Centers for Disease Control and Prevention

COVID-19

Interim Guidance for SARS-CoV-2 Testing in Correctional and Detention Facilities

Summary of Recent Changes

Updates as of March 17, 2021

- Updated testing priority hierarchy based on resources: 1) Diagnostic testing for people with COVID-19 signs and symptoms and close contacts (known and suspected exposures); 2) Screening testing of incarcerated/detained persons during intake and before transfer or release to identify asymptomatic individuals; and 3) Expanded screening testing to identify asymptomatic individuals.
- Updated recommendation to test at the end of a quarantine period.
- Thresholds for expanded screening testing (e.g. testing all persons in a housing unit).

Key Points

- Frequent testing for Severe Acute Respiratory Coronavirus-2 (SARS-CoV-2) is an important prevention measure in correctional and detention facilities.
- Diagnostic testing of persons with COVID-19 symptoms and persons with known or suspected exposure (including close contacts) plus screening testing are essential to stop the spread of COVD-19.
- Testing considerations specific to correctional and detention facilities include, for example, screening testing to identify asymptomatic individuals based on incarcerated/detained persons and staff movements between facilities and the community, as well as facility- and individual-level factors.

Introduction

This document describes SARS-CoV-2 testing strategies for correctional and detention facilities. Testing should be used in conjunction with other COVID-19 prevention strategies covered in Interim Guidance on Management of Coronavirus Disease 2019 (COVID-19) in Correctional and Detention Facilities. The purpose and process of the testing should be clearly communicated to incarcerated/detained persons and staff at the correctional or detention facility. Facility administrators should put procedures in place for rapid notification of test results and establish appropriate measures, such as medical isolation, quarantine, cohorting, and facility access restrictions. This guidance does not replace any applicable federal, state, Tribal, local, or territorial health and safety laws, rules, and regulations. CDC will update this guidance as needed and as additional information becomes available.

To understand the guidance that follows, please review:

- Interim Guidance on Management of Coronavirus Disease 2019 (COVID-19) in Correctional and Detention Facilities.

Categories of tests for SARS-CoV-2 for information on NAAT and antigen (or serology) tests.

Description of SARS-CoV-2 Testing Scenarios for information on diagnostic testing (for persons with COVID-19 symptoms, known exposure, or recent infection) and screening testing (for persons without known exposure to identify asymptomatic cases).

Safety procedures for performing expanded screening testing for SARS-CoV-2 in congregate settings.

Guidance from the Equal Employment Opportunity Commission on offering testing to staff.

Developing a COVID-19 Case Investigation and Contact Tracing Plan.

Considerations when testing

SARS-CoV-2 testing may be incorporated as part of a comprehensive approach to reducing transmission. Symptom screening, testing, and contact tracing are strategies to identify people infected with SARS-CoV-2 so that actions can be taken to slow and stop the spread of the virus.

COVID-19 vaccine is currently available in limited doses; therefore, CDC's Advisory Committee on Immunization Practices (ACIP) described recommendations for prioritization during the early phases of the vaccination program. As vaccine supply increases and additional priority groups receive vaccine, CDC's priorities for SARS-CoV-2 testing will change and the guidance will be updated. For example, as more staff are vaccinated, SARS-CoV-2 testing priorities may shift to focus on unvaccinated staff and incarcerated persons. For guidance on quarantine and testing of fully vaccinated people, including correctional facility staff and incarcerated persons, please visit Interim Public Health Recommendations for Fully Vaccinated People.

People undergoing testing should receive clear information on

the manufacturer and name of the test, the type of test, the purpose of the test, the performance specifications of the test, any limitations associated with the test, who will pay for the test, how the test will be performed, how and when they will receive test results, and;

how to understand what the results mean, actions associated with negative or positive results, the difference between testing for workplace screening versus for medical diagnosis, who will receive the results, how the results may be used, and any consequences for declining to be tested.

Individuals tested are required to receive patient fact sheets as part of the test's emergency use authorization (EUA).

