



**Human Rights Commission
Regular Meeting
February 17, 2022
Virtual/Electronic Meeting
6:30pm**

Agenda Packet Attachments

1. Agenda
2. 01-20-2022 HRC Regular Meeting Minutes
3. 01-31-2022 Letter to City Council Regarding COVID-19 conditions at ACRJ
4. OHR Staff Report
5. Draft amended HRC Rules & Procedures
6. Flyer for 02-22-2022 HRC Public & Subsidized Housing Conditions Discussion

Attachment 1



**Human Rights Commission
AGENDA
Regular Meeting
February 17, 2022
Virtual/Electronic Meeting
6:30 pm**

Please take Notice that this virtual meeting of the Human Rights Commission is for the purposes of planning, developing and drafting management and administration documents for the Human Rights Commission. For the purpose of addressing issues during the quarantine, this virtual meeting will be a limited public forum to discuss the agenda items presented below and to ensure the continuity of services provided by the Commission. The Commission Chair may limit public comments or discussion points that are unrelated to agenda items or that pertain to topics outside the scope of this Agenda. This will be a virtual/electronic meeting open to the public and registration information is available at www.charlottesville.gov/zoom.

The Commission welcomes comments and questions and commits to listening carefully and thoughtfully to what is presented. A maximum of sixteen public comment time slots are allotted per meeting. Each speaker will have three minutes to speak. The Commission requests that members of the public refrain from engaging in personal attacks against Commissioners and staff members and asks that comments and questions focus on matters related to human rights within the City.

Link to Human Rights Commission shared Box folder: <https://app.box.com/s/xy3wvnn2s1tj8h7trkknvd79bipyxezy>

1. WELCOME

- a. CALL TO ORDER
- b. ROLL CALL
- c. MISSION (recited by all): *Act as a strong advocate to justice and equal opportunity by providing citywide leadership and guidance in the area of civil rights.*

2. MATTERS BY THE PUBLIC

- a. PUBLIC COMMENT (Webinar attendees use the "raise hand" function, phone attendees use *9)
- b. COMMISSION RESPONSE TO MATTERS BY THE PUBLIC

3. MINUTES

- a. 01-20-2022 Regular Meeting Minutes*

4. BUSINESS MATTERS

- a. CHAIR UPDATE
- b. Updates regarding letter to Council regarding COVID-19 conditions at ACRJ
- c. OHR STAFF REPORT

5. WORK SESSION

- a. AD-HOC COMMITTEE UPDATES
- b. HRC Rules and Procedures amendments
- c. Public and Subsidized Housing Panel Discussion (02-22-2022, 6:00 pm)
- d. Town Hall Meeting (03-24-2022, 6:30 pm)
- e. HRC Annual Retreat (04-23-2022, 10:00 am)

6. MATTERS BY THE PUBLIC

- a. PUBLIC COMMENT (Webinar attendees use the "raise hand" function, phone attendees use *9)
- b. COMMISSION RESPONSE TO MATTERS BY THE PUBLIC

7. COMMISSIONER UPDATES

8. NEXT STEPS & ADJOURN

* ACTION NEEDED

Individuals with disabilities who require assistance or special arrangements to participate in the public meeting may call the ADA Coordinator at (434) 970-3182 or submit a request via email to ada@charlottesville.gov. The City of Charlottesville requests that you provide a 48-hour notice so that proper arrangements may be made.

Attachment 2



**Human Rights Commission
Meeting Minutes
Regular Meeting
January 20, 2022
Virtual/Electronic Meeting
6:30 pm**

Public link to meeting rebroadcasts on Boxcast: <https://boxcast.tv/channel/vabajtzeuyv3iclkx1a>

Public link to HRC documents on Box: <https://app.box.com/s/xy3wnn2s1tj8h7trkknvd79bipyxezy>

1. WELCOME

- a. CALL TO ORDER
 - i. Chair, Mary Bauer, called the meeting to order at 6:31 pm
- b. ROLL CALL
 - i. Mary Bauer
 - ii. Kathryn Laughon
 - iii. Jeanette Abi-Nader
 - iv. Ernest Chambers
 - v. Jessica Harris
 - vi. Wolfgang Keppley
 - vii. Andy Orban
 - viii. Lyndele Von Schill
- c. MISSION (recited by all): *Act as a strong advocate to justice and equal opportunity by providing citywide leadership and guidance in the area of civil rights.*

2. MATTERS BY THE PUBLIC

- a. PUBLIC COMMENT
 - i. Ang Conn
 1. Concerned with those detained at Albemarle-Charlottesville Regional Jail (ACRJ) who are experiencing a COVID-19 outbreak
 2. No clean supplies, no sanitizer, unsafe COVID practices; at one point, there was no heat
 - a. Staff are COVID-positive and still interacting
 - b. ACRJ Superintendent Col. Martin Kumer's press release says they only get clean supplies once a day
 3. Ms. Conn brought the issue to City Council, but no response—asks for someone to check on the people there
 4. Individuals are confined with others in a pod; this is inhumane treatment
 5. Asks if there is something the Commission could do to get someone to look at the conditions there, as City Council has just taken the word of Kumer that everything is being taken care of
 - a. Asks for someone to physically check on the individuals there
- b. COMMISSION RESPONSE TO MATTERS BY THE PUBLIC

- i. Commissioner was shocked by numbers from the People's Coalition about positive cases (around 45 individuals)
 1. Not certain what action the Commission could take, but agrees that the issue is very troubling
- ii. Commissioner thanks Ms. Conn for bringing the issue to the HRC's attention
- iii. Commissioner reports that a news report from the day before says there are 65 positive individuals, not 45
- iv. Commissioner asks who is legally accountable for the conditions
 1. Another Commissioner says it is a regional jail, so there is a Board comprising members from in and around Charlottesville; the City does not set policy, but it has representatives on the Board
 2. The Board is the body that the HRC would put pressure upon to change ACRJ conditions
- v. Commissioner supports reaching out to the Board and says there are four Charlottesville representatives that HRC could reach out to; one of them is on City Council
- vi. Commissioner suggests first writing a letter to City Council and any ACRJ Board members that represent Charlottesville
 1. Regarding the concern that guards are bringing in COVID
- vii. Chair determines that it is the general will of the Commission to write and perhaps speak to Council about this issue
 1. The Charlottesville ACRJ Board members are Lisa Draine (community member), Joe Platania (Commonwealth's Attorney), Sena Magill (City Council), James Brown (Sheriff), and Ashley Reynolds Marshall (Deputy City Manager for REDI)
 2. Commissioner suggests emailing all of these people
 - a. Says that the Commission can include City Council as well, but it seems that the Board has the most direct impact over ACRJ conditions
- viii. Current Chair says that drafting a letter/speaking to Council would perhaps be best suited for the new Chair at the conclusion of this meeting; could continue the conversation about how to proceed later
- ix. Commissioner asks Ang for more information about having a specific individual visit ACRJ
 1. Another Commissioner says some prisons have stopped visitation due to COVID; the Commission can look into visitation policies (would need to identify a person there)
- x. Commissioner suggests reaching out to the Board as well as Council, as the authority board will not meet again until February and this is a pressing issue
 1. Another Commissioner says that attending the next City Council meeting and raising this issue would also be helpful to direct more public attention to it
- xi. Jeanette volunteers to help whoever writes the letter by reaching out to some of the Charlottesville ACRJ Board members for more information for the letter, such as whether anyone has visited
- xii. Chair suggests determining specific action later in the meeting after

which a new Chair has been elected

xiii. Ms. Conn thanks the Commission for taking up this issue

3. MINUTES

- a. Review of minutes from 12/16/21
 - i. Ang Conn's name was misspelled as "Ange"; **will make this revision**
 - ii. Vote
 - 1. In favor: 8
 - 2. Opposed: 0
 - 3. Abstained: 0

4. BUSINESS MATTERS

- a. Rules & Procedures amendments
 - i. The full proposed changes were not included in the version made public, so the Chair suggests making only one of these changes in this meeting so that the other changes can be re-publicized in advance
 - ii. The critical change included in the public document is the quorum rules in 4.1 of the bylaws
 - 1. Page 4 of Rules and Procedures under "Conduct of Meetings"
 - iii. Change would be "A minimum of seven members of the Commission (quorum)" to "A majority of currently serving Commissioners"
 - iv. The Ordinance allows for only nine Commissioners, so the previous quorum would have prevented members from conducting business when only seven members attended
 - 1. Also, there will be only five Commissioners at the end of February if more people do not apply
 - v. Chair calls a vote
 - 1. In favor: 8
 - 2. Opposed: 0
 - 3. Abstained: 0
- b. Officer Elections
 - i. OHR Director presides over the election process
 - 1. The Elections Committee spokesperson will present the slate of candidates for Chair, then Vice-Chair
 - ii. Andy on behalf of the Elections Committee presents the nominations:
 - iii. Chair
 - 1. Nomination for Jessica Harris
 - a. Accepts nomination
 - 2. Nomination for Mary Bauer
 - a. Declines nomination
 - 3. Andy makes motion to nominate Jessica for HRC Chair
 - a. Jeanette seconds
 - 4. Lyndele notes that her nomination for Jessica was not included in the agenda packet
 - 5. Andy requests nominations from the floor
 - a. No new nominations
 - 6. Jessica's statement
 - a. Expresses gratitude for Commission's nominations and enthusiasm for continuing the HRC's work
 - 7. OHR Director leads vote for Chair
 - a. Jessica Harris: 8 votes

8. Jessica Harris becomes the new Chair of the Human Rights Commission
- iv. Vice-Chair
 1. There was only one nominee for Vice-Chair who is now Chair, so the floor is open for nominations for Vice-Chair
 - a. Wolfgang nominates Ernest Chambers
 - i. Ernest has not yet re-applied, but plans to do so; he is still eligible for nomination
 - ii. Andy seconds the nomination
 - iii. Ernest accepts nomination
 2. Andy makes motion to nominate Ernest for HRC Vice-Chair
 - a. Lyndele seconds
 3. Ernest's statement
 - a. Expresses appreciation for the HRC making movements to let the public know of its existence and role in City government
 4. OHR Director leads vote for Vice-Chair
 - a. Ernest Chambers: 8 votes
 5. Ernest Chambers becomes the new Vice-Chair of the Human Rights Commission
 - c. Chair update (Jessica)
 - i. No update
 - ii. Mary's updates
 1. Public and subsidized housing public hearing
 - a. LAJC and PHAR meeting was canceled due to weather and has not yet been rescheduled
 - b. The target of the last week in January for the public hearing likely will not happen, but Mary has reached out to PHAR to schedule another date to plan
 - c. Feedback from PHAR, LAJC, and residents has all been enthusiastic about holding the hearing
 - d. Offers to continue working on this project despite not being Chair
 - d. OHR Staff report
 - i. Report is attached in the agenda
 - ii. All 2021 data is now entered into the database
 - iii. FHAP update
 1. Had conversation with Kenneth Saunders, Director of Fairfax County OHR, about FHAP process
 2. Revisions to the ordinance are numerous due to adding in substantial equivalence for federal fair housing
 3. Still in process; awaiting a response from the City Attorney's Office on whether their questions were resolved
 4. Also talked to Kenny about internal EEO (complaints that come from City employees)
 - a. Fairfax does have an internal EEO process, as does Charlottesville, but Fairfax differs in that it has a consent decree that allows their OHR to be the internal EEO for Fairfax County

- i. The process and policy that governs it is still very separate, but Kenny sent it over with their Human Rights Ordinance
 - ii. They conduct the investigation internally then give the report to the City Attorney's Office
 - b. If an individual files a discrimination complaint with the EEOC since they are also a FEPA, that report comes back to the County Attorney's Office, who passes the internal report to the EEOC
 - i. It is a separate process—they do not actually investigate claims of discrimination in their power as a FEPA
- iv. Case 2021-11 correction: complaint is on hold, not incomplete
- v. Midway Manor
 - 1. Sent a letter to Midway Manor owners in response to concerns from community members
 - 2. Midway Manor changed not only property management, but also owners in the last month
 - 3. OHR staff is in touch with both of these parties
 - a. Received a response to the letter this week and **will pass on the response to the residents**
- vi. Everyone has been able to sign in to their .gov accounts
 - 1. Is everyone ready to fully make the switch to .gov accounts as primary emails?
 - 2. The PCRB still uses personal emails for Zoom links; tell Todd if there is any reason to use personal accounts for anything
- vii. Town Hall outreach
 - 1. Communications is down to 3, so will be flexible with their capabilities
 - 2. Have not yet gotten much information about distributing surveys, so talk to Todd to discuss survey, time frames, etc.
- viii. Can talk to Jessica and Ernest about their new roles and planning a retreat
- ix. Commissioner asks about meeting with Anna Mendez
 - 1. Mary had written a letter to the Director of People and Congregations Engaged in Ministry (PACEM)
 - a. They run congregate shelters for men and women, as well as an emergency shelter
 - 2. Anna Mendez had raised the concern of them not accepting people based on substance use disorder and mental health
 - 3. Anna had a meeting with Jason Whitehead and PACEM's attorney that OHR staff attended
 - a. Determined that PACEM does not intentionally screen out people due to substance use disorder and mental health challenges; many people there experience those things
 - b. They prioritize based on CDC's guidelines on who is at greatest risk for COVID to decide who gets priority placement at Premier Circle

