



COVID-19

CDC has updated its guidance for people who are fully vaccinated. See [Recommendations for Fully Vaccinated People](#).

Interim Guidance for SARS-CoV-2 Testing in Correctional and Detention Facilities

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Summary of Recent Changes

Updates as of June 7, 2021

- Streamlined and clarified diagnostic and screening testing for correctional and detention facilities
- Provided considerations for creating a long-term strategy based on community transmission and capacity for testing

Introduction

This document describes SARS-CoV-2 testing strategies for correctional and detention facilities. Testing should be used in conjunction with other COVID-19 prevention strategies covered in [Interim Guidance on Management of Coronavirus Disease 2019 \(COVID-19\) in Correctional and Detention Facilities](#). The purpose and process of the testing should be clearly communicated to incarcerated/detained persons and staff at the correctional or detention facility. Facility administrators should put procedures in place for rapid notification of test results and establish appropriate measures, such as medical isolation, quarantine, cohorting, and facility access restrictions. This guidance does not replace any applicable federal, state, Tribal, local, or territorial health and safety laws, rules, and regulations. CDC will update this guidance as needed and as additional information becomes available.

To understand the guidance that follows, please review:

- [Interim Guidance on Management of Coronavirus Disease 2019 \(COVID-19\) in Correctional and Detention Facilities](#).
- [Categories of tests for SARS-CoV-2](#) for information on NAAT and antigen (or serology) tests.
- [Description of SARS-CoV-2 Testing Scenarios](#) for information on diagnostic testing (for persons with COVID-19 symptoms, known exposure, or recent infection) and screening testing (for persons without known exposure to identify asymptomatic cases).
- Safety procedures for performing [broad-based testing](#) [testing everyone in the affected area(s) of the facility] for SARS-CoV-2 in congregate settings.
- Guidance from the [Equal Employment Opportunity Commission](#) [↗](#) on offering testing to staff.
- [Developing a COVID-19 Case Investigation and Contact Tracing Plan](#).

Considerations when testing

SARS-CoV-2 testing may be incorporated as part of a [comprehensive approach to reducing transmission](#). [Symptom screening](#), [testing](#), and [contact tracing](#) are strategies to identify people infected with SARS-CoV-2 so that actions can be taken to slow and stop the spread of the virus.

At this time, facility employees and incarcerated/detained persons with known or suspected exposure to someone with COVID-19 (including close contacts) should be tested for SARS-CoV-2 regardless of vaccination status. Increasing COVID-19 vaccination rates among facility employees and incarcerated/detained persons is an important step to prevent incarcerated and detained persons and correctional staff from getting sick with COVID-19 disease. COVID-19 vaccines protect more than just an individual's health, they also help minimize the spread of SARS-CoV-2. Work with your local department of health, health providers, and community organizations on effective ways to increase vaccination uptake. For guidance on testing of fully vaccinated people, please visit [Interim Public Health Recommendations for Fully Vaccinated People](#).

People undergoing testing should [receive clear information](#) on

- the manufacturer and name of the test, the type of test, the purpose of the test, the performance specifications of the test, any limitations associated with the test, who will pay for the test, how the test will be performed, how and when they will receive test results, and;
- how to understand what the results mean, actions associated with negative or positive results, the difference between testing for workplace screening versus for medical diagnosis, who will receive the results, how the results may be used, and any consequences for declining to be tested.

Individuals tested are required to receive patient fact sheets as part of the test's [emergency use authorization](#) [↗](#) (EUA).

Test types

Viral Tests

[Viral tests authorized](#) by the Food and Drug Administration (FDA) are used to **diagnose infection** with SARS-CoV-2, the virus that causes COVID-19. Viral tests evaluate whether the virus is present in respiratory or other specimens. Results from these tests help public health officials identify and isolate people who are infected to minimize [SARS-CoV-2 transmission](#). See FDA's list of [In Vitro Diagnostics Emergency Use Authorizations](#) for more information about the performance of specific authorized tests.

