COVID-19 TESTING: INDICATIONS FOR TESTING INMATES IN THE FEDERAL BUREAU OF PRISONS
7/24/2020

The primary diagnostic test for the Sars-CoV-2 virus which causes COVID-19 is a molecular test performed on respiratory secretions using nucleic acid amplification technology (NAAT), usually a reverse transcriptase-polymerase chain reaction (RT-PCR, or PCR). In the outpatient setting, a sample from the upper respiratory tract is recommended for most cases. The Centers for Disease Control and Prevention (CDC) considers the following to be acceptable samples - a swab of the nasopharynx, nasal mid-turbinate, anterior nares, or oropharynx, or an aspirate/washing from the nasopharynx or nasal passage. The Infectious Disease Society of America recommends against using oropharyngeal or salivary specimens due to concerns about accuracy of test results. Based on the available evidence and published recommendations, **the BOP-preferred sample for both symptomatic and asymptomatic cases is:**

- A swab from the nasopharynx, mid-turbinates, or anterior nares.

A lower respiratory tract specimen is usually reserved for testing in a hospital setting or for patients whose upper respiratory tract specimen has tested negative despite a high degree of clinical suspicion. Sputum induction is not recommended in the outpatient setting due to increased risk for exposure to respiratory droplets or aerosols. Testing for COVID-19 antibodies in the blood is also available but is not currently recommended for diagnosing COVID-19, with a few limited exceptions. In addition, its role in determining immunity is not yet defined.

- In general, the BOP does not recommend the use of antibody testing unless it is required by civilian health care entities for a patient to be evaluated.

COVID-19 PCR tests are performed by local / state health authorities, or commercial laboratories using an FDA-approved test (including Emergency Use Authorizations). Rapid, point-of-care (POC) tests that are FDA-approved are also available. All of the currently available POC tests must be performed by a lab certified for moderate/high complexity tests with the exception of the Abbott ID Now system which is temporarily CLIA-waived for COVID-19 testing.

- Institutions are strongly encouraged to identify a variety of sources for obtaining swabs/viral transport media, high volume PCR lab testing, and testing materials for the Abbott ID now system.
    - Communication and collaboration with local/state health authorities regarding institution testing strategies is recommended.
    - Utilization of the BOP national contract for COVID-19 testing is required.
    - If institutions require additional testing supplies and they are unable to obtain supplies from the sources above, they should consult with their local contract laboratory representative, Regional Health Services Administrator, Regional Infection Prevention and Control Consultant and the Regional Medical Director and then send the request to BOP-HSD/AIMS@bop.gov.
- Allocation and distribution of Abbott instruments and test kits will be determined by Central Office Health Services Division based on institutional needs and agency priorities.

- The major advantage of using the Abbott system is obtaining rapid test results. Potential limitations include false negative test results and the time required to run individual tests (10 to 15 minutes per test).
- Testing symptomatic inmates is the primary reason for use of the Abbott test in the BOP. A negative test result in a symptomatic person requires a specimen to be recollected and sent to a commercial lab.
- The Abbott system also may be used for testing asymptomatic persons being placed into quarantine or immediate releases who do not have time to complete a full quarantine, In such cases, a negative result does not require recollection and sending to a commercial lab.
- A positive Abbott ID Now COVID-19 test result does not require confirmatory testing by a commercial lab test.
- A negative Sars-CoV-2 test result from an Abbott ID Now test should not be used as the sole basis for patient management decisions due to concerns about higher rates of false negative results. *The BOP recommends against using the Abbott machine for release from quarantine or as the final test in a test-based release from isolation strategy*. A commercial lab test should be used for these purposes.

INDICATIONS AND PRIORITIES FOR TESTING

Initially, the primary indication for testing was the presence of symptoms consistent with COVID-19. With the increased availability of testing supplies and increased understanding of the epidemiology of transmission, expanded testing strategies have become an important tool in the prevention and management of COVID-19 infections, especially in congregate living / residential settings such as correctional facilities where social distancing may be difficult to achieve or maintain. The indications for testing in a correctional environment now include both asymptomatic and symptomatic inmates with compelling reasons or priorities for testing.

Specific indications for testing in the BOP are listed below in four main categories. If there are limitations in the number of tests that can be performed at a given location, prioritization of testing indications may be needed and should be done in consultation with the Regional Medical Director, Regional Health Services Administrator, and Regional Infection, Prevention and Control Consultant.

Symptomatic

- All inmates with symptoms consistent with or suggestive of COVID-19 should be tested and placed in isolation.

Asymptomatic inmates with known or suspected contact with a COVID-19 case

- When a staff or inmate case of COVID-19 is identified at an institution, a contact tracing of both inmates and staff should be performed expeditiously.
- All inmates identified as close contacts of the index case should be tested and placed into quarantine or isolation, based on test results or the presence of symptoms.

