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Updated COVID-19 Best Practices for Shelters and Homeless Service Providers Following the End of the Public Health Emergency

*This document reflects a compilation of information from the most recent CDC COVID-19 guidance relevant to these settings with additional resources and tools to clarify and explain key points. This document replaces the previously issued IDPH COVID-19 homeless setting update issued December 2021. Updates have been highlighted in **red**.*

Major New Concepts Since December 10, 2021	
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Applicability

This document is intended for homeless shelters and homeless service providers, overnight emergency shelters, day shelters, warming centers, domestic violence shelters, and meal service providers.

For Health Care Professionals: This document does **not** apply to dedicated patient care areas within these settings. Any health care 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.

Reason for Update

On May 11, 2023, the Illinois COVID-19 Disaster Proclamation ended, aligning with the U.S. Department of Health and Human Services end to the federal Public Health Emergency (PHE). The response to SARS-CoV-2, the virus that causes COVID-19, remains a public health priority. However, as a result of the concerted efforts of all those involved in ensuring high levels of vaccination, the availability of effective treatments, and use of infection prevention measures, there has been a substantial reduction in the risk for significant COVID-19 illness, hospitalizations, and deaths. Both the nation as a whole, and the state of Illinois, are in a better

place in the response than three years ago and are prepared to transition away from the emergency phase.

This document is an update to the IDPH homeless setting update released in December 2021, and is aligned with the CDC's Guidance on Management of COVID-19 in Homeless Service Sites and in Correctional and Detention Facilities that was released on May 11, 2023. People experiencing homelessness are at increased risk for infection during community spread of COVID-19. In addition, there is a high prevalence of certain medical conditions associated with severe COVID-19 among people experiencing homelessness, increasing the risk for severe outcomes from COVID-19 in these populations. Actions to limit the spread of COVID-19 in shelters will help keep clients, staff, and volunteers healthy, and help shelters and homeless service providers and ensure there is no disruption in services.

Use County-Level COVID-19 Data for Decision-Making

KEY POINTS

Shelters should monitor the CDC COVID-19 Data Tracker weekly and implement enhanced infection prevention and control measures based on the level of new COVID-19 hospital admissions over the past week in their county. This is the same metric that is being utilized by the CDC to issue alerts to the public regarding higher levels of SARS-CoV-2 circulating in the community and the need to take additional protective actions.

- **Per CDC, a COVID-19 new hospital admissions level of 20 per 100,000 population over the past week is used as the measure at which shelters should consider implementing Enhanced Prevention Strategies ("HIGH").**
- **If there is a steady increase in hospital admissions for respiratory infections including Flu and RSV over two weeks regardless of the actual rate of admissions, shelters should be vigilant and prepared to implement enhanced measures if necessary.**

Shelters and individuals may choose to implement **additional** protective measures when the **COVID-19 Hospital Admission Level is lower based on their discretion and taking into account the activity of other respiratory infections such as Flu and RSV.**

CDC recommends that homeless shelters coordinate their COVID-19 prevention and response efforts and conduct a risk assessment to inform implementation of a combination of everyday and enhanced strategies. Per the CDC's Guidance on Management of COVID-19 in Homeless Service Sites and in Correctional and Detention Facilities:

1. **Coordinating COVID-19 Prevention and Response Efforts**
   Health departments and organizations that serve people experiencing sheltered and unsheltered homelessness should remain connected following the end of the PHE to ensure ongoing coordination of COVID-19 response efforts.

2. Assessing Shelter Risk for Shelters and Homeless Settings

Homeless settings and shelters should use the COVID-19 New Hospital Admission Levels (See box above for description), and shelter-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 shelter-specific risks:

- **Shelter structural and operational characteristics:** Assess whether shelter characteristics or operations contribute to COVID-19 spread. For example, facilities may have a higher risk of transmission if they have frequent client 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 shelter are more likely to get very sick from COVID-19, for example, due to underlying health conditions, lack of COVID-19 vaccination, older age, pregnancy, or poor access to medical care.
- **COVID-19 transmission in the shelter:** Assess the extent to which transmission is occurring within the shelter, through diagnostic testing of people with COVID-19 symptoms of people with COVID-19 symptoms and their close contacts, as described below, under "Post-Exposure Guidance."

3. COVID-19 Prevention Strategies – Every Day and Enhanced

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 when the COVID-19 New Hospital Admission Levels are **HIGH**.

