STACY LEE: Good afternoon, everyone, and welcome to today's webinar, the “CDC Updated Respiratory Virus Guidance and the Impact on Confinement Facilities,” hosted by the Bureau of Justice Assistance and the Centers for Disease Control and Prevention. At this time, it is my pleasure to introduce Sara Sullivan, Senior Policy Advisor with the Bureau of Justice Assistance, to begin the presentation.

SARA SULLIVAN: Good afternoon, everyone. Thank you so much so joining. To make sure you are in the right place, this is the webinar on the new updated respiratory virus guidance by the CDC and its impact on confinement facilities. This webinar is being cohosted by the Bureau of Justice Assistance and the Centers for Disease Control and Prevention. My name's Sara Sullivan. I'm a Senior Policy Advisor at the Bureau of Justice Assistance and I'll be kicking us off today.

Again, thank you so much for joining. One note, we will have time to take questions at the end. And so if you have questions, please put them in the chat. I will be monitoring the chat and then I'll ask your questions at the end. So feel free throughout the presentation to go ahead and put your questions in. You can also put your questions in during the Q&A session into the chat.

So, on the BJA side, for those that are not familiar with BJA, we are part of the Office of Justice Programs at the U.S. Department of Justice. We are one of three grant-making entities at the Department of Justice. And we work on reducing crime recidivism and unnecessary confinement through grant administration and policy leadership. So nice to meet everyone.

CDC and BJA have been partnering on COVID response in confinement facilities for several years now. This webinar is being hosted on the BJA side by BJA's COVID-19 Detection and Mitigation, and Confinement Facilities Training and Technical Assistance Center. And we're happy to have two representatives from the Centers for Disease Control and Prevention as part of the webinar today. First up is Liesl Hagan. Liesl is the Senior Scientist for Correctional Health at CDC. And then, I also have Erica Reott. Erica is the Associate Director for Policy of the Coronavirus and Other Respiratory Viruses Division in CDC's National Center for Immunization and Respiratory Diseases. So with that, I'm going to pass it over to Liesl who will take it from here.

LIESL HAGAN: Thank you so much, Sara, and thank you for everyone for joining today. Particularly, thank you for your understanding and flexibility in taking the invitation for a webinar with just a couple of days' notice. We know that there's been a lot of questions around the guidance that was released last Friday and we're happy to be able to be here today to give you an overview of the guidance, describe how it applies to

correctional facilities, and then take your questions. So yes, so Erica is going to start us off with an overview of the updated respiratory virus guidance for the general public. The reasons that the guidance was updated, some data behind those decisions, and then an overview of how individuals can protect themselves from the respiratory viruses including COVID, flu, and RSV, and others. And then she'll transition over to me and I'll talk about how this applies to corrections, including what is the same since the last updated version of the correction's specific guidance for COVID-19, what has changed, and how facilities can evaluate their current practices based on the updated guidance. And then we will take your questions. So I will turn it over to Erica.

ERICA REOTT: Thank you so much, Liesl. So, I will likely unpack some of the context and content of the respiratory virus guidance that we released on March 1st. And I'll note that correction-specific guidance, along with other setting-specific guidances besides healthcare guidance have been archived. They're still on the internet on CDC's archive but are not the standing guidance for any given settings currently for respiratory viruses including COVID. So, do I also control the slides here. Next slide. Okay, great.

So, the goals of the respiratory guidance update really overall were to provide streamlined guidance that's built on effective strategies with the hopes that more people can take action to prevent respiratory viruses of various sorts. And so a lot of emphasis on practical recommendations that people can implement in their daily lives and wanting to make sure that those recommendations are clear and understandable and accessible. And we also sought to streamline the guidance across respiratory viruses. So right now, previously, you could go to CDC's webpage on hygiene and hand washing, and COVID, and the page on hygiene and hand washing in flu, and a page that talked about hand washing and hygiene for RSV prevention. And so across these common respiratory viral illnesses that have similar risk factors, that have similar modes of transmission, that have similar modes of prevention, where appropriately we tried to streamline that down into one overarching respiratory virus guidance message. There are certainly places that are still virus-specific, like, which immunization you should get or which treatment you might have access to, but where possible, we streamlined.

We certainly wanted to emphasize the strategies that effectively reduce risk in the updated guidance. And also balance the current post-emergency risk to real risk landscape we're seeing from COVID-19 and other respiratory viruses with other health and society needs, as we transition from a phase of pandemic to a recovery and maintenance phase. Go to the next slide.

So, some of the drivers of this were really informed by a deep assessment of how COVID is affecting the population nowadays. And so there's enablers and then there's things we looked at to see as indicators of how things have changed. Some of those enablers have been we got effective vaccines and treatments for COVID-19, each of those cut risks of severe disease in about half. We see that over 98 percent of people in the U.S. now have some degree of immunity, either hybrid immunity, like from past infection and vaccination, or one or the either. And just a reminder that immunity can wane, so that vaccination immunity is something that continually we're assessing when people need to get an updated dose to stay current with vaccines for protection. And then we have other effective tools that people, I think, have become increasingly familiar with over the course of the pandemic, especially ones like masks and steps for cleaner air and ventilation, of course also hygiene, and tests are now pretty widely available especially for COVID-19 at home. The result of this has indicated that hospitalizations are down significantly. So we are down more than 75 percent from our January 2022 peak, which was the all-time COVID hospitalization peak. Now, hospitalizations are pretty closely in the range of flu this past season. And we've seen that over about 95 percent of people who have been hospitalized are not current on their COVID-19 vaccine. And so that's just another point of emphasis that we have tools but in emphasis of this guidance is really shining a light on those key critical tools so that people know how critical it is for them to use those. We are also seeing fewer deaths, still significant but COVID is now, in 2023, the 10th leading cause of death, whereas in 2021, it was the third leading cause of death. And we're also seeing fewer cases of other complications of concern, like multisystem inflammatory syndrome in children, like long COVID, still very important considerations and concerns, but not as common as we see, increasing evidence that immunization helps prevent both of those. We can go to the next slide.

I'm seeing the note, can folks see the slides? Okay, good. Seems like some folks can at least hopefully. This is just a graphical representation of that immunity level. You can see in the green, that toward the end of last year, most people had both infection-induced and vaccination-induced antibodies to COVID-19, 98 percent of people had at least one or the other, if not both. So this has really grown from two years ago which is when a lot of this guidance we're replacing was initially designed. So we are in a different place and I don't want to undersell the threat that COVID-19 and other respiratory viruses pose, but just some context for why we feel like we are able to be a little bit more flexible in what's recommended and not as restrictive as we needed to be in a state of emergency. Next slide.

Here is one more point of data, I think, that's helpful to see, which is test positivity which is that orange line there, has remained similar or the same over time. But the blue bars, which indicate deaths in this graph, have declined significantly. So we've internally

called this a decoupling of the two data trends and we're seeing. It's not just that, in fact that people aren't getting COVID as much anymore. So when people get COVID, their outcomes are less severe because of the protections that we have in place. We can go ahead to the next slide.

