Interim Considerations for Health Departments for SARS-CoV-2 Testing in Homeless Shelters and Encampments

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These interim considerations are based on what is currently known about SARS-CoV-2 and COVID-19 as of the date of posting, July 1, 2020.

The US Centers for Disease Control and Prevention (CDC) will update these considerations as needed and as additional information becomes available. Please check the following CDC website periodically for updated interim guidance.

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.

Homeless service provider sites and encampments can present unique challenges for coronavirus disease 2019 (COVID-19) investigations and public health action. In congregate settings such as homeless shelters, the virus may spread easily among clients, staff, and volunteers. Additionally, many people experiencing homelessness are older adults or have underlying medical conditions [1], [2], which increases their risk of severe illness from COVID-19. This document describes testing strategies for homeless shelters and encampments. Testing to diagnose COVID-19 is one component of a comprehensive strategy and should be used in conjunction with promoting behaviors that reduce spread, maintaining healthy environments, maintaining healthy operations, and preparing for when someone gets sick.

State, Tribal, territorial, and local health departments should review these considerations in the context of local recommendations, resources, acceptability, and feasibility. These considerations are meant to supplement—not replace—any federal, state, local, territorial, or Tribal health and safety laws, rules, and regulations. For details on appropriate procedures and safety measures and personal protective equipment to use during testing, see procedure for testing in congregate settings.

The purpose and process of all testing and other public health activities should be clearly communicated to clients and staff at the homeless service site to promote understanding and acceptability. Testing strategies should be carried out in a way that protects privacy and confidentiality to the extent possible and that is consistent with applicable laws and regulations. In addition to state and local laws, regulations and policies, site administrators should follow guidance from the Equal Employment Opportunity Commission when offering testing to staff. Any time a positive test result is

identified, 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. Additionally, review the guidance for responding to cases at homeless shelters.

Types of COVID-19 tests

Viral tests are recommended to **diagnose current infection** with SARS-CoV-2, the virus that causes COVID-19. Viral tests evaluate whether the virus is present in a respiratory sample. Results from these tests help public health officials identify and isolate people who are infected to minimize COVID-19 transmission.

Antibody tests are used to **determine a past infection** with SARS-CoV-2. CDC does not currently recommend using antibody testing as the sole basis for diagnosing current infection. Because it is currently not clear whether a positive antibody test indicates immunity against SARS-CoV-2, antibody tests cannot be used to determine if an individual is immune.

CDC recommendations for SARS-CoV-2 testing have been developed based on what is currently known about COVID-19 and are subject to change as additional information becomes available.

When testing might be needed

The following document describes scenarios when SARS-CoV-2 viral testing may be appropriate in homeless shelters and encampments and outlines how to use community transmission levels to guide which testing strategies to use:

- Testing individuals with signs or symptoms consistent with COVID-19
- Testing asymptomatic individuals with recent known or suspected exposure to SARS-CoV-2 to control transmission

Testing individuals with signs or symptoms consistent with COVID-19

Consistent with CDC's recommendations, individuals with symptoms consistent with COVID-19 should be referred to a healthcare provider for evaluation and possible testing. One strategy to identify people with symptoms is to conduct symptom screening during standard shelter and outreach practices. However, because screening cannot identify individuals with COVID-19 who may be asymptomatic or pre-symptomatic, this strategy alone cannot prevent all individuals with COVID-19 from entering homeless service provider sites. Screenings should be conducted safely and respectfully and in accordance with any applicable privacy laws and regulations.

Clients, staff, or volunteers who have symptoms consistent with COVID-19 should wear a cloth face covering, if able. Staff and volunteers with symptoms should be advised to go or stay home. Clients with symptoms should be directed to stay in a pre-designated area, separated from other shelter clients and ideally in individual rooms.

Public health planning should incorporate arrangements for how symptomatic people who are experiencing homelessness will access testing, ideally with a rapid turnaround, whether by facilitating access to healthcare through Federally Qualified Health Centers or other community providers, shelter-based clinics, or mobile testing. Special consideration should be given to ensuring that people who are experiencing homelessness and have symptoms of COVID-19 have access to medical care.