- **Prevention strategies for everyday operations** should be in place at all times, even if COVID-19 New Hospital Admission Levels are low or medium. These include all the strategies listed below except those marked ***enhanced strategy***.

- **Enhanced prevention strategies** should be added to supplement the prevention strategies for everyday operations when COVID-19 New Hospital Admission Levels are **HIGH**, and when the shelter is in outbreak, or based on the assessment of shelter-specific factors that increase risk. This is not an exhaustive list. Contact your local health department to discuss additional measures based on the situation.

- **When adding enhanced prevention strategies, shelter operators should balance the need for COVID-19 prevention with the impact of reducing access to services and programming**.
  - Facilities may not be able to apply all enhanced COVID-19 prevention strategies due to local resource constraints or shelter and population characteristics. A multi-layered approach should be used to increase the level of protection by adding as many prevention strategies as feasible.
  - Depending on the risk in different areas of the shelter, enhanced prevention strategies can be applied across an entire shelter or can be targeted to a single housing area, wing, or building. Facilities with a higher risk profile can apply

enhanced prevention strategies at any time, including when the COVID-19 New Hospital Admission Levels are **NOT HIGH**.

4. **COVID-19 Vaccination Recommendations**
   Vaccination is the leading measure to prevent severe illness, hospitalization, and death from COVID-19, and to help shelters maintain normal operations. COVID-19 vaccines are safe, effective, and widely available. Shelter clients, service staff, and volunteers should be strongly encouraged to receive COVID-19 vaccination and remain up to date. Shelters, local health departments, and area health care providers should coordinate these efforts to assist persons experiencing homelessness with COVID-19 vaccination. However, vaccination status should *not* be used as a prerequisite to receive shelter, housing, or services.

5. **Considerations for Improving Ventilation**
   Improving ventilation practices can reduce the airborne concentrations of viral particles and reduce the risk that clients, staff, and volunteers will be exposed. Approaches include:
   - Consider using natural ventilation (i.e., opening windows if possible and safe to do so) to increase outdoor air dilution of indoor air when environmental conditions and building requirements allow.
   - Ceiling fans on low and potentially in reverse, can improve room air mixing, even if windows are not open, helping to distribute clean air and dilute viral particle concentrations throughout the room.
   - Consider using air purifying devices such as portable high-efficiency particulate air (HEPA) filtration systems to help enhance air cleaning (especially in higher-risk areas such as rooms occupied by COVID-19-positive individuals).
   - Collaborate with the local health department and experts in heating, ventilation, and air conditioning (HVAC) to identify resources for improving ventilation and air quality in advance of higher risk periods to be ready to deploy when needed.
   - For more information: CDC Improving Building Ventilation During COVID-19
   - **Enhanced strategy:** Where possible, consider holding group activities outdoors.
   - **Enhanced strategy:** If temperatures outside make it difficult to leave multiple windows open, consider safely securing window fans or box fans (sealing the perimeter around the box fan) to blow air out of selected windows.

6. **Signage**
   Facilities should consider placing signage at entrances and other strategic places to inform clients, staff, and volunteers of recommended actions to prevent the transmission of COVID-19. These alerts should include instructions about current IPC recommendations (e.g., when to use source control and perform hand hygiene).

7. **Hand Hygiene**
   - Encourage clients, staff, and volunteers to perform hand hygiene for at least 20 seconds with soap and water or an alcohol-based hand sanitizer with at least 60% alcohol.
   - Provide alcohol-based hand sanitizers at key points within the shelter, including registration desks, entrances/exits, and eating areas.

- Maintain a stock of hand hygiene supplies (soap, alcohol-based hand sanitizer, etc.). and make sure bathrooms and other sinks are consistently stocked with soap and drying materials for handwashing and that hand sanitizer is available.

8. **Clean and Disinfect**
   - Frequently touched surfaces at least daily and shared objects between use with an U.S. Environmental Protection Agency (EPA)-registered List N disinfectant).
   - **Enhanced strategy:** Apply enhanced cleaning and disinfection recommendations.

