SARA SULLIVAN: Thank you, everyone, for joining. I want to introduce myself, as well as my colleague, Liesl Hagan, who will also be presenting. My name is Sara Sullivan. I am a Senior Policy Advisor with the Bureau of Justice Assistance, which is a part of the Office of Justice Programs at the Department of Justice. And I'll let my colleague Liesl Hagan introduce herself.

LIESL HAGAN: Good afternoon, everybody. Liesl Hagan, I'm an epidemiologist at CDC and I serve as Senior Scientist for Correctional Health within our Office of Readiness and Response.

SARA SULLIVAN: Thank you, Liesl. So as you're all aware, the Biden Administration declared the end of the public health emergency declaration that was effective last week on May 11th, 2023. And we know there are many questions that folks have about how this will impact corrections agencies and other state and local confinement facilities. So during these office hours, we're going to share information about how this will or will not impact activities at BJA, at the Bureau of Justice Assistance and at CDC. We also want to hear from you and we'll be collecting questions that you have. We will answer to the best of our abilities, the ones that we can answer, and the ones that we do not have the answers to, we will follow up after today's session with a fact sheet that will include those additional answers. I do want to note, we can only speak to impacts at CDC and BJA. We cannot speak on behalf of other federal agencies. But if you do have questions that impact other federal agencies, we can try to gather that information through our federal partners to include those answers in the fact sheet that's going to follow those office hours.

So first up is Liesl Hagan. CDC recently made changes to their guidance for COVID-19 management and confinement facilities, those changes were released on Friday. Liesl will provide an overview of those changes and then she'll also share about other changes and continuing activities that are happening at CDC. Liesl, I'll kick it over to you.

LIESL HAGAN: Great. Thank you for the opportunity to share these updates today. First, as Sara noted, I'll go over a little bit about the expiration of the COVID-19 Public Health Emergency Declaration, and then we'll focus our time today on guidance updates in relation to this policy change that affect correctional facilities. We'll do a quick review of risk assessment framework for corrections that's been in place for most of the pandemic from CDC, and then I'll provide updates to data availability that affects the COVID-19 Community Levels that we've all been using for quite some time, as well as update to intake testing recommendations and updates to healthcare worker infection, prevention, and control guidance, and then we'll have a Q&A period.

So as Sara mentioned, on May 11th, last Thursday, the COVID-19 Public Health Emergency Declaration expired. COVID-19 is still a public health concern, people are still getting sick, some of them are still becoming severely ill or even dying from COVID-19, and so we're still focused on protecting people who are the most vulnerable. At this stage, we do have effective vaccines to prevent COVID, as well as effective treatments that are broadly available. So the overall objective of the expiration of the public health emergency is to shift from emergency pandemic response to a more sustainable approach that integrates COVID-19 activities into the broader public health framework, and also into existing pan-respiratory programmatic efforts.

So now we'll walk through a summary of how the end of the public health emergency declaration affects guidance specifically for correctional settings, and specifically what stays the same and what has changed. We'll start with a quick review of the recommended risk assessment strategy for COVID-19 in these settings.

So what stays the same about the guidance, one of the things that stays the same, is the way that we assess risk within correctional facilities, and that is that we continue to recommend that correctional and detention facilities use a combination of COVID-19 community data from their counties, as well as facility-specific risk information from their facilities to determine what prevention strategies to put in place at any given time. You can see in the left, COVID-19 community data which up until now has been the COVID-19 Community Levels at the low, medium, and high categorizations. And then we also have the facility-specific risks, and those continue to be largely the same as what's been recommended previously, and that is whether there's transmission in the facility, whether there's a risk of severe health outcomes in the population, and whether there is structural characteristics of the facility that could increase the risk of transmission.

Now, what changes here is the source of community data on COVID-19, and that has changed with the expiration of public health emergency. So before the end of the public health emergency, CDC recommended using COVID-19 Community Levels as the source of community data to guide prevention decisions in all settings, but also in correctional facilities specifically. And these community levels were calculated using a combination of data on the number of new COVID-19 cases in a county, as well as the number of hospital admissions for COVID, and the percentage of hospital beds occupied by COVID-19 patients. But the expiration of the public health emergency has affected the availability, specifically of case data. States are no longer required to report cases to CDC as they were during earlier phases of the pandemic, and as a result, CDC can no longer calculate these COVID Community Levels. However, hospital data do continue to be available at the county level to help guide prevention decisions. So,

because of that, we are transitioning from COVID Community Levels to COVID-19 hospital admission levels, and again, that's for all settings, not just for corrections. And so these hospital admission levels are county-level indicator, they're available for each county in the United States, and they're based on new hospital admissions for COVID-19 per 100,000 people in the population, and these data are updated weekly.

