New Integrated Approaches to Minimize the COVID-19 Risk and Address Rehousing Needs

To minimize COVID-19-related risk to people experiencing homelessness (PEH), Continuums of Care (COCs), Emergency Solutions Grants (ESG) recipients and subrecipients, Health Care for the Homeless (HCH) programs, Public Health Departments, public hospital systems, and other organizations have created or adapted community partnerships, cooperating to design new resources and approaches. As with natural disaster responses, rapid assessment of gaps specific to people experiencing homelessness, closing these gaps, and updating strategies based on feedback requires effective cross-sector coordination. New models for integrating services to protect people experiencing homelessness can assist communities to transition from crisis response to rehousing.

Partnerships created in Atlanta, Georgia exemplify the "whole community approach" outlined in the Centers for Disease Control and Prevention (CDC) guidance specific to serving people experiencing homelessness. Atlanta's CoC and HCH program created a unified and comprehensive plan that grew out of the CoC's partnerships with the local and state Departments of Health and the local HCH organization. Seattle-King County, Washington, an ESG recipient, created a similar partnership resulting in integrated resources shared across the community.

CoC, ESG, health, and community leaders can follow these examples and form partnerships to:

- Organize operations-level managers with homeless services, health care delivery, communicable disease prevention, and disaster response experience to map out processes for bridging complex systems;
- Involve decision makers to authorize expenditures of government funds from local, state, and federal sources for the homeless COVID-19 response, such as Coronavirus Aid, Relief, and Economic Security (CARES) Act and Federal Emergency Management Agency (FEMA) funding;
- Commit to regular meetings and consistently share information regarding gaps in services and evolving technical advice;
- Leverage existing relationships and partnerships among agencies and leaders, such as departments of public health, federal, state, and local governments, multi-cultural service providers, and faith-based organizations; and
- Leverage existing resources and tools for integrating pathways to health and housing, such as those developed through the Housing and Healthcare Integration Initiative and population-specific strategies.

Community Examples

The following examples of innovative, integrated resources and models are grouped according to the primary question which drove their development.

Q: How can communities isolate and care for PEH with active COVID-19 who are not referred to hospital treatment, and PEH with COVID-19 symptoms who are awaiting test results?

Alternative Care Sites (ACS) communities adapted facilities to isolate and quarantine people in individual rooms using hotel and motel rooms, vacant college dormitories, trailers, recreational vehicles, and tents with special walls to create individual bedrooms. Other organizations converted medical respite care (also known as recuperative care) facilities for this purpose. The National Health Care for the Homeless Council (NHCHC) produced an ACS technical assistance document which addresses the many facets of assembling and operating such facilities.

California's statewide ACS initiative, Project Roomkey, provides communities with comprehensive support and partnership in creating ACSs, and identifying hotels and motels for isolation and quarantine functions to mitigate

transmission and reduce hospital surge. In Alameda County, CA, existing partnerships among the CoC, Alameda Health Care Services Agency, Alameda County Healthcare for the Homeless, housing provider Abode Services, and other organizations facilitated the rapid deployment of Operation Comfort for isolation and quarantine in a converted hotel.

A variety of alternative care options, including private hotels, trailers, and recreational vehicles may be used with a dashboard system to track program growth. ACS models have also been developed in Guilford County, NC, Denver and Yakima, Washington, whose ACS was featured in a recent HUD webinar. Yakima Neighborhood Health leveraged its resources to integrate a testing initiative, providing care in its existing medical respite facilities. Guilford County, North Carolina's ACS strategy, includes highly accessible 24/7 transportation to ACS sites.

Hotlines and Call Centers Public Health–Seattle and King County and Boston Health Care for the Homeless created telephone hotlines, staffed by nurses and other clinicians with PEH-specific training during the COVID crisis. These centers provide telephone triage/assessment and referrals to testing and care, including referrals to primary care services, ACSs, and shelters created for at-risk PEH due to age and/or underlying chronic conditions. Los Angeles Homeless Services Authority created a call center specifically for responding to questions and referrals from homeless services providers. These hotlines provide infection prevention education and information to case managers.

Q: How can CoCs, ESG recipients, and healthcare partners integrate shelter and healthcare services to protect people at high risk?

Homeless services, Public Health, community healthcare, and other organizations have come together in many communities to organize protective living spaces, sometimes called **Non-Congregate Shelters** (NCS). NCSs provide private rooms and supportive services to PEH whose age or underlying chronic health conditions put them at high risk for poor COVID-19 recovery, per CDC guidance.

In Alameda County, CA, Operation Safer Ground is safe housing for PEH who are over age 65, medically fragile, or are at high risk due to health conditions. This sister site to Alameda's ACS Operation Comfort prioritizes individuals through a match of HMIS and health care agency data. Mobile health care services providers visit the converted hotel site regularly to provide health care access. Other cities use hotel rooms and other facilities to create NCS options, including Chicago, New Orleans, and Albuquerque.

Q: How can providers expedite COVID testing and referrals to appropriate care?

Several communities leveraged existing programs and staff to create innovative models to address this need. In Boston, Health Care for the Homeless programs and Public Health Departments coordinated closely with emergency shelters to provide universal testing following the discovery of positive cases within a given site. Health Care for the Homeless—Baltimore and Maryland report that this approach has proven critical to reducing the spread of the virus within Baltimore's shelter population.

Neighborcare Health created the mobile COVID-19 Assessment and Testing (CAT) Team in partnership with shelters, supportive housing providers, and the Public Health Department to offer testing on site and coordinates with Public Health–Seattle and King County's Isolation and Quarantine (I&Q) Units for symptomatic and/or COVID-19-positive patients unable to self-isolate. This team builds on Seattle's Housing Health Outreach Team (HHOT), which stations clinical staff in shelters and housing sites. CAT nurses, physicians, nurse practitioners, and support staff serve people who live outside or in congregate settings with shared spaces.

Q: How can shelter and other homeless services providers reduce virus transmission, including transmission tied to asymptomatic individuals?

Overflow Shelters, Education, and Specialized Rapid Response Teams: Several creative approaches to help emergency shelters, day centers, and other facilities meet disinfection, education, and social distancing recommendations have emerged. Community partners have arranged new temporary overflow shelters that allow established shelters to reduce their census and provide space for social distancing.

Field Assessment Support and Technical Assistance (FAST) teams provide comprehensive education and training related to cleaning, disinfection, social distancing, hand washing, and other hygiene issues to minimize COVID-19-related risk on site.

Public Health and community health care agencies address education issues with [infographic education posters](#) shelters, posted widely to ensure both staff and clients see them.

Massachusetts recommended communities [set up quarantine sites](#) for PEH who have been exposed to the virus but are not demonstrating symptoms. Communities use [existing facilities or outdoor tents to create these sites](#).

Effective and Sustained Flow of Updated Information: Widely-publicized web pages dedicated to the local homeless COVID-19 response have been created by [Atlanta's CoC](#) and the [Los Angeles Homeless Services Authority](#) to facilitate timely updates for a wide variety of local tools and resources as crisis response evolves. [Atlanta](#), [Seattle](#), and [Los Angeles](#) established weekly or bi-weekly homeless service conference calls. This strategy enhances critical information exchange among subject matter experts and other officials representing ESG recipients, CoCs, Public Health Departments, Emergency Management entities, and HCH programs.

Q: How can homeless system response strategies ensure access to harm reduction and other behavioral health services during the crisis?

Assistance for People with Substance Use Disorder: Fear about alcohol withdrawal and access to harm reduction services may discourage some people with Substance Use Disorder (SUD) from accessing testing, protective NCS, and other COVID-19-related services. Communities have recognized that failure to address barriers to services for PEH with SUD could increase the risk of COVID-19 outbreaks. Partnerships among HCH and other homeless services providers in [San Francisco](#) and [Seattle](#) have generated recommendations and [pilot protocols](#) to address this risk during the pandemic response, including harm reduction strategies for ACSs and maintaining access to Medication-Assisted Treatment (MAT) and buprenorphine in new settings.

National guidance about adapting harm reduction strategies to COVID-19-related initiatives includes [COVID-19 Guidance for People Who Use Drugs and Harm Reduction Programs](#), [Practicing Harm Reduction in the COVID-19 Outbreak](#), [State Strategies for Helping Individuals with Opioid Use Disorder Through The COVID-19 Epidemic](#), and [Reducing Harm for People Using Drugs & Alcohol During the COVID-19 Pandemic: A Guide for Alternate Care Sites Programs](#).

Access to Mental Health Services: As people move into ACSs and other new COVID-19-related residential facilities, they may be at greater risk of losing connection to existing mental health providers and medications. NHCHC's [Supporting Clients' Mental Health During Isolation and Quarantine](#) and [Massachusetts' Behavioral Health Connections at COVID-19 Testing](#) offer guidance to communities to minimize service gaps and ramp up counseling and other services.

Q: How can housing providers ensure adequate and timely access to medical and other health care services for people who have already moved into permanent housing or are in transition?

Housing providers have leveraged existing relationships with community health care providers to expedite telehealth and other appointments for their residents. In Springvale, ME, Baltimore, and New York City, [HCH programs](#) have pivoted quickly to telehealth to ensure residents have clear and accessible pathways to primary care and behavioral health services. This approach orients housing providers staff to new protocols and ensures residents have ready access to cell phones and internet connections in private spaces. [Telephone hotlines and call centers](#) facilitate referrals to appointments with HCH and other medical and behavioral health providers, including assistance with urgent concerns.

Q: How can local COVID responses prioritize safe housing placement and connection to needed health care supports for people at higher risk of poor COVID outcomes?

Communities should establish Coordinated Entry policies and procedures to ensure PEH at the highest risk for poor COVID-19 outcomes are prioritized for permanent housing. HUD's [COVID-19 Homeless System Response: Changes to Coordinated Entry Prioritization to Support and Respond to COVID-19](#) provides detailed guidance to achieve this goal and links to examples from around the country.

It is critical for Continuums of Care, ESG recipients, and other homeless services leaders to collaborate with their Public Health and HCH counterparts to establish processes that specifically account for [risks driven by constellations of mutually-compounding chronic and acute health issues](#). Communities have been working since before the pandemic to [improve the ability of their Coordinated Entry assessment and prioritization policies](#) to

flag compound risks and match people with needs for intensive health-related support to best-suited housing options.

Q: How can hospital discharge practices be adjusted during the pandemic to reduce poor outcomes for PEH?

Coordination between hospitals and homeless services providers has led to the development of resources for reducing risk when hospitals discharge homeless individuals who may have COVID-19 or COVID-19-like symptoms and still need isolation. Examples include protocols developed by the Greater New York Hospital Association and Texas Homeless Network's interactive map for coordination between hospitals and homeless crisis response systems.