- Nucleic acid amplification tests (NAATs), such as real-time reverse transcription-polymerase chain reaction (RT-PCR), detect viral ribonucleic acid (RNA) and indicate a current infection or a recent infection [with prolonged viral RNA detection](#) but without direct evidence for virus capable of replicating or of being transmitted to others. NAATs are high-sensitivity, high-specificity tests for diagnosing SARS-CoV-2 infection. Most NAATs need to be processed in a laboratory with variable time to results (~1–2 days), but some NAATs are point-of-care tests with results available in about 15–45 minutes.
- Antigen tests detect the presence of a specific viral antigen. Most can be processed at the point of care with results available in about 15–30 minutes. Antigen tests generally have similar specificity but are less sensitive than NAATs. Depending on the pre-test probability, antigen test results may need confirmation with a NAAT (e.g., a negative test in persons with symptoms or a positive test in persons without symptoms). Use of the [Antigen Testing Algorithm](#) [147 KB, 1 page] is **recommended** to determine when confirmatory testing is needed.

Antibody Tests

[Antibody \(or serology\) tests](#) are used to detect previous infection with SARS-CoV-2 and can aid in the diagnosis of [Multisystem Inflammatory Syndrome in Children \(MIS-C\)](#) and in [adults \(MIS-A\)](#). CDC does not recommend using antibody testing to diagnose current infection. Depending on the time when someone was infected and the timing of the test, the test might not detect antibodies in someone with a current infection. In addition, it is not currently known whether a positive antibody test result indicates immunity against SARS-CoV-2; therefore, at this time, antibody tests should not be used to determine if an individual is immune against reinfection. Antibody testing is being used for public health surveillance and epidemiologic purposes. Because antibody tests can have different targets on the virus, specific tests might be needed to assess for antibodies originating from past infection versus those from vaccination. For more information about COVID-19 vaccines and antibody test results, refer to [Interim Clinical Considerations for Use of mRNA COVID-19 Vaccines Currently Authorized in the United States](#).

For more information, please refer to [Overview of Testing for SARS-CoV-2](#).

Overview of testing scenarios

Diagnostic tests are intended to identify current infection in individuals and is performed when a person has signs or symptoms consistent with COVID-19, or when a person is asymptomatic but has recent known or suspected exposure to SARS-CoV-2.

Examples of diagnostic testing include:

- Testing people who have symptoms consistent with COVID-19 and who present to their healthcare provider
- Testing people as a result of contact tracing efforts
- Testing people who indicate that they were exposed to someone with a confirmed or suspected case of COVID-19
- Testing people who attended an event where another attendee was later confirmed to have COVID-19

Screening tests are intended to identify infected people who are asymptomatic and do not have known, suspected, or reported exposure to SARS-CoV-2. Screening helps to identify unknown cases so that measures can be taken to prevent further transmission.

Examples of screening include:

- Testing employees in a workplace setting
- Testing students, faculty, and staff in a school or university setting
- Testing a person before or after travel
- Testing at home for someone who does not have symptoms associated with COVID-19 and no known exposures to someone with COVID-19

Choosing a test

When choosing which test to use, it is important to understand the purpose of the testing (e.g., diagnostic, screening), analytic performance of the test within the context of the level of community transmission, need for rapid results, and other considerations. Table 1 summarizes some characteristics of NAATs and antigen tests to consider. Most antigen tests that have received [EUA from FDA](#) are authorized for testing symptomatic persons within the first 5, 7, 12, or 14 days of symptom onset. Given the risk of transmission of SARS-CoV-2 from asymptomatic and presymptomatic persons with SARS-CoV-2 infection, [use of antigen tests](#) in asymptomatic and presymptomatic persons can be considered. FDA has provided a list of [FAQ for healthcare providers who are using diagnostic tests in screening asymptomatic individuals](#), and the Centers for Medicare & Medicaid Services will [temporarily exercise enforcement discretion](#) [40 KB, 1 Page] to enable the use of antigen tests in asymptomatic individuals for the duration of the COVID-19 public health emergency under the Clinical Laboratory Improvement Amendments of 1988 (CLIA). Laboratories that perform screening or diagnostic testing for SARS-CoV-2 must have a CLIA certificate and meet regulatory requirements. Tests that have received an EUA from FDA for point of care (POC) use can be performed with a [CLIA certificate of waiver](#).