Now because the hospital admission data was one of the primary sources that was already used to calculate COVID-19 Community Levels, shifting to this metric on its own really has minimal impact on how counties are categorized in terms of low, medium, or high. And you can see a link at the bottom, and I'll put these links in the chat after I finish presenting. This particular link is to a publication that was released last week, that goes into a lot more detail about the differences between the COVID-19 Community Levels and the hospital admission levels in case you're interested. But as a highlight, it's an analysis showing that since February of 2022, there's a 99% concordance or higher between the Community Levels and hospital admission levels, so we really don't expect to see much change in how counties are categorized as low, medium, and high.

So, if your facility used COVID Community Levels in the past to contribute to your prevention decisions, you'll really use the same process that you did before, it's just that instead of looking at your county's community levels, you'll instead be looking at the hospital admission level to determine whether your county is in low, medium, and high. And you can check the COVID-19 hospital admission level for your county on our website, which is linked above, and again, I'll put this link in the chat. You just go over to your state, toggle down for your county, and it'll show up as low, medium, and high.

One thing that I want to note is that the thresholds for what constitutes low, medium, and high are exactly the same as they were before when it comes to hospital admission levels. Like I said, the hospital data were part of the COVID-19 Community Level to start with, and so we're using the same thresholds that we used before when we were using a combination of different metrics. So if there are fewer than 10 hospital admissions in the last week, then the county is categorized as low, 10 to 19 is categorized as medium, and 20 or above is categorized as high.

If you want to look at the COVID-19 hospital admission levels for the whole country, you can use this link above, and again, I'll paste that in the chat. And you can see here that as of the week ending May 6th, 2023, over 99% of counties in the U.S. have low COVID-19 hospital admission levels.

So now, for the corrections-specific guidance, again, that hospital admission data, that affects all settings. But when it comes to specific prevention strategies and corrections, there has been one major change.

And before I get to that, I would just want to provide a little bit of context for folks who may not be as familiar with the corrections guidance, and that's just to say that's throughout most of the pandemic, we have categorized prevention strategies for correctional and detention facilities as falling into one to two categories. The first on the left in blue is Strategies for Everyday Operations, and these are things that we want to see in place at all times, just as baseline infection control. And then there are Enhanced Prevention Strategies, and those are on top of the baseline, and those are things that you can add when risk increases. So either when your hospital admission level is in the high zone or when you've got any of those facility-specific risk concerns. And then as that risk declines, you can gradually remove those enhanced strategies. So this framework, the everyday and enhanced, is staying exactly the same as it was before. And this is really so that we can provide flexible guidance that facilities can use across a range of situations over time.

And just a quick little metric to show you how to make these decisions using the facility-level factors and the hospital admission levels, you can see up here you've got the COVID-19 hospital admission level. If it's low or medium and if there are no facility-specific risks of concern, then you can just stick with your strategies for everyday operations. If you're in the high zone for hospital admission levels or you do have some of those facility-specific risks, then we recommend adding some of those enhanced prevention strategies. And again, this is no change from before, it's just switching out that COVID-19 Community Level for the hospital admission level.

Now, what does change in terms of prevention strategies, is one thing, and that's the intake testing in correctional and detention facilities is now considered an enhanced strategy, rather than a strategy for everyday operations. So in our previous guidance, we have categorized universal COVID-19 testing at intake as a strategy for everyday operations, and as of this new update on May 11th, it is now considered an enhanced prevention strategy. So this just means that we only recommend it to be used when your hospital admission level for your county is high, or when you have facility-specific concerns about risk in your particular facility. I know that some facilities over time have used a routine observation period at intake instead of testing, and that might have just been because they couldn't access test kits readily, or they didn't have the staff to administer them. And so I just want to note that for those facilities that were using routine intake observation instead of testing, this change applied to that as well. So now, that routine intake observation is considered an enhanced prevention strategy

rather than a baseline everyday strategy. I do want to note though that we do want facilities to continue testing people who have COVID-19 symptoms, and people who have been exposed, just as for previous guidance, nothing has changed in that realm. I'm not going to go into all the different prevention strategies and where they fall as far as everyday or enhanced, but we do have a full list of those in the full guidance document, and we'll make sure to paste that link in the chat as well.

