

Isolation and Operational Considerations for Congregate Facilities

Module 4 Script

Hello and welcome to the fourth of five modules to assist in your winter planning and infection control measures.

Please share these modules with your staff and teams to increase awareness and elevate resources.

The goal of this module is to focus on isolation and operational consideration for congregate settings such as emergency shelters.

The PowerPoint presentations and videos of all the modules in this series are available on the HUD landing page. Should you need more in-depth technical assistance related to infection control and prevention in congregate facilities like emergency shelters and day centers, or in your non-congregate shelters, please visit the HUD Exchange at www.HUDExchange.info. In the “Program Support” dropdown at the top of the homepage, select “Request In-Depth Assistance” and follow the instructions on the next page.

Let’s dive into isolation and operational considerations for congregate facilities.

Staff should call emergency medical services if a resident has severe warning signs of COVID-19, the flu, or any other illness, including:

- Difficulty breathing or shortness of breath.
- Difficulty speaking in full sentences.
- Persistent pain or pressure in the chest.
- New confusion or an inability to rouse.
- Lightheadedness.
- Blue discoloration of lips, face, or nail beds.
- Dehydration (dry mouth and skin, dizziness, headache, fever and chills, rapid breathing, rapid heart rate, or muscle cramps).

Staff should review emergency care procedures with local public health partners.

When isolation spaces are limited due to the impact of COVID-19, or flu outbreak, shelter providers may need to consider isolating symptomatic residents onsite.

The practice of sheltering COVID-19-positive or symptomatic individuals using private rooms or sectioning off areas within existing congregate settings is known as isolation in place.

When will you know if your shelter needs to implement an isolation-in-place strategy? This decision tree can help with your strategy. Please note that this decision should not be made unilaterally, but rather, through coordination with your public health partners.

Let’s review the decision tree:

- If your community offers non-congregate shelter and is not at full capacity, then refer all mpox- or COVID-positive or other high-risk individuals to these external shelter facilities.
- If your community offers non-congregate shelter but is at capacity and there are no other alternate sites available, then isolation-in-place be necessary. Reach out to your public health partners and CoC leadership to talk through options.
- If your community does not offer non-congregate shelter or there are reasons why that is not or will not be an option in the near future, then isolation in place may be necessary. Again, discuss options with your public health and CoC partners.

Isolation-in-place areas should be physically separate sections of your facility, ideally separated by walls or in separate buildings. Additionally, the isolation-in-place area should include the following.

- A dining area. If one is unavailable, the next best option is to ensure meals are packaged and delivered to the isolation area so that residents do not have to collect their meals from the general dining area.
 - While individual bathrooms are ideal for privacy and security, most congregate facilities have shared bathrooms. If shared bathrooms are the only option, designate one of the shared bathrooms for the isolation area and stagger use, perhaps by establishing a schedule for residents, and maintain cleaning and disinfecting protocols.
 - Beds should be spaced at least six feet apart with residents sleeping head to toe. If necessary, beds can be spaced closer if the room is all mpox cases, flu cases or COVID-19 cases. Do not space individuals closer than six feet if they have different illnesses.
 - Hand sanitizer, tissues, and trash receptacles should be placed throughout the area. If the isolation space is for residents who have mpox, each person should have their own trashcan.
 - For COVID-19 isolation areas, adequate ventilation is helpful and may involve installing HEPA air filters, running exhaust fans continuously, or opening doors and windows if weather permits. Ensure any doors or windows connected to the non-isolation areas remain closed to limit virus exposure.

If the shelter space is too small to accommodate these configurations, consult with your public health partners to determine other solutions such as temporary walls, furniture, curtains hung from the ceiling, or other partitions to cordon off an isolation area.

Let's review the isolation times for both COVID-19 and mpox, because these factor into a shelter's IP needs.

