

KDHE Guidance for COVID-19 Non-Congregate Housing

Updated March 15, 2021

Introduction

Isolation of COVID-19 positive persons and persons under investigation (PUIs) is necessitated as part of a community mitigation strategy with the current pandemic. Positive cases and PUIs are identified through testing and contact investigations. Recommendation about how to isolate is made by the health department and if it is determined that a patient cannot effectively isolate in their current home, then alternative housing is offered. We recognize that these patients will have ongoing needs in addition to food, shelter, safety that includes management of their chronic medical conditions as well as monitoring of COVID-19 disease, specifically for resolution of symptoms and release from isolation, as well as watchfulness for deterioration that may require hospitalization. Isolation and quarantine guidance may differ for people who are fully vaccinated. See Isolation and Quarantine FAQ.

<https://www.coronavirus.kdheks.gov/DocumentCenter/View/134/Isolation--Quarantine-Guidance-and-FAQs-PDF---3-15-21>.

This document aims to outline a specific framework to accomplish this medical monitoring function.

Staffing

A clinician (Physician, APRN, RN) is tasked with maintaining contact with a cohort of patients in isolation housing. Ideally, the same clinicians, rotating call, would follow the same cohort for continuity, with additional clinicians added as more patients enter housing. A clinician will need sufficient knowledge to understand a wide variety of medical conditions and their management as well as skill in observation and medical assessment to identify worsening symptoms or deteriorating vital signs. There will be a designated on-call clinician available at all hours. In the event of a non-English speaker, a telephone interpreter service will be employed. In addition, it is suggested a mental health professional or social worker be assigned to each PUI and their family.

Record Keeping

The clinician will maintain a secure medical record for each patient, this may be paper in form and housed in a locked cabinet in the health care provider or local health department secure storage facility. The record will include demographics, medication and pharmacy information, medical history as well as a log of daily contacts, reported symptoms and oxygen saturation measurements.

Medical History

In addition to the general intake information, the patient will provide a list of current medications and pharmacy information. During initial contact with clinician, the clinician will perform a medical history and list the status of chronic medical conditions, current therapies aside from medications (i.e. CPAP, glucometers, indwelling catheters, etc.) and primary care physician contact info, as well as any treating specialists. (See page 4)

COVID-19 Specific Record Keeping

A record of the date of positive testing should be kept in the record to maintain timeline of symptoms and allow for assessment for release from isolation. The Kansas Department of Health and Environment (KDHE) defines recovery as 10 days from date of symptoms or 72 hours fever-free without the use of fever-reducing medication and significant improvement in symptoms whichever is longer. (See page 6)

Televisit Contact

At least one time per day, as scheduled, the clinician shall make contact with the patient via phone or video (depending on the technology possessed by patient) and inquire about any new symptoms or concerns. Specifically, a checklist format will be utilized. (See page 7) Contact information on how to speak with a clinician should be given to each case, and also posted in each alternate hosting facility. Patients should be told to contact a clinician if symptoms worsen or new symptoms appear.

Equipment

Oxygen monitoring equipment will be deployed to each isolation room with pictorial instructions as to how to use. The patient will be asked to measure their oxygen saturation at the time of their scheduled contact with clinician and report, which the clinician will record. Additionally, the patient may measure their oxygen saturation and will be instructed to contact the on-call clinician if it is <90%.

Exam and Triage

If a clinician determines that the patient is in need of examination, which may be due to worsening symptoms and/or declining oxygen saturation, an EMS team should be deployed, in appropriate personal protective equipment (PPE) to the facility and examined. If the patient is indeed hypoxic or otherwise in distress, the patient will be transported to the local hospital after notifying the Emergency Department of the arrival of a COVID-19 Positive patient or PUI, following isolation protocols.

Deliveries and Incidental Contact

Individuals doing deliveries or otherwise present (for maintenance, etc.) should wear masks when on-site at the non-congregate housing facility. KDHE recommends wearing a mask that fits snugly around the nose, mouth, and chin and has multiple layers of fabric. Alternatively, a thinner disposable mask may be worn underneath a cloth face mask to improve the fit. For more information on the mask guidance visit: <https://www.coronavirus.kdheks.gov/DocumentCenter/View/441/KDHE-Mask-Guidance-PDF---3-1-21>.

Deliveries should be made to a designated area that can be easily disinfected. All individuals on-site should keep a 6-foot distance between one another while at the facility.

In the case of meal delivery, meals may be delivered directly to a confirmed case or close contact, provided all parties are donning appropriate PPE.

