DARYL FOX: Good afternoon, everyone, and welcome to today's webinar, “Detection and Mitigation of COVID-19 in Confinement Facilities Award Updates,” hosted by the Bureau of Justice Assistance. At this time, it's my pleasure 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 so much, Daryl. Hi, everybody. Welcome to the “Detection and Mitigation of COVID-19 and Confinement Facilities” webinar. I'm so excited that you all were able to join us today. We have an exciting two hours planned for you. Why don't we go ahead and go through the agenda. So, first we're going to do a welcome. I'm going to introduce you to two of the other presenters, then we will talk about the partnership between the Bureau of Justice Assistance and the Centers for Disease Control and Prevention. Then we're going to do some funding highlights where we're going to talk about goals of the funding, allowable uses of funds, and some frequently asked questions that we're going to answer that have come to us over the past several months. Then I'm going to kick it over to Liesl Hagan from the CDC who's going to give updates to the CDC Guidance. And then, the next two sessions are going to be panel discussions with recipients in the states of Washington, California, and Minnesota where first, we're going to talk about reaching local jails.

And then, we're going to highlight work that's being done in the Washington State Department of Corrections. We're going to finish up with the question and answer session. As Daryl mentioned, please feel free to ask your questions in the Q&A. If we have time after each agenda item, we will ask questions then. If not, we will hold all questions until the Q&A session. And then finally, we're going to have a closing. Please stay on for the closing because there are new resources coming that will be available to you all that I want to make sure everybody has that information. So with that, we are going to begin.

So, many of you here are familiar, obviously, and have worked very closely with the Centers for Disease Control and Prevention. The CDC has partnered with the Bureau of Justice Assistance, which is part of the U.S. Department of Justice on this award. And the role of the Bureau of Justice Assistance is to provide substantive guidance to the CDC and specifically to the ELC on this award, as well as to provide technical assistance to the field. And I'll talk about that more at that time later on in the presentation.

I am Sara Sullivan. I am the representative from the Bureau of Justice Assistance. I am a Senior Policy Advisor at BJA and I'm part of BJA's Corrections, Reentry and Justice Reform team. I want to go ahead and introduce the two representatives from the CDC, if

they could both turn their videos on. We have with us Jason Snow. Jason is the ELC Program Manager at the CDC. And then, we also have Liesl Hagan. Liesl is a Senior Scientist for Correctional Health with the CDC. You will be hearing from them both later on in the presentation. Welcome Jason and Liesl.

JASON SNOW: Thank you very much.

SARA SULLIVAN: So…

JASON SNOW: [INDISTINCT] program coordinator.

LIESL HAGAN: Hi.

SARA SULLIVAN: Great. Liesl, do you want to chime in to say hello to folks? Okay. I think she was having some issue with her audio earlier. We'll give her time to get that fixed. So, for those that aren't familiar with the Bureau of Justice Assistance, we are a part of the U.S. Department of Justice, Office of Justice Programs. The Office of Justice Programs is an office within the U.S. Department of Justice that provides grant funding, training, research, and statistics. The Bureau of Justice Assistance is a component within OJP. And we support state, local, and tribal justice system.

OJP's mission is to provide federal leadership in preventing and controlling crime and to ensure fair and impartial administration of justice. BJA within OJP, we work with communities. We work with government. We work with nonprofit organizations to reduce crime, recidivism, unnecessary confinement, and to promote a safe and fair justice system. And the way we do this work is providing leadership, grant administration and criminal justice policy development to state, local, and tribal justice system to help implement and develop strategies to achieve safer communities. So, that is who DOJ, OJP, and BJA are who is partnered with the CDC.

So, part of that partnership will be providing technical assistance to recipients and subrecipients of this award. We have partnered with CNA who will be providing that technical assistance. We are in the process of onboarding them now. So, one of the next steps that I'll talk about later on at the end of the presentation is outreach that is going to happen between BJA and CNA with all the recipients in order to offer the technical assistance and conduct assessments of the TA needs in the field.

So, what does that technical assistance look like? So, this is a variety of things. So, the technical assistance is available to all recipients of the award and all subrecipients of the award. And it may look different in different jurisdictions. So, there will be targeted

technical assistance for each recipient based on your needs. So, that could look like training that's provided. That could look like subject matter expertise. The CNA team has both experts in healthcare and infectious disease, in COVID-19 detection and mitigation, as well as in criminal justice and confinement systems and confinement facilities specifically. So, they have a cadre of resources available of experts that can be called on at any time to assist. They can also provide a lot of assistance with connecting folks with others in the field. So, for example, if you're looking at implementing a particular practice and you'd like to talk with someone else at another recipient or in another confinement facility that's doing something similar, CNA can connect you with those folks as well.

They will also be developing resources that will be available to everyone. This webinar is an example of technical assistance. There will be a series of webinars coming up on other topics. Either BJA, CNA, or both will be hosting those webinars. They will also be disseminating best practices and fact sheets that will be available for folks. And they will be able to work with everyone on performance measurement, data collection, and analysis. They will also be developing learning communities. And I'll share more about those learning communities at the very end of the webinar.

So, one thing I want to highlight is a Guidance Document for this funding award. Most of you are familiar with this. If you are not familiar with it, I encourage everyone to go on to this link and review the Guidance Document. It was just made available in the chat for easy access to click on the link. There are a few things I wanted to highlight, even though many of you have seen the Guidance Document. There are a few things in it that I wanted to go ahead and highlight.

First, the project period ends July 31st, 2024. So, we are one year into a three-year award. Very early in the guidance, it's made clear and discussed that state recipients, so I know not all recipients are state recipients. This is specifically for state recipients that they need to support units of local government within their jurisdiction to reach the fullest complement of confinement facilities in the state. Confinement facilities is defined as both adult prisons and jails, juvenile confinement facilities, police lockup, and community confinement facilities.

So, one thing I want to make clear of what we mean by fullest complement of confinement facilities. So, that does not mean that every single facility in your state, every single facility in your jurisdiction needs to be reached. But what it does mean is that the funding needs to be made available to a cadre of facilities. So, for example, it cannot be used just to partner with the state Department of Corrections and focus on state prisons. The funding needs to go also to local facilities, local jails, local community

confinement facilities. It is up to each recipient how they determine who receives the funding, how much, and for what. And one of the panels will focus on that. But the funding does need to be made available to local facilities as well, not just those state facilities.

And lastly, while there's a big focus on testing for the funding, the one required activity relates to testing, there is also a lot more that the funding can be used for other than just testing. Some of the highlights of the 14 other optional activities are staffing for things such as developing protocols for facility preparedness and response efforts. It can be used for education and training. It can be used for video conferencing technology that can help with attorney visits, court appearances, but it can also be used for family visitations. It can be used for programming. It can even be used as a delivery method for telehealth. Other examples are expenses associated with improving communication access to families, to service providers, to educators, and to mental health professionals. It can be used to develop policies and practices to reduce the incarcerated population. And it can be used for things like software that can help with quality management, biosafety, and training needs. There are a variety of other things the funding can be used for. Those are just a few highlights. But I do want to make clear that the funding doesn't just have to be used for testing programs. And we really encourage folks to explore the opportunities in using funding for a comprehensive view of addressing detection and mitigation of COVID-19 in the facilities in your jurisdiction.

