DARYL FOX: Good afternoon, everyone. And welcome to today's webinar, “COVID-19 in Correctional Facilities: Updates to CDC Guidance and Available Funding for Detection and Mitigation Strategies,” hosted by the Bureau of Justice Assistance. At this time, I'd like to introduce Sara Sullivan, Senior Policy Advisor with the Bureau of Justice Assistance, for some welcoming remarks and to begin the presentation. Sara?

SARA SULLIVAN: Thank you very much. First, I want to thank everybody for joining us today. We have a fairly large audience which just shows still continued interest in this issue in the field. I want to introduce myself. My name is Sara Sullivan. I'm the Senior Policy Advisor with the Bureau of Justice Assistance and my colleague Liesl Hagan, who is a Senior Scientist for Correctional Health with the CDC. Next slide. During this webinar, I want to start out with just a brief overview of who OJP and BJA are. We're going to talk about the partnership between BJA and CDC on COVID response. And then I'm going to pass it off to Liesl who will give the majority of the presentation that will go into the updates that were released last month by the CDC regarding COVID-19 guidance for correctional and detention facilities. That'll take up the majority of our time today and then at the end, I'm going to talk about some funding that's available to confinement and correctional facilities on their COVID-19 detection and mitigation strategies and then we'll have time at the end for question and answer. I will say that Liesl has built into her presentation times to stop and offer a Q&A time as we go, so you don't have to hold your questions till the end, but we will have a final Q&A at the end in case there's anything in addition anyone wants to add.

So what is the Office of Justice Programs? The Office of Justice Programs is within the U.S. Department of Justice. And what the Office of Justice Programs or OJP does is support criminal justice community at the state and local level through grant funding, training and technical assistance, research, and statistics. And we are one of three grant-making components of the Department of Justice. Next. Within the Office of Justice Programs, we have the Bureau of Justice Assistance or BJA and our mission at BJA is to create safe, just, and engaged communities and we do that by providing resources, leadership, and solutions. The goal is really to reduce crime, reduce recidivism, and reduce unnecessary confinement and ensure that there is a safe and fair system. We do that through collaborative effort with communities, governments, and nonprofits. Next. So the American Rescue Plan Act of 2021 that was passed by Congress established the COVID-19 Detection and Mitigation in Confinement Facilities Program. That program is a joint venture between BJA and CDC. CDC administers the awards and I will talk about this program later on in the presentation. The CDC administers the awards and BJA is providing targeted technical assistance to subject matter expertise. So this is a joint venture between the two departments, between the two agencies. We're really excited to be co-hosting this webinar and having Liesl Hagan here with us. And with that, I'm going to pass it over to Liesl to provide the update to CDC's guidance on COVID-19 management and correctional facilities. So with that, Liesl, I pass it over to you.

LIESL HAGAN: Thank you so much, Sara. And I appreciate the partnership with BJA and appreciate the opportunity to talk with folks today about recent updates to our guidance for corrections. In this presentation, we're going to start off with the current COVID-19 context and talk a bit about CDC's community levels, which is essentially a framework for risk

assessment in the general population. And then we'll shift to updates in our corrections-specific guidelines which were posted on May 3rd. Some of you may have been able to attend a previous webinar with the National Commission on Correctional Healthcare on this same topic and this one would be much of the same content there, and—but we know that a lot of folks were not able to attend that session, so we appreciate this opportunity to reach more facilities with this information. Specifically, we're going to go through a new categorization of COVID prevention strategies. One is strategies for everyday operations and the second category is enhanced prevention strategies when the risk of COVID is higher. So we'll go through what those categories are and our risk assessment framework for when to shift between them and which prevention strategies fit into each bucket. We'll also go through a range of modified quarantine approaches that we've been developing in consultation with departments of corrections and also with jails of varying sizes who have weighed in on this topic with us over the course of the last few months. And finally, we'll go through a few technical content updates to the May 3rd posting of our guidance. And as Sara mentioned, we will have several opportunities for Q&A throughout this session.

This is a lot of information and it's quite dense. And so I'll do my best to be a very engaging presenter but would also appreciate you going ahead and proactively putting your questions in the Q&A box so that we can go through them as the topics arise, as we go through the content. So to start us off for the current COVID-19 context, I think most folks are aware that we have had an increase in cases recently over the last month or so but it appears that those cases are starting to plateau as you can see with the epidemic curve below, which shows the daily trends and numbers of COVID-19 cases in the United States that are reported to CDC. So on the far left, you see January of 2020 and all of the peaks and valleys in between taking us up to June 14th, just a couple of days ago. So cases are starting to plateau. Hospitalizations are continuing to increase slightly but deaths are starting to decrease slightly as well. And when we gave this presentation and updated this content about three weeks ago, four weeks ago, hotspots were concentrated in the northeast but at this point, there are hotspots scattered across the United States and different areas.

So within that context, I'd like to talk a bit about an overall shift in CDC guidance, where for the majority of the pandemic, we were very much focusing on limiting the spread of COVID-19 and preventing as many cases as possible. And now where we are in the pandemic currently, we have had a shift from preventing every case to trying to minimize severe disease from COVID and there are several reasons for that. And you'll see this across our guidance for all settings. The first reason is that population immunity against COVID is quite high. And this reduces the risk for severe outcomes in the population. In addition, recent variants have been associated with milder disease compared to variants earlier in the pandemic. And finally, because of the continued availability of vaccines and treatments, there is a wide range of tools available to prevent severe outcomes among people who do become infected. So for this reason, our recommendations for COVID across settings focus on prevention strategies that minimize the impact of severe COVID illness on health and society. So this means preventing medically significant illness as well as minimizing the burden of that medically significant illness on our healthcare systems. And finally continuing to protect the most vulnerable people through continued vaccination treatments and establishing enhanced prevention measures and settings where people

are more likely to see a greater impact of COVID. So this shift has a lot of data behind it and if you're interested in reading more about the reasons for this shift within the broader scope of CDC guidance, you're welcome to visit our science brief. We will be circulating the slides from this presentation, so if you come back to this one and click on that science brief link, it'll take you there and you can read all the details for the data underlying these decisions.