Close Contact Definition

A person is a "**close contact**" if any of the following situations happened while the person spent time with another person with COVID-19, even if they didn't have symptoms:

- Were within 6 feet of the person for 10 consecutive minutes or more
- Had contact with the person's respiratory secretions (for example, coughed or sneezed on; kissed; contact with a dirty tissue; shared a drinking glass, food, towels, or other personal items).
- Live with the person or stayed overnight for at least one night in a house with the person.

The chance of spreading the virus is greater the longer an infected person or persons are close to someone. It also matters if the infected person is coughing, sneezing, singing, shouting, or doing anything else that produces more respiratory droplets that contain virus or if there are exposures to more than one infected person. Under these higher risk situations, you may want to consider a close contact someone who has been within 6 feet of an infectious person or persons for 10 cumulative minutes or more in a 24-hour period.

The final decision on what constitutes close contact is made at the discretion of public health.

Considerations for housing confirmed cases and close contacts together in non-congregate setting

- For space considerations, it is acceptable to house confirmed cases together
- For space considerations, it is acceptable to house close contacts who were exposed to the same person together
- For space considerations, it is acceptable to house people under travel-related quarantine together

If it is necessary to house confirmed cases and close contacts together in a non-congregate setting such as a single floor of a dormitory, private rooms for individuals are ideal. If private rooms for individuals are not possible, house confirmed cases together but separate from close contacts. Close contacts who were exposed to the same person may also be housed together, but separate from confirmed cases.

If it is necessary to house confirmed cases and close contacts on the same floor of a building, for example, confirm each area or wing has its own HVAC system. You may erect plastic barriers between areas or wings separating confirmed cases and close contacts. Do not use plastic barriers to separate a single room in order to house confirmed cases and close contacts together.

If close contacts under quarantine, people under travel-related quarantine, and confirmed cases are to be housed within the same building, the most important measure to prevent transmission from one group to another is to ensure that everyone is maintaining quarantine. Which means no interaction outside of the person(s) with whom someone is under isolation or quarantine, except for visits by staff and medical

personnel. Ideally, this would mean separate floors or wings for the different groups with some monitoring of movements. Ideally, staff would be dedicated to one group. Ideally, there would also be separate HVAC systems for each of the groups. However, a potential non-congregate setting should not be eliminated because of the lack of multiple HVAC systems.

Considerations for shared spaces

Minimizing the amount of interaction individuals have with each other is also necessary. If possible, designate a separate bathroom for confirmed cases. Encourage limiting the use of shared spaces as much as possible, such as kitchens and common areas. Encourage use of masks when entering shared spaces. Any shared spaces should be cleaned regularly using EPA-registered disinfectants, at least twice per day.

Shared bathrooms should be cleaned regularly using EPA-registered disinfectants, at least twice per day (e.g., in the morning and evening or after times of heavy use).

Make sure bathrooms are continuously stocked with soap and paper towels or automated hand dryers. Hand sanitizer could also be made available. Make sure trash cans are emptied regularly. Provide information on how to properly wash hands. Encourage the use of bathroom totes for personal items to avoid direct contact of personal items with surfaces such as sinks or shelves. If bathrooms have exhaust fans, ensure they are functional and operating at full capacity.

Limit staff entering the rooms of confirmed cases unless it is necessary.

When considering allowing individuals to go outside for fresh air, follow all guidelines above for shared spaces. Confirmed cases who are isolated together may go out for fresh air together, and close contacts who are isolated together may also go out in a group (provided appropriate PPE is donned). The groups should never overlap, even in outdoor spaces.

Use of personal protective equipment (PPE)

Staff should wear medical face masks plus eye protection (i.e. goggles or face shield), commonly referred to as procedure masks or surgical masks, when interacting with close contacts within 6 feet. If a distance of at least 6 feet will be maintained at all times, a cloth face mask may be substituted for a medical face mask. If there is a shortage of medical face masks, staff may wear the same mask when interacting with close contacts as long as the mask remains unsoiled, or may change their mask between interactions with close contacts, making sure to wash hands before and after donning and doffing. Booties are not required.

Medical face masks should be provided to close contacts. Close contacts should wear the medical face mask when interacting within 6 feet of anyone outside of their quarantine room. Cloth face masks may be used instead of medical face masks if maintaining at least a 6-foot distance.

When interacting with confirmed cases, staff should wear medical face masks (i.e. procedure or surgical masks), eye protection (i.e. goggles or face shield), isolation gowns and gloves when interacting with confirmed cases within 6 feet. If a distance of at

least 6 feet will be maintained at all times, a cloth face mask may be substituted for a medical face mask. Hand hygiene should be performed before and after donning and doffing PPE, and PPE should be changed between visits with confirmed cases.

