COVID-19

Interim Guidance for SARS-CoV-2 Testing in Homeless Shelters and Encampments

Updated Feb. 10, 2022

Summary of Recent Changes

Updates as of February 10, 2022

- Updated information on quarantine and isolation for staff and clients of homeless service sites.

View Previous Updates

Key points

- Testing for Severe Acute Respiratory Coronavirus-2 (SARS-CoV-2) is an important outbreak prevention measure in homeless shelters and encampments.
- Diagnostic testing, including close contacts of known COVID-19 cases, and screening testing are important in combination to stop the spread of COVD-19.
- Supportive services may be needed when isolation is required for people experiencing homelessness.
- The level of community transmission can inform testing approaches in homeless shelters and encampments.

Note: This document is intended to provide considerations on the appropriate use of testing and does not dictate the determination of payment decisions or insurance coverage of such testing, except as may be otherwise referenced (or prescribed) by another entity or federal or state agency. CDC is a non-regulatory agency; therefore, the information in this document is meant to assist health departments and homeless service providers in making decisions rather than establishing regulatory requirements. This guidance does not replace any applicable federal, state, Tribal, local, or territorial health and safety laws, rules, and regulations. This guidance has been developed based on what is currently known about SARS-CoV-2 infection and COVID-19 and is subject to change as additional information becomes available.

Introduction

This document describes SARS-CoV-2 testing strategies for homeless shelters and encampments. Many persons experiencing homelessness are older adults and people with underlying medical conditions that put them at higher risk for severe COVID-19 illness. Testing should be used in conjunction with other COVID-19 prevention strategies by homeless service provider sites. Testing results should not be a barrier to accessing homeless services. SARS-CoV-2 testing should not be a pre-requisite for entrance to homeless service sites unless directed by state or local health authorities.

Any time a person tests positive for SARS-CoV-2, ensure that the individual is rapidly and appropriately notified, separated from others, provided appropriate medical care, and linked to appropriate alternative housing for isolation as necessary. Please review guidance for responding to COVID-19 cases at homeless shelters to identify close contacts of the person with the positive test. Testing procedures should protect privacy and confidentiality consistent with applicable laws and regulations. The purpose and process of the testing should be clearly communicated to clients and staff at the homeless service site. To understand the guidance that follows, please review:

- Guidance from the Equal Employment Opportunity Commission on offering testing to staff.
- Safety procedures for performing broad-based testing for SARS-CoV-2 in congregate settings.
- Categories of tests for SARS-CoV-2 for information on NAAT and antigen (or serology) tests.

Considerations when testing

SARS-CoV-2 testing may be incorporated as part of a comprehensive approach to reducing transmission. Symptom screening, testing, and contact tracing are strategies to identify people infected with SARS-CoV-2 so that actions can be taken to slow and stop the spread of the virus.

People undergoing testing should receive clear information on

- The manufacturer and name of the test, the type of test, the purpose of the test, the performance specifications of the test, any limitations associated with the test, who will pay for the test, how the test will be performed, how and when they will receive test results, and
- How to understand what the results mean, actions associated with negative or positive results, the difference between testing for workplace screening versus for medical diagnosis, who will receive the results, how the results may be used, and any consequences for declining to be tested.

Individuals tested are required to receive patient fact sheets as part of the test's emergency use authorization (EUA) .

Test types

There are currently two types of tests to identify SARS-CoV-2 infection or exposure: Viral and antibody tests.

Viral tests authorized by the Food and Drug Administration (FDA), including nucleic acid amplification tests (NAATs), and antigen tests, are used to diagnose current infection with SARS-CoV-2, the virus that causes COVID-19.

Tests can differ based on sensitivity (i.e., number of false-negative results/missed detections of SARS-CoV-2) and/or specificity (i.e., number of false-positive results/tests incorrectly identifying SARS-CoV-2 when the virus is not present).

- NAATs are high-sensitivity, high-specificity tests for diagnosing SARS-CoV-2 infection. Most NAATs need to be processed in a laboratory, and the time to obtain results varies (~1–3 days), but some NAATs are point-of-care tests with results available in about 15–45 minutes.
- Antigen tests are immunoassays that detect the presence of a specific protein on the surface of the virus. Different antigen tests generally have similar specificity, but are less sensitive than most NAATs. Most are less expensive than NAATs and can be conducted at the point of care testing site, usually with faster turnaround times. It may be necessary to confirm some antigen test results with a laboratory-based NAAT (i.e., a negative antigen test result in persons with symptoms or a positive antigen test result in persons without symptoms or known exposure). Based on the authorization from FDA , some point-of-care NAATs that provide presumptive results cannot be used for confirmatory testing. Use of the CDC Antigen Testing Algorithm is recommended to determine when confirmatory testing is needed.

Antibody (or serology) tests are used to detect previous infection with SARS-CoV-2 and can aid in the diagnosis of Multiple Inflammatory Syndrome in Children (MIS-C) and in adults (MIS-A). CDC does not recommend using antibody testing to diagnose current infection or to assess immunity. For more information on test types and how to choose a test, refer to Overview of Testing for SARS-CoV-2.

Overview of testing scenarios

Diagnostic testing is intended to identify current infection in individuals and is performed when a person has signs or symptoms consistent with COVID-19, or when a person is asymptomatic but has recent known or suspected exposure to SARS-CoV-2.

Examples of diagnostic testing include:

- Testing people who have symptoms consistent with COVID-19 and who present to their healthcare provider
- Testing people as a result of contact tracing efforts
- Testing people who indicate that they were exposed to someone with a confirmed or suspected case of COVID-19
- Testing people who attended an event where another attendee was later confirmed to have COVID-19

Screening tests are intended to identify infected people who are asymptomatic and do not have known, suspected, or reported exposure to SARS-CoV-2. Screening helps to identify unknown cases so that measures can be taken to prevent further transmission.

Examples of screening include:

- Testing employees in a workplace setting
- Testing students, faculty, and staff in a school or university setting
- Testing a person before or after travel
- Testing at home for someone who does not have symptoms associated with COVID-19 and no known exposures to someone with COVID-19

Choosing a test

When choosing which test to use, it is important to understand the purpose of the testing (e.g., diagnostic, screening), analytic performance of the test within the context of the level of community transmission, need for rapid results, and other considerations. Table 1 summarizes some characteristics of NAATs and antigen tests to consider. Most antigen tests that have received EUA from FDA are authorized for testing symptomatic persons within the first 5, 7, 12, or 14 days of symptom onset. Given the risk of transmission of SARS-CoV-2 from asymptomatic and presymptomatic persons with SARS-CoV-2 infection, use of antigen tests in asymptomatic and presymptomatic persons can be considered. FDA has provided a list of FAQ for healthcare providers who are using diagnostic tests in screening asymptomatic individuals , and the Centers for Medicare & Medicaid Services will temporarily exercise enforcement discretion to enable the use of antigen tests in asymptomatic individuals for the duration of the COVID-19 public health emergency under the Clinical Laboratory Improvement Amendments of 1988 (CLIA). Laboratories that perform screening or diagnostic testing for SARS-CoV-2 must have a CLIA certificate and meet regulatory requirements. Tests that have received an EUA from FDA for point of care (POC) use can be performed with a CLIA certificate of waiver.

