COVID-19

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

Updated May 3, 2022

Summary of Recent Changes

Updates as of May 3, 2022

- Separated the previous version of this guidance document into two sections:
  - **Framework to Assess COVID-19 Risk and to Select Prevention Strategies in Correctional and Detention Facilities** – *guidance on designing a flexible COVID-19 prevention plan based on COVID-19 Community Levels and facility-level factors*
  - **Appendix** – *detailed guidance on implementing specific prevention strategies in correctional and detention facilities*
- Separated COVID-19 prevention strategies into two categories and provided guidance on when to apply each category in correctional and detention facilities.
  - Strategies for Everyday Operations
  - Enhanced COVID-19 Prevention Strategies
- Added modified post-exposure quarantine options for facilities to consider to reduce the impact of quarantine on residents' mental health and access to services.
- Removed COVID-19-specific PPE recommendations for persons handling laundry or used food service items from people with COVID-19 or their close contacts.

View Previous Updates

This document provides guidance regarding the prevention of coronavirus disease 2019 (COVID-19), tailored for correctional and detention facilities housing adults and/or juveniles. This guidance is based on what is currently known about the transmission and severity of COVID-19 as of May 3, 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 and Terminology

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. These facilities include but are not limited to federal and state prisons, local jails, juvenile detention and correctional facilities, 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 the respective community-based departments of health and child welfare agencies. Some of these facilities and agencies might adapt CDC guidance for correctional and detention facilities based on their specific populations or operational needs. Note that this guidance does not define specific occupancy limits for any correctional or detention facility. It provides a framework to assess COVID-19 risk in a facility and to prioritize prevention strategies based on community and facility-level factors, including factors beyond the control of the facility. 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, local, tribal, or territorial health and safety laws, rules, and regulations.

It is important to note that youth who are detained or committed have unique needs related to their age and development, including a need for access to in-person learning. Facilities housing youth may also need to adapt aspects of this guidance document to comply with regulatory requirements and facility operations specific to the juvenile justice and child welfare systems.

This guidance may need to 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, local, tribal, or territorial, public health department if they need assistance in applying these principles or addressing topics that are not specifically covered in this guidance.

Definitions of terms

- **COVID-19 Prevention Strategies**
  - **Strategies for everyday operations:** COVID-19 prevention strategies that correctional and detention facilities should keep in place at all times, even when the COVID-19 Community Level is low.
  - **Enhanced COVID-19 prevention strategies:** Additional COVID-19 prevention strategies for facilities to use when the COVID-19 Community Level is medium or high, or when facility-level factors indicate increased risk.
- **Close contact or exposure to someone with COVID-19:** Persons with recent exposure to SARS-CoV-2 can be identified in correctional and detention facilities in two ways:
  - **Traditional case investigation and contact tracing.** Consult the CDC website for the current definition for when a person would be considered a close contact of someone with COVID-19.
  - **Location-based contact tracing.** When traditional case investigation and contact tracing are not feasible, facilities may identify persons with recent known or potential exposure to SARS-CoV-2 based on whether they spent time in the same locations as an infected person (e.g., all residents and staff members assigned to a housing unit where a case has been identified).
- **Incarcerated/detained persons** or **residents:** Adults and juveniles 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.
- **Medical isolation:** Physical separation of an individual with confirmed or suspected COVID-19 to prevent contact with others and reduce the risk of transmission.
- **Quarantine:** Physical separation of an individual who has had close contact with someone with confirmed or suspected COVID-19, to reduce the risk of transmission to others if the individual is later found to have COVID-19.
- **Staff:** All public or private sector employees working within a correctional or detention facility. "Staff" does not distinguish between healthcare, custody, food service, and other types of staff members, nor between government and private employers.
- **Up to date** on COVID-19 vaccines is defined by CDC guidance. This definition is subject to change over time based on updates to CDC vaccination guidance.

Framework to Assess COVID-19 Risk and to Select Prevention Strategies in Correctional and Detention Facilities

Section 1: Introduction

This document describes a flexible, long-term approach to COVID-19 prevention in correctional and detention facilities. First, it outlines community and facility-level indicators to use to assess COVID-19 risk in a facility. Second, it describes which COVID-19 prevention strategies should be used at all times (strategies for everyday operations) versus only at times of increased risk (enhanced prevention strategies). Additional information on applying each COVID-19 prevention strategy in correctional and detention facilities can be found in the Appendix.

When applying enhanced prevention strategies, correctional and detention facilities should weigh the risks associated with SARS-CoV-2 transmission against their impact on facility operations, mental health, and availability of services and programming for residents. Because of the variation across facilities (e.g., differences in layout, infrastructure, security level, mission, population health needs, on-site healthcare, and staffing levels) and shifting epidemiologic trends due to new SARS-CoV-2 variants and other factors, there is no single COVID-19 prevention plan that will apply across all facilities or time periods.

Section 2: Assessing COVID-19 Risk in Correctional and Detention Facilities

To develop a flexible, long-term COVID-19 prevention plan, correctional and detention facilities should first assess their unique COVID-19 risks to inform the intensity of prevention strategies needed over time. This risk assessment should be based on a combination of:

- CDC COVID-19 Community Levels
- Facility-level factors

COVID-19 Community Levels

CDC recommends using COVID-19 Community Levels to guide individual and community decisions about when to apply specific COVID-19 prevention strategies. COVID-19 Community Levels are categorized as low, medium, and high based on the number of COVID-19 cases in a given community and the impact of severe disease on community-based healthcare systems. Visit the CDC website to check any county's current COVID-19 Community Level and to see more detail about how these levels are determined.

When correctional and detention facilities assess a local area's COVID-19 Community Level, they should consider the community where the facility is located as well as the communities from which residents originate and where staff members live. Facilities receiving residents from international locations should make reasonable efforts to determine the risk level in originating countries. See the World Health Organization COVID-19 dashboard for case counts by country. Facilities that receive large numbers of residents from a wide geographical area may consider weighing facility-level factors more heavily than COVID-19 Community Levels in decisions about when to apply specific prevention strategies.

Note that correctional and detention facilities providing healthcare services should consult CDC's Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic (which uses COVID-19 Community Transmission Levels rather than COVID-19 Community Levels to guide application of certain COVID-19 prevention strategies in healthcare facilities) for guidance on recommended infection prevention and control strategies for patient care.

Facility-level Factors

Because COVID-19 Community Levels do not always reflect the COVID-19 risk in correctional and detention facilities, each facility should also assess facility-level factors that reflect its unique characteristics, operations, and populations to guide decisions about when to add or remove enhanced prevention strategies. Examples of relevant facility-level factors are detailed below. However, guidance is not available to set specific thresholds for these factors, or to specify how many factors to consider before shifting to enhanced prevention measures.

Facility-level factors to consider include:

- **Vaccination coverage:** Determine the proportion of staff and residents who are up to date on COVID-19 vaccines.