And so what that's manifested in is that we are positioned well now to have done some reassessment of our guidance, to look at what other countries have done, to look at what the data are indicating, and issue some updated guidance. Like I said, this guidance is unified across respiratory viruses. I want to emphasize that's common respiratory viruses, not ones that are rare and need special containment, something like measles which can spread in the air, but more common things like flu, COVID, RSV. We've unified them and we've created some core prevention strategies which are these really essential things we recommend for most people at all times, and then additional prevention strategies. And on the next slide, we'll unpack what those are.

So, the core ones are along the top, and these are immunizations. So there are specific immunization recommendations by virus and by age group in different categories, but the overarching recommendation is to stay up to the date on the immunizations that are recommended for you. And the website has a lot more details about how to operationalize this and what those might be. The next core recommendation is hygiene and that's to make sure that—sorry, an interloper. Hygiene, making sure we're washing hands, cleaning frequently touched surfaces, using respiratory etiquette. And all of the guidance I'll note now has information about how individuals might implement the recommendation but also some suggestions or ideas for organizations.

So, for this one, for example, it's making, hygiene supplies easily available, having maybe hand sanitizer near places that water and soap can't be available, et cetera. Then there are steps for cleaner air. CDC has a very robust suite of webpages about ventilation practices and things that can be done to improve indoor air, and this could be everything from an individual in a home opening their window to a larger facility using the right MERV level filters, using air purifiers. There's a whole lot of different options here, but the idea is just to keep air quality in mind and try to take some steps to improve air quality indoors.

Next, we have treatment and this is not available for every respiratory virus, but COVID and flu both have pretty good antiviral treatment. So if someone's at high risk for progression to severe disease and they start to feel sick with what seems like respiratory virus, we want them to get in touch with healthcare and see what they need to do next. Healthcare providers can prescribe treatment sometimes without testing, or they might recommend the person get tested for different respiratory viruses. But the

bottom line is treatment needs to be started early, so we want people to seek that out if they're at higher risk.

And then the final core element is staying away from others when you're sick so that you're not spreading respiratory viruses. And I'll impact that in a second, just want to flag what the additional prevention strategies are first, and those are the ones that are masking, distancing, testing. These are things that we are not actively recommending at any particular time. But suggesting that people can layer on, or organizations can recommend or encourage in their locations or whatever might be appropriate as needed. And we're noting that these things could be especially helpful in a few different contexts. One is, if there's a lot of illness going around, like that's a time where layering up and even amplifying your core strategies, makes a lot of sense. Another one is if you or the people around you have risk factors for severe illness, that's the time where you might want to take a little bit more action. And then finally, if you or the people around you were recently exposed to a respiratory virus, if you are sick with a respiratory virus, if you are recovering and recently had a respiratory virus, those are times layering up additional strategies make sense. Though they can help at any time, I think and people are encouraged to, I think, lean into the strategies that they're comfortable using on those additional layers.

The last thing I'll note on this slide is just that element of staying away from others when you're sick. So as you may recall, CDC's respiratory virus recommendations varied by virus before, so we had isolation guidance for COVID, and that was like a minimum of five days in isolation, plus a period of masking. There was a 24-hour fever-free feeling better policy for flu. We don't really have anything specific for RSV. So across the board now, what we're recommending is that people stay away from other folks to the greatest extent possible who are sick until both of these things are true for at least 24 hours. So your symptoms are getting better overall, like you're we're feeling better, and you're fever-free without fever-reducing medicine. And when both of those things are true, you can go about your normal activities and be around other people.

But there's a lot of language in the guidance about emphasizing. This is still a period of heightened risk, right? Your body is most likely past the period of peak infectiousness, but there are some people who are still shedding virus at that time, and so we want to be cognizant and layer up prevention strategies of your choosing. And a lot of that is contextually dependent, so if you're outdoors and you're visiting somebody who's not at particular risk and you're spacing out a little bit, that could be a protective option. If you're indoors and you open a window and have a mask on and you're around somebody, that might be the protective option you choose. But we want you to just be aware that transmission can still happen in certain cases at that time. And so some

exercise and precaution at that time makes sense. Especially if you're going to be around folks who are at high risk of severe illness, and then maybe a time that you want to continue to distance if feasible from people who are at higher risk. And that's for five days following the end of your isolation period or period of avoiding others. We can go to the next slide.

This just reiterates the same that I just explained. So I think we can go ahead on to the next slide.

This is just going to flag that if you did happen to test positive for a respiratory virus, for example, your organization wants to do—we don't actively recommend it—but could choose to do screening testing before new people come into a facility. And somebody tests positive even though they had no symptoms. So, if you test positive without having any symptoms you've already met the two criteria of not having a fever and not having any issues with symptoms. But we want you to at least take those five days of precaution. And so that again is layering up any of the prevention strategies, amplifying your use of those core strategies, layering on some additional strategies optimally when you're going to be with other people indoors.

And I think this is my final slide. And just know we also have specific pages on people who are at high risk for severe illness. So this includes older adults, young children, people with weakened immune systems, people who are pregnant or who have disabilities. For all of these groups, there are specific vaccine recommendations or educational messages that we want to make sure are consolidated on a one-stop shop and not currently how they are, which is a little bit spread around the website. So these are also accessible links off of the guidance for people to consider. And is that my last one? I think so. I might pass it over to Liesl. Yeah. Thanks.

LIESL HAGAN: Thank you so much, Erica. I appreciate that overview of the guidance. So for the rest of the rest of the presentation, I'm going to be walking us through what that general guidance means for correctional and detention facilities, including what stays the same from previous versions of the correction-specific guidance for COVID-19, what has changed, and specifically how facilities can evaluate their current practices within the context of this updated guidance.

So, to summarize, there are four elements that are going to stay the same compared to previous guidance for COVID-19, specifically for correctional and detention facilities. And there are five key changes. So we're going to go over each of those in just a moment. But before I do, I want to give you sort of the take-home message, which is that over the course of the COVID pandemic, we know that different facilities have

developed lots of different combinations of prevention strategies that work for them based on their unique needs, the needs of their populations, the risk factors of the people in their facilities, their staff and people who are incarcerated, as well as the unique layout of their facility. And I've already heard from a number of partners who have questions about whether they'll need to change that combination of strategies based on this new guidance.

And so, the main takeaway that I had for you is that yes, this guidance is less detailed, is not written from the perspective of what facilities need to do in corrections. And it doesn't include explicit recommendations for all of the decisions that your facilities are going to need to make in order to prevent respiratory illnesses in the way that you're accustomed to seeing it over the last four years. But it still has all the key elements that you're used to seeing. All those key core prevention strategies that you need to keep doing what works in your facility are still there. It's just a matter of knowing where to look and how to connect the dots to figure out where you fit within that framework. So I'm going to walk you through ways to do that right now. And my team is also here to continue to provide support and technical assistance. If anybody would like to talk through the guidance and talk through the ways that it specifically impacts your facility, I'm happy to do that after the webinar. My email will be in the chat and we can connect later.