- c. There was discussion about narrowing down the list of criteria (maybe to top five) to clarify that substance use disorder and mental health are not the most important factors
 4. Todd is unsure where the situation currently sits; Mary did not receive a written response, so she sent a follow-up
- x. Commissioner asks about the status of the community engagement event with Communications
 1. Presented the event to the Communications team, but it has become complicated during the transition of multiple team members leaving
 2. Communications was not able to give a concrete answer about potential platforms and tools
 3. OHR staff asks if it is feasible to postpone the February target to give Communications more time
 - a. Community Engagement committee wanted the poll to be out for a month, which would already push the event into March, so postponement would work
 4. **OHR staff can rediscuss administering the poll with Communications** unless Commissioners have any suggestions
 - a. Poll is drafted; just a matter of how it gets out
 - b. Could ask people in housing what the best way it is to get it—is this about how to get it to the target audience or what platform is best to use?
 - i. There are two events here: the housing conversation and the broader community engagement event, which is what is being planned now
 - c. Circling back with Communications and postponing the event to March is probably best
 5. Commissioner asks about the usefulness of a press release to get out the poll
 - a. Charlene used to use the TV station to broadcast
 6. Commissioner suggests putting the form in a QR code to make it accessible on mobile devices
 - a. Once HRC gets it out through the main channels, more creative avenues can be used
 7. Commissioner suggests some kind of in-person event like tabling so people can submit polls
- xi. Commissioner asks OHR staff to clarify whether the HRC is involved in the internal review process
 1. No; this is a process outlined in the personnel policies of the City
 2. Fairfax is unique in that the process is handled by their OHR
 - a. Not in their Human Rights Ordinance; it is a separate division
 - b. HRC is not involved at all; it is a confidential personnel process
 3. Todd can circulate the policy if people want to read more

4. Commissioner asks how/if the HRC responds to Chief Brackney's letter
 - a. The complaint was made public; not able to share much more about what she shared
 - b. Because there is no mechanism in Charlottesville to handle City employee complaints, the case is non-jurisdictional
 - c. However, there are other avenues; any City employee can file with the Attorney General's Office of Civil Rights or directly with the EEOC
 - i. Attorney General's Office of Civil Rights is a FEPA, so it will dual file
 - ii. Attorney General did just fire many employees from the division; there is no current Director (Mona Siddiqui was let go, in addition to the attorney who handled fair housing cases)
 - d. There are no current obligations to do anything about Chief Brackney's letter

5. WORK SESSION

- a. HR21-1 plain-language documents: Resolution, English flyer, and Spanish flyer
 - i. Vote
 1. Motion to approve: Kathryn
 2. Wolfgang seconds
 3. In favor: 8
 4. Opposed: 0
 5. Abstained: 0
 - ii. Commissioner asks if there is something to do with the resolution now that the plain language is approved
 1. Commission decides that the resolution is something they want to advocate for, so it must make action to get it in front of City Council
 2. **Todd will clean it up and save a finalized version with Jessica's signature to be put on the City website for the general public**
 - iii. Lyndele asks if there are follow-up items for these items that she can help with, such as getting them translated into other languages, as well as where these actions can be discussed
 1. OHR staff said there have been emails about IRC services, DSS translation services, and the question of what the HRC wants translated and into how many languages to determine cost
 2. Can discuss in Accessibility committee estimates for how many regular documents/languages will be translated per year, as well as what existing documents should be translated
 - a. May take Todd some time to get it off the ground and talk to Translation Services, but the process should eventually go smoothly
 - b. Commissioner suggests deciding on languages by looking at data
 - i. Wolfgang has anecdotal evidence from work

- with IRC and can share this offline
 - ii. Looking at City Court, social services like Region 10, or schools for which languages they use could also help
 - 3. LyndeLe will research which languages are most commonly used and will consult other Commissioners about this via email
 - 4. LyndeLe offers her friend coming to speak to a group about plain language; if people are interested, will the HRC tell City Council about this event?
 - a. Commissioner suggests making it part of the retreat
 - i. The retreat will be virtual, so the general public would be able to attend
 - b. Drafting letter to City Council about Ang's concerns with ACRJ
 - i. Chair asks for assistance in drafting letter
 - 1. LyndeLe volunteers
 - 2. OHR staff has materials available
 - ii. Will send letter to ACRJ Board including City Council
 - iii. Also would like to check in with the Board or others to ask if they have been to ACRJ to view conditions
 - iv. Speaking at City Council will bring public attention to the issue, though more focus should be on the Board; Mary suggests speaking at City Council to highlight the issue
 - v. Jessica will work on drafting the letter and speaking during Public Comment at the next City Council meeting
6. **MATTERS BY THE PUBLIC**
 - a. PUBLIC COMMENT
 - i. None
 - b. COMMISSION RESPONSE TO MATTERS BY THE PUBLIC
 - i. None
7. **COMMISSIONER UPDATES**
 - a. Jeanette
 - i. Extends gratitude to Mary and Kathryn for their serving as Chair and Vice-Chair of the HRC for the past period
 - b. OHR Staff update
 - i. Hiring process is underway; applications closed on 1/7/22 and have been reviewed
 - ii. One of the next steps is to form an interview panel; asks Chair to think about whether it will be her or another Commissioner who will serve on the panel
 - iii. Ernest volunteers to participate given it fits with his schedule
8. **NEXT STEPS**
 - a. Jessica
 - i. Draft letter to ACRJ Board and speak during the next City Council meeting
 - b. LyndeLe
 - i. Research commonly spoken languages and consult other Commissioners via email
 - ii. Assist Jessica in drafting ACRJ letter
 - c. Todd

- i. Correct Ang Conn's name misspellings in 12/16/21 minutes
- ii. Pass on response from Midway Manor owners to residents
- iii. Rediscuss administering Town Hall poll with Communications

9. ADJOURN

- a. Meeting adjourned at 7:45 pm

Pending HRC Approval

Attachment 3

CITY OF CHARLOTTESVILLE

"To be one community filled with opportunity"

Human Rights Commission
P.O. Box 911 · Charlottesville, Virginia 22902
Telephone 434-970-3023
humanrights@charlottesville.gov
www.charlottesville.gov/665/Human-Rights



January 31, 2022

Dear Mayor Snook and Members of City Council,

I am writing on behalf of the Charlottesville Humans Rights Commission to express concern and make recommendations to protect the health of incarcerated individuals at ACRJ. The purpose of the Human Rights Commission is to act as a strong advocate for justice and equal opportunity by providing citywide leadership and guidance in the area of civil and human rights, as well as act as an advisory body to City Council in matters pertaining to human and civil rights.

During our January 20th meeting, a concerned community member brought to our attention the high number of COVID cases within ACRJ, as well as their concern of inhumane treatment of the community at ACRJ. We are aware of the "Update: Community COVID Concerns" from Superintendent Col. Kumer, on January 20th, 2022 (Attachment 1).

The Human Rights Commission has the following concerns that it would like to bring to Council's attention:

- Adequate distribution of cleaning supplies
- Low vaccination rates among ACRJ staff (64%) and incarcerated individuals (66%)
- Information on ventilation within the ACRJ facility
- Lack of transparency in ACRJ staff mask use, COVID testing frequency, contact tracing protocols, or other procedures which may decrease COVID spread from staff to ACRJ incarcerated individuals
- The lack of mask use in the facility

Adequate distribution of cleaning supplies

The CDC provides specific guidelines for preventing the spread of COVID-19 among inmates (Attachment 2):

- Stocking up on and providing free access to soap (preferably liquid soap to promote use), tissues, and hand drying supplies, as well as hand sanitizer (where permitted based on security restrictions).
 - The Commission understands the limitations of being able to provide sanitizer.

- Conducting temperature checks and screening all new entrants, staff, and visitors for flu-like symptoms during the last 24 hours, and any contact they may have had with someone infected with COVID-19 in the last 14 days.
- Offering flu shots to people who are incarcerated, as limiting cases of flu can help speed the identification of people with COVID-19.
- Routinely cleaning and disinfecting surfaces and objects that are frequently touched.

The Commission requests that Council verify that these CDC procedures are being implemented or provide the community with information regarding the current procedures being used for quarantine and preventative measures, among both ACRJ staff and incarcerated individuals?

Low vaccination rates among staff (64%) and incarcerated individuals (66%)

The low vaccination rates among the ACRJ community are concerning. The Commission would like to know if there are any additional requirements to screen for COVID positive staff who are unvaccinated. Additionally, the Commission would like to know if COVID-19 vaccines and boosters are regularly available for ACRJ unvaccinated incarcerated individuals.

Information on ventilation within the ACRJ facility

COVID-19 is an airborne disease. Adequate ventilation is identified by the CDC (Attachment 3) as an extremely important factor in preventing spread of the disease. The Commission would like more information about how often the air quality of the jail tested and what additional filters and ventilation strategies are being employed to ensure that there is adequate air exchange throughout the facility.

Lack of transparency regarding ACRJ staff's use of preventative protocols

The Commission would like more information about the preventative protocols used by ACRJ staff (including but not limited to daily temperature checks, regular testing requirements, mask use adherence, contact tracing, and quarantine of COVID-positive staff).

Col. Kumer mentioned that housing cameras were used to observe mask use among ACRJ's incarcerated individuals. The Commission would like to know if the camera footage indicates that ACRJ staff are diligently using N-95 or equivalent masks while in the facility.

Lack of mask use within the facility

Col. Kumer's Jan 20th letter, references the lack of use of masks among ACRJ residents stating, "We do not issue medical grade masks to inmates since for them to be effective they would literally have to sleep with them on their face and maintain the effective seal around their face." ACRJ residents are part of a CDC-recommended plan for preventing COVID among incarcerated individuals. Col. Kumer's statement does not address procedures of quarantine with a confirmed case.

The CDC states (see Attachment 4), *"If you think someone who is incarcerated in the facility is sick with COVID-19, activate your emergency plan and notify local public health officials. Ensure that the sick person is wearing a clean, disposable facemask, and separate the sick person from others, ideally within an individual housing space and bathroom. Provide them with tissues for when they cough or sneeze, and a lined trash receptacle when possible."*

The Human Rights Commission believes that medical-grade or, preferably, high filtration masks should be freely available to all incarcerated persons who choose to use them. The Commission requests that ACRJ share information about the procedures used for quarantining COVID-positive incarcerated individuals.

The Human Rights Commission was created to provide advice and information to the City Council, and in this case, we look forward to hearing from Council on the issues listed above and what resolution the community can expect from your work with the ACRJ Board. Thank you for your attention to this urgent community matter.

Sincerely,

Jessica Harris
Chair
Human Rights Commission

Human Rights Commissioners:

- Jessica Harris (Chair)
- Ernest Chambers (Vice-Chair)
- Jeanette Abi-Nader
- Mary Bauer
- Wolfgang Keppley
- Kathryn Laughon
- Tobiah Mundt
- Andrew Orban
- Lyndele Von Schill

Attachment 1



ALBEMARLE-CHARLOTTESVILLE REGIONAL JAIL

160 Peregory Lane
Charlottesville, VA 22902

Phone: (434) 977-6981 Fax: (434) 977-0468
www.acrj.org

Colonel Martin Kumer
Superintendent

Update: COMMUNITY COVID CONCERNS

Updated January 20, 2022 at 9:30am

Superintendent Kumer's responses to ACRJ concerns expressed by the community. These responses were followed by a press release.

COVID Cases Updated:

- 1) As of this morning there are 41 Inmate active cases of COVID down from a high of 65
 - a. 23 Inmates have cleared the virus and are no longer considered contagious. Several more are expected to clear in the next few days.
- 2) As of this morning there are six staff active cases of COVID. Three more are expected to return to normal duties by this weekend.

Heating Concerns Update

- 3) With regards to the heat, my Chief of Facilities, Captain Thomas, tested the heat on both sides of GL housing area at 12:43 today. One side measured 75 degrees using an infrared thermometer and the other side measured 69 degrees. As Captain Thomas was walking out the inmates asked Captain Thomas NOT to touch the heat, they were "good".
 - a. Update: There was reported heating issue that a housing area was TOO hot. That will be addressed. There are no other reported heating issues as of this update.
- 4) I have confirmed that we have ample cleaning supplies that are approved by the CDC to kill the virus that causes COVID and they are being distributed daily and were distributed today. Per the DOC Life Health and Safety standards they cannot remain in the cell or housing unit. They are distributed once daily. We will begin distributing them twice per day, tomorrow as an added precaution.
- 5) With regard to hand sanitizer not being available to inmates. This is accurate. We do not supply hand sanitizer to inmates for the following reason.
 - a) CDC recommends washing hands with soap and water whenever possible because handwashing reduces the amounts of all types of germs and chemicals on hands. But if soap and water are not available, using a hand sanitizer with at least 60% alcohol can help you avoid getting sick and spreading germs to others. We do not provide inmates with alcohol in any form. There are many recovering alcoholics in the facility who would consume the sanitizer.

The guidance for effective handwashing and use of hand sanitizer in community settings was developed based on data from a number of studies."

<https://www.cdc.gov/handwashing/show-me-the-science-hand-sanitizer.html#:~:text=CDC%20recommends%20washing,number%20of%20studies>.