So part of that shift has been shifting us from focusing mostly on the number of cases that we're looking at, community transmission levels, to what we're calling at CDC COVID-19 Community Levels. And these community levels are essentially a framework for assessing COVID-19 risk in the general public. And there are three levels, low, medium, and high, and they're different from community transmission levels that we've looked at before because they take into consideration two things. It's not just the number of COVID cases that we're seeing in a county but also the impact of severe disease on local healthcare systems. And I'll take you through in a moment exactly how these are calculated and what data go into them. So with each increasing level, each increasing community level, CDC recommends increasing the intensity of COVID-19 prevention strategies. So one example in the general public is that when the community level is low, we recommend masking based on your personal preference. When the community level is at medium, we recommend considering masking if you're at risk for severe illness or if you have personal contacts who are at risk for severe illness. And then when the community level is high, we recommend going back to universal indoor masking in public. And so those types of stratifications by community level are available on the CDC website for a variety of different prevention strategies for the general public.

So to get a little bit more into how these community levels are calculated, there are several components. One has to do with transmission. And so you'll see on the left side of this chart, the number of COVID-19 cases, new COVID-19 cases in the past 7 days for 100,000 people in the population. And you'll see there are two rows in this chart for this. There's fewer than 200 new cases and then 200 or more. So when you're looking to see what your community level is, first you look at that particular metric and figure out whether you're in the top row or the bottom row. Then over in the middle, you'll see the two indicators for healthcare system strain, and this is measured first by the number of new COVID admissions per 100,000 population and also by the percent of staffed in-patient beds occupied by COVID-19 patients. And so you find the greater of those two and that'll tell you whether you're in the low, medium, or high category. So to take an example, if you're in a county that has 157 new cases of COVID per 100,000 people in the last 7 days, that would put you up in the higher row of the chart. So you start there. And if you have 7 new COVID admissions per 100,000 population over the last 7 days, then that would put you in the low community level. But let's say you also have 12% of your staffed in-patient beds occupied by COVID-19 patients. That would put you in the medium bucket. And so you take the higher of those two. And so this particular example county would be in the medium community level. You can find your particular county's community level on our COVID data tracker website. Again, this will be an active link when the slides are shared.

And then you can see, as I mentioned before, that there are hot and warm spots all over the country. It's not really necessarily concentrated in one particular area. And right now, we've just got a little bit over half of U.S. counties in the low community level zone, we got about a third in medium and a little under 10% in high. So compared with a few weeks ago when we gave this presentation, we've got more counties in medium and fewer in high. So we're still seeing the need for some enhanced prevention measures because of a pretty good concentration of counties in that medium or high band. So when you go to the website, you can either just click on the map to find your county or you can use the dropdown menus for the states or county there.

So, a note quickly about the differences between transmission levels and community levels. So as I mentioned, most of the time during the pandemic up until very recently, we were relying on what we called community transmission levels which you can see here on the right side of the slide. And these were categorized as low, moderate, substantial, and high, and were based only on the number of new COVID cases. But as we saw the severity of illness associated with newer variants decrease, we realized that we needed to look at more than just the number of cases. And so we shifted to this community levels concept to take into account not only transmission and the number of new cases but also the impact on healthcare facilities. So that's where you see us on the left with the community levels with just the three categories low, medium, and high. And you can see that if we were still using the community transmission levels, most of the country would be in the red, in high community transmission. But when you look at the community levels on the left, you can see it's a lot more balanced between the colors with the majority of it in the low community level, and that's because it takes into consideration severity as well as the number of cases. One important caveat to this is that healthcare facilities in particular, or nursing homes, hospitals, continue to use community transmission levels in order to determine which prevention measures to use. So they're not using the newer community levels. And this is because those settings need to have more conservative prevention practices because of the populations that they have and the populations that they serve. And this will be relevant to correctional facilities as well and I'll talk about this a little bit more later on. But we do continue to recommend that correctional facilities that provide healthcare services onsite continue to use the healthcare guidance and the community transmission levels to guide prevention strategies in their patient care areas. You can still use the corrections guidance for elsewhere in the facility, but for patient care areas we want you to continue using the healthcare guidance. Okay.

So next step, I'm going to get into how this type of risk assessment is different in corrections. We all know that correctional facilities have very unique and complex contexts, and that's the reason why we've had correctional tailored correctional guidance for COVID throughout the pandemic. So we did publish an update on May 3rd, and this update goes into how to apply this community level concept and risk stratification to correctional facilities. And so, as I said, we have now separated COVID-19 prevention strategies into two groups for corrections. And these, first of all, are strategies for everyday operations, which are really the baseline strategies that facilities should have in place at all times, no matter what's going on in the facility or in the community. And then during times of higher risk, we recommend layering on additional enhanced prevention strategies and adding as many of these as possible during periods of increased risk and

then removing those gradually when the risk decreases. So this kind of risk assessment really relies on continually monitoring what's happening in your community, in your facility, so that you can shift between this every day and enhanced modes of prevention based on what's going on. And so for corrections, we recommend using not only the community levels, but also several corrections-specific facility level factors that we'll get into in just a minute. But before we get into the facility level factors, just a note on how these COVID-19 community levels do and do not apply in correctional facilities. So it's all well and good to have these metrics, but for many correctional facilities, it can be very hard to define what community they should even be looking at when they're looking at this map. Should it just be the single county where the facility is located? Or should it be with surrounding counties? Because staff are living across multiple counties or across state lines, residents are transferred from facilities all over the state or in other states or even, you know, for immigration detention, even coming from other countries. So it can be very hard to figure out, you know, what community should you be looking at on this map when figuring out what the community levels are.

And then also, we know that community data don't fully capture the risks of what you see in your facilities. So we know that correctional facilities have been experiencing higher risks of transmission of COVID inside. We know that the populations who are incarcerated oftentimes have a higher risk of severe illness because of underlying medical conditions. And the community factors don't take into consideration internal healthcare resources. We talk about community healthcare resources and the impact of COVID on those healthcare systems, but it doesn't take into account your healthcare resources inside your facilities. And finally, we know that correctional facilities have inherent risks or increased risks to the mental health of the people who work there and who reside there, just inherent in the prolonged use of mitigation measures themselves. If you got these prevention strategies in place for long periods of time, you're going to have risks to people's mental health because of prolonged quarantine and that type of thing. So for that reason, we're recommending that correctional facilities loosen or strengthen their prevention strategies for COVID based on a combination of those community levels that we just talked about, but also four specific facility level factors. And I'm going to get into those in just a moment. But before I do, there are a couple of things to note about these.