So, just really regardless of whether your facility has been on the more conservative end of the spectrum throughout the pandemic, or if you've already relaxed some of these prevention strategies over time or early on, there are ways to work within this guidance to do what has been working for you over time.

So, let me go through those things now. So the things that stay the same, first of all, as Erica alluded to, there is separate healthcare guidance. The guidance that was released on March 1st, last Friday, does apply to non-healthcare portions of correctional and detention facilities, and CDC continues to offer separate guidance for healthcare settings. There are links here that Sara's going to drop into the chat with healthcare guidance specifically for COVID-19, for flu, and for general infection prevention and control. Now one of the questions that I've already gotten several times over the last week is how this translates to staff who are in healthcare roles compared to staff who are in non-healthcare roles and what this means for the recommended time for isolation for these people. And so I will tell you, there is not alignment over these two spaces, and we can talk about that a little bit more in a minute. And I know that that's going to be a challenge in messaging, because the guidance for healthcare personnel is much more prescriptive and gives a certain number of days for people to stay out of work before they come back after being ill, whereas the general public guidance is completely

symptom-based now, as Erica has just described. So that is an area that we know does not align and we can talk through some messaging for that.

The second thing that stays the same is layered prevention. And as Erica described in the infographic that she shared, the core prevention strategies and these additional prevention strategies are the same as they always have been. And these are the things that you've constantly been hearing over the last four years, the things that you put into practice in your facilities, in the ways that work for you. So none of these prevention strategies are changing, and these layering up of additional strategies are still available options at key times. And I'm going to keep coming back to this list of options when I describe the ways that you can implement some of these practices and continue to implement them in your facilities. So I want you to think about, to just of focus your mind on this slide right now, to see that these additional strategies are available when, as Erica said, respiratory viruses are causing a lot of illness, whether that's in your facility or in the community, when your facility includes people who have risk factors for severe illness, and when people in your facility have recently been sick or recovering or have recently been exposed. And that's all outlined on this infographic that Erica shared here down at the bottom. So I'm going to keep coming back to this to anchor us to this as we think through how this applies to corrections.

So, the third thing that stays the same is that people who are incarcerated will continue to rely on facilities for access to some of these core prevention actions and some of the additional prevention actions. The guidance is written more with thinking through what individuals can do to protect themselves. But it doesn't answer all the questions about the decisions that facilities need to make about how to make those prevention strategies available to people.

So, these are the same things that you've seen over and over again. So people who are in your facilities, whether those incarcerated people or staff to some extent to varying degrees rely on the facility for access to opportunities to stay up to date on their vaccines, access to soap and water for hygiene, making sure that frequently-touched surfaces are cleaned effectively, taking steps for cleaner air, whether that means ventilation in whatever way works in your facility with your security level and your layout. Ensuring that people have access to healthcare during confinement, including treatment when it's recommended for respiratory illnesses, finding ways for people who are sick to stay away from others to prevent transmission, and providing masks for people who want to use them. So these are going to be actions that are going to require action from the facility in order to allow these prevention actions to be undertaken by the people inside the facility. So that's still the same as it always has been.

The fourth thing that stays the same is the importance of monitoring people who are at risk for severe illness. So as Erica shared, hospitalizations and deaths for COVID have decreased. But COVID, as well as flu, RSV, and other respiratory viruses continue to be important public health threats. And we know that many people who are incarcerated are at risk for severe illness from respiratory viruses for a number of reasons. And so for that reason, it's really important to keep identifying people early who are at risk for severe illness and provide access to treatment if that's recommended for them. And that's not just for COVID-19 but for other respiratory illnesses as well.

So, those are the four things that are really, for the most part, staying the same since the last iteration of the COVID guidance for corrections. Now there are several things that have changed. One, is the way that CDC is recommending that facilities and individuals use hospital admission levels for COVID-19. And these were the, sort of, algorithms developed to identify thresholds for low, medium, and high hospital admissions for COVID-19 that were tied to specific prevention strategies for communities. And in earlier iterations of the guidance, we said, "Okay, when hospital admission levels are medium or are high, then you want to add on some of these in what we call enhanced prevention measures." And those data are still going to be available and they'll still be on CDC's website. But this updated guidance for respiratory illness no longer ties specific guidance recommendations to those COVID-19 hospital admissions levels. To the extent that you find them helpful, please keep using them as an indicator for when risk might be higher in your community, but they are no longer tied to specific prevention actions in the guidance.

The second thing that has changed, as Erica said, we're not using the term "isolation" so much anymore. It's changed to "staying home and away from others." And the reason for that change in terminology is just for simpler language. Just because the guidance is not setting-specific, it's not population-specific, and it's wording that is broadly used in public health or the general public. But we know that it may need to be phrased differently in correctional settings. And it definitely does not mean that we're undermining the importance of medical isolation within correctional and detention facilities for people who are sick. And so this is just so that, when we say stay home and away from others, it's the same way that we were using the word isolation before, but from just sort of a simpler language approach for the general public now that it's not setting-specific guidance.

The third thing that has changed is the recommended amount of time that the guidance recommends to stay away from others when you're sick. And as Erica already went through, this is all symptom-based now. This is not a prescribed number of days as it has been in the past. So I'm going to repeat a couple of Erica's slides just about staying

home and away from others when you have symptoms, or when people have symptoms that aren't explained by another cause, like seasonal allergies. So you stay home and away from others, when for 24 hours, both the symptoms are improving overall, and you haven't had a fever without fever-reducing medications. And then resume normal activities, go back into congregate living spaces but for the next five days, we still recommend layering on some of those additional prevention strategies in the infographic that I'll go back to. And that additional layering, again as Erica stated, is because there is still a risk of transmission during those five days—those data have not changed. It's more about balancing that after that initial period of having symptoms and having a fever, peak infection risk has passed for most people, but there's still a risk that people could be shedding virus. And so that's why we continue to recommend additional layered strategies for the next five days.

And so what I want to emphasize here is that if you test positive but you don't have symptoms, then you kind of skip the first part about staying away from others, but still take precautions for those five days after you have a positive test.

So, the important here point here that I want to emphasize is that this recommendation for the amount of time to stay away from others is the same for all non-healthcare settings. So in previous versions of the correction-specific guidance, this was different. For corrections, we had a longer duration of time that we are recommending isolation compared to other settings in the general public. But now this recommendation is the same. It's unified across all non-healthcare settings for all respiratory viruses. Except for the ones that Erica mentioned that are going to require special containment.

