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COVID-19 Best Practices for Correctional and Detention Facilities Following the End of the Public Health Emergency

This document reflects a compilation of information from the most recent CDC COVID-19 guidance relevant to these settings.

Applicability

The Illinois Department of Public Health (IDPH) has adopted the updated Centers for Disease Control and Prevention (CDC) Guidance on Management of COVID-19 in Correctional and Detention Facilities, which is summarized in this document. Clarifications have been added to aid facilities with assessing risk and responding to COVID-19 cases and outbreaks.

Because of the congregate living arrangements in correctional and detention facilities, the risk of COVID-19 transmission is higher in these settings compared with the general population. In addition, there is a high prevalence of certain medical conditions associated with severe COVID-19 among people who are incarcerated, increasing the risk for severe outcomes from COVID-19 in these populations.

For Health Care Professionals: This guidance does not apply to dedicated patient care areas within these settings. Any health care workers who provide care in these settings should follow Infection Control Recommendations for Health Care Personnel.

Assessing Facility Risk for Correctional and Detention Facilities

Correctional and detention facilities should use both COVID-19 hospital admission level and facility-specific risks to guide decisions about when to apply specific COVID-19 prevention actions. Assessing the following factors can help decide if additional layers of protection are needed because of facility-specific risks:

- **Facility structural and operational characteristics:** Assess whether facility characteristics or operations contribute to COVID-19 spread. For example, facilities may have a higher risk of transmission if they have frequent resident or staff turnover, a high volume of outside visitors, poor ventilation, or areas where many people sleep close together.
- **Risk of severe health outcomes:** Assess what portion of people in the facility are more likely to get very sick from COVID-19, for example, due to underlying health conditions, lack of COVID-19 vaccination, older age, pregnancy, or poor access to medical care.

- **COVID-19 transmission in the facility:** Assess the extent to which transmission is occurring within the facility through diagnostic testing of people with COVID-19 symptoms and their close contacts, as described below, under "Post-Exposure Guidance;" through routine screening testing (not routinely recommended, but some facilities might use it in consultation with their health department to facilitate early identification of infections in populations with especially high risk for severe illness from COVID-19); or other surveillance testing that the facility uses (such as wastewater testing). Results of testing at intake are not recommended as an indicator of transmission inside the facility, since infections identified at intake most likely occurred elsewhere.

Metrics for Action: County Level COVID-19 Hospital Admission Data

KEY POINTS

Facilities should continue to monitor the CDC COVID-19 Data Tracker weekly and implement select infection prevention and control measures (e.g., masking) based on the level of new COVID-19 hospital admissions over the past week in their county. This is the same metric that will be utilized by the CDC to issue alerts to the public regarding higher levels of SARS-CoV-2 circulating in the community and the need to take additional protective actions.

- **IDPH is recommending that a COVID-19 new hospital admissions level of 20 per 100,000 population over the past week be used as the measure at which facilities should consider implementing Enhanced Prevention Strategies ("HIGH").**
- **If there is a steady increase in hospital admissions for respiratory infections, including flu and RSV over two weeks regardless of the actual rate of admissions, facilities should be vigilant and prepared to implement enhanced measures if necessary.**

Facilities and individuals may choose to implement **additional** protective measures when the **COVID-19 Hospital Admission Level is lower based on their discretion and taking into account the activity of other respiratory infections, such as flu and RSV.**

COVID-19 Prevention Strategies

The actions facilities can take to help keep their populations safe from COVID-19 can be categorized as prevention strategies for **everyday** operations and **enhanced** prevention strategies when COVID-19 hospital admission levels are high.

- **Prevention strategies for everyday operations** should be in place at all times, even if COVID-19 hospital admission levels are low or medium. These include all of the strategies listed below except those marked *enhanced strategy*.

- **Enhanced prevention strategies** should be added to supplement the prevention strategies for everyday operations when COVID-19 hospital admission levels are high and when there

has been transmission within the facility (i.e., when in outbreak), or based on the assessment of facility-specific factors that increase risk. **This is not an exhaustive list. Contact your local health department to discuss additional measures based on the situation.**

When adding enhanced prevention strategies, facility operators should balance the need for COVID-19 prevention with the impact of reducing access to services and programming. Facilities may not be able to apply all enhanced COVID-19 prevention strategies due to local resource constraints, facility and population characteristics, or other factors (such as impact on lifestyle). However, they should use a multi-layered approach to increase the level of protection against COVID-19 by adding as many prevention strategies as feasible.