Test types

Viral Tests

Viral tests authorized by the Food and Drug Administration (FDA) are used to **diagnose infection** with SARS-CoV-2, the virus that causes COVID-19. Viral tests evaluate whether the virus is present in respiratory or other specimens. Results from these tests help public health officials identify and isolate people who are infected to minimize SARS-CoV-2 transmission. See FDA's list of In Vitro Diagnostics Emergency Use Authorizations for more information about the performance of specific authorized tests.

- Nucleic acid amplification tests (NAATs), such as real-time reverse transcription-polymerase chain reaction (RT-PCR), detect viral ribonucleic acid (RNA) and indicate a current infection or a recent infection with prolonged viral RNA detection but without direct evidence for virus capable of replicating or of being transmitted to others. NAATs are high-sensitivity, high-specificity tests for diagnosing SARS-CoV-2 infection. Most NAATs need to be processed in a laboratory with variable time to results (~1–2 days), but some NAATs are point-of-care tests with results available in about 15–45 minutes.
- Antigen tests detect the presence of a specific viral antigen. Most can be processed at the point of care with results available in about 15–30 minutes. Antigen tests generally have similar specificity but are less sensitive than NAATs. Depending on the pre-test probability, antigen test results may need confirmation with a NAAT (e.g., a negative test in persons with symptoms or a positive test in persons without symptoms). Use of the Antigen Testing Algorithm [147 KB, 1 page] is **recommended** to determine when confirmatory testing is

needed.

Antibody Tests

Antibody (or serology) tests are used to detect previous infection with SARS-CoV-2 and can aid in the diagnosis of Multisystem Inflammatory Syndrome in Children (MIS-C) and in adults (MIS-A). CDC does not recommend using antibody testing to diagnose current infection. Depending on the time when someone was infected and the timing of the test, the test might not detect antibodies in someone with a current infection. In addition, it is not currently known whether a positive antibody test result indicates immunity against SARS-CoV-2; therefore, at this time, antibody tests should not be used to determine if an individual is immune against reinfection. Antibody testing is being used for public health surveillance and epidemiologic purposes. Because antibody tests can have different targets on the virus, specific tests might be needed to assess for antibodies originating from past infection versus those from vaccination. For more information about COVID-19 vaccines and antibody test results, refer to Interim Clinical Considerations for Use of mRNA COVID-19 Vaccines Currently Authorized in the United States.

For more information, please refer to Overview of Testing for SARS-CoV-2.

Overview of testing scenarios

Diagnostic testing is intended to identify current infection in individuals and is performed when a person has signs or symptoms consistent with COVID-19, or when a person is asymptomatic but has recent known or suspected exposure to SARS-CoV-2.

Examples of diagnostic testing include:

- Testing people who have symptoms consistent with COVID-19 and who present to their healthcare provider
- Testing people as a result of contact tracing efforts
- Testing people who indicate that they were exposed to someone with a confirmed or suspected case of COVID-19
- Testing people who attended an event where another attendee was later confirmed to have COVID-19

Screening tests are intended to identify infected people who are asymptomatic and do not have known, suspected, or reported exposure to SARS-CoV-2. Screening helps to identify unknown cases so that measures can be taken to prevent further transmission.

Examples of screening include:

- Testing employees in a workplace setting
- Testing students, faculty, and staff in a school or university setting
- Testing a person before or after travel
- Testing at home for someone who does not have symptoms associated with COVID-19 and no known exposures to someone with COVID-19

Choosing a test

When choosing which test to use, it is important to understand the purpose of the testing (e.g., diagnostic, screening), analytic performance of the test within the context of the level of community transmission, need for rapid results, and other considerations. Table 1 summarizes some characteristics of NAATs and antigen tests to consider. Most antigen tests that have received EUA from FDA are authorized for testing symptomatic persons within the first 5, 7, 12, or 14 days of symptom onset. Given the risk of transmission of SARS-CoV-2 from asymptomatic and presymptomatic persons with SARS-CoV-2 infection, use of antigen tests in asymptomatic and presymptomatic persons can be considered. FDA has provided a list of FAQ for healthcare providers who are using diagnostic tests in screening asymptomatic individuals, and the Centers for Medicare & Medicaid Services will temporarily exercise enforcement discretion [40 KB, 1 Page] to enable the use of antigen tests in asymptomatic individuals for the duration of the COVID-19 public health emergency

under the Clinical Laboratory Improvement Amendments of 1988 (CLIA). Laboratories that perform screening or diagnostic testing for SARS-CoV-2 must have a CLIA certificate and meet regulatory requirements. Tests that have received an EUA from FDA for point of care (POC) use can be performed with a CLIA certificate of waiver.