9. **Masking and PPE**
   - **Wear Masks or Respirators and Personal Protective Equipment, as Appropriate**
     - Maintain a stock of personal protective equipment (PPE) for staff.
     - Offer high-quality masks/respirators to all clients and staff and provide other PPE for staff and clients based on risk (see below for more information on PPE).
     - **Enhanced strategy:** Require universal indoor masking.
   - **Indications for PPE/Masks and Respirators**
     - **Clients, volunteers, and staff may choose to wear well-fitted masks or respirators, based on their personal preference,** when in the common areas of the shelters, especially if attending a large gathering and to and from the dining areas or activities.
     - **Clients who have been exposed to someone with SARS-CoV-2 infection** should wear a well-fitted mask for 10 days after their exposure when around others.
     - **Clients who have COVID-19 or are suspected of having COVID-19** should wear a well-fitted mask or respirator for 10 days whenever they are around others.
     - **Staff who will have close contact with clients who are in isolation precautions, including during transport** should wear a NIOSH-approved respirator, eye protection (goggles/face shield), gowns/coveralls, and gloves.

10. **Ensure Testing is Accessible for COVID-19 When Needed**
    - Test clients and staff who either have symptoms of COVID-19 or have had a moderate-risk or higher-risk exposure (see **Table 1**, below).
      - Facilities that perform point-of-care (POC) antigen testing must comply with state and federal regulations and report all positive tests to IDPH. Instructions are located at: https://dph.illinois.gov/covid19/community-guidance/long-term-care/antigen-testing.html
    - For considerations on interpreting antigen test results in homeless shelters, see the CDC algorithm in the Appendix.
    - **Enhanced strategy:** Consult with your local health department about implementing routine screening testing of clients 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 important for people who are eligible for treatment.
    - Additional information is available from CDC: Guidance for Antigen Testing for SARS-CoV-2 for Healthcare Providers Testing Individuals in the Community.

11. Testing Plan and Response Strategy

The purpose and process of all testing and other public health activities should be clearly communicated to clients and to staff at the homeless service site to promote understanding and transparency. Shelters should ensure that they obtain verbal, informed consent for testing from clients. Testing strategies should be carried out in a way that protects privacy and confidentiality to the extent possible. Whenever a positive test result is identified, the shelter should ensure that the individual is notified, separated from others, referred for medical care, and, if necessary, linked to alternative housing for isolation.

Key components of the testing plan, shown in the "Contact Tracing and Testing in Homeless Shelters and Service Sites" in the appendix below are:

- **Immediate testing** should be performed on individuals with signs or symptoms consistent with COVID-19.
- **Testing should also be performed on individuals exposed to COVID-19 as described below.**

12. Identifying COVID-19 Exposed Persons for Testing

- A person with COVID-19 can spread the virus beginning two days prior to the onset of any symptoms (or two days prior to a positive test if they do not have symptoms).
- Persons with COVID-19 are considered infectious for 10 days although that time period may be shortened to seven days with a negative test (see below under "Implement Isolation for Clients, Staff, and Volunteers who Test Positive for SARS-CoV-2").
- After identifying a client, staff, or volunteer case of COVID-19, determine if the infectious individual had any contact that would constitute a moderate- or higher-risk exposure (see Table 1: Evaluating Exposure Risks for Clients, Staff, and Volunteers) using the strategies below:
- **Case Investigation and Person-Based Contact Tracing**
  - People who have been exposed (close contacts) to someone when they are infectious with COVID-19 should be identified based on their interactions with the positive individual. Table 1 can be used to determine if an interaction qualified as an exposure.
  - Case investigations should prioritize identification of close contacts who are more likely to get very sick from COVID-19 so that they can be referred to a health care provider to determine eligibility for treatment if they test positive for COVID-19.
  - Test exposed individuals at least five days after exposure or immediately if they develop symptoms.
- **Location-Based Contact Tracing**
  - Location-based contact tracing is preferable when identifying close contacts is difficult due to client and staff movements in and out of the shelter.
  - Location-based contact tracing identifies potential exposures based on where a person with COVID-19 spent time while infectious.
    - For clients, this could include their housing unit, transport bus, dining area, and any programmatic activities.

        - For staff and volunteers, this could include their duty station/unit, break room, carpool, and areas where they interacted with clients.
    - For areas of a shelter identified in location-based contact tracing, consider conducting testing of those who were present based on their exposure risk (see **Table 1**, in the Appendix below).
        - People who have had a moderate- or higher-risk exposure to someone known or suspected of having COVID-19 should be tested **at least five days after the exposure**. If symptoms develop before five days, they should be tested immediately.
- **If any additional cases are identified, shelters should consider adding enhanced prevention strategies.**
- *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.
- **All cases of COVID-19 must be reported to the local health department.**
- Anyone who has had a higher-risk exposure should mask for 10 full days afterward.
- **Enhanced Strategy: Shelter-wide testing option:**
    - **Whenever there is substantial or widespread transmission of COVID-19 within a shelter,** testing of all clients, staff, and volunteers should be considered.