The Centers for Disease Control and Prevention (CDC), in general, recommends at least seven days of isolation for COVID-19-positive individuals. The seven-day period

should start for individuals who are COVID-19-positive on the day of the positive test or the day on which symptoms first appeared — whichever is earlier. For example, consider a situation in which the individual takes a PCR test and results are not available until Day 2. The date of exposure is still considered to be Day 0. Symptoms should be monitored over the seven-day period.

Please note that the seven-day isolation period is contingent on several factors, including:

- The individual has a negative viral test on Day Seven,
- The individual has been fever-free for 24 hours with symptoms that are improving, and
- The individual was not hospitalized for severe illness due to COVID-19 and does not have a weakened immune system.

If the individuals meet all of these requirements, then the shelter could choose the seven-day isolation period.

The CDC recommends a longer isolation period for homeless service sites and other congregate settings because of the risk of widespread transmission in dense housing environments and the possibility of complications and severe COVID illness among people experiencing homelessness due to underlying medical conditions.

There is no defined isolation period for people who have mpox other than to say it generally lasts from two to four weeks, which translates to between 15 and 30 days. Isolation can end when the rash has healed, and a new layer of skin has formed. How much time this takes will be different for each person.

Cohorting occurs when a shelter groups residents with similar symptoms or illnesses together to maximize space and mitigate disease spread. Two cohorts are the minimum needed for isolation in place, but you may need to consider more if there are multiple contagious illnesses circulating in the shelter setting. Let's review who resides in each cohort using a two-cohort scenario:

Cohort A includes residents who:

- Have no symptoms and a negative COVID-19, mpox, or flu test.
- Have recovered from a recent COVID-19 infection (i.e., it has been 10 days since a positive test result or an assumed positive, and symptoms have subsided), or have recovered from mpox.
- Are asymptomatic new or returning program participants awaiting their COVID-19 or mpox test results.
- Are asymptomatic but were exposed to someone who was COVID-positive or has active mpox.

Cohort B is the isolation cohort and includes residents who are COVID-19-positive, flu-positive, or mpox-positive and those who are symptomatic with another contagious disease.

COVID-19-positive individuals can isolate together, those with flu can isolate

together, and people with mpox can isolate together, but they cannot isolate in the same cohort, so if you have COVID-19, flu, and mpox cases in the shelter at the same time, you may need to have multiple isolation cohorts - one for COVID-19-positive residents, one for flu-positive residents, and one for mpox-positive residents. Please talk with your public health partner if this situation occurs in your shelter.

There are times that you will need to move residents between the cohorts. These instances include:

- Residents in Cohort A (General Population) who test positive for COVID-19, mpox, or the flu or develop illness symptoms must transfer to the respective Isolation Cohort.
- Residents staying in the COVID-19 Isolation Cohort who are improving after seven days from symptom onset or a positive COVID-19 test can rejoin Cohort A after Day seven if they have a negative viral test. Those who do not can stay in isolation for 10 days and return to Cohort A after Day 10. Residents in an mpox Isolation Cohort need to remain isolated until their rash fully heals, and new skin growth has occurred.

Here are a few staffing considerations for any isolation-in-place implementation. Provide hazard pay to staff performing this critical work.

Designate staff who are up-to-date on vaccinations to support the isolation area. Being up-to-date on vaccinations means they have completed their vaccination series and have been boosted if a booster is available. Allow only isolation-assigned staff to enter the isolation area.

Prioritize staff who are N95 fit-tested for respirators to work in isolation areas.

- Maximize physical distancing while supporting residents (with noncontact service delivery, for example).
- Train staff on signs and symptoms of contagious illnesses, encourage self-monitoring for symptoms, and encourage staff to stay home if they are ill.
- Limit the movement of isolation-designated staff within other parts of the building(s).

Thank you for joining us. Before you go, please make sure you save the resources we have provided about isolation and operational considerations and check out the next module which will focus on isolation considerations in non-congregate settings.

<https://www.cdc.gov/poxvirus/monkeypox/clinicians/infection-control-healthcare.html>