So, with that, we want to address some frequently asked questions that we have received over the course of the past year, but more specifically, over the past few months around certain things that funding can be used for. And so, I'm going to turn it over to Jason Snow with the CDC who can address those first few bullets. Jason?

JASON SNOW: Thank you very much, Sara. So, one of the questions that we've been getting a lot over the past year is, "Can these funds be used for vaccination efforts?" And unfortunately, the answer is no. The legislation that provided the funds for the confinement facilities award, which is the shorthand for the long name you see here on the screen, detection and mitigation of COVID-19 in confinement facilities. We just shorthand it here at CDC call it our confinement facilities award. But the legislation have made available is the American Rescue Plan Act of 2021, and specifically with Section 2401. And I mention that because in the ARPA, we did have different sections that made different pots of money available. The confinement facilities funding came from Section 2401 which specified the points that can be used for testing and mitigation efforts. Therefore, we cannot include vaccination in this particular award. If ELC recipients do find a need to do vaccination education or other support efforts in confinement facilities, this is where we can take this opportunity to remind them that

there are other ELC current awards that they can explore that do provide some limited support and they should just reach out to their ELC project officer to explore options.

The second bullet here, other infectious disease mitigation, such as monkeypox. Again, as I said previously, this award was specifically for COVID-19. So, we do not have a [INDISTINCT] for other pathogens especially with monkeypox. That said, we do have a process here in place that we communicated through an email to the ELC recipients back on August 17th, whereby, for this award and other ELC awards, a waiver or a request for a waiver from the Office of Financial Resources can be made. There are no guarantees it will get approved. But for ELC recipients who do wish to explore making that type of addition to their current COVID-19 work, I'd just refer them back to that email and get through the required steps and provide the elements necessary to go through LFR review and determination.

And then finally, the question about tablets. This is like electronic tablets, whether it's iPads or other type of computer tablets. Is that allowable under this award? And the answer is, in most circumstances. So, the condition of how you're requesting to cover the cost of tablets is very important. Sara mentioned it was provided in the chat, a link on guidance. You'll notice in the guidance, there is an allowable cost section. And under cost number 12, there is an allowable cost for electronics that could help facilitate communication between residents, detainees, inmates, and their legal representation, family, mental health counselors, educators, and others. So, if the tablets are being used in that vein and you can tie the request to one of our activities in the approved work plan and also, again, tie it to the conditions outlined in allowable cost number 12 when the cost of tablets can be supported by [INDISTINCT] this award. Sara, I'll turn it back to you.

SARA SULLIVAN: Thanks, Jason. Just to follow up on the vaccination efforts, even though technically the funding cannot be used for vaccination efforts and there are other resources that are available as you mentioned, there is some room, for example, if a education campaign is being done under this award, the focus is on a comprehensive view of detection and mitigation in confinement facilities, vaccinations. And the focus of vaccinations can be included as part of that education campaign. It just cannot be an education campaign solely about vaccination efforts. Can you add to that or anything else you want to clarify to that point?

JASON SNOW: Yes. Thank you very much. The specificity that you pointed out is very important. So, if it's a standalone vaccination campaign, then that cannot be supported under this award. Again, this is about testing and mitigation efforts. But as Sara pointed out in the way that she phrased vaccination efforts in a larger public health education

program within confinement facilities, that definitely can be added in to a public health communication or public health education program. And that is not a problem whatsoever, as long as it, includes other mitigation strategies and testing and it's not the sole focus of said campaign or communication, then yes, it can be included under this award.

SARA SULLIVAN: Great. Thank you, Jason. I've gotten a lot of questions about that from folks. And those specific clarifications, I think are really important for folks to hear. So, thank you. The other two frequently asked questions we received is about how do we best reach jails and other local facilities and how other recipients are using the funding. And so, that is one of the reasons why we have the two panels that we have later on in the webinar so we can start addressing those questions, provide you some information here that addresses the answers to those questions. And we'll be providing future opportunity to learn more about what other recipients are doing. Anything else, Jason, you want to add before we move on?

JASON SNOW: No. I think we covered it all, but I'm happy to answer the chat in the Q&A towards the end.

SARA SULLIVAN: Wonderful. Thank you. With that, I am going to pass things over to Liesl Hagan. Again, I introduced her in the beginning. She's a Senior Scientist for Correctional Health and she has some updates on the CDC guidance for confinement facilities.

LIESL HAGAN: Thanks, Sara. Okay. I'm having some audio difficulties and now I'm getting echo. Can you hear me?

SARA SULLIVAN: I can hear you.

LIESL HAGAN: Okay. All right. I'm going to go ahead. Can you give me a thumbs up one more time? Sorry about this.

SARA SULLIVAN: I can hear you good.

LIESL HAGAN: Okay. Great. Okay. So, thank you very much for that introduction. I think I know most folks on this call have been in webinars together before. But my team is responsible for updating and maintaining the guidance for correctional and detention facilities for COVID broadly. So, I know that most folks are aware that general population guidance was updated recently, particularly around quarantine, stating that people who have been exposed no longer need to quarantine regardless of their

vaccination status. And we've had a lot of anticipation for when these recommendations are going to be extended to correctional and detention facilities in the same manner. So, I wanted to let everybody know on this call that we have been working on an update, really since even before that general population guidance came out. And it's currently in the final stages of CDC clearance.

So, there will be two major changes that will be reflected in this new document. The first is that it will no longer be a solely corrections document. It's going to be combining corrections along with what we're calling high-risk congregate settings. And these will be correctional facilities, homeless shelters, group homes, assisted living, and several others that are called out within the document. And so, the purpose of this change is to try to simplify the different guidance pages that CDC has and to consolidate them so that when there are updates, they can be made in a more streamlined way that won't take quite as long. So, that's the first change. It's the structure of it and the fact that it will no longer be corrections only.

The second update is about quarantine itself. So, as I mentioned for the general public, CDC no longer recommends quarantine for people who have been exposed. That change has not been made yet to the corrections guidance document. But in this larger congregate settings document, quarantine will no longer be explicitly recommended for people who are exposed. There will be a section describing quarantine and, giving recommendations for how it could be applied in situations where the health department and facility agree that it's an important strategy for protecting the health of the people in that facility. So, those considerations will be there, but it will no longer be a specific recommendation for corrections.

The guidance will still include these everyday prevention strategies that are already in the guidance document and also the enhanced prevention strategies that can be applied when there's higher risk of COVID in the community and in the facilities, so nothing related to that structure is going to change. And there will also be a section specifically for corrections. So, even though the Guidance Document broadly is a broader array of audiences or facilities, there will still be a small section at the bottom with specific corrections focused recommendations. None of that content is really going to change except for the quarantine piece. It's just trying to make it shorter and more streamlined. And in the process, it's just more general.

So, we recognize that the delay in updating this is causing confusion and can be frustrating. So, we will make sure to send out a link to the updated Guidance Document as soon as it's posted. And we'll be doing that through our corrections listserv here at CDC. So if you're not already a member of that listserv and you'd like to join, please

email us at specialpopulations@cdc.gov, and I'll put that email address in the chat as well, and then we'll add you to that listserv, and that way you'll get the link as soon as it's posted.

The other update that I'd like to provide relates to new information on COVID-19 booster vaccines. And just to contextualize this a little bit, I just want to reiterate, as Sara and Jason were just saying, that funding from this confinement facilities award does not cover vaccination, but education about vaccination can be a part of a broader public health communications strategy covered by the award. So in case anybody on this call is planning to use their funding for education efforts that do include vaccination, I'm just going over this to make sure that you have this up-to-date information. And again, I'll put some links in the chat.