Table 1. NAAT and Antigen Test Differences to Consider When Planning for Diagnostic or Screening Use

	NAATs	Antigen Tests
Intended Use	Detect <i>current</i> infection*	Detect <i>current</i> infection
Analyte Detected	Viral Ribonucleic Acid (RNA)	Viral Antigens
Specimen Type(s)	Nasal, Nasopharyngeal, Oropharyngeal, Sputum, Saliva	Nasal, Nasopharyngeal
Sensitivity	Varies by test, but generally high for laboratory-based tests and moderate-high for POC tests	Varies depending on the course of infection, but generally moderate-to-high at times of peak viral load*
Specificity	High	High
Test Complexity	Varies by Test	Relatively Easy to Use
Authorized for Use at the Point-of-Care	Most are not, some are	Most are, some are not
Turnaround Time	Most 1-3 days. Some could be rapid in 15 minutes	Ranges from 15 minutes to 30 minutes
Cost/Test[§]	Moderate (~\$75-\$100/test)	Low (~\$5-\$50/test)
Advantages	<p>Most sensitive test method available</p> <p>Short turnaround time for NAAT POC tests, but few available</p> <p>Usually does not need to be repeated to confirm results</p>	<p>Short turnaround time (approximately 15 minutes)</p> <p>When performed at or near POC, allows for rapid identification of infected people, thus preventing further virus transmission in the community, workplace, etc.</p> <p>Comparable performance to NAATs in symptomatic persons and/or if culturable virus present, when the person is presumed to be infectious</p>

Disadvantages

Longer turnaround time for lab-based tests (1–3 days)

May need [confirmatory testing](#)

Higher cost per test

Less sensitive (more false negative results) compared to NAATs, especially among asymptomatic people

A positive NAAT diagnostic test should not be repeated within 90 days, since people may continue to have detectable RNA after risk of transmission has passed

*The decreased sensitivity of antigen tests might be offset if the point-of-care antigen tests are repeated more frequently (i.e., serial testing at least weekly).

[§]Costs for: [NAATs](#), [Antibody tests](#)

Considerations for Different Testing Scenarios

Diagnostic testing

Testing persons with signs or symptoms consistent with COVID-19, regardless of vaccination status

- **Incarcerated/detained persons with symptoms**, regardless of COVID-19 vaccination status, should be given a [mask](#) (if not already wearing one and [if it can be worn safely](#)), moved to [medical isolation](#) in a separate environment from other individuals, [medically evaluated](#), and tested. Facility staff should carefully evaluate and support the mental health needs of individuals before and during medical isolation. If incarcerated/detained persons receive a positive test result for SARS-CoV-2, they should remain in medical isolation until they meet the [criteria for discontinuing isolation](#), but may be moved to a cohort with other people who have confirmed COVID-19, if needed. If a case is identified in an open dorm-style housing unit, all persons living in the same unit should be considered exposed. A single new case of SARS-CoV-2 infection in any correctional and detention center staff or incarcerated/detained person should be considered an outbreak. If an outbreak is occurring, facilities should also perform [daily symptom and temperature screening](#) for all incarcerated/detained persons who have been exposed to someone with confirmed or suspected COVID-19 until it has been at least 14 days since the last positive test. However, if someone tests positive at intake but has not had close contact with other members of the facility's population and is immediately placed in medical isolation, this infection could be considered an isolated case rather than a part of a larger outbreak.
- **Staff with symptoms**, regardless of COVID-19 vaccination status, should be excluded from work and tested. If the test result is positive, staff should [isolate at home](#) and follow CDC [guidance for caring for oneself](#). [Flexible sick leave and supportive policies](#) can reduce transmission among employees. Correctional facility administrators should establish [daily symptom and temperature screening](#) to identify staff with signs or symptoms consistent with COVID-19 and exclude them from entry. Symptom screenings cannot identify persons with COVID-19 who may be [asymptomatic or pre-symptomatic](#), and therefore will not prevent all persons with COVID-19 from entering the facility.