So, one final update has to do with guidance for infection prevention and control for healthcare workers. We know that a lot of facilities, correctional and detention facilities do provide onsite healthcare services, and for those that do, they need to continue using CDC infection control guidance for healthcare workers in patient care areas.

Now, the biggest change here is that the healthcare guidance as of May 8th no longer uses Community Transmission Levels to guide source control decisions, and that's because those Community Transmission Levels were also based on the same case data that are no longer available with the expiration of the Public Health Emergency Declaration. So, in the updated guidance as of May 8th, there's an appendix at the end to help facilities figure out when and how to implement broader use of source control, and I'll paste that link in the chat as well.

So in summary, the expiration of the Public Health Emergency Declaration has resulted in changes to COVID-19 data availability for all settings. And when it comes to correctional facilities, specifically, there are two changes that apply. The most striking is that COVID-19 hospital admission levels are going to replace the previous community levels that were used and also that healthcare guidance no longer uses Community Transmission Levels. And finally, for correctional facilities in particular, intake testing and any kind of routine intake observation period for COVID is now considered an enhanced prevention strategy, so only recommended when your hospital admission level is high or when there are facility-specific risks of concern. And now I'll turn it back over to Sara for questions.

SARA SULLIVAN: Thank you, Liesl. We did have a few questions come through in the chat, and we will get to those questions at the end in just a few minutes. And for folks that are not aware, if you go to the bottom of your screen, there is a Q&A-specific chat, that's where you could enter any questions that you have. So as a representative of BJA, I also just wanted to share about some of the impact of the work we are doing and then our collaboration with CDC. So we received a lot of preliminary questions about the impact of the end of the public health emergency on federal funding support, and so I'd like to speak to that as well.

So in 2021, BJA entered into an agreement with CDC to provide technical assistance to confinement facilities and recipients of the American Rescue Plan Act of 2021 funds. Among many things, the American Rescue Plan Act awards funds the state and local health departments to assess with COVID-19 Detection and Mitigation in Confinement Facilities. These funds are managed by CDC's ELC program, which stands for Epidemiology and Laboratory Capacity for Prevention and Control of Emerging Diseases. I am happy to share that this confinement facilities award will continue and has an end date of July 31st, 2024. If we learn of any changes in the future, it will be communicated to the recipients. Additionally, the technical assistance provided by BJA will continue through the COVID-19 Detection and Mitigation in Confinement Facilities Training and Technical Assistance Center.

So with that, I'm going to turn over to the questions. We received many questions prior to today, I'm going to start with those and address some of those first, and then we'll turn to your questions in the Q&A. Feel free to enter in your questions anytime and we will have time to address those at the end. So Anna, do you want to start shooting out some of the questions we received prior to the office hours?

ANNA RICHEY: Yes, thank you, Sara. I will start those now. So the first question states, "In regard to communal living facilities, some are concerned about the COVID-19 virus spreading to others in closed living quarters. Will the new guidance provide sufficient education to the population on the new updates?"

SARA SULLIVAN: So, as Liesl had just presented, the new guidance was issued in May. We will provide recording of these office hours in a couple weeks that you can make available to anyone on your staff. We also at the COVID training and technical assistance center are going to be working on educational resources that we will provide folks, and you guys are welcome to use those both for staff and folks who are incarcerated. Also, if there are any facilities on this call that want help developing with their communications plan, developing resources or tools, feel free to reach out to the COVID-19 training and technical assistance center, and there's technical assistance available to you to help with that. Anna, if you or someone on the CNA team can add into the chat for folks the email address that they can reach out to us, that would be great.

