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CDC Centers for Disease Control and Prevention

COVID-19

Guidance on Management of COVID-19 in Homeless Service Sites and in Correctional and Detention Facilities

Updated May 11, 2023

Last viewed by the First Circuit Library on 7/24/2023

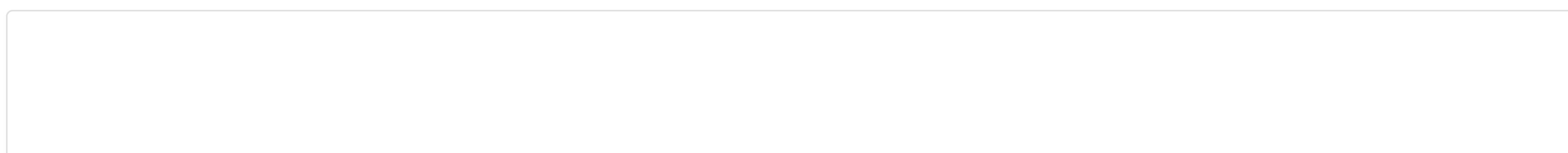
Summary of Recent Changes

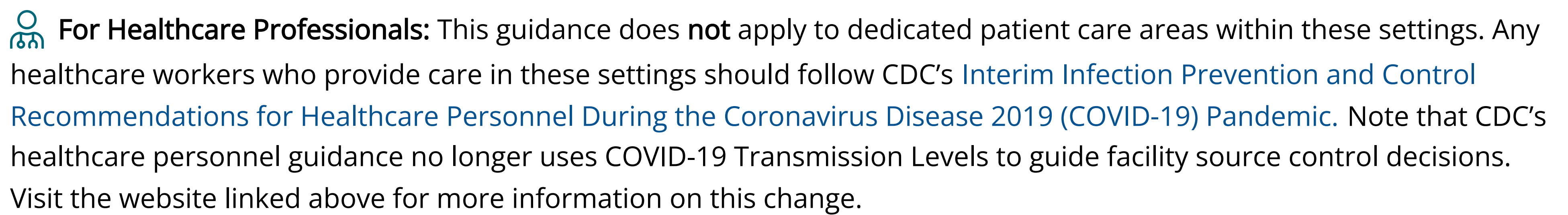
Updates as of May 11, 2023

- Replaces COVID-19 Community Levels with COVID-19 hospital admission levels to guide prevention decisions. Changes based on:
  - MMWR: COVID-19 Surveillance After Expiration of the Public Health Emergency Declaration — United States, May 11, 2023
  - MMWR: Correlations and Timeliness of COVID-19 Surveillance Data Sources and Indicators — United States, October 1, 2020–March 22, 2023
- Recommends intake testing in correctional and detention facilities be considered an Enhanced Prevention Strategy. Previous versions of this guidance document recommended intake testing as a Strategy for Everyday Operations.
- Provides information about changes to CDC's Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic, which should still be used by healthcare personnel in dedicated patient areas within homeless service sites and correctional and detention facilities.

Because of the congregate living arrangements in homeless shelters and correctional and detention facilities, the risk of COVID-19 transmission is higher in these settings compared with the general population. In addition, there is a high prevalence of certain medical conditions associated with severe COVID-19 among people experiencing homelessness and among people who are incarcerated, increasing the risk for severe outcomes from COVID-19 in these populations.

This guidance can be used to inform COVID-19 prevention actions in homeless service sites and correctional and detention facilities and replaces previous CDC guidance documents for these settings.




For Healthcare Professionals: This guidance does **not** apply to dedicated patient care areas within these settings. Any healthcare workers who provide care in these settings should follow CDC's Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic. Note that CDC's healthcare personnel guidance no longer uses COVID-19 Transmission Levels to guide facility source control decisions. Visit the website linked above for more information on this change.

