Centers for Disease Control and Prevention

COVID-19

Interim Guidance on Management of Coronavirus Disease 2019 (COVID-19) in Correctional and Detention Facilities

Updated Feb. 15, 2022

Summary of Recent Changes

Updates as of February 10, 2022

- Consolidated the following three guidance documents that were previously posted on the CDC COVID-19 Corrections webpage: Interim Guidance on Management of Coronavirus Disease 2019 (COVID-19) in Correctional and Detention Facilities; Interim Guidance for SARS-CoV-2 Testing in Correctional and Detention Facilities; and Recommendations for Quarantine Duration in Correctional and Detention Facilities.
- Reduced quarantine duration during routine operations from 14 days to 10 days.
- Added recommendations on isolation and quarantine duration for staff and residents in correctional and detention facilities during crisis-level operations.
- Added description of the use of medication for prevention of severe COVID-19 disease.
- Updated language on vaccination status to include booster doses and additional doses for people who are eligible for them. (Removed references to “fully vaccinated” to refer instead to being “up to date on COVID-19 vaccines.”)
- Updated recommendations on use of personal protective equipment (PPE), masks, and respirators for correctional residents and staff (Table 1).

View Previous Updates

This document provides guidance specific for correctional and detention facilities regarding coronavirus disease 2019 (COVID-19) and consolidates previous CDC corrections-specific guidance documents. This guidance is based on what is currently known about the transmission and severity of COVID-19 as of February 10, 2022.

The U.S. Centers for Disease Control and Prevention (CDC) will update this guidance as needed and as additional information becomes available. Please check the CDC website periodically for updated guidance.

Intended Audience

This document is intended to provide guiding principles for healthcare and non-healthcare administrators of correctional and detention facilities for adults and juveniles to assist in preparing for potential introduction, spread, and mitigation of SARS-CoV-2 (the virus that causes COVID-19) in their facilities. (Visit the CDC website for healthcare workers for more information pertinent to healthcare staff specifically.) These facilities include but are not limited to federal and state prisons; local jails; detention centers; law enforcement agencies that have custodial authority for persons who are detained (i.e., U.S. Immigration and Customs Enforcement, U.S. Customs and Border Protection, and U.S. Marshals Service); and their respective

community-based departments of health. Some of these facilities and agencies might adapt CDC guidance for correctional and detention facilities based on their specific populations or operational needs. This guidance will not necessarily address every possible custodial setting and may not use legal terminology specific to individual agencies' authorities or processes. This guidance does not replace any applicable federal, state, tribal, local, or territorial health and safety laws, rules, and regulations.

For the purpose of this document, "incarcerated/detained persons" or "residents" refers to persons held in a prison, jail, detention center, or other custodial setting. The term includes those who have been sentenced as well as those held for pre-trial or civil purposes.

"Staff" refers to the group of all public or private sector employees (e.g., contracted healthcare or food service workers) working within a correctional or detention facility. "Staff" does not distinguish between healthcare, custody, and other types of staff members, nor between government and private employers.

"Congregate settings" refers to a setting in which a group of usually unrelated persons reside for an extended period of time in close physical proximity. Congregate settings, including correctional and detention facilities, are characterized by a diverse and varying set of factors that can increase risk and affect exposure to and transmission of COVID-19.

Refer to CDC guidance on the definition of staying "up to date" on COVID-19 vaccines. This definition is subject to change over time based on updates to CDC vaccination guidance.

This guidance should be adapted based on an individual facility's physical space, staffing, population, operations, history of SARS-CoV-2 outbreaks, community factors, and other resources and conditions. Facilities should contact CDC (eocevent366@cdc.gov) or their state, tribal, local, and/or territorial public health department if they need assistance in applying these principles or addressing topics that are not specifically covered in this guidance.

Guidance Overview

The guidance below includes detailed recommendations on the following topics related to COVID-19 in correctional and detention settings:

1. Strategies for applying and sustaining COVID-19 prevention measures in correctional and detention facilities based on local data

To develop a long-term COVID-19 prevention plan, facilities should weigh the logistical and mental health challenges related to prolonged, intensive mitigation measures against the risks associated with transmission of SARS-CoV-2. To help provide considerations for this decision-making, this section includes:

- Prevention measures to keep in place at all times
- Metrics to guide modification of COVID-19 prevention measures at the facility level, using data on local trends and facility characteristics

Prevention measures to keep in place at all times

Facilities should maintain, at all times, the following aspects of standard infection control, monitoring, and capacity to respond to cases of COVID-19:

- **Provide COVID-19 vaccination, including boosters:** Continue to provide and encourage up to date COVID-19 vaccination for staff members and residents (including additional doses for people who are immunocompromised and others who are eligible for them, and boosters). (See Vaccination section below).
- **Maintain standard infection control:** Maintain optimized ventilation, handwashing, proper mask wearing, and cleaning and disinfection for standard prevention of infectious diseases, including COVID-19. For details, see the section below on Infection Prevention and Control and CDC's site on Safe and Proper Use of Disinfectants to Reduce Viral Surface Contamination in Correctional Facilities.
- **Maintain SARS-CoV-2 testing strategies:** Maintaining a robust testing program (including both diagnostic and screening testing) can help prevent or reduce transmission in congregate settings and provide critical data for ongoing assessment. Maintain the testing strategies below to the maximum extent possible based on facility resources and supplies.
  - **Diagnostic testing** should be performed for anyone who shows signs or symptoms of COVID-19 and for anyone who has been potentially exposed or identified as a close contact of someone with COVID-19, regardless of COVID-19 vaccination and booster status. See testing section below for details.
  - **Routine screening testing** should be performed for all residents at intake and before transfer and release, regardless of COVID-19 vaccination and booster status. See section below on Testing Considerations for SARS-CoV-2 for more information about testing strategies, including options for designing a screening testing program based on the unique features of a particular facility and its population.
- **Prevent COVID-19 introduction from the community:** Regardless of their vaccination and booster status, exclude staff members from work if they have symptoms of COVID-19, test positive for SARS-CoV-2, or have been potentially exposed or identified as a close contact of someone with COVID-19. See sections below on quarantine and isolation duration for staff during routine vs. crisis operations.
- **Prepare for outbreaks:** Monitor community data to be prepared for an outbreak and maintain the ability to effectively communicate to staff members and residents about what to expect if an outbreak occurs. Maintain the ability to respond quickly to an outbreak, including the ability to scale up medical isolation and quarantine.

The response to COVID-19 in correctional and detention facilities should consider the broader mental health impacts for residents and staff, both for those with and without pre-existing mental illness. Some COVID-19 prevention measures, such as prolonged quarantine periods, repeated isolation, and restrictions on visitation and programming, are known to lead to negative impacts on mental health and well-being.

