# Health Equity for People Experiencing Homelessness During the COVID-19 Pandemic

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Virtual Seminar for FXB Center for Health & Human Rights
April 2nd, 2020

# Outline

| | |
|---|---|
| Objectives & Background<br>• Vocabulary and Demographics<br>• Special Subpopulations<br>• HCH Programs | 15 min |
| Health & Homelessness | 5 min |
| COVID-19 Basics and Relevant Issues | 5 min |
| Impacts on HCH Programs | 10 min |
| Strategies and Implications | 10 min |
| Discussion | 15 min |

# Objectives

- Increase awareness among our academic community about homelessness and health, including:
  - Magnitude, types and trends of homelessness across the US
  - Unique health inequities and vulnerabilities related to COVID-19
- Invite feedback and input on the direction of our work and practice

# Helpful Vocabulary

## Populations

- Individuals or adults
- Families (primarily women with children)
- Unaccompanied youth or adolescents

## Subpopulations

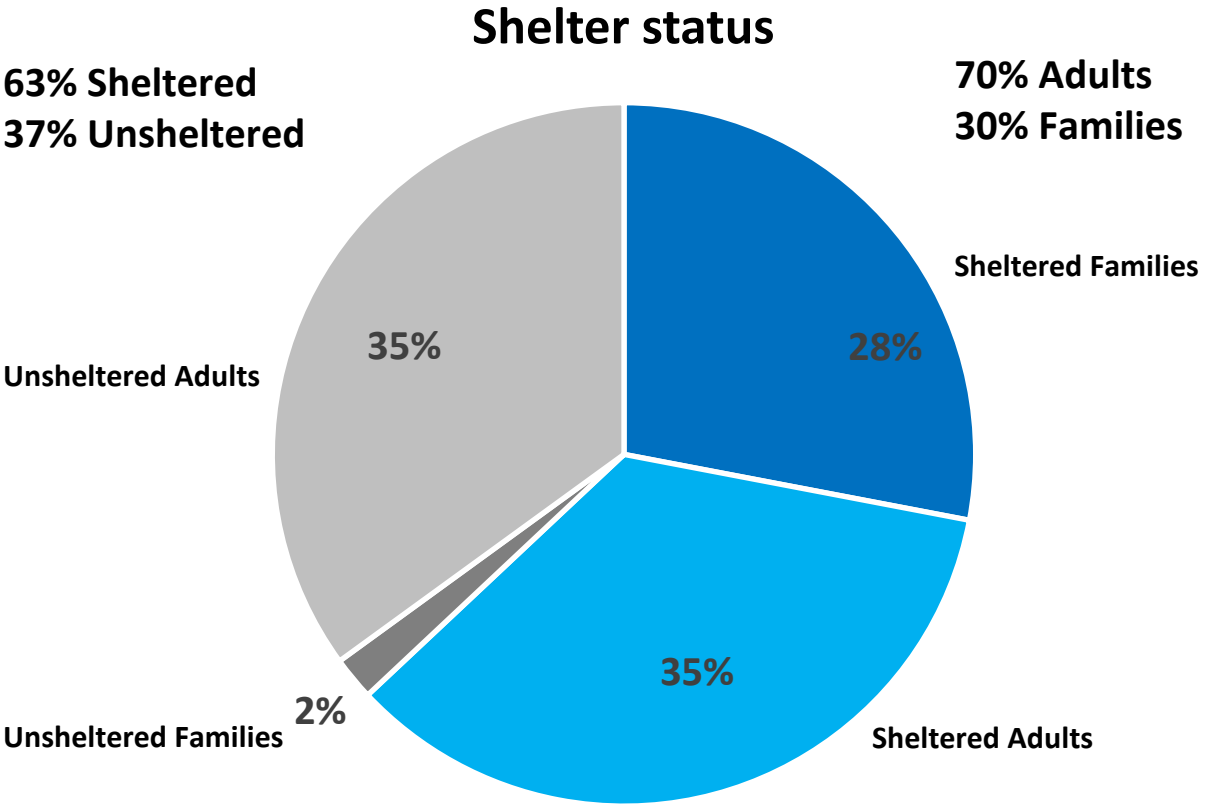
- Chronically homeless
- Sheltered and unsheltered
- Veterans
- Elders
- Permanent supportive housing
- Immigrants and limited-English speakers
- Transgender

# Demographics

- Data for National estimates from HUD* are from two sources:
  - Point-In-Time annual count (PIT)
  - **567,715** homeless people during PIT (2019)[1]
- One-Year shelter visit data estimates (HMIS)
  - **1.4 Million** used emergency shelter in one-year (2017)[2]