For more information on how to don and doff PPE, refer to [CDC guidance](#).

Medical face masks should be provided to confirmed cases. Confirmed cases should wear the medical face mask when interacting with anyone outside of their quarantine room.

Ventilation

Opening windows and doors to the outside, when weather permits, operating window or attic fans, or running a window air conditioner with the vent control open increases the outdoor ventilation.

For buildings with HVAC systems with filters, ensure that ventilation systems operate properly. Consider taking steps to improve ventilation in the building in consultation with an HVAC professional. Consider increasing the percentage of outdoor air, (e.g., using economizer modes of HVAC operations) potentially as high as 100% (first verify compatibility with HVAC system capabilities for both temperature and humidity control as well as compatibility with outdoor/indoor air quality considerations). Other possible actions include increasing total airflow to occupied spaces, disabling demand-control ventilation controls that reduce air supply based on temperature or occupancy, and improving central air filtration. Consider using portable high-efficiency particulate air (HEPA) fan/filtration systems to help enhance air cleaning.

Ideally, HEPA filtration systems would service the smallest number of rooms possible. For example, a system that services a floor is more ideal than a system that services a whole wing, and a system that services a whole wing is more ideal than a system that services a whole building. A potential non-congregate setting should not be eliminated because of the lack of multiple HEPA filtration systems.

Increasing ventilation before and after cleaning can also reduce risks from particles resuspended during cleaning, including those potentially carrying SARS-CoV-2.

Cleaning

When cleaning and disinfecting rooms or surfaces potentially exposed to SARS-CoV-2:

- When possible, wait 24 hours before cleaning a room that housed confirmed cases or close contacts.
- Perform adequate hand hygiene immediately before and after removing gloves, and after any contact with potentially infected fluids or contaminated surfaces. Hand sanitizer (at least 60% alcohol) or soap and water both valid options. When hands are visibly soiled always wash with soap and water.
- Wear medical face masks, eye protection, disposable gloves, and gowns for all tasks in the cleaning process, including handling trash, laundry, wastes,

regardless of whether you wait 24 hours to enter the space or not.

- Additional personal protective equipment (PPE) such as respiratory and eye protection might be required based on the cleaning/disinfectant products being used.
- PPE should be removed carefully to avoid contamination of the wearer and the surrounding area.
- Used PPE can be disposed of in regular trash bags and in standard trash receptacles; it is not considered biohazard.
- Laundry
 - Do not shake linens or bedding.
 - Follow standard laundry procedures with detergent and warm or hot water.
 - If linens require transport to be laundered, place linens in dissolvable laundry bag, trash bag, or linen bag. Tie the bag securely for transport.
 - Consider the use of pillow protectors and mattress covers. Change as often as needed or as seems reasonable.
 - Remove and launder all blankets, comforters, and duvet covers.
 - When possible, professionally launder linens and bedding to ensure proper cleaning and sanitation. If washing in a home washing machine, wash in hot water and dry on the hottest dryer setting.
 - Clean and disinfect clothes hampers, if available.
- Trash
 - Continue use of PPE when disposing of trash.
 - Be aware of sharps and jagged pieces of glass or metal.
 - Never use hands to “compact” trash in bags or bins.
 - Remove gloves and thoroughly wash hands after disposing of trash.
 - Disinfect trash barrel or bin before placing fresh bag or liner inside.

For more information on the use of disinfectants, types of surfaces, the frequency of cleaning and disinfection, and waste disposal, see the [Healthcare Facility Cleaning and Disinfection Guide](#).

When cleaning and disinfecting rooms that have not housed confirmed cases, routine cleaning and disinfecting procedures are adequate.

FORMS AND ADDITIONAL RESOURCES

- A Medical History Form
- B KDHE Releasing Cases and Contacts from Isolation and Quarantine
- C Televisit Contact Checklist and Record Keeping Form
- D Additional Resources

Medical History Form

Name: _____ DOB: _____

Best method of contact: Video via Facetime/Skype: Phone call:
phone number/Skype address: *phone number:*

Preferred language: _____

Date of COVID-19 test: _____ Date results received: _____

Date of Release: _____

Emergency Contact Name: _____

Emergency Contact Phone number: _____

Primary Care Provider: _____

Phone number: _____

Pharmacy: _____

Phone number: _____

Medical Specialists:

Specialist	Condition	Contact Information

Current Medications *(ensure patient has adequate supply):*

Name of Medication	Dose	Schedule

Chronic Medical conditions and necessary medical equipment:

Make specific note of chronic oxygen use and dose

Condition	Equipment needed	Oxygen (checkmark)	Dose

Mental health status: _____

Substance Use History:

Tobacco Use (<i>Advise of smoking policy</i>)	Alcohol Use (<i>Ask specifically for the amount of alcohol ingested daily; must assess for withdrawal</i>)

Is withdrawal support needed? Yes No

Household & Personal situation: _____

Form completed by: _____

Date: _____

KDHE Releasing Cases and Contacts from Isolation and Quarantine



RELEASING CASES FROM ISOLATION

MILD to MODERATE CASES

Requiring little to no hospitalization

Must be isolated for a minimum of 10 days after onset of symptoms, or sample collection if asymptomatic, and can be released after afebrile (without fever-reducing medication) for at least 72 hours and improvement in other symptoms, whichever is longer.

Note: Lingering cough, headache, fatigue, and loss of taste or smell may persist for weeks or months and should not delay the end of isolation.

Examples:

- A case that starts to feel well on day 2, and remains afebrile and feeling well for 72 hours, can be released from isolation after day 10 (returning to normal activities on day 11).
- A case that starts to feel well on day 7, and remains afebrile and feeling well for 72 hours, can be released from isolation after day 10 (returning to normal activities on day 11).
- A case that starts to feel well on day 14, and remains afebrile and feeling well for 72 hours, can be released from isolation after day 16 (returning to normal activities on day 17).



SEVERE CASES

Requiring ICU care or are severely immunocompromised

Must be isolated for a minimum of 20 days after onset of symptoms and can be released after afebrile (without fever-reducing medication) for at least 72 hours and improvement in other symptoms, whichever is longer.

Note: Lingering cough, headache, fatigue, and loss of taste or smell may persist for weeks or months and should not delay the end of isolation.

Examples:

- A case that started to feel well on day 12, and remained afebrile and feeling well for 72 hours, can be released from isolation after day 20 (returning to normal activities on day 21).
- A case that started to feel well on day 17, and remained afebrile and feeling well for 72 hours, can be released from isolation after day 20 (returning to normal activities on day 21).
- A case that started to feel well on day 19, and remained afebrile and feeling well for 72 hours, can be released from isolation after day 21 (returning to normal activities on day 22).



12/14/2020

RELEASING CONTACTS FROM QUARANTINE

HOUSEHOLD CONTACTS

Recommend quarantine for 14 days after the case has been released from home isolation (because exposure is considered ongoing within the house)**.

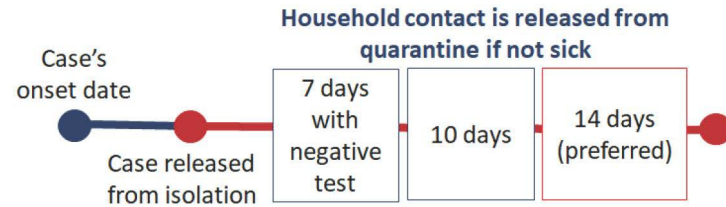
If you are not able to stay home for 14 additional days and you do not have symptoms, you may leave home earlier:

- After 10 days without testing; or
- After 7 days with a negative PCR test performed on or after day 6 (must remain in quarantine until results are received)

This means that household contacts may need to remain at home longer than the case.

Examples:

- A case that started to feel well 7 days after onset required isolation until day 10;
 - Household contact that is symptom free must remain quarantined through day 24 (returning to regular activities on day 25) **OR**
 - Household contact that is symptom free must remain quarantined through day 20 without testing (returning to regular activities on day 21) **OR**
 - Household contact that is symptom free must remain quarantined through day 17 if a PCR test was performed on or after day 16 and was negative (returning to regular activities on day 18)
- A case that started to feel well 14 days after onset required isolation through day 16;
 - Household contact that is symptom free must remain quarantined through day 30 (returning to regular activities on day 31) **OR**
 - Household contact that is symptom free must remain quarantined through day 26 without testing (returning to regular activities on day 27) **OR**
 - Household contact that is symptom free must remain quarantined through day 23 if a PCR test was performed on or after day 22 and was negative (returning to regular activities on day 24)



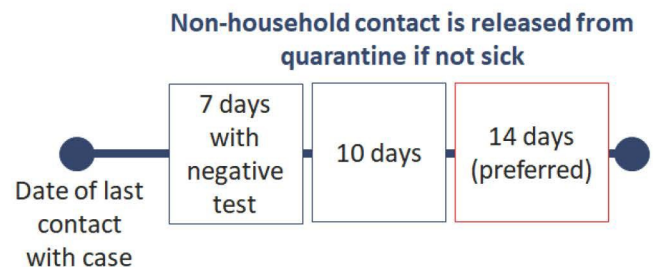
**** If you are able to have complete separation from the person in your house with COVID-19 (this means no contact, no time together in the same room, no sharing of any spaces, such as the same bedroom or bathroom), then follow the time frame for non-household contacts.**

NON-HOUSEHOLD CONTACTS

Recommend quarantine for 14 days after the date of last exposure with the person infected with COVID-19.