ALL inmates have access to soap and water at ALL times.

6) We do not issue medical grade masks to inmates since for them to be effective they would literally have to sleep with them on their face and maintain the effective seal around their face. The minute they remove the mask to eat, drink or shower they will have completely eliminated any benefit from the mask and have contaminated the housing area. The inmate population does not currently wear the masks they are provided. Today we viewed all of the housing area cameras at 12:55pm, January 18, and no inmate was visible wearing a mask in the entire population.

7) I do not have the authority to release any individual from incarceration. We have and will continue to work with the court to reduce the population through the use of HEI as safely and effectively as we can. The population as of today is 265, the lowest it has been in over 25 years.

Update: Population is 271.

8) We are operating under the assumption that every inmate and staff has COVID; it is referred to as universal precautions.

9) A significant portion of the trusty POD has tested positive for COVID. We had a secondary list of trusty approved and separated from that POD for just an emergency. It is not uncommon that a housing unit would test positive due to the nature of how COVID spreads and especially the Omicron variant.

a. UPDATE: The majority of our trusty population have cleared the virus and have returned to normal duties as of this update.

10) We have plenty of medical staff on hand who visit the housing areas to monitor for symptoms.

Attachment 2



FAQs for Correctional and Detention Facilities

Updated Jan. 26, 2021

The information provided in these FAQs does not cover all questions or issues faced by custodial settings (prisons, jails, and detention facilities). **As with the full [CDC guidance](#) document, this information may need to be adapted based on individual facilities' physical space, staffing, population, operations, and other resources and conditions.** Facilities should contact CDC or their [state, local, territorial, and/or tribal public health department](#) [↗](#) if they need assistance in applying actions or concerns not specifically covered in the [CDC guidance](#).

Administrators at Correctional and Detention Facilities

How to prepare your facility for the possible spread of COVID-19

What steps should I take to prepare my facility? ▼

Because of close contact and the number of people in correctional and detention facilities (including prisons and jails), staff and people who are incarcerated are at greater risk for the spread of germs. To help your facility prepare for the possible spread of [COVID-19](#), update your emergency operations plan. This includes:

- Adding key [COVID-19 prevention strategies](#) and posting information in the facility on how to limit the spread of germs.
- Reminding staff to stay home when sick.
- Identifying points of contact for local public health agencies.
- Identifying physical locations (dedicated housing areas and bathrooms) where you can medically isolate incarcerated persons, as well as where to quarantine known close contacts of people with COVID-19.
 - Follow guidance on medical [isolation](#) and [quarantine](#).
 - Medical isolation and quarantine locations should be separate.

COVID-19

- Ensuring adequate stocks of hygiene, cleaning, and medical supplies.
 - Hygiene: Soap (preferably liquid to promote use), tissues, and hand drying supplies, as well as hand sanitizers, when possible. Ensure no-cost access to soap.
 - Cleaning: [EPA-registered disinfectants](#) [↗](#) effective against the virus that causes COVID-19
 - *Medical supplies*: Supplies for daily clinic needs, [personal protective equipment \(PPE\)](#), and testing
- Creating and testing communications plans to share critical information.
- Setting up systems to safely transfer people between facilities and identifying alternative strategies to in-person court appearances, when possible.

court appearances, when possible.

- Prevent [confirmed and suspected COVID-19 cases and their close contacts](#) from being transferred between jurisdictions and facilities unless necessary for medical evaluation, medical isolation/quarantine, clinical care, extenuating security concerns, or to prevent overcrowding.
- Planning for staff absenteeism.


Follow [CDC guidance](#) on recommended PPE for staff who will have direct contact with an individual with possible COVID-19 infection, or infectious materials. Make contingency plans for the likely event of PPE shortages.

Follow the [CDC Interim Clinical Guidance for Management of Patients with Confirmed Coronavirus Disease \(COVID-19\)](#) and monitor the guidance website regularly for updates for staff evaluating and providing care for confirmed or suspected COVID-19 cases. When no on-site healthcare capacity is available, make a plan for how to ensure that people suspected to have COVID-19 will be medically isolated, evaluated, tested (if indicated), and provided medical care. Contact and collaborate with your state, local, tribal and territorial health departments for more specific guidance.

How can I lower the chance that my staff will get COVID-19?

The best way to protect your staff is to prevent exposure. Start by:

- Staying informed about updates to CDC guidance via the [CDC COVID-19 website](#).
- Making sure staff are aware of COVID-19 symptoms and requiring staff with any flu-like symptoms to stay home (or be sent home if they develop symptoms while at the facility).
- Offering telework for staff when feasible, and exploring ways to revise duties that require face-to-face interaction for staff at high-risk for severe illness.
- Ensuring staff use [everyday preventive actions](#) (such as washing hands, avoiding touching their eyes, nose, and mouth, covering their cough).
- Managing and monitoring staff absenteeism.
 - Alert local public health officials about large increases in staff absenteeism, particularly if absences appear due to respiratory illnesses (like the common cold or the flu, which have symptoms similar to COVID-19).
- Offering flu shots to staff, as limiting cases of flu can speed up the identification of people with COVID-19.
- Stocking and providing supplies that help prevent the spread of germs.
- Routinely [cleaning and disinfecting](#) the facility.
- Consult [CDC guidance](#) on recommended PPE for persons in direct contact with COVID-19 cases.

Review the [Occupational Safety and Health Administration website](#)  and [guidance for businesses and employers](#) to identify any additional strategies the facility can use within its role as an employer.

Staff evaluating and providing care for people with confirmed or suspected COVID-19 should follow the [CDC Interim Clinical Guidance for Management of Patients with Confirmed Coronavirus Disease \(COVID-19\)](#) and monitor the guidance website regularly for updates to these recommendations. Facilities without on-site health care capacity should make a plan for how they will ensure that suspected COVID-19 cases will be medically isolated, evaluated, tested (if indicated), and provided medical care. Contact and collaborate with your state, local, tribal, and territorial health departments for more specific guidance.

How can I lower the chance that people who are incarcerated will get COVID-19?


The best way to prevent illness among people who are incarcerated is to prevent exposure to the virus that causes COVID-19. Start by:

- Staying informed about updates to CDC guidance via the [CDC COVID-19 website](#).
- Making sure people who are incarcerated are aware of COVID-19 symptoms and remind them to notify staff right away if they might be sick.

- Posting information about and ensuring they use [everyday preventive actions](#) (such as washing hands, avoiding touching their eyes, nose, and mouth, covering their cough).
- Stocking up and providing free access to soap (preferably liquid soap to promote use), tissues, and hand drying supplies, as well as hand sanitizer (where permitted based on security restrictions).
- Conducting temperature checks and screening all new entrants, staff, and visitors for flu-like symptoms during the last 24 hours, and any contact they may have had with someone infected with COVID-19 in the last 14 days.
- Offering flu shots to people who are incarcerated, as limiting cases of flu can help speed the identification of people with COVID-19.
- Routinely [cleaning and disinfecting](#) surfaces and objects that are frequently touched.


How to prevent the spread of COVID-19 within my facility or from the local community into my facility

How can I find out if the virus has spread to the local community close to my facility?

You can get up-to-date information about local COVID-19 activity by keeping in touch with your local and state [public health officials](#) , and keeping up-to-date with the CDC website.

What steps should I take to protect my staff and people who are incarcerated if there is spread of COVID-19 in the local community close to my facility?

If COVID-19 is known to be spreading in the local community close to your facility, but there are no confirmed cases among people who are incarcerated, staff, or visitors who have been inside the facility within the past 14 days:

- Implement operational actions:
 - Restrict non-essential transfers of people between facilities and systems.
 - Use alternative strategies to limit in-person court appearances where possible.
 - Consider suspending co-pays for incarcerated persons seeking medical evaluation for COVID-19 symptoms.
 - Require staff to stay home if they are sick.
 - Consider suspending visitation or offering non-contact visits only.
 - Do not allow non-essential vendors, volunteers, or tours into the facility.
 - Consider suspending work release programs.
- Clean and disinfect the facility:
 - Use [CDC recommendations for cleaning and disinfection during the COVID-19 response](#) to routinely clean and disinfect surfaces and objects that are frequently touched, especially in common areas.
 - Use household cleaners and [EPA-registered disinfectants effective against the virus that causes COVID-19](#) 
- Focus on good hygiene:
 - Remind staff, visitors, and people who are incarcerated to use [everyday preventive actions](#) (such as washing hands, avoiding touching their eyes, nose, and mouth, covering their cough). Provide free access to soap (preferably liquid soap) and access to running water, hand dryers, tissues, and no-touch trash cans, when possible.
- Continually restock hygiene supplies throughout the facility.
- Consider increasing the number of staff and/or other people who are trained to clean common areas to ensure they are cleaned on a continual basis.
- Conduct [screenings](#) for symptoms and fever on all new entrants, staff, and visitors prior to entering the facility and [follow guidance](#).
- Use options to increase social distancing (increasing the physical space between people in the facility, ideally at


Attachment 3



Ventilation in Buildings

Updated June 2, 2021

Summary of Recent Changes

Updates as of June 2, 2021 

- Added a new Frequently Asked Question on protective barriers and ventilation.

[View Previous Changes](#)

CDC recommends a layered approach to reduce exposures to SARS-CoV-2, the virus that causes COVID-19. This approach includes using multiple mitigation strategies, including improvements to building ventilation, to reduce the spread of disease and lower the risk of exposure. In addition to ventilation improvements, the layered approach includes [physical distancing](#), [wearing face masks](#), [hand hygiene](#), and [vaccination](#).

SARS-CoV-2 viral particles spread between people more readily indoors than outdoors. Indoors, the concentration of viral particles is often higher than outdoors, where even a light wind can rapidly reduce concentrations. When indoors, ventilation mitigation strategies can help reduce viral particle concentration. The lower the concentration, the less likely viral particles can be inhaled into the lungs (potentially lowering the inhaled dose); contact eyes, nose, and mouth; or fall out of the air to accumulate on surfaces. Protective ventilation practices and interventions can reduce the airborne concentrations and reduce the overall viral dose to occupants.

Reoccupying a building during the COVID-19 pandemic should not, in most cases, require new building ventilation systems. However, ventilation system upgrades or improvements can increase the delivery of clean air and dilute potential contaminants. Consult experienced heating, ventilation, and air conditioning (HVAC) professionals when considering changes to HVAC systems and equipment. Buildings that provided healthy, code-compliant indoor air quality prior to the pandemic can be improved for pandemic occupancy using less costly interventions. Below is a list of ventilation interventions that can help reduce the concentration of virus particles in the air. They represent a list of “tools in the mitigation toolbox,” each of which can contribute towards a reduction in risk. Implementing multiple tools at the same time is consistent with CDC’s layered approach and will increase overall effectiveness of ventilation interventions. These ventilation interventions can reduce the risk of exposure to the virus and reduce the spread of disease, but they will not eliminate risk completely.

While the list of tools can be universally applied across indoor environments, applying them to different building types, occupancies, and activities under environmental and seasonal changes can be challenging. The specific combination of tools chosen for use at any point in time can change. It will be up to the building owner or operator (with expert consultation as needed) to identify which tools are appropriate for each building throughout the year. In addition to buildings, vehicles – including public transportation such as buses, subways, trains, school buses, carpools, and rideshares – are also areas where ventilation improvements can be applied to reduce the spread of the virus and lower the risk of exposure.

Tools to Improve Ventilation

Some of the following interventions are based on the American Society of Heating, Refrigerating, and Air-Conditioning Engineers (ASHRAE) [Guidance for Building Operations During the COVID-19 Pandemic](#) [78 KB, 3 pages]. Not all interventions will work in all scenarios. Use caution in highly polluted areas when increasing outdoor air ventilation. The following tools identify ways to improve ventilation:

- Increase the introduction of outdoor air:

COVID-19

- Open windows and doors, when weather conditions allow, to increase outdoor air flow. Do not open windows and doors if doing so poses a safety or health risk (e.g., risk of falling, triggering asthma symptoms) to occupants in the building. Even a slightly open window can introduce beneficial outdoor air.
- Use fans to increase the effectiveness of open windows:
 - To safely achieve this, fan placement is important and will vary based on room configuration. Avoid placing fans in a way that could potentially cause contaminated air to flow directly from one person to another (see FAQ below on [indoor use of fans](#)). One helpful strategy is to use a window fan, placed safely and securely in a window, to exhaust room air to the outdoors. This will help draw outdoor air into the room via other open windows and doors without generating strong room air currents. Similar results can be established in larger facilities using other fan systems, such as gable fans and roof ventilators.
- Ensure ventilation systems operate properly and provide acceptable indoor air quality for the current occupancy level for each space.
- Rebalance or adjust HVAC systems to increase total airflow to occupied spaces when possible.
- Turn off any demand-controlled ventilation (DCV) controls that reduce air supply based on occupancy or temperature during occupied hours. In homes and buildings where the HVAC fan operation can be controlled at the thermostat, set the fan to the “on” position instead of “auto,” which will operate the fan continuously, even when heating or air-conditioning is not required.
- Improve central air filtration:
 - [Increase air filtration](#) to as high as possible without significantly reducing design airflow. Increased filtration efficiency is especially helpful when enhanced outdoor air delivery options are limited.
 - Make sure air filters are properly sized and within their recommended service life.
 - Inspect filter housing and racks to ensure appropriate filter fit and minimize air that flows around, instead of through, the filter.
- Ensure restroom exhaust fans are functional and operating at full capacity when the building is occupied.
- Inspect and maintain exhaust ventilation systems in areas such as kitchens, cooking areas, etc. Operate these systems any time these spaces are occupied. Operating them even when the specific space is not occupied will increase overall ventilation within the occupied building.
- Use portable high-efficiency particulate air (HEPA) fan/filtration systems to enhance air cleaning (especially in higher risk areas such as a nurse’s office or areas frequently inhabited by people with a higher likelihood of having COVID-19 and/or an increased risk of getting COVID-19). See the FAQ below on [HEPA filters and portable HEPA air cleaners](#). (Note: Portable air cleaners that use filters less efficient than HEPA filters also exist and can contribute to room air cleaning. However, they should be clearly labeled as non-HEPA units.)
- Generate clean-to-less-clean air movement by evaluating and repositioning as necessary, the supply louvers, exhaust air grilles, and/or damper settings. See the FAQ below on [Directional Airflow](#). This recommendation is easier to accomplish when the supply and exhaust points are located in a ceiling grid system.
- Use [ultraviolet germicidal irradiation \(UVGI\)](#) as a supplemental treatment to inactivate SARS-CoV-2 when options for increasing room ventilation and filtration are limited. [Upper-room UVGI systems](#) [6.1 MB, 87 pages] can be used to provide air cleaning within occupied spaces, and in-duct UVGI systems can help enhance air cleaning inside central ventilation systems.
- In non-residential settings, run the HVAC system at maximum outside airflow for 2 hours before and after the building is occupied.