Table 1. NAAT and Antigen Test Differences to Consider When Planning for Diagnostic or Screening Use

	NAATs	Antigen Tests
Intended Use	Detect *current* infection^	Detect *current* infection
Analyte Detected	Viral Ribonucleic Acid (RNA)	Viral Antigens
Specimen Type(s)	Nasal, Nasopharyngeal, Oropharyngeal, Sputum, Saliva	Nasal, Nasopharyngeal
Sensitivity	Varies by test, but generally high for laboratory-based tests and moderate-high for POC tests	Varies depending on the course of infection, but generally moderate-to-high at times of peak viral load*
Specificity	High	High
Test Complexity	Varies by Test	Relatively Easy to Use
Authorized for Use at the Point-of-Care	Most are not, some are	Most are, some are not
Turnaround Time	Most 1-3 days. Some could be rapid in 15 minutes	

Ranges from 15 minutes to 30 minutes	
Cost/Test[§]	
Moderate (~$75-$100/test)	
Low (~$5-$50/test)	
Advantages	
Most sensitive test method available	
Short turnaround time for NAAT POC tests, but few available	
Usually does not need to be repeated to confirm results	
Short turnaround time (approximately 15 minutes)	
When performed at or near POC, allows for rapid identification of infected people, thus preventing further virus transmission in the community, workplace, etc.	
Comparable performance to NAATs in symptomatic persons and/or if culturable virus present, when the person is presumed to be infectious	
Disadvantages	
Longer turnaround time for lab-based tests (1–3 days)	
Higher cost per test	
A positive NAAT diagnostic test should not be repeated within 90 days, since people may continue to have detectable RNA after risk of transmission has passed	
May need confirmatory testing	
Less sensitive (more false negative results) compared to NAATs, especially among asymptomatic people	

[*]The decreased sensitivity of antigen tests might be offset if the point-of-care antigen tests are repeated more frequently (i.e., serial testing at least weekly).
^ Costs for: NAATs, Antibody tests

Considerations for Different Testing Scenarios

Diagnostic testing

Testing persons with signs or symptoms consistent with COVID-19

Correctional facility administrators should establish daily symptom and/or temperature screening to identify staff, visitors, and incarcerated/detained persons with signs or symptoms consistent with COVID-19. Symptom screenings cannot identify persons with COVID-19 who may be asymptomatic or pre-symptomatic, and therefore will not prevent all persons with COVID-19 from entering the facility.

Incarcerated/detained persons, facility staff, and visitors with COVID-19 symptoms should be separated from others.

- Staff should be tested and then sent home or to a healthcare facility and follow CDC guidance for caring for oneself. If the test result is positive, staff should isolate at home. Flexible sick leave and supportive policies can prevent and reduce transmission among employees.

Incarcerated/detained persons should be moved to medical isolation (individually, and separately from those with confirmed COVID-19 and others with suspected COVID-19) and tested. If incarcerated/detained persons test positive for SARS-CoV-2, they should be placed under medical isolation.

A negative antigen test in people with signs or symptoms of COVID-19 should be confirmed using a laboratory-based NAAT test. The person is presumed to be infected (and therefore should be medically isolated) until their status is confirmed with a NAAT. Use of the Antigen Testing Algorithm [49 KB, 1 Page] is recommended for confirmatory testing.

Testing asymptomatic persons with recent known or suspected exposure to SARS-CoV-2

Perform expanded testing of staff and incarcerated/detained persons if there is an outbreak in the facility. A single new case of SARS-CoV-2 infection in any correctional and detention center staff or incarcerated/detained person should be considered an outbreak. Incarcerated/detained persons and staff with positive test results should remain in isolation until they have met the criteria for discontinuing isolation. Quarantine and medical isolation in correctional and detention settings is described elsewhere.