And so just a few talking points about these vaccines. So there is a bivalent vaccine for COVID-19, which means it includes both the, you know, ancestral strain of COVID as well as Omicron. And so the idea is that will provide more protection for current variants that are circulating. And this bivalent vaccine was authorized by the FDA on August 31st, and was authorized by CDC and the ACIP on September 1st, and recommended for use. There's a Pfizer-BioNTech bivalent vaccine that can be used now as a booster in persons who are ages 12 years and older. And there's also a Moderna bivalent vaccine that can be used as a booster in persons ages 18 and older. So eligible people for this booster have to have completed their primary vaccine series for COVID, and it has to be at least two months after their last COVID-19 vaccine dose in order to receive the bivalent booster.

Also of note on bivalent vaccines that are mRNA vaccines are no longer authorized for use for booster doses in people ages 12 and older. But this monovalent vaccine, the previous monovalent vaccines are still used for the primary series. So overall, this is just an effort to move towards a more simplified and consolidated vaccination schedule for COVID-19. And we'd like you to know that a supply of the bivalent vaccine doses have been purchased by the U.S. government, and there is a group of federal and jurisdictional partners that are actively working to make sure that there's equitable distribution of the vaccine, and to support vaccine access for populations at high risk, including people who are incarcerated. So if you have any questions about the vaccine information for the bivalent vaccine, please feel free to email me as well, and I can get those questions answered for you. And so I will turn it back to you, Sara. Thank you.

SARA SULLIVAN: Thank you, Liesl. We do have time for a couple of questions before we move on to the first panel. One question, folks wanted that email address again to get on your listserv. If you could just go ahead and put it in the chat, that would be

helpful. That way everybody has access to that email. And then the second question is, how did you come to the policy change about quarantine for at-risk populations?

LIESL HAGAN: Thanks. So essentially, I can answer the question as it relates to the general population, and then apply that to corrections. So, in the general population, the considerations for eliminating the recommendation for quarantine really came as an effort to try to balance what we're seeing as far as the severity of COVID, as it currently stands in the community, which is, you know, not nearly as severe as we were seeing in earlier periods of the pandemic. So trying to balance that lower severity with the pretty intensive impact of quarantine on people's daily lives when it comes to school, and work, and, you know, family relationships, and mental health, and all of these other considerations. So it just represents an ongoing effort at CDC to balance the two sides of that equation, looking at the risks of transmission and severe disease as they currently stand, and balancing that with other societal considerations.

And so applying that to corrections, it's really largely the same. I can tell you that we've gotten a lot of questions in recent weeks, particularly about access to visitation. We've had concerned family members and advocacy groups contacting us to say, "Listen, people haven't had opportunities to see their families in person for, two and a half years at this point. Aren't we at a stage in the pandemic where we can start to loosen up on some of these precautions, so that we can prioritize people's relationships and their mental health? And so that's just one example of the efforts that we're making to try to balance that same equation for corrections, to understand that severity is lower at this stage in the pandemic, and that people have a lot of other needs related to their mental health and well-being, and just the ability to cope with the very stressful situation that they find themselves in within the correctional facility. And the same goes for, you know, staffing and staff resiliency as well. So that's really where we are. I can say also that tthere's still the ability and support for quarantine within the high-risk congregate settings document that's going to come out. So if facilities work with their health departments and find that they really do believe that the population in a particular congregate setting is still at high risk for severe disease. If there's an outbreak, then there's still support for a public health action to enable quarantine in that facility. So we're not saying don't ever use it, but it's more consult with your local health department, state health department to determine when it makes sense to apply.

SARA SULLIVAN: Thank you, Liesl. We did get a number of other questions. And for those folks that ask those questions, we will address them in the Q&A session at the end, just stay tuned for that. Thanks, Liesl. Okay. We are going to move on to our first panel, which is reaching local jails. I will ask Jennifer, both Rebeccas, Ric, and Ryan, to please turn on your video so we can all see you, as we transition to the first panel.

Wonderful. Okay. So the first panel is about reaching local jails. And I want to give everyone an opportunity to introduce yourself. So, Jennifer, why don't you go first?

JENNIFER ZIPPRICH: Hi, I'm Jennifer Zipprich, and I'm a Supervisor in our COVID section at the Minnesota Department of Health.

SARA SULLIVAN: Great. And your colleague, Rebecca.

REBECCA HUEBSCH: Hi. I'm Becca Huebsch. I'm also an Epidemiologist with Minnesota Department of Health.

SARA SULLIVAN: Thank you. And moving on to our two representatives from Washington, Ric.

RIC BISHOP: Good afternoon, everyone. My name is Ric Bishop. I'm a recently retired chief deputy out here in the state of Washington over two jail facilities, and now currently with the Washington Association of Sheriffs and Police Chiefs, WASPC, as a Program Coordinator.

REBEKAH GUENTHER: I'm Rebekah Guenther. I'm a testing partnerships coordinator with the Washington State Department of Health.

SARA SULLIVAN: Great. And last but not least, the representative from California, Ryan.

RYAN SCHMIDT: Good afternoon, everyone. My name's Ryan Schmidt. I am the Chief of the Epidemiology and Laboratory Capacity Section here with the California Department of Public Health within the Emergency Preparedness Office.

SARA SULLIVAN: Wonderful. Thank you all for joining us. So as we mentioned, one of the requirements of this award is that state recipients have to work with units of local government within their jurisdiction to reach the fullest complement of confinement facilities in the state. And each of you have taken a slightly different approach to how you do that. So I'm hoping all three states, you guys, can please share what your approach was to reaching local jails in your state. And California, why don't we start with you? And then we'll go to Washington and then Minnesota.

RYAN SCHMIDT: Sure. Thank you, Sara. You know, because CDPH typically works closely with our local county public health departments, we collaborated closely with the State Department of Corrections and Rehabilitation, as well as the California Board of

State and Community Corrections, to determine which facilities would be included in the distribution of the funds locally. We really relied on these agencies' expertise and resources, and both agencies were able to identify all county sheriff offices and their contacts, as well as various probation departments across the state, and their contact information for us.

And from there, we identified the average daily population at each of the facilities to come up with their proposed funding amounts based again on daily population. Working with the local sheriff and probation departments has really opened up and broadened our reach at the state level in working with brand new populations, as well as brand new stakeholders.

SARA SULLIVAN: Great. Thank you. Washington?

RIC BISHOP: Thank you.

REBEKAH GUENTHER: Thank you, Sara. Washington Department of Health wanting to ensure that the funds reached a broad spectrum of confinement facilities, we partnered with Department of Children, Youth, and Families to support juvenile facilities, Department of Corrections to support prisons, and Washington Association of Sheriffs and Police Chiefs, or WASPC, to support jails across Washington State. WASPC is uniquely positioned and has the expertise to support and distribute the grant funds to local jails. Now, I'll hand it off to Ric to explain more.