  COVID-19 vaccines are highly effective in preventing severe illness, hospitalization, and death from COVID-19. Facilities that do not have high up to date vaccination coverage should consider applying enhanced prevention strategies even when the COVID-19 Community Level is low.

- **Transmission in the facility:** Evaluate the current level of SARS-CoV-2 transmission within the facility. Transmission can be assessed through diagnostic testing of symptomatic persons and their close contacts, through ongoing routine screening testing, or surveillance testing that the facility uses (such as wastewater testing). Results of testing at intake are not recommended as an indicator of transmission inside the facility, since infections identified at intake most likely occurred elsewhere.

  Because of the risk of unrecognized infection, any new case of COVID-19 in a staff member or resident in a correctional or detention facility should prompt follow-up as described in the Appendix, including a case investigation and/or location-based contact tracing and testing of persons identified as close contacts. Facilities should shift to enhanced prevention strategies if one or more additional cases are identified after follow-up, even if the COVID-19 Community Level is low. Note that enhanced prevention strategies that are put in place due to transmission can be targeted to certain portions of a facility (rather than a whole building or complex) as long as movement and staff assignments are restricted between areas with and without known transmission.

- **Risk of severe health outcomes:** Determine whether the facility's residents or staff are more likely to get very sick from COVID-19. Additionally, evaluate whether the facility is able to assess infected residents' eligibility for COVID-19 therapeutics and, for eligible residents, to ensure timely access to treatment to prevent severe health outcomes. See Nonhospitalized Patients: General Management | COVID-19 Treatment Guidelines . Facilities should consider applying enhanced prevention strategies even when the COVID-19 Community Level is low if they are unable to do one of the following: a) access and administer COVID-19 therapeutics on-site to prevent severe health outcomes among residents more likely to get very sick from COVID-19, OR b) assess residents' risk for severe outcomes and ensure timely access to care outside the facility.

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

  Facilities with dense housing arrangements (e.g., dorm/open barracks), frequent population turnover, or ventilation systems that do not meet code-minimum ventilation requirements may consider applying some enhanced prevention strategies, even when the COVID-19 Community Level is low.

Section 3: Strategies for Everyday Operations vs. Enhanced COVID-19 Prevention Strategies

At all times, facilities should keep certain strategies for everyday operations in place. In addition, facilities should maintain the ability to add or remove enhanced COVID-19 prevention strategies based on ongoing risk assessment as described above. When shifting from a period of higher to lower risk, avoid removing enhanced COVID-19 prevention strategies all at once.

Table 1 provides a summary of which prevention strategies are recommended as strategies for everyday operations (in place at all times) vs. as enhanced COVID-19 prevention strategies (added or removed based on risk assessment). See the Appendix for detailed information on tailoring each of these prevention strategies to correctional and detention facilities.

Table 1: Strategies for Everyday Operations vs. Enhanced Prevention Strategies

COVID-19 Prevention Strategy	Strategies for Everyday Operations*	Enhanced COVID-19 Prevention Strategies*
Up to date COVID-19 vaccination	✓	
Standard infection control	✓	
Enhanced ventilation†		✓

COVID-19 Prevention Strategy	Strategies for Everyday Operations*	Enhanced COVID-19 Prevention Strategies*
Testing		
symptomatic people	✓	
close contacts of people with COVID-19	✓	
all residents at intake (or routine observation period)	✓	
before transfer		✓
before/after community visits		✓
before release		✓
routine screening testing		✓
Access to COVID-19 therapeutics	✓	
Medical isolation & quarantine	✓	
Well-fitting masks/respirators		
offer to residents and staff	✓	
universal indoor masking		✓
Prepare for outbreaks	✓	
Routine observation periods during transfer/release protocols		✓
Minimize movement and contact across housing units and with the community		✓
Physical distancing		✓

*At all times, facilities should keep Strategies for Everyday Operations in place. In addition, facilities should add Enhanced COVID-19 Prevention Strategies when the COVID-19 Community Level is medium or high, or when facility-level factors indicate increased risk. Facilities may not be able to apply all Enhanced COVID-19 Prevention Strategies due to local resources, facility and population characteristics, and other factors, but they should add as many as feasible, as a multi-layered approach to increase the level of protection against COVID-19. Refer to the CDC Framework to Assess COVID-19 Risk and to Select Prevention Strategies in Correctional and Detention Facilities for details.
†As a Strategy for Everyday Operations, enhanced ventilation options should be identified, obtained, and tested in advance of higher risk periods to be ready to deploy when needed.

Strategies for Everyday Operations

At all times, correctional and detention facilities should maintain the following aspects of standard infection control, monitoring, and capacity to respond to COVID-19 cases:

- **Provide up to date COVID-19 vaccination, including boosters:** Continue to provide and encourage up to date COVID-19 vaccination for staff members and residents (including boosters, as well as additional doses for people with weakened immune systems and for others who are eligible for additional doses).

- **Maintain standard infection control strategies:** Maintain recommended handwashing and cleaning and disinfection for standard prevention of infectious diseases, including COVID-19. Ensure that ventilation systems operate properly and provide acceptable indoor air quality for the current occupancy level for each space. Make improvements and repairs as necessary. Prepare in advance for periods of higher risk by identifying, obtaining, and testing enhanced ventilation interventions that will be deployed as enhanced prevention strategies when needed (see below for examples and additional resources). Ensure that recommended personal protective equipment (PPE) is available for staff and residents based on their level of risk. (See the Appendix for a table detailing recommended PPE.)
- **Maintain diagnostic testing and intake testing strategies:** Maintaining a robust COVID-19 testing program can help prevent transmission in congregate settings and can provide critical data for ongoing assessment of the facility's long-term prevention plan. Maintain the COVID-19 testing strategies below to the maximum extent possible based on facility resources and supplies. See the Appendix for details about each testing strategy.
  - **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 (either through traditional contact tracing or through location-based contact tracing), regardless of COVID-19 vaccination and booster status.
  - **Routine COVID-19 screening testing OR a routine observation period should be implemented for all residents at intake,** regardless of COVID-19 vaccination and booster status. The routine observation period option should only be used in the following scenarios: a) Residents under intake observation are housed individually, OR b) Residents under intake observation are housed in small cohorts due to mental health concerns associated with individual housing, and all cohort members begin the observation period on the same day and will be tested at the end of the observation period. See the Appendix for detailed information on implementing routine observation periods during intake.
  - In facilities that use wastewater testing, continuing its use as a strategy for everyday operations when the COVID-19 Community Level is low can provide timely data to guide decisions about when to shift to enhanced COVID-19 prevention strategies.
  - COVID-19 screening testing at intake can be added to existing policies for routine intake testing for other infectious diseases, such as tuberculosis, though testing may not need to occur at the same time points for all diseases.
- **Assess residents' risk for severe health outcomes from COVID-19 and ensure timely treatment after infection for those who are eligible for COVID-19 therapeutics.** For facilities without onsite healthcare capacity, have a plan in place to ensure timely access to care offsite. See Nonhospitalized Patients: General Management | COVID-19 Treatment Guidelines .
- **Maintain medical isolation and quarantine procedures for residents:** Regardless of their vaccination and booster status, medically isolate residents who test positive for SARS-CoV-2 and quarantine residents who have been potentially exposed or identified as a close contact of someone with COVID-19 (either through traditional contact tracing or through location-based contact tracing). See the Appendix for detailed information on a) modified approaches to quarantine to reduce the impact of quarantine on mental health, in-person learning, and essential facility operations, b) duration of medical isolation during routine vs. crisis-level operations, and c) ensuring that the conditions in medical isolation and quarantine housing are not punitive and support mental health. Maintain the ability to quickly scale up medical isolation and quarantine during an outbreak.
- **Prevent COVID-19 introduction from staff:** 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 the Appendix for detailed information on a) standard and modified approaches to quarantine for staff and b) isolation duration for staff during routine vs. crisis-level operations.
- **Offer masks/respirators to all residents and staff who want them:** Facilities should make well-fitting masks or respirators available to any residents and staff who would like to use them based on their personal preference. See the Appendix for detailed information on types of masks and respirators and considerations for using them in correctional and detention facilities.
- **Prepare for outbreaks:** Monitor COVID-19 Community Levels and facility-level factors to be prepared for periods of increased SARS-CoV-2 transmission. Maintain communication with staff members and residents about what to expect if an outbreak occurs, and with external partners including public health and other local correctional and detention facilities.