Because of the potential for asymptomatic and pre-symptomatic transmission, unvaccinated close contacts (people who have been within 6 feet for a combined total of 15 minutes or more during a 24-hour period) of persons with COVID-19 should quarantine and be tested. In correctional and detention facilities, congregate living situations make determinations of close contact difficult. A determination of close contact may include all persons with known or suspected exposure to SARS-CoV-2, defined by a particular setting (such as all incarcerated/detained persons and staff assigned to a dormitory or unit). The health department may ask the correctional or detention facility administration for assistance in identifying close contacts or individuals with known or suspected exposure to COVID-19. See Expanded Screening Testing section below.

Facilities can re-test people quarantined as a cohort every 3-7 days until testing identifies no new cases for 14 days since the most recent positive result. Staff who are exposed but must continue to work should be tested every 3–7 days.

Management of known or suspected exposures

A positive antigen test in people with no signs or symptoms of COVID-19 who had known or suspected exposure should be confirmed using a laboratory-based NAAT test. The person is presumed to be infected (and therefore should be medically isolated) until their status is confirmed with a NAAT.

Unvaccinated incarcerated/detained persons and staff with known or suspected exposure should quarantine for 14 days. Information is available here about quarantine duration in correctional facilities.

Unvaccinated incarcerated/detained persons who had known or suspected exposures should ideally quarantine in individual cells. If space does not allow individual cells for quarantine, individuals should quarantine in quarantine cohorts (e.g., dormitory or unit) of individuals who were exposed at the same time. The smallest cohort groups possible should be used when individual cells are not available.

Unvaccinated staff who are close contacts or have known or suspected exposure and have negative test results may be permitted to work only as a last resort—if they remain asymptomatic, wear a procedural mask, and worker infection prevention recommendations and controls and risk mitigation precautions are implemented. Consider assigning duties with limited staff movement and interaction with other staff and incarcerated/detained persons. In these cases, the staff member is considered to be in modified quarantine in the work setting but should continue to follow quarantine procedures when outside of work.

Incarcerated/detained persons who have known or suspected exposure and have negative test results may be permitted to work only as a last resort, as with staff. Incarcerated/detained persons who work while quarantined should be housed with their work cohort.

All close contacts, including persons with known or suspected exposure should adhere to preventive measures including physical distancing, hand hygiene, and wearing masks.

Special considerations for diagnostic testing of persons with known or suspected exposure to SARS-CoV-2

Initial tests. All unvaccinated persons with known or suspected exposure to someone who received a positive test result should receive an initial test as soon as possible after they have been identified. Incarcerated/detained persons

with known or suspected exposure to COVID-19 should be re-tested around the end of the 14-day quarantine period (between days 12-14), before quarantine precautions are lifted, and before persons return to general housing areas.

Expanded screening testing when contact tracing is challenging. In settings where contact tracing is difficult, such as in a large dormitory with many people sharing sleeping spaces and bathrooms, facilities may choose to conduct expanded screening testing.

Serial re-testing of a quarantine cohort is recommended if quarantine cohorts are used. Infected persons may transmit SARS-CoV-2 to others several days before the onset of symptoms, or if they never develop symptoms.

Facilities can re-test people quarantined as a cohort every 3–7 days until testing identifies no new cases for 14 days since the most recent positive result. Staff who are exposed but must continue to work should be tested every 3–7 days. The re-testing interval should be more frequent in the context of escalating outbreaks and can be less frequent testing when transmission has slowed. The testing interval should be based on the stage of an ongoing outbreak (more frequent testing in the context of an escalating outbreak; less frequent when transmission has slowed) and on the type of test (more frequent for antigen tests).

Anyone testing positive during re-testing should be placed in medical isolation, and the 14-day quarantine period should re-start for the remainder of the cohort.

Testing in the context of a confirmed prior diagnosis: Asymptomatic persons who have recovered from SARS-CoV-2 infection may not need to undergo repeat testing or quarantine in the case of another SARS-CoV-2 exposure within 3 months of their initial diagnosis.

CDC recommends a time and symptom-based strategy, rather than a test-based strategy, for release from medical isolation for those who have already tested positive for SARS-CoV-2. Adults with more severe illness or who are immunocompromised may remain infectious up to 20 days or longer after symptom onset, so a test-based strategy could be considered in consultation with infectious disease experts. For all others, a test-based strategy is no longer recommended except to discontinue isolation or precautions earlier than would occur under the symptom-based strategy.