RIC BISHOP: Thanks, Rebekah. Sorry to cut in on you there. First of all, folks, sorry, I apologize. I'm sitting at PDX, or Portland International, and so I apologize for any background sound. WASPC Membership includes every sheriff and police chief in the state of Washington. And that includes all 56 jails in the state. So we determined that because jails are built to community standards and each of them is unique, even though jails may look on the outside like they're cookie-cutters, each of them are unique in their own design. We decided to use the Request for Proposal process so that each facility could give us their unique problems, or concerns, or challenges, and their unique strategies for addressing COVID-19. So that was our approach in getting the RFP process out.

SARA SULLIVAN: Thank you. And now Minnesota.

JENNIFER ZIPPRICH: Hi. I'll just start out by mentioning that I led a unit that was newly formed during the pandemic to respond to outbreaks in correctional settings. And so we didn't have established relationships with jails or other correctional settings when this

pandemic and our work started, and so a lot of our work was around kind of formulating those relationships. And so when the ELC funds became available, we, through our work with facilities, had initially thought that we would put the money into a testing contract that facilities could access. But we were prompted by the Minnesota Sheriffs Association to consider just sending the money directly to facilities. And so, we worked directly with our MDH leadership to ensure that there would be testing resources available. And then we decided to just pursue an approach where we would send the funds out to facilities through a reimbursement process. And this process really allowed the facilities the maximum flexibility to use their funds in a way that best worked for them. And knowing that, you know, testing recommendations changed, and their needs changed, this was a way that they could access funds. And we targeted any licensed facility in the State of Minnesota with any corrections-licensed facility with a license that capacity of 30 or more for the funding awards.

SARA SULLIVAN: Thank you. So, I want to kind of make clear, pull out what the, three distinct strategies were. So, in Washington State, you guys worked with the Washington Association of Sheriffs and Police Chiefs as a subrecipient, and then that entity made the funding available to local jails throughout the state. I believe you all did that through an RFP. And jails had to apply for that funding and it was either approved or not. Do I have that right, Ric and Bekah?

RIC BISHOP: That’s absolutely correct. We use subject matter experts both from medical as well as correctional subject matter experts to review the proposals and make sure they fit within the scope of the award. And a few of our people were creative and they didn't get approved.

SARA SULLIVAN: Okay. Thanks. And with Washington and—I'm sorry, with California, Minnesota, you both made the funding available directly to jails from the health department to the jails. The difference, I think, between the two is with California, you all submitted out the funding that would be available, and each of the jail jurisdictions had to submit a budget and a work plan in order to access the funding that had to be approved. Where in Minnesota, jurisdictions just had to kind of raise their hand and say yes or no, they did or did not want the funding. And then you all provided technical assistance and training to those subrecipients on the guidance of the funding, and what the allowable costs are, and what the funding cannot and can be used for. Do I have that right in both states?

RYAN SCHMIDT: That is correct.

JENNIFER ZIPPRICH: You got it. Yeah.

SARA SULLIVAN: Okay. Wonderful. Ryan, you spoke about this a little bit, but if you need to talk about how you got that information out to the jurisdiction? How each jail became aware of the funding that was available, and how they could access that funding?

RYAN SCHMIDT: Sure. So, as soon as we received the contact information for the county sheriff departments and probation departments, CDPH released a direct allocation letters to each of those agencies. This letter included important information around the grant requirements and expectations, the required application documents, which included a spend plan and work plan, as well as each agency's allocation. After the direct allocation letters were provided, CDPH held a webinar with all of the recipients to review everything in greater detail and to answer any lingering questions that the agencies might have had. And due to the governor's emergency declaration, we went with a direct allocation letter in lieu of a contract, as these were emergency funds in response to COVID-19. And the goal was to rapidly release the funding to these agencies as soon as possible. We also provided a 25% advance payment since many of these agencies struggled to find the money when it's strictly a reimbursement basis. So we also provided that as well.

SARA SULLIVAN: Thanks. Anyone want to jump in from Washington or Minnesota?

RIC BISHOP: I'll jump in from Washington real quick.

SARA SULLIVAN: Great.

RIC BISHOP: During the first part of the pandemic, WASPC initiated a weekly forum for jail commanders to meet via Zoom or whatever platform was started, then we went to Zoom. That took in all jails in the state and that took in jails from the size of six beds to 2,500. Each week we would discuss updates from CDC. We would discuss strategies, challenges of each jail, regardless of the size. And subsequently, when this money became available, it was first announced in that weekly forum, and then we did the formal grant letters to each facility. Each elected official, each chief of police, as well as our guests that we had in those forums, the local health jurisdictions, the Department of Corrections, and the Department of Health. And that's how we got the word out to every agency in the state.

JENNIFER ZIPPRICH: And I'll just jump in to say, we worked with our Minnesota Sheriffs Association contact to have an email sent out to jail facilities, with the information about the RFP, which was essentially a REDCap survey that asked if the

facility was interested or not. So that was a very low-barrier RFP process. And we also worked with our DLC licensing facility lead, and they communicated the same information out to all of the eligible DLC licensed facility, so the juvenile facilities, halfway houses, other licensed facilities. So, and then I think the other thing we did was we had a webinar after we identified facilities that were interested in receiving the funding and outlined the allowable expenses and just the technical side of the funding piece.

SARA SULLIVAN: Great. Thank you. Could you guys talk about, based on these different approaches, kind of what percentage or how many jails within your state are receiving the funding, and what's the range of awards that they're getting? And anyone can go first.

RYAN SCHMIDT: Sure. Here in California, we initially identified 96 county jails and juvenile detention centers. And this did not include Los Angeles County because they received their funding separately through the CDC. And after, providing direct allocation letters, the response rate was about 60% of those facilities accepted their allocation. And the range of awards, we included a base allocation of $4,000 and the max allocation was 2.2 million.

JENNIFER ZIPPRICH: And I'll say in Minnesota, about 50% of the facilities that were eligible responded that they were interested. And after going through the contract process, 44% of facilities that were eligible went through with the process, and the award ranged from approximately 4,000 at the low-end to 100,000 at the high-end.

RIC BISHOP: Initially, I had quite a large number of phone calls from different sheriffs and police chiefs. A number of them indicated that they had the equipment that they needed or information that this grant covered. At the end of the day, it was 10% in the jails in the state. But some of those jails are a little bit larger. So we actually covered 20% of our beds in the state of Washington, and those awards range from 18,000 to 780,000.

SARA SULLIVAN: Great. Thank you. Before we move on to the technical assistance questions, is there anything anyone else wants to add as it relates to your approach to funding local jail? Okay. So let's move on. So I know in addition to the funding that you all are providing, many of your health departments are also offering technical assistance to local jails. And that work, that technical assistance work, is also being provided by these funds. Can you talk about the assistance you're providing? And why don't we start with Minnesota?

REBECCA HUEBSCH: Absolutely. So like Jennifer said earlier, we created a team sort of at the beginning of the pandemic to support correctional facilities through the pandemic. So, we had many focuses, but the three major focuses were to provide direct assistance and advice to jails when they were experiencing an outbreak, then also to conduct surveillance, and monitor cases, and report that data on our MDH website in Minnesota. And then finally to create sort of toolkits and resources that would help them to implement the CDC guidance, and make decisions about what they wanted to do in their facility to best protect the residents and staff.

So, some examples of those resources, we created a case investigational toolkit that kind of took the recommendations and best practices, and turned them into more a processed oriented document with step-by-step instructions for responding to a case and link to appropriate resources. We also created a few other documents to help when they needed to mitigate resource constraints during a surge and sort of weigh different strategies against each other. We also have a testing tool to help facilities decide what form of testing is best suited for their needs, and also how to access that testing through the State of Minnesota. And then, finally, we've recently released a therapeutics checklist to sort of guide facilities through the process of creating a therapeutics implementation strategy. So, those are just some of the resources but we also do still work with facilities more one-on-one to provide support when needed.

SARA SULLIVAN: Great. Washington, you want to go next?

RIC BISHOP: Sure.

SARA SULLIVAN: Okay.

RIC BISHOP: We also have a toolkit that's been distributed from our Department of Health. But more importantly, when this started, I was commanding two jails and I reached out—and I know Dr. Melnick is on the line from the state of Washington—but I reached out to him when I had a large number of cases in one of my facilities and we just couldn't get a handle on it. Through their health department, Dr. Melnick, they send a strike team down to our main facility. And within two days, they had recommendations that our local medical provider nor our local correction, myself included, recognized kind of a forest and trees type thing, but they came in, examined our processes, gave some real solid advice, and we were able to get our cases under control and start to really bring things down. And that strike team approach, and I know that they've done it in other facilities and since I've retired and joined WASPC, we've helped get that information out and how to access health through the local health jurisdictions as well as getting large teams for testing to at least a couple of facilities to help them get a

handle and address those cases. That's from both the user and a provider standpoint. Thank you.

SARA SULLIVAN: Thank you. Bekah, you want to jump in from the Health Department perspective?

REBEKAH GUENTHER: Thanks, Ric. And thanks, Sara. Excuse me. Washington State decided to prioritize the funding of testing resources for confinement facilities as part of this grant opportunity. Washington is…

SARA SULLIVAN: Bekah, your audio kind of got really low volume all of a sudden. Maybe just try to mute and unmute, and see if that fixes it.

REBEKAH GUENTHER: Can you hear me now?

SARA SULLIVAN: Yes. Just talk very loud because your volume is really low and I know I have my volume all the way up. So that's okay. Go ahead.

REBEKAH GUENTHER: My volume is all the way up, so should I just start over from the beginning? Washington State decided to prioritize the funding of testing resources for confinement facilities as part of this grant opportunity. Washington is a home rural state, and as such, the local health jurisdictions are the primary partners for local jails and provide technical assistance in terms of COVID-19 outbreak, mitigation, and response. So, the Washington State Department of Health doesn't provide technical assistance directly to local jails unless requested by local health.

However, as Ric has alluded to you, as part of this grant funding, we did create a toolkit. It's a resource created for and distributed to subrecipients including local jails. It contains the grant activities and strategies, broad overview of allowable costs, links to pertinent CDC and DOH guidance for confinement facilities, as well as relevant DOH contacts for specific expertise areas as routinely updated and maintained.

SARA SULLIVAN: Go ahead, Ryan. Chime in with California.

RYAN SCHMIDT: Sure.

SARA SULLIVAN: Thank you, Bekah. Thank you, Ryan.

RYAN SCHMIDT: So, in addition to our contract managers who provide ongoing technical assistance through budget revisions and work plan revisions, CDPH has an

outbreak consultation team who provides technical assistance to county jails and juvenile facilities experiencing COVID-19 outbreaks upon request by local health departments. The CDPH outbreak consultation team is comprised of physicians, epidemiologists, industrial hygienists, and health educators supporting local health departments experiencing large or complex outbreaks of COVID-19 in the correctional setting.

The types of assistance provided by CDPH to jails has included outbreak management, consultations from subject matter experts to provide recommendations related to medical isolation, quarantine, testing, and/or occupational health issues. CDPH has also developed a SharePoint toolkit website for local health departments called Management of COVID-19 Outbreaks in Correctional Facilities. And this toolkit provides a centralized collection of resources to assist local health departments with the control and prevention of COVID-19 outbreaks in correctional settings. Access to this toolkit is limited to public health departments.

SARA SULLIVAN: Great. Thank you. And I'm seeing from the chat some discussion, there are few other places in other states that are taking similar approaches that you all are, so it's great to hear from other people. Anything else before we wrap up that you all want to share, either about the funding component or about the technical assistance that you are providing, particularly any benefits that you're seeing so far?

JENNIFER ZIPPRICH: I would just want to add that there were a number of people at MDH that worked on this the best who, are not with us here, but I just wanted to acknowledge that it took the work of many people to get the contracts in place and to do a lot of the administrative work that this involved, so I wanted to mention that. And also, just mention that our Department of Administration has established master contracts for testing that facilities can access. And so we've held at least one training and then sent information out to facilities on how they can access the state master contracts for testing so that they could get the negotiated rates for tests, and that is something that they could also use their ELC funds for. So, I think that was extremely useful for our team to have that kind of support from other members, other colleagues in state government.

RYAN SCHMIDT: You know, here in California, our team is funded by and we oversee multiple ELC COVID supplements, but this funding specifically enabled us to increase our response capacity specific to confinement facilities, so that was super helpful.

RIC BISHOP: And from the state of Washington, jails and inmate populations in particular don't always get a lot of attention, so I know that on behalf of WASPC and the jail commanders in this state we did appreciate, and still appreciate the work done by

CDC and our partners in the state to help with our inmate health and their population. Thank you.

SARA SULLIVAN: Great. Thank you all. Well, with that, we will wrap up this panel, but you all don't go anywhere because we will have time for a Q&A after the next panel to include questions both of this panel and the next panel, so thank you all. I appreciate your time. Feel free to go off video.

And now, I'd like to welcome the representative from the Washington State Department of Corrections. If those three individuals could come on camera so we can all see you, that would be great. There you are. Okay. So we have three individuals from the Washington Department of Corrections who are going to share from the State Department of Corrections' perspective some interesting things that they're doing as it relates to detection and mitigation of COVID-19 and state prison system. I'm going to let them first go ahead and introduce themselves. Carrie, would you like to go first and then we'll go to Jamison, and then Dean.

CARRIE HESCH: Hello, everyone. My name is Carrie Hesch. I'm the Washington State Department of Corrections Statewide Testing Supervisor.

JAMISON ROBERTS: Good afternoon. Jamison Roberts. I'm the Emergency Operations Center Manager for the last 900 days of COVID response, and my normal job is the Chief of Emergency Operations for Washington State Department of Corrections.

DEAN SMITH: And I'm Dean Smith, I am the Department of Corrections Wastewater Surveillance Manager.

SARA SULLIVAN: Wonderful. Thank you all for being here. I really appreciate your time. So, in addition, obviously, to local jails, health departments, like the Washington, State Health Department have partnered with the corrections agencies like yourself to address the funding needs for state prisons, and you're one of those agencies that's a subrecipient of your state's COVID-19 confinement funding.

So I know of the myriad of activities you have in place that are being supported by these funds, there are two that really caught my attention, specifically your testing programs as well as your wastewater testing program. So, why don't we start with the wastewater testing program? I know this is in the early stages, but can you walk everyone through this program?

DEAN SMITH: Yes. Certainly. In a nutshell, we're in the process of rolling out a wastewater testing program to all of our facilities across the state, which should allow us to detect positive COVID-19 cases in a facility through testing wastewater as opposed to mass testing of staff and incarcerated individuals. It started as a pilot program in partnership with Department of Health at five of our facilities in the early part of 2021 and now we're looking to take it statewide.