The ventilation interventions listed above come with a range of initial costs and operating costs, which, along with risk assessment factors – such as community incidence rates, facemask compliance expectations and room occupant density – may affect the selection of tools. The following are examples of cost estimates for ventilation interventions:

- No cost: opening windows; inspecting and maintaining dedicated exhaust ventilation; disabling DCV controls; repositioning outdoor air dampers
- Less than \$100: using fans to increase effectiveness of open windows; repositioning supply/exhaust diffusers to create directional airflow
- \$500 (approximately): adding portable HEPA fan/filter systems
- \$1500 to \$2500 (approximately): adding upper room UVGI

Ventilation FAQs

1. Can COVID-19 be transmitted through HVAC (ventilation) systems? ∨

The risk of spreading SARS-CoV-2, the virus that causes COVID-19, through ventilation systems is not clear at this time. Viral RNA has reportedly been found on return air grilles, in return air ducts, and on heating, ventilation, and air conditioning (HVAC) filters, but detecting viral RNA alone does not imply that the virus was capable of transmitting disease. One research group reported that the use of a new air-sampling method allowed them to find [viable viral particles within a COVID-19 patient's hospital room](#) with good ventilation, filtration and ultraviolet (UV) disinfection (at distances as far as 16 feet from the patient). However, the concentration of viable virus detected was believed to be too low to cause disease transmission. There may be some implications for HVAC systems associated with these findings, but it is too early to conclude that with certainty. While airflows within a particular space may help spread disease among people in that space, there is no definitive evidence to date that viable virus has been transmitted through an HVAC system to result in disease transmission to people in other spaces served by the same system.

Healthcare facilities have ventilation requirements in place to help prevent and control infectious diseases that are associated with healthcare environments. For more information, see the CDC [Guidelines for Environmental Infection Control in Health-Care Facilities](#).

Non-healthcare (e.g., businesses and schools) building owners and managers should, at a minimum, maintain building ventilation systems according to state and local building codes and applicable guidelines. Ensuring appropriate outdoor air and ventilation rates is a practical step to ensure good indoor air quality.

2. How long will it take to dilute the concentration of infectious particles in a room once they are generated? ∨

While large droplets (100 micrometers [μm] and larger) will settle to surrounding surfaces within seconds, smaller particles can stay suspended in the air for much longer. It can take several minutes for particles 10 μm in size to settle, while particles 5 μm and smaller may not settle for hours or even days. Dilution ventilation and particle filtration are commonly used to remove these smaller particles from the air. Larger particles can also be removed using these strategies, but since they fall out of the air quickly, they might not have a chance to get captured by filtration systems.

The time required to remove airborne particles from a space can be estimated using [Table B.1](#) in the CDC's [Guidelines for Environmental Infection Control in Health-Care Facilities](#) (2003). The estimates assume the source of infectious particles is no longer present in the space. The estimates are based upon the rate that particle-free air is delivered to the room and the desired removal efficiency (99% or 99.9%). The particle-free air, measured in air changes per hour (ACH), can be uncontaminated supply air or the clean exhaust from a High Efficiency Particulate Air (HEPA) fan/filtration system [See HEPA filtration discussion below].

Although there are some highly contagious airborne diseases (like measles) where CDC provides specific guidance for 99.9% clearance wait times, the general recommendation in CDC's [Guidelines for Environmental Infection Control in Health-Care Facilities](#) is to wait to allow for a 99% reduction of any generated airborne particles before re-entering the room.

In the absence of guidance specifying a longer wait period for SARS-CoV-2, the wait time associated with 99% clearance is appropriate for healthcare and other spaces. Regardless of whether the 99% or 99.9% column on [Table B.1](#) is used, the value in the table is usually an under-estimation of the actual dilution clearance time as noted in the table's footnotes which include the following statement: "The times given assume perfect mixing of the air within the space (i.e., mixing factor = 1). However, perfect mixing usually does not occur. Removal times will be longer in rooms or areas with imperfect mixing or air stagnation." Appropriate use of Table B.1 to establish clearance times from any space requires multiplying the time in the table by a mixing factor (k) that ranges between 1 and 10. This factor represents how well the ventilation system mixes and dilutes the concentration of airborne particles within the room.

As a rule of thumb, rooms with higher airflow rates (6 ACH and higher) and good placement of supply and exhaust grilles (hospital airborne infection isolation rooms) are considered to have "good" mixing and thus a mixing factor of $k = 3$ is often used for these spaces. In that case, the time identified from Table B.1 should be multiplied by 3 to determine the actual clearance time prior to re-entry. Nonventilated or poorly ventilated spaces have typical values of k ranging from 8 to 10. Increased ACH generally lead to reductions in k , although k can also be reduced by the use of a fan in the space, which does not have an impact on ACH. Ultimately, wait times can be reduced by increasing ACH, reducing k , or a combination of both.

Example 1. Given: A room measuring 12 feet x 10 feet with a ceiling height of 10 feet is served with a 100% outdoor air ventilation system that delivers 65 cubic feet per minute (cfm) of supply air ($Q_s = 65$ cfm) and exhausts 80 cfm of air from the room ($Q_e = 80$ cfm). The room has average air mixing, so assign $k = 5$.

Question: How much time is required to reduce the airborne concentration by 99 percent?

Solution: Since Q_e is larger than Q_s by 15 cfm, the heating, ventilation, and air conditioning (HVAC) system is pulling 15 cfm of air into the room from adjacent areas (i.e., the room is under negative pressure). For this example, the 15 cfm of transfer air is assumed to be free of infectious airborne particles. The clean volumetric air flow rate (Q) is the larger value between Q_s and Q_e , so $Q = 80$ cfm. Calculate the air changes per hour:


$$\text{ACH} = [Q \times 60] / (\text{room volume}) = (80 \text{ cfm} \times 60) / (12' \times 10' \times 10') = 4800/1200 = 4.0 \text{ ACH}$$

Using [Table B.1](#) the perfect mixing wait time based on 4 ACH and a 99% reduction of airborne particles is 69 minutes.

Using the mixing factor of 5, the estimated wait time for 99% reduction of airborne contaminants in the room is $5 \times 69 = 345$ minutes or 5 hours and 45 minutes.

Note: Determining the true value of the mixing factor is difficult and requires special equipment to measure air flows and conduct tracer gas decay testing. Thus, conservative estimates of k are often used (as described above). Also, the addition of an air cleaning device (e.g., a portable HEPA filtration unit) within the same room will reduce the wait time. The flow rate from the air cleaning device can be added to Q determined above, which will increase the overall ACH in the room. The air movement created by the air cleaning device can also decrease the value of k . Together, the increased ACH and decreased k can help substantially reduce wait times. See [Example 2](#) for more information, including an example of the calculations.

3. Can ventilation filters effectively capture SARS-CoV-2 viral particles?

Filters for use in heating, ventilation, and air conditioning (HVAC) systems are generally tested under procedures outlined in ANSI/ASHRAE Standard 52.2-2017-Method of Testing General Ventilation Air-Cleaning Devices for Removal Efficiency by Particle Size. This standard was developed by ASHRAE, a global society focused on building systems, indoor air quality, and sustainability in the built environment, and is available for [free online viewing](#)  during the ongoing pandemic. Based on the filtration efficiency determined by the testing procedures, filters are assigned a Minimum Efficiency Reporting Value (MERV). The MERV provides a measure of the "filter efficiency" over the range of particle sizes prescribed in the test procedure. MERV values range from 1 to 16 and higher MERV values correspond to more efficient filters.

Research shows that the particle size of SARS-CoV-2 is around 0.1 micrometer (μm). However, the virus generally does not travel through the air by itself. These viral particles are human-generated, so the virus is trapped in respiratory droplets and droplet nuclei (dried respiratory droplets) that are larger than an individual virus. Most of the respiratory droplets and particles exhaled during talking, singing, breathing, and coughing are less than 5 μm in size. CDC recommends using

the highest efficiency ventilation filters possible, without having detrimental effects on overall HVAC system performance. ASHRAE has similar guidance; however, they recommend a minimum filtration efficiency target of MERV 13, provided there are not substantial negative impacts on the HVAC system performance and occupant comfort. A MERV 13 filter is at least 50% efficient at capturing particles in the 0.3 μm to 1.0 μm size range and 85% efficient at capturing particles in the 1 μm to 3 μm size range. Collectively these particles are capable of remaining airborne for hours and are most associated with deep lung penetration. A MERV 14 filter is at least 75% and 90% efficient, respectively, at capturing those same particles. Efficiencies for MERV 15 and MERV 16 filters are even higher. Thus, the recommended filters are significantly more efficient at capturing particles of concern than a typical MERV 8 filter, which is only around 20% efficient in the 1 μm to 3 μm size range and is not rated for capture efficiency of the smaller 0.3 μm to 1.0 μm particles.

Increasing filtration efficiency can increase the pressure drop across the filters. This can lead to increased fan energy, reduced airflow rates, and/or issues controlling indoor temperature and relative humidity levels. Scientific developments in filter design and manufacturing have reduced the amount of the increased pressure drop and its resulting impact on HVAC operations, but not all filters have adopted the newer technology. Prior to a filtration upgrade, the specific filters under consideration should be investigated for their pressure drop ratings at the flow rate(s) of intended use and the potential impacts of that pressure drop evaluated against the capabilities of the existing HVAC system.

High-efficiency particulate air (HEPA) filters are even more efficient at filtering human-generated infectious particles than MERV 16 filters. However, outside of a few unique applications, HEPA filters are rarely used in central HVAC systems. [See the question on [Portable HEPA Filtration](#) to learn more about them and their application in protective air cleaning].

4. What is meant by “directional airflow?” How and where should it be used? ∨

Directional airflow is a protective ventilation concept where air movement flows in a clean-to-less-clean direction. This ventilation concept is applied to areas where the “clean” environment requires a higher level of protection and/or where the “less-clean” environment has a higher risk of containing airborne contaminants (activities or occupancy by individuals with a higher risk of being infectious). Examples of “clean” spaces might include healthcare facility triage stations or rooms/corridors adjacent to higher risk activities. Examples of “less-clean” spaces might include spaces that contain known/suspect infectious persons or spaces where a known activity has increased likelihood of generating infectious airborne particles.

The creation of directional airflow can be accomplished within a particular space or between two adjacent spaces. This can be done passively, through intentional placement of supply and exhaust heating, ventilation, and air conditioning (HVAC) grilles, or by the intentional creation of pressure differentials between adjacent spaces through specification of offset exhaust and supply air flow rates. Creation of the directional airflow can also be done actively, through the use of fans exhausting through open windows, strategic placement of ductwork attached to portable HEPA filtration units, or dedicated exhaust systems (installed or portable) that generate a desired airflow by exhausting air out of windows, doorways, or through temporary ducts. In specific settings, specialized local control ventilation interventions that establish the desired airflow directions can also be used (see the [NIOSH Ventilated Headboard](#)).



Directional airflows must be evaluated carefully. Testing of the directional airflow effectiveness can be accomplished using visual tracer techniques that use “smoke tubes” or handheld “fog generators.” Other tools, such as electronic monitors or visual aids to monitor pressure differences can be used when directional airflow is established between two adjacent spaces. To reduce the potential for directing airflow from infectious towards non-infectious space occupants, it is important that the “clean” and “less-clean” space determinations be established using infection control risk assessment considerations.

