

COVID-19 Interim Testing Recommendations: Congregate Settings for People Experiencing Homelessness and Individuals and Families Residing in Emergency Shelters

INTERIM GUIDANCE

As congregate living settings, shelters and encampments are environments that can lead to rapid and widespread transmission of SARS-CoV-2, the virus that causes COVID-19. Additionally, widespread community transmission and movement of staff and guests¹ in and out of a facility or an encampment results in a continuous risk of the introduction of SARS-CoV-2. Reverse transcription polymerase chain reaction (RT-PCR) testing is used to detect SARS-CoV-2. This testing is important to determine the scope and magnitude of COVID-19 outbreaks and to inform outbreak response interventions designed to further limit transmission. This document refers only to RT-PCR testing, which detects the nucleic acid from SARS-CoV-2 virus, not other antigen tests or antibody tests.

Reports from homeless shelters in other states suggest that when symptomatic staff or guests with confirmed COVID-19 are identified, asymptomatic guests and staff often test positive as well.² Point prevalence surveys in homeless shelters as well as nursing homes and correctional facilities, different types of congregate living settings, have reported similar findings.^{3,4} Testing is one component of a broad-based response plan that includes implementing various mitigation strategies, infection prevention and control measures, plans for isolation and quarantine of guests, guest and staff health

¹ For the purpose of this guidance, all shelter guests, people experiencing homelessness, and individuals residing in encampments are referred to as “guests.” This guidance covers both homeless settings and other emergency shelter settings.

² Mosites E, Parker EM, Clarke KE, et al. Assessment of SARS-CoV-2 Infection Prevalence in Homeless Shelters — Four U.S. Cities, March 27–April 15, 2020. *MMWR Morb Mortal Wkly Rep* 2020;69:521–522. DOI: <http://dx.doi.org/10.15585/mmwr.mm6917e1>

³ Wallace M, Marlow M, Simonson S, et al. Public Health Response to COVID-19 Cases in Correctional and Detention Facilities — Louisiana, March–April 2020. *MMWR Morb Mortal Wkly Rep* 2020;69:594–598. DOI: <http://dx.doi.org/10.15585/mmwr.mm6919e3>

⁴ Arons, M.M., K.M. Hatfield, S.C. Reddy et al. Presymptomatic SARS-CoV-2 Infections and Transmission in a Skilled Nursing Facility. *NEJM*. Apr 24, 2020. DOI: 10.1056/NEJMoa2008457

screening, exclusion of ill staff, and planning for staffing surge capacity in case of staff shortages. All of these other considerations must be in place for effectively applying testing to reduce transmission.

While this guidance largely focuses on congregate shelters and encampments, the Minnesota Department of Health (MDH) recognizes that some transitional and supportive housing settings serving people currently experiencing or those who have experienced homelessness have congregate setting features (compared to non-congregate apartment living that would be considered a private residence in terms of the COVID response). In such settings, the guidance in this document may apply.

COVID-19 Testing Key Points

- It is currently unknown if entry testing for homeless service sites, shelters, and encampments as an isolated strategy provides any reduction in person-to-person transmission of SARS-CoV-2. **Therefore, MDH and the CDC do not recommend entry testing for shelters, homeless service sites, and encampments.** Settings should continue to implement and enforce other infection preventive strategies such as physical distancing, source control (cloth face coverings), hand washing, and enhanced cleaning and disinfection.
- All symptomatic individuals and staff⁵ in shelters and encampments should be promptly excluded from work (if employee), isolated (if guest), and tested for SARS-CoV-2 by RT-PCR. Testing of asymptomatic guests and staff is recommended in specific circumstances.
- Facilities should initiate response actions such as isolation of guests and quarantine of their close contacts, and work exclusion of infected staff members and quarantine of their close contacts, when they receive a SARS-CoV-2 positive RT-PCR-result. Settings must quickly respond to positive laboratory results. When testing occurs in an encampment rather than a facility, the local municipality is responsible for responding to testing results. Local municipalities are also responsible for providing options for isolation (and transportation to isolation).
- On July 22, 2020, CDC released updated guidance on the [Duration of Isolation and Precautions for Adults with COVID-19 \(www.cdc.gov/coronavirus/2019-ncov/hcp/duration-isolation.html\)](https://www.cdc.gov/coronavirus/2019-ncov/hcp/duration-isolation.html), including a recommendation that retesting for previously lab-confirmed COVID-19 cases is not recommended within the first three months after the onset date of initial COVID-19 infection or test date for individuals who were asymptomatic at their time of testing. As such, people who have been lab-confirmed COVID-19 positive within 90 days of a point prevalence study (PPS) do not need to be tested as part of that PPS.

