CDC has released guidance to assist healthcare facilities with mitigating staffing shortages, which include considerations for allowing asymptomatic HCP who have had an exposure to a COVID-19 patient to continue to work after options to improve staffing have been exhausted and in consultation with their occupational health program. Refer to that guidance for additional recommendations if this is allowed.

* Fever is either measured temperature ≥100.0ºF or subjective fever. Note that fever may be intermittent or may not be present in some patients, such as those who are elderly, immunosuppressed, or taking certain medications (e.g., NSAIDs). Clinical judgement should be used to guide testing of patients in such situations. Respiratory symptoms consistent with COVID-19 are cough, shortness of breath, and sore throat. Medical evaluation may be recommended for lower temperatures (<100.0ºF) or other symptoms (e.g., muscle aches, nausea, vomiting, diarrhea, abdominal pain headache, runny nose, fatigue) based on assessment by occupational health or public health authorities. Additional information about clinical presentation of patients with COVID-19 is available.

Page last reviewed: April 15, 2020

Exhibit D

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF NEW YORK

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	: 20-CV-01590 (RPK)
HASSAN CHUNN, et al	:
	:
Petitioners,	:
	: United States Courthouse
	: Brooklyn, New York
-against-	:
	:
	: April 13, 2020
WARDEN DEREK EDGE,	: 1:00 p.m.
	:
Respondent.	

- - - - - - - - - - - - - - - - - X

TRANSCRIPT OF CIVIL CAUSE FOR PETITION
FOR WRIT OF HABEAS CORPUS
BEFORE THE HONORABLE JUDGE RACHEL P. KOVNER
UNITED STATES MAGISTRATE JUDGE

A P P E A R A N C E S:

For the Petitioners:	EMERY CELLI BRINCKERHOFF & ABADY LLP 600 Fifth Avenue, 10th Floor New York, NY 10020 BY: KATHERINE RUTH ROSENFELD, ESQ.
	BENJAMIN N. CARDOZO SCHOOL 55 5th Avenue Eleventh Floor New York, NY 10003 BY: BETSY R. GINSBERG, ESQ.
For the Respondent:	UNITED STATES ATTORNEYS OFFICE EASTERN NEW YORK 271 Cadman Plaza East Brooklyn, NY 11201 BY: JAMES R. CHO, ESQ. JOSEPH ANTHONY MARUTOLLO, ESQ. SETH EICHENHOLTZ, ESQ.

ALSO PRESENT, DIERDRE VON DORNUM, ESQ.

Court Reporter: **SOPHIE NOLAN**
225 Cadman Plaza East/Brooklyn, NY 11201
NolanEDNY@aol.com

Proceedings recorded by mechanical stenography, transcript produced by Computer-Aided Transcription

(Telephonic conference.)

THE COURT: This is *Chunn versus Edge*. It's 20-CV-1590 and I would ask the parties state their appearances.

MS. ROSENFELD: Katherine Rosenfeld and Betsy Ginsberg for petitioners.

THE COURT: Great.

MR. CHO: Your Honor, if I may, James Cho for the Government and I can introduce my team as well. We have Seth Eichenholtz, U.S. Attorney's Office, Joseph Marutollo, U.S. Attorney's Office; Paulina Stamatelos, U.S. Attorney's Office; Lisa Olson, DOJ Federal Program; Kieran Howard (phonetic), Bureau of Prisons Regional Counsel and Holly Pratesi (phonetic), Bureau of Prisons.

I'm James Cho, U.S. Attorney's Office.

THE COURT: We also have Judge Mann on the line too.

MS. VON DORNUM: Dierdre von Dornum. I just joined.

THE COURT: Okay. So I know we've had a bunch of calls in this case, but I will just repeat my general conference call request which is, if you are speaking, if you could identify yourself at the start so the court reporter can take it down and try not to overlap with each other that would be helpful because that's hard to take down.

So I think we have a bunch of matters relating to discovery to talk about and I think the first bucket of them

are whether discovery should be allowed given that this is a habeas, whether discovery should be expedited and whether discovery should be stayed. So they are all pretty closely related questions I think, but that's sort of the first bucket of things that I have.

Well, I have read submissions that were put in on this up until an hour ago and I see that the Government just put in a submission maybe a half an hour ago and I received that -- because my ECF doesn't update immediately, I received it five minutes ago and I've sort of scanned it, but I have not read it in great detail. So let me turn it over on those three issues to you all; if there is anything you want to add from the submissions that were put in as of Saturday night, including the Government if there is anything you want to call to my attention from this letter that wasn't developed in the earlier submissions.

MR. CHO: The letter we submitted to Your Honor about a half an hour ago was in response to your order from Saturday asking us to be prepared to discuss objections to the discovery requests. So we outlined, I think in great detail, our overall objections to the discovery demands. Certainly our position is; one, we intend to dismiss and certainly no discovery is necessary on a motion to dismiss. So we want to request a stay of discovery for that reason, but also in federal habeas cases, courts generally do not provide for

discovery in those types of cases, and again this is a habeas case as well.

THE COURT: Got it. Okay.

Since I read your letter on this, is there anything else you want to add on whether the discovery should be allowed, whether discovery should be expedited or whether discovery should be stayed?

MS. GINSBERG: No, Your Honor. I don't think we have anything to add and I would say that I have also only scanned the respondent's long letter that we only just received and didn't actually know it was coming in our earlier meet and confer today, so I would be happy to respond to any of the objections they raised here, but we haven't gone through their letter thoroughly yet.

THE COURT: Okay. So on the issue of whether to allow discovery, I take the point that habeas petitioners are not entitled to discovery as a matter of ordinary course under the ordinary civil rules. I think both the Government and the petitioners agree, though, that there this is a good cause standard under which courts can allow discovery and so here I'm citing *Gracie versus Cramley* (phonetic) which is a Supreme Court case and it says: Where specific allegations before the court show reason jato believe that the petitioner may, if the facts are fully developed, be able to demonstrate that he is entitled to relief, it's the duty of the court to a provide

the necessary facilities and procedures for an adequate inquiry.

So under that I think courts look to whether if -- depending on how the evidence were developed, if petitioner could have a claim that that's something the courts consider in deciding whether to authorize discovery. So here I think that the may standard is a relatively low bar and the things that the petitioner is seeking discovery on are things that are relevant to an Eighth Amendment claim could potentially make out an Eighth Amendment claim at least potentially under a may Standard.

So petitioners should put forward evidence in their TRO papers suggesting there is some basis for disputing some important things about the conditions of the compliance at the MDC; the inmates saying they don't have access to soap. You have numbers suggesting that there is very, very little testing going on at a facility that is recently large. I don't remember the exact number in the most recent report, but it's on the order of about seven people tested in the most recent report. It's a large facility I think of about 1,500 or so people. And then you have the petitioners putting forward in their TRO paperwork some inmate accounts suggesting that there are people who are symptomatic and not being tested.

As you all know, there are a bunch of conditions of

confinement cases being litigated now during the COVID epidemic and I do think these questions of testing protocols and access to soap and sanitation are the kinds of things that courts are treating as a potential basis for an Eighth Amendment claim where one recent case focused very specifically on those two things where I think a TRO was issued recently.

So I'm not myself addressing making any decision obviously about the merits of any of those claims, but I think we're not talking about a may standard. I think we are talking about a relatively low bar because this here is good cause to allow some discovery into those things.

The respondent has argued some about the TRO in this case and highlighted that I didn't issue a TRO, but it does seem to me that there's a very different standard for a TRO than just for authorizing discovery. It's a pretty high bar to get a mandatory injunction at the very start of your case, but I think the standard to submit evidence that may support your claim at the end of the day is a lower one. So that's as to whether discovery should be allowed and I think it's reasonable to have some discovery here. There is due cause for some discovery here.

So then I think the next issue is that should discovery be expedited and here again I think it is a reasonableness or a good cause standard and one of the cases

that I look to is Judge Lynch case, *Ayyash versus Bank Al-Madina*, 233 FRE 325, SDNY 2005. So looking at the cases under -- certain cases addressing expedited discovery, it seems like it's a reasonableness or good cause is a flexible standard.