Table 1. NAAT and Antigen Test Differences to Consider When Planning for Diagnostic or Screening Use

	NAATs	Antigen Tests
Intended Use	Diagnose *current* infection	Diagnose *current* infection
Analyte Detected	Viral Ribonucleic Acid (RNA)	Viral Antigens

Specimen Type(s)	Nasal, Nasopharyngeal, Oropharyngeal, Sputum, Saliva	Nasal, Nasopharyngeal
Sensitivity	Varies by test, but generally high for laboratory-based tests and moderate-to-high for POC tests	Varies depending on the course of infection, but generally moderate-to-high at times of peak viral load*
Specificity	High	High
Test Complexity	Varies by test	Relatively easy to use
Authorized for Use at the Point-of-Care	Most are not, some are	Most are, some are not
Turnaround Time	Most 1-3 days. Some could be rapid in 15 minutes	Ranges from 15 minutes to 30 minutes
Cost/Test^	Moderate (~$75-$100/test)	Low (~$5-$50/test)
Advantages	Most sensitive test method available Short turnaround time for NAAT POC tests, but few available Usually does not need to be repeated to confirm results	Short turnaround time (approximately 15 minutes)+ When performed at or near POC, allows for rapid identification of infected people, thus preventing further virus transmission in the community, workplace, etc. Comparable performance to NAATs for diagnosis in symptomatic persons and/or if culturable virus present
Disadvantages	Longer turnaround time for lab-based tests (1–3 days) Higher cost per test A positive NAAT diagnostic test should not be repeated within 90 days, because people may continue to have detectable RNA after risk of transmission has passed	May need confirmatory testing Less sensitive (more false negative results) compared to NAATs, especially among asymptomatic people and with some variants

*The decreased sensitivity of antigen tests might be offset if the POC antigen tests are repeated more frequently (i.e., serial testing at least weekly).
^ Costs for: NAATs
+Refers to point-of-care antigen tests only.

Considerations for testing in different scenarios

Diagnostic testing

Testing persons with signs or symptoms consistent with COVID-19

Persons experiencing homelessness who have COVID-19 signs and/or symptoms should be escorted to a private area as described in Interim Guidance for Homeless Service Providers. The client should wear a mask covering the nose and mouth and possibly be sent to a healthcare facility, depending on the severity of symptoms. Testing can be performed in accordance with the emergency use authorization to determine if the individual is infected with SARS-CoV-2 by antigen test or NAAT.

- If the result is negative using an antigen test, the result should be confirmed by a laboratory-based NAAT. For more information: Point-of-care tests for screening and the Antigen Test Algorithm .
- Clients with a positive viral test (NAAT or antigen) or those who have symptoms of COVID-19 should be isolated either on site or at an isolation facility. All clients and staff who receive a positive test result for COVID-19, regardless of vaccination or booster status, should isolate for 10 days from the date symptoms began or the date of the positive test if they do not have symptoms.
  - In some circumstances, shortening isolation duration for clients or staff may be necessary. Decisions to shorten isolation should be made in coordination between homeless service sites and state, local, territorial, or tribal health departments.
  - Clients and staff may follow general population guidance in other community settings. For example, if a client is working in a setting other than the homeless service site (and it is not a congregate setting at higher risk for transmission), they may return to work in accordance with the general population guidance.
  - See "Investigating and responding to COVID-19 cases at homeless service provider sites" for more details on quarantine and isolation in these settings.
- Testing is not recommended to determine when infection has resolved, nor when to end isolation. NAATs have detected SARS-CoV-2 RNA in some people's respiratory specimens up to 3 months after they have recovered from COVID-19. Prolonged viral RNA detection (i.e., a positive NAAT without new symptoms) does not indicate that the virus is capable of replicating or capable of transmission to others.
- A test-based strategy could be considered in consultation with infectious diseases experts for persons who are severely immunocompromised.
- For information on retesting persons previously infected with SARS-CoV-2, visit Duration of Isolation and Precautions for Adults with COVID-19.