ANNA RICHEY: Definitely, thank you. The second question states, "I am concerned that COVID fatigue will result in an abrupt removal of some remaining measures that should continue at baseline. Basic facility-wide preventive measures including hand hygiene and enhanced facility cleansing should remain in place. This also includes practices like masking for face-to-face clinical care, quarantine at intake, and ongoing symptomatic

testing of new arrestees or transfers. If emergency funding help defer the cost of these measures but those costs haven't yet shifted to regular budgets, the practices could end abruptly for that reason as well. How will the end of the public health emergency and resulting guidance impact standard infection prevention measures from COVID-19?"

SARA SULLIVAN: Thanks. So as was clear in the updated guidance that Liesl had presented on, it's important that detection and mitigation protocols and practices continue. And adherence to the CDC guidelines be considered as baseline response within any correctional facility, even after the end of the public health emergency. You could access those updated guidance resources. There's a link in the chat that was provided on where you can find a copy of that updated guidance. Also, the funding made available to help departments through the ELC does not end as I said until July 2024. I will say that correction systems and facilities should be planning now for the end of that funding if you are receiving that funding and how to best absorb infectious disease, detection and mitigation efforts within your current budget moving forward after the end of that grant period, again which is July 2024. Why don't we go ahead? I want to make sure we have time for the questions that came through the Q&A today. Leola, do you want to start sharing some of the questions that are in the chat and Liesl or I, depending on what the question is, can help answer them.

LEOLA ABRAHAM: Sure. I was just trying to group some of the questions together. So, I'm just going to read them in the order they came in but try to group some of them. The first question that asks a couple of different times is, are we able to or will we receive a copy of Liesl's PowerPoint presentation?

LIESL HAGAN: I'll send a cleared version of the presentation to Sara after we get off today and she can distribute it.

LEOLA ABRAHAM: Okay. Thanks, Liesl. The next question, there's a couple of questions regarding quarantine and isolation, so I'll just kind of read them together and let's see where we can take it. One says, "Has anything changed in regard to quarantine/isolation for correction settings?" Another one says, "I'm assuming routine observation and quarantine are similar or the same?" And then, a question about, "Any discussion on quarantine in terms of time reference?"

LIESL HAGAN: Sure. I can answer those. So just to clarify, the routine observation period that I mentioned per intake, that is an enhanced strategy that's meant to try to catch cases before people enter the general population and that is an enhanced prevention strategy. There's also a mention of routine observation periods during transfer and release protocols as well and again, those are enhanced strategies during

periods of higher risk that facilities can put in place if that is a logistical possibility for them.

One thing that I should say about the enhanced prevention measures is that we know that not every facility is going to be able to put all of them in place at all times, so it's really a matter of choosing the ones that work best in your particular setting. When it comes to quarantine and isolation, quarantine is for people who have been exposed but are not yet showing symptoms. And then isolation is for people who have symptoms and are awaiting testing or for people who have been confirmed to have COVID. There are no changes to the guidance in relation to the duration of isolation in quarantine for correctional facilities. When it comes to isolation, we still recommend 10 days for both staff and for people who are incarcerated if they are infected. But we recognize that there may be periods of time where there are staffing shortages or space shortages that make that difficult. And so we recommend that facilities get in touch with their state and local health department to figure out what kinds of modifications to that may work.

We do still have in our guidance that isolation can be shortened, can be ended at seven days with a negative test. And if PCR testing is used, that means a negative PCR collected on day seven. If point of care antigen testing is used, then that means the negative test on day five and another negative test on day seven before isolation is discontinued. We still recommend, though, even if isolation is discontinued that masking continue for the full 10 days for people who have been infected.

Quarantine for people who have been exposed is a little bit different. About a year ago, we discontinued the routine recommendation of quarantine in correctional facilities just because we recognize that this was producing a barrier to people's access to programming and mental health services and things like that that are really critical for their wellbeing. And so we basically leave it as an optional consideration for facilities in the guidance and we outline different ways that facilities might think about modifying quarantine to enhance or maximize access to those services. So again, quarantine is not a routine recommendation but it is still mentioned in the guidance and there have been no changes to isolation or quarantine recommendations in this update.

SARA SULLIVAN: I just want to chime in. I know we only have—this is scheduled to go until 4:00 and we only have three minutes left. I am able to stay on a little bit longer to help address some of these questions. Liesl and Leola, I don't know if you're available as well.

LEOLA ABRAHAM: Sure. Do you want me to ask the next one?

SARA SULLIVAN: Yeah, that'd be great.