One thing that courts sometimes look to is whether a preliminary injunction request is pending or being made, expedited a factor but is not sufficient in and of itself. Other things they look at are the purpose of the discovery and the burden on the opposing party and here it seems to me like this is a pretty narrow discovery request being made and we can talk more about whether any specific pieces of it are burdensome or unreasonable.

But this is a relatively limited request seeking information that's relevant to the claims and I don't think it's going to be especially burdensome and, of course, it is a somewhat time-sensitive matter in light of the epidemic. So I think there's good reason to move forward quickly in this case in light of that. So it seems to me like there's good reason to have expedited discovery here.

So then the question is -- and obviously these factors are all pretty overlapping, but the stay of discovery question involves a number of similar factors. The petitioners argue that a good cause standard applies to this also and I don't take respondent to be disputing that there's

a good cause standard for a stay of discovery because they cite -- as setting out the standard that they want for stay of discovery, they cite this case *Spencer Trask Software and Info Services*, 206 FRD-367, and that's a good cause standard case.

So starting from that case, it says and other cases say as well: A stay pending a motion to dismiss is by no means automatic. You shouldn't routinely stay discovery simply because a motion to dismiss has been filed. Instead, you should consider the breadth of discovery sought, the burden of responding to it and the strength of the dispositive motion as a basis for the stay application.

So those are basically factors that I've talked about before with respect to burden and breadth and the only additional factor is the strength of the dispositive motion and here I think the petitioners are right that basically the respondent hasn't told us a lot about what the motion is going to be and that makes it hard to conclude much about the strength of the motion at this point.

The arguments that the Government was making at the TRO stage were mostly merits arguments which is completely appropriate to the TRO stage, but it's not clear to me that any of those -- obviously a motion to dismiss, there's a relatively limited set of arguments that can be made on that type of motion and it's not clear to me from papers that I've seen at this point what the strength of a motion to dismiss

will be.

And so, taking into account all those factors, I don't think that a stay is appropriate, you know, as with some of the earlier discovery points that respondent has alluded to, denial of the TRO as one of the reasons to stay discovery, and again I would say a mandatory TRO is very, very hard to get and I don't think a plaintiff's inability to meet that high standard with respect to the particular relief that we are seeking on a particular record shows that respondent has a meritorious motion to dismiss which I think is the real question when what is being sought is a stay in order to litigate a motion to dismiss.

So that's where I am on those preliminary issues which is, just to recap, under a good cause standard some discovery here is appropriate and it's appropriate to expedite that discovery. And based on what I know now, I'm not inclined to stay the discovery. So insofar as there is a stay request pending now, I would deny it. That kind of moves us to the scope and timing issues unless there is anything else you all want to talk about on those preliminary matters.

Okay, go ahead.

MR. CHO: Nothing from the Government at this time.

THE COURT: Okay. I think that what I am anticipating on scope and timing is that I'm hoping we can develop a little bit more what the objections are and I'm

anticipating that we may issue -- I may jointly with Judge Mann issue, an order on some of those issues. I may play more of a secondary role in talking through some of these discovery questions beyond this call because Judge Mann has expertise in these matters that exceeds my own.

But maybe a place to start will be -- and I think part of this may be addressed in the letter that the Government filed, so I'm just flagging that you may need to recapitulate some of it because I haven't had the opportunity to read it thoroughly and I think your friends on the other side may not have either, but if I'm right about the document demands, the three things that are being requested are the testing protocols from February 1st to date at MDC for COVID-19, documents that show how much soap was received at the facility from February 1st to date, and sick call requests from March 13th to date in redacted form.

Maybe it would make sense for us to talk about each of those in sequence.

Is there an objection to the testing protocols?

MR. CHO: I can go through our objections, which I also outlined in our letter as well, but for document request number one requesting testing protocols, those protocols are already being produced to the Court pursuant to Administrative Order 2020-14. That order specifically says the BOP needs to produce protocols for screening and testing inmates which is

exactly what the petitioners are seeking here in document request number one.

So we would obviously object on the grounds that that information is already available to petitioners on the Court's website and that information will continue to be updated pursuant to that administrative order. So that was the basis for our objection initially to that request.

THE COURT: If I remember right, I think that in their earlier letter petitioners suggested that the information that you're providing to the Court in the letters doesn't really say what the protocols are; it doesn't say whether you're testing people when they're symptomatic or what criteria your applying when you are deciding whether to test people. I don't want to get into a fight about whether or not what you are filing was contemplated in the administrative order which I think is part of what petitioners are raising, but I take it that petitioners' request is basically tell us what criteria you're applying to test people.

Is that something you think you are already disclosing?

MR. CHO: Yes, Your Honor. The request that was filed on Friday all it says is testing protocols for COVID-19 in effect at the MDC and that's also what the administrative order requires as well; protocols for testing inmates. So it it's almost verbatim. They don't ask for anything else on top

of that.

MS. GINSBERG: Your Honor, while the letter response to the administrative order talks some about the screening protocols, they do not explain what the testing criteria are. They say how many people have been tested but that's not the testing protocol and criteria. And so we're not here either to talk about whether they are in compliance to such order, but rather this is information that we need in this case.

THE COURT: So do you want to respond to that with a clarification of what they're looking for in some explanation of, when people are tested, what the criteria are for that? That doesn't seem like what you're providing already and it seems that's what they're looking for.

MR. CHO: Well, I can certainly refer to our responses to the administrative order, but again I can only rely upon what they ask for and they only asked for testing protocols and we believe we've already responded to those requests. I mean, we can certainly meet and confer with petitioners on that request but, I mean, their demand says what the says and it's identical to what the administrative order requires.

JUDGE MANN: I lost power this morning, so I can't even access ECF. So I haven't seen the Government's letter at all, let alone not had enough time to review it. So I'm at a great disadvantage, but I guess a more-pointed question I

would ask is this: Since the demand is not -- it's not an interrogatory, it's a request for documents, is it the Government's position that there are no responsive documents regarding testing protocols and the criteria used to determine when to administer tests other than what is set forth in the response to Judge Mauskopf's administrative order?

MR. CHO: At this time the Government is not prepared to say there are or not additional documents, but we certainly know the documents that have already been produced to the Court are certainly responsive because they're asking for same information. But I can't say, as we sit here today, that there are no additional documents.

JUDGE MANN: Well, since petitioners' counsel indicated that what they're looking for specifically would be documents that set forth what the testing criteria are, let's just drill down on that particular area. I take it you're not disputing that what's been posted on the website, the Court's website, does not contain such criteria; can you say whether or not there are documents that specify the testing criteria?

MR. CHO: I'm not sure whether the responses from BOP don't address that. I'm not exactly sure. I'd have to go back and check the submissions that have already been provided to the Court. So I can't say for sure whether they do or do not address that question.

MS. GINSBERG: Your Honor, I'm looking at the April

9th letter to Judge Mauskopf now and there is nothing in there about testing criteria at all. The fact that the Court asked for this doesn't mean that it's here and I think also Judge Mann pointed out to the extent that there are documents setting forth what those criteria are, we would ask for those.

MR. CHO: Your Honor, if I may, I think the nature of our discussions now reflects the reason why perhaps this call may be premature with Your Honor because, look, we have submitted our objections. We haven't had a chance to meet and confer in-depth with petitioners and they're raising additional inquiries now that we were not aware of before this call. So I don't know how productive it will be having a discussion with Your Honors on all of these points without having had those discussion.

Because, again, their request on Friday was very short. It just said testing protocols and now they're seeking information on testing criteria which is different from what they had requested before. So I just don't know how productive an ongoing discussion on each of these requests will be at this time without at least having the parties have a chance to talk about these issues and the Court having not seen our letter.