Applying or modifying COVID-19 prevention measures at the facility level using data on local trends and facility characteristics

As epidemiologic trends shift due to new variants and other factors, administrators may consider strengthening or relaxing COVID-19 prevention measures for individual facilities based on the five primary metrics listed below. No single metric should be used alone in decision-making. Consult with local public health partners in decision-making about modifying prevention measures, especially for facilities without internal public health or infectious disease experts. Any relaxing of prevention measures should be conducted in a stepwise fashion, one prevention measure at a time, with continued diagnostic testing and screening in place to carefully monitor for cases of COVID-19 in the facility before making changes to additional prevention measures. Communicate clearly with staff and residents about any changes made to procedures.

- **Vaccination coverage:** Determine the proportion of staff and residents who are up to date on their COVID-19 vaccines. COVID-19 vaccines are highly effective in preventing severe illness, hospitalization, and death from COVID-19. Although not enough information is available to determine a specific level of vaccination coverage needed to modify facility-level prevention measures, maximizing up to date COVID-19 vaccination coverage is critical to protect staff members and residents.

- **Transmission in the facility:** Evaluate the current and historical level of COVID-19 transmission within the facility.

  Facility-level prevention measures should not be lifted when transmission is occurring within the facility. Because of the risk of unrecognized infection, a single new case of SARS-CoV-2 infection in a staff member or resident in a correctional

or detention facility should be evaluated as a potential outbreak. (However, if a resident 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 result could be considered an isolated case rather than transmission in the facility.)If historical transmission levels in the facility have been high or if outbreak response has been difficult, maintain COVID-19 prevention measures for a longer duration.

- **Transmission in the community:** Monitor the level of COVID-19 transmission in the surrounding community.

  Consider the community where the facility is located as well as the communities from which residents originate and where staff members live. County-level transmission indicators can be found on CDC's COVID Data Tracker website. Maintain prevention measures when community transmission levels are higher, since introduction of the virus into the facility is more likely during those times.

- **Demographic and health-related characteristics:** Determine the proportions of the facility's residents and staff who are at increased risk for severe COVID-19 illness. Consider the potential impact of prolonged mitigation measures on mental health.

  Maintain facility-level prevention measures for longer durations in facilities with high proportions of people at increased risk for severe illness.

- **Facility structural and operational characteristics**: Assess how facility characteristics and operational protocols can contribute to SARS-CoV-2 spread within the facility.

  Maintain COVID-19 prevention measures for longer durations in facilities where the layout (e.g., dorm/open barracks vs. individual cells), ventilation, or movement patterns inhibit physical distancing or the frequency of air exchange, and where staff members work across multiple units that otherwise have no shared close contacts.

2. Communication

Administrators maintain preparation for COVID-19 by ensuring that all persons in the facility know the symptoms of COVID-19 and the importance of reporting those symptoms if they develop. They should ensure that materials are easy to understand by non-English speakers, those with low literacy, and people with disabilities. Other essential actions are detailed below.

Develop information-sharing systems with external partners.

- Public health partners
  - Identify points of contact in relevant state, local, tribal, and territorial public health departments. Actively engage with the health department to understand in advance which entity has jurisdiction to implement public health control measures for COVID-19 in a particular correctional or detention facility.
  - Notify and coordinate with the public health department when a person has suspected or confirmed COVID-19. Request any necessary assistance.
  - Stay informed about updates to CDC guidance via the CDC COVID-19 website as more information becomes known.
- Correctional partners
  - Communicate with other correctional facilities to share information including the number of cases and deaths (e.g., disease surveillance) and absenteeism patterns among the staff.
  - Where possible, put plans in place to restrict transfers of residents between facilities during their quarantine or isolation period, unless released from custody or a transfer is necessary for medical care, infection control, lack of quarantine/isolation space, or extenuating correctional, judicial, or security concerns.

Encourage all persons in the facility to take actions to protect themselves and others from COVID-19, including staying up to date on their COVID-19 vaccines, wearing well-fitting masks or respirators indoors, practicing physical distancing as much as possible, and maintaining good hand hygiene.

- Provide residents and staff with up-to-date information about COVID-19 and changes to facility policies on a regular basis.

- Train staff on the facility's COVID-19 plan.
- Address concerns related to reporting symptoms (e.g., being sent to medical isolation), and explain that quarantine and medical isolation are not the same as disciplinary solitary confinement. In addition, ensure that medical isolation and quarantine are truly operationally distinct from disciplinary solitary confinement (see section on Medical Isolation and Quarantine).
- Post signs throughout the facility about ways staff and residents can protect themselves and others from COVID-19. Example signage and other communications materials are available on the CDC website.
- Ensure that the pandemic plan addresses staff safety and potential staffing shortages.
  - Identify duties that can be performed remotely. Where possible, allowing staff to work from home can be an effective physical distancing strategy to reduce the risk of SARS-CoV-2 infection during an outbreak.
  - Consider offering revised duties to staff members who are at increased risk for severe COVID-19 illness. Review the sick leave policies of each employer that operates within the facility. Employers are encouraged to implement flexible, non-punitive paid sick leave and supportive policies and practices as part of a comprehensive approach to prevent and reduce transmission among employees and to prevent introduction into the resident population.
  - Plan for absences. Staff members should stay home when they are sick, or they may need to stay home to care for a sick household member or care for children in the event of school and childcare dismissals. Identify critical job functions and plan for alternative coverage. Consider increasing keep on person (KOP) medication orders in case of healthcare staff shortages.

3. Vaccination

Increasing COVID-19 vaccination rates and ensuring that staff and residents stay up to date on their COVID-19 vaccines is the most important tool available to prevent correctional staff and residents from getting sick with COVID-19. Currently authorized or approved vaccines in the United States are highly effective in protecting against severe illness, hospitalization, and death. For more information on vaccine effectiveness, visit Ensuring COVID-19 Vaccines Work.

COVID-19 and other vaccines, including influenza vaccines, may be co-administered at the same time. See the Interim Guidance for Routine and Influenza Immunization Services During the COVID-19 Pandemic for additional considerations for influenza vaccination of persons in congregate-settings during the COVID-19 pandemic.

Correctional and detention facilities should:

- Ensure that vaccines and boosters are available for all staff and residents in order to stay up to date.
- Promote COVID-19 vaccination by educating the staff and residents on the effectiveness, safety, and importance of vaccines; consider recruiting residents who received the vaccine to be peer supporters to encourage other residents to get the vaccine and recruiting staff peers to encourage staff vaccination.
- Work with local health departments, healthcare providers, and community organizations on effective ways to increase vaccination uptake, informed by input from residents about why they may not wish to receive the vaccine.

Additional vaccine resources:

- Stay Up to Date with Your Vaccines
- COVID-19 vaccine communications resources available to print specifically for correctional facilities: Print Resources
- Building Confidence in COVID-19 Vaccines
- COVID-19 Vaccine Information for Specific Groups
- Ensuring the Safety of COVID-19 Vaccines in the United States
- COVID-19 Vaccine Booster Shot
- COVID-19 Vaccine Communication Toolkit
- Frequently asked Questions about the COVID-19 Vaccine
- COVID-19 Rapid Community Assessment Guide

4. Infection prevention and control

For more Infection Prevention Control information for healthcare workers, see CDC's Infection Control Guidance for Healthcare Professions about Coronavirus (COVID-19).