Enhanced Prevention Strategies

In addition to the strategies for everyday operations above, facilities should add enhanced COVID-19 prevention strategies when the COVID-19 Community Level is medium or high, or when facility-level factors indicate increased risk. Facilities with low risk tolerance can apply any enhanced prevention strategies at any time, even when the CDC COVID-19 Community Level is low.

Depending on the risk in different areas of the facility, enhanced prevention strategies can be applied across an entire facility OR can be targeted to a single housing unit, wing, or building.

When selecting enhanced prevention strategies, facilities should consider their impact on mental health, access to in-person learning (especially for youth populations), and the likelihood of compliance from staff and residents. Facilities may not be able to apply all enhanced prevention strategies due to local resources, facility and population characteristics, and other factors, but they should add as many as feasible, as a multi-layered approach to increase the level of protection against COVID-19. **Enhanced prevention strategies for correctional and detention facilities include the following:**

- **Require masks/respirators indoors:** Require all residents, staff, visitors, vendors, volunteers, and any other persons in the facility to wear a well-fitting mask or respirator while indoors.
- **Enhance ventilation in the facility:** Use enhancements to code-minimum ventilation requirements to improve overall ventilation in the facility. For options to improve ventilation in buildings, such as increasing the introduction of outdoor air, using portable HEPA filters, and using upper room or in-duct ultraviolet germicidal irradiation systems (UVGI), see COVID-19 Ventilation in Buildings. These options should be identified, obtained, and tested in advance of higher risk periods to be ready to deploy when needed.
- **Strengthen SARS-CoV-2 testing strategies:** In addition to providing low-barrier diagnostic testing at all times and universal screening testing or a routine observation period for residents at intake (strategies for everyday operations), add other screening testing strategies to identify cases early and to prevent transmission during movement. Options include:
  - **Routine screening testing for residents and staff** – see the Appendix for more information on designing a screening testing program based on the unique features of a particular facility and its population.
  - **Additional movement-based screening testing:**
    - Before transfer to another facility
    - Before/after community visits
    - Before release
- **Add routine observation periods during movement:** Implement routine observation periods as part of intake, transfer and/or release processes to minimize transmission to/from other facilities and the community during movement. See the Appendix for implementation details.
- **Minimize movement and contact across housing units and with the community:** For short-term periods, reduce contact between different areas of the facility, and between the facility and the community, to prevent transmission. Examples include:
  - Restricting contact between housing units, including maintaining consistent staff assignments and ensuring that internal work details do not include residents from multiple housing units who do not otherwise interact
  - Restricting work release programs
  - Postponing non-essential community visits
  - Restricting movement across different areas of the facility
  - Restricting movement between facilities
  - Restricting in-person visitation (while ensuring access to virtual options)

  Consider the impact of prolonged restrictions on mental health and well-being for residents and staff with and without pre-existing mental illness.
- **Implement physical distancing strategies where feasible:** Increase the amount of physical space between people where possible. Examples include:
  - Staggering use of common spaces by different housing units
  - Limiting the size of group activities
  - Temporarily suspending group activities where residents will be in closer contact than they are in their housing environment (while considering impact on mental health and access to services)
  - Implementing decompression/population reduction strategies

Appendix: Considerations for Applying COVID-19 Prevention Strategies in Correctional and Detention Facilities

This Appendix provides details on tailoring specific COVID-19 prevention strategies to correctional and detention settings. Refer to the full guidance document above for recommendations on when to apply each prevention strategy, based on a combination of COVID-19 Community Levels and facility-level factors.

COVID-19 prevention strategies described in this Appendix include:

- Vaccination
- Standard infection prevention and control
- COVID-19 testing
- Routine observation periods during movement protocols
- Medication to prevent severe disease
- Medical isolation and quarantine
- Masks and respirators
- Preparing for outbreaks
- Physical distancing
- Visitation
- Re-entry considerations

COVID-19 Vaccination

COVID-19 vaccination is a strategy for everyday operations in correctional and detention facilities and is the most important tool available to prevent severe COVID-19. 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 residents and staff in order to stay up to date.
- Promote COVID-19 vaccination by educating staff and residents on the effectiveness, safety, and importance of vaccines.
- Work with local health departments, healthcare providers, and community organizations on effective ways to increase vaccination uptake, informed by input from residents and staff about why they may not wish to receive the vaccine. Consider recruiting residents and staff who received the vaccine to be peer supporters to encourage others to be vaccinated.

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
- Workplace Vaccination Program
- COVID-19 Vaccine Information for Specific Groups
- COVID-19 vaccine information for children and teens
  - Vaccines for Children and Teens
  - Resources to Promote the COVID-19 Vaccine for Children & Teens
- Ensuring the Safety of COVID-19 Vaccines in the United States

- COVID-19 Vaccine Booster Shot
- Frequently asked Questions about the COVID-19 Vaccine
- COVID-19 Rapid Community Assessment Guide

Standard Infection Prevention and Control

Infection prevention and control strategies are strategies for everyday operations in correctional and detention facilities.

Note that correctional and detention facilities providing healthcare services should consult CDC's Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic (which uses COVID-19 Community Transmission Levels rather than COVID-19 Community Levels to guide application of certain COVID-19 prevention strategies in healthcare facilities) for guidance on recommended infection prevention and control strategies for patient care.