First of all, and it's important to think about these four facility level factors in combination. There isn't a single factor, you know, that should be a standalone trigger for when to move from everyday prevention to enhanced. So as an example, let's say your facility is primarily dorm-based housing with maybe 50 to 100 people housed together. So we know that's a risk for increased transmission if COVID is inside the facility. But let's say your vaccination coverage is really high, you don't have any cases in the facility and you're not a facility that houses people who have high acuity medical needs and have the risk of severe outcomes from COVID, then you may consider the overall risk in your facility to be pretty low. But if any of those factors was less favorable, let's say your facility does have people with high acuity medical needs or you're in the middle of an outbreak, then the facility's risk is higher and you should have more prevention strategies in place. Second of all, you know, the community levels are pretty black and white. You've got low, medium, and high. But unfortunately, the facility level factors are a bit fuzzier, and they require some more subjective decision-making when you're applying them. And so these are

guidelines. We don't have objective thresholds to tell you when to consider vaccinations high versus low or even how many of these facility level factors you should be considering together before you shift from every day to enhanced prevention modes. Every facility is going to be different, and so this information is really meant to empower you to use your own local data to decide what your level of risk tolerance is for your facility and when your facilities should start layering on additional prevention strategies.

So with those caveats in mind, I'm going to go through each of these. The first that you need to consider when you're figuring out should you be in everyday prevention versus enhanced prevention mode is what proportion of your staff and your residents are up to date on their COVID-19 vaccines? And what that means is whether people have not just gotten their primary series of the vaccine, but also if they've received all of the recommended doses for their age group and for their, you know, other factors that influence, you know, medical history, that kind of thing. And we know that vaccines are safe and highly effective against severe illness and death. And they're really one of the best tools that we have to prevent severe outcomes and they continue to perform well against known variants. So if your vaccination coverage is not high, consider using some of these enhanced prevention measures even when your community level is low. Again, we don't have a number to tell you this is considered high, this is considered low. But just think about it relative to other groups, you know, what does vaccination coverage look like in your county and the community and, you know, the state next door? Or, you know, look at your staff versus your residents, are you seeing a big disparity there? And if you feel like the coverage is not high, then layer on more, more prevention strategies. CDC has developed some vaccination communication materials for corrections specifically. So please feel free to visit our websites to get some of these print resources that are tailored to people in correctional settings.

So the second facility level factor to guide prevention strategies has to do with whether there's transmission in your facility right now. So any time there's a case identified among residents or staff, the facility should be conducting follow up to determine whether or not an infected person could have exposed anyone else. And if somebody has been exposed, those people need to be tested as well, so all of that is called diagnostic testing. When you're testing people who have symptoms and also testing people who have been in contact with or shared space with those people. So if you're starting to see cases and you realize that some of their close contacts are also positive, then that tells you that you do have transmission in your facility. Similarly, if you have routine screening testing programs, let's say your facility tests 10% of their population every week or, you know, some percentage of staff get tested every week. And you're starting to see positives in that routine screening testing. Then you, again, you need to check and see if there are any close contacts who have been infected. And if there are, then, you know, you've got transmission inside. Other facilities are doing wastewater testing as a form of surveillance testing. So if you start to see the levels in your wastewater increase, then you've likely got transmission inside your facility. And any time that you do have transmission, we recommend that you shift immediately to your enhanced prevention strategies, at least in the areas where transmission is occurring. You don't have to apply them to the entire facility if transmission is limited to one particular building or one particular section. But that

is a pretty clear trigger to go ahead and add some enhanced prevention strategies to prevent further transmission.

The third factor is about risk of severe health outcomes. And there are really two components here. One is whether you've got people in your staff or your resident population who are older, have certain medical conditions, or some disabilities that are associated with higher risk of severe COVID. The second factor here is whether you have access to treatment. So if you do have people who are eligible for treatment after they're infected, how easy is it for your facility to get access to those medications? And if you can't get access to the medications, how easy is it to transfer people to the community for care? A lot of these medications have a very specific and brief window during which people can be treated after infection and so it's important to access the medications or transfer to people for care in a very timely manner. So if your facility can't do that, then it's important to think about using some of these enhanced prevention measures if you've got folks in your facility who are at risk of severe outcomes and you're not going to be able to treat them or transfer them quickly if they get infected.

And finally, we know that there are facility characteristics in correctional facilities and others that contribute to transmission through their dense housing, frequent population turnover, people coming in and out, you know, regularly, and older ventilation systems that don't meet code-minimum requirements. And so if you have any of these things in your facilities, then consider using some of the enhanced prevention measures that we're going to go over, even if the overall community level is low. So in our next section, we're going to get into specifically which prevention strategies belong in which bucket, everyday versus enhanced. So I promise we'll get to that in a minute. But for now, let's pause and take any questions that people have about community levels, applying them to corrections, and the facility level factors that we've talked about.

SARA SULLIVAN: Thanks, Liesl. We do have a question that's come through. "Do you expect that the strategies that are listed as everyday prevention and enhanced prevention will change over time?"

LIESL HAGAN: And so I'll get to that in just a minute. We talked about which prevention strategies are in which bucket, but largely this risks stratification, and this categorization of the prevention strategies is really about normalizing standard public health practices within facilities. And so we don't anticipate that there will be a lot of change in which prevention strategies go in which bucket. But we'll go over those in just a little bit.

SARA SULLIVAN: Great. We did have one comment come through that I'll just read, which is, "In our state we are unable to ask about vaccination status for staff and I'm sure this affects other agencies too." Didn't know if you had anything you wanted to add to that comment.