So again, I want to point you again to kind of, noting these additional prevention strategies because the next few slides are going to rely heavily on these when to layer on additional prevention strategies. Again, it's when there's a lot of illness happening in your community from respiratory viruses, when people around you have risk factors or severe illness, and if people have been recently exposed or sick or recovering. So we're going to keep coming back to this as I walk you through the ways that some of these changes can affect corrections and how you can continue to implement some of the practices that you're used to implementing that work for you.

So, the fourth thing that's changing is quarantine. Quarantine, which again, is staying away from other people after you're exposed but you're not yet sick. This is different from isolation. Quarantine is no longer explicitly recommended in the guidance after exposure to respiratory viruses for any particular group. In the last version of the COVID-19 guidance for corrections, this was still listed as an enhanced prevention strategy that could be undertaken by facilities if they felt that it was useful in their facility.

But that's no longer explicitly recommended in the guidance. However, physical distancing is an additional optional strategy that is still within the guidance that facilities can layer on when somebody has been exposed. So again, going back to this infographic, we've got distancing as a prevention strategy and quarantine is a form of distancing. And so if this is something that you've been using and it has been useful for you and you're mindful of all of the different competing pros and cons of this approach, knowing that extended periods of quarantine have been really harmful within correctional environments to mental health for staff and incarcerated people, now we definitely need to keep that in mind. But we're not recommending a specific number of days if this happens. It doesn't have to mean a total lockdown. I know there are a lot of facilities that have come up with creative ways to keep groups of people who have been exposed separate without restricting their access to in-person services too much by cohorting. And so those strategies are still practicable within the guidance. And there are also other layers that you can add when physical distancing is impractical or when it is potentially harmful. So physical distancing isn't your only option here, but it is one of the options.

The fifth thing that's changed, again, is testing at intake. So in previous versions of the corrections guidance, testing at intake was explicitly recommended as an enhanced prevention strategy, and that is no longer the case. But just like our previous slide, testing is an additional optional strategy within the guidance that facilities can layer on as needed to identify people who should stay away from others. And so if you're seeing high rates of, respiratory illness in your community and your facility, then testing could still be a good strategy for you to employ. But there are a couple important notes here about testing is that we know that point-of-care tests—the rapid tests, the antigen tests that we've all been using a lot—they often do not detect COVID-19 in early stages of illness and that is when most transmission occurs. So there can be a lot of false negative results for flu and for COVID-19. But, false positives are rare. As I've heard Erica say before, a false negative has a big asterisk by it. It could just be that somebody is infected, but the testing is too early to detect the virus. So with that in mind, we know that testing at intake and at any other time will not identify everybody with respiratory viruses, but if that's a tool that you're layering on as part of your combination of strategy, that is still there for you.

So those are the things that had generally stayed the same and changed throughout the guidance. And I want to spend the last couple of slides talking about how correctional and detention facilities can implement isolation or staying away from others in their facilities within this new guidance.

So, one of the questions that I've heard the most often is, "Well, we can't provide space for everybody who has a runny nose." And we know that facilities won't have individual housing in most cases for everybody who has respiratory symptoms. And so this is another place where those additional strategies can be useful because, again, testing is there as an option for us. And so testing somebody who is sick is something that's still recommended as an additional optional strategy that's setting-specific, or context-dependent, I should say. And so that can be used by facilities if they need to prioritize these individual housing areas that they have. If that's a resource that's limited, you can test people when they're sick and then prioritize your individual spaces for people who have illnesses of greatest concern. So that's a tool that's available to help with implementing staying away from others. Again, just noting the limitations of testing and the false negatives that we know we see. And also noting, too, that if you're cohorting people who test positive, make sure that you are only grouping those people together who have tested positive for the same virus so that you don't end up getting co-infection of flu and COVID and other things by bringing people together with different illnesses.

And then in addition, going back to that recommendation that we recommend layering additional strategies for five days after somebody's symptoms are improving or they're fever-free. This really gets to the question about how to decide how long someone needs to be in isolation, or staying away from others in corrections. And this is another place for these additional strategies of testing and physical distancing [that] can help you implement what's working for your facility. And so, if somebody is fever-free and they don't have any more symptoms but you still want to be conservative, you can still use a test-based approach. I'd refer you to the healthcare guidance to make sure that you're thinking about how often, we don't just want one viral test. If it's a point-of-care test, it's two tests, 48 hours apart that we would like to see. And that hasn't changed as far as a test-based approach. And all of those details are in the healthcare guidance. And, again, physical distancing is another added layer of protection that is within the guidance for when somebody has been sick or recovering. And so, if your facility is choosing to remain on the more conservative side because of the risk of transmission after people don't have symptoms anymore, you can still use your testing-based approach. You can still use a longer period of staying away from others through physical distancing if that's what the facility has chosen to do.

So again, just bringing you back to this infographic, I keep coming back to it, but I really do think that the most important information is right here. And Sara has put that in the chat. And I know that Erica said that this is being translated, or can be translated into Spanish as well, so that work is underway. But you can really sort of anchor yourself to this bit at the bottom about when to layer those prevention strategies and where to find

where your facility fits along the spectrum of conservative prevention measures to more permissive ones.

And so as a final note, we know that there will still be situations when there are outbreaks of flu and COVID in your facilities. And in these situations, these same recommendations apply, that we recommend that you layer on additional strategies. And if you do need tailored support based on your particular facility and your population and things aren't working the way that it used to and you'd like to rethink things, I really encourage you to reach out to your health department about that. And here's a link here that Sara's going to drop in the chat as well for how to get in touch with your state and local health departments. The websites for all the health departments are in here. And we're also happy to help you get in touch with your health department. If you'd like an actual name and a person to get in touch with instead of just a website, please feel free to reach out to me.

I know that a lot of facilities have invested in their relationships with their health departments during COVID and we're hoping that those relationships can continue and continue to serve you as you face these challenges with respiratory illnesses and whenever challenges arise with outbreaks.

So before Q&A, I really want to emphasize how much I appreciate all of you coming today. And not just today, but we have been on a lot of webinars together, I think over the last four years. And I have really relied on hearing from you all in the field and how the different iterations of the guidance is affecting you and affecting your staff and affecting the people in your care and custody. And that has been critical for us to be responsive in our guidance. And so it really is a turning point, I think in the way that CDC is approaching this in that we are in a different stage with COVID now. And this is a unified approach to respiratory guidance overall that we're hoping can be simpler and easy to implement. And we want to continue to hear from you. And so whatever feedback you have, please send it my way. My email is here, lhagan@cdc.gov. And if you have any general questions about the Respiratory Virus Guidance that may not be specific to corrections, you can send it to Erica Shoff at the NCIRD Partnerships box. But please do stay in touch. And, as I said, I'm happy to walk through any specifics about this with any of you if you want to reach out. So thank you so much and I'll turn it over to Sara for the Q&A.