SARA SULLIVAN: Great. If you could tell us a little bit more about that pilot program. When you started out in pilot, now you're looking to go statewide. What were some of the lessons learned from that program that's really informing the way you're approaching this next phase?

DEAN SMITH: Well, we discovered the process was too labor intensive and at times, it took way too long to obtain the results. The initial equipment that we were provided by the Department of Health, it was a manual process and it required lab-style extraction and mixing of reagents. And from start to finish, I think it could take up to five hours to obtain a result from a sample. And we had two testing locations and [INDISTINCT] transported, taken to the testing sites. And it wasn't long before the logistics kind of caught up with us, trying to get somebody to commit to five hours of extra work, along with their full-time obligations find the ways to transport the samples economically and keeping the required testing chemicals in stock, it kind of set us up for failure.

So, now, we're going to be using some automated PCR testing technology at each facility. And so each facility will be equipped with auto samplers [INDISTINCT] and it requires a few strokes of the keyboard and introducing about one milliliter of wastewater, and boom, you start the test. And the other— one of the major issues that we also faced on it was the time with the older equipment, you know, and get that results, it, you know, it could take up to a week to actually get a result from one of the facilities and have to transport the sample. And now, with the automated system, we'll have the result in less than 40 minutes.

SARA SULLIVAN: Great. So it sounds like you both addressed the timeframe of how long it was taking to get the results to very short turnaround and you addressed the manual part that required so much staff time. It's now much less staff intensive based on the new testing equipment that you're using, is that right?

DEAN SMITH: It is. That's correct.

SARA SULLIVAN: Okay. Great. Can you talk about— one of the issues that we've heard that other systems that have looked into doing wastewater testing are really

challenged with is knowing where the positive results are coming from. So, how useful is testing wastewater if they can identify where it's coming from or they can't even be clear if it's—the positive result is coming from a visitor or a volunteer. And there's some really interesting things that you guys are planning on doing in order to address this issue, can you talk about that?

DEAN SMITH: Sure. So once we get a positive result, we just simply are going to move upstream. So right now, we're testing at the effluent of the facility, which catches all the wastewater that's leaving the facility. And, we've taken each facility and we looked at the blueprints and we broke it down, we determined sampling points, that would dissect the prison, in the halves and quarters, quadrants, whatever you want to call it and then we just kind of move upstream. We'll split a prison in half, if we get positives on both sides, we keep going up. If positive is only coming from one side of the prison, then we split that half and half. And eventually, we're able—at most facilities—we are able to actually sample right up to a living unit, so, we could be fortunate enough to find the one living unit if such as the case where the positive cases were coming from.

JAMISON ROBERTS: Well…

DEAN SMITH: And at that point in…

JAMISON ROBERTS: Yeah, go ahead, Dean.

DEAN SMITH: I was just going to say, at that point, then the clinical team can move in and then they can rapid test, and, figure out who actually is positive for COVID-19.

SARA SULLIVAN: So that's a great transition to my next question, which is about the wastewater testing program will help you streamline your overall testing procedures in facilities.

JAMISON ROBERTS: I think everybody on the call understands and knows how cumbersome and resource intensive it is to do a widespread testing in both staff and the incarcerated, and it's always been part of our glidepath to shutting things down or to transitioning was this wastewater and that we could stop doing a serial testing. Washington State does serial testing of staff. So, once a week, we do a PCR test. We just recently switched to a rapid test and then, of course outbreak—or regular monitoring of our population. So the idea of switching this model to a passive wastewater surveillance is, again, hopefully, less resource intensive, less impactful to the population and the staff, and shows that, "Hey, there's some light at the end of the tunnel of COVID and we can start moving on to other things." But we still need to have

some passive surveillance and some trigger points that are created in order to start that— once Dean gets to the front door, we can deploy appropriate resources and get those staff and incarcerated tests so we can appropriately respond to the general population as well.

SARA SULLIVAN: Great. Anything else you want to add about the wastewater testing program before we transition over to Carrie's testing program?

JAMISON ROBERTS: I think, Sara, you covered it pretty well. We had a pilot program. We're just now switching to really implement the entire program as Dean has been hired where—have all the resources or equipment that's on order. The one thing that we do have is a lot of partnership work with DOH and local jurisdictions to figure out what all those numbers mean, how do we dissect. We get that—how high or what is the trigger points to go onto that unit for additional testing or to see—to state, "Hey, we do have COVID or COVID is an issue and we need to take those additional steps." So a lot of more legwork to do but we're off to a good start looking forward to exploiting that new technology.

SARA SULLIVAN: Great. Thanks. So as we're talking about the testing, let's transition now to talk about the robust testing program that you all have, not the wastewater, but the regular testing program. Carrie is the Statewide Testing Coordinator. You are brought on as a result of these funds, which is great. Can you talk about your approach to setting up the testing program?

CARRIE HESCH: So I'm just going to start by talking about when I first came into the role, it was approximately six months into our response and I initially started with the Occupational Health and Wellness Units and COVID response there, and then moved over to Jamison's team. And prior to that, I worked inside a prison, so I had a really good understanding about staffing issues, space-related issues, and how that would affect setting up these teams. So I knew it was going to be crucial that we set up sustainable processes at each facility, also our CCD, our Community Corrections Divisions, and our reentry centers for these testing operations. We needed to be able to stand them up or do more close based on the speed of our response. And also, looking at how we would mitigate burnout and provide support to these teams would be crucial to the success. So, I really began with an assessment, which was fast of all our facilities, the testing operations, the staff involved, the training that they had received, and also looking at the testing for our incarcerated patients because we have two separate protocols that we operate under for incarcerated patients and staff. The staff one actually looks at visitors, volunteers, contract staff, as well as our blue badge staff.

So looking at the 24/7 operation that was already in place, talking with Department of Health, our partner in this response, and with other stakeholder groups to include logistics, EOU, occupational health, health services, public health labs, and our platform partner, Ligos, we troubleshooted any of the issues that were coming up based around testing. And I provided a lot of targeted technical training in real time as our response evolved related to how we would collect tests, how they would log into the testing portal and training there, the PPE requirements based around that, building out our testing areas and team requirement and retention for testing teams. The protocol questions to include how to report positive results, the data collection and reporting, and the responsibilities of protecting that private medical information was also crucial. And our response and set up of the testing teams.

SARA SULLIVAN: Great. Thanks. Can you talk about that standard protocol that you've developed and the training you're providing at the facility level specifically?

CARRIE HESCH: So we have, like I said, two protocols. The protocols are in concert with monitoring community-level data and coordinating with our partners, providing our stakeholder teams the framework that quickly responds to this outbreak was really important. So the protocols were developed based around their needs. And it really began as a linear model, but over the course of this response, it became more of a fluid document so that we can engage all of our stakeholders in really defining and sharing our best practices and planning in how we can improve our future response. So the protocols contain everything from testing principles to general requirements for testing, mitigation activities, definitions related to the response, and return to work criteria for staff who are positive or who are identified as close contacts.

So the two protocols, we call them Version 33, which is the version we're at now for the Infection Control and Prevention Protocol. This provided the framework for our health services teams to operate efficiently and provide the safest environment for our incarcerated patients through mitigation practices. And this protocol is written and owned by our Chief Infection Prevention Physician, so it's being constantly updated, literally daily. And I think we're releasing new versions monthly at this point.