LEOLA ABRAHAM: Sure, okay. “So Liesl, you mentioned in your comments just now that mask wearing is still recommended, is that correct?”

LIESL HAGAN: Mask wearing is recommended for people who have—so universal indoor masking is recommended as an enhanced prevention measure. So at baseline, universal indoor masking is not recommended but if your hospital admission level is high or if you have transmission in the facility or have other facility specific concerns then facilities can require masking as they did before. The exception to that is when people have been exposed to COVID, we do continue to recommend that they wear a mask for 10 days even if they're not implementing quarantine. And if somebody has been isolated because they're infected with COVID, then we recommend that when they're around people who are not also infected that they wear a mask through 10 days.

LEOLA ABRAHAM: Okay. The next question is related. “So what's the latest policy?” someone asked. “What's the latest policy regarding PPE and test kits?”

LIESL HAGAN: I'm not sure if I understand that question completely. There's been no changes on what PPE should be worn under different scenarios and that is still addressed in the correction-specific guidance and it hasn't changed at all.

LEOLA ABRAHAM: Okay. The next two questions touch on reporting to a certain extent, so I'll read both of them. They're slightly different though. The slides stated that those who are exposed should be tested, which leads me to this question, “Is the identification of exposed persons in correctional facilities still recommended, i.e., contact tracing?” That's the first one if you want to answer that. I'll ask the next one after.

LIESL HAGAN: Sure. So contact tracing is not routinely recommended, like a person-based contact tracing sort of strategy and that's been the case for a while just because we recognize how difficult it is to track where such a large number of people have been over time. And so what we recommend is more of a place-based contact tracing, a recommendation where if people are identified as being positive in a particular housing unit, then facilities may want to figure out who was in that housing unit with them who may have been exposed or if similarly, if they have a shared work assignment and may have spent time with other people there. So that's the kind of place-based contact tracing that we recommend. And yes, we do recommend that people who have been exposed should be tested no sooner than five days after their exposure.

LEOLA ABRAHAM: The following one question slightly related is a reporting question. So someone asks, “Are jails still required to continue reporting COVID cases?”

LIESL HAGAN: So jails—any facilities should still follow their state's required reporting practices to their state and local health departments. Jails don't report directly to CDC but they do report to their state and local health departments.

LEOLA ABRAHAM: Okay, thank you. There's several more questions. Another question is, “Should correctional facilities work with their local health departments or get approval from them when going into enhanced measures?”

LIESL HAGAN: I would say I'd really defer to the state on that. Each state is going to have their own way of working with facilities in their jurisdictions. And so I would recommend that they get in touch and find out what their health department prefers but in general, I don't think that approval is necessarily required but certainly maintaining those contacts in checking with the health department to see if they have any guidance would be a good practice. And particular health departments may have different preferences or different advice about how to go about doing this.

LEOLA ABRAHAM: Next question is, “Really appreciate the updated guidance. With some court-mandated intake testing in a few facilities, we are likely going to continue intake testing on a facility-specific basis short-term but will seek local court redress in near future or after data collection.” I think this is more of a statement, but I don't know if you have a comment on that at all.

LIESL HAGAN: Sure. Just so we're aware that there are local considerations based on litigation that's ongoing and we can't comment on that litigation but just over time as our guidance has changed, usually that's brought into discussions related to intake testing and other types of prevention strategies and how recommendations have been changed over time.

LEOLA ABRAHAM: The next question is, “When assessing facility risk includes facility structural and operational characteristics. These characteristics include poor ventilation or areas where many people sleep close together. Is there a metric for assessing poor ventilation or how many people can be close together?”

LIESL HAGAN: So, we don't provide any specific metrics for this partly because there's just not a lot of data around specificity there. I will say and I don't have the link for this unfortunately, I just learned yesterday that CDC is working on recommendations for optimal number of air exchanges per hour for public ventilation or for ventilation in public

spaces. And I imagine that in the future, this guidance will be used to inform ventilation in correctional and detention facilities as well. But at this stage, we do not have specific metrics to guide those practices. And really essentially those facility-specific risk indicators are meant more as a way to help facilities think through the different things that might influence risk in their facilities but not to provide hard and fast cutoffs.

LEOLA ABRAHAM: Okay. Three more questions. I apologize for the person whose question I skipped but I've got you now. So, “Can you share the rationale for changing the guidance for intake testing to an enhanced prevention strategy?”