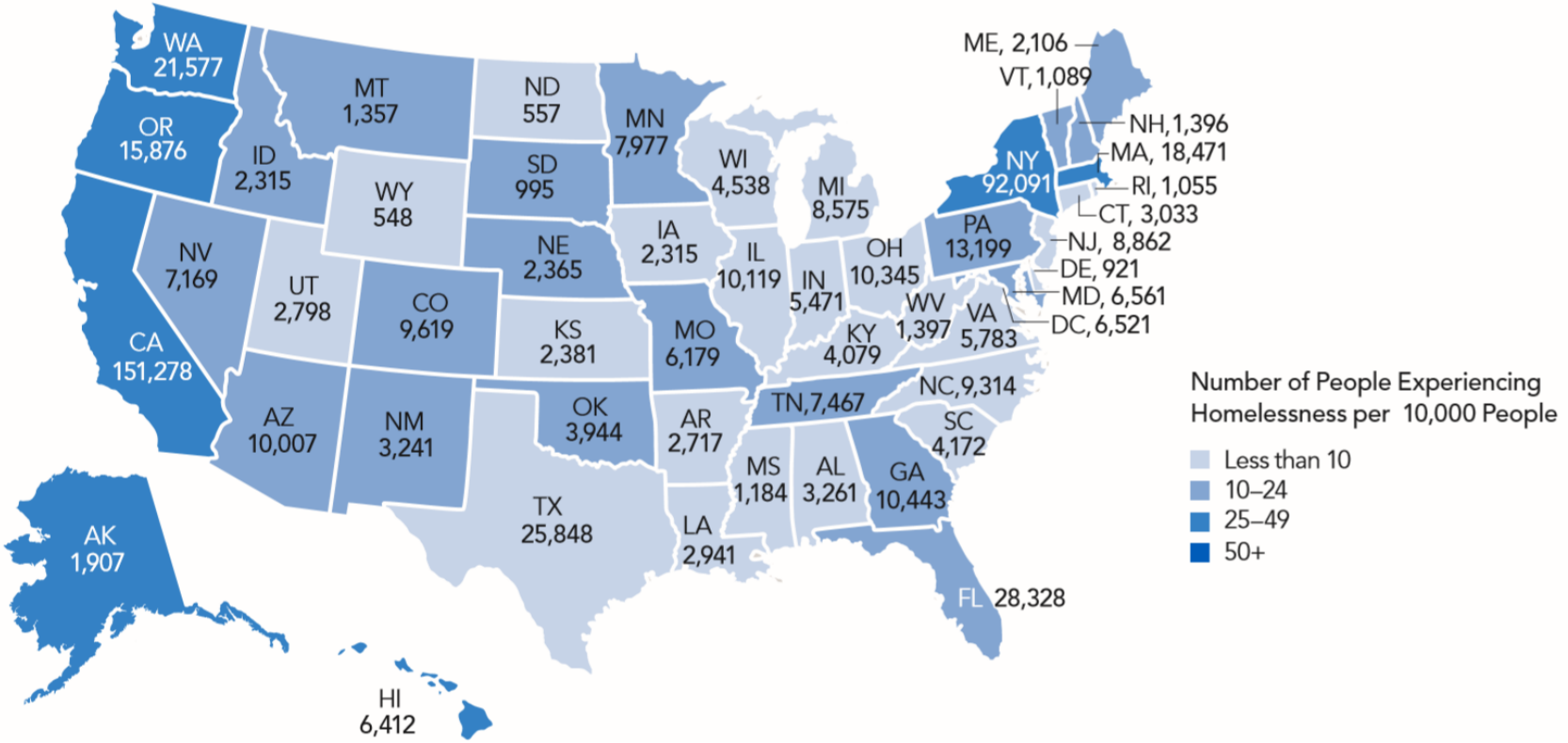
*HUD: U.S. Dept of Housing and Urban Development
1 HUD 2019 Annual Homeless Assessment Report to Congress Part 1
2 HUD 2017 Annual Homeless Assessment Report to Congress Part 2

# 2019 Point-In-Time Data




The U.S. Department of Housing and Urban Development. The 2019 Annual Homeless Assessment Report to Congress PART 1: Point-in-Time Estimates of Homelessness. 2019.