 - For persons who develop new symptoms consistent with COVID-19 during the three months after the date of initial symptom onset, for whom an alternative etiology cannot be diagnosed or identified, retesting might be warranted and that person and their provider should consult with an infection control or infectious disease expert.
- A single negative SARS-CoV-2 RT-PCR-result indicates that an individual did not have detectable virus material present at the time of testing, and repeat testing will be needed if the individual develops symptoms compatible with COVID-19 or has persistent symptoms compatible with COVID-19 without another identified etiology.

⁵ Staff includes outreach providers as well as shelter staff and volunteers.

- Point-in-time testing can provide a snapshot of infection burden across a setting, but repeat testing over time is needed to monitor the spread of infection.
- Strategies for SARS-CoV-2 testing: Symptomatic only, symptomatic and targeted asymptomatic, or setting-wide testing should be developed with consideration of how laboratory results will inform the public health response. **Testing is recommended for all close contacts of persons with SARS-CoV-2 infection, regardless of the presence of symptoms.** The public health response following setting-wide testing will depend on availability of isolation space, acceptability of isolation space to the community being tested, and capacity for the setting or municipality to implement the isolation strategy along with the additional supports needed (staffing, food, toileting, handwashing) depending on the configuration of the isolation space.
 - More information on close contacts can be found at [CDC: Health Departments: Interim Guidance on Developing a COVID-19 Case Investigation & Contact Tracing Plan: Overview \(www.cdc.gov/coronavirus/2019-ncov/php/contact-tracing/contact-tracing-plan/overview.html\)](https://www.cdc.gov/coronavirus/2019-ncov/php/contact-tracing/contact-tracing-plan/overview.html).
- Setting-wide guest and staff testing can be used to inform response but should not be used as a singular strategy. Preparations should be made for the potential impact on staffing levels, the need for isolation space, need for enhanced mitigation strategies, and communication with guests, families, and staff.
- Testing does not replace robust mitigation or infection control strategies.

The goal of this guidance is to reduce SARS-CoV-2 transmission and death related to COVID-19 in shelter and encampment settings.

Specimen Collection

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

Specimen Type

Nasopharyngeal (NP) and nasal swabs are recommended specimen types for COVID-19 testing. However, nasal swabs are preferred for testing in these settings, given the discomfort associated with NP swab collection and the growing evidence that viral load in the nasal cavity is likely sufficient for detection. Use of nasal swabs will facilitate compliance with the repeated testing approaches described in this document. Use of self-collected nasal swabs under observation by clinical staff might be feasible and appropriate. Nasal swabbing of employees can be conducted by clinical staff or by self-swab. Place swab in a sterile tube containing acceptable transport media and store at refrigeration temperature before transporting to the laboratory for testing.

PPE Use and Infection Prevention and Control during Specimen Collection

When collecting diagnostic respiratory specimens from a person with possible COVID-19, consider the following:

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

Testing of Individual Guests

Testing of Symptomatic Guests

Guests presenting with any of the following symptoms should be immediately isolated and tested: fever ($\geq 100.0^{\circ}\text{F}$ or subjective), cough, shortness of breath, chills, headache, muscle pain, sore throat, or new loss of taste or smell. Further evaluation should also be considered for lower temperatures ($< 100.0^{\circ}\text{F}$) or other symptoms not attributable to another diagnosis, including nausea, vomiting, diarrhea, abdominal pain, runny nose, and fatigue. Educate guests on the symptoms of COVID-19 and how to report symptoms to shelter staff or outreach providers.