JUDGE MANN: Well, I certainly would and must defer to Judge Kovner on this, but my own view is it might be useful just to air some of these issues to help focus the parties in

their discussions and to assist the two judges in coming up together with some rulings.

MS. GINSBERG: Your Honor, the parties spoke today and we inquired as to whether there was anything else to meet and confer about. This isn't new. I don't actually think we're asking for something different right now, I think the protocol for testing includes the testing criteria and we would certainly like to hash this out now as much as possible given the need for expedited discovery here.

THE COURT: So let's at least talk through -- it sounds like testing protocols, the Government is not certain whether there are more written documents that exist beyond what's been given to the Court or submitted to the Court; is that right?

MR. CHO: That's correct, Your Honor.

THE COURT: Okay. And the objection I'm hearing is basically that insofar as what's being requested is for protocols and that it's protocols and information that has been submitted to Judge Mauskopf.

Judge Mann, do you want to ask anything else about that?

JUDGE MANN: Well, I guess the one thing I would want clarification from petitioners, in addition to testing criteria, is there other information that you are seeking in your document demand number one, that is not addressed in the

reports to Judge Mauskopf that have been posted?

MS. GINSBERG: Yes. What I see in those letters to Judge Mauskopf is the number of people tested and the number of people testing positive. So what we're looking for is their protocol, what procedures they follow in deciding who and when to test and how someone might request a test. So I don't see any of that laid out in those responses to Judge Mauskopf. And, so, we assume there must be a document that lays out what those are and whether that's a memo or an e-mail or something telling the people at MDC here is who you test. And, obviously, if no such written document exists, we would want to know that as well.

It strikes me as odd that at this stage in the litigation that the respondent isn't aware as to whether there's any document laying out what the testing protocol is.

THE COURT: Just to drill down on what you're seeking from the defense is what other criteria are being applied besides when testing occurs and how would you request a test; is that right?

MS. GINSBERG: Yes, Your Honor.

JUDGE MANN: I believe also petitioners indicated what procedures were followed regarding who and when to test and how requested. And the Government at the present time is unaware whether there are any such documents apart from the letter sent to Judge Mauskopf, so I don't think the Court can

decide anything at this point except ask the Government to look into that.

MR. CHO: Your Honor, should we talk the second request?

THE COURT: I was asking about the second request, which was documents to show how much soap was received at the MDC from February 1st to date.

MR. CHO: Your Honor, so, one overarching argument or objection that we have to the extent they're seeking information dealing with all inmates at the MDC and not just the two remaining petitioners Rodriguez and Rabadi. In their letter from Saturday, they say they are not seeking classwide discovery nor have they moved for class certification at this time. So one overarching objection we raised in our letter is that to the extent any discovery touches on information dealing with all inmates at the MDC that that request is overly broad and not important to the needs of this case.

In terms of specifics as to soap at the MDC, there are different departments within the MDC that order soap separately. Our records dealing with purchases and shipments of soap at the MDC are not maintained centrally or electronically. So there's some difficulty on the part of MDC to provide a quick response to that request for all soap shipments to the MDC at this time.

So we will certainly continue to discuss this

question with the BOP, but that was our initial objection to that overbroad request. But certainly to the extent that there are documents available dealing with soap shipments, we will provide those responsive documents if they are not privileged.

JUDGE MANN: How many different departments at the MDC put in orders for soap?

MR. CHO: At this time I don't know a specific number.

JUDGE MANN: When you say they're not maintained centrally, I assume we're not talking about the Bureau of Prisons, you're saying they're not maintained centrally even within MDC?

MR. CHO: That's correct. There are district departments within the MDC that make purchases as they see fit and there's not one centralized purchasing department or entity that could purchase soap at MDC.

JUDGE MANN: But you don't know how many departments there are, so you don't know -- you're saying that it's burdensome, but you don't know if there are two versus fifteen different departments?

MR. CHO: Right. Again, we just got the request. They're still checking but that's the information that I've been provided at this time.

JUDGE MANN: And you also say that it's not

maintained electronically. They don't have any record of invoices for example? Nothing is maintained electronically?

MR. CHO: Well, they're asking for shipments and what was received at the MDC. They're not asking for invoices. So certainly a request could be made for soap, as I'm sure all of us know now, we may make a request now, but we may not have the shipment anytime soon. So they're asking only for shipments and I'm not 100 sure -- I mean, we're trying to uncover the invoices but I'm not exactly sure of the shipments and how that would be recorded.

JUDGE MANN: But there may be an electronic record that is invoices?

MR. CHO: There might be, but there may not be as well. I'm not 100 percent sure because if an individual orders an online shipment that may be saved electronically but I'm not sure.

JUDGE MANN: So I take it you don't know, if there is an electronic record of the invoices, whether those invoices would have anything on it about estimated delivery date or actual delivery date?

MR. CHO: That's correct.

MS. GINSBERG: One of the reasons why we think this request is particularly important and quite narrow is that we have been receiving reports that there hasn't been soap handed out on the units in at least a week. And, you know, certainly

it seems like this information would be on invoices when it was shipped. There may even be records of distribution within the facility.

I would also note that BOP is on this call and to the extent that they can provide additional information, that could potentially move things along more quickly.

MR. CHO: I do want to note, Your Honor, that we're dealing with only two petitioners here and to the extent they have not received soap, they can certainly provide evidence to the Court in terms of which soap they have been able to use or what soap they have received. So, again, this broad request for all soap deliveries to the MDC is just far beyond the scope of the current litigation.

THE COURT: Well, it's true that the petitioners can submit their own evidence about a lack of soap, including a lack of soap for these two individuals. The Government has submitted a declaration that soap is being distributed and I'm thinking the Government would argue that it's to the two individuals here. If it's just focusing on the two individuals' claims, wouldn't evidence about whether soap was or was not being brought into the facility bear on whether these two individuals are getting soap or not?

MR. CHO: Your Honor, whether shipments of soap are coming into the MDC, it's different from whether these two petitioners are getting soap. Right? So it may be coming in

or certainly be there and if these petitioners aren't getting soap, then we don't see the relevance of shipments of soap to the MDC.

THE COURT: Well, let's say that evidence showed that no soap had been delivered to the MDC from February 1, 2020 to date and let's say that the Government was drawing on the declaration that individuals were getting soap and the two named petitioners were saying that they were not getting soap, isn't the evidence about whether any soap came into the MDC during that period be relevant to assessing those claims?

MR. CHO: Well, an argument can also be made if the MDC already had soap there is no need for additional soap shipments to be sent to the MDC.

THE COURT: There are other things you could argue. I guess it would depend on whether you might be able to put forward evidence that there was soap in the facility, you might not. It just seems like the evidence is relevant to these two individuals' claims even though you might make argument that the best explanation is the lack of soap orders or something else.

MR. CHO: Understood, Your Honor, but what we say in our letter is we will look for responsive documents and if any documents do exist, we will produce those documents.

THE COURT: Okay.

Judge Mann, is there anything else you wanted to ask

on the soap issue?

JUDGE MANN: Nothing beyond what Your Honor has already stated.

THE COURT: So then I think the final document request is that sick calls requests made from March 13th to the present in redacted form to omit the person's name and number.

MR. CHO: Your Honor, if I may correct that?

THE COURT: Yes.

MR. CHO: So, initially our response to both Rodriguez and Rabadi have indicated to the SDNY judges that they are asymptomatic. So presumably they would not have made any sick call requests. So their request for sick call is far beyond the scope of this litigation and we would certainly object to sick call requests for all other inmates at the MDC -- at any given time there are 1,700 inmates at the MDC -- for a couple of reasons.

First, sick call requests touch upon an inmate's private, confidential medical history and they have privacy rights which are not implicated in this case because they are nonparties to this litigation. And so the BOP certainly objects to producing sick call requests for anyone other than these two petitioners.

JUDGE MANN: I'm sorry, I just wanted to ask one question that goes to the HIPAA argument that you're making.

HIPAA, doesn't that relate to information with an identifiable patient so that if it's redacted it would not come within the HIPAA privacy requirements; isn't that correct?