5. What is a HEPA filter and why use a portable HEPA air cleaner? ∨

Research shows that the particle size of SARS-CoV-2 is around 0.1 micrometer (μm). However, the virus generally does not travel through the air by itself. These viral particles are human-generated, so the virus is trapped in respiratory droplets and droplet nuclei (dried respiratory droplets) that are larger. Most of the respiratory droplets and particles exhaled during talking, singing, breathing, and coughing are less than 5 μm in size. By definition, a High Efficiency Particulate Air (HEPA) filter is at least 99.97% efficient at capturing particles 0.3 μm in size. This 0.3 μm particle approximates the most


penetrating particle size (MPPS) through the filter. HEPA filters are even more efficient at capturing particles larger **and** smaller than the MPPS. Thus, HEPA filters are no less than 99.97% efficient at capturing human-generated viral particles associated with SARS-CoV-2.

Portable HEPA filtration units that combine a HEPA filter with a powered fan system are a preferred option for auxiliary air cleaning, especially in higher risk settings such as health clinics, vaccination and medical testing locations, workout rooms, or public waiting areas. Other settings that could benefit from portable HEPA filtration can be identified using typical risk assessment parameters, such as community incidence rates, facemask compliance expectations, and room occupant density. While these systems do not bring in outdoor dilution air, they are effective at cleaning air within spaces to reduce the concentration of airborne particulates, including SARS-CoV-2 viral particles. Thus, they give effective air exchanges without the need for conditioning outdoor air.

In choosing a portable HEPA unit, select a system that is appropriately sized for the area in which it will be installed. This determination is made based on the air flow through the unit, which is typically reported in cubic feet per minute (cfm). Many portable HEPA filtration units are assigned a Clean Air Delivery Rate (CADR) (See [EPA's Guide To Air Cleaners In The Home](#)  ) , which is noted on a label in the operators manual, on the shipping box, and/or on the filtration unit itself. The CADR is an established standard defined by the Association of Home Appliance Manufacturers (AHAM). Participating portable air cleaner manufacturers have their products certified by an independent laboratory, so the end user can be assured it performs according to the manufacturer's claims. The CADR is generally reported in cfm for products sold in the United States. The paragraphs below describe how to select an appropriate air cleaner based on the size of the room in which it will be used. The procedure below should be followed whenever possible. If an air cleaner with the appropriate CADR number or higher is not available, select a unit with a lower CADR rating. The unit will still provide incrementally more air cleaning than having no air cleaner at all.

In a given room, the larger the CADR, the faster it will clean the room air. Three CADR numbers are given on the AHAM label, one each for smoke, dust, and pollen. The smoke particles are the smallest, so that CADR number applies best to viral particles related to COVID-19. The label also shows the largest room size (in square feet, ft²) that the unit is appropriate for, assuming a standard ceiling height of up to 8 feet. If the ceiling height is taller, multiply the room size (ft²) by the ratio of the actual ceiling height (ft) divided by 8. For example, a 300 ft² room with an 11-foot ceiling will require a portable air cleaner labeled for a room size of at least 415 ft² ($300 \times [11/8] = 415$).

The CADR program is designed to rate the performance of smaller room air cleaners typical for use in homes and offices. For larger air cleaners, and for smaller air cleaners whose manufacturers choose not to participate in the AHAM CADR program, select a HEPA unit based on the suggested room size (ft²) or the reported air flow rate (cfm) provided by the manufacturer. Consumers might take into consideration that these values often reflect ideal conditions which overestimate actual performance.

For air cleaners that provide a suggested room size, the adjustment for rooms taller than 8 feet is the same as presented above. For units that only provide an air flow rate, follow the "[2/3 rule](#) 

 to approximate a suggested room size. To apply this rule for a room up to 8 feet tall, choose an air cleaner with an air flow rate value (cfm) that is at least 2/3 of the floor area (ft²). For example, a standard 300 ft² room requires an air cleaner that provides at least 200 cfm of air flow ($300 \times [2/3] = 200$). If the ceiling height is taller, do the same calculation and then multiply the result by the ratio of the actual ceiling height (ft) divided by 8. For example, the 300 ft² room described above, but with an 11-foot ceiling, requires an air cleaner that can provide at least 275 cfm of air flow ($200 \times [11/8] = 275$).

While smaller HEPA fan systems tend to be stand-alone units, many larger units allow flexible ductwork to be attached to the air inlet and/or outlet (note that larger ducted units don't fall under the "room air cleaner" description and may not have a CADR rating). Using ductwork and placing the HEPA system strategically in the space can help provide desired clean-to-less-clean airflow patterns where needed. Ducted HEPA systems can also be used to establish direct source capture interventions for patient treatment and /or testing scenarios (See CDC/NIOSH discussion on [Ventilated Headboard](#)). Depending on the size of the HEPA fan/filter units and how the facility in which they are being used is configured, multiple small portable HEPA units deployed to high risk areas may be more useful than one large HEPA unit serving a combined space.

Example 2. Given: The room described in [Example 1](#) is now augmented with a portable HEPA air cleaning device with a smoke CADR of 120 cfm ($Q_{\text{hepa}} = 120$ cfm). The added air movement within the room improves overall mixing, so assign $k = 3$.

Question: How much time is saved to achieve the same 99% reduction in airborne contaminants by adding the portable HEPA device to the room?

Solution: The addition of the HEPA filter device provides additional clean air to the room. Here, the clean volumetric air flow rate (Q) is: $Q = Q_e + Q_{\text{hepa}} = 80 \text{ cfm} + 120 \text{ cfm} = 200 \text{ cfm}$.

$ACH = [Q \times 60] / (\text{room volume}) = (200 \text{ cfm} \times 60) / (12' \times 10' \times 10') = 12,000/1,200 = 10 \text{ ACH}$.

Using [Table B.1](#), the perfect mixing wait time based on 10 ACH and a 99% reduction of airborne particles is 28 minutes.

Using the mixing factor of 3, the estimated wait time for 99% reduction of airborne contaminants in the room is $3 \times 28 = 84$ minutes. Thus, the increased ACH and lower k value associated with the portable HEPA filtration unit reduced the wait time from the original 5 hours and 45 minutes to only 1 hour and 24 minutes, saving a total of 4 hours and 21 minutes before the room could be safely reoccupied.

Adding the portable HEPA unit increased the effective ventilation rate and improved room air mixing. This resulted in over a 75% reduction in time for the room to be cleared of potentially-infectious airborne particles.

6. Does ultraviolet germicidal irradiation (UVGI) kill SARS-CoV-2? ∨

Yes. Ultraviolet germicidal irradiation (UVGI), otherwise known as germicidal ultraviolet (GUV), is a disinfection tool used in many different settings, such as residential, commercial, educational, and healthcare settings. The technology uses ultraviolet (UV) energy to inactivate (kill) microorganisms, including viruses, when designed and installed correctly.


There is still a lot to learn about SARS-CoV-2 and the extent of airborne viral particles and spread. However, UVGI can inactivate viruses in the air and on surfaces.* The design and sizing of effective UVGI disinfection systems requires specific knowledge and experience.

Seek consultation with a reputable UVGI manufacturer or an experienced UVGI system designer prior to installing UVGI systems. These professionals can assist by doing necessary calculations, making fixture selections, properly installing the system, and testing for proper operation specific to the setting.

*Note: CDC's recommendation for primary surface disinfection in occupied environments is to follow the CDC/EPA guidance for surface disinfection.

7. What types of ultraviolet germicidal irradiation (UVGI) devices are available for cleaning and disinfection in the workplace? ∨

Upper-room UVGI

Upper-room (or upper-air) UVGI uses specially designed UVGI fixtures mounted on walls or ceilings to create a disinfection zone of ultraviolet (UV) energy that is focused up and away from people. These fixtures disinfect air as it circulates from mechanical ventilation, ceiling fans, or natural air movement. The advantage of upper-room UVGI is that it disinfects the air closer to and above people who are in the room. Since the 1980s, UVGI systems have been widely used for control of tuberculosis (TB). The CDC guidance [Environmental Control for Tuberculosis: Basic Upper-Room Ultraviolet Germicidal Irradiation Guidelines for Healthcare Settings](#)  provides information on appropriate UVGI system design, related safe operation, and maintenance. Based on data from other human coronaviruses, a UVGI system designed to protect against the spread of TB should be effective at inactivating SARS-CoV-2 and therefore prevent spread. UVGI systems usually require a few UV fixtures to be effective. For example, a rectangular-shaped waiting room with 10–30 occupants will require 2–3 upper-air UVGI fixtures. As part of system installation, care must be taken to control the amount of UV energy directed or reflected into the lower occupied space below levels recognized as safe. Reputable UVGI manufacturers or experienced UVGI system designers will take the necessary measurements and make any required adjustments to prevent harmful UV exposures to people in the space.

Potential Application: Can be used in any indoor environment; most useful in spaces highly occupied with people who are or may be sick.

In-Duct UVGI

In-duct UVGI systems are installed within a heating, ventilation, and air-conditioning (HVAC) system. These systems are designed to serve one of two purposes:

1) Coil treatment UVGI keeps HVAC coils, drain pans, and wetted surfaces free of microbial growth. These devices produce relatively low levels of UV energy. This energy is continually delivered 24 hours a day, which is why they are effective. Coil treatment UVGI devices are not designed for disinfecting the air and should not be installed for the purpose of air disinfection.

Potential Application: Can be used to reduce HVAC maintenance and improve operational efficiency within large, commercial HVAC systems or residential HVAC systems; not recommended for inactivating airborne pathogens.

2) Air disinfection UVGI systems can be effective at applying intense UV energy to inactivate airborne pathogens as they flow within the HVAC duct. HVAC air disinfection UVGI systems generally require more powerful UV lamps or a greater number of lamps, or both, to provide the necessary UVGI required to inactivate pathogens in a short period of time. Air disinfection systems are often placed downstream of the HVAC coils. This location keeps the coil, drain pan, and wetted surfaces free of microbial growth and also disinfects the moving air.

Potential Application: Can be used inside any HVAC system to disinfect infectious airborne pathogens.

Far-UV (or Far-UVC)

Far-UV is one of many emerging technologies that have become popular during the COVID-19 pandemic. While standard UVGI fixtures emit UV energy at a wavelength around 254 nanometers (nm), far-UV devices use different lamps to emit UV energy at a wavelength around 222 nm. Aside from the wavelength, a major difference between the two technologies is that standard UVGI systems are specifically designed to avoid exposing people to the UV energy, while many far-UV devices are marketed as safe for exposing people and their direct environment to UV energy. A review of peer-reviewed literature indicates that far-UV wavelengths can effectively inactivate microorganisms, including human coronaviruses, when appropriate UV doses are applied. Questions remain about the mechanisms of killing microorganisms and overall safety. Far-UV might prove to be effective at disinfecting air and surfaces, without some of the safety precautions required for standard UVGI. Far-UV devices are best viewed as new and emerging technology. Consumers considering an emerging technology such as Far-UV should read the [FAQ on emerging technologies](#) below.

8. Many new air disinfection devices are marketed for their ability to inactivate SARS-CoV-2. How can I tell if they work as advertised? ▼

CDC does not provide recommendations for, or against, any manufacturer or product. There are numerous technologies being heavily marketed to provide air cleaning during the ongoing COVID-19 pandemic. Common among these are ionization, dry hydrogen peroxide, and chemical fogging disinfection. Some products on the market include combinations of these technologies. These products generate ions, reactive oxidative species (ROS, which are marketed using many names), or chemicals into the air as part of the air cleaning process. People in spaces treated by these products are also exposed to these ions, ROS, or chemicals.

While variations of these technologies have been around for decades, relative to other air cleaning or disinfection methods, they have a less-documented track record when it comes to cleaning/disinfecting large and fast volumes of moving air within heating, ventilation, and air conditioning (HVAC) systems or even inside individual rooms. This does not necessarily imply the technologies do not work as advertised. However, in the absence of an established body of peer-reviewed evidence showing proven efficacy and safety under as-used conditions, the technologies are still considered by many to be “emerging.”

As with all emerging technologies, consumers are encouraged to exercise caution and to do their homework. Registration alone, with national or local authorities, does not always imply product efficacy or safety. Consumers should research the technology, attempting to match any specific claims against the intended use of the product. Consumers should request testing data that quantitatively demonstrates a clear protective benefit and occupant safety under conditions consistent with the intended use. When considering air cleaning technologies that potentially or intentionally expose building


with the intended use. When considering air cleaning technologies that potentially or intentionally expose building occupants, the safety data should be applicable to all occupants, including those with health conditions that could be aggravated by the air treatment. In transient spaces, where average exposures to the public may be temporary, it is important to also consider occupational exposures for workers that must spend prolonged periods in the space.

Preferably, the documented performance data under as-used conditions should be available from multiple sources, some of which should be independent, third-party sources. Unsubstantiated claims of performance or limited case studies with only one device in one room and no reference controls should be questioned. At a minimum, when considering the acquisition and use of products with technology that may generate ozone, verify that the equipment meets UL 867 standard certification (Standard for Electrostatic Air Cleaners) for production of acceptable levels of ozone, or preferably UL 2998 standard certification (Environmental Claim Validation Procedure (ECVP) for Zero Ozone Emissions from Air Cleaners) which is intended to validate that no ozone is produced.

9. Can carbon dioxide (CO₂) monitors be used to indicate when there is good ventilation? ▼

Carbon dioxide (CO₂) monitoring can provide information on ventilation in a given space, which can be used to enhance protection against COVID-19 transmission. Strategies incorporating CO₂ monitors can range in cost and complexity. However, greater cost and complexity does not always mean greater protection.