Hand Hygiene

- All individuals in the facility should use preventive actions including regularly washing their hands, avoiding touching their eyes, nose, and mouth, and covering their cough.
- Facilities should ensure adequate access to hand hygiene materials at no cost to staff or residents. 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 pandemic, including Safe and Proper Use of Disinfectants to Reduce Viral Surface Contamination in Correctional Facilities.
- Facilities should have a plan in place to restock cleaning and disinfection supplies quickly during a COVID-19 outbreak.

Ventilation

- As a strategy for everyday operations, facilities should ensure that ventilation systems operate properly and provide acceptable indoor air quality for the current occupancy level for each space. Improvements and repairs should be made as necessary.
- As an enhanced prevention strategy, facilities should use enhancements to code-minimum ventilation requirements to improve overall ventilation in the facility. For more information about ventilation considerations and strategies to improve ventilation, such as increasing the introduction of outdoor air, using portable HEPA filters, and using upper room or in-duct ultraviolet germicidal irradiation systems (UVGI), see COVID-19 Ventilation in Buildings. These options should be identified, obtained, and tested in advance of higher risk periods to be ready to deploy when needed.

Recommended PPE

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 2.

- Ensure that staff members and residents who are required to wear PPE have been trained to correctly don, doff, and dispose of PPE 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
- Maintain 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 to dispose 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 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 Respiratory Protection Standard .
- If staff members must serve multiple facility areas, ensure that they change PPE when leaving medical isolation or quarantine spaces. If a shortage of PPE supplies necessitates reuse, prevent cross-contamination by ensuring that staff members move only from areas of low to high exposure risk while wearing the same PPE. 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 a medical isolation unit.
- In case of PPE shortages, use strategies for safely optimizing PPE supplies.

Table 2. Recommended Personal Protective Equipment (PPE) and Source Control for Residents and Staff in a Correctional or Detention Facility

The PPE described below may only be required for certain activities. See footnotes for details. Note that when the COVID-19 Community Level is low, a well-fitting mask or respirator should be offered and provided to all residents and staff who want them. When the COVID-19 Community Level is medium or high, or when facility-level factors indicate higher risk, facilities should require all persons in the facility to wear a well-fitting mask or respirator indoors.

	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[§]				
Working in an area designated for quarantine or medical isolation (*without* having close contact with persons under quarantine or isolation precautions)	X[§]					
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						

	NIOSH-approved Respirator*	International Respirator* or Disposable Procedure Mask	Cloth Mask	Eye Protection†	Gloves†	Gown/Coveralls†
Working in medical isolation or quarantine areas (*without* close contact with persons under quarantine or isolation precautions)	X					
Having close contact with (including transport) or providing medical care to persons under quarantine or isolation precautions	X			X	X	X
Performing temperature checks for any persons who are *not* under quarantine or isolation precautions**		X[§]		X	X	
Working in areas of the facility not designated for quarantine or medical isolation		X[§ ¶]				

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

[†]If residents or staff are using cleaning products, additional PPE may be needed based on the cleaning product label. See CDC guidelines for details.

[§]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.

[¶] When the COVID-19 Community Level is low, a well-fitting mask or respirator should be offered and provided to all residents and staff who want them. When the COVID-19 Community Level is medium/high or facility-level factors indicate higher risk, facilities should require all persons in the facility to wear a well-fitting mask or respirator indoors.

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

COVID-19 Testing

Types of tests and accessing testing supplies

For information on types of tests and how to choose a test, refer to Overview of Testing for SARS-CoV-2, the virus that causes COVID-19.

Facilities can contact their state or local health departments to request access to testing supplies when they are available locally. If testing supplies are unavailable, facilities can consider screening for COVID-19 symptoms (including temperature checks) and asking about recent close contact with someone with COVID-19. Facilities may also consider adding symptom

checks) and asking about recent close contact with someone with COVID-19. Facilities may also consider adding symptom screening as an added layer of protection in addition to testing. Symptom screening can help identify staff members, visitors, vendors, or volunteers 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 and temperature checks alone will not prevent all transmission, because it will not identify people with asymptomatic or pre-symptomatic infection.*

Diagnostic testing

Diagnostic testing is used to identify current infection 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 someone with COVID-19. Viral tests authorized by the Food and Drug Administration (FDA) for diagnostic testing include nucleic acid amplification tests (NAATs) and antigen tests. Antibody tests are used to detect past infection with SARS-CoV-2. CDC does not recommend using antibody testing to diagnose current infection or to assess immunity.

Diagnostic testing is a strategy for everyday operations in correctional and detention facilities and should be implemented at all times, even when the COVID-19 Community Level is low. Ensuring the availability of low-barrier diagnostic testing can help identify cases early and limit the size of outbreaks.

Testing persons with signs or symptoms consistent with COVID-19

- **Residents with COVID-19 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 from the date when symptoms began. **Multiple residents with confirmed COVID-19 can be housed as a cohort in a dorm or cell environment, even if the dates of their positive test results are different.** Facilities should consider suspending co-pays for residents seeking medical evaluation for possible COVID-19 symptoms, especially during outbreaks, to remove possible barriers to symptom reporting.
- **Staff members with COVID-19 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 from the date when symptoms began. (However, staff may use CDC guidance for the general public for isolation duration when they are not at work.) See section below on isolation duration for staff during crisis-level operations.
- **Visitors, vendors, and volunteers with COVID-19 symptoms**, regardless of COVID-19 vaccination and booster status, should be denied entry and encouraged to seek testing.

COVID-19 case follow-up

Because of the risk of unrecognized infection, any new case of COVID-19 in a staff member or resident in a correctional or detention facility should prompt a case investigation and testing of close contacts as described below. The facility's ability to test staff may be limited by facility-specific policy.

Facilities should add enhanced prevention strategies when there is transmission occurring in the facility. If a case is identified in a resident who 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 and may not trigger enhanced prevention strategies. However, it may still be necessary to test other people who were exposed during intake or transport before that decision is made.

Persons with recent exposure to SARS-CoV-2 can be identified in two ways:

- **Traditional case investigation and contact tracing.** Consult the CDC website for the current definition for when a person would be considered a close contact of someone with COVID-19. Case investigations should prioritize elicitation of close contacts who are more likely to get very sick from COVID-19 so they can be referred to a healthcare provider to determine eligibility for treatment if they test positive for SARS-CoV-2.
- **Location-based contact tracing.** When traditional case investigation and contact tracing are not feasible, facilities may identify persons with recent known or potential exposure to SARS-CoV-2 based on whether they spent time in the same locations as an infected person (e.g., all residents and staff members assigned to a housing unit where a case has been identified).