- A negative antigen test in staff or incarcerated/detained persons with signs or symptoms of COVID-19 should be confirmed using a NAAT test. If the NAAT is positive, the individual can be medically isolated with other people with confirmed COVID-19. Use of the [Antigen Testing Algorithm](#) is recommended for [confirmatory](#) testing. A negative antigen result for a symptomatic person may not need confirmatory testing if the person has a low likelihood of SARS-CoV-2 infection. For example, a low likelihood of SARS-CoV-2 infection would be a person who has not had a known or suspected exposure to a person with COVID-19 within the last 14 days or is fully vaccinated or has had a SARS-CoV-2 infection in the last 3 months.
- **Visitors with symptoms**, regardless of COVID-19 vaccination status, should be denied entry and encouraged to seek testing through their healthcare provider or local health department. Correctional facility administrators should establish [daily symptom and temperature screening](#) to identify visitors with signs or symptoms consistent with COVID-19 and exclude them from entry. Symptom screenings cannot identify persons with COVID-19 who may be [asymptomatic or pre-symptomatic](#), and therefore will not prevent all persons with COVID-19 from entering the facility.

Testing asymptomatic persons with recent known or suspected exposure to SARS-CoV-2

Because of the potential for [asymptomatic and pre-symptomatic transmission](#), [close contacts](#) (people who have been within 6 feet of persons with COVID-19 for a combined total of 15 minutes or more during a 24-hour period) should be tested **regardless of their COVID-19 vaccination status**. However, in correctional and detention facilities, contact tracing to identify each individual close contact can be difficult. Therefore, persons considered to be close contacts may include all persons defined by a particular setting (such as all incarcerated/detained persons and staff assigned to a dormitory or unit). Please refer to [Recommendations for Quarantine Duration in Correctional and Detention Facilities](#) for information about quarantine for people with known or suspected exposure to SARS-CoV-2 in correctional facilities.

- **Initial tests:** All persons with known or suspected exposure to someone with COVID-19, regardless of their COVID-19 vaccination status, should receive an initial rapid point-of-care test as soon as possible after they have been identified. Refer to the [Antigen Testing Algorithm](#) for further guidance on follow-up testing after the initial test.
- **Broad-based testing when contact tracing is challenging:** In settings where contact tracing is difficult, such as in a large dormitory, facilities should conduct [broad-based testing](#) which involves testing everyone in the affected area(s) of the facility, regardless of their COVID-19 vaccination status. For details on performing testing for large numbers of individuals, review CDC guidance on [Performing Broad-Based Testing for SARS-CoV-2 in Congregate Settings](#).
 - The scope of broad-based testing should be based on the extent of movement (of staff and incarcerated/detained persons) between parts of the facility with and without cases. Examples of broad-based testing strategies include:
 - Testing all persons in a single housing unit where someone has tested positive, if there has not been movement to or contact with other areas of the facility through staff or incarcerated/detained persons (i.e., incarcerated/detained persons have not left the housing unit and staff work exclusively in that housing unit and nowhere else in the facility).
 - Testing all persons in an entire building or complex when cases have been identified in multiple parts of the building or complex, or if there has been movement between parts of the building or complex with and without cases.
 - Note that if someone tests positive at intake but has not had close contact with other members of the facility's

population and is immediately placed in medical isolation, this person's positive test would not trigger broad-based testing and could be considered an isolated case rather than a part of a larger outbreak.