MR. CHO: Understood, but to the extent we go through these sick call requests whether they have a name on there or not, or a registration number, we don't know whether that information could still implicate a certain inmate. For example, if people know a certain inmate has a certain condition which is reflected in the sick call request, people may still be able to figure out who the inmate is based on the conditions identified in the sick call request.

But I do want to add, in our letter to the Court, that we are prepared to produce medical records for these two inmates Rabadi and Rodriguez. We submitted to petitioners' attorneys this morning a HIPAA release for their medical records and we will conduct a search for any sick call requests that those two inmates have made. But in terms of sick call requests generally, there are many methods by which an inmate can request a sick call.

They can make an oral request to a BOP staff member, they can get a staff member a hard copy piece of paper requesting sick call or they can also submit a request electronically using the Trulincs system. So many of those methods would be maintained in the inmate's own medical record. So it would require the BOP to respond to this

request to go through all 1,700 inmates' medical records and other documents that those inmates may have to identify whether sick call requests were made. And, again, with the electronic systems there are certain records that are maintained electronically and an inmate could send an electronic request through Trulincs, but again those are requests made by the inmates and we would have to go through those inmates' e-mail accounts to identify at those sick call requests.

THE COURT: If somebody submits a sick call request through one of these methods, then at the point at which they are authorized by BOP and before a doctor sees them, I would think there is some central channeling mechanism, a doctor or another staff member --

MR. CHO: Well, when an inmate makes these sick call requests, it's the BOP position that they want to address those concerns as soon as they can. So either they may be scheduled to see a medical professional or the medical professional may respond immediately to their request without there being any paperwork or paper trail reflecting that request being made and the response to that request.

So there are many ways for inmates to receive medical care and that's why the BOP does it this way so if there are any issues an inmate can seek relief through the sick call process because they are given multiple avenues by

which to make those requests.

THE COURT: Just to make sure I understand this, just to go one by one, let's just set aside the oral requests for a moment. If somebody submits a hard copy request, is that request maintained anywhere after that aside from the individual person's file?

MR. CHO: It could be or may not be. I know those requests are then sent to the medical unit to schedule but what happens beyond that it may be maintained or it may not be maintained. The important thing is that the inmate gets seen by a medical professional. I think that's what the BOP's primary concern is.

THE COURT: I understand that, but I am trying to figure out what kinds of records exist and how they might be compiled. So I'm wondering if you know whether once somebody submits a hard copy request if there is a folder used to hold the sick call requests -- whether there's a centralized compilation of it or not.

MR. CHO: There may be, but I'm not sure.

THE COURT: Okay. And then through the Trulincs system, I'm sure these requests are kept in the individual e-mail account but I would think that they are also kept in the account of the recipient.

MR. CHO: Right. The thing is those requests can be made to multiple people, it doesn't have to be just one

person. For example, an inmate can make a request to their unit team who are not medical professionals. They can make a request to the medical staff. So there are many different repositories by which the call can be made but certainly those are electronic so conceivably there's a way to retrieve those electronic documents. But I believe in petitioners' letters they said they're not seeking ESI or electronic data at this time but certainly there is a mechanism by which sick call requests are made electronically but through multiple choices.

THE COURT: I was just asking, you can make a request to multiple sources if you're an inmate; if you're a recipient for a request like that, do you send it to a single centralized source?

MR. CHO: That's the thing, Your Honor, I don't think it's necessarily centralized. The reason why they do it this way is to make sure inmates have multiple ways to seek relief or to be seen by a physician. So certainly we can look into where these requests are sent ultimately, whether it's the medical unit or some other unit, but again there are multiple avenues by which they can make these requests and I don't necessarily think it's centralized.

MS. GINSBERG: Your Honor, my understanding is that it is somewhat centralized. My understanding is that BOP has taken a position that all sick call requests are made electronically and that they all end up in a centralized

location electronically. Obviously BOP can get back to us on exactly how that goes, but my understanding is that's how it goes. If there happens to be hard copy requests that somehow don't get logged electronically, we're not asking that the respondent go through individual medical records to look for those although my understanding is that also medical records are maintained electronically.

Our request here is to be able to look at how medical care is being delivered during this epidemic to understand whether people who need care are able to get care including the petitioners. So, we have said that they are at heightened risk for infection and have said that the facility is unable to care for them should they become infected and, so, the ability for the medical system to handle these requests and to address them in a timely way is critical to our claim.

Certainly to the extent that we're able to ask about some of this in the 30(b)(6) deposition, it may obviate the need certainly for looking through individual medical records to get at this information. Although, to the extent that it's all centralized and electronic, we think that should be easy enough to gather.

THE COURT: Do you have a response to the HIPAA claim?

MS. GINSBERG: My understanding on HIPAA is

consistent with what Judge Mann said which is that where the documents are deidentified there is no HIPAA concern. It is also true that HIPAA contains a provision that allows for the court order of confidential medical information. However, I don't think that matters here because we're not asking for anything that would violate HIPAA, Your Honor.

THE COURT: Judge Mann, is there anything else you want to ask about this medical request issue?

JUDGE MANN: I don't think so.

THE COURT: Okay. So should we talk about the 30(b)(6) at this point?

MR. CHO: Sure.

MS. GINSBERG: Sounds good, Your Honor.

THE COURT: Again, Government, this might be something that you have addressed in the submission that recently came across ECF. So you may just need to recapitulate any thoughts you have.

MR. CHO: Sure. So in the 30(b)(6) notice we received yesterday afternoon they set forth nine topics and by my count 46 subparts for a total of 55 distinct topics. Certainly our position is initially based on our read of the 30(b)(6) notice that the request is overly broad and very far reaching. In their letters they say they only seek to depose a witness but presumably, based on the 55 topics they have identified, I don't believe it would be possible to identify

just one witness who can address all 55 issues.

On top of that, we did have a brief meet and confer this morning regarding 30(b)(6). Many of these requests or many of the topics in the 30(b)(6) could be responded to through other discovery methods either through document requests or interrogatories. For example, in topic one they ask for total numbers of employees that can be responded to in either a document request or an interrogatory. Topic number two talks about housing units and to identify housing units. Again, that can be responded to in a document request as well and the other topics as well.

They seek housing assignments. For example in topic three; medical care available at MDC in topic four; procedures in topic five; rules and regulations in topic six; more procedures in topic eight; and removal in topic nine. Again, those are more akin to requests for documents or interrogatories and we think those are more-preferred methods to be able to respond to those requests for information.

THE COURT: It sounds like there was a meet and confer about the Rule 30(b)(6) this morning. I don't know if petitioners have thought about whether some of these requests could be handled through document requests or interrogatories.

MS. GINSBERG: Sure, Your Honor. You know, what respondent has just said is that document requests and interrogatories are the preferred way of handling this. I

think that means it's their preferred way of handling this, but it's certainly not our preferred way. And the reason it's not our preferred way is because we're looking for expedited discovery. We think that 30(b)(6) is the most efficient way to do this.

The respondent has said that we have lots and lots of topics in here. We could have noticed this 30(b)(6) deposition with the topics just being, you know, the MDC's response to COVID-19. The reason that we laid it out as we did was because we thought that would help expedite things. If we told the respondent everything that we intend to ask about in the deposition, it would allow them to prepare more quickly, to understand what it is we're looking for in the deposition rather than just seeking more generally about the response to COVID-19.

In terms of the number of witnesses, it's up to them whether they decide to present one witness who either has knowledge of these topics or who obtains knowledge of these topics or whether it's easier for them to just include different people to talk about the topics that they're most familiar with. When, during the meet and confer I asked whether there wasn't an individual who was tasked with responding to the MDC -- responding to COVID-19 on behalf of the MDC, they didn't know and I think that is an important thing for them to know and if there is someone I would imagine

that that person has knowledge of these topics and could speak to these topics.

THE COURT: Judge Mann, is there anything you want to ask about this 30(b)(6) issue?