Assessing a Facility's Risk

CDC recommends that homeless service sites and correctional and detention facilities use a combination of COVID-19 hospital admission levels and facility-specific risks to guide decisions about when to apply specific COVID-19 prevention actions. Assessing the following factors can help decide if additional layers of protection are needed because of facility-specific risks:

- **Facility structural and operational characteristics:** Assess whether facility characteristics or operations contribute to COVID-19 spread. For example, facilities may have a higher risk of transmission if they have frequent resident or staff turnover, a high volume of outside visitors, poor ventilation, or areas where many people sleep close together.
- **Risk of severe health outcomes:** Assess what portion of people in the facility are more likely to get very sick from COVID-19, for example, due to underlying health conditions, older age, pregnancy, or poor access to medical care.
- **COVID-19 transmission in the facility:** Assess the extent to which transmission is occurring within the facility. Transmission can be assessed through diagnostic testing of people with COVID-19 symptoms and their close contacts, through routine screening testing (not routinely recommended, but some facilities might use it in consultation with their health department to facilitate early identification of infections in populations with especially high risk for severe illness from COVID-19), or other surveillance testing that the facility uses (such as wastewater testing). Results of testing at intake are not recommended as an indicator of transmission inside the facility, since infections identified at intake most likely occurred elsewhere.

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COVID-19 Prevention Strategies

The actions facilities can take to help keep their populations safe from COVID-19 can be categorized as prevention strategies for everyday operations and enhanced prevention strategies.

- **Prevention strategies for everyday operations** should be in place at all times, even if the COVID-19 hospital admission level is low or medium. These include all of the strategies listed below except those marked *enhanced strategy*.
- **Enhanced prevention strategies** should be added to supplement the prevention strategies for everyday operations when the COVID-19 hospital admission level is high, any time there has been transmission within the facility itself, or based on the assessment of other facility-specific factors that increase risk. These include the strategies listed below that are marked *enhanced strategy*.

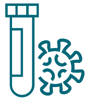
When adding enhanced prevention strategies, facility operators should balance the need for COVID-19 prevention with the impact from reducing access to services and programming. Facilities may not be able to apply all enhanced COVID-19 prevention strategies due to local resource constraints, facility and population characteristics, or other factors. However, they should add as many as feasible, as a multi-layered approach to increase the level of protection against COVID-19. Depending on the risk in different areas of the facility, enhanced prevention strategies can be applied across an entire facility, or can be targeted to a single housing area, wing, or building. Facilities with lower risk tolerance can apply enhanced prevention strategies at any time, even when the COVID-19 hospital admission level is low or medium.

Support Staff and Residents to Stay Up to Date with COVID-19 Vaccines

Encourage and enable staff, volunteers, and residents to stay up to date on COVID-19 vaccination. Where possible, offer the vaccine onsite and support peer outreach to promote vaccination.

Improve Ventilation

- Ensure HVAC systems operate properly and provide acceptable indoor air quality.
- **Enhanced strategy:** Where possible, consider holding group activities outdoors.
- **Enhanced strategy:** Increase and improve ventilation as much as possible. Identify, obtain, and test enhanced ventilation options in advance of higher risk periods to be ready to deploy when needed. Short-term and long-term tools to improve ventilation in buildings can be found on the CDC website.



Provide Testing for COVID-19, When Needed

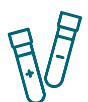
- Test residents and staff who have been exposed or who are symptomatic, in accordance with CDC testing guidance.
  - If testing staff onsite is not feasible (e.g., due to employment policy or availability of testing supplies), advise staff who have been exposed or who are symptomatic to seek testing offsite.
  - If applicable, consider suspending co-pays for residents seeking medical evaluation and testing for possible COVID-19.
- **Enhanced strategy:** Consult with the state, local, tribal, or territorial health department (or equivalent) about whether to implement routine screening testing of residents and/or staff if there are concerns about the population being at especially high risk for severe illness from COVID-19. Routine testing can help identify infections early, which is especially important for people who are eligible for treatment.

Wear Masks or Respirators and PPE, as Appropriate

- Maintain a stock of personal protective equipment (PPE).
- Offer high-quality masks/respirators to all residents and staff, and provide other PPE for staff and residents based on risk (see below for more information on PPE).
- **Enhanced strategy:** Require universal indoor masking, regardless of vaccination status.

Promote Infection Control and Facility Cleaning

- Conduct standard infection control, cleaning, and disinfection at all times.
- Maintain supplies for hand hygiene, cleaning, and disinfection, at no cost to residents or staff.
- **Enhanced strategy:** Add enhanced cleaning and disinfection



Implement Post-Exposure Guidance

Test residents and staff who have been exposed at least five full days after exposure (or sooner, if they develop symptoms) and require them to wear a mask while indoors for 10 full days after exposure, regardless of vaccination status.

