STAY SAFE MN

COVID-19 Testing Recommendations for Jails, Prisons, and Detention Facilities

INTERIM GUIDANCE | JUNE 2, 2020

As congregate living facilities, jails, prisons, and detention facilities provide an environment that can lead to rapid and widespread transmission of COVID-19. Additionally, widespread community transmission and movement of staff and inmates in and out of a facility result in a continuous risk of introduction.

Reverse transcription polymerase chain reaction (RT-PCR) testing is used to detect SARS-CoV-2, the virus that causes COVID-19. This testing is a priority to determine the scope and magnitude of COVID-19 outbreaks and to inform outbreak response interventions designed to further limit transmission. This document refers only to RT-PCR testing, which detects the nucleic acid from SARS-CoV-2 virus, not other antigen tests or antibody tests.

Reports from jails and prisons in other states suggest that when symptomatic staff or inmates with confirmed COVID-19 are identified, asymptomatic inmates and staff often test positive as well.[1] Nursing homes, also a type of congregate living setting, have reported similar findings.[2] Testing is one component of a broad-based response plan that includes implementing various mitigation strategies, infection prevention and control measures, plans for isolation and quarantine of inmates, inmate and staff health screening, exclusion of ill staff, and planning for staffing surge capacity in case of staff shortages. All of these other considerations must be in place for effectively applying testing to reduce transmission.

COVID-19 Testing Key Points

- All symptomatic inmates should be isolated and symptomatic staff should be promptly excluded from work, and all should be tested for SARS-CoV-2 by RT-PCR. Testing of asymptomatic inmates and staff is recommended in specific circumstances.
- Facilities should initiate response actions when inmates or staff members receive a SARS-CoV2-positive RT-PCR result, such as isolation of inmates and quarantine of their close

contacts, and work exclusion of infected staff members and quarantine of their close contacts. Facilities must quickly respond to positive laboratory results. Refer to the following MDH and CDC resources for detailed guidance:

  - MDH: Jails and Correctional Settings (www.health.state.mn.us/diseases/coronavirus/guidejail.pdf)
  - CDC: Correctional and Detention Facilities (www.cdc.gov/coronavirus/2019-ncov/community/correction-detention/index.html)

- A single negative SARS-CoV-2 RT-PCR-result indicates that an individual did not have detectable virus material present at the time of testing. Consequently, repeat testing will be needed if the individual develops symptoms compatible with COVID-19 or has persistent symptoms compatible with COVID-19 without another identified etiology.
- Point-in-time testing can provide a snapshot of infection burden across different units, but repeat testing over time is needed to monitor the spread of infection.
- Strategies for SARS-CoV-2 testing include: symptomatic testing only, symptomatic and targeted asymptomatic testing, or facility-wide testing. Plans should be developed with consideration of how laboratory results can inform a public health response in the facility. This will depend on each facility's physical space, existing response plans, and capacity.
- Facility-wide inmate and staff testing can be used to inform the response but should not be used as an isolated strategy. Preparations should be made for the potential impact on staffing levels, need for enhanced mitigation strategies, and communication with inmates, families, and staff.
- Testing does not replace robust mitigation or infection control strategies.
- The goal of this guidance is to reduce SARS-CoV-2 transmission and death related to COVID-19 in jails, prisons, and detention facilities.

Specimen Collection

Facilities should refer to CDC: Interim Guidelines for Collecting, Handling, and Testing Clinical Specimens for COVID-19 (www.cdc.gov/coronavirus/2019-nCoV/lab/guidelines-clinical-specimens.html).

Specimen Type

Nasopharyngeal (NP) and nasal swabs are recommended specimen types for COVID-19 testing. However, nasal swabs are preferred for testing in these settings, given the discomfort associated with NP swab collection and the growing evidence that viral load in the nasal cavity is likely sufficient for detection.

Use of nasal swabs will facilitate compliance with the repeated testing approaches described in this document. Use of self-collected nasal swabs might be feasible and appropriate. Nasal swabbing of employees can be conducted by clinical staff or by self-swab.

Place swab in a sterile tube containing acceptable transport media and store at refrigeration temperature before transporting to the laboratory for testing.

PPE Use and Infection Prevention and Control during Specimen Collection

Consider the following when collecting diagnostic respiratory specimens from a person with possible COVID-19:

- Procedure should be performed in a medical isolation space or other designated space with the door closed.
- Staff in the room should wear a surgical facemask (or N95 respirator, if available), eye protection, gloves, and a gown. If respirator supplies are limited, they should be prioritized for other procedures with higher risk for producing infectious aerosols (e.g., CPR).
- Only staff who are essential to collect the specimen should be present.
- Surfaces should be cleaned and disinfected in the room where specimens are collected.