SARA SULLIVAN: Thank you, Liesl. Thank you, Erica. Very much appreciate it and appreciate your partnership with the Bureau of Justice Assistance. We have a lot of questions that came through the chat. I'm going to do as much as I can to kind of group them into questions, but, at some point, I may just start going through based on how

they were received. So the first question—and they're in the Q&A and the chat—the first question is about reporting. "With the implementation of this new guidance, do correctional agencies still need to report COVID-19 positive cases to our local health authorities?"

LIESL HAGAN: I'm going to see if Erica wants to take that one from a broader perspective.

ERICA REOTT: Yeah. Sure. I don't actually personally know what the current requirements are for reporting from correctional facilities, like as far as CDC's involvement with that. I think it may be something that depends on your particular state and locality. I don't think at this juncture we are requiring it to be reported directly to CDC. But I say that with a big caveat and not entirely confident and can look further into it, unless you know otherwise, Liesl.

LIESL HAGAN: Yeah. Is it nationally notifiable still just on a broad basis?

ERICA REOTT: I believe that that is ending, right?

LIESL HAGAN: Okay.

ERICA REOTT: So, yeah.

LIESL HAGAN: I hate that we have to come back to that for our very first question, but I will say it's…

ERICA REOTT: Yeah. I'm going to work it in my chat over here and get you an answer hopefully faster, and you're talking about cases, not deaths? Is that right? Okay. Yeah.

LIESL HAGAN: Cases.

SARA SULLIVAN: Yes.

LIESL HAGAN: And the thing that's nationally notifiable, which is it's a set of infectious diseases that, by law, state health departments have to report to CDC, then there is also a requirement for any healthcare provider that identifies cases to report those cases to their health department so that their health department can report to CDC. It sounds like we're just not sure if there's going to be a change in status in the notifiability of COVID-19. Is that right, Erica?

ERICA REOTT: Yes. Let me confirm. I have a thought, but I don't want to speak out of turn, so I'm going to confirm some thoughts real quick here then get back to you.

LIESL HAGAN: We'll come back to that one.

SARA SULLIVAN: Okay. Next question is about tracking. "Will we still be tracking COVID activities at our facilities? And since we won't be testing, what metrics will we or should we be tracking besides vaccinations?"

LIESL HAGAN: I would say vaccinations is the most important one, but I think it also depends on what kinds of prevention strategies you're going to have in place in the facility. And so, we are still recommending that people who are sick be separated from others. And so, if your facility is using a symptoms-based approach, as our current guidance recommends, then there would be tracking involved in checking on those patients and their symptoms. And if you're essentially trying to figure out where that sweet spot is for you and where you want to end isolation, if you're going to continue with a time-based strategy, then you might want to track what's happening over time so that you can see where your data are lining up and if you're having outbreaks compared with how long people are staying away from other people. And so that's just more for your internal quality control and quality improvement measures. But, individual health departments may have different requirements and different desires for data from facilities. So I would encourage you to get in touch with your health department to find out what their continued expectations are because those are going to vary from jurisdiction to jurisdiction.

SARA SULLIVAN: Thank you. Next question says, "So is it fair to say that we can now align our influenza and COVID protocol and procedures for both staff and patients into one standard?"

ERICA REOTT: I'm sorry. Can you hear me?

SARA SULLIVAN: Yup. We can hear you.

ERICA REOTT: Okay. Just making sure I wasn't double muted. I'm still looking at the national notifiable thing, which I do updates, but was it COVID and flu into one standard?

SARA SULLIVAN: Correct.

ERICA REOTT: Yes. By and large. I mean, there are unique elements like, obviously, which vaccine you get or which treatment a person might use, and there's certainly, I think, information for people who have one of these viruses, about what their course of illness might look like that'd be helpful to them. But as far as prevention and what you do when somebody's sick, in terms of how long they should stay away from others, you can unify COVID, flu, RSV, any of those.

SARA SULLIVAN: Great. Thank you. We have a series of questions about isolation and quarantine. I'm going to pull up that first one. This one's a little long. It's a two part. "Will there be any…" —can you guys hear me, because I think my video is—okay. Great. "Will there be any specific recommendations regarding the need for isolation for both COVID-19 and influenza in the non-healthcare portions of corrections living units? And would isolating in place be acceptable now despite airborne transmission for COVID-19, especially in open bar units?"

LIESL HAGAN: So the answer to the second question is no. Whenever somebody has respiratory symptoms with this new guidance, the recommendation is to stay away from other people. So that would pretty much bar isolating in place for people who are in congregate housing units. That said, again, I know facilities are not going to have enough space to individually house everybody who has symptoms, and so that's when some of these additional strategies can come in. If you need to prioritize the individual spaces that you have and you want to do that by testing, then that is one way to do it. Knowing that tests are not always going to catch every case of flu or every case of COVID. It is a way to try to triage this if you don't have enough individual isolation space.

SARA SULLIVAN: Thank you. We already did that reporting.

LIESL HAGAN: I want to clarify quarantine there, because I wonder if the question was quarantine in place, not isolation in place. Let me just address that really quick because I know there's some…

SARA SULLIVAN: Yeah. Go ahead.

LIESL HAGAN: The terminology quarantine in place is something that I've heard a lot, and that's something where the physical distancing after somebody has been exposed is one of those additional prevention strategies that you can layer on but it's not one of our core prevention strategies. And so quarantine is not explicitly recommended. It's something that you could do but it's not going to be within that set of core prevention strategies. And so if you were going to implement quarantine in your facility, then doing

that quarantine in place would be an option. But just thinking through sort of the caveats that I discussed earlier about knowing that the impact that prolonged quarantine can have on people when they don't have access to in-person services and in-person visitation. So just balancing those risks.

SARA SULLIVAN: Thank you. And you may have covered some of these questions, but I think it's worth repeating for those—"So what are ongoing recommendations for medical isolation? This has presented operational challenge for correction facilities but has been an important aspect to limit disease transmission and spread. So, again, what are ongoing recommendations for medical isolation?"

LIESL HAGAN: So the recommendations, in some sense, are the same, in terms of the fact that we need to get people away from others when they're sick with respiratory viruses, including COVID. And so that's not changing. The need for that isn't changing. It's just that the terminology is changing. We're not calling it isolation anymore. But I fully expect that facilities are probably going to keep calling it isolation and I'll probably slip up every now and then and call it isolation, especially because that terminology, staying away from others and obviously staying home doesn't work for these settings, and so isolation is essentially the same as it always was from a placement perspective. What's changed is the duration and how to determine when people can end that period of time. And so where it used to be a prescribed number of days, now it's saying, okay, wait until your symptoms are improving overall and you haven't had a fever for 24 hours and then you can stop staying away from others.

But the difficulty with corrections, as we all know, is that because there is that, residual risk of transmission, even after people have passed that peak stage of shedding virus after they're not symptomatic anymore. Some facilities are going to want to continue to be more conservative and keep people away from others or in isolation for longer than just that symptomatic period. And so that's really the difference is the fact of isolation and the need for it when people are sick hasn't changed. It's more about thinking through when you're going to set the criteria for release and returning to people's regular housing units and how that's going to take place. I hope that answers your question.