13. Implement CDC "Post-Exposure Guidance"

Clients and non-health care staff who have had a moderate – or higher-risk exposure – should test at least five full days after exposure (or sooner, if they develop symptoms) and should wear a well-fitted mask while indoors for 10 full days after exposure.

Managing Clients with Moderate-Risk or Higher-Risk Exposures

Clients do not need to be quarantined following exposure unless they develop symptoms or test positive for SARS-CoV-2. Clients who have been exposed should be monitored for the development of symptoms, to ensure prompt treatment to prevent severe illness or hospitalization.

- Testing following exposure.
    - Test clients five full days after exposure, even if they do not develop symptoms. Count day of exposure as day 0.
    - If clients develop symptoms, test immediately.
    - No testing is required if clients have had COVID-19 within the last 30 days as the risk of reinfection is low.
- Clients should wear a mask for 10 days post-exposure.

Managing Staff and Volunteers with Moderate-Risk or Higher-Risk Exposure
Work restriction is not required for staff and volunteers following a moderate-risk or higher-risk exposure, regardless of vaccination status, unless they develop symptoms or test positive for SARS-CoV-2.

- **Staff and Volunteers**
  - Testing following exposure:
    - Test staff five full days after exposure, even if they do not develop symptoms. Count day of exposure as day 0.
    - If staff develop symptoms, test immediately.
    - No testing is required if staff have had COVID-19 in the last 30 days as the risk of reinfection is low.
    - Staff should wear a well-fitted mask for 10 days post-exposure.
- **Health Care Personnel**
  - **If a shelter has health care workers on-site,** they should follow the recommendations from the CDC's Updated Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic

14. Isolate Clients, Staff, and Volunteers who Test Positive for SARS-CoV-2

- Isolate staff, volunteers, and clients who test positive for COVID-19 away from others, or away from the shelter, 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 test*, isolation can be shortened to seven days as long as:
  1. Symptoms are improving, **AND**
  2. the individual has been fever-free for 24 hours (without the use of fever-reducing medications), **AND**
  3. the individual was not hospitalized, **AND**
  4. the individual does not have a weakened immune system.
- **Note: the isolation period for shelters is longer than recommended for the public because of the risk of transmission in these settings and the high prevalence of underlying medical conditions associated with severe COVID-19.**
  - If multiple clients have tested positive, they can isolate together in the same area.
  - Ensure continuation of support services, including behavioral health and medical care, for clients while they are in isolation.
  - If crisis-level conditions arise, such as severe shortages of staffing or space, shelters and service sites should consult with their local health department for guidance and support before contingency or crisis staffing measures are implemented.

*Either a NAAT test, such as a PCR test, typically performed in a laboratory, or an onsite antigen test may be used to determine if isolation can be shortened to seven days. If using a NAAT, a single test is acceptable and must be obtained no sooner than day 5 of isolation. If using an antigen test, two negative tests must be obtained, one no sooner than day 5 and the second 48 hours later. Because NAAT tests can remain positive for some time, antigen testing may be preferred.

15. Increase Distance

Routine physical distancing is no longer emphasized in the updated CDC recommendations unless the shelter is experiencing an outbreak or when the COVID-19 New Hospital Admission Level is **HIGH**. However, when respiratory illnesses are circulating in the community, it is best practice for higher-risk facilities to 1) take measures to limit crowding in communal spaces and 2) encourage physical distancing at large gatherings, such as parties or events.

- **Enhanced strategy:** Create physical distance of 6 feet or more in common areas when COVID-19 New Hospital Admission Levels are **HIGH** or the shelter is experiencing an outbreak.
- **Enhanced strategy:** Reduce movement and contact between different parts of the shelter when the shelter is experiencing an outbreak.
- **Enhanced Strategy**: In meal service areas, create at least 6 feet of space between seats and/or allow either for food to be delivered to clients or for clients to take food away.
- **Enhanced Strategy:** Create a way to make physical distancing between clients and staff easier, such as staggering meal services or having maximum occupancy limits for common rooms and bathrooms.
- **Enhanced Strategy**: In general sleeping areas (for those who are not experiencing respiratory symptoms), try to make sure client's faces are at least 6 feet apart. Align mats/beds so clients sleep head-to-toe.

