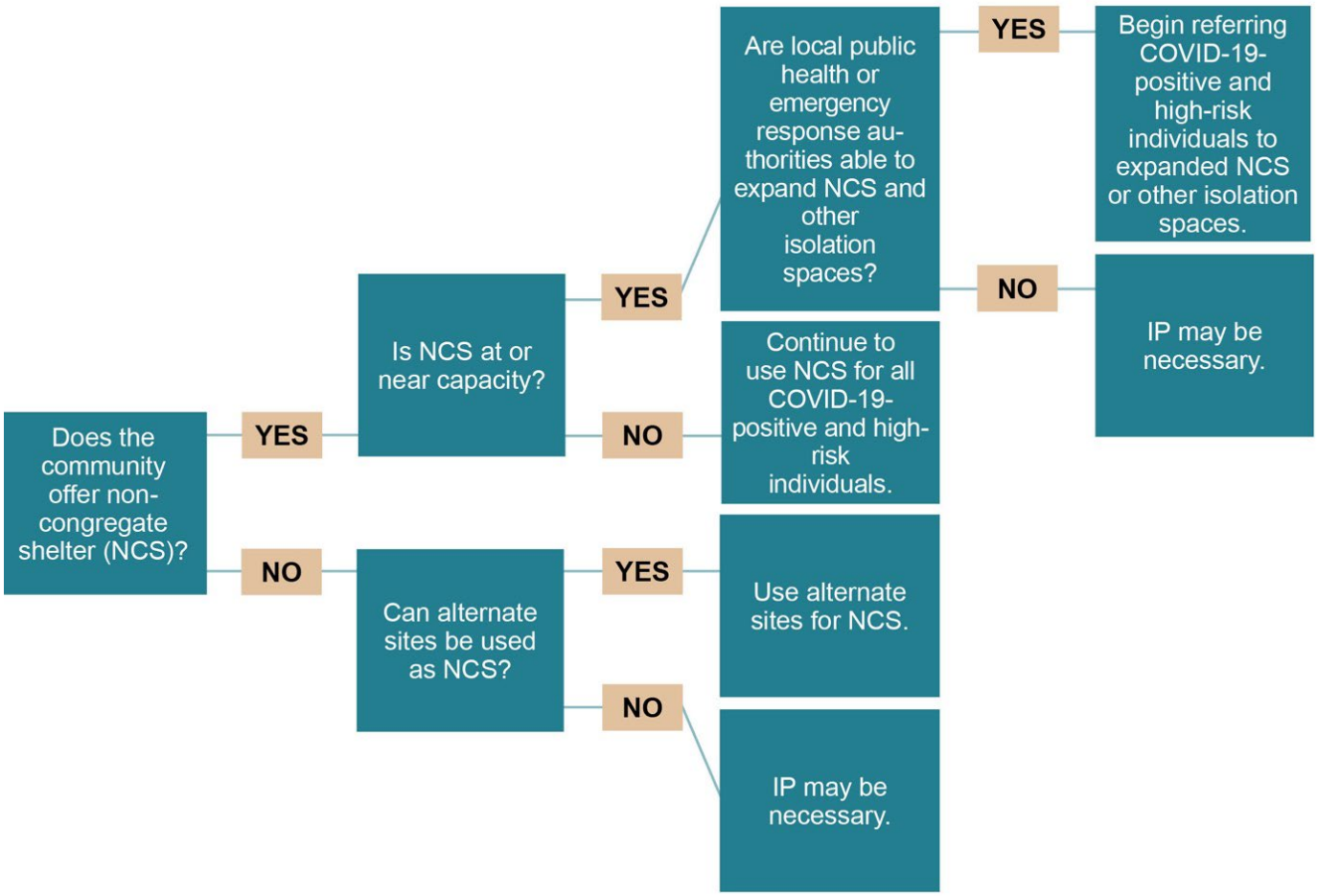
Shelter-Based Isolation in Place

When isolation spaces are limited due to the impact of COVID-19, shelter providers may need to consider isolating COVID-19-positive and symptomatic residents onsite. This is known as **Isolation in Place (IP)**. IP is the practice of sheltering COVID-19-positive or symptomatic individuals using private rooms (such as offices) or sectioning off areas within existing congregate settings.

How Will I Know if the Shelter Needs to Implement IP?

Local public health or emergency response authorities may notify shelter providers that off-site isolation and quarantine spaces are unavailable. Otherwise, Continuums of Care (CoCs) or shelter providers should reach out to their local public health department before implementing an approach to ensure all other options have been exhausted. The following decision tree may help providers consider their options and determine next steps. Once determining that IP may be necessary, providers are encouraged to work with their local public health partners on implementing this approach.



Physical Attributes of IP[1]

The IP area should be a separate section of the facility. Ideally, these areas would be separated by walls or in separate buildings. If their congregate shelter space is too small to accommodate this configuration, providers should consult with local public health departments to determine other solutions such as temporary walls, furniture, curtains hung from the ceiling, or other partitions to cordon off an isolation area. Additionally, the IP area should include:

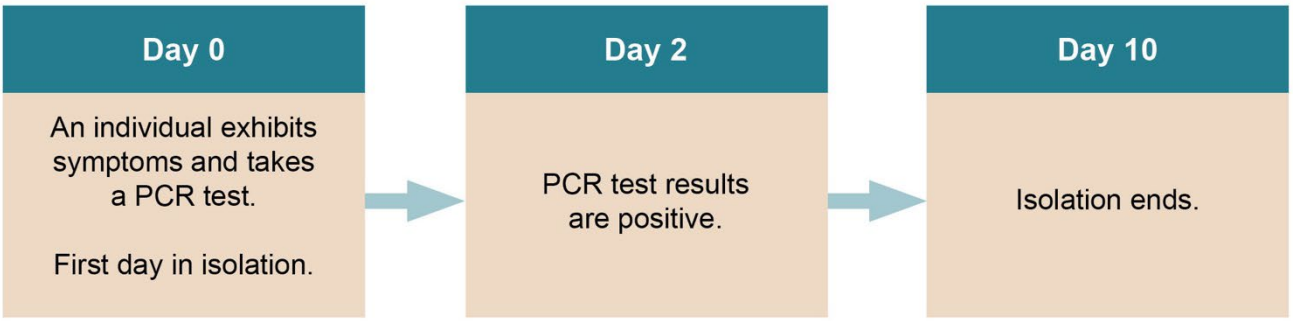
- A dining area (if unavailable, ensure meals can be packaged and delivered to the isolation space so that residents do not have to collect their meals from the general dining area).
- Individual bathroom facilities (if bathrooms are shared, stagger usage and maintain cleaning and disinfecting protocols).
- Beds spaced six feet apart with residents sleeping head to toe (if six feet is not feasible, beds can be spaced closer due to all residents' COVID-19 status).
- Hand sanitizer, tissues, and trash receptacles placed throughout the area.
- Adequate ventilation. This 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-IP area remain closed to limit virus exposure.

Cohorting[2]

When isolating in place, shelters should cohort residents. You may have three different groups of residents: those who have tested positive for COVID-19, those who are symptomatic but have not tested positive for COVID-19 (and are waiting for either a test or a negative/inconclusive test result), and those who are COVID-19-negative and not experiencing symptoms of COVID-19.

When cohorting shelter residents, providers should prepare to move residents between cohorts depending on their COVID-19 status. The Centers for Disease Control and Prevention (CDC) recommends 10 days of isolation or quarantine in congregate settings. The 10-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 10-day period.



Cohorting Examples

If a shelter chooses to implement IP, a minimum of two cohorts are needed. For larger shelters that are able to create three zones, residents can be further separated into three groups. Below are examples of cohort arrangements; shelters should work with local public health authorities to determine appropriate cohorts and movement patterns for their community.

Cohort Option 1: Two Cohorts (minimum needed for IP)

Cohort A (General Population)

Residents who:

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[1] Adapted from Seattle King County and Los Angeles Departments of Public Health.
[2] Concept and cohorts adapted from LA Public Health Recommendations.

- Have no symptoms and a negative COVID-19 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).
- Are asymptomatic new or returning program participants awaiting their COVID-19 test results.
- Are asymptomatic but were exposed to someone who was COVID-19-positive.

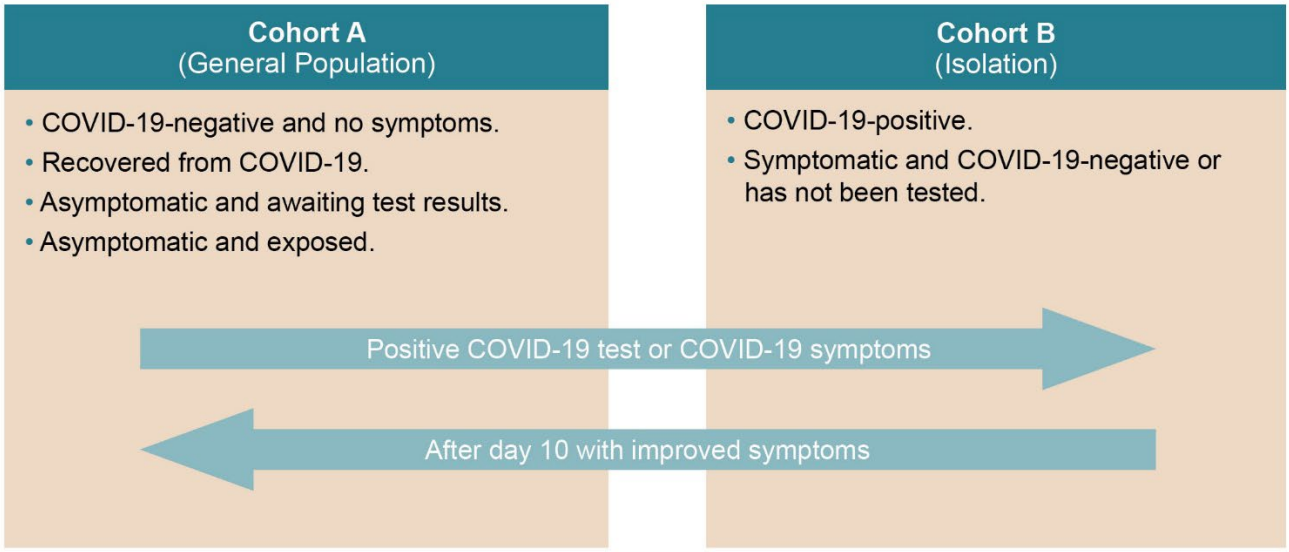
Cohort B (Isolation)