JUDGE MANN: Not beyond what's been discussed and I obviously want to take a look at what the Government submitted earlier today.

Maybe I should ask, Mr. Cho, does your letter of this afternoon address these specific 30(b)(6) topics?

MR. CHO: We do in general form, Your Honor, given the time. We had less than 24 hours to review it before this call. We noted our initial objections generally to what we saw in the 30(b)(6) notice, but what I do want to apprise Your Honor is based on our meet and confer. We're not objecting to the 30(b)(6) objections, but we do object to the scope of the requests as made and I indicated to petitioners' counsel that to the extent they can further limit their request they may be more productive for us to be able to identify appropriate 30(b)(6) witnesses. We don't have a blanket objection to depositions generally, but we do object to the scope and the breadth of the topics that they're seeking at this time and we invited them to further limit their requests.

JUDGE MANN: Speaking for myself, I'm actually surprised to hear the Government say that the preferred way would be by responses to interrogatories or document demands

because if there are someone who is tasked or a group of individuals tasked with responding to COVID -- for example, take item number two, they may know off the top of their heads the response to that question about the housing units; whereas it would seem to me that it might be more burdensome to say, okay, go search for documents or having to write out responses to interrogatories that are then sworn to by that individual.

Now, I personally think that item number one that might be -- since we're talking about numbers, that an individual may not remember it, that one is more appropriate for an interrogatory, but for some of the others I'm a little puzzled that the Government would think that it's less burdensome to have to go search for documents, whether it's to produce the documents or whether it's to then provide interrogatory responses, so I would just ask the Government to, you know, to clarify and respond to that.

MR. CHO: Sure, understood.

Well, with respect to topic number two where they are seeking information dealing with housing units, again, typically when it deals with housing units those are documents where certain inmates are located. So one specific BOP official may not actually know where all inmates are housed at any given time at the MDC because there's always movement within the MDC. So essentially documents can show where inmates are being housed at any given time but a BOP official

may not know where any single inmate is at any given time.

JUDGE MANN: Well, I assume that in responding to that whether whatever form the discovery demand is in, you are not going to be searching for the records relating to individual inmates. So that -- wouldn't there be someone who knows what the MDC -- where the MDC has been placing individuals who are in isolation or quarantine without having to go search records?

MR. CHO: Well, in topic two they talk about people placed in isolation, people admitted to the facility, people transferred within the MDC. So these are inmate-specific decisions and I understand Your Honor's perspective of what about entire units, but I'm not sure if a response can be given that way because one inmate may be in an isolation unit today, in a quarantine unit tomorrow, in the SHU the next day. And so that fluctuates based on the inmate himself or herself.

So I think this just goes to the point of how the request is extremely broad and it's going to be difficult for us to ascertain exactly what they're seeking. Right? We are open to them limiting their request perhaps to the two particulars because that's easy. We can retrieve that information quite quickly, but for all 1700 inmates at the MDC that's a different story.

MS. GINSBERG: Your Honor, I think it's hard to imagine how to interpret topic number two as asking to be told

where each individual person at the MDC is being housed. What we want to know is which units specifically are being used for isolation, for quarantine, for exposure, where new people being admitted to the facility are being housed and for how long; where people are being transferred within the MDC. So I don't -- I don't think that that's a reasonable interpretation of what we're asking for here.

JUDGE MANN: I get your point about A and B. I understand those to mean you are asking which units are on isolation or quarantine, which units are new people being assigned to. I'm not sure I understand what C is asking.

MS. GINSBERG: So, Your Honor, I think with C what we want to know is about movement within the facility particularly from intake into other units and between isolation and non-isolation, quarantine and non-quarantine, because our understanding is that at least some of that has been happening inappropriately in a way that might further the spread of infection in the facility.

JUDGE MANN: Let me ask counsel for petitioners, is it the name of the unit that you're interested in or the general question of whether or not there is a specific housing unit or units in which -- in which quarantined or isolated individuals are placed due to suspected COVID-19 exposure and so on with respect to B and C. Is it you want to know whether there are particular units being used for those purposes or

whether there is no specific unit?

MS. GINSBERG: Well, I think it's both whether there is such a unit or are such units and also which units are so designated.

JUDGE MANN: Sorry, I'm hung up on this one piece of it but what is C? Is there a specific unit to which people are being transferred from -- I'm not sure I understand it. Is there a sentence you could give me that rephrases that request?

MS. GINSBERG: Can I try my hand at it? Just transfers within the MDC went from general population to the SHU. I assume that's what it's getting at are their intra-facility transfers, am I correct?

MS. ROSENFELD: Judge, just to jump in because I think I may have written this confusing sentence.

Yes, that's exactly right, Judge Mann. So we understand, that is right, people come into unit 41 through intake and then they're transferred. They went to unit 42 and then some people from unit 42 went to unit 72. So we just want to understand during the recent time period where intra-facility transfers have occurred, which unit.

MR. CHO: Your Honor, just to let you know and it is an issue that we haven't really addressed yet, but there are obviously security concerns dealing with where certain inmates are placed. Certain inmates cannot be placed on the same

unit; for example, they may be cooperators for the Government in criminal cases or there are other reasons why certain inmates can't be located within units with other inmates.

So again, as I read topic number two, while there may be general questions about certain types of units, ultimately where inmates are placed is an inmate-by-inmate specific inquiry that we can't ignore because decisions are often made based on a lot of criteria including separating information, because inmates can't be placed next to each other due to they are being cooperative with the Government for other reasons. So those are inmate-by-inmate inquiries.

JUDGE MANN: But I take it petitioners aren't asking for you to identify particular inmates and explain why they were placed in certain locations. Right? They're just asking you to say where inmates are placed in these particular categories; whether they're in isolation or quarantine, when new people are admitted to the facilities and then to explain or to say where inmates have been transferred to and from. So are you asserting that that implicates security concerns?

MR. CHO: Well, not just topic two, but I think one overarching question that petitioners are seeking here is why certain decisions were made. So I don't think you can divorce that inquiry from these attorneys' concerns. Right? I think that's one of the inquiries that they have in these requests overall; that they want to know why certain decisions were

made, why certain inmates were placed in certain areas within the MDC.

JUDGE MANN: I don't know how many inmates there are now. I know it was over 1,700. Is it down to 1,500 now?

MR. CHO: No, it's still hovering around 1,700 as of the past couple days, Your Honor.

JUDGE MANN: Do you happen to know just ballpark, of the 1,700 inmates, how many of people are subject to separation orders or requests or something similar that would be one of these overriding concerns that you have just referred to?

MR. CHO: Your Honor, that information is looked at for every single inmate. Those are part of every inmate's file. They look at those concerns for everyone. It's not just a select few.

MS. GINSBERG: Your Honor, I don't know why we're talking about this. We're not asking for any information about a particular individual. We're asking more generally here how they are housing people with exposure, with symptoms, who are newly admitted to the facility or moved around the facility. We're not asking about the particular placement of a named individual. So I don't think any of what we've asked for here contemplates any of these attorneys' concerns that we are talking about.

THE COURT: Did you have anything else to the

30(b)(6) issue?

MR. CHO: Not at this time, Your Honor.

THE COURT: Judge Mann, do you have anything else on this point?

JUDGE MANN: No other questions at this time.

THE COURT: So then I think the other discovery request is the notice of entry. I'm looking at the letter and I see there's some discussion of that subject again, but I have only just scanned it so I would be grateful if the Government would tell us where they are.

MR. CHO: Sure. Initially, we object on the grounds that petitioners have already submitted to the Court for expert reports dealing with conditions at the MDC for which they claim petitioners should be released. So any additional inspection of the MDC is unwarranted because these four experts, including the one they want to go back to the MDC for an inspection, have already expressed their unqualified opinions as to conditions at the MDC and in none of those expert reports have they said that they need an inspection of the MDC to come to their conclusions about how conditions are at MDC and that would warrant release of these petitioners.

So our additional objection was on the grounds that no expert inspection is necessary and would be duplicative of what is already in before Your Honor in terms of their expert declaration.