Testing asymptomatic persons with recent exposure to SARS-CoV-2

Testing asymptomatic persons with recent exposure to SARS-CoV-2

All persons identified as close contacts of someone with COVID-19, including all persons identified through location-based contact tracing, should be tested for SARS-CoV-2, *regardless of symptoms or COVID-19 vaccination or booster status*.

- Administer an initial diagnostic test as soon as possible (but not within the first 24 hours after close contact, because a test is unlikely to be positive that quickly).
- If the initial test result is negative, administer a second diagnostic test at least 5 days after the exposure occurred. (If the initial test was performed at least 5 days after the exposure, a second test is not needed.) See additional considerations below for serial testing in quarantine cohorts.
- People who had confirmed COVID-19 within the past 90 days and subsequently recovered do not need to be tested after exposure unless they develop new symptoms.
- For details on testing large numbers of people, such as those identified as close contacts through location-based contact tracing, review CDC guidance on Performing Broad-Based Testing for SARS-CoV-2 in Congregate Settings. Given the potential for rapid transmission, ensure there is a plan in place to prepare medical isolation spaces for a large number of infected persons. 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 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 wing, floor, building, or complex when cases have been identified in multiple areas, or if there has been movement between areas with and without cases.

Screening testing

Screening testing is used to identify people infected with SARS-CoV-2 who are asymptomatic or pre-symptomatic and do not have known or suspected exposure to someone with COVID-19. Screening testing can be a valuable tool in correctional and detention facilities for detecting infections early to help stop transmission quickly. NAATs or antigen tests can be used for screening testing.

Some forms of screening testing (i.e., testing at intake) are strategies for everyday operations in correctional and detention facilities, and other forms of screening testing are enhanced prevention strategies. Each screening testing strategy below is labeled accordingly.

Movement-based screening testing

Testing residents at intake, before transfer to another facility, and before/after community visits or release can help prevent introduction of virus into the facility, across facilities, and from the facility into the community.

- **Testing at intake (strategy for everyday operations)**. At intake, test all incoming residents OR implement a routine observation period. If intake testing is used, house incoming residents separately from the rest of the facility's population (individually if feasible) while waiting for their test results. The routine observation period option should only be used under the following scenarios: a) Residents under intake observation are housed individually, or b) Residents are housed in small cohorts due to mental health concerns associated with individual housing, and all cohort members begin the observation period on the same day and will be tested at the end of the observation period. (See additional details on implementing routine observation periods at intake below.)
- **Testing before transfer to another facility (enhanced prevention strategy)**. Consider testing all residents before transfer to another correctional/detention facility. Wait for a negative test result before transfer, and do not transfer residents with a positive test unless necessary for medical care, infection control, lack of medical isolation/quarantine space, or extenuating correctional, judicial, or security concerns.
- **Testing before release (enhanced prevention strategy)**. Consider testing residents before release from the facility. If using this strategy, test as close as possible to the day of the release. 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 more likely to get very sick from COVID-19. Notify public health authorities for assistance arranging medical isolation upon release for people who have a positive test result.
- **Testing before/after community visits (enhanced prevention strategy).** Consider testing residents before community visits (e.g., medical trips, court appearances, community programs). If using this strategy, test as close as possible to the

visits (e.g., medical trips, court appearances, community programs). If using this strategy, test as close as possible to the day of the visit. Facilities can also consider testing residents 5 days after they return from community visits. Facilities may consider routine screening testing for residents participating in work release programs (see below).

Routine screening testing

Routine screening testing is an enhanced prevention strategy. However, even when the COVID-19 Community Level is low, routine screening testing can help identify increasing case trends early and can contribute to long-term COVID-19 prevention plans.

Routine screening testing is the regular testing of asymptomatic persons with no known or suspected exposure to SARS-CoV-2, to identify COVID-19 cases early and help prevent widespread transmission. Ideally, a routine screening testing program includes both residents and staff regardless of vaccination status. It can include all residents and staff members in a facility, or a targeted or random subset chosen according to criteria the facility designates (examples below).

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

Prioritize facilities/housing units that:

- House resident populations more likely to get very sick from COVID-19
- Have low rates of up to date vaccination (including residents and staff)
- Have difficulty maintaining prevention strategies such as physical distancing or adequate ventilation (e.g., in dormitory-based housing or in older facilities)
- Have had recent cases or outbreaks
- Have high levels of interaction with the community (e.g., through in-person visitation or frequent turnover, off-site medical visits, work release, or court appearances)

Prioritize individuals who:

- Are more likely to get very sick from COVID-19
- (Staff) Have self-identified to their employer that they are more likely to get very sick from COVID-19 due to an individual medical condition
- (Residents) Mix with persons in other housing units, for example:
  - Are assigned to work details that include residents from other housing units (e.g., food service, laundry)
  - Participate in programming with residents from other housing units
- (Residents) Participate in:
  - Off-site work release programs
  - Frequent off-site medical visits
  - Frequent in-person court appearances
- (Staff) Work in:
  - A facility designated for medical care
  - Multiple areas of the facility
  - Multiple congregate facilities (e.g., more than one correctional/detention facility, homeless shelters, group homes, or schools)
- (Staff) Live or spend time with other staff members who work in other areas of the facility (e.g., family or household members, carpools)

Routine Observation Periods during Movement Protocols

Routine observation periods can be used as part of intake, transfer, and/or release processes to minimize potential transmission to/from other facilities or the community during movement. These observation periods are sometimes referred to as "routine intake/transfer/release quarantine" but are not related to a potential exposure to someone with COVID-19 and

should not be combined with post-exposure quarantine cohorts. Rather, they are periods where residents are housed separately from the rest of the facility's population (ideally individually, or as small cohorts if individual housing is not possible or is not advisable due to mental health concerns).

As a strategy for everyday operations, correctional and detention facilities should implement screening testing OR a routine observation period for all residents at intake. The routine observation period option should only be used under the following scenarios: a) Residents under intake observation are housed individually, OR b) Residents under intake observation are housed in small cohorts due to mental health concerns associated with individual housing, and all cohort members begin the observation period on the same day and will be tested at the end of the observation period. Routine observation periods during transfer and/or release (or during intake if not already in place) can be added as enhanced prevention strategies.

Observation periods should be 7-10 days if the residents under observation are not tested at the end of the observation period. A shorter period (minimum of 5 days) could be used if combined with testing at the end of the observation period.

Medication to Prevent Severe Disease

As a strategy for everyday operations, correctional and detention facilities should maintain awareness of how to access medications to prevent severe COVID-19 in the resident population. Facilities without onsite healthcare capacity should maintain a plan to assess residents' risk for severe health outcomes and to ensure timely access to treatment outside the facility.

Monoclonal antibodies

The FDA has expanded EUAs for use of some investigational monoclonal antibody medications to prevent SARS-CoV-2 infection and severe health outcomes, including in correctional populations, under certain conditions. Refer to the National Institutes of Health website on Characteristics of SARS-CoV-2 Antibody-Based Products for details related to specific medications, including when they are recommended for use.