Traditionally, CO₂ monitoring systems are expensive, require extensive knowledge to accurately install and set up, and require sophisticated control programs to effectively interact with the building heating, ventilation and air-conditioning (HVAC) systems in real time. They were not designed to protect building occupants from disease transmission. Developers of whole-building CO₂ monitoring equipment/software for HVAC system operations have been around for decades, with the technology most often applied in the pursuit of energy savings. As the current pandemic response has progressed, this technology has been marketed as a potential tool for providing an indication of building ventilation efficacy, leading to questions about whether monitoring indoor CO₂ concentrations can be used as a tool to help make ventilation decisions.

In some well-designed, well-characterized, well-maintained HVAC environments, the use of fixed CO₂ monitors can be informative. When used, these monitors are often incorporated into demand-controlled ventilation (DCV) systems that are designed with a primary intent of maximizing energy efficiency through reductions in outdoor air delivery. However, guidance throughout the pandemic has been to exceed minimum ventilation whenever possible, in addition to masking, physical distancing, enhanced filtration, and other intervention-focused considerations. From the beginning of this pandemic's response, both CDC and [ASHRAE](#)  have advised to deactivate DCV systems and operate the ventilation systems at maximum airflows, within the safety limitations of the equipment.

Fixed-position CO₂ monitors measure CO₂ concentration as an indicator of the number of people in the space. As the CO₂ concentration increases, the HVAC DCV system increases the amount of outdoor air ventilation in the space to dilute CO₂ (and vice versa). The number of CO₂ sensors, the placement of those sensors, and their calibration and maintenance are collectively a large and complex issue that must not be overlooked. For example, the CO₂ concentration measured by a fixed, wall-mounted monitor may not always represent the actual concentrations in the occupied space. If air currents from the room HVAC, or even make-up air from windows, flows directly over this monitor location, the corresponding concentration measurements will be artificially low. If the room has good air mixing, the measured concentration should approximate the true concentration, but rooms are rarely well mixed, particularly in older buildings with aging ventilation systems (or none at all). Also, if an elevated CO₂ concentration results in an air flow increase to one room, that air may be "stolen" from other rooms on the same HVAC system. This may result in elevated CO₂ concentrations in those other spaces which the HVAC system is unable to control.

Limited information exists regarding a direct link associating CO₂ concentrations to a risk of COVID-19 transmission. Changes in CO₂ concentrations can indicate a change in room occupancy and be used to adjust the amount of outdoor air delivered. However, CO₂ concentrations cannot predict who has SARS-CoV-2 infection and might be spreading the virus, the amount of airborne viral particles produced by infected people, or whether the HVAC system is effective at diluting and removing viral concentrations near their point of generation. As a simple example, a small room with three occupants will have the same level of CO₂ (and hence the same outdoor air ventilation rate controlled by the DCV system) whether no one has SARS-CoV-2 infection or whether one or more people are infected with the virus. Ventilation based on CO₂ measurements cannot recognize the increased risk of transmission in the second scenario.

A more modest, cost-efficient, and accurate use of CO₂ monitoring is the use of portable instruments combined with HVAC systems that do not have modulating setpoints based on CO₂ concentrations. The CO₂ meter can be purchased for under \$300 and its measurements can be collected/logged near the breathing zones of occupied areas of each room. Under this approach, the HVAC outdoor air dampers could be set to introduce more outdoor air than code requires (as recommended by CDC and ASHRAE) and the resulting CO₂ concentrations in rooms at the real-world occupancy levels documented using a calibrated, handheld portable CO₂ meter. This documentation will be the CO₂ concentration benchmarks for each room under the HVAC operating conditions and occupancy levels.

One potential target benchmark for good ventilation is CO₂ readings below 800 parts per million (ppm). If the benchmark readings are above this level, reevaluate the ability to increase outdoor air delivery. If unable to get below 800 ppm, increased reliance on enhanced air filtration (including portable HEPA air cleaners) will be necessary. Once the benchmark concentrations are established, take periodic measurements and compare them to the benchmarks. As long as the ventilation airflow is unchanged (outdoor air or total air) and the occupancy capacity is not increased, future portable CO₂ concentrations that are 110% of the benchmarks indicate a potential problem that should be investigated. Under the pandemic response, a pragmatic application of portable CO₂ measurement tools is a cost-effective approach to monitoring building ventilation.

10. Should indoor temperature and humidity be used to help reduce the risk of COVID-19 transmission? ▼

For COVID-19, the first steps in reducing the indoor concentrations of the virus are [wearing face masks](#), [physical distancing](#), and reducing occupancy levels. Improved ventilation is an additional prevention strategy. For ventilation systems, increasing outdoor air above the code minimum requirements, increasing total ventilation, and increasing filtration efficiencies are more effective at controlling infectious disease transmission than controlling indoor temperature and humidity. However, the use of temperature and/or humidity to reduce the risk of disease transmission should be considered on a case-by-case basis, taking into account the building enclosure, heating, ventilation, and air-conditioning (HVAC) system capabilities, level of control and/or building automation, local COVID-19 transmission rates, any unique clinical features of the occupants, and local climate.

Both temperature and humidity can influence the transmission of infectious diseases, including COVID-19, but that influence has practical limitations. Research on the impact of temperature has shown that SARS-CoV-2, the virus that causes COVID-19, is sensitive to elevated temperatures, with over 99.99% inactivation in only a few minutes at 70°C (158°F). However, this temperature is far outside the limits of human comfort and could damage some building materials. While temperatures lower than 70°C (158°F) are also effective, the required exposure time for inactivation increases as the temperature decreases. So, elevated temperatures offer the potential for decontamination of SARS-CoV-2 virus in the air or on surfaces, but the use of increased temperature solely for decontamination is not generally recommended and is not realistic for occupied spaces. Another important consideration is that when the temperature in a space is elevated, the corresponding relative humidity level decreases.

Current evidence is not persuasive that humidity significantly reduces transmission of SARS-CoV-2 beyond the level resulting from good ventilation and filtration. Some research studies have shown that the survival of viruses, including human coronaviruses, may be reduced when the relative humidity is in the 40–60% range. However, the reductions are modest and there are outliers to these findings. Consequently, neither ASHRAE nor CDC recommends introducing humidification for the sole purpose of limiting transmission of COVID-19. While not affecting transmission, there are peer-reviewed studies that suggest preventing excessive dryness in the air could help maintain the effectiveness of the human body's immune system.

Some HVAC systems can actively control both temperature and humidity. However, the majority of HVAC systems do not have dedicated humidification capabilities. Some dehumidification happens during warmer months as a byproduct of cooling humid warm air below its dew point and causing water to condense out of the air. Less common is the ability to limit low humidity by introducing water vapor into the dry supply air.

Most existing residential and commercial buildings located in cold climates are not constructed to resist the corrosion and excessive moisture accumulation that can result from long-term, whole-building humidification. If additional winter humidification is used to maintain comfort and prevent excessive dryness of nasal and ocular membranes, first analyze the building enclosure to verify that condensation and moisture accumulation will not become a problem. ASHRAE

Standard 160 (Criteria for Moisture-Control Design Analysis in Buildings) provides guidance for hygrothermal analysis of building enclosures. For commercial buildings that are properly constructed to allow for long-term humidification, and which have humidification capabilities already installed, there is no reason not to humidify the air to comfortable levels during the winter months.

In residential settings, portable in-room humidifiers may be used for sensory comfort and to reduce excessively low relative humidity levels. In these instances, use a humidifier with a built-in humidistat and control the relative humidity level near 40%. Higher humidity levels are not necessarily better and may lead to localized mold growth, mildew, and other long-lasting indoor air quality issues. Maintenance and cleaning of portable humidification systems is very important. Change the water in the humidifier daily and maintain and clean the humidifier in accordance with manufacturer recommendations.

11. Can fans be used to decrease the risk of COVID-19 transmission indoors? ∨

Yes. While fans alone cannot make up for a lack of outdoor air, fans can be used to increase the effectiveness of open windows, as described in the [CDC list of ventilation improvement considerations](#). Fans can also be used indoors to improve room air mixing. Improved room air mixing helps distribute supplied clean air and dilute viral particle concentrations throughout the room, which reduces the likelihood of stagnant air pockets where viral concentrations can accumulate. As with all fan use during the COVID-19 pandemic, take care to minimize the potential to create air patterns that flow directly across one person onto another:

- Avoid the use of the high-speed settings
- Use ceiling fans at low velocity and potentially in the reverse-flow direction (so that air is pulled up toward the ceiling)
- Direct the fan discharge towards an unoccupied corner and wall spaces or up above the occupied zone.

Fans can also enable clean-to-less-clean directional airflow. Such applications should be evaluated closely to avoid unintended consequences and only adopted when supported by a safety risk assessment.

12. Will using protective barriers interfere with improved ventilation? ∨

Barriers can physically separate spaces that are next to each other. When used for infection control, the barrier is intended to prevent someone on one side of the barrier from exposing a person on the other side of the barrier to infectious fluids, droplets, and particles. Whether a barrier interferes with improved ventilation depends on how it is installed. Protective barriers can sometimes help improve ventilation, but they can sometimes hinder ventilation too. Sometimes they have no effect on ventilation.

Protective barriers can assist with improved ventilation when used to facilitate directional airflows or desired pressure differentials between clean and less-clean spaces. The barrier can be aligned with the intended airflow to help direct it towards a desired location, such as an HVAC return air grille or a portable air cleaner inlet. Example scenarios for this type of barrier deployment include those where there is a known source of potentially infectious aerosols, such as a dental operatory or COVID-19 testing station.

Alternatively, the barrier might be placed between two areas to better isolate one side of the barrier from the other. In this configuration, the barrier can also assist the HVAC design scheme in establishing a desired pressure differential between the adjacent spaces. If necessary, small pass-through openings or a retractable panel incorporated into the barrier can allow transfer of physical objects from one side to the other. Examples where this type of barrier application might be applied include a receptionist's desk or a ticket booth.

When not carefully installed, barriers can sometimes hinder good ventilation. Barriers can unintentionally interrupt the airflow distribution within a space, thus allowing a concentration build-up of human-generated or other aerosols that may remain suspended in the air for minutes to hours. In this case, people could be exposed to higher concentrations of infectious aerosols than they would without the barriers in place. The larger the barrier, the greater the likelihood that

this may occur. To reduce this likelihood, ensure that barriers are correctly positioned for the anticipated occupancy and that they are no larger than necessary to prevent direct transfer of respiratory droplets that could “spray” directly from one person onto another.

Any time barriers are deployed, airflow distribution testing with tracer “smoke” or handheld fog generators should be conducted. This testing can assist in evaluating airflow distribution within the occupied spaces. If stagnant air pockets are seen to occur, barrier redesign or reorientation can help to minimize the occurrence. Airflow distribution modifications such as adjusting the positioning of supply air louvers or the discharge of portable air cleaners can also assist in eliminating the development of stagnant air pockets.

Previous Updates

Updates from Previous Content



As of March 23, 2021

- Simplified language in the overall list of tools to improve ventilation.
 - Added three new Frequently Asked Questions (FAQs) on the usefulness of carbon dioxide monitors to inform ventilation decisions, the usefulness of temperature and relative humidity to control the spread of COVID-19, and the use of fans indoors.
 - Expanded the FAQ on emerging technologies to include more products available on the market.
 - Added additional information with simple calculations to the FAQ on portable HEPA air cleaners to help consumers choose appropriate units for their spaces.
-

Last Updated June 2, 2021

Attachment 4



COVID-19

We have the tools to
Fight Omicron



Vaccines & Booster



Masks



Testing

Symptoms of COVID-19

Updated Feb. 22, 2021

Watch for Symptoms

People with COVID-19 have had a wide range of symptoms reported – ranging from mild symptoms to severe illness. Symptoms may appear 2-14 days after exposure to the virus. Anyone can have mild to severe symptoms. People with these symptoms may have COVID-19:

- Fever or chills
- Cough
- Shortness of breath or difficulty breathing
- Fatigue
- Muscle or body aches
- Headache
- New loss of taste or smell
- Sore throat
- Congestion or runny nose
- Nausea or vomiting
- Diarrhea

This list does not include all possible symptoms. CDC will continue to update this list as we learn more about COVID-19. Older adults and people who have severe underlying medical conditions like heart or lung disease or diabetes seem to be at higher risk for developing more serious complications from COVID-19 illness.

Feeling Sick?

[Check Symptoms with Self-Checker](#)

[Get Tested for COVID-19](#)

When to Seek Emergency Medical Attention

Look for emergency warning signs* for COVID-19. If someone is showing any of these signs, **seek emergency medical care immediately**:

- Trouble breathing
- Persistent pain or pressure in the chest
- New confusion
- Inability to wake or stay awake
- Pale, gray, or blue-colored skin, lips, or nail beds, depending on skin tone

*This list is not all possible symptoms. Please call your medical provider for any other symptoms that are severe or concerning to you.

Call 911 or call ahead to your local emergency facility: Notify the operator that you are seeking care for someone who has or may have COVID-19.