Hand hygiene

- All staff members and residents should use everyday preventive actions including regularly washing their hands, avoiding touching their eyes, nose, and mouth, and covering their cough.
- Facilities should ensure that staff members and residents have adequate access to hand hygiene materials at no cost. These materials should include soap, water, and clean towels or alcohol-based hand sanitizer with at least 60% alcohol.

Cleaning and disinfection

- Facilities should adhere to CDC recommendations for cleaning and disinfection during the COVID-19 response.
- Facilities should have a plan in place to restock supplies as needed during a COVID-19 outbreak.

Physical distancing

- Physical distancing is the practice of increasing the space between individuals and decreasing frequency of contact to reduce the risk of spreading a disease (ideally maintaining at least 6 feet between all people, even those who do not have symptoms). Physical distancing strategies can be applied on an individual level (e.g., avoiding physical contact), a group level (e.g., canceling group activities where people would be in close contact), and an operational level (e.g., rearranging chairs in the dining hall to increase distance between them or using protective barriers if space is limited).
- Make a list of possible physical distancing strategies that could be implemented as needed at different stages of transmission intensity. When distancing is not possible, protective barriers may be used in areas such as offices and classrooms. Strategies will need to be tailored to the individual space in the facility and the needs of the residents and staff.
- Consider options to prevent overcrowding (e.g., diverting new intakes to other facilities with available capacity, and encouraging alternatives to incarceration and other decompression strategies where allowable).
- When feasible and consistent with security priorities, encourage staff members to maintain a distance of 6 feet or more from a person with COVID-19 symptoms while interviewing, escorting, or interacting in other ways. Staff members should always wear recommended PPE when in close contact with a person with COVID-19 symptoms.
- If there are people with COVID-19 inside the facility, prevent unnecessary movement between different parts of the facility and mixing of people from different housing units. For example, maintain consistent duty assignments for staff across shifts to prevent transmission across different facility areas, and modify resident work detail assignments so that each detail includes only residents from a single housing unit.
- If possible, designate a room near each housing unit to evaluate residents with COVID-19 symptoms, rather than having them walk through the facility to the medical unit. If this is not feasible, consider staggering sick call.

Symptom screening and temperature checks

- Screening for COVID-19 symptoms (including temperature checks) and asking about recent exposure can help identify staff members or visitors who should be excluded from a facility before entry and residents (at intake or in the existing population) who should be evaluated for potential medical isolation or quarantine. Symptom screening alone will not prevent all transmission, since it is largely based on voluntary self-report and will not identify people with asymptomatic infection.
- Symptom screening and temperature checks should be used in combination with a screening testing program (described below) to minimize the risk of SARS-CoV-2 transmission. Symptom screening and temperature checks should be conducted daily during the quarantine period among residents who have been exposed to someone with COVID-19.

Routine Mask or Respirator Use

- All staff members and residents should wear a well-fitting cloth or disposable procedure mask or a respirator as much as possible while indoors (unless contraindicated), even in areas not used for quarantine or medical isolation. If masks or

respirators are not worn outdoors, ensure that physical distancing is maintained. Correct and consistent mask or respirator use is key to preventing the spread of droplets and very small particles that contain the virus (i.e., source control). Provide masks or respirators at no cost to residents and staff and clean or replace them routinely.

- Considerations for choosing a mask or respirator:
  - Masks and respirators can provide different levels of protection depending on the type of product and how they are used. Choose the most protective mask or respirator that fits well and can be worn consistently.
  - Loosely woven cloth products provide the least protection; layered finely woven products offer more protection; well-fitting disposable procedure masks and KN95s offer even more protection, and well-fitting National Institute for Occupational and Safety & Health (NIOSH)-approved respirators (including N95s) offer the highest level of protection.
  - When possible based on facility resources and supply, offer different types of masks and respirators to staff and residents so that they can choose the option that fits them best and that they can wear consistently. The options that are offered in correctional and detention facilities may be limited by safety and security considerations, such as concerns about metal nose wires. In environments where the risk of transmission is higher (e.g., post-exposure quarantine units) and safety and security considerations allow, residents should be offered masks or respirators providing the same level of protection as those provided to staff in a similar environment. See Table 1 for recommended masks and respirators for different scenarios.
- Clearly explain the purpose of masks and respirators and when their use may be contraindicated.
- See Table 1 for more information about when different types of masks and respirators are recommended for residents or staff based on their scope of duties and risk of exposure to SARS-CoV-2.

Recommended PPE and PPE Training for Staff Members and Residents

- Recommended PPE for staff members and residents in a correctional facility will vary based on the type of contact they have with someone with COVID-19 or their close contacts. See Table 1 for recommended PPE for residents and staff members with varying levels of contact with people with COVID-19 or their close contacts. In case of shortages, use strategies for safely optimizing PPE supplies.
- Ensure that staff members and residents who are required to wear PPE have been trained to correctly don, doff, and dispose of PPE that they will need to use within the scope of their responsibilities:
  - PPE donning and doffing training videos and job aids
  - Protecting Healthcare Personnel (as found on the CDC website)
  - Infection control guidance for healthcare professionals about COVID-19
  - CDC COVID-19 Correction Unit's Infection Prevention and Control training slides
- Have designated PPE donning and doffing areas outside all spaces where PPE will be used. These spaces should include the following (See the full list of recommended materials in the CDC Correction Unit's Infection Prevention and Control training slides):
  - A dedicated trash can for disposal of used PPE (one for laundry and one for trash or biohazard)
  - A hand washing station or access to alcohol-based hand sanitizer with at least 60% alcohol
  - Posters illustrating correct donning and doffing procedures
- If not already in place, employers operating within the facility should establish a respiratory protection program, as appropriate, to ensure that staff members are fit-tested, medically cleared, and trained for any respiratory protection they will need within the scope of their responsibilities. Residents may also be considered for enrollment in a respiratory protection program depending on their work-related exposure risk. For example, residents working in an environment where they may be exposed to COVID-19 – such as in a medical isolation unit – would be considered for enrollment due to occupational risk. For more details, see the OSHA Emergency Temporary Standard for Healthcare Workers , which contains guidance for the elements needed in a mini respiratory protection program, which is relevant for healthcare workers outside of traditional hospitals and clinics, if certain criteria are present.
- If staff members must serve multiple facility areas, ensure that they change PPE when leaving the medical isolation or quarantine space. If a shortage of PPE supplies necessitates reuse, ensure that staff members move only from low to high exposure risk areas while wearing the same PPE to prevent cross-contamination. For example, start in a housing unit where no one is known to be infected or exposed, then move to a space used as quarantine for close contacts, and end in an isolation unit.

Table 1. Recommended Personal Protective Equipment (PPE) and Source Control for Residents and Staff in a Correctional or Detention Facility

Note: To maximize protection from highly transmissible SARS-CoV-2 variants of concern and prevent possible spread to others, residents and staff members of correctional facilities should wear a cloth or disposable procedure mask or respirator regardless of vaccination and booster status while indoors, and should maintain physical distancing outdoors if not masked. The PPE described below may only be required for certain activities, see footnotes for details.

	NIOSH-approved Respirator*	International Respirator* or Disposable Procedure Mask	Cloth Mask	Eye Protection	Gloves	Gown/Coveralls
Residents						
With confirmed or suspected COVID-19, or showing symptoms of COVID-19		X†				
Quarantined (individually or in a cohort) as a close contact of someone with COVID-19		X†				
Handling laundry or used food service items from someone with COVID-19 or their close contacts		X†		¶	X	¶
Working in an area designated for quarantine or medical isolation (*without* having close contact with persons under quarantine or isolation precautions)	X†			If using cleaning products, additional PPE may be needed based on the cleaning product label. See CDC guidelines for details.		
Working in an area designated for quarantine or medical isolation (*with* close contact with persons under quarantine or isolation precautions)	X†			X	X	X
Living or working in areas of the facility not designated for quarantine or medical isolation		X†				
Staff						
Working in medical isolation or quarantine areas (*without* close contact with persons under quarantine or isolation precautions)	X			If using cleaning products, additional PPE may be needed based on the cleaning product label. See CDC guidelines for details.		
Having close contact with (including transport) or providing medical care to persons under quarantine or isolation precautions	X			X	X	X

	NIOSH-approved Respirator*	International Respirator* or Disposable Procedure Mask	Cloth Mask	Eye Protection	Gloves	Gown/Coveralls
Performing temperature checks for any persons who are *not* under quarantine or isolation precautions**		X†		X	X	
Handling laundry or used food service items from someone with COVID-19 or their close contacts		X†		¶	X	¶
Working in areas of the facility not designated for quarantine or medical isolation		X†		If using cleaning products, additional PPE may be needed based on the cleaning product label. See CDC guidelines for details.		

* NIOSH-approved respirators include N95s. International respirators include KN95s and KF94s. Visit the CDC website Types of Masks and Respirators for a full list of NIOSH-approved and international respirators.

†Masks and respirators can provide different levels of protection depending on the type and how they are used. Choose the most protective mask or respirator that fits well and can be worn consistently. Loosely woven cloth products provide the least protection; layered finely woven products offer more protection; well-fitting disposable procedure masks and KN95s offer even more protection, and well-fitting NIOSH-approved respirators (including N95s) offer the highest level of protection. When possible, offer different types of masks and respirators to staff and residents so that they can choose the option that fits them best and that they can wear consistently. The options that are offered in correctional and detention facilities may be limited by safety and security considerations, such as concerns about metal nose wires. In environments where the risk of transmission is higher (e.g., post-exposure quarantine units) and safety and security considerations allow, residents should be offered masks or respirators providing the same level of protection as those provided to staff in a similar environment.

¶ For individuals handling laundry or used food service items from someone with COVID-19 or their close contacts: Eye protection should be added if there is a risk of splashes or sprays, or if otherwise required based on the selected cleaning products. Gowns should be added if the individual's clothing will come into contact with soiled linen or used food service items, or if otherwise required based on the selected cleaning products.

** Sanitize or change gloves between each temperature check. A gown could be considered if extensive contact with the person being screened is anticipated.

Considerations for Visitors

- If transmission in the facility and/or substantial community transmission is occurring, restrict non-essential vendors, volunteers, and tours from entering the facility or sections where transmission has been occurring.
  - Consider restricting visitation when there is moderate to high community transmission to prevent the introduction of the virus into the facility.
  - Suspending in-person visitation should only be done in the interest of the residents' physical health and the health of the community. Visitation is important to maintain residents' mental health. If visitation is suspended, facilities should identify alternative ways for residents to communicate with their families, friends, and other visitors.
- Require visitors to wear cloth masks, disposable procedure masks, or respirators (unless contraindicated) and perform symptom and exposure screening and temperature checks for all visitors and volunteers on entry.
- Display signage and other communications materials outside visiting areas explaining the COVID-19 symptom screening and temperature check process. Ensure that materials are understandable for non-English speakers, those with low literacy, and people with disabilities.
- Exclude visitors and volunteers who do not clear the screening process or who decline screening or are not wearing masks or respirators (unless contraindicated).
- Provide alcohol-based hand sanitizer with at least 60% alcohol in visitor entrances, exits, and waiting areas.

- Use protective barriers such as sneeze guards in visitation rooms, when possible, as a part of a layered strategy to prevent SARS-CoV-2 transmission.
- Use physical distancing and visual cues such as stickers or decals to maintain physical distancing.
- Instruct visitors to postpone their visit if they have symptoms of COVID-19.

5. Testing considerations

People undergoing testing in any setting, including correctional and detention facilities, should receive clear information on what the results mean, recommended actions associated with negative or positive results, the difference between testing for screening versus for medical diagnosis, who will be able to access the results, and how the results may be used. Individuals tested are required to receive patient fact sheets as part of the test's emergency use authorization (EUA).

Because of the risk of unrecognized infection, a single new case of SARS-CoV-2 infection in a staff member or resident in a correctional or detention facility should be evaluated as a potential outbreak. If a resident 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 result could be considered an isolated case rather than a part of a larger outbreak. However, it may be necessary to test other people who were exposed during intake or transport.

A. Test types

There are currently two types of tests to identify SARS-CoV-2 infection or exposure: Viral and antibody tests.

Viral tests authorized by the Food and Drug Administration (FDA), including nucleic acid amplification tests (NAATs), and antigen tests, are used to **diagnose current infection** with SARS-CoV-2, the virus that causes COVID-19.

Tests can differ based on sensitivity (i.e., number of false-negative results/missed detections of SARS-CoV-2) and/or specificity (i.e., number of false-positive results/tests incorrectly identifying SARS-CoV-2 when the virus is not present).

- NAATs are high-sensitivity, high-specificity tests for diagnosing SARS-CoV-2 infection. Most NAATs need to be processed in a laboratory, and the time to obtain results varies (~1–3 days), but some NAATs are point-of-care tests with results available in about 15–45 minutes.
- Antigen tests are immunoassays that detect the presence of a specific protein on the surface of the virus. Different antigen tests generally have similar specificity, but are less sensitive than most NAATs. Most are less expensive than NAATs and can be conducted at the point of care testing site, usually with faster turnaround times. It may be necessary to confirm some antigen test results with a laboratory-based NAAT (i.e., a negative antigen test result in persons with symptoms or a positive antigen test result in persons without symptoms or known exposure). Based on the authorization from FDA, some point-of-care NAATs that provide presumptive results cannot be used for confirmatory testing. Use of the CDC Antigen Testing Algorithm is recommended to determine when confirmatory testing is needed.