Antiviral medications

In addition, antiviral medications are available that are effective in preventing severe health outcomes in persons with COVID-19. The National Institute of Health COVID-19 Treatment Guidelines provide information about these medications and describe what is known about their effectiveness.

These medications can be ordered at no cost through the office of the Assistant Secretary for Preparedness and Response (ASPR) within the Department of Health and Human Services, from the manufacturer, or in some cases through facilities' usual medication procurement mechanisms.

Medications are *not* a substitute for vaccination. Vaccination remains the best tool to prevent severe illness and death from COVID-19.

Medical Isolation and Quarantine

Isolation (for persons with suspected or confirmed COVID-19) and quarantine (for persons who have been exposed to someone with COVID-19) are strategies for everyday operations in correctional and detention facilities. The guidance below includes recommendations for modified isolation protocols during short-term periods of crisis-level operations, as well as modified quarantine approaches that can be considered based on a combination of factors including current COVID-19 Community Level, facility-level factors, and residents' mental health.

Managing medical isolation and quarantine spaces

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 for short periods 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. Note that when traditional contact tracing is not feasible, close contacts can be identified through location-based contact tracing.)

Note that facilities may determine that individual 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.

Manage medical isolation and quarantine units as follows to prevent further transmission:

- Keep residents' movement outside the medical isolation/quarantine space to a 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 if a resident needs to be transferred to a healthcare facility.
- Minimize shared air between medical isolation/quarantine spaces and other spaces within a building. Ventilation to/from the medical isolation/quarantine space should be separate from ventilation to other spaces within the same building. Air should flow from clean to less clean areas.
- 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 medical isolation/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 and Table 2.
- Clean and disinfect areas used by people with COVID-19 and their close contacts on an ongoing basis during medical isolation/quarantine.

Ensure that medical isolation and quarantine are operationally distinct from punitive segregation.

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 encourage prompt reporting of COVID-19 symptoms and support mental health, 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:

- As much as possible, provide similar access to radio, TV, reading materials, personal property, commissary, showers, and other resources as would be available in individuals' regular housing units.
- As much as possible, allow residents to return to their previously assigned housing spaces after medical isolation/quarantine ends, if that is their preference.
- 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.
- To support mental health, consider allowing increased telephone time or other opportunities to communicate with others outside the facility during the medical isolation or quarantine period.
- Communicate regularly with residents in medical isolation or quarantine about the duration and purpose.

Medical isolation during routine operations

Medical isolation for residents with suspected or confirmed COVID-19

Regardless of their vaccination and booster status, residents showing symptoms of COVID-19 (suspected COVID-19) or testing positive for SARS-CoV-2 (confirmed COVID-19) should wear a well-fitting cloth or disposable procedure mask or respirator and should be immediately placed under medical isolation and medically evaluated (including eligibility for COVID-19 therapeutics). Facilities without onsite healthcare capacity to medically evaluate and/or treat residents 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.

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 should monitor the guidance website regularly for updates to these recommendations.

Residents with suspected or confirmed COVID-19 should wear a well-fitting cloth or disposable procedure mask or respirator under the following circumstances:

- Immediately upon identification of symptoms or positive test, until placed in medical isolation
- Once in the medical isolation space, whenever another individual enters (unless the person entering a medical isolation space for confirmed COVID-19 also has confirmed COVID-19)
- If they leave the medical isolation space for any reason

Residents with suspected COVID-19 should be tested for SARS-CoV-2 and should ideally be housed individually while waiting for test results. If the resident's SARS-CoV-2 test result is positive, they can be moved to cohorted medical isolation with other residents with confirmed COVID-19. If the resident's test result is negative, they 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 with confirmed COVID-19 may be housed in medical isolation as a cohort (rather than in single cells), even if they tested positive on different dates. Cohorting residents during medical isolation can mitigate some mental health concerns associated with individual medical isolation and can increase capacity for medical isolation during case surges. Considerations for cohorted medical isolation include:

- Only residents with a positive SARS-CoV-2 test result 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.

Medical isolation can be discontinued based on the following criteria:

- **Residents with asymptomatic infection** – Medical isolation can end 10 days after the first positive test result (with Day 0 being the date their specimen was collected).
- **Residents with mild or moderate, symptomatic illness** – Medical isolation can end 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. Loss of taste and smell can persist for weeks or months after recovery and need not delay end of isolation.
- **Residents with severe illness** – Medical isolation can end 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. Extending duration to up to 20 days may be warranted.
- **Residents who are moderately or severely immunocompromised** – Medical isolation should extend to 20 or more days because these people can have a longer infectious period. Use a test-based strategy to end isolation, and consult with an infectious disease specialist to determine the appropriate duration.

See section below on recommended duration of medical isolation during short-term periods of crisis-level operations (e.g., severe staffing or space shortages).

Isolation for staff with COVID-19 symptoms or a positive test

Staff with COVID-19 symptoms should be excluded from work and advised to seek testing, regardless of their COVID-19 vaccination and booster status. Staff members with a positive test result (with or without symptoms) should be excluded from work for 10 days from the date when symptoms started, or from the date of the positive test if they do not have symptoms (with Day 0 being the date their specimen was collected). (However, staff may use CDC guidance for the general public for duration of isolation when they are not at work.) See section below on isolation duration for staff during crisis-level operations.

The same recommendations apply for access to the facility by visitors, vendors, and volunteers.

The same recommendations apply for access to the facility by visitors, vendors, and volunteers.

Modifying isolation protocols during crisis-level operations

Because of the potential for rapid, widespread transmission of SARS-CoV-2 in congregate environments and evidence that infected people who are up to date on their COVID-19 vaccines can transmit the virus to others, CDC recommends maintaining 10-day isolation periods as much as possible for all infected residents and staff in correctional and detention facilities, regardless of their vaccination and booster status. (However, staff may use CDC guidance for the general public for duration of isolation when they are not at work.)

During crisis-level operations (examples below), facilities may need to consider short-term alternatives to the recommended 10-day isolation periods for staff and/or residents. Facilities should consult their state, local, tribal, or territorial 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 medically isolate all residents who have been infected for the full 10-day period, 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 isolation for residents and staff). Facilities should ensure that both residents and staff understand that reduced isolation protocols are short-term, crisis-management tools and that the facility will return to the full 10-day isolation recommendations.