We had specific requests on top of that and I can go through those one by one. Certainly some of the requests from the inspection for logbooks and posted orders can be responded to in a document request or interrogatory, so an inspection would not be necessary for that request. The request is not limited by any specific time period or duration or scope or nature. Another objection is that the petitioners' attorneys and their expert want to confidentially interrogate incarcerated individuals.

There are two regulations that require a process -- well, I take that back. They also want to inquire of staff members as well. So with respect to the staff members, there is a process by which under the Touhy regulations that they need to make a request to the DOJ to talk to any staff members. But it's the Government's position that there should not be any discussion with staff members while they're working at the MDC and, in fact, one of the orders that they referenced in their Saturday letter, one of the orders specifically forbids the attorneys to conduct any interviews of inmates or staff members and that was cited in their letter to the Court. That was the *Mack versus City of New York* case, number 14-CV-3321 in the Southern District of New York, docket number 36.

But with respect to interviews of inmates, certainly the inmates have a right to privacy and not be subjected to

such interviews and we're not quite sure what the term "confidential" means, whether it means respondents cannot be present during those interviews.

We also note that presumably all these criminal defendants or inmates have had or currently have criminal defense counsel and there's no indication here that they would allow their criminal defense lawyers to be present during these confidential interviews, and we certainly object to any confidential interviews on the grounds that we cannot ascertain who these individuals talked to during this inspection, if they are indeed confidential.

Now, the request asking for an inspection of the entire MDC, including units were these two petitioners have never been housed, we certainly object to the breadth of an inspection of the entire MDC. For example, they identify the women's unit. These petitioners have not been housed in the women's unit, for example, and certainly the conditions at the MDC is fluid and constantly changing and any inspection on one given day would have limited relevance to this litigation going forward because conditions do change every day.

And one more point, and this is obviously an overarching argument we have in our objections, that this is a secure facility with both minimum and maximum security inmates and classifications and allowing an open-ended inspection of the entire MDC including interviews of inmates and BOP staff

would be extremely burdensome and disruptive to the security of the facility.

THE COURT: I want to give the petitioners an opportunity to respond to any of the points there that they want to, but three particular things I'm wondering if you could address are the utility of the site inspection by Dr. Venters given that he's already opined on these issues without having conducted a site visit, and then the issue of interviewing inmates and interviewing staff members including the Touhy issue and the counsel issue, and I would be interested if you have any site inspection cases where that has been ordered and then if there's any cases where scope of the facility issue giving access to the other staff.

MS. GINSBERG: So, with respect to the need for the inspection, of course we have experts who presented declarations to the Court about their understanding of COVID-19 and what was happening at the MDC, but my guess is that if we were to present these experts at a PI hearing they would be questioned about their knowledge of specifically what is going on right now at the MDC and we would want them to be able to testify with some particularity about what they see at the MDC. These Rule 34 inspections are quite common in prison litigations when we are talking about processes and procedures in medical care and certainly nobody has claimed that Dr. Venters is not a qualified expert to do this. And, of

course, having him be able to really evaluate and look at what is happening in the facility as someone with those correctional health and epidemiological experience, I think would provide great knowledge to the Court.

So I don't think it would be duplicative of what he's already put in or the other experts have already put in because none of them have had access to the facility and I think maybe my colleague wanted to also jump in on this point.

MS. ROSENFELD: I did, thanks Betsy.

Dr. Venters has not opined at all about conditions within the MDC. If you look at his declaration, it's a very short declaration that we put in on an expedited basis, but basically at paragraph 5 he talks about -- he's informed that there's one prisoner and two staff members who are positive and he opines on sort of epidemiologically where he would expect infections to be generally, and then in paragraph 6 he opines very generally about best practices for facilities managing COVID epidemics.

There is nothing in Dr. Venters' declaration about MDC in particular, how they're handling this. It was a statement in general of best practices for disease management within jails; so the Government is not correct that Dr. Venters has already opined on conditions within MDC. He did run the jailhouse system at Riker's Island for many years in many capacities, including during other infectious disease

outbreaks. And as my colleague said, having this expert go into the facility and see what is actually going on, how is social distancing being implemented there, where are medical staff in relation to where people are living, those kinds of things are extraordinarily useful and it can very easily and straightforwardly be done without interruption to the facility.

As Your Honor is probably aware, last winter there was a court-ordered inspection that involved Judge Torres and MDC, but Ms. von Dornum, who is also on the phone, conducted a two-person inspection under a court order. I think she said it was around two hours. They were accompanied by several BOP officials who are on this call. It was very uneventful and not disruptive in any way. So we certainly think that, given the long practice of allowing medical experts to go into prisons to gain the kind of firsthand knowledge that you can only gain by seeing and being somewhere in an orderly and careful way is appropriate here.

MS. GINSBERG: Your Honor, as to the question to employees that we've included in the notice of inspection, this is something also that happens regularly. In a case that I think we cited in our letter, *United States versus Dearie,* the civil division of the Justice Department took the position that this is permissible under the rules, that it's important in order to allow the expert to understand how processes

within -- in that case it was a jail -- worked, and it's something that in my 20-plus years of civil litigation experience happens all the time.

On the Touhy issue, my understanding is that what those regulations address are testimony and we're not asking for testimony. We're not asking that those statements go into the record, but it's really important for the expert to be able to speak to people in the facility, to say, hey, what is this; hey, what do we use this area for, to enable him to actually conduct the inspection properly. So I don't think that falls under Touhy.

With respect to what respondent called confidential interrogation -- and I would reject that characterization. We're not looking to interrogate anyone -- anyone our expert would speak to, they would speak to voluntarily. And in response to their concern about not ascertaining who they spoke to it would be in plain sight, but I think the reason that it's important that these are confidential and what I mean by that is it's really out of the earshot of the rest of us.

I think some people are fearful of reporting things right now. They're fearful they're going to end up in the SHU if they say they have symptoms. They worry about retaliation if they report conduct and so in order to protect them we would like our expert to speak to them somewhat

confidentially. We are not asking for a private room. We're talking about in-unit conversations out of earshot of the rest of the tour.

You know, in terms of the criminal defense counsel issue, I'm not sure this would be an issue that criminal defense counsel would be concerned about and of course we have Ms. von Dornum from the Federal Defenders who could certainly speak to whether her office would object to any of this. I would also note that BOP employees spoke to the two petitioners outside of their criminal defense counsel and outside of our presence. So that concern doesn't -- doesn't --

JUDGE MANN: Well, can I ask you just one question more specifically about that? As you all know, the EDNY and I'm sure at SDNY, folks are getting many, many bail applications that raise conditions of confinement issues and also compassionate release applications is raising those issues. So I guess I'm wondering if there were interviews that were being conducted about the nature of the conditions over there, it seems like you would be talking to people about the kind of issues that they may have pending and requests to the court about in their own cases.

MS. GINSBERG: It's certainly possible and I'm not sure -- I mean, we could certainly try to figure out a way to avoid those issues and we could certainly ask people about,

you know, whether they have submitted any requests or have attorneys representing them in those circumstances so that we don't ask them about things in which they're already represented. We could also speak to people who are represented by the Federal Defenders Office on consent from the Federal Defenders that they are fine with us speaking with clients at their office.

MS. VON DORNUM: Your Honor, I apologize for jumping in. First of all we would consent to our clients, even those with pending motions and perhaps particularly those with pending motions, being interviewed and I can do that on a formal basis if that's useful, but when I went on the blackout tour of the MDC ordered by Chief Judge Irizarry, I went with EDNY U.S. Attorney's Office Investigator John Ross. He and I walked around the facility, as counsel mentioned, for a couple of hours, escorted by staff.

He and I went up to each cell together and explained to the inmates exactly who we were and what we were going to ask about and said to each person you do not have to talk to us if you are at all uncomfortable, here is what we're asking, it could be publicly reported. And I would note that when Judge Torres went that I was with her again, three days later led by a troop of prosecutors, she also just made very clear to people that you don't have to talk to me at all, that that's totally up to you.

