

COVID-19

Homeless System Response: Coordinating with Public Health for Safe Transitions into Housing

COVID-19 remains an active threat to the life and health of people experiencing homelessness—especially those most vulnerable to severe illness or death from the disease, including Black people, Indigenous people, and people of color (BIPOC); older adults; and those with chronic health conditions. Moving into safe, stable housing will provide individuals and families experiencing homelessness the opportunity to protect themselves from the virus. As a result, many communities have made [expedited rehousing](#) the cornerstone of their overall homelessness COVID-19 strategic plans. Emergency Solutions Grants (ESG) recipients and subrecipients require input from a variety of experts and stakeholders to help minimize COVID-19-related risk within rehousing processes. They will need to ensure that their planning reflects robust representation of BIPOC (who are disproportionately impacted by COVID-19 and homelessness in their communities) as well as persons with lived experience of homelessness in order to craft processes that work best for the most vulnerable people. They will need to account for the increased risk of severe COVID-19 complications and death among BIPOC resulting from higher incidences of and mortality from a wide variety of the [chronic health conditions associated with poor COVID-19 outcomes](#). They will also need to access up-to-date public health information and collaborate with local public health and emergency management personnel to agree upon tactics, tools, and resources. This document serves as a resource for planning safe transitions into permanent housing from isolation and quarantine spaces, protective non-congregate shelter (such as hotels, etc.), new overflow shelter sites, regular emergency shelters, and the streets.

Rehousing Health and Safety Needs

As communities are adapting their homeless response systems to the pandemic, the following have emerged as needs¹ that must be addressed to facilitate rapid, safe, and successful rehousing efforts:

- A. Access to *real-time* or *expedited* local COVID-19 testing, isolation, and quarantine options as needed when moving between locations or while receiving housing assistance.
- B. Current and accessible information about COVID-19 prevention measures such as disinfecting and cleaning guidance, personal hygiene recommendations, and social and physical distancing recommendations.
- C. Timely referrals to primary care, behavioral health care, benefits, and other services to help ensure sustained access to health care services.
- D. Assessment tools to accurately gauge the severity of pre-existing chronic medical conditions, mental health conditions, limited mobility, visual impairment, hearing impairment, and/or memory issues that can increase vulnerability to dangerous COVID-19 complications and compromise safe and successful transitions to housing.
- E. Tailored in-home services and supports to ensure safety in new housing for individuals with the highest risk for COVID-19 complications and significant chronic barriers to self-sufficiency.

Strategies for Assuring Safe and Successful Transitions to Housing

The following are examples of system strategies that respond to the needs above:

¹ Of course, many of these needs pertain *not only* to assisting people actively transitioning into housing, but also to helping those who have already established permanent housing or for whom a housing placement has not yet been identified.

System Strategy	Needs Addressed	Communities Using This Strategy	Advantages	Tips for Implementation
COVID-19 hotlines/call centers	A, B, C	Seattle	<ul style="list-style-type: none"> • Provides rehousing case managers, other key homeless services staff, and people experiencing homelessness with an accessible one-stop shop for assessment, triage, and updated answers to frequently asked questions. • Linkages to COVID-19 testing, COVID-19 treatment, isolation/quarantine, protective non-congregate shelter (NCS), and primary care. 	<ul style="list-style-type: none"> • Collaborate with Public Health Departments or Health Care for the Homeless agencies to specifically tailor the call center model to the needs of homeless service providers and their clients. • Provide training to call center staff in best practices that are trauma-informed and grounded in: <ul style="list-style-type: none"> • Preventing implicit bias and assuring equal access to treatment options. • Understanding the historical impact of systemic racism on disparities in health and housing outcomes. • Promote cultural humility and recognition of differences in how people in different racial and ethnic groups relate to health care services and providers.
Mobile testing teams that coordinate their work with housing, shelter, NCS, and outreach providers	A, B, C	Seattle	<ul style="list-style-type: none"> • Provides a robust resource to target hot spots and overcomes barriers to accessing assessment, testing, prevention information, and other resources. 	<ul style="list-style-type: none"> • Leverage learnings and borrow staff from existing programs that integrate health care services with those provided by shelter, housing, meal programs, or encampment operators. • Consult the template for Seattle's program. • Ensure that testing teams can provide free service to vulnerable clients regardless of whether they have health insurance. • Include agencies primarily serving BIPOC and persons with lived experience in program design work.