Depending on the risk in different areas of the facility, enhanced prevention strategies can be applied across an entire facility, or can be targeted to a single housing area, wing, or building. Facilities with higher risk profile can apply enhanced prevention strategies at any time, including when the COVID-19 hospital admission level is low or medium.

Encourage Staff and Residents to Stay Up to Date with COVID-19 Vaccines
Encourage and enable staff, volunteers, and residents to stay up to date on COVID-19 vaccination. Where possible, offer vaccine onsite and support peer promotion of vaccination.

Improve Ventilation
- Ensure HVAC systems operate properly and provide acceptable indoor air quality.
- **Enhanced strategy:** Where possible, consider holding group activities outdoors.
- **Enhanced strategy:** Increase and improve ventilation as much as possible. Identify, obtain, and test enhanced ventilation options in advance of higher risk periods to be ready to deploy when needed. Short-term and long-term tools to improve ventilation in buildings can be found on the CDC website.

Wear Masks or Respirators and Personal Protective Equipment, as Appropriate
- Maintain a stock of personal protective equipment (PPE) for staff.
- Offer high-quality masks/respirators to all residents and staff, and provide other PPE for staff and residents based on risk (see below for more information on PPE).
- During times when masking is not required in a facility, individuals should be allowed to use a mask or respirator based on personal preference, informed by their perceived level of risk for infection based on their recent activities, and their potential for developing severe disease if they are exposed.
- High-quality masks or respirators should be provided at no cost to residents and staff when indicated and replaced as needed. When possible, offer different types of masks and respirators to staff and residents so that they can choose the option that fits them best and that they can wear consistently.
- The options that are offered in correctional and detention facilities may be limited by safety and security considerations, such as concerns about metal nose wires.

- In environments where the risk of SARS-CoV-2 transmission is higher and safety and security considerations allow, residents should be offered masks or respirators providing the same level of protection as those provided to staff in a similar environment.
- **Enhanced strategy:** Require universal indoor masking, regardless of vaccination status.

Indications for PPE/Masks and Respirators

- **When indoor masking is required (or when individual residents or staff choose to wear masks based on their personal preference),** all residents and staff may use disposable face masks, barrier face coverings, or NIOSH-approved respirators.
- **Residents with confirmed or suspected COVID-19** may use disposable face masks, barrier face coverings, or NIOSH-approved respirators.
- **Staff and residents working in areas of the facility designated for isolation or quarantine** should only use NIOSH-approved respirators.
- **Staff and residents who will have close contact with residents who are under quarantine or isolation precautions, including during transport,** should use NIOSH-approved respirators, eye protection, gowns/coveralls, and gloves.

If not already in place, employers should establish a respiratory protection program, as appropriate, to ensure that staff members are fit-tested, medically cleared, and trained for any respiratory protection they will need within the scope of their responsibilities. Residents may also be considered for enrollment in a respiratory protection program depending on work-related exposure risk. For example, residents working in an environment where they may be exposed to COVID-19, such as in a COVID-19 medical isolation unit, would be considered for enrollment due to occupational risk. For more details, see the OSHA Respiratory Protection Standard.

See Types of Masks and Respirators for a full list of NIOSH-approved and international respirators.

Promote Infection Control and Facility Cleaning

- Institute standard infection prevention and control measures, cleaning, and disinfection at all times.
- Maintain supplies for hand hygiene, cleaning, and disinfection.
- **Enhanced strategy:** Apply enhanced cleaning and disinfection recommendations.

Increase Distance

Routine physical distancing is no longer emphasized in the updated CDC recommendations.

- **Enhanced strategy:** Create physical distance in congregate areas (where possible) when COVID-19 hospital admission levels are high or the facility is experiencing an outbreak.
- **Enhanced strategy:** Reduce movement and contact between different parts of the facility and between the facility and the community (as applicable).