LIESL HAGAN: Sure. That's a really good point. And it's a very important point to highlight that not every state, not every county, or facility has the same access to information and has the ability to test or vaccinate staff. So if you have the information, use it. If you don't, you know, rely on some of these other measures like vaccination in your population and,

you know, the risk level of your population and ability to treat people. So it's one of those things where it's just going to contribute to your overall assessment and risk and you may not have every data point. But that's why it's important for every facility to think about if there's, you know, individually and with the data that you have.

SARA SULLIVAN: Thanks. And then one more question, the person wrote, “It seems like fewer people are being tested now than earlier in the pandemic. Can we really rely on the community levels or community transmission levels to tell us how much risk is in the community when we know that there are a lot of people with COVID who are either not testing or using at-home tests and aren't reported to public health?”

LIESL HAGAN: Right. And that's an important point too, because as we see milder disease associated with this virus, you're going to have more people who are asymptomatic and don't test because they don't even realize that they're infected or could be infected and they don't have symptoms, or their symptoms are so mild that they just don't think about testing or they may not think it's important to test. So you're right, I think there are fewer people testing or more people not testing for a lot of reasons. And so that's where it's important to think about some of these other factors as well, you know. The other important point is that there are a lot of home tests that are happening, fewer of these are happening at healthcare providers because folks are using antigen tests and other types of rapid tests. And so even when there is testing happening, it may not be reported and may not be reflected in some of the data sources that we use for community levels. And so that's one reason why it's important to consider not only the community levels but also these facility level factors that we're talking about since we know that community levels are—you know, they do reflect the community and we know that the data are not perfect.

SARA SULLIVAN: Great. We have one more question. “Could you clarify again exactly what the enhanced prevention strategies are for corrections? But I think you're going to get to that in the future section.”

LIESL HAGAN: Yeah. Yes. So that's going to be the next section. We'll get right to that in just a couple slides.

SARA SULLIVAN: Great. That's it.

LIESL HAGAN: Okay. Perfect segue. So now, we will get into what prevention strategies we recommend at each level addressed for corrections specifically. So, you know, we've got all these different prevention strategies from vaccines to making sure people wash their hands, getting treated, quarantine, isolation, you know, where does each of these fall in terms of the framework that we're talking about? So just to go over this again, for corrections, we have separated prevention strategies into these two groups. There are strategies for everyday operations, and these again are to be used at baseline. And there are enhanced prevention strategies, and we recommend that you shift between them based on the community levels and the facility level factors that we just talked about. So, two important notes here, one is to reiterate the fact that enhanced strategies are meant to be added on top of the baseline strategies for everyday operations. So it's not an either/or

type of thing, it's about keeping your strategies for everyday operations in place and then, during periods of higher risk, adding some of the prevention strategies on top. And the second note is we know that all facilities are not going to be able to put every single enhanced prevention measure in place just because of differences in resources and population needs, operations, all of those types of things. So what we're recommending is that facilities put as many of these in place as they can because every additional strategy increases the level of protection. So the goal of this framework is to provide a flexible way to assess risk and to create flexibility in your strategy that can be used across a wide range of situations over time. So whether we're dealing with variants that cause severe illness or mild illness, or variants that spread easily or those that don't, we wanted to create a document where facilities can reference over time and see themselves in regardless of where you are in the pandemic or if your situation is changing rapidly, you can still kind of find where you are and find a way forward. So you know, I can't promise that there won't be additional updates to this guidance, but we're hoping that this update will give you more flexibility over some of these scenarios, you know, as time goes on.

So to choose whether you should be in strategies for everyday operations versus enhanced, here's just kind of a little bit of an algorithm to help you. So first, you define your current COVID-19 community level based on the information that we just talked about. If you're in a low community level, then you ask yourself, does your facility have any of those facility-level factors that we just talked about that indicate increased risk? Is vaccination coverage low? Do you house people who are at increased risk for severe illness? Do you have, you know, built environment factors like ventilation systems that could increase the risk of transmission? Or do you have cases in your facility? If the answer to that is no, then you would be in this everyday operations bucket. If the answer is yes, then we would want you to add some enhanced prevention strategies. And then, if your community level is medium or high, we recommend that you just bump straight up to adding some of those enhanced strategies.

So here—we're essentially going to create a little incremental list of which strategies fall under everyday operations in the blue on the left compared to enhanced prevention on the right. And again, everyday operations, these strategies are to keep in place at all times and then, enhanced prevention strategies want you to add as many as you can when the risk level is higher. So some of these strategies are going to fall under both categories because they are different types of, you know, testing, for example, and some might be applicable all the time. And some, you might only want to have in place during periods of higher risk. So we'll go over each of these. And so vaccination is the first one and this is definitely an everyday operations prevention strategy. We recommend that facilities keep offering vaccination as they are able to by law, both to staff and to residents. And this includes boosters. So infection control is one of those strategies that has elements that fall under everyday operations, so standard infection control is one of those. So keeping up with making sure people are washing their hands, doing your standard cleaning and disinfection, making sure that recommended PPE is available for people who need it, and ensuring your ventilation systems operate properly. These are all things for everyday operations that should be in place at all times.

But then when it comes to things like enhancing your ventilation, that's something that you would put in place when you have a higher risk in your community. So for example, if you have extra HEPA filters that you were going to put in place when there is an outbreak, then you would go ahead and add that in once you realize that there were cases happening. One important note here is that it's important to identify what those enhanced ventilation strategies are during a period of normal operation, so that you're not trying to quickly shift and buy the equipment and put new things in place while things are, you know, getting very chaotic because you have cases in your facility. So during everyday operations, you want to identify how you can enhance your ventilation, buy whatever equipment you need, test it out, and have a plan for implementing it, so that when things do get crazy, you can just go ahead and pop it in and get going. And then, we do have a list of tools to enhance ventilation on our website and again, this link will be available once we send out the slides.

So COVID testing is another prevention strategy that really falls under both everyday and enhanced, depending on what kind of testing we're talking about. The diagnostic testing, which again is testing people with symptoms and testing anybody who's been exposed to somebody who has COVID, this is everyday operations and, you know, we do recommend that everybody who has symptoms and everybody who's been exposed should get tested. And the same is true for intake testing. Intake is really one of the few opportunities that facilities have to keep COVID from coming in just because it's—you know, you got staff coming in and out of your facility and that's—you know, that's not something that you can really control whether staff come in and they have COVID and maybe don't know it. But when you've got people transferring in from other facilities or coming in off the street or, you know, whatever forms of intake that you have, we do recommend that you continue testing people at intake as an everyday operations strategy. An exception here is we know that there are some facilities that are not able to get access to testing supplies for whatever reason at any particular time.