Antibody (or serology) tests are used to detect previous infection with SARS-CoV-2 and can aid in the diagnosis of Multiple Inflammatory Syndrome in Children (MIS-C) and in adults (MIS-A). CDC does not recommend using antibody testing to diagnose current infection or to assess immunity. For more information on test types and how to choose a test, refer to Overview of Testing for SARS-CoV-2.

B. Diagnostic testing

Diagnostic testing is intended to identify current infection and is performed when a person has signs or symptoms consistent with COVID-19, or when a person is asymptomatic (without symptoms) but has recent known or suspected exposure to someone with COVID-19. See Overview of Testing for SARS-CoV-2 for details.

Facilities should consider suspending co-pays for residents seeking medical evaluation for possible COVID-19 symptoms, to remove possible barriers to symptom reporting.

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

- **Residents with symptoms**, regardless of COVID-19 vaccination or booster status, should be moved to medical isolation in a separate environment from other people (ideally individually), medically evaluated, and tested. If the test result is positive, medical isolation should continue for 10 days. Multiple residents with confirmed COVID-19 can be housed as a cohort (in a dorm or cell environments) regardless of the date of their positive test result. Facility staff should carefully evaluate and support the mental health needs of residents during medical isolation.
- **Staff members with symptoms**, regardless of COVID-19 vaccination and booster status, should be excluded from work and advised to seek testing. If the test result is positive, staff members should be excluded from work for 10 days. (However, staff may use the guidance for the general public for duration of isolation when they are not at work.) See section below on isolation duration for staff during routine vs. crisis operations.
- **Visitors with symptoms**, regardless of COVID-19 vaccination and booster status, should be denied entry and encouraged to seek testing through their healthcare providers or local health department.

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 were less than 6 feet away from an infected person for a total of 15 minutes or more over a 24-hour period) should be tested *regardless of their COVID-19 vaccination or booster status*.

In correctional and detention facilities, contact tracing to identify each individual's close contacts, including visitors, can be difficult. Therefore, people considered to be close contacts may include all persons defined by a particular setting/location (such as all residents and staff members assigned to a dormitory or unit where a case has been identified). Refer to the quarantine considerations section for information about quarantine for people with known or suspected exposure to SARS-CoV-2 in correctional and detention facilities.

- **Initial tests**: All persons with known or suspected exposure to someone with COVID-19, *regardless of their COVID-19 vaccination and booster status*, should receive an initial diagnostic test as soon as possible after they have been identified as a close contact (but not within the first 24 hours after exposure/close contact, since a test is unlikely to be positive that quickly). If the initial test is negative, they should receive a second diagnostic test at least 5 days after the exposure/close contact. (If the initial test was performed at least 5 days after the exposure/close contact, a second test is not needed.) Depending on local laboratory capacity, rapid point-of-care tests may offer the shortest turnaround time to facilitate timely action based on results.
- **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 in areas where an exposure has occurred. Broad-based testing involves testing everyone in the affected area(s) of the facility, *regardless of their COVID-19 vaccination and booster status*. For details on performing testing for large numbers of people, 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 members and residents) between parts of the facility with and without cases. Examples of broad-based testing strategies include the following:
    - 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 the staff or residents (i.e., residents have not left the housing unit and the staff members work exclusively in that housing unit).
    - 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.
  - If a resident 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 result would not trigger broad-based testing and could be considered an isolated case rather than a part of a larger outbreak. However, it may be necessary to test other people who were exposed during intake or transport.
  - Facility administrators should consider including staff in broad-based testing efforts *regardless of vaccination and booster status*, in order to help ensure that any COVID-19 cases are identified quickly, and to slow transmission. If it is not feasible to test staff members 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., people who are exposed are quarantined together rather than individually due to space constraints or mental health concerns), facilities should conduct serial re-testing of the entire quarantined cohort, *regardless of their vaccination and booster status.*
  - Facilities should re-test people quarantined as a cohort every 3–7 days until testing identifies no new cases in the cohort for 10 days since the most recent positive result. The testing interval should be based on the stage of an ongoing outbreak (i.e., testing every 3 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 10-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 their vaccination and booster status.
- **Testing people with prior diagnosis of SARS-CoV-2 infection**: People who have recovered from SARS-CoV-2 infection within the past 90 days and have been re-exposed to SARS-CoV-2 may not need to be tested but should still 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 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 and management, including quarantine and medical isolation if indicated, should proceed as it would for someone who had not previously been diagnosed with SARS-CoV-2 infection. Facilities should also consider the potential for coinfection of influenza and COVID-19.

C. Screening testing

Screening testing is intended to identify people infected with SARS-CoV-2 who are asymptomatic or pre-symptomatic and do not have known, suspected, or reported exposure to SARS-CoV-2. NAATs, antigen tests, or both can be used for screening testing. Screening testing can be a valuable tool in correctional and detention facilities because it can detect SARS-CoV-2 early to help stop transmission quickly. Screening testing may be particularly useful in areas with moderate to high community transmission, to catch asymptomatic infections early.

Movement-based screening testing

Movement-based screening testing is the routine screening testing of residents at intake, before transfer to another facility, and before community visits or release. All residents, regardless of vaccination and booster status, should undergo testing at these time points to help prevent introduction of virus into the facility, across facilities, and from the facility into the community.

Screening testing based on movement should include testing for residents in the following scenarios:

- **At intake**. Test all incoming residents at intake, and house them separately from the rest of the facility's population (individually if feasible) while waiting for test results. Testing can be combined with a 10-day observation period (sometimes referred to as "routine intake quarantine") before persons are assigned housing with the rest of the facility's population (especially if community transmission is high). People under routine intake quarantine should be quarantined separately from those quarantined due to exposure to COVID-19. If incoming residents undergo intake quarantine, consider re-testing them at the end of the intake quarantine period before they are assigned housing with the rest of the facility's population. If residents undergo intake quarantine as a cohort, consider testing every 3–7 days if community transmission is high to prevent transmission within the cohort.
- **Before transfer to another facility**. Test all residents before transfer to another correctional/detention facility. Wait for a negative test result before transfer. Testing before transfer can be combined with a 10-day observation period (sometimes referred to as "routine transfer quarantine") before an individual's projected transfer date. People under routine transfer quarantine should be quarantined separately from those quarantined due to exposure to COVID-19.

Routine transfer quarantine is recommended particularly when there is transmission known to be occurring within the originating facility.

- **Before release**. Test residents leaving the facility as close as possible (and no more than 3 days prior) to the day of the release (whether into the community or to a halfway house or other transitional location). Testing before release is particularly important if residents will be housed in other congregate settings (e.g., homeless shelters, group homes, or halfway houses) or in households with persons who are at higher risk of severe illness from COVID-19, including older adults and people with certain medical conditions. Testing before release can be combined with a 10-day observation period (sometimes referred to as "routine release quarantine") before a person's release date. People under routine release quarantine should be quarantined separately from those quarantined due to exposure to COVID-19. Notify public health authorities for assistance arranging medical isolation upon release for people who have a positive test result.
- **Before community visits.** If performing testing before community visits, test residents leaving the facility as close as possible (and no more than 3 days prior) to the day of the visit (e.g., medical trips, court appearances, community programs). If community transmission is high, facilities can consider testing 5 days after return.