Residents who:

- Are COVID-19-positive.
- Are symptomatic and do not have a confirmed positive COVID-19 test (i.e., they are either waiting for a test or they have received a negative/inconclusive test result).

Moving Residents Between Cohorts in Option 1

- Residents in Cohort A (General Population) who test positive for COVID-19 or develop symptoms must transfer to Cohort B (Isolation).
- Residents who are improving after 10 days from symptom onset or positive COVID-19 test can rejoin Cohort A after day 10. If resources permit, testing can be done on Day 10 prior to transfer from Cohort B to Cohort A. Discuss the practice of testing to end isolation with local public health authorities before implementing this policy.



Cohort Option 2: Three Cohorts

Cohort A (General Population)

Residents who:

- Have no symptoms and a negative COVID-19 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).

Cohort B (Quarantine)

Residents who:

- Are asymptomatic new or returning program participants awaiting their COVID-19 test results.
- Are asymptomatic but were exposed to someone who was COVID-19-positive.
- Are symptomatic and do not have a confirmed positive COVID-19 test (i.e., either waiting for a test or has received a negative or inconclusive test result).

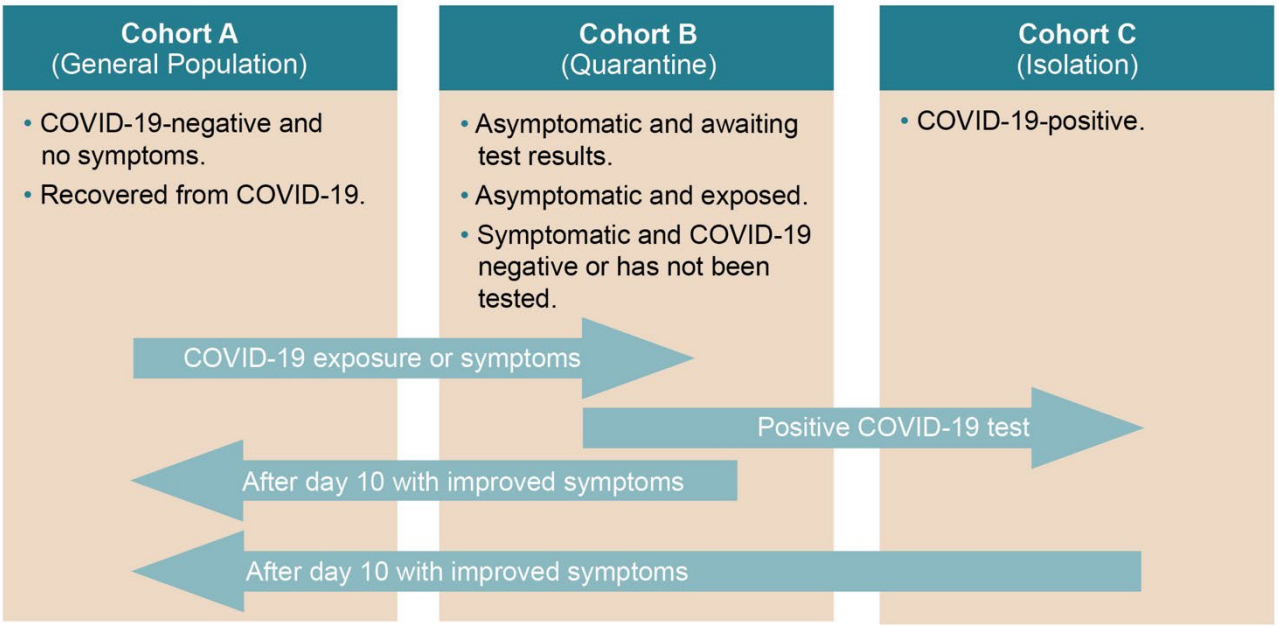
Cohort C (Isolation)

Residents who:

- Are COVID-19-positive (symptomatic and asymptomatic).