16. Space Planning

Additional spaces (e.g., alternative offsite facilities) may be needed for people experiencing homelessness when a shelter is experiencing an outbreak. These additional spaces or sites could include:

- Overflow shelter spaces or sites to reduce crowding or respond to higher shelter demands.
- Isolation spaces or sites for people who are confirmed to be positive for COVID-19 but do not need to be hospitalized.
- Quarantine spaces (if quarantine is used).
- 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 may be considered. Partners should consider planning how to connect clients to housing opportunities after they have completed their stay in these temporary sites.

17. Recommendations for Ensuring Access to Shelter and Homeless Services

Homeless shelters should not close or exclude people who are having symptoms or test positive for COVID-19 without a plan for where these clients can safely access services and stay. 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. Decisions about alternative housing sites should be made in coordination with the local health department. Alternative housing sites include:

- **Overflow sites** to accommodate shelter decompression (to reduce crowding) and higher shelter demands.
- **Isolation sites** for people who are confirmed to be positive for COVID-19.

18. Screening for Symptoms of COVID-19

- At this time, shelters and homeless settings are no longer required to actively screen everyone entering the building.
- **Enhanced Strategy:** However, if their risk assessment suggests screening would be helpful, homeless settings and service sites may still elect to screen people entering the building.

19. Support Timely Access to Treatment

Effective COVID-19 treatments are now widely available but must be started within a few days after symptoms develop. Treatment has been shown to reduce the risk of severe COVID-19 disease and hospitalization, especially in the elderly and those with underlying health conditions. **As soon as a client is diagnosed with COVID-19:**

- Support timely treatment for those eligible. Facilities without onsite health care capacity should plan to ensure timely access to care offsite.
- Contact the local health department right away if you have trouble securing treatment for clients with COVID-19.
- **Treatment Information is available at:**
  - National Institutes of Health (NIH) COVID-19 treatment guidelines.
  - A clinical decision tree is also available to help clinicians determine if a client is eligible for COVID-19 treatment and the right choice of treatment.

20. Unsheltered Homelessness

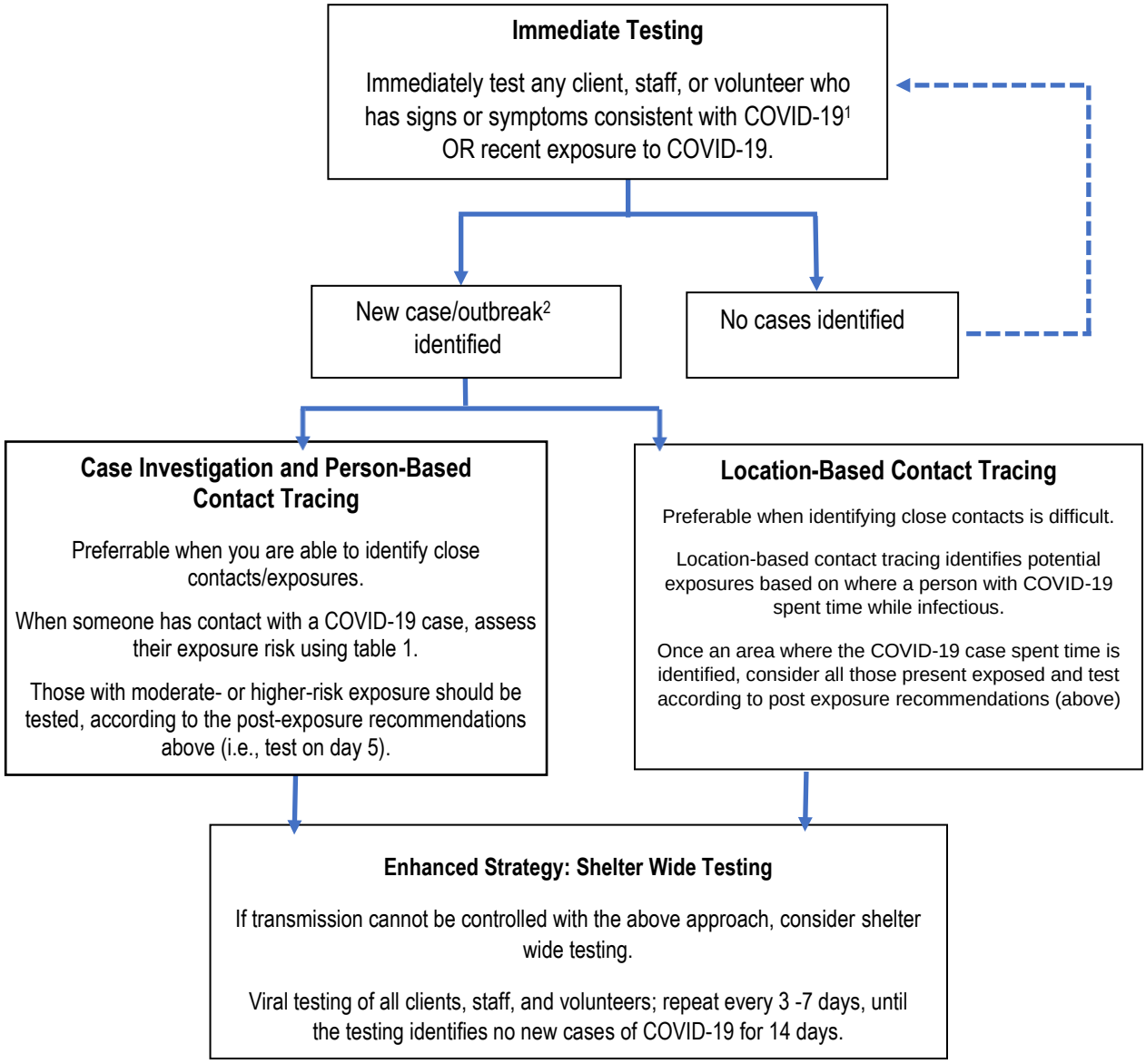
Although people experiencing unsheltered homelessness do not reside in a congregate setting, the risk of severe COVID-19 can be high in this group because of underlying medical conditions and lack of access to health care. When the COVID-19 hospital admission level is **HIGH**, organizations can help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