Testing to determine resolution of infection

Accumulating evidence supports ending isolation and precautions for persons with COVID-19 using a symptom-based strategy. Adults with more severe illness or who are immunocompromised may remain infectious up to 20 days or longer after symptom onset, so a test-based strategy could be considered in consultation with infectious disease experts for these people. For all others, a test-based strategy is no longer recommended except to discontinue isolation or precautions earlier than would occur under the symptom-based strategy.

Screening testing

Testing asymptomatic persons without known or suspected exposure to SARS-CoV-2

Viral testing of asymptomatic staff or incarcerated/detained persons without known or suspected exposure to SARS-CoV-2 – known as screening testing – in correctional and detention facilities can detect COVID-19 early and stop transmission quickly, particularly in areas with moderate to high community transmission of COVID-19. Screening testing is a key component of a layered approach to prevent SARS-CoV-2 transmission. Screening testing allows early identification and isolation of persons who are asymptomatic or presymptomatic, or have only mild symptoms and who may be unknowingly transmitting virus. For screening testing in correctional facilities, either NAATs or antigen tests (or both) could be used. Important attributes to consider when selecting the type of test or tests used for screening include availability, costs, and turnaround time. In screening where antigen tests are used, a laboratory-based confirmatory NAAT testing is recommended for individuals who test positive.

Screening testing for staff should be considered in all facilities. This should include:

- Testing of all staff before entering the facility every 3–7 days, and
- Targeted testing of new staff, those returning from a prolonged absence, travel, or other concerns related to exposure. In some facilities, COVID-19 cases have been initially identified among staff before any cases have been identified among incarcerated/detained persons. If there are barriers to staff testing, facilities can investigate options

to work with community partners (e.g. local hospitals or clinics) or state/local health departments to implement staff testing.

Screening testing for incarcerated/detained persons should be implemented and can include the following strategies, listed in order of priority for implementation and described in sections below:

Screening testing based on movement between facilities and between the facility and the community.

Expanded screening testing of all persons in a housing unit, building, or facility regardless of symptoms.

Serial screening testing of all (or a random sample of) incarcerated/detained persons.

Use of point-of-care (POC) tests, such as antigen tests, can play an important role in testing as a mitigation strategy due to the short turn-around time for results. Antigen tests for SARS-CoV-2 are generally less sensitive than real-time reverse transcription polymerase chain reaction (RT-PCR) and other nucleic acid amplification tests (NAATs) for detecting the presence of viral nucleic acid. The decreased sensitivity of antigen tests might be offset if the point-of-care antigen tests are repeated more frequently (i.e., serial testing). Thus, when screening large numbers of persons (e.g., a well-defined cohort) without known or suspected exposure to SARS-CoV-2, a less sensitive test can be appropriate if the test can be performed more frequently and provide rapid results with immediate isolation of infected individuals.

Screening testing based on movement between facilities and between the facility and the community

When implementing screening testing, facilities should prioritize testing to prevent the introduction of the virus into the facility and to prevent transmission to another facility or into the community. Screening testing should include testing for incarcerated/detained persons in the following scenarios.

At intake. Test all incoming incarcerated/detained persons and house them individually (when feasible) while waiting for test results. Testing can be combined with a 14-day observation period (sometimes referred to as "routine intake quarantine"), ideally in single cells, before persons are assigned housing with the rest of the facility's population. This practice can reduce the risk of transmission from sources outside the facility.

Before transfer to another facility or reassignment in the facility. Test all incarcerated/detained persons before transfer to another correctional/detention facility. Wait for a negative result before transfer. Testing before transfer can be combined with a 14-day observation period (sometimes referred to as "routine transfer quarantine"), ideally in single cells, before an individual's projected transfer date. If testing and transfer quarantine cannot be performed for security or logistical reasons, then intake quarantine may occur in the receiving facility for 14 days upon arrival. Refer to Interim Guidance on Management of Coronavirus Disease 2019 (COVID-19) in Correctional and Detention Facilities for more information about transfer and release recommendations.