LIESL HAGAN: Yes. So it has to do partly with resource constraints and partly with the overall shift at CDC from preventing transmission to preventing severe illness and death among people who have COVID. So we know that different facilities have different resources when it comes to testing and there has been a lot of conversation over the course of the pandemic about the feasibility of intake testing. However, up until this point, we have kept it as a strategy for everyday prevention just because it is one of the few ways that facilities have to prevent the introduction of the virus into their facilities. Otherwise, there's really not much they can do to prevent that from happening. But over time, as the variants of SARS-CoV-2 that have been circulating have caused less and less severe disease overall, and as treatments that are effective have become broadly available and vaccines have become broadly available, there's been an overall shift at CDC away from trying to prevent every case and trying to prevent all transmission just because it's basically impossible to prevent every single case when it's a global spread situation like this. And shifting towards, making sure that vaccines are readily available, that people are assessed for treatment rapidly after they test positive and that those treatments are readily available. And so our guidance for corrections has followed that shift away from preventing transmission and more for an emphasis of using resources and staffing to identify infections early and making sure that folks get treated if they are infected.

LEOLA ABRAHAM: Thanks, Liesl. We probably won't have time for all the questions, but we will follow up, as Sara mentioned, with the fact sheet, trying to answer some of these questions or all of them rather. But the last two questions are, “Do states or CDC determine what constitutes a COVID outbreak in a correctional facility?”

LIESL HAGAN: That's a question that we've been wrestling with throughout the pandemic. CDC has never provided a number of epidemiologically linked cases that would constitute an outbreak. At one point, we have been encouraging facilities to basically treat any single case as a possible outbreak and that is because of just the potential for rapid transmission within these congregate settings. But again, as that

transition has occurred away from preventing all transmission and towards preventing severe outcomes, we've sort of backed away from that strategy and really it's been up to states and individual facilities to determine what number of cases they consider to be grounds for investigating an outbreak.

LEOLA ABRAHAM: Okay. And then, final question, someone said that they thought that the grant ended this November and I know both of you spoke to that, so I wonder if we could just clarify the funding.

SARA SULLIVAN: Sorry, can you repeat that one more time, Leola?

LEOLA ABRAHAM: You mentioned the end of the funding period and someone was asking, “I thought this ended in November,” so I just thought it would be good to clarify.

SARA SULLIVAN: Yeah. Thank you. So the funding from ELC that is going to state and local jurisdictions ends July 2024 but those funds are going to health departments. If you are a confinement facility receiving funding through this award, you are likely receiving that funding from your health department as a sub-awardee. Sub-awards from health departments to confinement facilities may have different end dates. They may have different project period dates. It could be that the award was just made for a year, six months, whatever that timeline is. So, not all sub-award project periods are the same as the project period for the funding from ELC to the recipients who are the health departments. So I hope that clarifies. If you are a confinement facility that is receiving funding from your health department, feel free to reach out to them to clarify and confirm what your end date is for your sub-award.

So I think that is all the time we have. We did get a few more questions that were in the Q&A chat as well as that we received prior too as I mentioned. So we'll be sending out an email, probably more than one because I don't want to delay getting you some information but we'll send you an email with Liesl's PowerPoint presentation with some of the links that she provided as well as a link to the recording for this event. And then, we will be developing, as I mentioned, a fact sheet that will include some of the answers from today as well as some questions that we weren't able to answer and some of those answers. Please feel free to send any additional questions you have to the TTA center email address that was included in the chat. I believe it starts with BJA, so you'll see it. Feel free to send any questions there. Also, if you are not formally registered for this event but you're sitting in with someone else, which means you will not be included on the communication post this event, please feel free to email that email address as well and ask that you're included in the email blast with all of the resources from these office hours. With that, Liesl, do you have any other closing thoughts?

LIESL HAGAN: Nothing further. Thank you.

SARA SULLIVAN: Great. Well, thank you everyone else for joining. As mentioned, the end of the public health emergency declaration does not equate to the end of COVID-19 or a focus from BJA and CDC on COVID-19 detection and mitigation in confinement facilities, so BJA and our technical assistance center is still here and available to you. If you have any technical assistance needs, please feel free to reach out. And have a great afternoon.