The following are guiding principles for reducing isolation periods during crisis-level operations:

- Reductions in isolation duration should be as minimal as possible to mitigate the crisis scenario.
- Decisions to shorten isolation duration should be made independently for staff and for residents, based on the specific resources that are constrained at the time.
- Before reducing isolation duration, consider alternatives (e.g., shifting from individual to cohorted medical 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 and access to COVID-19 therapeutics to prevent severe illness.
- 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 medical isolation units or in assignments where they have minimal contact with others until day 10.
- If a facility shortens isolation duration, it is possible to incorporate a negative test result 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 test 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

Standard quarantine approach

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

The most stringent form of quarantine, with the lowest risk of transmission, is to individually quarantine all residents who have been in close contact with someone with confirmed or suspected COVID-19 for 10 days from the date of the last exposure, regardless of their vaccination and booster status. Note that when traditional contact tracing is not feasible, close contacts can be determined through location-based contact tracing.

Movement outside the quarantine space should be kept to a minimum. All quarantined residents should receive an initial diagnostic test as soon as possible after identification as a close contact (but not within the first 24 hours after a known exposure, because a test is unlikely to be positive that quickly) and should be monitored for symptoms once per day.

Residents who are more likely to get very sick from COVID-19 should also be evaluated for eligibility for COVID-19 therapeutics to prevent severe outcomes. If a resident develops symptoms, follow procedures detailed above for medical isolation of people with suspected COVID-19.

If the initial test result is negative, the resident should receive a second diagnostic test at least 5 days after the close contact in order to facilitate early identification of a potential infection to prevent severe outcomes. (If the initial test was performed at least 5 days after the close contact, a second test is not needed.) Day 0 is the date of last exposure/close contact.

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 or suspected COVID-19.

Residents who have been exposed to someone with COVID-19 should wear a well-fitting cloth or disposable procedure mask or respirator under the following circumstances:

- Immediately upon identification as a close contact of someone with COVID-19 (if not already in a quarantine space)
- When 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

Considerations for Cohorted Quarantine

Ideally, facilities should individually quarantine close contacts of persons with confirmed or suspected COVID-19, unless mental health concerns preclude individual housing. Cohorting multiple quarantined close contacts could result in further transmission. If cohorted quarantine is necessary**, reduce transmission risk by selecting housing spaces for quarantine** 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 more likely to get very sick from COVID-19. Ideally, they would not be cohorted with other quarantined residents, to reduce their chance of infection. If cohorting is unavoidable, make all possible accommodations to reduce exposure for residents who are more likely to get very sick from COVID-19.

In addition, consider possible co-infection with other respiratory illnesses, such as influenza, in quarantine decisions. Individual quarantine is recommended for residents with co-infection.

Serial testing for cohorted quarantine. If quarantine cohorts are used, transmission may continue if some members of the cohort have an unrecognized infection. Serial testing of the entire quarantined cohort, *regardless of their vaccination and booster status,* can identify additional infections early and prevent continued transmission. When the transmissibility of circulating SARS-CoV-2 variant(s) is high, serial testing may be challenging to implement because of reduced staffing levels and/or large numbers of residents in cohorted quarantine. In such situations, facilities may choose to prioritize serial testing primarily when the circulating SARS-CoV-2 variant(s) also causes high rates of severe illness, with a focus on identifying infections early to prevent severe health outcomes. Facilities with a low risk tolerance may consider using serial testing in quarantine cohorts more routinely.

- **To implement serial testing, 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 may be sufficient when transmission has slowed). In addition, continue diagnostic testing for residents with symptoms.
- 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.

Quarantine for staff members

All staff members who have been potentially exposed or identified as a close contact to someone with COVID-19 should be advised to seek testing. If the test result is positive, staff members should be excluded from work for 10 days from the date when symptoms began, or from the date of the positive test if they do not have symptoms (with Day 0 being the date their specimen was collected).

Staff members should quarantine if their test result is negative. The quarantine approach with the lowest risk of transmission to residents and staff in the facility is to exclude exposed staff from work for 10 days after their last exposure, regardless of their vaccination and booster status. (However, staff may use the CDC guidance for the general public for duration of quarantine when they are not at work.) See section below on modified quarantine approaches that could be applied to staff.

The same recommendations apply for access to the facility by visitors, vendors, and volunteers.

Modified quarantine approaches

Because of the potential for rapid, widespread transmission of SARS-CoV-2 in congregate environments and evidence that infected people who are up to date on their COVID-19 vaccines can transmit the virus to others, CDC recommends maintaining 10-day quarantine periods as much as possible for all residents and staff in correctional and detention facilities who have been potentially exposed or come into close contact with someone with COVID-19, regardless of their vaccination and booster status. However, quarantine protocols for residents and/or staff may need to be modified in some facilities to balance the risks of severe disease from COVID-19 and the impact of prolonged quarantine on residents' mental health, or to adapt to changes in disease severity and transmissibility from different SARS-CoV-2 variants. Quarantine protocols for staff may also need to be modified during case surges to ensure adequate staff coverage to maintain safety, security, and essential services in the facility.

Quarantine can be very disruptive to the daily lives of residents because of the limitations it places on access to programming, recreation, in-person visitation, in-person learning, and other services. These challenges are especially pronounced when residents must be quarantined as cohorts, because quarantine periods can become prolonged due to continued transmission. In addition, recommended serial testing every 3–7 days during cohorted quarantine has been difficult for facilities to accomplish during large outbreaks when testing and staffing resources have been strained.

Table 3 presents a range of modified quarantine approaches that can be considered for residents and/or staff, with variations in duration, testing, movement, and monitoring strategies. When choosing among these approaches, facilities should consider the current COVID-19 Community Level (which incorporates both transmission and disease severity for currently circulating variants) in combination with facility-level factors and what is known about the incubation period of the variants circulating at the time. During times when risk tolerance is low (e.g., when disease severity is high), facilities should choose lower risk strategies.

Table 3. Standard and modified quarantine approaches in correctional and detention facilities

Quarantine Characteristic	Standard approach	Modified approaches*
Who is required to quarantine *(applies to residents and staff)*	All exposed residents and staff, regardless of vaccination and booster status	Only exposed residents and staff not up to date on their COVID-19 vaccines and who have not recovered from a prior SARS-CoV-2 infection in the last 90 days