Moving Residents Between Cohorts in Option 2

- Any resident who tests positive should be transferred to Cohort C (Isolation).
- Residents in Cohort A (General Population) who develop symptoms or were exposed must move to Cohort B (Quarantine).
- Residents in Cohort B (Quarantine) who are asymptomatic or improving after 10 days can be moved to Cohort A (General Population) after being tested between days 5–7 and receiving a negative COVID-19 test result. If residents in Cohort B (Quarantine) test positive between days 5–7, they should be moved to Cohort C (Isolation) and complete a full 10-day isolation.
- Residents in Cohort C (Isolation) who are asymptomatic or improving after 10 days from their COVID-19-positive test result can be transferred to Cohort A.



Escalation to Emergency Care[3]

Staff should call emergency medical services if a resident has severe warning signs of COVID-19, 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.
- Light-headedness.
- 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.

[3] Adapted from Chicago, IL, Seattle King County, and Los Angeles DPHs.

Operational Considerations[4]

Staffing Considerations	
General	• Scale up available staffing and create a plan to address staffing shortages. • Minimize the number of face-to-face interactions with residents among staff who are not up to date on COVID-19 vaccination. • Maintain physical distance between all staff, residents, and volunteers.
Isolation-Area Staff	• Designate staff who are up to date on vaccinations[5] to support the isolation area. • Allow only isolation-assigned staff to enter the isolation area. • Maximize physical distancing while supporting residents (with non-contact service delivery, for example). • Prioritize staff who are N95 fit tested for respirators to work in isolation areas. • Limit the movement of those designated staff within other parts of the building(s). • Provide hazard pay to staff performing this critical work.
Isolation Requirements for Staff	• Follow CDC recommendations and quarantine or isolate away from the shelter for 10 days. • Do not pressure staff to come to work if they are ill or exposed. • During a critical staff shortage, local public health authorities may advise that asymptomatic shelter staff may return to work after a shorter duration, provided they wear a mask at ALL times. They should not remove their mask during breaks or in common eating areas. These decisions should be discussed with local public health partners.

Infection Control	
Prevention Measures	• Require universal masking for all individuals within the indoor shelter setting. • Encourage all residents to wear a surgical mask indoors regardless of isolation status. • Ensure surgical masks (preferable to cloth) are available for staff, volunteers, and residents. • Outfit staff and volunteers assigned to the isolation area with gowns, gloves, and N95 respirators. • Encourage proper hand hygiene throughout the shelter.
Meals	• Separate symptomatic and asymptomatic residents during meals. • Stagger meals, if necessary, to keep symptomatic and asymptomatic residents separate. • Clean facilities and diningware after use by each group to reduce transmission risks. • Mobile partitions (such as linens or moveable screens) should be used to encourage compliance with separation in shared spaces.

[4] Adapted from Seattle King County and Los Angeles DPHs.

[5] "Up to date" on vaccinations means an individual who is eligible for a booster has received it. Individuals who are not yet eligible for boosters are considered up to date on vaccinations two weeks after both doses of the two-dose series of Pfizer or Moderna or two weeks after the single-dose series of Johnson & Johnson.

Interpersonal Contact	• Restrict visitors and other residents from entering the isolation area. • Allow only staff providing essential care to enter the isolation area. • Designate a path through the building for residents in isolation that limits contact with other residents. • Consider designating separate smoking areas based on cohorts.
Cleaning and Disinfecting	• Follow CDC guidance for cleaning and disinfecting the facility. • If separate bathrooms are unavailable, clean after each use by a COVID-19-positive resident.

Screening	
General Considerations	• Provide signage and assess all new residents at the time of admission for symptoms of COVID-19 and for close contact with a COVID-19-positive individual. • Screen for COVID-19 symptoms of all staff and residents at least twice daily and at least three times daily for residents who are positive or exposed. • Remind residents to report any new COVID-19 symptoms to staff. • Encourage residents to participate in COVID-19 testing as often as resources allow. • During an outbreak, any resident with symptoms of respiratory illness can be presumed to have COVID-19.
Initiating and Ending Isolation/ Quarantine	• Upon identification of a COVID-19-positive or symptomatic resident, immediately move the individual into a space designated for isolation or quarantine (as applicable), and ensure they wear a surgical mask over their nose and mouth. • Keep a daily log of all residents in isolation and quarantine to monitor symptoms and determine when criteria are met for ending the resident's isolation or quarantine.

Community examples:

Seattle/King County, WA

The U.S. Department of Housing and Urban Development's (HUD's) Office of Special Needs Assistance Programs (SNAPS) Office Hours Community Spotlight: Los Angeles, CA