If You Are Sick

- › [Check symptoms with Coronavirus Self-Checker](#)
- › [Get tested](#)
- › [What to do if you are sick](#)
- › [Isolate if you are sick](#)
- › [When to quarantine](#)
- › [How to care for someone who is sick](#)

Difference between COVID-19 & Flu

Influenza (Flu) and COVID-19 are both contagious respiratory illnesses, but they are caused by different viruses. COVID-19 is caused by infection with a new coronavirus (called SARS-CoV-2), and flu is caused by infection with [influenza viruses](#).

COVID-19 seems to spread more easily than flu and causes more serious illnesses in some people. It can also take longer before people show symptoms and people can be contagious for longer. More information about differences between flu and COVID-19 is available in the different sections below.

Because some of the symptoms of flu and COVID-19 are similar, it may be hard to tell the difference between them based on symptoms alone, and [testing](#) may be needed to help confirm a diagnosis.

While more is learned every day about COVID-19 and the virus that causes it, there is still a lot that is unknown . This page compares COVID-19 and flu, given the best available information to date.

Handouts & Videos

Symptoms of Coronavirus (COVID-19)

Know the symptoms of COVID-19, which can include the following:

The infographic consists of two rows of four panels each. The top row shows: 1) A person coughing into their elbow. 2) A person with a cloud around their mouth representing shortness of breath. 3) A person with a fever and a thermometer. 4) A person with a shiver. The bottom row shows: 1) A person vomiting. 2) A person with a toilet icon representing diarrhea. 3) A person with a sad face and a red 'X' over their nose and mouth representing loss of taste or smell. 4) A person with a sad face and a red 'X' over their nose and mouth representing loss of taste or smell.

Cough, shortness of breath or difficulty breathing

Fever or chills

Vomiting or diarrhea

New loss of taste or smell

[Symptoms of COVID-19 \(PDF\)](#)
Patients with COVID-19 have experienced mild to severe respiratory illness.

SYMPTOMS OF CORONAVIRUS (COVID-19)

Know the symptoms of COVID-19, which can include the following:

The infographic consists of two rows of five panels each. The top row shows: 1) A person coughing into their elbow. 2) A person with a cloud around their mouth representing shortness of breath. 3) A person with a fever and a thermometer. 4) A person with a shiver. 5) A person with a sad face and a red 'X' over their nose and mouth representing loss of taste or smell. The bottom row shows: 1) A person vomiting. 2) A person with a toilet icon representing diarrhea. 3) A person with a sad face and a red 'X' over their nose and mouth representing loss of taste or smell. 4) A person with a sad face and a red 'X' over their nose and mouth representing loss of taste or smell. 5) A person with a sad face and a red 'X' over their nose and mouth representing loss of taste or smell.

Cough, shortness of breath, or difficulty breathing

Fever or chills

Muscle or body aches

Vomiting or diarrhea



New loss of taste or smell

[cdc.gov/coronavirus](https://www.cdc.gov/coronavirus)

[Symptoms of COVID-19 \(Video\)](#)
Symptoms can include fever, cough and shortness of breath.

COVID-19 ASL Video Series

Symptoms of Coronavirus



[ASL Symptoms of Coronavirus \(Video\)](#)

More Information

- [People at Increased Risk](#)

- [Healthcare Professionals](#)

Last Updated Feb. 22, 2021

Attachment 4

Measures	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	TOTALS
<i>Primary Service: Public Hearing</i>	0	0	0	0	0	0	0	0	0	0	0	0	0
<i>Primary Service: Volunteer Coordination</i>	0	0	0	0	0	0	0	0	0	0	0	0	0
<i>Primary Service: Helpline - COVID Response</i>	0	0	0	0	0	0	0	0	0	0	0	0	0

Administrative and Reporting:

- Hiring process: Community Outreach & Administrative Specialist
 - Application period closed on 01/07/2022
 - Applications reviewed
 - Assembling interview panel and interview questions

- 2020 Departmental Scorecard update completed
 - Link to Scorecard: [Human Rights \(clearpointstrategy.com\)](https://clearpointstrategy.com)
 - Data for individual service satisfaction surveys from 2019 and 2020 entered.
 - Need to create and distribute collaborative partner satisfaction surveys
 - This may be something we have to develop in early 2022

- 2021 Departmental Scorecard update
 - Not yet initiated

- 2020 Annual Report
 - Still in progress
 - No requests from Council yet for annual or quarterly reports
 - No progress made on the report this month, as intake and service provision continue to dominate staff time

- 2021 Annual Report
 - Not yet initiated

- Amendments to Charlottesville Human Rights Ordinance for FHAP substantial equivalence under review
 - OHR Director met with Deputy City Attorney to review amendments and make further revisions
 - Pending follow up for HUD includes the following:
 - Clarifying the federal vs. state definitions and standards for reasonable vs. probable cause
 - Clarifying whether federal timeframes are business days or calendar days for continuity throughout ordinance
 - Clarifying whether housing enforcement procedures can include separate language that distinguishes “rendering a determination” vs. “filing a charge,” given that Council must pass the ordinance prior to HUD’s approval of FHAP status and likely before Council will fund adequate staffing in the City attorney’s office to accommodate filing civil actions
 - There is a clear need to think carefully about the staffing required in both the OHR and City Attorney’s Office and how that will be funded before we enter into the FHAP agreement

- No new work on FEPA agreement, as FHAP process take precedence
 - Recall that the FHAP agreement provides substantial opportunities and resources to expand and improve the OHR, whereas the FEPA really only just increases workload with insufficient support to increase staffing or training

Complaints pending authorization for further action:

- Case 2021-12
 - Housing discrimination on the basis of disability
 - Unable to reach complainant for additional information

Active Fact-finding Inquiries:

- None.

Active Investigations:

- Case 2020-2
 - Housing discrimination on the basis of race
 - Investigative Report submitted 9/2/2021
 - Inconclusive determination presented to Complainant on 12/1/2021
 - Awaiting response from DCM for REDI regarding follow-up meeting with Complainant
- Case 2021-4
 - Employment discrimination on the basis of sex
 - Investigation authorized 05-03-2021
 - Investigation in progress
- Case 2021-5
 - Employment discrimination on the basis of sexual orientation and race
 - Mediation at impasse
 - Formal investigation in progress

Pending Mediation:

- Case 2021-11
 - Housing discrimination on the basis of disability

Active Mediation:

- Case 2021-2
 - Employment discrimination on the basis of race

- Awaiting signature of Complainant on settlement agreement
- Case 2022-1
 - Housing discrimination on the basis of disability

Closed Cases CY2022:

- None.

Outreach:

- Service Provision
 - Most outreach on hold given staff capacity to address the overwhelming volume of active and incoming inquiries
 - Midway Manor
 - Property management and ownership has changed
 - New manager and owner have responded with intent to resolve resident concerns
 - OHR Director and others did follow-up outreach to residents on 2/11 and 2/15
 - Follow-up consisted of providing updates regarding actions to-date, providing a sign-on letter opportunity to request an in-person meeting between residents and property owners, and providing a template for a reasonable accommodation request letter to property owners for people with disabilities who seek a long-term resolution to the function of the elevators and intercom system.
- Education & Awareness
 - On hold due to staff capacity
- Facilitation & Leadership
 - Outdoor Equity
 - OHR Interns have consolidated the information for the presentation but now need guidance from OHR staff to assemble the final presentation
 - This project is on hold given other priorities
 - Piedmont Housing Alliance is holding another half day mobility summit and outdoor equity is a focus topic
 - OHR Director may sit on a panel as part of this summit
 - Public Housing Association of Residents – Residents for Respectful Research (RRR)
 - First three R3 Resident Reviewers have been hired and started Tuesday, 01/18/2022
 - The R3 Coordinator has developed a comprehensive onboarding and training curriculum for the Reviewers
 - OHR Director continues to serve on the advisory board to provide input and guidance, as requested
 - Affordable Housing
 - Thomas Jefferson Planning District Commission (TJPDC) awarded \$250K Virginia Eviction Reduction Program (VERP) implementation grant
 - OHR Director sits on advisory panel to the implementation grant
 - First quarter meeting March 30, 2022
 - Piedmont Housing Alliance has opened the Financial Opportunity Center and Housing Hub

- VERP funding to hire housing navigator and landlord relations coordinator
- UVA Equity Center Virginia Housing Justice Atlas Advisory Group
 - Multi-partner group working in collaboration with RVA Eviction Lab to collect data on evictions
 - May be a good source of information for future advocacy regarding right to counsel
- CRHA Resident Services Committee – Neighborhood Crisis Intervention sub committee
 - Continued monthly and sometimes bi-monthly meetings to develop a potential alternative, peer-supported crisis intervention system that can supplement and support clinical services and can intervene in lieu of ECO/TDO system
 - This continues to be a focal point for OHR Director engagement as many individuals seeking services through the OHR present with mental health challenges and some have come for assistance during mental health crises
- Homelessness Summit
 - DCM for REDI has been coordinating dialogue with service providers, community members, and City staff to address gaps in the homeless system of care
 - Next meeting March 4, 2022

Attachment 5

RULES AND PROCEDURES OF THE HUMAN RIGHTS COMMISSION
CITY OF CHARLOTTESVILLE, VIRGINIA

The Human Rights Commission, established pursuant to Article XV, Sections 2-430 to 2-443 of the Charlottesville City Code (the Charlottesville Human Rights Ordinance), hereby adopts the following rules and procedures for the execution of its duties and responsibilities thereunder:

1. Composition of the Human Rights Commission

1.1. The Commission membership shall consist of no less than nine members appointed by City Council, and shall be broadly representative of the City's population, with consideration of racial, gender (including gender identity, transgender status, and sexual orientation), religious, ethnic, disabled, socio-economic, geographic neighborhood and age groups within the City.

1.2 Of the members first appointed, at least three shall be appointed for terms of three years, at least three shall be appointed for terms of two years, and at least three shall be appointed for terms of one year. Thereafter members shall be appointed for terms of three years each. Despite the expiration of a member's term, the member shall continue to serve until a successor is appointed by City Council. Any vacancy during a term shall be filled by the City Council for the unexpired portion of that term. Following notice to the member, any member of the Commission may be removed for good cause by a majority vote of City Council.

1.3 Members of the Commission shall serve without compensation, but funds may be appropriated in the City's annual budget for reasonable and necessary expenses to be incurred by Commission in the conduct of its prescribed functions.

2. Officers and Duties

2.1 Officers. The officers of the Human Rights Commission shall be a Chair, a Vice Chair and a Secretary, who shall have the duties set forth below.

2.2 Duties of Officers.

(1) Chair. The Chair shall be elected from the Commission's membership. It shall be the duty of the Chair to execute all documents on behalf of the Commission, to act as liaison between the Commission and the Office of Human Rights and Director of the Human Rights Commission, to cause all resolutions, approvals and other actions of the Commission to be executed or carried out, to determine that all matters delegated to the Commission by state statute, city ordinance, or at the instance of the City Council are properly brought before the Commission.

(2) Vice Chair. The Vice Chair shall be elected from the Commission's membership, and shall exercise the powers and perform the duties of the Chair during the absence, disability or disqualification of the Chair.

(3) Secretary. The Director of the Human Rights Commission shall be the Secretary of the Commission. The Secretary shall not be a member of the Commission, and shall have no right to vote. It shall be the duty of the Secretary to keep minutes of the Commission's proceedings in accordance with the requirements of the Virginia Freedom of Information Act ("FOIA") and any other applicable provisions of law; to give notices required by law or these bylaws; to prepare, in consultation with the Chair, the agenda for all meetings of the Commission; to be custodian of and maintain the Commission's public records and other records, as required in the performance of its duties and functions; to inform the Commission of correspondence relating to the business of the Commission and to respond to such correspondence unless responsibility is otherwise assigned by the Chair; to act as liaison with the City Manager, City departments and agencies, and to execute on behalf of the Commission any documents requiring the signature of the Secretary. In the event the Secretary is absent from any meeting, the Chair presiding at the meeting shall designate an individual to perform the duties of Secretary for that meeting.

2.3 Terms and Vacancies. The term of office for the Chair and Vice Chair shall be for one year. The Chair shall be eligible for reappointment to no more than one additional one year term. Should any vacancy occur among the offices described above, the Commission shall fill that vacancy as promptly as practicable and the individual elected to such office shall serve for the unexpired term of that office.

2.4 Officer Elections Procedures. The Chair shall appoint a nominating committee of no less than three members of the Commission, who shall meet in October of each year to make recommended nominations for the offices of Chair and Vice Chair. The recommended slate will be presented to the full Commission at the December meeting. At the Commission's January meeting of each year, the officer election rules currently in place (attached) may be invoked by any member who wishes to make nominations in addition to the Nominating Committee's recommended slate.

3. Meetings

3.1 Annual Meetings. The Commission shall hold an annual organizational meeting, which shall take place during the first regular meeting of the Commission in the month of January of each year. At the organizational meeting, the members of the Commission shall elect officers, establish its regular meeting schedule, and adopt the work plan for the ensuing year. The Commission may also conduct such other business as shall be placed on the agenda in accordance with the provisions of these bylaws.

3.2 Regular Meetings. Regular meetings shall be held on the third Thursday of each month. The basic order of business will be as set forth in 4.3, following below.

3.3 Special Meetings. Special meetings may be called by the Chair, the Vice Chair in the absence of the Chair, or by any two members, upon written request to the Secretary.