Routine screening testing

Routine screening testing is the regular testing of all or a subset of residents and staff in a facility, with the goal of identifying COVID-19 cases early to prevent widespread transmission. Routine screening testing can include point-of-care testing and laboratory testing, and it can include all residents and staff members in a facility, or a targeted or random subgroup according to criteria the facility designates (examples below).

For any routine screening testing strategy that is put in place, testing at least weekly is recommended. Routine screening testing programs ideally include both residents and staff. If staff are tested during routine screening testing, consider testing them on the first day of their work week (defined as four or more consecutive work days), rather than randomly or regularly on another day of the work week, if feasible. If community prevalence increases rapidly, consider more frequent testing. If performing large scale testing on-site, consider staggering testing throughout the day or on different days to avoid overcrowding, long wait times, and burden on testing staff. If it is not feasible to test staff as part of a screening testing program, facilities should investigate options to work with community partners or state/local health departments to test staff.

Data on facility and community transmission level and testing capacity can guide decisions about when to implement routine screening testing strategies. Consider routine screening testing when community transmission is substantial or high (Table 2). The community transmission indicators below can be found for your county on CDC's COVID Data Tracker website.

Table 2. Indicators of Community Transmission*

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§ that were positive during the last 7 days¶	<5%	5%–7.9%	8%–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) multiplied by 100,000.

§ Nucleic acid amplification tests

¶ Number of positive test results 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. See "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 prioritization and selection of the subset:

Facility-level factors

- Facilities that have had cases or outbreaks within the past month
- Housing units where preventive measures such as physical distancing or adequate ventilation are difficult to implement (e.g., dormitory-based housing)
- Facilities allowing in-person visitation
- Facilities with high levels of community movement (e.g., frequent off-site medical visits, work release, or court appearances)
- Facilities with frequent admissions of new residents or residents transferring in from other facilities
- Units within facilities, as well as facilities within a correctional system, housing resident populations at higher risk of severe illness from COVID-19

Individual-level factors

- Residents and staff members who are at higher risk of severe illness from COVID-19†
- Residents assigned to critical on-site work details within the facility that require them to leave their housing unit or mix with persons in other housing units (e.g., food service, laundry)
- Residents participating in:
  - Work release programs
  - Off-site medical visits
  - Court appearances
- Staff working in:
  - 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)
- Staff members who live or spend time with other staff members who work in other areas of the facility (e.g., family or household members, carpools)

6. Medical isolation and quarantine

Medical isolation refers to the physical separation of an individual with confirmed or suspected COVID-19 infection to prevent their contact with others and reduce the risk of transmission. In this context, isolation does NOT refer to punitive isolation for behavioral infractions within the custodial setting. Staff are encouraged to use the term “medical isolation” to avoid confusion, and should ensure that the conditions in medical isolation spaces are distinct from those in punitive isolation. Residents in medical isolation should receive regular visits from medical staff and should have access to mental health services.

Quarantine refers to the physical separation of an individual who has had close contact with someone with confirmed or suspected COVID-19 to determine whether they develop symptoms or test positive for the disease. Quarantine reduces the risk of transmission to others if the individual is later found to have COVID-19.

Facilities should have a plan in place to ensure that *separate physical locations* (dedicated housing areas and bathrooms) have been identified to:

- Medically isolate residents with *suspected* COVID-19 (ideally individually while awaiting test results)
- Medically isolate residents with *confirmed* COVID-19 (individually or as a cohort)
- Quarantine residents identified as close contacts of those with confirmed or suspected COVID-19 (ideally individually, but as a cohort if necessary)

Facilities’ medical isolation and quarantine plans should include expansion contingencies to prepare for surges in cases and/or close contacts. Regardless of the location, facilities should ensure that placement in medical isolation or quarantine does not create barriers to access to medical or mental health care.

Note that facilities may determine that single-cell housing is not advisable in some situations due to mental health concerns. If close contacts are quarantined as a cohort, keep the number housed together as small as possible to minimize the risk of further transmission.

Residents with confirmed COVID-19 may be housed in medical isolation as a cohort (rather than in single cells). Cohorting residents during medical isolation can mitigate some mental health concerns associated with individual isolation and can increase capacity for medical isolation during case surges. Considerations for cohorted medical isolation include:

- Only residents with *laboratory-confirmed* COVID-19 should be housed together as a cohort. Do not cohort those with confirmed COVID-19 together with those with suspected COVID-19, with close contacts of people with confirmed or suspected COVID-19, or with those with other illnesses.
- When choosing a space to cohort groups of residents with confirmed COVID-19, use a single, large, well-ventilated room with solid walls and a solid door that closes fully. Using a single room will conserve PPE and reduce the chance of cross-contamination across different parts of the facility.

Movement of residents who are housed in medical isolation or quarantine units should be restricted as follows:

- Keep residents' movement outside the medical isolation/quarantine space to an absolute minimum.
- Serve meals inside the medical isolation/quarantine space.
- Provide medical care inside the medical isolation/quarantine space, unless it is not physically possible to do so, or unless a resident needs to be transferred to a healthcare facility.
- Exclude medically isolated/quarantined residents from all group activities outside the medical isolation/quarantine space.
- Where possible, restrict medically isolated/quarantined residents from leaving the facility (including transfers to other facilities) during the medical isolation/quarantine period, unless released from custody or a transfer is necessary for medical care, infection control, lack of medical isolation/quarantine space, or extenuating correctional, judicial, or security concerns.
- Staff assignments to quarantine spaces should remain as consistent as possible, and these staff members should limit their movements to other parts of the facility. These staff members should wear recommended PPE appropriate for their level of contact with people under medical isolation/quarantine. See PPE section below.
- Clean and disinfect areas used by people with COVID-19 on an ongoing basis during medical isolation.

A. Clearly communicate to residents and staff that quarantine and medical isolation are not intended to be punitive

Because of limited individual housing spaces within many correctional and detention facilities, infected or exposed people are often placed in the same housing spaces that are used for administrative or disciplinary segregation. To avoid being placed in these conditions, residents may be hesitant to report COVID-19 symptoms or close contact with people with COVID-19, leading to continued transmission within shared housing spaces and, potentially, lack of timely health care and greater risk of adverse health outcomes for people infected with SARS-CoV-2 who delay reporting symptoms. Ensure that medical isolation and quarantine are *operationally* distinct from administrative or disciplinary segregation, even if the same housing spaces are used for both. For example

- Make efforts to provide similar access to radio, TV, reading materials, personal property, commissary, showers, and other resources as would be available in individuals' regular housing units.
- To support mental health, consider allowing increased telephone time or other opportunities to communicate with others inside and outside the facility during the isolation or quarantine period.
- Communicate regularly with residents who are in medical isolation or quarantine about the duration and purpose.
- Ensure that staff understand that the same restrictions placed on residents in segregated housing when used for disciplinary reasons should not be applied to residents housed in the same spaces for COVID-19 related reasons.