Implement Isolation Guidance

Isolate staff, volunteers, and residents who test positive for COVID-19 away from other residents or away from the facility, as applicable, for 10 days since symptoms first appeared or from the date of sample collection for the positive test (if asymptomatic). If the individual has a negative viral test*, isolation can be shortened to be 7 days, as long as symptoms are improving and the individual has been fever-free for 24 hours, the individual was not hospitalized, and the individual does not have a weakened immune system. Note that the isolation period for homeless service sites and correctional and detention facilities is longer than the duration recommended for the general public because of the risk of widespread transmission in dense housing environments and the high prevalence of underlying medical conditions associated with severe COVID-19.

- If multiple residents have tested positive, they can isolate together in the same area. However, people with confirmed and suspected COVID-19 should not be housed together.

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- Ensure continuation of support services, including behavioral health and medical care, for residents while they are in isolation.
- During crisis-level operations, such as severe shortages of staffing or space, facilities may need to consider short-term reductions to the recommended isolation period for staff and/or residents. Facilities should consult their state, local, tribal, or territorial health department (or equivalent) to discuss approaches that would meet their needs while maximizing infection control.

* Either a NAAT (molecular) or antigen test may be used to determine if isolation can be shortened to 7 days. If using a NAAT, a single test must be obtained within 48 hours prior to returning to work (for staff) or ending isolation (for residents). If using an antigen test, two negative tests must be obtained, one no sooner than day 5 and the second 48 hours later.

Support Access to Treatment, as Needed

Effective treatments are now widely available and must be started within a few days after symptoms develop to be effective. Support timely treatment for those eligible; facilities without onsite healthcare capacity should plan to ensure timely access to care offsite.

Monitor and Communicate Potential Outbreaks or Needs

- Continue wastewater testing, if used, as an early warning for outbreaks.
- Continue partnerships and plan for outbreak communications, staffing shortages, spaces for quarantine (in facilities that choose to implement it; not routinely recommended) and isolation, and continuity of services.

Increase Distance

- **Enhanced strategy:** Create physical distance in congregate areas where possible.
- **Enhanced strategy:** Reduce movement and contact between different parts of the facility and between the facility and the community (as applicable).

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Quarantine

Quarantine (separating and restricting the movement of people who were exposed to a contagious disease to prevent further transmission in case they become sick) for COVID-19 is no longer recommended for the general public. In shelters and correctional and detention facilities, quarantine can be very disruptive to the daily lives of residents because of the limitations it places on access to programming, recreation, in-person visitation, in-person learning, and other services. However, because of the potential for rapid, widespread transmission of SARS-CoV-2 in these settings, some facilities may prefer to continue implementing quarantine protocols for residents, staff, and/or volunteers who have been exposed to someone with COVID-19. Facilities can base their quarantine policy on their risk tolerance, including factors such as the health of their staff and resident populations and the impact of quarantine on mental health and staffing coverage.

Facilities that choose to implement quarantine can consider a range of approaches to balance their infection control and operational needs and the mental health needs of their residents and staff. Facilities may shift between quarantine approaches to adapt to changes in disease severity and transmissibility of different SARS-CoV-2 variants, or to respond to staffing and space shortages during case surges.

Considerations for facilities implementing quarantine include the following:

- **Housing** – Residents who have been exposed can be quarantined individually or cohorted with others who have been exposed (cohorted quarantine). Facilities using cohorted quarantine should be aware that transmission can occur within the cohort if someone is infected. Using smaller cohort sizes can help minimize continued transmission. Once a cohort is established, additional persons exposed at different times should not be added.
- **Testing** – Serial testing may be used during cohorted quarantine. Within quarantine cohorts, serial testing every 3-7 days can identify new cases early. If new cases are identified in the cohort, the quarantine period should restart. Serial testing

can be used for all residents in a cohort, or prioritized for people who are more likely to get very sick from COVID-19 to identify infections early and assess them for treatment promptly.