    - Because Sars-CoV-2 is very contagious and may be spread by asymptomatic as well as symptomatic individuals, expanded testing of all inmates in an entire housing unit should be considered, especially if the unit has open sleeping areas (rather than cells with solid walls and doors) or common areas where inmates have close contact.
- Institution-wide testing of inmates may be considered where one or more inmate or staff cases of COVID-19 have been identified.
    - This is recommended especially if substantial transmission is confirmed beyond the index case or if staff or inmates have moved about the institution.
- Periodic retesting of COVID-19 negative close contacts or broader retesting is recommended when there is widespread institution transmission.
    - A testing frequency of every 3 to 4 days is preferred whenever feasible in consultation with Regional Infection, Prevention and Control Consultant and the Regional Medical Director.

Asymptomatic inmates with no known or suspected contact with a COVID-19 case

- All inmate intakes to the BOP should be tested.
    - New intakes include new commitments, voluntary surrenders, writ returns, and any inmate brought to a BOP facility by the U.S. Marshals Service, Justice Prisoner and Alien Transportation Service, Customs and Border Patrol, and Immigration and Customs Enforcement.
        - ➔ Testing of new BOP admissions/intakes does not negate the need for a full 14-day quarantine.
    - BOP intrasystem transfers need to be tested and quarantined on arrival at their gaining / designated institution. .
    - Inmates returning from the community including court hearings, an extended time in an emergency department or crowded waiting area, residing overnight in the community or alternative setting including hospitalization, furlough, work release, etc…
    - Inmates with frequent or regular trips to the community (e.g. court hearings, work release), may need to be housed in a separate housing group and tested periodically (e.g. once every three to seven days).
- All inmates on admission to and discharge from quarantine (test in / test out)
    - This includes all types of quarantine – intake, exposure, and release/transfer.
    - Testing out of quarantine must be performed on or after the 14th day of quarantine while the inmate remains in quarantine.
- The following inmate releases and transfers should be tested.
    - Full Term releases, Good Conduct Time releases, detainer releases, furloughs, transfers to Residential Re-entry Centers/Home Confinement, transfers to private facilities, and transfers to other BOP facilities or correctional jurisdictions.
    - Inmates who are placed in release / transfer quarantine must follow the test in / test out approach.
    - *Inmates with a history of COVID-19 who have been released from medical isolation using CDC criteria (symptom-based, time-based, or test-based) do not need to be placed in quarantine and should not be tested within 90 days of their initial symptoms or positive test results.*

        - If it has been longer than 90 days, follow established release / transfer procedures to include quarantine and COVID-19 testing.
        - Those who test positive need to be evaluated on a case-by-case basis and considered for possible placement in isolation, especially if symptomatic.
- Asymptomatic inmates required to be tested in order to be seen at a civilian health care system.
- Asymptomatic inmates transferring to / arriving at a BOP Medical Referral Center
- For residential health care units at MRCs (e.g. Nursing Care Center units) without any known or suspected cases of COVID-19, baseline testing of inmate residents is recommended by the CDC in conjunction with baseline plus periodic retesting of staff.
- Testing all inmates at an institution without any known COVID-19 cases as part of an institution-wide surveillance program.
    - The effectiveness, feasibility, and role of this type of testing in a correctional setting is not clearly defined and requires considerable resources. Low participation rates are likely to limit its effectiveness and institution health care staffing levels are likely to be insufficient to accomplish it.
    - When institution-wide surveillance testing of inmates is not feasible, alternative strategies may be considered, e.g. periodic testing of inmates with risk factors for severe COVID-19 illness, CPAP users, inmates who work in groups or who may interact with large numbers of staff or inmates as part of their duties (e.g. food service, orderlies), inmates housed in a residential health care unit, etc...

Release from COVID-19 isolation

- **Testing for release from COVID-19 isolation is no longer recommended** (based on CDC guidance dated July 20, 2020, https://www.cdc.gov/coronavirus/2019-ncov/hcp/disposition-in-home-patients.html).
- **The BOP now recommends using a symptom-based approach for releasing inmates with symptomatic COVD-19 from isolation and a time-based approach for releasing inmates with asymptomatic COVD-19 from isolation.**
    - Asymptomatic inmates can be released from medical isolation 10 days *after the date of their first positive RT-PCR test.*
    - Inmates with mild or moderate symptoms can be released from medical isolation 10 days *after symptom onset* and resolution of fever for at least 24 hours, without the use of fever-reducing medications, and with improvement of other symptoms.
    - Inmates with severe COVID-19 symptoms requiring hospitalization or severely immunocompromised inmates can be released from medical isolation 20 days after symptom onset.
    - Although these same strategies are appropriate for COVID-19 patients who are severely immunocompromised, the CDC indicates a test-based approach may also be *considered* in these cases. Consultation with the Regional Medical Director is recommended prior to using a test-based strategy in this scenario.
        - https://www.cdc.gov/coronavirus/2019-ncov/hcp/disposition-in-home-patients.html
        - Severely immunocompromised is defined as being on chemotherapy for cancer, untreated HIV infection with CD4 T lymphocyte count < 200, combined primary