3.4 Work Sessions. Work sessions are special meetings that may be held at the request of the Chair, or the Vice Chair in the absence of the Chair. Work sessions shall be held for the purpose of inquiry and discussion and no official action shall be taken at such meetings.

3.5 Public meetings; exceptions for Closed Sessions. Meetings of the Commission shall be open meetings, as that term is defined within FOIA, except that the Commission may hold closed meetings when authorized pursuant to Va. Code Section 2.2-3711, and upon compliance with the closed meeting procedures and certification requirements set forth within Va. Code Section 2.2-3712.

3.6 Notice of Meetings.

3.6.1. The Secretary shall give notice of all meetings (annual, regular, special and work session) to all members of the Commission, five days prior to such meeting, or, for a special meeting or work session, such other notice as is reasonable under the circumstances. Such notice shall state the time and place of such meetings. With respect to regular meetings and the annual meeting, such notice shall be accompanied by an agenda prepared in accordance with the provisions of these rules and procedures and accompanied by such documentation as may be reasonable to permit the members of the Commission to consider the business which they are called upon to act. With respect to work sessions and special meetings, the notice shall state the purpose of the meeting or the nature of the discussion or inquiry to be undertaken and shall be accompanied by such documentation as may be available and practicable to provide to enable the members of the Commission to thoughtfully consider the business to come before the meeting.

3.6.2. The Secretary shall place notice of the date, time and location of each Commission meeting in a prominent public location at which notices of City Council meetings are regularly posted, and shall also post such notice on the City's website. This public notice shall be posted at least three (3) working days prior to the meeting; however, notice of a special meeting or work session may be given upon fewer than 3 days' notice, if reasonable under the circumstances and if such notice is given contemporaneously with the notice provided to Commission members. At least one copy of all agenda packets and, unless a specific FOIA exemption applies, all materials furnished to Commission members for a meeting, shall be made available for public inspection in the office of the Director/ Secretary at the same time such documents are furnished to the Commission.

3.6.3. For the purposes of this section, and as used throughout these rules and procedures, the term “notice” shall mean and include any format within the definition of a “public record” set forth in FOIA, at Virginia Code Sec. 2.2-3701.

4. Conduct of Meetings.

4.1 Quorum. A majority of currently serving Commissioners (“quorum”) must be in attendance at a meeting of the Commission in order for business to be legally transacted. Except as expressly provided in Virginia Code Section 2.2-3708(G) or 2.2-3708.1, the Commission shall not conduct a meeting where its business is discussed or transacted through any means of communication where the members are not physically assembled.

4.2 Procedure. All meetings of the Commission shall be conducted in accordance with [Martha’s Rules of Order as amended and adopted by the Commission on February 20, 2020](#). ~~Roberts’ Rules of Order (Newly Revised) as applicable to small boards~~. The Chair of the Commission, or in his or her absence, the Vice Chair, or in the absence of both, the person having been designated by the Chair as parliamentarian shall preside at meetings of the Commission.

4.3 Proceedings. At any meeting of the Commission, the Commission may hear, review, discuss and act upon, and otherwise transact business related to, any matters within its role, and within the scope of its duties and responsibilities, as described within the Charlottesville Human Rights Ordinance. At any regular meeting and annual meeting of the Commission, the order of business to come before the meeting shall be as expressed on the agenda sent out with the notice of the meeting provided, however, the presiding officer, with the consensus or affirmative vote of a majority of the Commissioners, may change the order of business on the agenda for any reason, or may add a matter to the agenda.

4.4 Voting. All business transacted by the Commission shall be authorized by a vote of the majority of members present and voting taken at a lawful meeting conducted in accordance with these rules and procedures. At all meetings of the Commission, each member present shall be entitled to cast one vote providing there is a physical quorum. A decision on whether to hold a public hearing on a complaint of an unlawful discriminatory practice shall not be valid unless authorized by a majority of the full Commission members. No vote of the Commission shall be taken by secret or written ballot. A member may vote by telephone or other electronic communication means as expressly authorized by FOIA Section 2.2-3708.1.

4.5 Committees. The Commission may, in its discretion, delegate any of its duties or responsibilities to a panel of not less than three Commissioners. Any such panel shall constitute a committee of the Commission, which shall transact the delegated business of the Commission following the same rules, procedures and meeting requirements applicable to the Commission, except it shall not be authorized to vote on any matter. Rather, any such committee shall bring its recommendations to the full membership of the Commission for a vote in accordance with these rules. No such committee may include individuals who are not members of the

Commission; however, the Commission may appoint advisory committees or form task forces which may include individuals who are not members of the Commission.

4.5.1 Ad hoc Committees. The Chair may recommend the formation of Ad hoc Committees for the purpose of addressing specific issues of concern to the Commission or to develop and implement projects approved by the Commission. ~~Standing Committees. The following standing committees of the Commission have been formed by resolution in accordance with these rules and meet regularly as follows:-~~

~~Administrative Matters Committee~~

~~Community Engagement Committee~~

~~Age, Disability, and Religious Discrimination~~

~~Committee Race Discrimination Committee~~

~~Sex Discrimination Committee~~

The Chair of the Commission appoints members of each Ad hoc Committee ~~standing committee~~ and a Chair of each committee is selected from committee members. Commission staff is responsible for assisting Committee chairs with setting Committee meeting agendas and preparing Committee reports for presentation to the full Commission during its regular meetings.

5. Conflicts of Interest.

5.1 All members of the Human Rights Commission are subject to the Virginia State and Local Government Conflict of Interests Act (Va. Code 2.2-3100 et seq.) (“COIA”) and are required to read and familiarize themselves with the provisions of COIA.

5.1.1. In the event that any member shall have a “personal interest in a transaction” as defined by Va. Code Section 2.2-3101, in a matter before the Commission, the member shall be required to make a declaration of such interest before participating in the transaction, and the member may be required to disqualify himself from participating in the transaction. The member’s obligations in a given situation shall be determined in accordance with Va. Code Section 2.2-3112. It is the obligation of each member to ascertain whether he or she has a personal interest in a transaction, and to take action in accordance with Va. Code 2.2-3112 immediately upon concluding that a personal interest does exist; however, the issue of personal interests of a commission member may also be raised by other members or by individuals who are not members.

Any member of the Commission may request an advisory opinion from the Commonwealth's Attorney or the City Attorney or his or her representative, as to whether a personal interest exists and, if so, what are the Commissioner’s obligations under COIA. An opinion of the Commonwealth’s Attorney or the City Attorney shall have the effect specified in Va. Code Sec. 2.2-3121.

5.1.2. Every declaration and disqualification required pursuant to COIA shall be reflected in the public records of the Commission for a period of five (5) years, in the office of the Director/ Secretary.

5.1.3. In the event of a disqualification, the disqualified member shall be prohibited from (i) attending any portion of a closed meeting when the matter in which he or she has a personal interest is discussed, and (ii) discussing the matter in which he or she has a personal interest with other members of the Commission, with the Director, or with other officers or employees of the City government, at any time.

5.1.4. At all times, Commission members shall conduct themselves and the Commission's business in accordance with all applicable requirements of COIA, including those provisions not specifically referenced within these rules and procedures.

6. Community Participation

6.1 Public notice. Public notice of all meetings of the Commission will be provided as set forth in 3.6, above. In addition, the Commission may direct the Secretary to give additional or special notice, or advertise or announce specific matters before the Commission, as the Commission may deem appropriate.

6.2 Public Participation. At the beginning and at the end of each of its open meetings the Commission will receive public comment in accordance with City Council's "Rules for Public Participation," which Rules are hereby adopted and incorporated by reference within these rules and procedures, as rules of the Commission.

7. Amendments.

These bylaws, rules and procedures may be amended by vote of a majority of the Commission at any meeting provided, however, notice of such proposed amendment shall be given to each member of the Commission in writing at least five days prior to such meeting.

AMENDMENTS

**Charlottesville Human Rights Commission Policy on Individual Participation in Meetings by Electronic Means under §2.2-3708.1 of the Virginia Code
Administrative Policy No. 1: Approved May 21, 2015**

- I. **Policy Statement:** It is the policy of the Charlottesville Human Rights Commission (CHRC) that individual members of the CHRC may participate in meetings of the Commission by electronic means as permitted by Virginia Code §2.2-3708.1.

- II. **Eligibility:** This policy shall apply to the entire membership of the CHRC and without regard to the identity of the member requesting remote participation or the matter considered or voted on at the meeting.
 - A. **Emergency/Personal Absence:** Members unable to attend the meeting due to an emergency or personal matter qualify under this policy provided that the individual can identify with specificity the nature of the emergency or personal matter, the public body holding the meeting the meeting records in its minutes the nature of the emergency or personal matter, and the remote location from which the member participate is identified in the minutes.

 - B. **Disability Absence:** Members of a public body unable to attend the meeting due to a medical condition qualify under this policy provided that the individual notifies the chair of the public body that such member cannot attend a meeting due to a temporary or permanent disability or other medical condition that prevents the member's physical attendance, the public body records this, and the remote location from which the member participates is identified in the minutes.

- III. **Quorum Required:** Whenever an individual member wishes to participate from a remote location, a quorum of the CHRC must be physically assembled at the meeting location, and arrangements will be made for the voice of the remote participant to be heard by all persons at the meeting location.

- IV. **Meeting Procedures:** The reason that the member cannot attend the meeting and the remote location from which the member participates will be recorded in the meeting minutes. When such individual participation is due to an emergency or personal matter as designated in section II A above, such participation is limited to two meetings or 25 percent of the meetings of the CHRC per member each calendar year, whichever is fewer.

- V. **Approval Process:** Individual participation from a remote location shall be approved by the Chair of the CHRC, unless such participation would violate this policy or the Virginia Freedom of Information Act (FOIA).

- VI. **Challenges:** If a member’s participation from a remote location is challenged, then the Commission members present shall vote whether to allow such participation. If the commission votes to disapprove the member’s participation because such participation would violate this policy, such disapproval will be recorded in the minutes with specificity.

- VII. **General Applicability to Committees:** This policy applies to all committees, subcommittees, and task forces of the CHRC. Where remote participation occurs at a sub-committee or task force the chair of such committee shall assume responsibility for the approval process.

Election of the Chair and Vice-Chair
Adopted March 20, 2014

The Human Rights Commission Rules and Procedures (2.2) provide that a Chair and Vice-Chair shall be annually elected. This is to set forth the customary procedure as modified from the 2013 City Attorney memo regarding the election of Mayor and Vice-Mayor for the City of Charlottesville.

1. The Director will Chair the meeting during the officer elections process.
2. The Director will ask for nominations for the Office of Chair.
3. Only names that are moved and seconded will be placed in nomination. Any Commission member may move or second his or her own name.
4. After one or more persons are nominated and it appears that no one else wishes to make a nomination, the Director will ask if there are any further nominations. If there are no responses, the Director will declare that nominations for the Office of Chair are closed.
5. Commissioners will then vote on the first person nominated for the Office of Chair. A Commission member who is nominated may vote for himself or herself.
6. If a majority of those present and voting affirmatively vote for the first candidate, that person is elected Chair and there is no further voting. If the first candidate does not receive a majority, the Commission will then vote on the second person nominated. If no nominee receives a majority, there will need to be a motion, second and vote on reopening nominations.
7. After a Commissioner is elected as Chair, the same procedure will be followed for the election of Vice-Chair. Following the election of the Vice-Chair, the newly-elected Chair will chair the remainder of the meeting.

Martha's Rules of Order
As adopted by the HRC on February 20, 2020

1. The proposal is presented. Clarifying questions are taken.
 - a. Proposal should always be in writing.
2. Friendly amendments are offered. Discussion is allowed only on the amendments.
 - a. Amendments should be prepared in advance when possible.
3. Speakers in favor of the proposal present their views.
 - a. This is not a time for debate.
 - b. Time limits should be set and enforced.
4. Speakers in opposition to the proposal present their views.
 - a. This is not a time for debate.
 - b. Time limits should be set and enforced.
5. General discussion and/or debate OR small group discussion time on the proposal is allowed.
 - a. Time limit on discussion is set by the group.
 - b. Facilitator helps group identify key issues.
 - c. Motion to table or refer is in order and requires $\frac{3}{4}$ vote.
6. First vote is taken.
 - a. People vote
 - i. In favor of the proposal, or
 - ii. Can live with the proposal, or
 - iii. Opposed to the proposal.
 - b. If a majority of those present votes "in favor" or "can live with," proceed to Step 8.
 - c. If less than a majority of those present votes "in favor" or "can live with," proposal dies.
7. Those voting in opposition are allowed to state their objections and concerns.
 - a. No discussion is allowed, only clarifying questions.
8. The second vote is taken as in Step 6.
 - a. It takes a majority of those present to override objections and pass the proposal.

Attachment 6

The Charlottesville Human Rights Commission and The Public Housing Association of Residents (PHAR) invite you to a public discussion about the current state of public and subsidized housing in Charlottesville.

When

Tuesday, February 22, at 6:00 pm

Where

This virtual public meeting will be hosted on Zoom by the City of Charlottesville. You can register for this meeting by visiting the webpage below and selecting this meeting from the list of upcoming meetings:

charlottesville.gov/zoom

You can also use the QR Code below to access a direct registration link for the meeting:

