COVID-19 Testing: Congregate Settings for People Experiencing Homelessness or Living in Emergency Shelters

INTERIM TESTING RECOMMENDATIONS

2/2/2021

Supervised group living settings, shelters, and encampments are environments that can lead to rapid and broad spread of SARS-CoV-2, the virus that causes COVID-19. Additionally, broad community spread and movement of staff and guests in and out of a facility or an encampment results in a continuous risk of introducing SARS-CoV-2. For the purpose of this guidance, all people staying in shelters, experiencing homelessness, or living in encampments are referred to as “guests.” This guidance covers both homeless and other emergency shelter settings.

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

Reverse transcription polymerase chain reaction (RT-PCR) testing is used to detect SARS-CoV-2. This testing is important to learn the scope and size of COVID-19 outbreaks and to guide actions to further limit the spread. This document refers only to RT-PCR testing, which detects the nucleic acid from SARS-CoV-2 virus. It does not refer to other antigen tests or antibody tests.

When staff or guests with confirmed or symptoms of COVID-19 are identified in a setting, guests and staff without symptoms often test positive as well, as suggested by reports from homeless shelters in other states.1 Similar findings2,3 are reported when point prevalence surveys are done in homeless

COVID-19 testing recommendations for shelters and encampments

shelters, nursing homes, correctional facilities, and other types of supervised group living settings. This type of testing identifies the number of people with a disease or condition at a specific point in time.

Testing is one part of a broad-based response to prevent and control infections. Other measures include a range of strategies for isolating and quarantining guests, doing guest and staff health screenings, excluding ill staff, and planning for staffing surge capacity in case of staff shortages. All of these other measures must be in place to apply testing effectively and to reduce the spread.

This guidance largely focuses on supervised group (congregate) shelters and encampments. However, the Minnesota Department of Health (MDH) recognizes that some other settings may also have similar features, such as transitional and supportive housing settings that serve people who have and are currently experiencing homelessness. Guidance in this document may apply to these settings as well. It does not apply to non-congregate apartment living, which would be considered private residences in terms of the COVID-19 response.

COVID-19 testing key points

- It is currently unknown if entry testing as an isolated strategy provides any reduction in person-to-person spread of SARS-CoV-2 for homeless service sites, shelters, and encampments. Therefore, MDH and the CDC do not recommend requiring entry testing for shelters, homeless service sites, and encampments. Settings should continue to apply and enforce other infection prevention strategies, such as symptom screening, physical distancing, source control (cloth face coverings), hand washing, and enhanced cleaning and disinfection.

- Promptly exclude shelter and encampment staff from work and isolate guests who have symptoms, and test for SARS-CoV-2 by RT-PCR. Staff includes outreach providers, shelter staff, and volunteers.

- Facilities should start response actions when they receive a SARS-CoV-2 positive RT-PCR-result. These actions include isolating guests, excluding infected staff members from work, and putting close contacts in quarantine. Settings must respond quickly 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 for transportation to isolation.

- CDC released updated guidance July 22, 2020, on the Duration of Isolation and Precautions for Adults with COVID-19 (www.cdc.gov/coronavirus/2019-ncov/hcp/duration-isolation.html). It also recommends against retesting people who previously had lab-confirmed COVID-19 within three months of the start of the initial COVID-19 infection or of the test date if the person did not have symptoms at the time they were tested. This means people who had a lab-confirmed COVID-19 infection within the last 90 days do not need to be tested as part of a point prevalence survey.

- If such a person shows symptoms during this 90-day period, and an evaluation fails to identify a diagnosis other than SARS-CoV-2 infection (e.g., influenza), then the person may warrant evaluation for SARS-CoV-2 reinfection, in consultation with an infectious disease or infection control expert. Isolation may be warranted during this evaluation, particularly if symptoms developed after close contact with an infected person.
A single negative SARS-CoV-2 RT-PCR-result indicates that a person did not have detectable virus material present at the time of testing, and repeat testing will be needed if the person develops symptoms of COVID-19 or has persistent symptoms of COVID-19 without another identified diagnosis.

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 for how laboratory results will inform the public health response. **Testing is recommended five to seven days after exposure 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; how acceptable the isolation space is to the community being tested; capacity for the setting or municipality to carry out the isolation strategy; the configuration of the isolation space; and other supports, such as staffing, food, toileting, and handwashing.


Setting-wide guest and staff testing can be used to help plan levels of a response to COVID-19, but should not be used as the only strategy. Preparations should be made for the potential impact on staffing levels, available isolation space, and communication with guests, families, and staff. Consider enhanced actions that may be needed to reduce the spread of disease.

Testing does not replace robust mitigation or infection control strategies.

**Specimen collection**


**Specimen type**

Nasopharyngeal 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 nasopharyngeal swab collection and the growing evidence that viral load in the nasal cavity is likely sufficient for detection. Accordingly, nasal swabs may be an appropriate alternative, particularly for repeated testing. Nasal swabbing of employees can be done by clinical staff or by self-swab. After swabbing is complete, place the swab in a sterile tube containing acceptable transport media and store at refrigeration temperature before transporting to the laboratory for testing.

New methods for testing include the use of saliva testing. Antigen tests are an area of active study.
Infection prevention and control during specimen collection

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

- Collection should be performed in a medical isolation space or other designated space, with the door closed.
- Staff in the room should wear a surgical facemask, or N95 respirator if available; eye protection; gloves; and a gown. If respirator supplies are limited, 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 individual guests

Testing symptomatic guests

Guests presenting with any symptoms compatible with COVID-19 should be isolated and offered testing. Further evaluation should also be considered for those with temperatures of less than 100.0 degrees Fahrenheit or with 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 asymptomatic close contacts

MDH and CDC recommend testing asymptomatic close contacts of someone with lab-confirmed COVID-19. MDH recommends considering a testing schedule any time after day five of first exposure. Guests without symptoms who test positive for COVID-19 should be moved to isolation.

Transportation to testing

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, if possible, to reduce the risk of transmission during transportation to testing. MDH is available to assist in coordinating mobile specimen collection: contact Health.R-Congregate@state.mn.us.

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

Testing symptomatic staff and volunteers

Active screening should be done for all staff and volunteers when reporting to work. This means someone asking staff if they have any symptoms or have any known exposure. This includes active assessment for fever (temperature higher than 100.0 degrees Fahrenheit, or subjective); cough; shortness of breath; chills; headache; muscle pain; sore throat; or new loss of taste or smell. Consider further evaluation for any new chills or subjective fever, or other symptoms not attributable to another diagnosis, including nausea; vomiting; diarrhea; abdominal pain; runny nose; and fatigue. Staff and volunteers at supervised group 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 to get tested for COVID-19. Symptomatic staff awaiting COVID-19 test results should not work.

Testing asymptomatic staff and volunteers

Staff and volunteers identified as a contact of someone with lab-confirmed COVID-19 should be excluded from work for 14 days and self-monitor for symptoms. This includes staff and volunteers who were exposed to someone with confirmed COVID-19 in their household, the community, or within the workplace. Contact MDH for guidance and access to staffing resources if critical staffing shortages arise and exposed employees must continue to work.

- Staff and volunteers excluded from work due to contact with someone with lab-confirmed COVID-19 are advised to test any time after day 5 following exposure.

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 staff and volunteers with symptoms.

Population-based testing

Testing across living settings: Point prevalence survey

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

A point prevalence survey must include both guests and staff, because each of these groups is a key factor in spreading COVID-19 within a setting. Not every individual on-site may agree to get tested, which is expected; the intent is to offer testing to anyone who might have been exposed.

People with previously diagnosed COVID-19 do not need to be retested within 90 days of the start of their symptoms or of a test date if they had no symptoms at the time of testing. If doing setting-wide testing, 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 masks and other personal protective equipment needed to care for all guests who test positive for COVID-19, and to provide training in putting on, taking off, and wearing masks and other personal protective equipment. Facilities should also consider grouping COVID-19-positive guests on-site, or have a plan for off-site isolation, in partnership with their local public health department.

When planning for isolation, settings should consider scenarios for a small number of people and for numbers of 10 or more. Facilities should prepare for potential short-term staffing shortages that result from detection of staff members who test positive. Staff with COVID-19 must stay out of work for a minimum of 10 days after the start of symptoms, or a minimum of 10 days after the date of testing if they had no symptoms when tested.

Situations in which it is appropriate to do setting-wide testing of guests and staff include, but are not limited to:

- A single guest or staff member with multiple exposures to others on-site is confirmed to have COVID-19.
- Two or more guests or staff are confirmed to have COVID-19 within a 72-hour period.
- Four of more people have symptoms of COVID-19 within a 72-hour period.
- A staff member who had close contact with other staff or guests tests positive for COVID-19 and worked in the setting while ill, or worked in the 48 hours prior to getting symptoms or in the 48 hours prior to testing if they did not have symptoms.
- When community spread is uncontrolled and impacts to the homeless service system is significant, testing may be considered without testing triggers listed above if the settings are:
  - Larger shelters that have group, rather than individual rooms.
  - Facilities that are connected to other community settings and shelters and an outbreak that is undetected or detected late contributes to the spread of COVID-19 across a network of programs.

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

- Even if no cases are identified, a facility may consider additional testing, depending on the size of the initial cluster and the number of people believed to have been exposed.
- Although there is no period of time when one can be guaranteed not to miss infected individuals, MDH recommends that a setting consider repeating a point prevalence survey after seven days, if cases are identified.
- If there is an active outbreak with a significant number of people testing positive, testing at shorter intervals may be indicated to identify those who are infected in a timely manner and to move them to isolation.
- Facilities may consider limiting the repeat point prevalence survey to specific units where COVID-19 infections were identified.
- As additional guests test positive for COVID-19 in each round of testing, they should be immediately identified for isolation. Their contacts who are also guests should be identified for quarantine and contacts who are staff should be identified for work exclusion/home isolation or quarantine.
  - While the CDC has provided an option for shortened quarantine for some settings, **MDH guidance for shelters and homeless service settings remains unchanged.** A 14-day quarantine period is recommended for people who live in congregate settings and a 14-day work exclusion for those who work in congregate settings.
- The setting should continue to repeat point prevalence surveys until transmission is under control.
- The interval between repeated surveys may be longer or shorter, depending on the setting’s 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 round of testing is scheduled.
- As more data becomes available, MDH will update recommendations, if appropriate.

**Testing units or individual buildings**

Based on the situation, testing specific units or floors of buildings may be indicated (e.g., limiting testing to a person’s social circle/physical environment). If guests or staff with COVID-19 are identified, consider expanding the point prevalence survey to additional units. Facilities should consult with MDH when testing capacity is a concern.

**Grouping people with COVID-19**

If the number of COVID-19 cases exceeds available individual isolation space, grouping guests should be done to separate those who have tested positive for COVID-19 from those who have no symptoms or who have tested negative. Because of the potential for infection without symptoms, testing should be used to guide how people are grouped. Anyone who has tested positive for COVID-19 may be grouped only with others who have tested positive.
Isolation space considerations

The COVID-19 isolation unit should have dedicated bathrooms, entrances, or elevators, depending on the configuration of space. People in an isolation group should not be mixed with people in any other groups. Considerations of chemical dependency or other needs (e.g., pets) should be factored into an isolation design to minimize contact among different shelter populations, while still encouraging isolation. Any shared space used by those in isolation should be thoroughly cleaned and disinfected before use by any other group.

Those without symptoms who test positive in a point prevalence survey should not be isolated with people who have symptoms. People with symptoms who test positive can isolate together as a group.

Isolation spaces can be a group 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 people may prefer other settings, such as safe isolation camping sites. Identifying isolation space options that meet the needs of the people involved will contribute to them staying in isolation, which will help to reduce further spread of COVID-19.

If isolating on-site is not possible, local municipality planning will need to include transportation to and from the isolation.

MDH recommends working with local outreach providers to get direct input from people experiencing homelessness about what spaces they would prefer and would most likely accept if isolation is necessary.

To minimize the risk of spreading COVID-19, staff working in a COVID-19 unit should be dedicated to that unit and not assigned to work in other areas. These staff should be trained in and have access to appropriate personal protective equipment.

Other general recommendations

- Because the point prevalence survey approach involves a significant amount of coordination and logistical support, it is important to have a clear plan for all aspects of the survey:
  - Communication with staff, guests, and possibly the public.
  - Logistics of specimen collection, transport to a reference laboratory, and reporting back results to staff and guests.
  - Medical monitoring of guests who test positive.
  - Training staff to use personal protective equipment.
  - 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 guests and staff who have symptoms.
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- Use a list to track guests and staff with signs and symptoms of COVID-19, dates that symptoms started, 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 more than two guests and/or staff with symptoms of COVID-19.
  - Individual guests or staff identified with confirmed or suspected COVID-19.