And then Version 13 is our staff testing protocol, and that provides the framework for our staff testing teams and Incident Command post the facility level to respond rapidly and effectively through the testing mitigation strategy under the outbreak status. So this was really crafted over time and including testing operations that covered not only staff but our volunteers, our visitors, and contractors. So, I helped develop and manage this, but it is really important to know that these protocols are the culminations of many hours of work through a team environment to include our DOH partner, emergency operations

unit, the prisons division leadership, safety team, occupational health team, health services providers, and our testing team members who are literally the boots on the ground. It's really important that whenever you're developing a protocol that everyone has a seat at that table and can provide that input, because really, it's not going to work if you don't do that.

When it comes to training, I wanted our testing teams to have a sustainable process locally, so that it will allow that mostly these staff members are volunteer, so they're doing this work in standing up a testing operation in the event of a need or an outbreak. And they're still having the ability to perform their regular job and mitigate burnouts. So, it's really key that we are working with them daily to help support these teams.

So COVID really required us to pivot our training operations to an all virtual platform. To mitigate further the spread of virus, we didn't want to be going into facilities and, possibly picking it up, so also understanding that people really learn in different ways. I knew it was going to be a challenge, so it would be critical that I identified the subject matter expert at each facility that could learn these protocols through this virtual platform and translate that training to provide in-person or hands-on education for our staff at the local level. So this subject matter expert was generally where the branch director hat or the testing lead, is what we would call them. And then we would build out the testing team chain of command to include team members for both staff and incarcerated testing. And then we'd maintain those contact lists and we’d connect teams so that they could share best practices and training through the virtual platform.

Additionally, we had partnered with the BD Veritor vendor who provided with the COVID test we were using. They actually set up a virtual learning platform that was exclusive for our department so that our team members could go in there, review audio training video, chat with instructors in a live format or do deeper dive if they wanted to really read up on the testing that was available. And then on my side, I would provide a monthly, weekly, or a daily educational training, as needed, related to the needs of our teams. And these teams generally, included representatives or guest speakers from our Emergency Operations Unit, like Jamison, HR Department, our Health Services team, as well as business partners to include the public health labs and Department of Health Representatives.

SARA SULLIVAN: Great. And when we had last spoke, there are the particular testing portal that you're using for this. Can you share more about that?

CARRIE HESCH: Yeah. So we utilized the TestDirectly portal. This is the critical platform that directly interfaces our staff and our health services teams with the public

health labs. And over time, we have been able to refine our business processes that help us to reduce the time between collecting that test and the results, from initially 78 hours or longer to 24 hours or less, so that's a huge improvement in that response time. And, you know, we know that's important when we're responding to COVID. So I manage the portal from what we call the Ligos Platform. And in partnership with the Ligos architects and developers, we can ask for changes in our business needs and, so they develop it—we test it and then we deploy it and our team members let us know if it's working and if improvements are required. So our testing teams operate under a Clinical Laboratory Amendment waiver, which is a CLIA waiver, and it allows testing teams to generate orders, collect tests, release requisition orders to the lab and review results. And this proper response also helps mitigate the spread quickly.

TestDirectly is utilizing concert with our department's DOTS System, which is a system we use to protect our staff and incarcerated-sensitive medical information and that's utilized mainly by our occupational nurses who put in all of the information that they received in coordination with the TestDirectly portfolio profile so that they can make the best possible response. And that's really it for the Ligos side.

SARA SULLIVAN: Great, thanks. And for—I'm going to pull you in now, Dean and Carrie, for both of the testing programs, the testing programs that you're running, Carrie, and then Dean with the Wastewater Testing Program that will be expanding soon. Are results of those shared with your State Health Department?

DEAN SMITH: Yes, they are.

CARRIE HESCH: Yes. We have a really robust reporting requirement that's included in all of our protocols. It literally is a line-by-line item of how to report our positives tests and also in protecting the privacy of our patients.

SARA SULLIVAN: Okay. Great. We have a comment in the chat that is such an amazing approach to COVID mitigation. There's a question that comes with that, but I'll leave it to the end for the question. Did you want to add somebody, Jamison?

JAMISON ROBERTS: Yes, Sara. Just on the waste waterside not only are we reporting but we're also working with DOH to determine what those triggers are, what the data actually means and they're working with, I think, the University of Washington also on exactly that wastewater and the percentages and what that translates to for the population and COVID activity.

SARA SULLIVAN: Great. Thanks. And lastly, I want to talk—Jamison, I think, this is for you. There's some work you're doing as a result of these funds with setting up hospital tents at different facilities. Can you talk about that work?

JAMISON ROBERTS: Yeah, sure. So one of the major impacts of COVID is obviously the, the lack of resources, but also just capacity, right? So when we have to stand up isolation and quarantine, we're taken away from our capacity, so one of our strategies at compensating for that was large—were basically camps, hospital tents. So we got two early on in COVID and then we are purchasing a third with the grant funding available here to, again, be able to—they're on trailers, they're mobile, we can take them to any facility at any time. The three—if all three tents were stood up at once, it would give us close to additional 90 beds. Our intent is to use them as what we call a regional care facility. So for isolation or those that require additional elevated levels of hospital care, we can do that within our secure perimeters, shift some of our medical resources over to them, but we wouldn't be taking away from our inpatient units or additional capacity that we may require.

And then those tents they come with full HVAC, they come with donning and doffing areas before you enter and exit the facility. They come with showers, toilets. So it's been a good resource to actually deploy or kind of stage ahead of time when we anticipate or see additional community levels start rising, we can kind of put them in areas where they might be utilized or…

SARA SULLIVAN: Right. Before I ask the last question, I just want to remind folks, if you have questions for either panel, feel free to put them in the chat at any time and then we can go ahead and ask them at the end. Great. So, is there anything else that we haven't covered that you guys want to share about any of these programs or uses of the funding that you guys are working on?

JAMISON ROBERTS: I think I'd just double down on what Carrie had said. It's really been a team approach. We use Incident Command System here in Washington so really had participation from every Operational Division and Support Division with the department to sit down and make sure that our strategies in how we spend this money is kind of coordinated and it all kind of fits together. As you can see, the capacity rolling into the wastewater and then the testing, it's all pretty much a handshake and a conversation so making sure you have all your players at the table to collaborate and make those decisions I think is pretty important.

SARA SULLIVAN: Great. Thanks. So with that, let's move into the Q&A session. We have a lot of questions for Liesl, but we do have questions for some of our panelists. So,

I want to start with those and then we'll transition over to the questions for CDC. We have a couple, specifically Jamison, asking for a link to the hospital tents you use. I don't know if that's something you're able to provide, but you can go ahead and put it in the chat. And they are also asking about information on the mobile tents and the estimated cost for each unit. I don't know if you have that off the top of your head or if you just have any information on the cost.

JAMISON ROBERTS: The cost was about $900,000 for the recent one that we bought. Again, that doesn't come with generators, but that's the tent system. And again, I will give you an email or a link here in a second.

SARA SULLIVAN: Okay. Great. Next question is about the wastewater surveillance. The person that said an amazing approach to COVID mitigation, I think they're looking for specifics on how you actually conduct the wastewater surveillance. I know you spoke to this a bit, Dean, before, but can you just talk a little bit more in detail about how you actually conduct the surveillance?