Testing asymptomatic persons with known or suspected exposure to SARS-CoV-2

Close contacts of persons with COVID-19 should quarantine for 10 days from the date of their last known contact and be tested at least 5 days after their last known close contact, regardless of vaccination or booster status. However, identifying close contacts of persons experiencing homelessness can be challenging. Location-based contact tracing can be used—that is, broader testing of clients, staff, and volunteers in locations the person with COVID-19 recently visited. Additional considerations include:

- Persons experiencing homelessness may need access to quarantine housing and staff should quarantine at home when possible.
- During crisis situations, it may be necessary to consider options for shortening quarantine duration for clients or staff. Facilities should consult their state, local, territorial, or tribal health department in these situations. Reducing quarantine duration may be recommended for groups at lower risk of infection first (e.g., those who are up to date on their COVID-19 vaccines).
- If a close contact of a person with COVID-19 has a negative test result initially, the person may be tested again at least 5 days after the last known close contact or immediately if symptoms develop later during quarantine.

Screening testing

Testing asymptomatic persons without known or suspected exposure to SARS-CoV-2 for early identification, isolation, and disease prevention

Widespread testing, regardless of signs or symptoms, is a key component of a layered approach to prevent SARS-CoV-2 transmission in congregate settings. This screening allows early identification and isolation of persons who are asymptomatic, presymptomatic, or have only mild symptoms and who may be unknowingly transmitting virus. For interpretation of screening test results, please see the Antigen Test Algorithm . Frequency of screening testing can be informed by the level of community transmission (Table 2).

Data on community transmission level can guide decisions about screening testing strategies in homeless shelters and encampments (Table 2). If facility-wide testing is indicated, NAAT or antigen testing can be offered to all clients and staff.

- Clients and staff who have symptoms of COVID-19 or receive a positive test result for COVID-19, regardless of vaccination or booster status, should isolate for 10 days from the date symptoms began or the date of the positive test if they do not have symptoms.
- Clients with a positive test should be connected to a place where they can isolate safely and access necessary services.
- Staff with a positive test should seek medical care if needed.
- Continue repeat viral testing of all previously negative or untested clients, staff, and volunteers, generally every 3 days to 7 days, until the testing identifies no new cases of SARS-CoV-2 infection for a period of at least 14 days since the most recent positive result.
- Given the possibility for widespread outbreaks in shelter settings, CDC recommends conducting screening testing at least weekly.

Homeless service providers can consider adding aggregate testing results in the CDC and National Health Care for the Homeless Council data portal to help understand the impact of COVID-19 on the staff and clients of homeless shelters and encampments.

Table 2. Community Indicators at the County Level@

Indicator	Low	Moderate	Substantial	High
Cumulative number of new cases per 100,000 persons within the last 7 days*	>10	10–49	50–99	≥100
Percentage of NAATs that are positive during the last 7 days†	>5%	5%–7.9%	8%–9.9%	≥10%

Indicators should be calculated for counties or core based statistical areas, although in rural areas with low population density, multiple jurisdictions might need to be combined to make the indicators more useful for decision-making. The indicators listed can be found by county on CDC's COVID Data Tracker Website under "county view."

@ If the two indicators suggest different transmission levels, the higher level should be selected.

* Number of new cases in the county (or other administrative level) in the last 7 days divided by the population in the county (or other administrative level) and multiplying by 100,000.

† Number of positive tests in the county (or other administrative level) during the last 7 days divided by the total number of tests resulted in the county (or other administrative level) during the last 7 days. Calculating Severe Acute Respiratory Syndrome Coronavirus 2 (SARS-CoV-2) Laboratory Test Percent Positivity: CDC Methods and Considerations for Comparisons and Interpretation.

Table 3. Potential Actions based on Community Indicator Level

Prevention Strategy	Low Transmission (Blue)	Moderate Transmission (Yellow)	Substantial Transmission (Orange)	High Transmission (Red)

Prevention Strategy	Low Transmission (Blue)	Moderate Transmission (Yellow)	Substantial Transmission (Orange)	High Transmission (Red)
Conduct standard case identification and investigation**				
Implement screening testing: Test subsets of individuals according to designated criteria***				
Implement screening testing: Increase frequency of testing subsets of individuals according to designated criteria***				
Screening testing: Continue testing subsets on regular basis; consider facility-wide testing at least weekly Implement facility-wide testing if: • A positive test result is identified at the site, • A positive test result is identified in a sentinel site,**** • A cluster of probable cases at the site exceeds a pre-determined threshold, or • A site is identified in location-based contact tracing.				
Implement facility-wide testing at least weekly with follow-up testing if cases are identified				