Ensure Testing is Accessible for COVID-19, When Needed

- Test residents and staff who either have symptoms of COVID-19 or have had an exposure to COVID-19, in accordance with CDC testing guidance.
- **Enhanced strategy:** Consult with your local health department about implementing routine screening testing of residents and/or staff if there are concerns about the population being at especially high risk for severe illness from COVID-19. Routine testing can help identify infections early, which is important for people who are eligible for treatment.
- **Enhanced strategy:** As an additional enhanced prevention strategy, test all new residents entering correctional and detention facilities at intake.
- **Enhanced strategy:** As an alternative to intake testing, facilities can use a routine observation period at intake, during which residents are housed separately from the rest of the facility's population. The duration of the observation period should be at least five days if residents test negative at the end of the observation period, or seven days (minimum) to 10 days (optimum) if residents are not tested. Individual housing is preferred under this strategy; if cohorting is necessary, do not add residents to an existing cohort during their observation period.
- **Enhanced strategy:** An additional *enhanced prevention strategy* for correctional and detention facilities is to test residents during transfer and/or release protocols. Routine observation periods can be added during movement protocols as well as additional *enhanced prevention strategies*.
- Facilities that perform point-of-care (POC) antigen testing must comply with state and federal regulations and must report all positive tests to IDPH. Instructions for reporting are the same as for long-term care facilities and can be found here: https://dph.illinois.gov/covid19/community-guidance/long-term-care/antigen-testing.html

Identifying Exposures

A person with COVID-19 can spread the virus beginning two days prior to the onset of any symptoms (or two days prior to a positive test if they do not have symptoms). Persons with COVID-19 are considered infectious for 10 days ,although that time period may be shortened to seven days with a negative test (see below under "Isolation Guidance for Residents and Non-Health Care Staff"). People who have been exposed (close contacts) to someone when they are infectious with COVID-19 can be identified through contact tracing as described here:

- **Case Investigation and Person-Based Contact Tracing**
  - See CDC recommendations for Investigating a COVID-19 Case.
  - Case investigations should prioritize identification of close contacts who are more likely to get very sick from COVID-19, so that they can be referred to a health care provider to determine eligibility for treatment if they test positive for COVID-19.
- **Location-Based Contact Tracing**
  - Location-based contact tracing may be preferable in correctional and detention facilities where traditional person-based contact tracing is ineffective because of crowding, mixing of residents and staff, difficulty identifying close contacts, and residents' movements in and out of the facility.
  - Location-based contact tracing identifies potential exposures based on where a person with COVID-19 spent time while infectious. For residents, this could include their housing

unit, transport bus, dining area, and any programmatic activities; for staff and volunteers, this could include their duty station/unit, break room, carpool, and areas where they interacted with residents.
    - In areas identified during location-based contact tracing, consider testing those who were present during the same time period as the positive individual.
    - **If any additional cases are identified, facilities should consider adding enhanced prevention strategies.**
    - **All cases of COVID-19 must be reported to the local health department.**

Quarantine

Quarantine (separating and restricting the movement of people who were exposed to a contagious disease to prevent further transmission in case they become sick) for COVID-19 is no longer recommended for the general public. In correctional and detention facilities, quarantine can be very disruptive to the daily lives of residents because of the limitations it places on access to programming, recreation, in-person visitation, in-person learning, and other services.

However, because of the potential for rapid, widespread transmission of SARS-CoV-2 in these settings, some facilities may prefer to continue implementing quarantine protocols for residents, staff, and/or volunteers who have been exposed to someone with COVID-19. Facilities can base their quarantine policy on their risk tolerance, including factors such as the health of their staff and resident populations and the impact of quarantine on mental health and staffing coverage.

Facilities that choose to implement quarantine can consider a range of approaches to balance their infection control and operational needs and the mental health needs of their residents and staff. Facilities may shift between quarantine approaches to adapt to changes in disease severity and transmissibility of different SARS-CoV-2 variants, or to respond to staffing and space shortages during case surges.

Considerations for facilities implementing quarantine include the following:

- **Housing** – Residents who have been exposed can be quarantined individually or cohorted with others who have been exposed (cohorted quarantine). Facilities using cohorted quarantine should be aware that transmission can occur within the cohort if someone is infected. Using smaller cohort sizes can help minimize continued transmission. Once a cohort is established, additional persons exposed at different times should not be added.
- **Testing** – Serial testing may be used during cohorted quarantine. Within quarantine cohorts, serial testing every 3-7 days can identify new cases early. If new cases are identified in the cohort, the quarantine period should restart. Serial testing can be used for all residents in a cohort, or prioritized for people who are more likely to get very sick from COVID-19 to identify infections early and assess them for treatment promptly.
- **Movement** – To maintain access to programming during quarantine, facilities may choose to allow residents quarantined as a cohort to move outside of their housing space and continue daily activities as a group. Residents in quarantine should not mix with residents or staff not assigned to their cohort and should wear a mask indoors.