B. Medical isolation for people with suspected COVID-19

As soon as a resident shows symptoms of COVID-19, they should be given a cloth or disposable procedure mask or respirator (if not already wearing one and if it can be worn safely), immediately placed under medical isolation in a separate environment from other people (ideally individually), and medically evaluated and tested for SARS-CoV-2. Facilities without onsite healthcare capacity to medically evaluate and/or treat residents with suspected COVID-19 should have a plan in place to ensure that timely evaluation and treatment take place through an offsite medical facility, additional healthcare providers, or other means.

- If the resident's SARS-CoV-2 test result is positive, they can be moved to a cohorted medical isolation unit with other people with confirmed COVID-19.
- If the SARS-CoV-2 test result is negative, the person can return to their prior housing assignment unless they require further medical assessment or care or if they need to be quarantined as a close contact of someone with COVID-19.

Residents who are medically isolated due to suspected COVID-19 should wear cloth or disposable procedure masks or respirators under the following circumstances:

- Whenever another individual enters the medical isolation space
- If the resident leaves the medical isolation space for any reason

The clinical staff evaluating and providing care for people with confirmed or suspected COVID-19 should follow the CDC Interim Clinical Guidance for Management of Patients with Confirmed Coronavirus Disease (COVID-19), including wearing recommended PPE, and monitoring the guidance website regularly for updates to these recommendations.

C. Medical isolation for people with confirmed COVID-19

As soon as a person tests positive for SARS-CoV-2 they should be given a cloth or disposable procedure mask or respirator (if not already wearing one and if it can be worn safely), immediately placed under medical isolation in a separate environment from other people (individually or in a cohort with other people with confirmed COVID-19), and medically evaluated. Medical isolation can be discontinued 10 days after symptom onset and after resolution of fever for at least 24 hours, without the use of fever-reducing medications, and with improvement of other symptoms. See section below on recommended duration of medical isolation during short-term periods of crisis-level operations (e.g., severe staffing or space shortages).

Facilities without onsite healthcare capacity to medically evaluate and/or treat residents with suspected COVID-19 should have a plan in place to ensure that timely evaluation and treatment take place through an offsite medical facility, additional healthcare providers, or other means.

Residents who are medically isolated should wear cloth or disposable procedure masks or respirators under the following circumstances:

- Whenever another individual enters the medical isolation space (excluding others with confirmed COVID-19)
- If the resident leaves the medical isolation space for any reason

The clinical staff evaluating and providing care for people with confirmed or suspected COVID-19 should follow the CDC Interim Clinical Guidance for Management of Patients with Confirmed Coronavirus Disease (COVID-19), including wearing recommended PPE, and monitoring the guidance website regularly for updates to these recommendations.

D. Quarantine of close contacts of those with confirmed or suspected COVID-19

Regardless of vaccination and booster status, residents who have been in close contact with someone with confirmed or suspected COVID-19 (whether the infected person is another resident, staff member, or visitor) should receive an initial diagnostic test as soon as possible after they have been identified as a close contact (but not within the first 24 hours after exposure/close contact, since a test is unlikely to be positive that quickly) and should quarantine for 10 days. If the initial test is negative, they should receive a second diagnostic test at least 5 days after the exposure/close contact. (If the initial test was performed at least 5 days after the exposure/close contact, a second test is not needed.) If an individual is quarantined due to close contact with someone with suspected COVID-19 who is subsequently tested and receives a negative result, they can be released from quarantine.

Residents who are quarantined should be monitored for COVID-19 symptoms at least once per day, including temperature checks. If a resident develops symptoms, they should be considered a person with suspected COVID-19. Follow procedures detailed above for medical isolation of people with suspected COVID-19.

Quarantined residents can be released from quarantine restrictions if they remain asymptomatic and have not tested positive for SARS-CoV-2 during the 10 days since their last potential exposure or known close contact with someone with confirmed COVID-19 (if that person was tested) or suspected COVID-19 (if that person was not tested). Ending quarantine before 10 days have passed is not recommended, even with a negative test. See section below on recommended duration of quarantine during short-term periods of crisis-level operations (e.g., severe staffing or space shortages).

Quarantined residents should wear cloth or disposable procedure masks or respirators under the following circumstances:

- Whenever another individual enters a quarantine space that is occupied by a single resident
- When quarantined residents are housed as a cohort
- If a resident under quarantine leaves the quarantine space for any reason

E. Cohorted Quarantine

Facilities should make every possible effort to individually quarantine close contacts of residents with confirmed or suspected COVID-19 unless mental health concerns preclude individual housing. Cohorting multiple quarantined close contacts could result in transmission of SARS-CoV-2 from those who are infected to those who are uninfected. If cohorted quarantine is necessary, reduce transmission risk by selecting the housing spaces that:

- Are well ventilated
- Minimize the number of residents sharing the housing space
- Maximize the physical distance between residents sharing the housing space
- Are physically separated (i.e., solid walls and solid doors) from non-quarantine spaces

If cohorting close contacts is necessary, be especially mindful of those who are at increased risk for severe COVID-19 illness. Ideally, they should not be cohorted with other quarantined residents. If cohorting is unavoidable, make all possible accommodations to reduce exposure for residents with increased risk of severe illness. (For example, intensify physical distancing strategies for residents with increased risk.)

F. Quarantine for staff members

All staff members who have been exposed to someone with COVID-19 should be advised to seek testing and should be excluded from work for 10 days after their last exposure, regardless of their vaccination and booster status. (However, staff may use the guidance for the general public for duration of quarantine when they are not at work.) See section below on recommended quarantine duration for staff during short-term periods of crisis operations (e.g., severe staffing shortages).

- If quarantine duration is reduced for staff members during crisis-level operations, then facility management should require exposed staff members to:
  - Continue to self-monitor for symptoms of COVID-19 through day 10 after known or suspected exposure to or close contact with a person with COVID-19
  - Immediately isolate if symptoms of COVID-19 occur
  - Adhere to all recommended prevention strategies, including wearing a well-fitting mask or respirator, physical distancing, and maintaining good hand hygiene

G. Shortening quarantine or isolation during crisis-level operations

In December 2021, CDC updated and shortened the recommended quarantine (after potential exposure or close contact with someone with COVID-19) and isolation (after testing positive) periods for the general public. Because of the potential for rapid, widespread transmission of SARS-CoV-2 in congregate environments and evidence that people who are fully

vaccinated can transmit the virus to others, CDC recommends maintaining 10-day isolation and quarantine periods for both residents and staff in high-risk congregate settings, including correctional and detention facilities. (However, staff may use the guidance for the general public for duration of quarantine and isolation when they are not at work.)

These recommended 10-day quarantine and isolation periods are preferred to reduce the risk of transmission. During crisis-level operations (examples below), facilities may need to consider short-term alternatives to the recommended 10-day quarantine and/or isolation periods for staff and/or residents. Because each facility's resource constraints, population, and transmission risks are unique, there is not a standard set of alternate strategies that CDC recommends for all correctional and detention facilities to follow under crisis-level operations. Facilities should consult their state, tribal, local, or territorial health department to discuss approaches that would meet their needs while maximizing infection control during these short-term periods.