Quarantine Characteristic	Standard approach	Modified approaches*
Movement outside the quarantine space *(applies to residents)*	Keep movement outside the quarantine space to a minimum.	Allow a quarantine cohort to move outside the quarantine space and continue daily activities as a group, but without mixing with residents or staff not assigned to their cohort. Maintain consistent staff assignments to support cohort integrity. Maintain use of well-fitting masks or respirators among staff and residents while indoors, and implement serial testing for residents.
Duration *(applies to residents and staff)*	Quarantine for 10 days after last exposure/close contact with someone with COVID-19.	*Test-out option*: Quarantine for no fewer than 5 days, with a negative viral test result after Day 5. *Daily testing option:* Test daily for no fewer than 5 days, and allow normal activities/access to the workplace as long as viral test results are negative.
Testing (during individual quarantine) *(applies to residents)*	After the initial diagnostic test, test residents again after Day 5.	After the initial diagnostic test, release residents from quarantine after the full recommended 10-day period with no additional testing. (Test residents who develop symptoms, make additional testing available on request, and actively offer testing to residents more likely to get very sick from COVID-19 to identify infections early and assess treatment eligibility.)
Testing (during cohorted quarantine) *(applies to residents)*	Implement serial testing as recommended above, every 3-7 days for the entire cohort.	*Reduced cohort size option:* After the initial diagnostic test, implement serial testing every 3-7 days for the entire cohort. Use small cohort sizes to reduce the risk of continued transmission and prolonged quarantine periods. *Reduced testing option – **during crisis-level operations only**:* After the initial diagnostic test, test residents who develop symptoms, and make additional testing available on request. Actively offer additional testing to residents more likely to get very sick from COVID-19 to identify infections early and assess treatment eligibility. Release cohorted residents from quarantine after 10 days have passed without any new cases.
Monitoring *(applies to residents)*	Conduct daily symptom checks for all quarantined residents.	Conduct daily symptom checks only for quarantined residents more likely to get very sick from COVID-19. Identifying symptomatic infection early can facilitate timely treatment and reduce the risk of severe outcomes.

Regardless of the quarantine approach facilities choose, all residents and staff in the facility who have been potentially exposed or have close contact with someone with COVID-19 should wear a well-fitting cloth or disposable procedure mask or respirator 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

In addition, if quarantine duration is reduced for staff members, facilities should still require exposed staff members to:

- Continue to self-monitor for symptoms of COVID-19 through day 10 after a known or suspected exposure
- Immediately isolate and get tested if symptoms of COVID-19 occur
- Adhere to all recommended prevention strategies for people who have been exposed to someone with COVID-19, including physical distancing and maintaining good hand hygiene

Masks and Respirators

As a strategy for everyday operations in place at all times, provide a well-fitting mask or respirator to any residents and staff members who would like to use them based on their personal preference. Require universal indoor mask/respirator use as an enhanced prevention strategy when the COVID-19 Community Level is medium or high, or when facility-level factors indicate increased risk.

Correct and consistent mask or respirator use is key to preventing the spread of droplets and very small particles that contain the virus. Clearly explain the purpose of masks and respirators and when their use may be contraindicated. Provide masks or respirators at no cost to residents and staff and clean or replace them routinely.

In situations where the use of a respirator is not required either by the employer or by an Occupational Safety and Health Administration (OSHA) standard, the employer may still offer filtering facepiece respirators or permit employees to use their own respirators as long as the employer determines that such respirator use will not in itself create a hazard. This is considered voluntary use under the Respiratory Protection Standard. CDC encourages employers to permit workers to voluntarily use filtering facepiece respirators like N95s. If an employer allows voluntary use of filtering facepiece respirators, the employer must provide users with 29 CFR 1910.134 Appendix D – Information for Employees Using Respirators When Not Required Under the Standard . See 29 CFR 1910.134(c)(2) for additional requirements applicable to voluntary respirator use.

See Table 2, including footnotes, for additional considerations for choosing a mask or respirator, including information on different types as well as safety and security considerations for their use in correctional and detention facilities.

Preparing for Outbreaks

Maintain COVID-19 preparedness through essential actions detailed below.

- Monitor COVID-19 Community Levels and other local data, as well as updates to CDC and state public health websites, to inform decisions about when to add enhanced prevention strategies.
- Refine the facility's long-term COVID-19 plan as needed based on new information, and ensure staff are trained on the current plan. Ensure that the long-term COVID-19 plan includes:
  - Plans to procure COVID-19 vaccines and therapeutics to prevent severe outcomes
  - Plans to procure SARS-CoV-2 testing supplies
  - Ways to scale up medical isolation and quarantine spaces during an outbreak
  - Plans for operating during staffing shortages
  - Plans to restock PPE and cleaning and disinfection supplies during outbreaks
  - Considerations for offering revised duties during outbreaks for staff members who are more likely to get very sick from COVID-19
  - Plans to communicate with staff and residents about how they can protect themselves and others from COVID-19. Example signage and other communications materials are available on the CDC website. Printed materials should be easy to understand by non-English speakers, those with low literacy, and people with disabilities.
- Maintain collaborations with state, local, tribal, and territorial public health departments.
- Maintain communications with other correctional facilities to share information and collaborate on protocols to prevent transmission between facilities during resident transfers.
- Review the sick leave policies of each employer that operates within the facility. Employers are encouraged to implement flexible, non-punitive paid sick leave policies to reduce SARS-CoV-2 introduction and transmission in the facility.
- Ensure that all persons in the facility know the symptoms of COVID-19and the importance of reporting symptoms if they develop.

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. Physical distancing strategies can be applied on an individual level (e.g., avoiding close contact), a group level (e.g., temporarily suspending 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). Physical distancing is an enhanced prevention strategy that can be considered when the COVID-19 Community Level is medium/high or when facility-level factors indicate increased risk.

- Make a list of possible physical distancing strategies that could be implemented as needed at different stages of transmission intensity. 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).
- 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.
- Consider increasing keep on person (KOP) medication orders.
- Identify staff duties that can be performed remotely.

Visitation

At all times (even when COVID-19 Community Level is low):

- Provide alcohol-based hand sanitizer with at least 60% alcohol in visitor entrances, exits, and waiting areas.
- Instruct visitors and volunteers to postpone their visit if they have symptoms of COVID-19.

When COVID-19 Community Level is medium/high or when facility-level factors indicate increased risk:

- Consider restricting non-essential visitors, vendors, volunteers, and tours from entering the facility, or restricting their interaction with sections of the facility where transmission is occurring. Suspending in-person visitation and volunteer services should only be done in the interest of the residents' physical health and the health of the community. Visitation and services provided by volunteers are 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.
- If facilities maintain in-person visitation or volunteer services during periods of higher risk:
  - Require visitors and volunteers to wear a well-fitting cloth or disposable procedure mask or respirator while indoors.
  - Consider using protective barriers in visitation rooms and encouraging physical distancing.
  - Consider requiring visitors and volunteers to provide documentation of a negative SARS-CoV-2 test result within the last 72 hours before entry.

Re-entry considerations

- If a resident 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.
- When the COVID-19 Community Level is medium/high or when there is transmission in the facility, offer all residents screening testing before release, regardless of COVID-19 vaccination and booster status.
- Provide residents preparing for release with COVID-19 prevention information, hand hygiene supplies, and masks or respirators.
- Ensure that linkages to community services account for modified operations of providers due to COVID-19.
- When providing information on Medicaid enrollment and healthcare resources in the community, include information on continuity of care for chronic conditions that may make a person more likely to get very sick from COVID-19.
- When the COVID-19 Community Level is medium/high and when possible, encourage residents 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.

capacity for physical distancing.

Previous Updates

Updates from Previous Content

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.

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.
- 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.

Last Updated May 3, 2022