SARA SULLIVAN: I believe so. Next up. "Will the CDC update the guidance to provide a specific section for correctional settings? Right now on the website, it's only currently listed as an FAQ point."

LIESL HAGAN: So I can tell you the team that I am on now includes several different congregate settings. We include correctional intention facilities, shelters for people

experiencing homelessness, as well as schools. And we are working to determine whether we can create a broad congregate settings document as sort of a companion document to this, but we have not yet gotten the green light. And so we recognize the importance of putting some of this on paper to help folks see themselves in this guidance, and we are going to continue to advocate for that, but I can't promise it will necessarily be there and I don't know what the timeline would be on that. But in lieu of that, and even if we do get that out there in the world, I am happy to take anybody's call to think through all of this. A large part of my role, I believe, continues to be engaging with individual facilities and helping them figure out what this means for them, and I'm committed to making sure that you get answers.

SARA SULLIVAN: Thank you, Liesl. We had a few questions about masking and really just clarifying that there's no masking requirement following symptom resolution?

ERICA REOTT: Yes. That's correct. So following symptom resolution, we recommend five days of elevating your use of strategies, and that could be any combination of the core or additional—like enhancing the core or adding more of the additional prevention strategies. So, I think that's another one that's going to be setting specific. For example, some of our recommendations to the general public are like, "Oh, hey, if you're going to gather with folks, maybe this is a time to do it outside." Obviously, in a correctional setting that may not be an appropriate or feasible recommendation, and so it would make sense for, I think, certain settings to, you know, adopt unique policies or practices, and masks could certainly be one of them. We also highlight tests as an option, specifically for COVID. It's not actively recommended that you test towards the end of your symptoms but we note that you can. And, a negative isn't a surefire negative but a positive might give you more information that it might not yet be time to be around others in higher risk settings. So I think the overall thrust of the entirety of Respiratory Virus Guidance is, as we move out of a state of emergency, there's a little bit more flexibility, and I certainly appreciate, in organizational setting, that can be a little bit challenging. But I agree with Liesl. I think on a case-by-case basis too, we can try to help come up with ideas of how to operationalize that in different settings. But that's a long answer to briefly saying no, masks are never actively recommended as something we say you need to wear a mask in a given circumstance outside of healthcare settings.

STACY LEE: Thank you. All right. So we are at time. So first, I want to thank Liesl and I want to thank Erica for joining us and for all this information. If you would like to share this with others or know people who weren't able to join or want to revisit this, we will be posting the recording on BJA's website. If you are registered for the webinar, you will receive the link once it is available. I'm sorry we were not able to get to all of the questions. If you still have your question and it has not already been answered, feel free

to email. I put an email address in the chat. It is bjacdmcf@cna.org. Feel free to send your question there. We will collect them and then I'll work with my colleagues at CDC to figure out the best way to get those answers to everyone. So with that, Liesl, Erica, any final words?

LIESL HAGAN: Just reiterating if there are questions that come up after the webinar that you think of, feel free to email me directly. I put my email in the chat. And thank you so much to Sara and to BJA for all of their work throughout the pandemic and their support and collaboration.

SARA SULLIVAN: Great. And Liesl, I just saw your note to me that you can stay on later. If you're still game for that. Erica, you're welcome to stay on as well. If you need to hop off, totally understand. But I know we have a lot of questions we didn't get to here, so it might be easier to just keep going and tackle them if that's okay with you guys.

LIESL HAGAN: That's fine with me, but, Erica, I totally understand that you need to get to your next engagements.

ERICA REOTT: Same with me. I'm happy to stay.
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SARA SULLIVAN: Okay. Great. Great. Let's just keep rocking then. Next question. "Previously, the COVID guidance included a more expansive list of individuals at high risk of severe disease such as SUD, mental illness, and metabolic disease. How should healthcare providers in corrections facilities and other organizations square the existing evidence about the vulnerability of these groups with their absence from the current guidance?"

ERICA REOTT: Yeah. Great question. To clarify, people with underlying medical conditions are absolutely a group that is at high risk of severe disease depending on the virus circumstances. We still have some content, I believe, on our website, admittedly, that's pretty outdated about analysis of the magnitude of risk for various underlying health conditions, and so we know conditions that cause immunosuppression are really at the peak there of risk, but, really, any underlying health condition can exacerbate a person's risk. So, unfortunately, I think the reality is just there are so many various medical conditions and so many combinations of those that can present that we more want to refer to people that work with their individual healthcare provider about understanding their risk and those circumstances than able to make any blanket state…

SARA SULLIVAN: Thank you. The next question is about what to do after an exposure. "Should incarcerated people, after an exposure to COVID, be monitored for symptoms and fever?"

ERICA REOTT: Yeah. So, in general in the guidance and the general population, it is quite common actually nowadays that people are exposed and the majority of people who are exposed aren't going to know that they were exposed. It's going to happen before somebody knows that they were symptomatic. It's going to happen somewhere where you're exposed to somebody you don't even know and we're not doing contact tracing anymore like we were in the general population. So a lot of this is structured towards that. However, we do have like this, you know, general principle that, exposure or not, it's kind of safe to assume that these viruses are circulating. They are out there. And if you start to feel these symptoms and don't have another explanation that makes more sense, like, “oh, I have food poisoning right now” or, something, for example, we want you to consider that you might have a respiratory virus and undertake the recommendation to stay away from other folks until you don't have a fever, if you did have one, and those symptoms are getting better. So vigilance about symptoms is kind of always recommended regardless of known exposure or not. Now, if you do know for sure you had an exposure, the guidance does recommend or highlight that as a time where you want to layer prevention. And, again, it isn't prescriptive about what prevention that looks like, so that could mean wear masks for a period of time, that might mean distancing from others. Any of the options on the menu, kind of you can lean into then or choose to have your organization recommend.

LIESL HAGAN: And if I can add to that too, I know that there was a period of time early in the pandemic when our guidance for corrections in COVID was specifically recommending monitoring, multiple times a day, for people who had been exposed. And so I'm curious if that's where this question is coming from. And we don't make any explicit recommendations for symptom monitoring for people who are exposed. And, correct, we haven't made that recommendation probably since maybe 2021 I would think. So if that's where that question is coming from, that recommendation that used to be there is not a recommendation for the general public and it hasn't really been, even in the correction-specific guidance, for a while, partly because we know it was such a huge labor-intensive endeavor for staff.

SARA SULLIVAN: Great. Next question is, "We have an incarcerated individual that has tested positive in a multiple occupancy housing unit. Historically, we have isolated the positive individual into our infirmary and then we would test all other individuals in that unit to get a baseline test result. We would then quarantine the unit for five days. Everyone would be re-tested and then clear the unit if they tested negative. If any

positive, we would re-test again after another five days. Is this practice no longer needed?"