And some of them have really successfully implemented essentially an intake observation period. And we used to call these quarantine periods, like a routine intake quarantine. But it really doesn't have anything to do with exposure and so quarantine isn't the most accurate word for it. So this is one change to the guidance that we no longer refer to routine quarantine during movement, we talk about it as an observation period. So in a facility that doesn't have access to testing in the quantities required to do intake testing for everybody, there is an option to do an intake observation period instead. But this is really only advisable if individual housing can be used during the observation. There are some facilities that don't do individual housing because of mental health and suicide concerns, and if that's the case then, you know, people can be housed as very small cohorts as long as they start the observation period at the same time. No new people are introduced during that time and people are tested at the end. So these are really the only circumstances where we deviate from that testing and intake. If you have to do an observation period instead, you know, try as much as you can to do individual housing or incorporate testing into that observation period.

So moving over to the enhanced prevention side, there are additional testing strategies that fit under here. The first is about routine screening testing. And this is any time you're

testing people who don't have symptoms and don't have—to their knowledge, haven't been exposed to anybody who has COVID. And so we recommend that facilities add routine screening testing programs, so this might be testing a certain percentage of the population every week or something like that, or increase the frequency of a routine screening testing program that you already have in place. And then, another testing option for enhanced prevention is adding testing to your transfer and release protocols. And again, that's just to minimize any transmission that might happen during movement. So routine observation periods, again, this actually doesn't have anything to do with exposure to COVID, it's not quarantine per se, it just has to do with housing people separately before or after movement so that you minimize transmission during that time.

So if you're in a situation where your facility has a higher risk of COVID then you may add routine observation periods as an enhanced prevention measure, but it's not something that fits into the everyday operations bucket. In terms of the duration here, if you're not using testing in combination with the observation period, then we recommend a 7- to 10-day observation period. But if you are testing, then you can reduce that to a minimum of 5 days with a negative test at the back end. Isolation and quarantine. These are strategies for everyday operations. There can be variability on how these are implemented, and we can get into that in a few minutes. But in some form, isolation and quarantine are strategies for everyday operations to separate people who are sick from people who are not, and separating people who have been exposed and might be sick from people who are not. So this is everyday operations. And we will talk about some modified approaches to quarantine in just a minute.

Treatment for COVID. And this includes not only assessing residents for risk of severe outcomes, but also having the capacity to treat them in-house or transfer them for care. This is a strategy for everyday operations as well. Masking, this is another one that fits across both categories. During the everyday operations, we recommend offering masks to everybody, staff and residents, and so they can use them according to their personal preference. And then, when the risk is higher requiring masks indoors as an enhanced prevention measure. Movement and distancing, both of these are enhanced prevention measures. So when we talk about minimizing movement, we're talking about minimizing movement within your facilities, so trying to make sure that your work details include residents just from a single housing unit, keeping your staff assignments consistent, just making sure that you got as little interaction between parts of your facility as possible to minimize transmission.

We're also talking about minimizing movement between facilities. So you might choose to stop transfers for a short period of time if you've got an outbreak, and also minimizing movement between the facility and the community. So this might be pausing work-release programs, pausing in-person visitation, but as with all of these things, it's important to note that they should be for short-term periods because of the impact that these—you know, doing these for prolonged periods of time can have on mental health of residents and staff. Same thing with physical distancing and we recommend that you reduce crowding as possible whenever you've got any of these higher risk situations. We know that it's really hard to reduce crowding and to implement social distancing between people within correctional settings. And so it's something that we add as an enhanced prevention

measure and just finding whatever strategies you can to reduce either the number of people in your facility or increase the distance between them.

And finally, preparing for outbreaks is a strategy for everyday operations. And this has to do with just continually monitoring what your community level is, making sure your staff and residents understand what to expect if there is an outbreak, and keeping in touch with state and local public health. So as I said, we know that none of this is a one-size-fits-all situation, every facility is different with different styles of housing, sizes, turnover, population, risk factors, and mental health risks, all of these things are going to influence which enhanced preventions you can implement. And so it may not be feasible to put all of them in place, so what we recommend is that you just add as many as possible during periods of higher risk. And you can apply these enhanced prevention strategies, like I said, to a whole facility or you can target it just to specific areas where you know that there is a problem.

And as always, we recommend that you consider the impact of these strategies on mental health, in-person learning, particularly for youth populations who are detained, as well as the likelihood of compliance with some of these strategies. And then, as we've said, make sure that you gradually remove these things during periods of lower risk. So at this point, if there are any questions about these specific strategies and which bucket they fall into, when to use them, we can have more questions about that at this point.

SARA SULLIVAN: Yeah. So we actually have quite a number of questions that I'm going to—so here's the first one. “Is social distancing no longer a strategy recommended for everyday operations?”

LIESL HAGAN: So social distancing is always going to help you, whether you're in everyday operations or enhanced prevention. But we recognize that this is something that can't always be done in corrections. And so it is not something that we have in the everyday bucket. But I will say any facility that wants to do more during everyday operations can always put some of these enhanced prevention strategies in place, even when there's not an outbreak or they're not in a period of higher risk. So for the purposes of categorization, social distancing, decreasing crowding is an enhanced prevention strategy. But you can always put it in place if you want to.

SARA SULLIVAN: All right. So the next few questions are about testing. Some of these questions came in maybe before you got to that section. But I'm going to ask them anyway, because I think some of these are worth repeating. “Is COVID-19 testing recommended for all patients coming into the prison, regardless of community transmission levels?”

LIESL HAGAN: Yes. And as I said, intake is one of your few points where you can keep COVID from coming into your facilities. So we do recommend intake testing, continuing intake testing as a strategy for everyday operations.

SARA SULLIVAN: Here's another question about admissions. “Should individuals admitted into a correctional or detention center be quarantined, and if so, for how long?”