<p>Special transportation arrangements for accessing COVID-19 services and make services accessible through a single phone number</p>	<p>A</p>	<p>Greensboro</p>	<ul style="list-style-type: none"> • Speeds access to critical services for those most at risk of hospitalization or death and reduces time required of case managers in arranging or providing transportation assistance. 	<ul style="list-style-type: none"> • Explore local partnerships with transit authorities and first responders. • Analyze community demographic data to facilitate ease of access in neighborhoods with greater concentrations of BIPOC which may be underserved by public transportation, cabs, and other transportation options. • Include agencies primarily serving BIPOC and persons with lived experience in program design.
<p>Access to special in-home cleaning and meal delivery services for permanent supportive housing (PSH), single room occupancy (SRO), and other buildings</p>	<p>E</p>	<p>San Francisco</p>	<ul style="list-style-type: none"> • Provides a resource to assist housing providers in ramping up prevention methods and minimizing virus infection rates and transmission among residents. 	<ul style="list-style-type: none"> • Develop partnerships between housing providers and aging services providers, other community-based organizations, and government agencies to adapt in-home services, such as cleaning and meal delivery, to the needs of people who have transitioned from homelessness into their own housing unit. • Analyze demographic data to assure access in buildings and programs serving higher percentages of BIPOC.
<p>Integration of Health Care for the Homeless (HCH) and other community health care clinicians into permanent housing programs to provide on-site or telehealth care</p>	<p>A, B, C</p>	<p>Denver Portland</p>	<ul style="list-style-type: none"> • Significantly increases access to COVID-19-related and other health services, especially for people with pre-existing barriers related to chronic medical issues, behavioral health conditions, mobility challenges, and cognitive impairment. 	<ul style="list-style-type: none"> • Refer to examples of existing programs integrating health services into housing. • Coordinate with health care providers to match BIPOC clinicians to BIPOC clients. • Provide health care clinicians with training in trauma-informed care, preventing implicit bias, cultural humility, and the historical impact of systemic racism on disparities in health and housing outcomes.

<p>Widely publicized web pages dedicated to the local community's homeless COVID-19 response with continuously updated information about a wide variety of tools and resources</p>	<p>A, B, C</p>	<p>Atlanta Los Angeles</p>	<ul style="list-style-type: none"> • Provides agencies leading rehousing efforts and other service providers with a single, accessible information source that can be easily integrated into processes for assisting clients with a variety of supports. 	<ul style="list-style-type: none"> • Explore existing web pages such as: https://www.kingcounty.gov/depts/health/locations/homeless-health/healthcare-for-the-homeless/covid.aspx.
<p>Weekly or twice-weekly conference calls that include homeless service providers, public health subject matter experts, emergency management personnel, and community health care providers such as HCH programs</p>	<p>A, B, C</p>	<p>Los Angeles Seattle</p>	<ul style="list-style-type: none"> • Becomes a platform for creating innovative approaches to address COVID-19 care and protection in a way that is tailored to meet the specific needs identified by Continuums of Care (CoCs), ESG recipients, and homeless services providers. • Assures that interventions are informed by up to date recommendations and data from public health and emergency management experts. 	<ul style="list-style-type: none"> • Listen in on a call hosted in another community to get ideas to plan yours. • Include people with lived experience, BIPOC, culturally specific organizations, and other groups into regular check-in structures and ensure that they have an equal voice in decision-making.
<p>Rapid deployment of public health teams with environmental health specialists and nurses</p>	<p>B</p>	<p>Seattle</p>	<ul style="list-style-type: none"> • Provides housing agencies and other service providers with a comprehensive approach to minimizing COVID-19-related risk at sites that are or may become virus hotspots. 	<p>Review the ESG recipient King County's process for creating this and similar new tools.</p>