LIESL HAGAN: I would say…

ERICA REOTT: I'll say the practice is an option that you could do. Like nothing you went through is incongruent or like, you know, outside of the scope of the options in the guidance, but I don't know that I would say it's needed. But, Liesl, please go ahead.

LIESL HAGAN: Yes. That's exactly what I was going to say is that's not against guidance. You can find your way to that in the guidance through the different prevention strategies that you can layer on after somebody's been exposed. But I would say just in keeping with the overall theme of just trying to reduce the burden on people in all sectors of society, knowing that hospitalizations and deaths have gone down for COVID, it's just about that risk balance. We're not seeing as much on the risk side when it comes to hospitalizations and deaths. And so the question is, how much of your facility resources and how much of your mental health resources, capacity of people—do you want to put into those types of intensive prevention strategies? And that's really just a question that each facility has to navigate for themselves.

SARA SULLIVAN: There's a follow-up question to that which is, "So how could you handle that situation in a less intensive way?"

ERICA REOTT: Yeah, so this is, I think, to Liesl's point and place, where you can get kind of creative. I think the least intensive way I would think that would be in accord with the guidance is to move that person away from others and follow the protocol about how long they should stay away from others and do nothing else, right? That would be in accord with guidance. It's not the most protective option but it is something like we're meeting the minimum standard there. A step up from that could be letting folks who may have been exposed know, "Hey, you may have been exposed to a respiratory virus. Like make sure to pay attention to how you're feeling and if you're starting to feel ill, let us know," or whatever the next step is. Or it could be, "Hey, you were exposed—may have been exposed. We want to make sure, masks are available here," and that sort of thing. It could be, at your organization, maybe you choose to say, "We would like to encourage mask use for everybody who has been in this space." There's many permutation of options, but the only critical thing that is, again, CDC doesn't exactly require things, but like required or strongly recommended in the guidance is making sure that person stays away from others while they're actively sick. Liesl, other thoughts?

LIESL HAGAN: Yeah. I completely agree with everything you say. I think the only thing I would add—and I saw Chad Zawitz on earlier. I don't know if he's still here. I'm going to call you out, Chad. Maybe I shouldn't. But we had so many conversations about quarantine during the thick of the pandemic, and we talked about how it seems like, in many ways, intensive quarantine procedures doesn't necessarily prevent people ultimately from getting COVID, it just delays it, because it keeps it contained and then eventually it finds its way around. And so for some facilities that are very densely populated and have high populations, it may be that these sorts of quarantine measures do keep everybody from getting sick at once and can reduce the burden of medical isolation for staff for so many people at one time. But I think some facilities have found that despite their best efforts to do exactly what the questionnaire was describing and to follow the quarantine and isolation approach with fidelity, people were still getting COVID. And so the fact of the matter is it's so transmissible that within a congregated environment, you might not be able to keep it from spreading. And so in those situations, that's where the balance comes in. How much of a burden do you want to put on people's mental health, on durability to get out and get to programming, you know? And that really partly depends on whether they're at risk for severe illness. So that's going to be sort of a game-time decision depending on who's in that unit and what their risk level is and things like that. So I'm afraid it's not really cut and dry.

SARA SULLIVAN: Okay.

ERICA REOTT: I'll add one more note on that, what Liesl said too, which is, I think, that's also a time where it recommends if there's a lot of illness in your community, you might want to do more. And so if your facility is like it's cold and flu season and like we've got a lot of people in the infirmary and things are getting a little bit out of hand right now, that could be a time where you want to lean and escalate a little bit more and have a stricter protocol than when you have the flexibility. So, yeah. That's all I wanted to add to that.

SARA SULLIVAN: We have two questions around staff testing positive. "What do you recommend for our staff that test positive?" One person says, "Right now, we currently mandate that the officer stay out of work for five days." Another person says, "If an officer is positive and symptomatic, do they come back 24 hours after improvement or five days of symptoms? A little confused."

ERICA REOTT: Yeah, so the public guidance in a general setting, would be that that person could go about their normal activities after two things are true. So say it's me and my fever ends right now at 5:12, I'm going to say that've been starting to feel better and stuff. This time tomorrow, 24 hours later, if those things are still true, I can go about

my normal activities and I'm encouraged to take precautions. Your setting might say like there is a compelling reason, we need to set a higher bar and we want you distanced for five days. You might say, this is a time where we really want to make sure you're not going into this area where there's highly vulnerable populations. You could add in additional interpretations of what that period of precaution looks like, but as far as what we're telling people about how long they need to stay away from others, if I'm sick for a week and a half and I have a, fever that whole time, I'm home and away from others that whole time. And then 24 hours after I felt better and my fever's been gone, then I can go about normal activities. So it's another example of, I think, there's a minimum standard that we're kind of putting forward and ideas about what you can layer on, but nothing more prescriptive than that.

SARA SULLIVAN: What would you recommend, or what's the suggested guidance, for people who test positive but are symptom free?

ERICA REOTT: Yeah, so if you test positive and are symptom free, it's this one. Yup, so where you've met the two criteria of you haven't had a fever in 24 hours, you, you know, never had symptoms, so you're not feeling better, you've never felt sick at all. So we want you to go straight to that period of precaution. So for the next five days, layer on some protective strategies, whatever that might look like to you. If in that time you develop symptoms or you spike a fever or something, or at any time, you're kind of starting from square one and staying away from others from the beginning. But if you continue to have no symptoms, you can take these precautions for the next five days. And, again, you could take this very extremely. And, physical distancing is an option, and so you could say this means not going near other people for five days as the option you want to encourage in your setting. But I think to Liesl's point, that's a really big tradeoff for a virus that is not creating necessarily the health impacts that it once was. So I think while we're treating maybe COVID here a little bit more like flu and other common respiratory viruses, I'll also note we're treating flu and other respiratory viruses a little bit more stringently than we did before, whereas flu was just 24 hours fever-free before, now we also have this five day of precautions after that too. So trying to kind of hit a streamlined balance, I think, is the goal there.

SARA SULLIVAN: Thanks. "What is the guide…"—and you talked about this a little bit, Liesl, and I know I put some links in the chat—"What is the guidance for the infirmary and other medical units and how does that differ from what's being presented?"

LIESL HAGAN: So that's where we refer people to the healthcare-specific guidance. And there's a lot of information in there about healthcare workers and infection control precautions in delivering patient care. And there's also specific requirements or

recommendations for healthcare personnel staying out of work while they have COVID. And that's really where it's a little tricky because the recommendations for healthcare workers are more stringent, in terms of the amount of time to stay away from other people, compared to this general guidance, because right now it's seven days for healthcare workers as long as they've been fever free for 24 hours and their symptoms are improving.

SARA SULLIVAN: Liesl, you touched on this a bit, but are there recommendations for universal screening of new intakes for correctional facilities?