Before visits or release into the community. Test all persons 1–3 days before visits (e.g. clinics, court appearances, community programs) or release (whether into the community or to a halfway house or other transitional location), particularly if it is known that they will be releasing to other congregate settings (e.g., homeless shelters, group homes, or halfway houses) or to households with persons who are at higher risk of severe illness from COVID-19. Community members that visit the facility, including medical providers, should also be tested as close to the day of the visit (no more than 3 days prior). Testing before release can be combined with a 14-day observation period (sometimes referred to as "routine release quarantine"), ideally in single cells, before a person's release date. This practice can reduce the risk of transmission from the facility to the community and allows the opportunity for the facility to notify public health authorities for assistance arranging recommended medical isolation upon release for people who test positive.

Expanded screening testing

In correctional and detention facilities, where physical distancing is often impracticable, it can be difficult to determine who has been in close contact with someone with COVID-19. For these situations, options for expanded screening testing are recommended. Expanded screening testing is not intended to replace case investigation or response-based testing.

Expanded screening testing should be considered following a positive test from diagnostic or screening testing when targeted testing of close contacts based on contact tracing is not practicable (e.g., in large dormitory units). If someone tests positive at intake but has not had close contact with other members of the facility's population and is immediately placed in medical isolation, this person's positive test result would not trigger expanded screening

testing.

The scope of expanded screening testing should be based on the extent of movement (of staff and incarcerated/detained persons) between parts of the facility with and without cases. Examples of expanded screening testing strategies include:

- Testing all persons in a single housing unit where someone has tested positive if there has not been contact with other areas of the facility through staff or incarcerated/detained persons.
- Testing all persons in an entire building or complex when cases have been identified in multiple parts of the building or complex, or if there has been contact between parts of the building or complex with and without cases. This can happen in situations such as when staff work in multiple units, or through incarcerated/detained persons who have moved through multiple areas of the facility during work detail.

Facility administrators should strongly consider including staff in expanded screening testing efforts. In some facilities, COVID-19 cases have been initially identified among staff before any cases have been identified among incarcerated/detained persons. Because staff move between the facility and the community daily, the risks of introducing infection into the facility from the community and/or bringing infection from the facility back into the community is ongoing. If there are operational, contractual, and/or legal reasons to refrain from testing staff within the facility or concerns about using facility resources/personnel to test staff, facilities should investigate options to work with community partners or state/local health departments to implement staff testing.

Before conducting expanded screening testing, facilities should make plans for how they will modify their operations based on results and ability to act on those results.

- Given the potential for high numbers of asymptomatic infections, ensure that plans include isolation options to house large numbers of infected persons and quarantine options to house large numbers of close contacts. For example, consider how the facility's housing operations could be modified for multiple test result scenarios (e.g., if testing reveals that 10%, 30%, 50%, or more of a facility's population is infected with SARS-CoV-2).

Review CDC guidance on Performing Broad-Based Testing for SARS-CoV-2 in Congregate Settings for information on choosing a physical location for testing, ensuring adequate ventilation, planning movement through the testing location, and providing recommended PPE.

Serial screening testing for all or a random sample of incarcerated/detained persons

Facilities should consider implementing serial screening testing among additional incarcerated/detained persons and staff, or among a select group according to criteria it designates. Given the incubation period for COVID-19 (up to 14 days), CDC recommends conducting screening testing every 3-7 days. Screening testing can increase the likelihood of early case identification to prevent widespread transmission. Two strategies for serial screening testing include serial screening testing every 3-7 days for all (or a random selection of) individuals in a facility, or targeted screening testing based on facility- or individual-level factors. The testing interval should be based on the stage of an ongoing outbreak (more frequent testing in the context of an escalating outbreak; less frequent when transmission has slowed) and on the type of test (more frequent for antigen tests).