Examples of crisis-level operation scenarios:

- Staffing shortages threaten to compromise the safety and security of the facility or the continuity of essential operations.
- There is insufficient space to isolate/quarantine all residents who have been infected/exposed for the full 10-day periods, and other options to increase space have been exhausted.

Once the period of crisis-level operations has passed, facilities should return to the recommendations for periods of routine operations (10 days for quarantine and isolation). Facilities should ensure that both residents and staff understand that reduced quarantine and/or isolation protocols are short-term crisis-management tools and that the facility will return to the full 10-day quarantine and isolation recommendations.

The following are guiding principles for reducing quarantine and/or isolation periods during crisis-level operations:

- Reductions in duration should be as minimal as possible to mitigate the crisis scenario.
- Decisions to shorten duration should be made independently for staff and for residents, based on the specific resources that are constrained at the time. (For example, shortening isolation and/or quarantine for staff due to staffing shortages would not automatically trigger shortened duration for residents as well.)
- Before reducing quarantine and/or isolation duration, consider alternatives (e.g., shifting from individual to cohorted isolation units for residents or reducing the resident population).
- Take into consideration the risk of transmission within the facility (e.g., layout) and the risk profile of the facility's population.
- Consider reducing quarantine duration for groups at lower risk of infection first (e.g., those who are up to date on their COVID-19 vaccines).
- If crisis-level protocols allow infected staff to return to work before 10 days of isolation, the risk of transmission can be reduced by assigning them to work exclusively in isolation units or in assignments where they have minimal contact with others until day 10.
- If a facility shortens quarantine and/or isolation, it is possible to incorporate negative test results into these protocols (i.e., "test-out" strategies). The following factors are necessary for facilities to incorporate test-out strategies without compromising essential functions:
  - Sufficient testing supplies and staff capacity to maintain recommended diagnostic testing and screening testing at intake (see section above on testing)
  - Fast turn-around time to inform timely decision-making
  - Sufficient staff capacity to continue to prioritize care and treatment for residents at high risk for severe COVID-19
  - Note that test-out strategies to reduce isolation periods should be based on negative results from two consecutive respiratory specimens collected ≥24 hours apart.

In facilities with severe resource constraints during crisis-level operations, it may be necessary to modify other COVID-19 prevention measures detailed elsewhere in this document, in order to prioritize the prevention of severe outcomes from COVID-19. Facilities should consult their state, tribal, local, or territorial health department if they are considering such short-term modifications.

7. Medication for prevention of severe disease

The FDA has expanded EUAs for use of certain investigational monoclonal antibody medications to prevent SARS-CoV-2 infection, including in correctional populations, under the following conditions:

- There is an occurrence of COVID-19 in other individuals in the same institutional setting, **and;**
- The patient being treated is not fully vaccinated or is not expected to mount an adequate immune response to complete COVID-19 vaccination, **and;**
- The patient being treated is at higher risk for progression to severe COVID-19, including hospitalization or death (e.g., they have certain comorbidities).

In addition, antiviral medications are now available that are effective in preventing severe outcomes from COVID-19. These medications can be ordered at no cost either through the office of the Assistant Secretary for Preparedness and Response (ASPR) within the Department of Health and Human Services, the manufacturer, or possibly through their usual mechanism for obtaining medications. The National Institute of Health COVID-19 Treatment Guidelines provide information about these drugs and describe what is known about their effectiveness.

Medications are *not* a substitute for vaccination. Corrections management should consult facility healthcare providers about their use for post-exposure prophylaxis.

8. Considerations for reentry programming

- If a person preparing for release is not up to date on their COVID-19 vaccines, offer vaccination again. If they decline, provide them with information about where they can get vaccinated after release.
- Provide screening testing before release for all residents, regardless of COVID-19 vaccination and booster status.
- Ensure that facility reentry programs include information on accessing:
  - Housing, social services, mental health services, and medical care, including medication-assisted treatment for opioid use disorder to substance use, harm reduction, and/or recovery support . Ensure that linkages to community services account for modified operations of providers due to COVID-19.
  - Medicaid enrollment and healthcare resources, including continuity of care for chronic conditions that may place a person at increased risk for severe illness from COVID-19 (e.g., HIV, hepatitis, tuberculosis, etc.).
- Provide residents about to be released with COVID-19 prevention information, hand hygiene supplies, and masks or respirators.
- When possible, encourage residents who are being released to seek housing options among their family or friends in the community, to prevent crowding in other congregate settings such as homeless shelters. When linking residents to shared housing, link preferentially to accommodations with the greatest capacity for physical distancing.

Previous Updates

Updates from Previous Content

As of June 9, 2021

- Considerations for modifying COVID-19 prevention measures in correctional and detention facilities in response to declining community transmission

As of May 6, 2021

- Updated cleaning and disinfection information

As of February 19, 2021

- Clarification that correctional and detention facilities should continue to use a 14-day quarantine period. Recommendations for quarantine duration in correctional and detention facilities
- Updated language on quarantine recommendations
- Updated language on quarantine recommendations
- Updated language for the close contact definition.
- Updated criteria for releasing individuals with confirmed COVID-19 from medical isolation (symptom-based approach).
- Added link to CDC Guidance for Performing Broad-Based Testing for SARS-CoV-2 in Congregate Settings
- Reorganized information on Quarantine into 4 sections: Contact Tracing, Testing Close Contacts, Quarantine Practices, and Cohorted Quarantine for Multiple Close Contacts
- Added testing and contact tracing considerations for incarcerated/detained persons (including testing newly incarcerated or detained persons at intake; testing close contacts of cases; repeated testing of persons in cohorts of quarantined close contacts; testing before release). Linked to more detailed Interim Considerations for SARS-CoV-2 Testing in Correctional and Detention Facilities.
- Added recommendation to consider testing and a 14-day quarantine for individuals preparing for release or transfer to another facility.
- Added recommendation that confirmed COVID-19 cases may be medically isolated as a cohort. (Suspected cases should be isolated individually.)
- Reduced recommended frequency of symptom screening for quarantined individuals to once per day (from twice per day).
- Added recommendation to ensure that PPE donning/doffing stations are set up directly outside spaces requiring PPE. Train staff to move from areas of lower to higher risk of exposure if they must re-use PPE due to shortages.
- Added recommendation to organize staff assignments so that the same staff are assigned to the same areas of the facility over time, to reduce the risk of transmission through staff movements.
- Added recommendation to suspend work release programs, especially those within other congregate settings, when there is a COVID-19 case in the correctional or detention facility.
- Added recommendation to modify work details so that they only include incarcerated/detained persons from a single housing unit.
- Added considerations for safely transporting individuals with COVID-19 or their close contacts.
- Added considerations for release and re-entry planning in the context of COVID-19.

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