If you are not able to stay home for 14 additional days and you do not have symptoms, you may leave home earlier:

- After 10 days without testing; or
- After 7 days with a negative PCR test performed on or after day 6 (must remain in quarantine until results are received).



12/14/2020

Shortened Quarantine Guidance

CDC Announces Shortened COVID-19 Quarantine Periods

KDHE adopts CDC's guidance with modifications

KDHE continues to recommend a 14-day quarantine following exposure to COVID-19, as the incubation period for this disease is 14 days. CDC has released modified guidance allowing for shorter quarantine periods to increase better compliance with quarantine and increase people getting tested. Local Health Departments may choose to opt into this guidance. For information in your county, please contact your local health department.

How the Shortened Time Period Works

(Please check in with your local health department for specific information in your community)

7 Day Quarantine (Includes Testing and No Symptoms)

- After exposure, you monitor yourself for symptoms daily or participate in monitoring by Public Health for 7 full days.
- If you have no symptoms during this time frame, on Day 6, you may get a sample taken for a PCR test (antigen and antibody tests are NOT allowed for this purpose).
- If the test is negative, and you remain symptom-free, you can be removed from quarantine after seven full days, which is on Day 8.
- If Testing Results are pending, you must wait until you receive results.

10 Day Quarantine (No Testing and No Symptoms)

- After exposure, you monitor yourself for symptoms daily or participate in Public Health monitoring for 10 full days.
- If you have no symptoms during the 10 days, you can be released from the quarantine without a test on Day 11.

KDHE recommends all exposed people should self-monitor for fourteen (14) days from exposure and contact healthcare provider if symptoms develop. Disease can still develop through day 14.

Who is Not Eligible for Shortened Quarantine:

- Residents of long-term care and assisted living facilities
- Offender populations in Department of Corrections prisons



For more information, visit kdheks.gov/coronavirus



Televisit Contact Checklist and Record Keeping Form

Date: _____

Name: _____ DOB: _____

Best method of contact: _____ Video via Facetime/Skype: _____ Phone call: _____
phone number/Skype address: _____ *phone number:* _____

Time: _____ Clinician: _____

Reported Oxygen Saturation: _____

Reported Concerns/Symptoms:

Symptoms	Duration	Notes

Specific Symptom Review (*X all that apply; additional information should include duration, intensity and onset*):

X if yes	Symptom	Additional Information
	Fever _____ ° F or C	
	Cough	
	Shortness of Breath or difficulty breathing	
	Repeated shaking with chills	
	Muscle pain	
	Headache	
	Sore throat	
	New loss of taste or smell	
	Persistent pain or pressure in the chest	
	Mental health issues	
	Needs/referrals	

Notes: _____

Other Resources

Resources for Clinicians:

CDC COVID-19 Guidance for Shared or Congregate Housing:

<https://www.cdc.gov/coronavirus/2019-ncov/community/shared-congregate-house/guidanceshared-congregate-housing.html>

Resources for Individuals & Families:

Guidance for Large or Extended Families Living in the Same Household:

<https://www.coronavirus.kdheks.gov/DocumentCenter/View/1066/Living-in-Close-Quarters>

Instructions while awaiting test results or if you test positive for COVID-19:

<https://www.coronavirus.kdheks.gov/DocumentCenter/View/956/Home-Isolation-PDF---5-4-20>

Living in Shared Housing:

<https://www.cdc.gov/coronavirus/2019-ncov/daily-life-coping/shared-housing/index.html>

Resources for Employers:

Cleaning and Disinfecting Your Facility:

<https://www.cdc.gov/coronavirus/2019-ncov/community/disinfecting-building-facility.html>

References:

1. United States Environmental Protection Agency. Ventilation and Coronavirus (COVID-19). Retrieved August 2020 from <https://www.epa.gov/coronavirus/ventilation-and-coronavirus-covid-19>
2. Centers for Disease Control and Prevention. COVID-19 Employer Information for Office Buildings. Retrieved August 2020 from <https://www.cdc.gov/coronavirus/2019-ncov/community/office-buildings.html>
3. Centers for Disease Control and Prevention. Using Personal Protective Equipment (PPE). Retrieved August 2020 from <https://www.cdc.gov/coronavirus/2019-ncov/hcp/using-ppe.html>