<p>Identification of severe health-related vulnerabilities among elders residing in protective NCS and provision of intensive supports that will follow vulnerable individuals as they transition from NCS to permanent housing</p>	<p>D, E</p>	<p>Los Angeles</p>	<p>Reduces risks of:</p> <ul style="list-style-type: none"> • Coronavirus infection. • Complications from both COVID-19 and pre-existing chronic conditions. • Hospitalization. • Exits back into homelessness resulting from insufficient support around mutually compounding health risks and chronic barriers to self-sufficiency. 	<ul style="list-style-type: none"> • Ground rehousing interventions for older adults in research on homelessness and aging, identifying and working with cognitive impairments, and risks associated with early-onset geriatric conditions. • Collect and analyze demographic data on admissions and exits from NCS to ensure that BIPOC, who are more likely to experience health-related vulnerabilities because of the impact of systemic racism, receive protective interventions at rates that are (at a minimum) reflective of their proportion of the local population of people experiencing homelessness who are at greatest risk of serious illness or death from COVID-19.
<p>Rapid Rehousing (RRH) programs specifically developed as a bridge to PSH</p>	<p>D, E</p>	<p>Houston</p>	<ul style="list-style-type: none"> • Reduces exits to homelessness for people at high risk for COVID-19 complications by providing safe interim housing until a PSH unit becomes available. 	<ul style="list-style-type: none"> • Review RRH technical assistance resources. • Collect and analyze demographic data from Bridge-to-PSH initiatives to ensure that BIPOC with health-related vulnerabilities succeed in achieving housing stability and that the rates of positive outcomes for BIPOC are at least as high as for white clients.

Local Partners for ESG Recipients in COVID-19-Related Community Needs Assessment, Strategy Development, and Feedback Loops

Ongoing [multi-directional information sharing and planning](#) at the local level is essential to identifying and addressing service gaps as they emerge and implementing strategies such as those listed above. ESG recipients and subrecipients will need to engage and maintain close coordination with:

- CoCs and their providers—
 - Assures coordination and compatibility of pandemic-related adjustments to assessment policies/procedures, data/analytics, and training across the entire continuum.
- People with lived experience of homelessness, especially BIPOC (who are disproportionately impacted by both homelessness and COVID-19), who should be an integral part of any team identifying local service gaps and making decisions about funding, policies, strategies, and/or programs—
 - Assures that needs assessments, service provision modalities, and service locations reflect direct input from BIPOC and agencies primarily serving BIPOC, thus minimizing faulty, white-centric assumptions and inadvertent bias.
- Local public health departments, including Communicable Disease and Environmental Health Units—
 - Assures continuous consideration of updated public health recommendations and coordination of messaging, training, and services.
- Local human services departments, Departments of Aging, and social services providers—
 - Assures greater effectiveness in identifying, serving, and reducing COVID-19 risk for the most vulnerable people.
- HCH agencies and other Community Health and Community Mental Health providers—
 - Assures efficient targeting of health care expertise and clinical services to reach and serve the most vulnerable.
- Culturally specific organizations and community-based organizations who can provide access to, and receive information from, BIPOC, LGBTQ-identifying individuals, and people from other marginalized groups about needs, service gaps, accessibility of strategies, etc.—
 - Assures that the needs of marginalized people will be more effectively addressed by leveraging critical community relationships and coordinating services.
- Local officials (e.g., mayor's offices, county executives)—
 - Assures that strategic planning leverages resources available to elected officials and begins to address any barriers to building political consensus early in the process.
- Local emergency management departments—
 - Assures that emergency management planners routinely account for the particular vulnerabilities and specific crisis response needs of people experiencing homelessness as compared to the general population.
- Local hospital emergency departments and social services personnel—
 - Assures that hospital discharge decisions and referral protocols take into account new or expanded resources and services that can improve the post-discharge safety of people experiencing homelessness who are especially vulnerable to dangerous COVID-19 complications and/or have been treated for COVID-19.

Information Dissemination to Homeless Services Provider Staff and Clients

ESG recipients should collaborate with public health departments to design and disseminate important information on health and safety measures to homeless service provider staff and clients. Make information accessible by ensuring that it is easy to read and understand for people regardless of level of health literacy, available in languages commonly used in the community, and available in multiple formats from numerous sources. Develop printable [infographics](#) and other educational materials specifically tailored to the needs of homeless service

provider staff, who can, in turn, post printed materials for their clients or distribute them during outreach. They should post these materials on well-publicized [web pages](#) dedicated to the homeless COVID-19 response, discuss their use with providers on community [conference calls](#), and disseminate through community-based organizations, culturally specific organizations, and other groups that may be more trusted by BIPOC and people from other marginalized groups than government, the health system, and other drivers of systemic racism. ESG recipients can also provide guidance to sub-recipients around developing policies and procedures to incorporate the utilization of new resources, such as those highlighted in the table above, into standard outreach, case management, and housing navigation work.