So there could be some objections, but I do think there are ways around that and we could also obviously inform defense lawyers in advance of when the expert would be going and that they could tell us if there are people they did not wish to be spoken to. So I think there are definitely ways around that issue. And of course, although we would be talking about conditions, we would not talking about their cases which is as you know some part of what the compassionate release motions hits on is the 3553(a) factors and I think those are the sensitive parts for the inmates, not whether they've been getting soap or not.

And just in terms of the inconvenience or burden to the facility, when I walked around with Investigator Ross and we were escorted by legal counsel and one of the assistant wardens, we were there for several hours and did not seem, even in the SHU, to disconcert any of the staff. We didn't get in anyone's way, we went exactly where they told us, but we were by direct order of the chief judge able to speak directly to inmates and to staff and both did speak to us. And as Ms. Ginsberg says, I do believe only two gave testimony and the BOP legal counsel did not object to us talking to staff and staff came up to us and volunteered information as they may well wish to do here.

But just to say I think it could be accomplished without too much disruption and we came basically unannounced

on a couple of hours notice, so this would be with even more notice, but it did not, as far as I know or as far as anyone has ever said, caused any problems for the facility.

JUDGE MANN: Well, was there an order in Chief Judge Irizarry's case? Do you know the docket in that case?

MS. VON DORNUM: Yes, I do, it was an administrative order. I believe it's docketed on the court website under administrative orders. It's from January -- I'm sorry, it's from February 2nd and there was no case. It was during the blackout and she just ordered us in.

I think at the very outset -- I don't know if it was Ms. Ginsberg or Ms. Rosenfeld, you had mentioned that there was another case that you were relying on but my phone chose that moment to be a little bit indistinct, so I wanted to ask you about that again on the interviewing issue.

MS. GINSBERG: Yes. That's *United States versus Erie County*. It's a 2010 Western District of New York case.

MS. VON DORNUM: Okay.

MS. GINSBERG: That was brought by the United States Department of Justice.

MS. VON DORNUM: Okay.

MS. GINSBERG: Your Honor, just one final point. We included a number of cites in our letter to cases where we, as lawyers, have gone into the facility and we also described a case where we went to the Riker's Island facility with expert.

The cases where lawyers have gone to tour jails for the purpose of understanding where a specific incident might have occurred, like an incident of excessive force; obviously different than the medical expert inspection. And the Macks case was one of those cases where lawyers went to simply look at photographs of a place where an incident of violence had occurred and so there was no need for interviews. I just wanted to draw a distinction.

THE COURT: Yes.

MS. GINSBERG: Your Honor, I think some of the other orders included would be more akin to what we are talking about. Your Honor also asked about, you know, orders generally and one thing I would note is that in a lot of cases, and certainly in the most recent Rule 34 inspection that I did, there would be no order because oftentimes the parties negotiate these including with staff interviews and confidential prison interviews. Certainly the last time I did this all of that was included in the ultimate Rule 34 notice, but never an order from a court.

THE COURT: The warrant issue --

MR. EICHENHOLTZ: Your Honor?

THE COURT: Yes.

MR. EICHENHOLTZ: If I may quickly, Seth Eichenholz from the Government. I was the discovery officer in the civil division for a long time and I just wanted to weigh in very

briefly on the Touhy issue. Obviously Touhy would not apply to these inspections in state and city facilities the plaintiffs are referring to. I also am not clear whether Touhy would apply in the context of which Ms. von Dornum is referring to where it's outside of litigation.

But within litigation, Touhy regulations apply to documents, information and testimony about those documents. So I do believe that they would apply in this case and I think it's an issue that -- I'm sure Your Honor isn't ruling at this moment about it, but it is an issue that I don't think should be dismissed as easily as I heard from petitioner.

MS. VON DORNUM: Your Honor, I was just going to ask that when I returned with Judge Torres it was under active litigation in *United States versus Winston Perez* and she directly interviewed a number of staff, including the warden, the SHU tenant, the electrician. It was all on the record with a court reporter and there was no Touhy objection lodged -- but there were many, many prosecutors there so that is not to say that one could not be lodged, but she did exactly that and on the record with a court reporter during that litigation.

JUDGE MANN: So, Mr. Eichenholtz, the text that you read -- which I think you're quoting from the regs or paraphrasing it -- was documents, information or testimony about those documents and where is it that you think this

would fall within that group?

MR. EICHENHOLTZ: I believe it would be information. Information because it's not sworn testimony. So it would be providing information about BOP's policies and procedures which, pursuant to the Touhy regs, is not information and not documents, but it was in the possession, custody and control as an individual but rather in the United States and they would be providing that information in the context of their role as an employee of the United States, or in this case the BOP.

It doesn't have to be a complicated process in terms of seeking approval and the regulations I think would tend to allow for approval in certain situations, but you can't just walk up to a BOP staff member. It would be the Government's position that for information we need to know who is going to be approached in advance and the Government would need the opportunity to approve that individual to provide that information.

THE COURT: Well, let me ask petitioners, I think the last question I had to you all in response to the objections that the Government had raised was the issue of the physical scope of the toured facility and I wanted to know if you wanted to respond to that and the women's unit does seem like the place where that argument is especially strong perhaps, although I understand the Government is making a

broader argument.

MS. GINSBERG: On the women's area, I think our concern with the MDC generally is that there are staff moving, staff and other employees, moving around the facility, and just as they cannot unfortunately limit the virus to one place within the facility, we wouldn't want to limit our inspection because clearly what they're doing in other parts of the facility impact where the petitioners are going to be.

That said, we would certainly be open to some narrowing and not going to actually every single housing unit, but, for example, maybe not going to the women's unit and having the opportunity to request certain housing units based on what we understand they're doing in those different housing units.

THE COURT: Judge Mann, do you want to go down any the notice and --

JUDGE MANN: I'm sorry, Judge Kovner, was that addressed to me because you were very indistinct.

The only additional question that I would ask is, apart from the objections that the Government has articulated in its letter and during this proceeding, do you have any specific objections to the proposed expert, Dr. Venters, in terms of his qualifications?

MR. CHO: We may, Your Honor, but we haven't had a chance to fully vet and evaluate his credentials.

THE COURT: Okay. I appreciate you all talking through the discovery issues. I think you all submitted kind of different proposed timing on different events in this case and I wonder if you all have a thought on how to proceed. Do you want us to evaluate and so order a schedule or do you want to meet and confer about it further or how do you propose that we proceed?

MS. GINSBERG: Your Honor, I think our preference would be, given the need for expedited discovery that the Court has acknowledged, that the Court enter a discovery schedule that we don't meet and confer on this and we just move forward with discovery.

MR. CHO: Your Honor, I think it would be productive for us to have additional time to meet and confer with petitioner's counsel. As we have said today, there are a lot of open issues. We're seeking further limitation in terms of their discovery requests. I think it would be more productive for us to have that opportunity to meet and confer like a normal course to kind of hash out some of these issues before coming back to Your Honor for a discovery schedule.

THE COURT: The timing that you all proposed, it seems to have certain dates and then -- I think the third entry on here is respondent provides responsive documents or objections and discovery demands and responses or objections to notice of inspection. So it seems like that schedule was

contemplating that you would already have an additional opportunity to come back.

Well, do you want more time? Because it seems like you are going to have some time built into the schedule for raising objections to the petitioners' discovery demands if you want to under either parties' schedule, so do you want more time even before a schedule is set?

MR. CHO: Well, we set forth our schedule on Friday taking into account anticipated discovery demands from petitioners. Again, I'm trying to streamline discovery here and if we can work out some things I think that's great. But, you know, we set forth our schedule in our letter on Friday so that's our position today but certainly we would be open to trying to resolve some these issues beforehand.