DEAN SMITH: Yeah, it looks like the questions they want to know is how often as well, so…

SARA SULLIVAN: Oh, how often. Thank you. There you go. How often? I'm glad you caught that one word that I missed.

DEAN SMITH: So with what we're doing, we’re—the maintenance crews at the facilities are the ones who are coming to help me with this. So, there are a through—Friday group. So we are starting off with five samples. So we're going to be doing a weekday daily samples. So we will will have five twenty-four hour composites. If there is an outbreak, then that's when I get involved and I may be over there on the weekends pulling samples. But right now, it's five days. There are some because of the cost for each sample. If there is no COVID detected, we are contemplating maybe switching to three days, maybe a Monday, Wednesday, Friday, unless we come up with a positive and then, of course, we'll switch back to two at least the five days.

SARA SULLIVAN: Great. Thank you. And Jamison went ahead and in the Q&A put the link for the mobile tent, I am also going to drop it in the chat just to make sure no matter where you're looking, you receive that. There was another question that came that was already answered. Let me make sure there isn't anything else for the panelists. Before we move on.

I think that is it for the panelists. The rest of the questions are either for Jason, Liesl, or myself. So thank you to all of the panelists for joining, I appreciate it. Liesl and Jason, if you wouldn't mind hopping back on, we can go to the questions for you. I will also note that this webinar is being recorded, so if there is any part of the webinar that you missed or couldn't hear well, feel free, we're going to send an email out for everyone that registered with a link to the webinar recording and where to access it. So if you are here, you will have that link in your email within about a week and you can kind of go back and listen to any portion of the webinar that you would like to. So let me go to these questions.

Jason, somebody asked if you could reiterate your answer regarding using the funds for monkeypox.

JASON SNOW: Sure. And I also dropped the answer in the Q&A and also on the chat. But essentially the process we have to go through since these are special COVID funds is that if you're a subrecipient or a contractor on this, you need to work with the ELC recipient directly, because the ELC recipient will have to put in a request to get a waiver from OFR, the Office of Financial Resources here, that CDC will be able to use these funds to do the current COVID action needs and just augment or expand to include monkeypox. We cannot do anything that is 100% monkeypox. That cannot be a standalone monkeypox effort. It has to be what is in the current work plan doing any of the either required or optional activities and so I mentioned at the beginning of this webinar, to do those activities predominantly focused on COVID, but to expand to also include monkeypox. And again, we have to get a waiver approved first by the Office of Financial Resources before we can do that expansion, but it is an avenue to explore.

SARA SULLIVAN: Great. Thank you. We did have some questions about reaching local jails. I just want to say that if anyone on this call wants to talk with us about their strategy for reaching local jails and opportunities, maybe to adjust or expand that strategy or just talk to us about what your strategy is, please feel free to reach out to us directly. I'm going to go ahead and put my email in the chat. You can also reach out to your project officer and feel free to reach out to them and they can get you in touch with me as well. And we'll be opening up direct communication now that our Technical Assistance Provider is on board, so it will be an opportunity to connect with us as well. Let me put this in the chat. And now let me move to some of the questions for Liesl. Liesl, could you repeat the type of facilities that will be covered in the high-risk congregate settings guidance?

LIESL HAGAN: Sure. Sorry, I'm still having audio difficulties. So the types of facilities that will be specifically called out in the high-risk congregate settings document will be

correctional and detention facilities, homeless service sites, water pumps and assisted living facilities. But it's written in such a way that there is a definition of what we mean by high-risk congregate setting. And so other settings, if they meet those criteria, could also utilize this document.

SARA SULLIVAN: Thank you. Next question. "Will there still be a routine observation period upon admission?"

LIESL HAGAN: Yes. So the routine observation period refers to intake procedures, and our recommendation on that front has not changed. Like I said, there is a corrections specific box towards the bottom of the document and that's where you'll see the routine observation period of intake. Just to clarify though, it's always been sort of an either/or and it'll continue to be that way either doing a routine observation period at intake or testing everybody at intake. So that will remain unchanged.

SARA SULLIVAN: Great. Next question. "Do you have any updates on when the updated guidance will be published?"

LIESL HAGAN: I wish that my answer were different, however no. We were told last week that it was going to be posted on Friday of last week, but that did not manifest. So I will tell you there are a lot of different settings obviously that are looking for this update to be posted. And so there's a lot of pressure being exerted for this to be posted as soon as possible. And so we are representing corrections in that sphere to try to get this posted quickly.

SARA SULLIVAN: Great. We have a clarification. "Skilled nursing facilities are not included in the congregate setting?"

LIESL HAGAN: Correct. So skilled nursing facilities, I believe, would still qualify as falling underneath the health care guidance. So, one particular point about that that perhaps would be worth reiterating is that this guidance is intended for non-healthcare portions of these facilities. So correctional and detention facilities, I think as everybody on this call is aware, some of them have pretty high level of medical care available on site and others have a more limited amount of care that's available onsite. And so in a facility, for example, that has a pretty sophisticated medical operation on site, this guidance for high risk congregate settings would apply to areas that are not dedicated to patient care. Those that are dedicated to patient care would still need to follow the Clinical Health Care Guidance Document that is maintained on the CDC website.

SARA SULLIVAN: Thank you. I think that is all of the questions. We received one or two more. We've received one regarding the wastewater testing, so I'm going to go back to Washington. They're asking, "What's the name of the testing method used for wastewater?" Dean or Jamison, can you answer that?

DEAN SMITH: Right now, the machine that I'm testing out is [INDISTINCT] an expert from [INDISTINCT].

SARA SULLIVAN: Okay. Thanks. Okay. I think that is it for the questions. We'll go through the questions afterwards, and if there's a question that we did not get to, we'll find a way to answer that question, where the link will be for the audio recording of the webinar. So we'll try to make sure that all the questions are answered, but I think that for the most part is everything. So, you know, to close up, first, I want to thank all the panelists for joining. I want to thank all the presenters. A few things that are upcoming that I want to let folks know about, there will be future webinars. This will be one of many. Next, we might focus on what jails are doing to utilize the funds. We might focus on juvenile facilities, police lockup, community corrections facilities. We might also—we're looking into some non-testing programs such as ventilation systems. A few recipients are using their funding to reduce their incarcerated population. We likely would do a highlight on that as well. So look out for future communication about future webinars.

We also want to hear from you about what you want to learn about. So as I mentioned, now that a CA provider is on board, we'll be opening up communications directly between BJA and the recipients and subrecipients and CMA, which is the Technical Assistance Provider and recipient and subrecipient. So when we do that, please feel free to share. If you're interested in more webinars, what you would like that information to focus on, what you would like to learn that other systems are doing.

On that note, I want to talk about two peer groups. So, the representatives from the Oklahoma Health Department have put together a peer group of other health departments, other recipients that are going to be meeting monthly to share lessons learned, to share challenges, to share how each health department, how each recipient is utilizing their funds. In a follow up email, we will provide information for the recipients that are on this call. We will provide information if you want to get tapped into that group and get access to that group, we will provide information on how to do so.

In addition, the technical assistance provider will likely be setting up a similar peer group for confinement facilities for subrecipients. And so look out for information about that as well, if that's something that you'll be interested in.

So with that, we are going to wrap up early. Everyone gets 26 minutes back in their calendars. Again, really appreciate your time. Really appreciate you joining us. Hope this information was useful and we look forward to talking to you in the near future. Have a great afternoon everyone.