- **Duration** – For facilities choosing to implement quarantine after a person is exposed to someone with COVID-19, a 10-day quarantine period provides the greatest protection from potential COVID-19 transmission to other residents and staff but is disruptive to their lives and to facility operations. One option to balance these needs is to shorten the quarantine period if an exposed person tests negative after five days, but to continue masking indoors through day 10.
- **Monitoring** – Rather than requiring health care staff to check all quarantined residents for COVID-19 symptoms, facilities can prioritize symptom checks for residents more likely to get very sick from COVID-19 to identify infections early and assess treatment eligibility.

Implement CDC Post-Exposure Guidance

Residents and non-health care staff who have had an exposure to COVID-19 should test at least five full days after exposure (or sooner, if they develop symptoms) and should wear a well-fitted mask while indoors for 10 full days after exposure, regardless of vaccination status.

Managing Residents with Exposures to COVID-19

Quarantine is not required for residents following a COVID-19 exposure, regardless of vaccination status. However, residents who develop symptoms or test positive for SARS-CoV-2 should be isolated immediately. Residents who have been exposed should be monitored for the development of symptoms, to ensure prompt treatment to prevent severe illness or hospitalization.

- Testing following exposure
  - Test residents five full days after exposure, even if they do not develop symptoms. Count day of exposure as day zero.
  - If residents develop symptoms, test immediately.
  - No testing is required if residents have had COVID-19 within the last 30 days, as the risk of reinfection is low.
- Residents should wear a mask for 10 days post-exposure.

Managing Staff with Exposure to COVID-19

Work restriction is not required for staff following a COVID-19 exposure, regardless of vaccination status, unless they develop symptoms or test positive for SARS-CoV-2.

- **Health Care Personnel** should follow the recommendations from CDC's Isolation and work restriction guidance. For strategies to mitigate health care personnel staffing shortages, see Contingency and crisis management.
- **Non-Health Care Staff**
  - Testing following exposure
    - Test staff five full days after exposure, even if they do not develop symptoms. Count day of exposure as day zero.
    - If staff develop symptoms, test immediately.
    - No testing is required if staff have had COVID-19 in the last 30 days, as the risk of reinfection is low.
  - Staff should wear a well-fitted mask for 10 days post-exposure.

Implement Isolation Guidance for Residents and Non-Health Care Staff who Test Positive for SARS-CoV-2

(See Table 1 in Appendix A below for Details)

- Isolate staff, volunteers, and residents who test positive for COVID-19 away from other residents or away from the facility, as applicable, for **10 days** since symptoms first appeared or from the date of sample collection for the positive test (if asymptomatic).

- If the individual has a negative viral test,* isolation can be shortened to seven days, as long as symptoms are improving and the individual has been fever-free for 24 hours (without the use of fever-reducing medications), the individual was not hospitalized, and the individual does not have a weakened immune system.

- **Note that the isolation period for correctional and detention settings is longer than the duration recommended for the general public, because of the risk of widespread transmission and the high prevalence of underlying medical conditions associated with severe COVID-19.**
    - If multiple residents have tested positive, they can isolate together in the same area. However, people with confirmed and suspected COVID-19 should not be housed together.
    - Ensure continuation of support services, including behavioral health and medical care, for residents while they are in isolation.
    - During crisis-level operations, such as severe shortages of staffing or space, facilities may need to consider short-term reductions to the recommended isolation period for staff and/or residents. Facilities should consult with their local health department for additional guidance and support.

** Either a NAAT test, such as a PCR test, typically performed in a laboratory, or an onsite antigen test may be used to determine if isolation can be shortened to seven days. If using a NAAT, a single test is acceptable and must be obtained no sooner than day five of isolation. If using an antigen test, two negative tests must be obtained, one no sooner than day five and the second 48 hours later. Because NAAT tests can remain positive for some time, antigen testing may be preferred.*

Management of Staffing Shortages

(See Table 1 in Appendix A below for Details)

- **Conventional staffing:** Normal facility staffing levels.
- **Contingency staffing:** Staffing shortages are imminent and, if action is not taken, will interrupt facility operations. Contingency strategies are used to mitigate staffing shortages.
- **Crisis staffing:** Staffing shortages already exist and crisis strategies are used in order to continue facility operations at a safe level.
- **Considerations if using contingency or crisis staffing strategies:**
    - The risk of COVID-19 transmission within the facility is likely higher.
    - Staff should feel well enough and be willing to work.
    - Staff should wear an N95 respirator and physically distance, even among co-workers.