Testing asymptomatic individuals with recent known or suspected exposure to SARS-CoV-2 to control transmission

Testing is recommended for all close contacts of persons with COVID-19. Typically, people who are close contacts are identified through person-based contact tracing. However, in homeless service sites and encampments, crowding, mixing of clients and staff, and other constraints can limit the effectiveness of person-based contact tracing. Given challenges with tracing close contacts of people experiencing homelessness, location-based contact tracing can be used to identify potentially exposed sites rather than individual contact-based tracings. In these situations, broader testing of clients, staff, and volunteers (e.g., facility-wide testing, as defined below) can be considered as a part of a strategy to control transmission of SARS-CoV-2. Additional considerations during quarantine and while awaiting test results include:

- All individuals with potential exposure should wear cloth face coverings, if able.
- Clients may need access to specific quarantine housing and staff should be advised to quarantine at home, as possible.
- Anyone with known or suspected exposure who develops symptoms should be linked to follow-up testing, even if they had initially tested negative.

See further details below on integrating exposure-based testing into a public health strategy.

Testing asymptomatic individuals without known exposure to SARS-CoV-2 for early identification in homeless shelters and encampments

In special populations, testing of asymptomatic individuals without known exposure to SARS-CoV-2 may allow for early identification of COVID-19 cases and outbreaks, especially among persons in congregate living settings. If there is moderate or substantial transmission in the community, initial and regular facility-wide testing may be considered as approaches to limit the virus's spread in homeless shelters [3].

It is unknown if entry testing for homeless service sites and encampments provides any additional reduction in person-to-person transmission of the virus beyond what would be expected with implementation of other infection preventive measures (e.g., social distancing, cloth face covering, hand washing, enhanced cleaning and disinfection). **Therefore, CDC does not recommend entry testing for homeless service sites and encampments.**

Using community transmission levels to guide asymptomatic testing

Flexible strategies are necessary to mitigate the effects of the COVID-19 Public Health Emergency (PHE) in homeless shelters and encampments. This section describes how the level of community transmission can be used to guide decisions about the types of testing strategies that may be considered. Health departments and administrators of homeless service sites, in partnership with healthcare providers, should decide whether and how to implement these testing considerations to identify cases among people who are asymptomatic, including both those with and without known exposure to COVID-19.

Those providing services for people experiencing homelessness should continue to follow guidance for basic COVID-19 prevention among people who are staying in homeless shelters or experiencing unsheltered homelessness.

Facility-wide (universal) testing involves offering viral testing for SARS-CoV-2 to all clients and staff who were affiliated with the site or encampment any time from 2 days before the individual began experiencing symptoms, or 2 days before a positive test in an asymptomatic individual, until they were isolated.

- Any client who tests positive should be connected to a place where they can safely isolate and access necessary services until they meet criteria to discontinue isolation.
- Staff who test positive should be advised to seek medical care as needed and to stay home until they meet criteria to discontinue isolation.
- Repeat testing of all previously negative or untested clients, staff, and volunteers (e.g., once a week) is recommended until the testing identifies no new cases of COVID-19 for at least 14 days since the most recent positive result.
- It will not always be possible to provide testing to every individual who would qualify, but the intent is to broadly offer testing to anyone who might have been exposed.

Community transmission categories: The transmission categories included in Table 1 are described in the CDC Community Mitigation Framework. Health departments should consider setting precise incidence indicators that reflect these categories and are suitable to the local context.
Table 1: Identifying when facility-wide testing in homeless shelters or encampments is indicated

	None to Minimal	Minimal to Moderate	Moderate to Substantial
Community Transmission Description	Isolated cases or limited community transmission; case investigations under way; no evidence of exposure in large communal setting	Sustained transmission that is not large-scale but with high likelihood or confirmed exposure in communal settings and with the potential for rapid increase in cases	Large-scale, uncontrolled or controlled community transmission, including in communal settings
Baseline Activities	Conduct regular case identification and investigation*	Increase access to testing at the site according to designated criteria**	Consider initial and regular facility-wide testing
When to Conduct Facility-wide Testing	A laboratory-confirmed case is identified at the site, or A laboratory-confirmed case is identified in a sentinel site***, or A cluster of probable cases at the site exceeds a pre-determined threshold, or A site is identified in location-based contact tracing		No trigger needed; follow-up testing triggered if cases are identified