- The group identified for broad-based testing can then be quarantined as a cohort, described further below.
 - Facility administrators should consider including staff in [broad-based testing efforts](#), regardless of vaccination status. Including staff in broad-based testing programs will help ensure that any COVID-19 cases are identified quickly, and transmission can be slowed. If it is not feasible to test staff at the facility, facilities should work with community partners or state/local health departments to implement staff testing.
 - Facilities should make plans for how they will modify their operations based on test results. Given the potential for rapid transmission and high numbers of infections, ensure that plans include medical isolation options to house large numbers of infected persons and quarantine options to house large numbers of close contacts. For example, consider how the facility's housing operations could be modified for multiple test result scenarios (e.g., if testing reveals that 10%, 30%, 50%, or more of a facility's population is infected with SARS-CoV-2).
- **Serial re-testing of a quarantined cohort:** If [quarantine cohorts](#) are used (i.e., if people who are exposed are quarantined together rather than individually due to space constraints), facilities should conduct serial re-testing of the quarantined cohort.
 - Facilities should re-test people quarantined as a cohort every 3–7 days regardless of their COVID-19 vaccination status until testing identifies no new cases in the cohort for 14 days since the most recent positive result. Staff who are exposed should quarantine at home if possible, but those who must continue to work should be tested every 3–7 days. The testing interval should be based on the stage of an ongoing outbreak (testing every three days can allow for faster outbreak control in the context of an escalating outbreak; testing every 5-7 days is sufficient when transmission has slowed).
 - Anyone testing positive should be removed from the cohort, placed in medical isolation, and the 14-day quarantine period should re-start for the remainder of the cohort.
 - If any person in the quarantine cohort develops symptoms, refer to the section titled "[Testing persons with signs or symptoms consistent with COVID-19, regardless of vaccination status](#)" above.
 - **Testing in the context of a confirmed prior diagnosis of SARS-CoV-2:** Testing asymptomatic persons who have recovered from SARS-CoV-2 infection during the 3-month period after their initial positive test is complicated by the fact that some people have detectable viral fragments from their prior infection; a positive test result during this period may reflect a prior infection rather than a new infection that poses risk for transmission. Facility administrators should consult their jurisdiction's [health department](#) to determine the best testing strategy for this population given current local factors such as viral variants. People who have recovered from SARS-CoV-2 infection within the past 90 days and have been re-exposed to SARS-CoV-2 should receive regular temperature and symptom screening checks. If a person develops new symptoms during the 90-day period after their initial infection and an evaluation fails to identify a diagnosis other than SARS-CoV-2 infection (e.g., influenza), then the person likely warrants evaluation for SARS-CoV-2 reinfection in consultation with an infectious disease or infection control expert. Medical isolation might be warranted before and during this evaluation, particularly if symptoms developed after close contact with an infected person or in association with an outbreak setting. If more than 90 days have passed since a prior SARS-CoV-2 infection, testing should proceed as it would for someone who had not previously been diagnosed with SAR-CoV-2.

Testing to determine resolution of infection

Adults with more severe illness or who are immunocompromised may remain infectious up to 20 days or longer after symptom onset, so a test-based strategy could be considered in consultation with infectious disease experts for these people. For all others, a test-based strategy is no longer recommended except to discontinue isolation or precautions earlier than would occur under the symptom-based strategy.

Screening testing

Viral testing of persons without symptoms or known or suspected exposure to SARS-CoV-2 is known as screening testing. Screening testing among people who are not fully vaccinated is a key tool in preventing SARS-CoV-2 transmission among staff and people living in correctional facilities. Screening testing allows early identification and isolation of persons who are [asymptomatic or pre-symptomatic](#), or have only mild symptoms and who may be unknowingly transmitting the virus. Screening testing, in conjunction with [symptom](#) screening, can be valuable in correctional and detention facilities because it can detect COVID-19 early and help stop transmission quickly, particularly in areas with moderate to high community transmission of COVID-19. NAATs, antigen tests, or both can be used (see [Choosing a test](#) above). Vaccinated incarcerated/detained persons and staff, and persons who have recovered from SARS-CoV-2 infection during the 3-month period after their initial positive test can be exempted from screening testing if feasible.