- **Movement** – To maintain access to programming during quarantine, facilities may choose to allow residents quarantined as a cohort to move outside of their housing space and continue daily activities as a group. Residents in quarantine should not mix with residents or staff not assigned to their cohort and should wear a mask indoors.
- **Duration** – For facilities choosing to implement quarantine after a person is exposed to someone with COVID-19, a 10-day quarantine period provides the greatest protection from potential COVID-19 transmission to other residents and staff, but is disruptive to their lives and to facility operations. One option to balance these needs is to shorten the quarantine period if an exposed person tests negative after 5 days, but to continue masking indoors through day 10.
- **Monitoring** – Rather than requiring healthcare staff to check all quarantined residents for COVID-19 symptoms, facilities can prioritize symptom checks for residents more likely to get very sick from COVID-19 to identify infections early and assess treatment eligibility.

Personal Protective Equipment and Source Control

The types of personal protective equipment (PPE) and source control recommended in homeless services sites and correctional and detention facilities are detailed below.

- **When indoor masking is required (or when individual residents or staff choose to wear masks based on their personal preference),** all residents and staff may use disposable facemasks, barrier face coverings, or NIOSH-approved respirators.
- **Residents with confirmed or suspected COVID-19** may use disposable facemasks, barrier face coverings, or NIOSH-approved respirators.
- **Staff and residents working in areas of the facility designated for isolation or quarantine** should only use NIOSH-approved respirators.
- **Staff and residents who will have close contact with residents who are under quarantine or isolation precautions, including during transport,** should use NIOSH-approved respirators, eye protection, gowns/coveralls, and gloves.

If not already in place, employers should establish a respiratory protection program, as appropriate, to ensure that staff members are fit-tested, medically cleared, and trained for any respiratory protection they will need within the scope of their responsibilities. Residents may also be considered for enrollment in a respiratory protection program depending on work-related exposure risk. For example, residents working in an environment where they may be exposed to COVID-19, such as in a COVID-19 medical isolation unit, would be considered for enrollment due to occupational risk. For more details, see the OSHA Respiratory Protection Standard.

See Types of Masks and Respirators for a full list of NIOSH-approved and international respirators.

Identifying Exposures

People who have been exposed can be identified in two ways:

Case Investigation and Person-Based Contact Tracing

Case investigations can prioritize identification of close contacts who are more likely to get very sick from COVID-19, so that they can be referred to a healthcare provider to determine eligibility for treatment if they test positive for COVID-19.

Location-Based Contact Tracing

Location-based contact tracing may be preferable in homeless service sites and correctional and detention facilities where traditional person-based contact tracing is ineffective because of crowding, mixing of residents and staff, difficulty ascertaining close contacts, and residents' movements in and out of the facility. Location-based contact tracing identifies people with recent known or potential exposure based on whether they spent time in the same areas as a person with COVID-19 during the time the infected person was considered infectious. The infectious period is considered to be two days

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prior to onset of any symptoms, or two days prior to the positive test if they do not have symptoms, through the end of isolation. This process can help identify additional facilities (or portions of facilities) that might need investigation and testing. Examples of how to conduct location-based contact tracing include:

- *Service sites and programs for people experiencing homelessness:* Work with homeless service providers to use Homeless Management Information Systems (HMIS) and other homeless service data collection systems to identify where the person with a COVID-19 positive test checked in during the time they were infectious.
- *Correctional and detention facilities:* Identify areas where someone who has tested positive for COVID-19 spent time while they were infectious. For residents, this could include their housing unit, work detail, transport bus, dining area, and any programmatic activities; for staff and volunteers, this could include their duty station, break room, and carpool.

For sites/areas of a facility that have been identified in location-based contact tracing, consider conducting location-based testing.

If any additional cases are identified, facilities should consider adding enhanced prevention strategies.

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Additional Considerations

For Homeless Service Sites

1 Coordinating COVID-19 Prevention and Response Efforts

Because the continuation of services is essential for people experiencing homelessness, community coalitions should work together to avoid shelter closures or the exclusion of people who have symptoms or positive test results for SARS-CoV-2. Decisions about whether residents with mild illness due to suspected or confirmed COVID-19 should remain in a shelter or be directed to alternative care sites should be made in coordination with local health departments. Vaccination should not be a pre-requisite for residents to access homeless services unless directed by local health departments.

Health departments should ensure that they are connected with organizations that serve people experiencing sheltered and unsheltered homelessness. Consider designating a staff member to be the point of contact for COVID-19 prevention coordination with homeless service organizations and incorporating housing or homelessness status into data collection to support timely follow-up for cases among people experiencing homelessness.

2 Space Planning

Additional spaces (e.g., alternative offsite facilities) may be needed for people experiencing homelessness when the COVID-19 hospital admission level is high. These additional spaces or sites should include:

1. Overflow shelter spaces or sites to reduce crowding or respond to higher shelter demands
2. Isolation spaces or sites for people who are confirmed to be positive for COVID-19 but do not need to be hospitalized
3. Quarantine spaces (if quarantine is used), and
4. Protective housing for people who are more likely to get very sick from COVID-19 to stay away from high-risk congregate settings

Depending on resources and staff and volunteer availability, non-congregate housing options (such as hotels/motels) with individual rooms should be considered. Partners should plan for how to connect clients to housing opportunities after they have completed their stay in these temporary sites.

3 Unsheltered Homelessness

Although people experiencing unsheltered homelessness do not reside in a congregate setting, the risk of severe COVID-19 can be high in this group because of underlying medical conditions and lack of access to healthcare. When the COVID-19 hospital admission level is high, organizations can help people experiencing unsheltered homelessness protect themselves against COVID-19. Additionally, when the COVID-19 hospital admission level is

high, encampment closure should only be conducted as part of a plan to rehouse people living in encampments, developed in coordination with local homeless service providers and health departments.

For Correctional and Detention Facilities

1. ### Testing at Intake (Enhanced Prevention Strategy)

An additional *enhanced prevention strategy* in this setting is to consider testing all new residents entering correctional and detention facilities at intake. As an alternative to intake testing, facilities can use a routine observation period at intake, during which residents are housed separately from the rest of the facility's population. The duration of the observation period should be at least 5 days if residents test negative at the end of the observation period, or 7 days (minimum) to 10 days (optimum) if residents are not tested. Individual housing is preferred under this strategy; if cohorting is necessary, do not add residents to an existing cohort during their observation period.

2. ### Testing During Transfer and Release (Enhanced Prevention Strategy)

An additional *enhanced prevention strategy* for this setting is to consider testing residents during transfer and/or release protocols. Routine observation periods can be added during movement protocols as well, as additional *enhanced prevention strategies*.

3. ### Masks and Respirators

Even when a facility does not require masking, it should allow individuals to use a mask or respirator based on personal preference, informed by their perceived level of risk for infection based on their recent activities and their potential for developing severe disease if they are exposed.
High-quality masks or respirators should be provided at no cost to residents and staff when indicated and replaced as needed – both when universal indoor masking is required and when residents or staff choose to wear a mask based on their personal preference. When possible, offer different types of masks and respirators to staff and residents so that they can choose the option that fits them best and that they can wear consistently. The options that are offered in correctional and detention facilities may be limited by safety and security considerations, such as concerns about metal nose wires.

In environments where the risk of SARS-CoV-2 transmission is higher and safety and security considerations allow, residents should be offered masks or respirators providing the same level of protection as those provided to staff in a similar environment.

4. ### Isolation and Quarantine Spaces

Because of limited individual housing spaces within many correctional and detention facilities, infected or exposed people are often placed in the same housing spaces that are used for administrative or disciplinary segregation. To encourage prompt reporting of COVID-19 symptoms and to support mental health, ensure that medical isolation and quarantine are *operationally distinct* from administrative or disciplinary segregation, even if the same housing spaces are used for both. For example, as much as possible, provide similar access to radio, TV, reading materials, personal property, commissary, showers, clean clothing and linens, and other resources as would be available in individuals' regular housing units.

5. ### Visitation and Programming

Visitation and programming are essential for residents' mental health and well-being. When possible, maximize access to opportunities for in-person visitation and programming, even when the COVID-19 hospital admission level is high.

6. ### Youth Detention Facilities

It is important to note that youth who are detained or committed have unique needs related to their age and development, including a need for access to in-person learning. Facilities housing youth may also need to adapt

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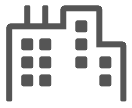
aspects of this guidance document to comply with regulatory requirements and facility operations specific to juvenile justice and child welfare systems.



Information for Other Community Congregate Living Settings (e.g., Group Homes, Assisted Living)

- How can congregate living settings assess risk?
- How can congregate living settings help keep people safe from COVID-19?

Learn More

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