Appendix:

Table 1: Evaluating Exposure Risks for Clients, Staff, and Volunteers (Based on the CDC's Understanding Your Exposure Risk)				
Evaluate an exposure for each criterion and write the level of risk in the last column				
Criteria	**Lower Risk**	**Moderate Risk**	**Higher Risk**	**Evaluate Exposure** (write low, moderate, or high in the box for each criterion evaluated)
Exposure Time	Short duration (Very brief time, e.g., passing in hall, store, etc.)	Moderate duration (Less than 15 minutes, e.g., working out in a gym, sitting in group setting together)	Longer duration (15 minutes or more, e.g., worked together all day, live together)	
Activities that may involve exertion	Little to no exertion (e.g., sitting watching tv, meditation, yoga, quiet activity)	Some exertion: (e.g., sitting together and talking to each other)	Exertion: Coughing, singing, shouting, or breathing heavily	
Symptomatic	Asymptomatic-infected person did not display any symptoms	Not applicable	Symptomatic-infected person coughing, etc.	
Mask wearing*	Both persons were masked	One person was masked	No masks were worn by either person	
Ventilation	Encounter with infected person was outdoors	Well-ventilated indoor setting (fans going, air filters, windows open, etc.)	Poorly ventilated indoor setting	
Distance	Distance of 6 feet or more between the infected person and exposed person	Moderately close, (within 3 feet) to the infected person	Very close or touching the infected person	
Scoring Exposure Risk and Required Action Steps				
If all six criteria are evaluated as lower-risk, no further action is required by the shelter, client, or staff				
If one or more criteria are evaluated as a moderate-risk or higher-risk, follow the CDC's "Post Exposure Guidance" above.				

- *Staff who were wearing an N95 respirator and eye protection are not considered exposed, even if the person with COVID-19 was not wearing a mask.

Considerations for Contact Tracing and Testing in Homeless Shelters and Service Sites



[1] CDC Symptoms of COVID-19: https://www.cdc.gov/coronavirus/2019-ncov/symptoms-testing/symptoms.html

[2] IDPH definition of a COVID-19 outbreak in Homeless Shelters: Two or more individuals (clients and/or staff) who are laboratory-confirmed COVID-19 cases, AND are epidemiologically linked to the shelter, and have onset of illness or positive SARS-CoV-2 test (if asymptomatic) within 14 days of each other. An outbreak is considered resolved once no new cases are identified over a period of at least 14 days.

[3] A **close contact** is defined by CDC as **someone who was within 6 feet of an infected person for at least 15 minutes within a 24-hour period** starting from two days before illness onset (or, for asymptomatic cases two days prior to positive specimen collection) until the time the infected person is isolated.

[4] CDC Testing A for Homeless Shelters: https://www.cdc.gov/coronavirus/2019-ncov/community/homeless-correctional-settings.html

[5] Some local health departments may choose to extend the period of testing.