LIESL HAGAN: So there are not recommendations for that anymore. That is not in the guidance as a core strategy, but I would point you to my favorite infographic and say that when respiratory viruses are causing a lot of illness in the community, you can use tests as a layered prevention strategy. And so let's say you're in a period of time where there's a ton of respiratory viruses circulating in the outside community and you're in jail and you have a lot of turnover with people coming in and out, then you might consider that testing at intake is something you would want to do as a layered prevention strategy. But, again, just acknowledging that there are a lot of false negatives with COVID tests, particularly early in infection, and that's when most transmission occurs. And there can be a lot of false negatives for influenza tests as well. So that's something that can be layered on. But with a lot of these strategies, even looking in the chat, I'm seeing people say, "Well, cases are going to be missed if we don't test. Cases are going to be missed if we don't monitor." That's true. That is absolutely true. We're not going to be able to catch every case. And that's the reality that we're in because it is so transmissible and testing is not perfect. But that's why this sort of layering approach is important because it's kind of like where there's a hole here, maybe it'll be covered up by this other strategy over here.

SARA SULLIVAN: Thanks. "Are health or symptom questionnaires still a good idea for staff and visitors before entering a facility?"

LIESL HAGAN: I think we got to a point a long time ago in the pandemic where we realized that that juice probably wasn't worth the squeeze. It was taking a lot of staff time and there was a lot of misreporting of people saying that they didn't have symptoms and maybe they did and vice versa. And so I don't know of a lot of facilities, at least that I've talked to, that are still implementing that. It's not something that I would say don't do it. If you want to screen people on entry to help as a layered prevention strategy that's really just kind of self-monitoring for symptoms is what it comes down to, but that's not explicitly recommended. Erica, do you have anything to add on that?

ERICA REOTT: No. I agree with what you said, Liesl. Thanks.

SARA SULLIVAN: One note for someone. They said their closed captioning has stopped working on their end, and will closed captioning be available in the recording, and the answer is yes. So I'm assuming the answer is no to this, Liesl, but I want to double-check. "Since testing before intake is not required, I'm assuming you're no longer recommending any testing for COVID prior to transfer to other facilities. Can you confirm?"

LIESL HAGAN: That's definitely not an explicit recommendation, but I would say again you can think of that in terms of the additional prevention strategies. When you want to think about testing, this could fall into the category of maybe somebody is transferring to another facility where they might be in contact with people who have risk factors for severe illness or they're just really concerned about transmission between facilities. I don't think that's out of the realm of what would be reasonable as a facility protocol, but it's not going to be something that's explicitly recommended.

SARA SULLIVAN: Thank you. I have two more questions and then we'll end there. I will say, for folks, there were quite a number of comments and concerns shared in the Q&A in the chat. We have seen those. We will also make sure that we do a download of those and share them with our CDC colleagues to make sure that your input is received. So the final two questions. One is, "How do you use symptom improvement as a metric when the drive to get out of isolation in a carceral setting is so high?"

LIESL HAGAN: That is a great question. Not one that I have a great answer to, unfortunately. And I think because we have that fever metric that is more objective, that can help us, because if you have a fever, you have a fever as opposed to other symptoms. I would say there are symptoms that are objectively observable as well. If somebody is coughing and the healthcare provider who is supervising that medical isolation space can monitor that person's symptoms over time. So there's nothing saying that you can't use a monitoring approach for symptoms to allow people to set criteria for exiting isolation. That's totally fine, if you've got the bandwidth for that. I think when we're talking about symptom monitoring, it had to do with symptoms after exposure, not necessarily for people who are sick. I know that a lot of times there's not much difference between isolation and quarantine in some facilities, so that may be a distinction without a difference. But if there is a concern about people not reporting their symptoms accurately, then certainly monitoring is an option.

SARA SULLIVAN: And then the final question. "Are there any lessons learned that can foster effective communications about masking? It seems that masks are to respiratory

disease what condoms are to STD. Any thoughts based on CDC's experience and learning during the pandemic that we should know about?" And I would probably expand that not just to masking but to vaccination and other kind of personal mitigation strategies that people could take, but this question was specifically about masking.

LIESL HAGAN: I love that question. I wish my division director was on this call. So the part of CDC that I'm a part of now is a brand-new division and one of our sections is going to be focusing on behavioral science and public health response. And that's one of the key questions is how do we message the mitigation strategies that we're recommending in a way that will induce people to want to do them. And I don't know that we have an answer for that now, but that is a question that my branch specifically is going to be addressing. And I think it's important for us to think of that within the correctional environment as well. I've been to a lot of facilities where people have their masks down here, and then as soon as, you know, CEOs walk by they're up over their nose. And I'm pretty sure everybody has seen that. And, in reality, I think we all know that in a confined environment like this, it's not really realistic to expect people to wear a mask 24/7 when that is the place that they're living. So I don't know that there's ever going to be a behavioral strategy that's going to make people want to put on a mask 24 hours a day, seven days a week in that kind of space, particularly, for people who are confined and not staff who can go home and take it off. I think it has to do with individual risk assessment.

Probably the best strategy is education. That if people have risk factors for severe disease, then it's going to be more important for them not only to wear a mask if they are seeing people who have respiratory symptoms around them but, also, as Sara said, to get vaccinated, so that continuing education is important to make sure that people have the information they need in order to make individual decisions. And there are some data around strategies for messaging vaccination, and the most compelling piece of it that I have seen personally is just about who the messenger is. And, that's who the trusted messenger is in your facility is going to be different. We heard that healthcare staff were generally trusted more on vaccination messaging compared to security, custody staff or administration staff. But it might also be that people want to hear from somebody outside the facility that they want to see materials or hear somebody talk about vaccination who works in an outside entity. And I don't think that's necessarily going to be true for every person in every facility, but those are the data that I've seen, is that it's about figuring out who people trust and then getting that message to come from those trusted messengers. But that's easier said than done and it's going to require some legwork on the part of the facility to figure out what that means for your particular environment. More to come on that.

SARA SULLIVAN: We'll use this to plug a new resource that we'll be releasing soon, which is around health education through peers. So training people who are incarcerated to be peer health educators for other incarcerated people. So we'll be putting out a guide on how facilities can implement a similar program. So if you are not on our listserv, please send us an email at the email address I just posted in here. Liesl, I have offered to take all of the additional questions people may have on that email. Is there an email your unit that you want to include as well or should we direct everyone to send their follow-up questions to the email I put in the chat?

LIESL HAGAN: I would say if there's anything that really hasn't been addressed or if there are particularities of your situation that you want to talk through, feel free to email me directly. I'm a little limited in how I can get questions back to an amalgamated Q&A document because it would have to go through CDC clearance if I did that, and, trust me, you don't want to go through that. I know I don't. And it would be three months before I was able to get it back to you. So I think it would probably be more efficient just to email me directly.

SARA SULLIVAN: Thank you, everyone, for your time. Again, thank you, Liesl. Thank you, Erica. And, everybody, have a good evening.

LIESL HAGAN: Thank you very much.

STACY LEE: This will end today's presentation.