Movement-based screening testing

Movement-based screening is a selective screening approach which involves screening people at intake, before transfer to another facility, and before visits or release into the community. Facilities should implement movement-based screening testing to prevent the introduction of the virus into the facility and to prevent transmission to another facility or into the community. Vaccinated incarcerated/detained persons and staff, and persons who have recovered from SARS-CoV-2 infection during the 3-month period after their initial positive test can be exempted from movement-based screening testing if feasible. However, jurisdictions may choose to continue movement-based screening testing even for fully vaccinated incarcerated/detained persons in the event of an outbreak in the facility or a high community transmission level (see Table 1). Screening testing based on movement should include testing for incarcerated/detained persons in the following scenarios:

- **At intake.** Test incoming incarcerated/detained persons, including those returning after more than 24 hours away from the facility, and house them individually (when feasible) while waiting for test results. For persons who are not fully vaccinated, testing can be combined with a 14-day observation period (sometimes referred to as “routine intake quarantine”) before persons are assigned housing with the rest of the facility’s population. In this case, individuals should be quarantined separately from those with confirmed or suspected COVID-19. If incoming incarcerated/detained persons undergo intake quarantine, consider re-testing every 3-7 days.
- **Before transfer to another facility.** Test incarcerated/detained persons before transfer to another correctional/detention facility. Wait for a negative test result before transfer. For persons who are not fully vaccinated, testing before transfer can be combined with a 14-day observation period (sometimes referred to as “routine transfer quarantine”) before an individual’s projected transfer. In this case, individuals should be quarantined separately from those with confirmed or suspected COVID-19. Ideally, testing and a 14-day quarantine would occur at the originating facility before transfer and again at the destination facility at intake; at a minimum it should occur at one facility or the other. Refer to [Interim Guidance on Management of Coronavirus Disease 2019 \(COVID-19\) in Correctional and Detention Facilities](#) for more information about transfer and release recommendations.
- **Before visits or release into the community.** Test incarcerated/detained persons leaving the facility as close to

the day of the visit (e.g., medical trips, court appearances, community programs) or release (whether into the community or to a halfway house or other transitional location) as possible (no more than 3 days prior). This is particularly important if they will be released to other congregate settings (e.g., homeless shelters, group homes, or halfway houses) or to households with persons who are at [higher risk of severe illness from COVID-19](#). For persons who are not fully vaccinated, testing before release can be combined with a 14-day observation period (sometimes referred to as “routine release quarantine”), ideally in single cells, before a person’s release date. Notify public health authorities for assistance arranging medical isolation upon release for people who receive a positive test result. This practice can reduce the risk of transmission from the facility to the community.

Routine screening testing

Routine screening testing can increase the likelihood of early case identification to prevent widespread transmission. Facilities should consider implementing routine screening testing among all incarcerated/detained persons and staff who are not fully vaccinated or among a select group according to criteria it designates. If it is not feasible to test staff at the facility, facilities should investigate options to work with community partners or state/local health departments to implement staff testing. Vaccinated incarcerated/detained persons and staff, and persons who have recovered from SARS-CoV-2 infection during the 3-month period after their initial positive test can be exempted from routine screening testing if feasible.

Data on facility and [community transmission level](#) and testing capacity can guide decisions about routine screening testing strategies. Routine screening testing for staff and incarcerated/detained persons who are not fully vaccinated should be conducted at least weekly when community transmission is substantial or high (Table 1). The community transmission indicators below can be found for your county on CDC’s [COVID Data Tracker Website](#).

Table 2. Community Indicators at the County Level[@]

Indicator	Low	Moderate	Substantial	High
Cumulative number of new cases per 100,000 persons within the last 7 days*	<10	10-49	50-99	≥100
Percentage of NAATs^a that were positive during the last 7 days†	<5%	5.0%-7.9%	8.0%-9.9%	≥10%

[@] If the two indicators suggest different transmission levels, the higher level should be selected.

* Number of new cases in the county (or other administrative level) in the last 7 days divided by the population in the county (or other administrative level) and multiplying by 100,000.

^a Nucleic acid amplification tests

† Number of positive tests in the county (or other administrative level) during the last 7 days divided by the total number of tests resulted in the county (or other administrative level) during the last 7 days. [Calculating Severe Acute Respiratory Syndrome Coronavirus 2 \(SARS-CoV-2\) Laboratory Test Percent Positivity: CDC Methods and Considerations for Comparisons and Interpretation](#)

If routine screening testing is conducted only among a subset of individuals or facilities within a correctional system, the following factors can guide the selection of the subset:

Cases or outbreaks in the facility within the past month	Incarcerated/detained persons and staff who are: <ul style="list-style-type: none"> • Not fully vaccinated* • At higher risk of severe illness from COVID-19**
Dormitory-based housing units where physical/social distancing is especially difficult	Incarcerated/detained person assigned to critical on-site work details within the facility that require them to leave their housing unit (e.g., food service, laundry)
In-person visiting	Incarcerated/detained persons participating in: <ul style="list-style-type: none"> • work release programs • off-site medical visits • or court appearances
Community movement (e.g., off-site medical visits, work release, or court appearances)	Staff working in: <ul style="list-style-type: none"> • A facility designated for medical care (e.g., medical facility, long-term care or skilled nursing facility) • Multiple areas of the facility • Multiple congregate facilities (e.g., more than one correctional/detention facility, homeless shelters, group homes, or schools)
Frequent admissions of newly incarcerated/detained persons or those transferring in from other facilities	Staff who live or spend time with other staff who work in other areas of the facility (e.g., family or household members, carpools)
Units within correctional/detention facilities housing	Staff who are newly hired or who are returning from a

incarcerated/detained **populations at higher risk of severe illness from COVID-19**

prolonged absence^{***}

* Fully vaccinated means 2 weeks after receipt of second dose in a 2-dose series, such as the Pfizer or Moderna vaccines, or 2 weeks after a single-dose vaccine, such as Johnson & Johnson's Janssen vaccine

**Includes individuals with [medical conditions that increase or may increase risk of severe COVID-19](#). Identifying infections early can help ensure timely medical attention to prevent severe outcomes.

***If routine screening testing is occurring in the facility, consider testing staff who are newly hired and those returning from a prolonged absence before they begin/resume their duties.

Previous Updates

Updates from Previous Content



March 17, 2021

- Frequent testing for Severe Acute Respiratory Coronavirus-2 (SARS-CoV-2) is an important prevention measure in correctional and detention facilities.
- Diagnostic testing of persons with COVID-19 symptoms and persons with known or suspected exposure (including close contacts) plus screening testing are essential to stop the spread of COVID-19.
- Testing considerations specific to correctional and detention facilities include, for example, screening testing to identify asymptomatic individuals based on incarcerated/detained persons and staff movements between facilities and the community, as well as facility- and individual-level factors.

October 21, 2020:

- Added links to the updated close contact definition.
- Updated language to align with updated definition.

August 10, 2020:

- Accumulating evidence supports ending isolation and precautions for persons with COVID-19 using a symptom-based strategy. This update incorporates recent evidence to inform the duration of isolation and precautions recommended to prevent transmission of SARS-CoV-2 to others, while limiting unnecessary prolonged isolation and unnecessary use of laboratory testing resources.

Content source: [National Center for Immunization and Respiratory Diseases \(NCIRD\), Division of Viral Diseases](#)