- **Serial screening testing** can be conducted among all incarcerated/detained persons and among all staff, or by randomly selecting individuals for testing. Facilities using random selection should plan to test at least 25% of incarcerated/detained persons and staff every 3-7 days.
- **Targeted serial screening testing based on facility-level factors.** Within a single facility, an expanded ongoing testing strategy could be designed in several ways.
  - **Testing based on risk.** A facility could target certain parts of the facility for serial screening testing based on risk of transmission in the settings. Examples of risk-based testing priorities could include incarcerated/detained people and staff assigned to dorm-based housing units (as opposed to cell-based units).
  - **History of cases in the facility.** Consider prioritizing expanded testing in facilities that have had recent cases or outbreaks of COVID-19.
  - **Type of housing in the facility.** Consider prioritizing expanded testing in facilities with dormitory-based housing units where physical/social distancing is especially difficult.
  - **In-person visiting.** Consider prioritizing expanded testing in facilities where in-person visitation is occurring.
  - **Community movement.** Consider prioritizing expanded testing in facilities where incarcerated/detained people

make more visits into the community (e.g., off-site medical visits, work release, or court appearances), especially in areas where there are higher levels of community transmission of SARS-CoV-2.

Turnover within the facility. Consider prioritizing expanded testing in facilities that have frequent admissions (newly incarcerated/detained persons or those transferring in from other facilities).

Staff interactions. Consider prioritizing expanded testing in facilities employing staff who work in multiple correctional/detention facilities or in other congregate settings (e.g., homeless shelters, group homes, or schools), or employing staff who are in frequent close contact (e.g., family or household members, carpools) with others who work in different parts of the facility or in other congregate settings.

Populations at higher risk of severe illness from COVID-19. Consider prioritizing expanded testing in facilities with a high proportion of people who are at higher risk for severe illness from COVID-19 (e.g., facilities designated for medical care such as medical facilities, long-term care facilities, or skilled nursing facilities).

Targeted serial screening testing based on person-level factors. Across facilities, there may be certain groups of people who are at higher risk of SARS-CoV-2 infection or at higher risk for severe illness from COVID-19, regardless of the particular facility where they live or work. Some of these person-level factors should be considered when prioritizing categories of people for serial screening testing.

Incarcerated/detained persons and staff who are medically high-risk. Consider serial screening testing for people who are at higher risk of severe illness from COVID-19, including those with medical conditions that increase or may increase risk of severe COVID-19. Identifying infections early can help ensure timely medical attention to prevent severe outcomes.

Incarcerated/detained person assigned to on-site work details. Consider serial screening testing for people who are assigned to critical work duties within the facility (e.g., food service or laundry) that require them to leave their housing unit.

Incarcerated/detained persons participating in work release programs. Consider serial screening testing for people who participate in community-based work release programs.

Staff working in a facility designated for medical care. Consider serial screening testing for staff who must continue to work in a correctional/detention facility designated for medical care (e.g., medical facility, long-term care facility, or skilled nursing facility).

Staff working in multiple areas of the facility. Consider serial screening testing for staff who work in multiple areas of the facility, or who live or spend time with other staff who work in other areas of the facility (e.g., family or household members, carpools).

Staff working in multiple congregate facilities. Consider serial screening testing for staff who work in more than one correctional/detention facility or in another congregate setting (e.g., homeless shelters, group homes, or schools), or those who have frequent close contact (e.g., family or household members, carpools) with others who work in different parts of the facility or in other congregate settings.

Frequency of screening testing

Screening testing approaches may include initial testing described in the screening testing for staff and serial screening testing for incarcerated/detained persons sections above. Facility administrators may find the following factors helpful to consider when determining the interval for periodic testing:

- The availability of testing, turnaround time, and cost
- The latency time period between exposure and development of a positive SARS-CoV-2 viral test
- How many staff or incarcerated/detained persons tested positive during previous rounds of testing
- Relevant experience with outbreaks at the facility

Testing any less frequently than once a week is unlikely to be effective in identifying recently infected asymptomatic persons who need to be isolated. Additionally, outbreak control depends largely on the frequency of testing and the speed of returning results for rapid medical isolation.

Previous Updates

Updates from Previous Content

October 21, 2020:

- Added links to the updated close contact definition.
- Updated language to align with updated definition.

August 10, 2020:

- Accumulating evidence supports ending isolation and precautions for persons with COVID-19 using a symptom-based strategy. This update incorporates recent evidence to inform the duration of isolation and precautions recommended to prevent transmission of SARS-CoV-2 to others, while limiting unnecessary prolonged isolation and unnecessary use of laboratory testing resources.

Last Updated Mar. 17, 2021