LIESL HAGAN: So that goes along with the testing question. So if you see here under everyday operations, if you can see my arrow, we recommend essentially either testing or an observation period and that person used the word quarantine, which is what we used to call this, as an intake quarantine. But this was causing a lot of confusion because quarantine is usually associated with somebody who's been exposed but people who are coming in may not have been exposed. So we're calling this an observation period at this point. But the important point is that we recommend that you either test people or do and ideally an individual observation period during intake. So those are really the two best options there, either testing or an individual observation period.

SARA SULLIVAN: “But then on that point, if an individual tests negative in intake, then an observation period is no longer necessary?”

LIESL HAGAN: Correct. So that would be something that if the facility has a low risk tolerance and they want to do both, they're more than welcome to do that. I know many facilities have been doing that successfully, particularly in facilities that may have a mission that includes treatment for people who have high acuity medical needs, you know, their risk tolerance might be lower, so they might choose to do both of those things. But for everyday operations, our recommendation is one or the other, and if they test negative, they can go on into the general population.

SARA SULLIVAN: “And how long should the observation period be?”

LIESL HAGAN: So ideally it would be 10 days. But there is a way there—so kind of earlier in these slides, if you are testing at the end of the observation period, then we recommend a minimum of 5 days with a negative test. But if you're not testing, then 7 to 10 days.

SARA SULLIVAN: Right. For the sake of time. Why don't we move on to the next section?

LIESL HAGAN: Okay. So, quarantine is another big change to this guidance, we know that quarantine has been a challenge to implement for a variety of reasons. We have updated our guidance to offer several modified approaches to quarantine to help reduce the impact on operations and mental health. Before we get into that, I just want to quickly review what our standard approach to quarantine is, both for individual quarantine and cohorted quarantine when individual spaces aren't available. And so this is the strategy with the lowest transmission risk. And so as far as who gets quarantined, this is everybody. Anybody who's exposed, regardless of their vaccination status, would be quarantined under the standard quarantine approach. And if it's individual quarantine, it would be 10 days. And if it's cohorted, it would be quarantine until 10 days have passed with no new cases identified. And that's because we recommend that in cohorted quarantine, the whole cohort be tested serially every 3 to 7 days. So you may get more cases identified as the quarantine period goes on and you may have to restart that time.

For individual quarantine, the testing is a little bit different. You have your initial diagnostic test. And then we also recommend a second test at least 5 days after exposure. And this test isn't necessarily to end quarantine earlier it's just to make sure to identify infection early. So this person who's quarantined individually is infected. Then we would want their

infection to be identified early so that they can be treated quickly if they're eligible for treatment. Under the standard quarantine approach, we recommend minimal movement outside the quarantine space, and we recommend monitoring for symptoms daily. So again, this is kind of the gold standard, lowest transmission risk for quarantine. But we know that there are a lot of challenges with this, partly because in cohorted quarantine in particular, you end up restarting over and over again if you get more cases. And so we've seen facilities that have had quarantine periods of several months where people don't have access to programs or visitation, and it can have serious impacts on mental health, both for residents and for staff. It's not only one of the challenging parts of the pandemic for corrections to implement, but it's also one of the most difficult prevention strategies for us to modify. And that's because it's based on the incubation period of the virus, and we can't change that. Another reason it's hard to modify is that quarantine can have a really important impact on continued transmission in congregate settings. So it's one of the tools that we have to reduce transmission. But as we've said at this point of the pandemic, where we're focused more in reducing severe outcomes and not on preventing every case, we do need some flexibility to make sure that local needs are met and to adapt to variants with different characteristics.

So what you'll see in our guidance, if you go to our webpage is we have a table, it's table 3 and it's modified quarantine approaches. I'm not going to get into each one, but we do have a range and they allow variation in all of these characteristics: who's quarantined, for how long, how much testing is recommended, how much movement is allowed, and how much monitoring is recommended. And so there are lots of different strategies listed here, and you can go in and read them and figure out which ones apply best to your facilities. And an important thing here to note is that we did develop these in collaboration with about five different departments of corrections, as well as about seven different local jails of varying sizes to hear about the things that they were doing to try to make quarantine more manageable in their facilities. And really, the main feature of this list is that it emphasizes risk tolerance and having different levels of strategies, depending on what your risk tolerance is at any given time.

So if you're in a period of time where the circulating variant is associated with more severe disease, let's say a variant comes down the pipe and it's causing people a lot of hospitalizations and a lot of deaths. Then you're going to want a stricter quarantine approach because reducing transmission becomes more important. But if you're in a situation where the variant is not really causing a lot of severe illness, then you may want to put in place more permissive approaches to quarantine to balance those mental health risks and also programmatic needs. So I encourage you to go to our guidance and take a look at these different strategies there and feel free to contact me with questions. Really when we talk about risk balance, all of these prevention strategies are about risk balance. On the left side, you've got all the risks associated with COVID, from transmission to severe illness, death, and post-COVID conditions. And on the right, you've got the impact of these prevention measures themselves on mental health, quality of life, and operational needs. And so this framework and this guidance is meant to help you balance those two sides of the equation. You know, which strategies are going to work best for you, which ones are going to have high compliance, and which ones are going to result in, you know, low incidence of severe disease.

So to wrap it up, I just want to go through a couple of additional technical updates. We talked about this one already, just the idea of routine observation periods. Just to note that we're not calling this routine quarantine anymore because there was a lot of confusion about what is exposure-based quarantine, you have quarantine after somebody's exposed versus a quarantine that's done just to separate people during movement but they haven't had a known exposure. So we're talking about this now as routine observation periods when there hasn't been an exposure. Secondly, one thing that you will see in our guidance is that there's less emphasis now on symptom screening and temperature checks. And this is because we know that these tools have low sensitivity. It really doesn't catch all infections. If people aren't symptomatic or if they don't want to be transparent about their symptoms, then this strategy is not going to catch people who are infected. And in addition, we know that it's also very staff and time intensive. So it's something that's in the guidance as a tool that can be used, but it's not a strong recommendation. Just because we know that it's, you know, it has all of these pros and cons to it here. In addition—or to a caveat that I should say, it's still important to do symptom screening and temperature checks after somebody has had an exposure and they're in quarantine. And that, again, is just to help identify infections early. And if somebody is infected after they're exposed, then to go ahead and find out if they're eligible for treatment to prevent severe outcomes. That's really the only circumstance where we emphasize symptom screening and temperature checks in the current version of the guidance.