Testing of Individual Inmates

Testing of Symptomatic Inmates

Inmates presenting with any of the following symptoms should be immediately isolated and tested: fever (>100.0◦F or subjective), cough, shortness of breath, chills, headache, muscle pain, sore throat, or new loss of taste or smell. Further evaluation should also be considered for lower temperatures (<100.0◦F) or other symptoms not attributable to another diagnosis, including nausea, vomiting, diarrhea, abdominal pain, runny nose, and fatigue. Educate inmates on the symptoms of COVID-19 and how to report symptoms to medical staff.

Testing of Asymptomatic Quarantined Inmates

MDH and CDC recommend a 14-day quarantine for the following groups:

- Inmates who are contacts of confirmed or suspected COVID-19 cases
- New intakes to the facility

- Inmates returning to the facility following public exposure (e.g., hospitalization, court appearances)

Inmates under quarantine should be monitored for symptoms twice daily. Symptomatic inmates should be immediately transported to isolation and tested for COVID-19.

MDH recommends COVID-19 testing for asymptomatic quarantined inmates on day 12 of quarantine to enable release into the general population on day 14 if the test is negative. Asymptomatic inmates who test positive for COVID-19 should be moved to isolation.

Facilities should consider testing inmates quarantined as a cohort on day 7 in addition to day 12. If any inmates within the cohort test positive, the quarantine clock resets to day 0 and the process is repeated.

Testing of Individual Staff

Testing of Symptomatic Staff

Active screening should be conducted for all staff when reporting to work. This includes active assessment for fever (>100.0°F or subjective), cough, shortness of breath, chills, headache, muscle pain, sore throat, or new loss of taste or smell. Further evaluation should also be considered for lower temperatures (<100.0°F) or other symptoms not attributable to another diagnosis, including nausea, vomiting, diarrhea, abdominal pain, runny nose, and fatigue. Staff of congregate living facilities are a priority group for COVID-19 testing in Minnesota and should be referred for testing immediately.

Staff should not work while sick, even if presenting with mild signs or symptoms. If illness develops while at work, staff must immediately separate themselves from others, alert their supervisor, and leave the workplace. If they become ill at home, they should be advised to stay out of work and get tested for COVID-19.

Testing of Asymptomatic Staff

Staff identified as a contact of a COVID-19 case should be excluded from work for 14 days and self-monitor for symptoms. This includes staff who were exposed to a case in their household, the community, or within the workplace. Contact MDH for guidance if critical staffing shortages arise and exposed employees must continue to work. More information is available here: MDH: Interim Recommendations for Critical Infrastructure Workers Who Have Had Exposure to a Person with Suspected or Confirmed COVID-19 (www.health.state.mn.us/diseases/coronavirus/guidebusiessential.pdf).

MDH recommends that asymptomatic staff identified as a COVID-19 case contact be tested for COVID-19 according to the following protocol:

- Staff who are excluded from work due to contact with a COVID-19 case should be tested at day 12, and if the test is negative, may return to work after 14 days.
- Staff identified as a contact of a COVID-19 case and who must continue to work should wear a mask for source control and be tested at day 7 and day 12 after the date of last exposure to the case.

Asymptomatic staff with a positive COVID-19 test who do not develop symptoms should be excluded from work for 10 days from the date of specimen collection. If symptoms develop during the 10-day work-exclusion period, they should follow the return-to-work guidance for symptomatic staff. All confirmed cases of COVID-19 should wear a facemask for source control upon returning to work through day 14 after symptom onset or specimen collection if asymptomatic.

Population-based Testing to Interrupt Transmission and Guide Cohorting

Facility-wide Testing: Point Prevalence Survey

Testing a group of individuals on a single day is referred to as a "point prevalence survey," or PPS. This approach provides information on the overall number of affected individuals in the facility on the day that specimens are collected. If testing capacity allows, a facility-wide PPS of all residents should be considered in facilities with confirmed cases of COVID-19. If resources are limited, testing may be prioritized to specific units or buildings depending upon the physical space, where the cases are occurring and mixing of staff and inmates in the facility (see "Testing of Units", below). The PPS can help a facility identify symptomatic and asymptomatic infected inmates, who can be cohorted on a dedicated unit.

A PPS must include both inmates and staff, because each of these groups is a key factor in transmission within a facility. If undertaking facility-wide PPS, facility leadership must be prepared for the likely detection of multiple asymptomatic inmates who test positive for SARS-CoV-2. Facilities should make plans to provide staff with appropriate PPE to care for all COVID-19-positive inmates as well as training in PPE use, donning, and doffing. Facilities should also develop plans for cohorting COVID-19-positive inmates, including scenarios with a small number of cases and scenarios of 10 or more cases.

Facilities should prepare for potential short-term staffing shortages that result from detection of positive staff members. Staff with COVID-19 must stay out of work for a minimum of 10 days after onset of symptoms, and if asymptomatic, a minimum of 10 days after the date of testing.