Testing of Asymptomatic Quarantined Guests

MDH and CDC recommend a 14-day quarantine for individuals who are contacts of confirmed or suspected COVID-19 cases.

Individuals under quarantine should be monitored for symptoms twice daily. Symptomatic guests should be immediately isolated and offered COVID-19 testing.

Asymptomatic quarantined guests should be tested for SARS-CoV-2. Testing should not happen within the first five days following last exposure (if asymptomatic). MDH recommends considering a testing schedule of day 7 or day 12. Asymptomatic guests who test positive for COVID-19 should be moved to isolation.

Transportation to Testing

If symptomatic guests need to go to a drive-through testing site or clinic, [MDH: Interim Guidance for Facilities Providing Non-Emergency Transportation Services during COVID-19](#) (www.health.state.mn.us/diseases/coronavirus/guidetransport.pdf) provides information that may reduce transmission from passengers with known or suspected COVID-19 to others before, during, and after they are transported in a private vehicle.

MDH recommends that shelters and outreach providers work with their local public health departments and local health care systems to arrange for mobile specimen collection (swabbing) if possible to reduce the risk of transmission during transport. MDH is available to assist in coordinating mobile specimen collection: contact Health.R-Congregate@state.mn.us.

Testing of Individual Staff and Volunteers

Testing of Symptomatic Staff and Volunteers

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

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

Testing of Asymptomatic Staff and Volunteers

Staff and volunteers identified as a contact of a COVID-19 case should be excluded from work for 14 days and self-monitor for symptoms. This includes staff and volunteers who were exposed to a case in their household, the community, or within the workplace. Contact MDH for guidance if critical staffing shortages arise and exposed employees must continue to work. More information is available here:

[MDH: COVID-19 Recommendations for Critical Infrastructure Businesses and Industries \(www.health.state.mn.us/diseases/coronavirus/guidebusiessential.pdf\)](https://www.health.state.mn.us/diseases/coronavirus/guidebusiessential.pdf).

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

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

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

Population-based Testing to Interrupt Transmission and Guide Cohorting

Testing Across Living Settings: Point Prevalence Survey

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

A PPS must include both guests and staff, because each of these groups is a key factor in transmission within a setting. Reminder: People with previously diagnosed COVID-19 do not need to be retested within 90 days of their initial symptom onset or test date (if asymptomatic at the time of testing). If undertaking setting-wide PPS, leadership or local public health must be prepared for the likely detection of multiple asymptomatic guests who test positive for SARS-CoV-2. Plans should be made to provide staff with appropriate PPE to care for all COVID-19-positive guests and training in PPE use, donning, and doffing. Facilities should also consider cohorting COVID-19-positive guests onsite, or identify a plan for off-site isolation in partnership with their local public health department. When planning for isolation, settings should consider scenarios with a small number of cases and a scenario of 10 or more cases. Facilities should prepare for potential short-term staffing shortages that result from detection of positive staff members. Staff with COVID-19 must stay out of work for a minimum of 10 days after onset of symptoms, and a minimum of 10 days after the date of testing, if asymptomatic. Situations in which it is appropriate to conduct setting-wide testing of guests and staff include, but are not limited to:

- Two or more guests or staff are confirmed to have COVID-19 within a 72-hour period
- Four or more individuals present with COVID-compatible symptoms within a 72-hour period.
- A staff member tests positive for COVID-19 and worked in the setting while ill, worked in the 48 hours prior to developing symptoms, or worked in the 48 hours prior to testing (if asymptomatic) **and** had close contact with other staff or guests.
- If testing resources allow, a PPS might be warranted in a setting with no known COVID-19-positive guests or staff if the setting is considered at high risk (e.g., shared staff with a COVID-19-positive setting) to provide situational awareness in the setting and potentially identify asymptomatic cases early.