MS. GINSBERG: Your Honor, we appreciate that in the normal course we would take more time to meet and confer and of course we would do that, but I think that where we are right now in this case and in the world is anywhere but normal and we have been really trying to move things along and I think that having a schedule set now that does build in some additional time to have the Court hear objections on discovery issues, allows for whatever the Government might need there, but also allow them to press forward and to take this discovery. And I think my colleague also has something to add there.

MS. ROSENFELD: Yes, I just wanted to let you know that we think it's -- the expedited schedule to be set by the Court is incredibly important. We are happy to confer with counsel once the schedule is set to work on issues as they come up, but we do think a schedule is needed. Just today we received information from people at the facility who reported that there were multiple ambulances at the facility this weekend; that officers are telling symptomatic persons that there are not enough tests, that the fifth floor and the eighth floor are on quarantine with conditions being extremely bad; dirty, garbage not being collected; that there is no soap or toilet paper on Unit 72; that there are serious staff shortages such that the assistant warden was handing out commissary on Unit 72 on Friday; that people were making medical requests for attention that are not being responded to. This is all just information that was trickled down to us today.

So I know that the Court is aware of this, but we feel that it is urgent. There are now four reported positive tests at the MDC as of April 12th and 12 staff members. So we feel that every day that goes by that we're not getting information and moving forward is a lost day.

JUDGE MANN: Would Judge Kovner prefer if I just sign off now so as to not disrupt the rest of the proceedings?

THE COURT: Absolutely not, unless you want to. I'm

fine with the beeping.

JUDGE MANN: All right. Well, again I apologize.

I do have one question and I think this should be one that maybe we can just take it off the checklist and that is, is the Government going to be seeking to serve any discovery demands on petitioners?

That's one of the items that's included in the proposed case management plan containing deadlines.

MR. CHO: Yes, we do intend to serve discovery, Your Honor.

JUDGE MANN: All right. I would just add that, in terms of going forward, there were a number of questions that came up and Mr. Cho indicates that he didn't have the answers and I think it would be very useful to get answers to those questions very quickly because that may determine the scope of the discovery and how much time is needed.

MR. CHO: Understood, Your Honor.

THE COURT: So unless Judge Mann has anything else on this, maybe we should take all of this under advisement at this point.

JUDGE MANN: I don't have anything further. Fortunately, no beeps either. I guess the one non-discovery-related thing that is on my list is the issue of timing for a motion to dismiss and I think the Government proposed a schedule for that.

Government, is that still a schedule you want or is that something that is contingent on -- that you don't want me to order at this point?

MR. CHO: Yes, that's still the schedule that we would like, Your Honor.

JUDGE MANN: Okay.

And Ms. Ginsberg, is that schedule amenable to you?

MS. GINSBERG: Yes, Your Honor, it is.

JUDGE MANN: Okay. So then that's at least one thing I can quickly accomplish.

THE COURT: Anything else from either side?

MS. GINSBERG: No, Your Honor, not from Petitioners.

MR. CHO: And nothing for the Government, Your Honor.

JUDGE MANN: Well, thanks again. I appreciate you all jumping on this call and spending so long and also all of your work over the holiday period.

MS. GINSBERG: Thank you, Your Honor.

MR. CHO: Thank you, Your Honor.

THE COURT: Thank you.

JUDGE MANN: Goodbye.

(Matter adjourned.)

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UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF NEW YORK
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HASSAN CHUNN, *et al.*,

Petitioners,

-against-

Civil Action No.
20-CV-1590
(Kovner, J.) (Mann, M.J.)

WARDEN DEREK EDGE,

Respondent.

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DECLARATION OF ASMA TEKBALI, M.P.H.

In accordance with the provisions of Section 1746 of Title 28, United States Code, I, the undersigned, Asma Tekbali, M.P.H., do hereby make the following declaration, under penalty of perjury, pertinent to the above-styled cause of action:

1. I have reviewed the Petitioners' motion *in limine* filed on May 9, 2010 ("Motion"), in which they seek to preclude my proffered expert testimony on: standards for medical care, the policies and procedures at the Metropolitan Detention Center ("MDC"), and conclusions about actual practice at the MDC. I submit this declaration in response to Petitioners' Motion. Additionally, annexed hereto is my *Curriculum Vitae* (Tekbali 113), which I fully incorporate herein.

2. I serve as an epidemiologist and infection preventionist at Lenox Hill Hospital and Northwell Health ("Northwell").

3. As background, epidemiologists focus primarily on the patterns and statistics of diseases, how infections can be spread, and investigating outbreaks.

4. An infection preventionist is considered to be a hospital epidemiologist. Infection preventionists seek to improve the quality of patient care and maintain the safety of hospital staff. There is a deeper clinical aspect for infection preventionists; we are the authority for physicians and nurses when it comes to isolating patients or performing tests. It is not uncommon for infection preventionists to be involved in clinical care and to engage directly with patients. Furthermore, infection preventionists are heavily involved in nearly every aspect of hospital safety, including food preparation and linen services.

5. Prior to COVID-19 reaching the City of New York, I was involved in Northwell's emergency management plan in anticipation of the pandemic. To date, Northwell is believed to have treated the most COVID-19 patients in the world.

6. I am on the frontlines of COVID-19 at the very epicenter of the pandemic in New York City, and I have current and relevant experience when it comes to the prevention of COVID-19.

7. My colleagues and I in the epidemiology department at Northwell make the final determination on all infection control matters within the hospital. Physicians are required to speak with me for guidance on patient isolation, testing, and safe discharge. My decisions, and the decisions of my colleagues, regarding issues related to epidemiology holds authority over the physician's decision.

8. I consult with and advise a diverse group of departments at Northwell, including food services, linen services, sanitation, and engineering on infection control matters.

9. I have consulted on many patient cases related to homeless shelters, group homes, and nursing homes. Indeed, infection control can be applied and adapted to any setting. My profession calls for the ability to adapt guidance for a facility's unique capabilities.

10. As an infection preventionist, I, among other things, regularly review pertinent records, medical documents, and available statistical analyses of the hospital's infections to reach conclusions. Additionally, I am closely involved in the clinical management of a patient, and often have the opportunity to speak directly to patients alongside their providers. A patient may need guidance on isolation practices, mask usage, or have questions about laboratory testing and request to speak directly with me. My background in microbiology and diagnostic testing provides me with expert knowledge on testing sensitivity, efficacy, and specificity.

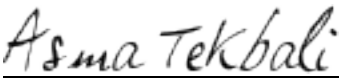
11. Healthcare providers often call me directly to consult on a testing decision based on a patient's symptom presentation. I advise physicians on whether symptoms are consistent with tuberculosis, for example. Furthermore, if a patient does show symptoms consistent with an infectious disease that their provider has not noticed, I am able to look through their medical records and provide a recommendation on isolation and what to test for.

12. I have two peer-reviewed articles accepted for publications in the AMERICAN JOURNAL OF OBSTETRICS & GYNECOLOGY relating to COVID-19. *See* A. Tekbali, *et al*. (2020), "Pregnant versus non-pregnant SARS-CoV-2 and COVID-19 Hospital Admissions: The first 4 weeks in New York" AMERICAN JOURNAL OF OBSTETRICS; and M. Blitz, A. Grünebaum, A. Tekbali (2020), "Intensive Care Unit Admissions for Pregnant and Non-Pregnant Women with COVID-19". AMERICAN JOURNAL OF OBSTETRICS (accepted for publication on May 4, 2020). The AMERICAN JOURNAL OF OBSTETRICS & GYNECOLOGY is ranked second out of 183 obstetrics & gynecology journals, with one of the highest impact factors of 6.120 in 2018-19. It should be noted that Northwell has published more research on COVID-19 than any institution in the world.

13. I believe the documentation provided to me for my review in this matter was sufficient to gain a clear picture on what is occurring at the MDC.

14. I am well-qualified to reach conclusions on how incarcerated individuals should be housed and how their movements should be restricted from an infection control standpoint. In short, I am well-qualified to opine as an epidemiologist and an infection preventionist in this matter.

Executed on this 10th day of May 2020, in New York, New York.



Asma Tekbali