*Passive surveillance.
**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 is none to minimal: Regular case identification and investigation

In areas where community transmission is none to minimal, health departments should use their standard surveillance system (passive surveillance) and case investigation processes to identify confirmed and probable cases (according to the Council of State and Territorial Epidemiologists case definition of COVID-19) among people experiencing homelessness or homeless service staff:

- Investigate whether infected individuals have been affiliated with any homeless service facility or encampment (e.g., working or staying there) from 48 hours before they had symptoms until they were isolated, even if it was not their primary place of work or shelter.
- Conduct facility-wide testing as soon as possible if a person affiliated with the site is confirmed to have COVID-19.
- Review CDC guidance for responding to cases at homeless service sites for further information about case investigation and outbreak response.

Community transmission is minimal to moderate: Increase asymptomatic testing access

In addition to the regular case identification and investigation strategies described above, health departments in areas where community transmission is minimal to moderate can consider working with partners to increase testing access in homeless shelters and encampments (i.e., creating an active surveillance system). Offering testing systematically to individuals affiliated with the site according to designated criteria can increase the likelihood of early identification of cases. Examples of increased testing strategies that health departments or health care providers could use alone or in combination for homeless shelters include:

- **Enhanced symptom-based testing access:** Increase access to testing and early identification of cases by stationing medical providers at homeless service sites to offer testing to anyone with symptoms of COVID-19. If any client, staff member, or volunteer tests positive, then conduct facility-wide testing.
- **Random-selection testing:** Offer testing to randomly selected clients, staff, or volunteers (e.g., every third person) at the site on a regular basis. If a client or staff member tests positive, then conduct facility-wide testing. Although jurisdictions may choose to use this option, the ideal frequency of testing is still unknown.
- **Setting positive symptom screening thresholds:** Track instances of COVID-like illness (e.g., probable cases) at the site if testing is pending or not available. Set a threshold for response similar to what you might use at a long-term care facility, for example ≥2 cases of COVID-like illness are identified at the facility within 14 days. If the pre-defined threshold is surpassed, then conduct facility-wide testing.
- **Sentinel sites:** Choose a single site to conduct regular (e.g., weekly), facility-wide testing. Or, consider connected sites to be sentinel sites for each other (e.g., correctional facilities or nearby homeless shelters). If one or more cases are identified in the sentinel site, then conduct facility-wide testing at each site.

Community transmission is substantial: Initial and regular testing

In areas where community transmission is substantial, health departments may consider coordinating with partners to offer facility-wide testing for all clients, volunteers, and staff in all sites at least once, regardless of whether an initial case of COVID-19 has been identified. Repeat testing of all previously negative or untested clients, volunteers, and staff (e.g., once a week) is recommended 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, consider prioritizing sites for testing according to one or more of these factors:

- *Size*. Consider starting testing in larger sites.
- *Turnover*. Consider starting testing in locations that have many new admissions per week.
- *Connectedness with other facilities*. Consider starting testing with facilities that share staff or have overlaps in clients.
- *Crowding levels*. Consider starting testing at sites that have difficulty creating physical distance between clients.
- *Congregate vs. individual rooms in shelters*. Consider starting testing at sites that have shared sleeping areas.
- *Vulnerability of population*. Consider starting testing at sites where people are at increased risk for severe illness.

[1] Department of Housing and Urban Development. The 2017 Annual Homeless Assessment Report (AHAR) to Congress, PART 2: Estimates of Homelessness in the United States. October 2018. Available at: https://files.hudexchange.info/resources/documents/2017-AHAR-Part-2.pdf

[2] Fazel S, Geddes J, Kushel M. The Health of Homeless People in High-Income Countries: Descriptive Epidemiology, Health Consequences, and Clinical and Policy Recommendations. The Lancet. 2014 Oct 25;384(9953):1529-40

[3] 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.mm6917

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