- Consider the types of tasks these workers perform to limit the potential for exposing others to COVID-19, if possible.
- If staff work following exposure during the 10-day quarantine period and develop symptoms, they should be evaluated for COVID-19.

Isolation and Quarantine Spaces
To encourage prompt reporting of COVID-19 symptoms and to support mental health, ensure that medical isolation and quarantine are *operationally distinct* from administrative or disciplinary segregation, even if the same housing spaces are used for both. For example, as much as possible, provide similar access to radio, TV, reading materials, personal property, commissary, showers, clean clothing and linens, and other resources as would be available in individuals' regular housing units.

Health Care Staff with confirmed COVID-19

- **Health care personnel** should follow CDC's Isolation and work restriction guidance for work exclusions while ill, testing requirements, and return to work criteria. For strategies to mitigate health care personnel staffing shortages, see Contingency and crisis management.

Support Timely Access to Treatment
Effective treatments are now widely available and must be started within a few days after symptoms develop. Treatment has been shown to reduce the risk of severe COVID-19 disease and hospitalization, especially in the elderly and those with underlying health conditions. Support timely treatment for those eligible; facilities without onsite health care capacity should plan to ensure timely access to care offsite.

- **Treatment Information is available at:**
  - National Institutes of Health (NIH) COVID-19 treatment guidelines.
  - A clinical decision tree is also available to help clinicians determine if a resident is eligible for COVID-19 treatment and the right choice of treatment.

Visitation and Programming
Visitation and programming are essential for residents' mental health and well-being. When possible, maximize access to opportunities for in-person visitation and programming, even when COVID-19 hospital admission levels are high.

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

Definitions

- **Close Contact:**

- Being within 6 feet of a person with confirmed SARS-CoV-2 infection for a period of 15 minutes or longer within a 24-hour period.
- Having unprotected direct contact with infectious secretions or excretions of the person with confirmed SARS-CoV-2 infection.
- Distances of more than 6 feet might also be of concern, particularly when exposures occur over long periods of time in indoor areas with poor ventilation.

- **Up to date**: An individual has received the primary series of COVID-19 vaccine (either two doses or one dose, depending on the vaccine), and has received all additional and booster doses for which they are eligible as recommended by the CDC. (CDC up to date recommendations for COVID-19 vaccines)

Appendix A: Summary Tables

Table 1: Work Exclusions and Restrictions for Staff with COVID-19 Infection

Vaccination Status	Conventional	Contingency	Crisis (Must notify LHD)[2]
	Work Exclusion and Required Testing	**Work Exclusion and Required Testing**	**Work Exclusion and Required Testing**
Vaccination status does not affect work exclusions or restrictions	Ideally, staff should be excluded from work for 10 days. Staff can return to work after 10 days since symptoms first appeared or from the date of sample collection for the positive test (if asymptomatic). No testing required to return to work if off work for 10 days. **OR** A facility may choose to shorten staff work exclusion to seven days if the following criteria are met: • At least seven days have passed since symptoms first appeared or from the date of sample collection for the positive test (if asymptomatic). • Viral testing* is negative. • The individual has been fever-free for 24 hours (without the use of fever-reducing medications), and symptoms (e.g., cough, shortness of breath) are improving. * Either a NAAT test, such as a PCR test, typically performed in a laboratory, or an onsite antigen test may be used to determine if isolation can be shortened to seven days. If using a NAAT, a single test is acceptable and must be obtained no sooner than day five of isolation. If using an antigen test, two negative tests must be obtained, one no sooner than day five and the second 48 hours later. Because NAAT tests can remain positive for some time, antigen testing may be preferred.	Asymptomatic staff may return to work if at least five days have passed since the date of their first positive viral test (day 0). Symptomatic staff may return to work if at least five days have passed since symptoms first appeared; have mild-to-moderate symptoms that are improving and fever-free for 24 hours (without the use of fever-reducing medications). Facilities may choose to confirm resolution of infection with a negative NAAT (molecular) or a series of two negative antigen tests taken 48 hours apart.* Antigen testing is preferred if testing asymptomatic staff who have recovered from SARS-CoV-2 infection in the prior 90 days due to PCR sensitivity.	Allowed to work but should have duties prioritized. No additional testing is required to return to work.

[1]Either an antigen test or NAAT can be used as a clearance test to return to work; however, antigen testing is preferred because a NAAT test may remain positive for some time following infection.
[2]LHD – Local health department