And finally, just to reiterate, as I said earlier, there is still healthcare-specific guidance that applies to corrections. And so, as I said, the healthcare guidance continues to use more conservative metrics to guide the application of prevention strategies for patient care. And that's the community transmission levels rather than the community levels. So if your facility has onsite healthcare, then you still need to be following the healthcare guidance for those patient care areas. You can use the corrections guidance in all other areas. But in patient care areas, it needs to be the healthcare guidance. And that link can be found here as well.

So just to summarize, you know, this update really focuses on a shift to preventing severe health outcomes from COVID rather than preventing every case. And we know there's flexibility needed there. And that flexibility is really based on continually assessing the risk in your community and the risk in your facility based on COVID community levels and corrections-specific facility level factors. You know, during times of lower risk, use these strategies for everyday operations. And then when your risk is higher, add on some of these prevention strategies where you can and remove them gradually when things start to simmer down. And finally, just to reiterate, we know that every facility is different and that you're going to have to prioritize your prevention measures to balance the COVID-related risks with other needs related to mental health and programs.

So if you would like any consults on doing that or just have questions for us that aren't answered during the webinar, please feel free to contact us. You can reach us at SpecialPopulations@cdc.gov. We do have a new team at CDC that's dedicated to the health of people who are incarcerated and people who are experiencing homelessness. And so most of those of us who have been working on the COVID guidance for these populations have now shifted into this new team where we focus on public health broadly

within these populations. So you can reach us there for COVID and non-COVID-related questions. And so thanks again to BJA for hosting and I will turn it back over to Sara.

SARA SULLIVAN: Thank you. There are quite a number of questions that have come through the chat. I'm going to ask one here, Liesl for you to answer, and then I can wrap my slides up in the last two minutes. And what we'll do is, Liesl and I will work together to see if maybe we can answer some of these questions after the webinar and post the answers to the questions on BJA's page where the webinar was listed. So for those of you that asked the question or interested in the answers to the questions, keep a look out for the answers to those in the next few days. So the question is, “With the mildness of the Omicron variant and effective treatment medication, will there be a shift in lifting restrictions? Our facility tests every inmate and we're finding 90% of positives asymptomatic.” And we got a similar question, which is, “Is there some statistic or other measures CDC is looking for before dropping COVID-19 prevention strategies altogether? Or are we not there yet?”

LIESL HAGAN: It's a great question, and I think it gets back to the question about whether prevention strategies would change between the everyday versus the enhanced. And some of these are always going to be around, you know, just like any other infectious disease, any time somebody has symptoms or who have been exposed, you're going to want to test them. And if you have an outbreak, you might have to do more expanded testing. You know, hygiene types of considerations, ventilation, those things are here to stay and they're not going to go anywhere as far as recommendations from CDC because this is just about normalizing infection control for all infectious diseases not just COVID. When it comes to the specifics about, you know, quarantine duration, isolation duration, you know, we have the flexibility in our guidance to adapt to different disease severity during crisis operations or just during periods of lower or higher risk. So the goal of this guidance document as it stands is to provide the flexibility for facilities to adapt to different circumstances whether it's low risk or high risk. But some of these strategies are going to stick around.

SARA SULLIVAN: Great. Thank you. And I want to thank Liesl for all of her and her team's work in providing guidance to correctional facilities during this time. So last thing we'll present on—and I'll make this quick because I know we're coming up on time. I wanted to make sure everyone was aware of funding that has been made available to state and local facilities. Through the ARPA of 2021, $700 million was approved to be made available to adult prisons and jails, juvenile facilities, police lockups, and community confinement facilities across the country. That money is being sent to health departments in all 50 states, U.S. territories, and several large metro areas which include Chicago, DC, Houston, Los Angeles, New York City, and Philadelphia. And so those recipients are responsible for the distribution of those funds throughout their jurisdiction in partnership with the confinement facilities and their jurisdictions. That money is being filtered through the CDC. In addition, the Bureau of Justice Assistance will be working on providing technical assistance that will be made available to recipients and subrecipients and the technical assistance provider will be coming onboard here in the fall. Next slide.

If you want more information about this funding, including required and optional activities, allowable costs, this is the webpage that you can go to which provides a guidance document which lays out all of that information. If you don't know if your facility is receiving funding or you want to inquire further, I recommend you contact or reach out to the leadership of your facility, of your agency. And if they need information about ways to potentially access this funding, they should reach out to their contact at their health department to inquire further.

All right. Liesl, we're going to continue with the Q&A so we can make sure that all the questions get answered. So next up, there's actually a question, “What is the effect on the allowable expenses of the grants?” So there are quite a number of allowable expenses of the grant and each one of them will have a different effect. So I recommend going to the link that was provided on one of the last slides of the PowerPoint presentation to go to the guidance document. And that will provide a full list of all the allowable expenses. Okay. Next up, Liesl, this is for you. “Can routine observation periods last 7 days with two negative tests?”

LIESL HAGAN: So, that would go beyond what we're recommending. But if facilities would like to be more conservative and put additional measures in place, that's an option that they could consider. What we recommend for routine observation periods is 7 to 10 days if no testing is taking place. And then if they are going to test at the end, then it can be a minimum of 5 days. But if a facility wanted to have a longer observation period or multiple tests required because they have a lower risk tolerance, that's fine.

SARA SULLIVAN: Great. This next question, “Do you have recommendations for facilities that previously did not require employees to quarantine or test after exposure within the prison due to crisis staffing levels?”

LIESL HAGAN: And so our crisis management section is still in our guidance. And essentially when it comes to medical isolation, we continue to recommend a 10-day isolation period as much as possible. But there is a section there about how to consider reductions in isolation duration during periods of staffing shortages. And when it comes to quarantine, basically what we recommend is consulting table 3 in our guidance, which provides a whole range of modified quarantine strategies. And some of these are the things that facilities were using during the Omicron surge when they had staffing shortages. And so, as I mentioned, we developed that table in consultation with quite a few facilities across the country who were sharing exactly what types of things they did during those crisis operations. The only thing I would add there is that, you know, particularly for medical isolation, we recommend going back to the standard after the period of crisis has ended.