*Levels of community transmission defined as total new cases per 100,000 persons in the past 7 days (low, 0-9; moderate, 10-49; substantial, 50-99; high, ≥100) and percentage of positive tests in the past 7 days (low, <5%; moderate, 5-7.9%; substantial, 8-9.9%; high, ≥10%).

**Passive surveillance using laboratory-based surveillance and case investigation.

***Active surveillance; see below for example criteria.

****Sentinel site=a site that provides a signal for whether outbreaks might be occurring at adjacent sites.

Community transmission phase: Low

Health departments use standard surveillance (passive) and case investigation processes.

- Investigate whether SARS-CoV-2-infected individuals have been affiliated with any homeless service site or encampment from 48 hours before they had symptoms until they were isolated.
- Offer SARS-CoV-2 viral testing to all clients and staff affiliated with the site or encampment where cases have been identified any time from 48 hours before the individual began experiencing symptoms (or 2 days before a positive test in an asymptomatic individual), until that person was isolated.
- Review CDC guidance for responding to cases at homeless service sites for further information about case investigation and outbreak response.

Screening testing may be considered by state or local health authorities.

Community transmission phase: Moderate

Health departments can consider offering systematic testing to individuals affiliated with the site according to designated criteria to increase the likelihood of early identification of cases (active surveillance).

- **Enhanced symptom-based testing access:** Station medical providers at homeless service sites to offer testing to anyone with symptoms of COVID-19. If this yields a positive test, conduct facility-wide testing.
- **Random-selection screening testing:** Offer screening testing to randomly selected (e.g., every third person) clients, staff, or volunteers at the site on a regular basis such as weekly. Testing should occur at least weekly. If this yields a positive test, conduct facility-wide testing.
- **Setting positive symptom screening thresholds:** Track COVID-19-like illness (probable cases) at the site if testing is pending or not available.
- **Sentinel sites:** Choose a single site to conduct facility-wide screening testing on a regular basis such as weekly. Consider connected sites to be sentinel sites for each other such as correctional facilities or nearby homeless service provider sites. If one or more cases is identified in the sentinel site, conduct facility-wide screening testing at each site.

Community transmission phase: Substantial

Health departments and healthcare providers can consider screening testing at higher frequency. If any cases are detected, facility-wide testing and other mitigation measures should then be conducted to interrupt transmission.

- Combine screening strategies such as offering both enhanced symptom-based screening and random-selection screening.
- Increase the frequency of random screening testing and the number of people tested at each site. In screening settings where antigen tests are used, confirmatory NAAT testing is recommended for individuals who test positive. For interpretation of screening test results, please see the Antigen Test Algorithm [457 KB, 1 page]. Persons with a positive test (NAAT or antigen) should be isolated either on site or at an isolation facility.

Community transmission phase: High

Health departments should continue regular screening and may consider coordinating with partners to offer facility-wide screening testing for all clients, volunteers, and staff in all sites weekly, regardless of whether an initial case of COVID-19 has been identified. Repeat testing of all previously negative or untested clients, staff, and volunteers weekly until the testing identifies no new cases of COVID-19 for at least 14 days since the most recent positive result. If resources for testing are limited, sites can be prioritized according to one or more of these factors: larger size, higher turnover, higher connectedness (staff or client overlap) with other facilities, more crowding (less space), more congregate rooms (fewer individual rooms), vulnerability of population (disproportionate risk or relatively higher risk for severe illness).

Previous Updates

Updates as of March 17, 2021

- Updated description of tests, testing scenarios, and phases of community guidance to align with testing overview Overview of Testing for SARS-CoV-2.

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