Situations where it is appropriate to conduct facility-wide testing of inmates and staff include, but are not limited to:

- One or more inmates are confirmed to have COVID-19 and likely acquired the infection in the facility or significant staff and/or inmate exposures occurred.
- A staff member tests positive for COVID-19 and worked in the facility while ill, worked in the 48 hours prior to developing symptoms, or worked in the 48 hours prior to testing (if asymptomatic).
- If testing resources allow, a PPS might be warranted in facilities with no known COVID19-positive inmates or staff if the facility is considered at high risk (e.g., shared staff with a COVID-19-positive facility, high level of community transmission) to provide situational awareness in the facility and potentially identify asymptomatic cases early.

A negative test only indicates that an individual, unit, or facility, did not have detectable virus at the time of testing, and repeat testing might be needed. A negative test at one point in time should not instill a sense of security. Because of this, the turnaround time for PPS testing must be short (< 72 hours) and repeat PPS testing should be considered, according to the following guidance:

- If no cases are identified, facilities should ensure that any quarantined inmates are tested on quarantine day 12, according to the above guidance, and can consider future PPS testing when criteria are met.
- Although there is no period of time when one can be guaranteed not to miss infected individuals, MDH recommends that a facility consider repeating the PPS after 7 days if cases are identified.
- Facilities may consider limiting repeated PPS to specific units where cases were identified.
- As additional positive inmates are detected during each PPS round, they should be immediately identified for isolation and their contacts identified for quarantine (if inmates) or work exclusion/home isolation (if staff).
- The facility should continue to repeat PPS until a minimum of two rounds return no new positive residents.
- The interval between repeated PPS might be longer or shorter, depending on the facility's population changes (e.g., frequency of new intakes).
- Retest anyone who was previously negative but developed symptoms, regardless of when the next PPS test interval is scheduled.
- As more data become available, MDH will update recommendations, if appropriate.

Because of ongoing community transmission in Minnesota, there will be a need for ongoing testing. Because staff and some inmates move in and out of the facility, the risk of introducing COVID-19 will be ever present. Even after completing a PPS series, with consecutive rounds that detect no positive inmates or staff, facilities will need to periodically test staff and will need to continue testing quarantined inmates. Any loosening of visitor restrictions will also necessitate changes to the PPS approach and frequency.

Testing of Units or Individual Buildings

In situations where there are not enough resources to conduct a facility-wide PPS, then performing PPS on units that house or mix with symptomatic inmates should be prioritized, followed by units with shared staff. If inmates or staff with COVID-19 are identified, consider expanding the PPS to additional units. Facilities should consult with MDH when testing capacity is a concern.

Due to the nature of inmate movement and housing arrangements, some facilities may need to quarantine an entire unit or units in response to an identified case. MDH recommends testing of the entire quarantined unit per the guidance detailed for asymptomatic quarantined inmates above.

Cohorting COVID-19 Cases

If the number of COVID-19 cases exceeds available single-cell isolation space, grouping of inmates, or "cohorting," should be done to separate COVID-19- positive inmates from those inmates who are asymptomatic or have tested negative. Because of the considerable potential for asymptomatic infection, testing should be used to guide the cohorting process; only laboratory confirmed cases of COVID-19 should be cohorted.

The COVID-19 isolation unit should have dedicated bathrooms and there should be no mixing of the isolation population with any other inmate populations. Any shared space used by those in isolation should be thoroughly cleaned and disinfected before use by any other group.

To minimize transmission risk, there should be dedicated staff working on a COVID-19 unit who are not assigned to work in other areas of the facility. These staff should be trained and have access to appropriate PPE.

Other General Recommendations

- Because the PPS approach involves significant coordination and logistical support, have a clear plan for all aspects of the PPS:
  - Communication with staff, inmates, their families, and possibly the public
  - Logistics of specimen collection, transport to reference laboratory, and reporting back results to staff and inmates
  - Medical monitoring of positive inmates
  - Staff training on use of PPE
  - Points of contact at both MDH and the facility for ongoing communication around public health recommendations and future testing guidance.
- Maintain a very low threshold for testing of symptomatic inmates and staff.

- Use a line list to track inmates and staff with signs and symptoms consistent with COVID19, dates of symptom onset, test dates, and results.
- Report to MDH:
  - Inmates hospitalized for severe respiratory infection without an identified cause
  - Sudden death of an inmate not attributable to a known cause
  - Clusters of ≥2 inmates and/or staff with respiratory symptoms or with known or suspected COVID-19
  - Individual inmates or staff identified with confirmed or suspected COVID-19
- Do not allow staff who test positive for COVID-19 to work in any area of the facility and base their return to work on guidance available in MDH: Jails and Correctional Settings (www.health.state.mn.us/diseases/coronavirus/guidejail.pdf).

References

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2. Arons, M.M., K.M. Hatfield, S.C. Reddy et al. Presymptomatic SARS-CoV-2 Infections and Transmission in a Skilled Nursing Facility. NEJM. Apr 24, 2020. DOI: 10.1056/NEJMoa2008457

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