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

- If no cases are identified, facilities should ensure that any quarantined guests are tested on quarantine day 12, according to the above guidance, and can consider future PPS testing when criteria are met.
- Although there is no period of time when one can be guaranteed not to miss infected individuals, MDH recommends that a setting consider repeating the PPS after 7 days if cases are identified.
- Facilities may consider limiting the repeat PPS to specific units where cases were identified.

- As additional positive guests are detected during each PPS round, they should be immediately identified for isolation and their contacts identified for quarantine (if guests) or work exclusion/home isolation or quarantine (if staff).
- The setting should continue to repeat PPS until a minimum of two rounds return no new positive residents.
- The interval between repeated PPS might be longer or shorter, depending on the settings population changes (e.g., frequency of new intakes) and current lab/testing capacity.
- Retest anyone who was previously negative but developed symptoms regardless of when the next PPS test interval is scheduled.
- As more data become available, MDH will update recommendations, if appropriate.

Because of ongoing community transmission in Minnesota, there will be a need for ongoing testing. Because staff and guests move in and out of settings, the risk of introducing COVID-19 will continue to be present.

Testing of Units or Individual Buildings

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

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

Cohorting COVID-19 Cases

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

Isolation Space Considerations

The COVID-19 isolation unit should have dedicated bathrooms, entrances, or elevators, depending on the configuration of space, and there should be no mixing of the isolation population with any other shelter populations. Considerations of chemical dependency or other needs (e.g. pets) should be factored into an isolation design to minimize contact with other shelter populations, while encouraging adherence to isolation. Any shared space used by those in isolation should be thoroughly cleaned and disinfected before use by any other group.

Isolation spaces can be a congregate setting with many beds per room. An advantage of such a design is the economy of scale with regard to delivery of food and services. Other patients may prefer other settings, such as safe camping isolation sites. Identifying isolation space options that meet the needs of

the patient community will contribute to isolation adherence and help to reduce further spread of COVID-19.

If isolating onsite is not possible, local municipalities will need to consider transportation to and from the isolation site in their planning.

MDH recommends working with local outreach providers to receive direct input from persons experiencing homelessness to learn what spaces for isolation may be the most preferable and most likely to be acceptable to individuals for whom isolation is indicated.

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

Other General Recommendations

- Because the PPS approach involves a significant amount of coordination and logistical support, it is important to have a clear plan for all aspects of the PPS:
 - Communication with staff, guests, their families, and possibly the public
 - Logistics of specimen collection, transport to reference laboratory, and reporting back results to staff and guests
 - Medical monitoring of positive guests
 - Staff training on use of PPE
 - Points of contact at MDH, local public health, and the setting for ongoing communication around public health recommendations and future testing guidance.
- Maintain a very low threshold for testing of symptomatic guests and staff.
- Use a line list to track guests and staff with signs and symptoms consistent with COVID-19, dates of symptom onset, test dates, and results.
- Report to MDH:
 - Guests hospitalized for severe respiratory infection without an identified cause
 - Sudden death of a guest not attributable to a known cause
 - Clusters of ≥ 2 guests and/or staff with respiratory symptoms or with known or suspected COVID-19
 - Individual guests or staff identified with confirmed or suspected COVID-19
- Do not allow staff who test positive for COVID-19 to work in any area of the settings and base their return to work on guidance available in [MDH: Guidance for Work Exclusion of Homeless Service Providers Exposed to a Suspected or Confirmed COVID-19 Case \(www.health.state.mn.us/diseases/coronavirus/homelessassess.pdf\)](http://www.health.state.mn.us/diseases/coronavirus/homelessassess.pdf).



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