SARA SULLIVAN: Great. This next question, “Isn't it true that testing upon admission could show a negative test, so they should be retested after 3 days?”

LIESL HAGAN: So this is another question about risk tolerance. It's absolutely true that you can have false negative tests, and that's for antigen tests or PCR tests. There's always the possibility of a false negative. So if a facility has a low level of risk tolerance,

for example, if they're a facility that part of their mission is medical care for people with high acuity medical needs, then they might have greater standards or higher standards for testing at intake because they want to make extra certain that nobody is infected before they come into their general population. Under those circumstances, then a facility might choose to retest and hold people in some kind of observation period during the time that they're waiting to retest them.

SARA SULLIVAN: Thank you.

LIESL HAGAN: But that would go beyond our standards for everyday operations.

SARA SULLIVAN: Okay. Next question was about masking. “Are there any masking recommendations for new intakes if there is no observation period or if they are under observation in a small cohort?”

LIESL HAGAN: So again, this is about risk tolerance. I love the direction this question is taking because I think it's a great idea to layer on these mitigation measures. If you've got an intake observation period and you have to cohort people and, you know, it's a great idea to have them mask. But our recommendations are solely based on this combination of community-level and facility-level factors. So it really depends on how that facility weighs those community-level factors. If they feel like there's a higher risk of people coming in with COVID because there's a lot of new cases in the community or because they feel like, you know, just any number of things that could influence the risk in their facility, they're more than welcome to layer on masking even when the community level is low. So it's really about what that particular facility is comfortable with. But again, that does go beyond what we recommend for strategies for everyday operations.

SARA SULLIVAN: Great. This is around quarantine period. And I like this question because I know a lot of facilities are dealing with the initial issue of appropriate placements for quarantine and isolation. So this question asks “Finding appropriate housing placement to complete the quarantine period is always a concern. If the COVID-19 acuity in the community is well, how can we transition to modified quarantine approach if we don't have knowledge of the vaccination status of the staff?”

LIESL HAGAN: So I think what this question is asking is whether all modified quarantine approaches hinge on vaccination status, and the answer to that is no. So if you go to table 3 in our guidance, you'll see a variety of different modified quarantine strategies. Only one of them has to do with vaccination status. And basically, what that says is one way to modify quarantine to make it less stringent is to only require it for people who are not up to date on their vaccinations. But to this person's point, if you don't know the vaccination status of people, then you just might not choose to implement that form of modified quarantine. And you may choose to modify your quarantine in a different way.

SARA SULLIVAN: Great. This next question has to do with if different sections of a facility might be treated differently. “So the algorithms for which strategy to use refer to housing areas and dorms and not medical departments, correct?”

LIESL HAGAN: Correct. So that gets to the distinction that we made between healthcare guidance from CDC and corrections guidance. And so the corrections guidance that I've presented today can be used anywhere in the facility except for patient care areas. When it comes to patient care areas, then we defer to healthcare guidance. And one of the main differences there is that the healthcare guidance uses community transmission levels rather than community levels to guide which prevention strategies are in place. And essentially that just means they're using a more conservative set of metrics to layer on additional prevention strategies. So you very well could have two different decisionmaking processes in your medical areas and your nonmedical areas as far as COVID prevention.

SARA SULLIVAN: Great. Let me see if there are any others in this section. I don't think you answered this, so I'll ask it. “Is COVID-19 testing recommended for all patients coming into the prison, regardless of community transmission level?”

LIESL HAGAN: Yes. We recommend intake testing for residents in correctional and detention facilities, regardless of community transmission levels and regardless of community levels and regardless of facility level factors. That's just a baseline measure for everyday operations.

SARA SULLIVAN: Great. And a few other questions. “Would you recommend short-term or permanent, the release of at-risk individuals to home supervision? If so, what would be your recommended threshold?”

LIESL HAGAN: This has been a question that's come up throughout the pandemic, as I'm sure folks in this webinar are aware. And so CDC does not explicitly recommend any particular depopulation strategy. We do recommend that as, you know, a strategy to decrease crowding, that population-reduction strategies would be one option. And home confinement is one of the ways that facilities have operationalized that. And we do not have a specific threshold for what conditions or what age groups would be considered for that. I know that some facilities have developed their own algorithms based on the information on the CDC website about which characteristics are associated with severe disease. So if facilities want to take a look at that site, that link is in our slide deck on one of the facility-level factor pages related to the risk of your population. I will note that on the CDC website as of what's known currently, age is really the most important factor. So, you know, there are the medical conditions and disabilities that are associated with severe illness. But age is also really important. So that needs to be taken into consideration whenever people are making these kinds of decisions. And then I'll add to that, too, that one of the reasons the CDC doesn't weigh in in a more specific way is that we know that there are a lot of different security and public safety considerations here. And so we're never going to be the final decisionmakers on a topic like this, because it does have to do with safety and security.

SARA SULLIVAN: I will add to that that one of the allowable activities for the use of the funding and this could—even if you're not looking at use of funds, this could just provide some context to the answer to that question, “Is expenses associated with looking at efforts to safely reduce populations and facilities?” So that is one of the optional activities for the use of funding that is provided by CDC to facilities and to the field. And so, you

know, that's an insight into the strategies that both CDC and the Bureau of Justice Assistance have deemed allowable or provable strategies for COVID-19 detection and mitigation. And that will wrap up our Q&A. Thank you so much, Liesl, for staying on with us to answer those last few questions.

LIESL HAGAN: Thank you, Sara.

SARA SULLIVAN: I just want to say thank you everybody for joining us. Thank you to Liesl for joining us. And in the next few days, you will receive an email with a link where you can find this PowerPoint presentation. You can find the recording of this webinar. And as I said, we'll look to answering the questions that are in the chat that we weren't able to respond to and posting those questions and answers on the web page as well. So thank you everybody, for joining us and enjoy the rest of your afternoon.