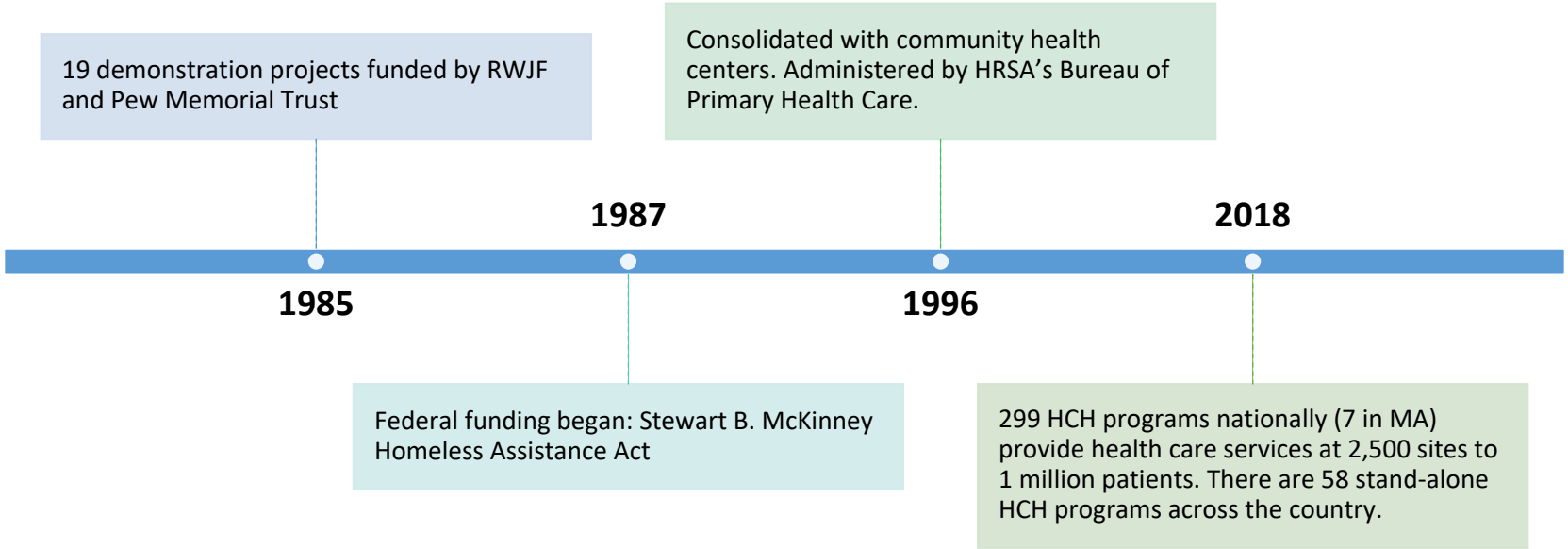
# 2019 Estimates of Homelessness by State




*https://files.hudexchange.info/resources/documents/2019-AHAR-Part-1.pdf


Boston Homeless Census 2019
Homeless Population 6,203
Sheltered Adults 2,227
Unsheltered Adults 121
Sheltered Families 3,855

# Health Care for the Homeless (HCH) Programs




# Medicine *Where* It Matters

BOSTON HEALTH CARE *for the* HOMELESS PROGRAM

**Hospital-based Clinics**

BHCHP maintains strong ties to our local hospitals, including Boston Medical Center and Mass General Hospital, in the care of our patients. With onsite clinical space, our staff provides primary care, monitors our homeless patients who are hospitalized, and supports the follow up and discharge planning after a hospital stay.

**Family Team Sites**

As the number of homeless families in and around Boston continues to grow, BHCHP works hard to meet the demand for quality health care in family shelters, such as St. Mary's Center for Women and Children.

**Jean Yawkey Place**

As BHCHP's integrated medical facility in the South End, Jean Yawkey Place unites medical care, behavioral health, and oral health services under one roof through our outpatient and dental clinics, pharmacy, and respite program known as the Barbara McInnis House.

**Shelter-based Clinics**

In order to be easily accessible to homeless people, BHCHP provides care in shelters, day programs and other unique locations throughout greater Boston, including Pine Street Inn & St. Francis House.



1 Boston Medical Center
2 Boston Night Center
3 Bridge Over Troubled Waters
4 Cardinal Medeiros Center
5 Casa Esperanza Men's Program
6 Casa Esperanza Women's Program
7 Casa Nueva Vida
8 Crossroads Family Shelter
9 EMPath (formerly Crittendon Women's Union)
10 Engagement Center
11 Entre Familia
12 Father Bill's Place
13 Friends of the Unborn
14 **Jean Yawkey Place**
15 Kingston House
16 Lindemann Mental Health Center
17 Margaret's House
18 Massachusetts General Hospital
19 Nazareth Residence
20 New England Center & Home for Veterans
21 Pine Street Inn at Shattuck
22 Pine Street Inn Men's Clinic
23 Pine Street Inn Women's Clinic
24 Project Hope
25 Rosie's Place
26 Safe Harbor
27 Salvation Army
28 Sojourner House
29 Southampton Street Shelter
30 St. Ambrose
31 St. Anthony's Shrine
32 St. Francis House
33 St. Mary's Center for Women & Children
34 Stacy Kirkpatrick House
35 Suffolk County House of Correction
36 Transitions
37 Women's Lunch Place
38 Woods Mullen Shelter
39 Y2Y

**Not shown:**
- Alleyways, park benches, under bridges
- Asian Task Force Against Domestic Violence *(Boston)*
- EVA Center *(undisclosed location)*
- Finex House *(undisclosed location)*
- Home Suites Inn *(Waltham)*
- Home Visits *(varied)*
- Pine Street Inn Permanent Housing *(varied)*

*as of May 16, 2019


STOP & SHOP

# Link Between Homelessness & Health

- 1.5 million homeless
- PEH have higher rates of illness and die on average 12 years sooner than the general US population
  - Poor health is a major cause of homelessness
  - Homelessness creates new health problems and exacerbates existing ones
  - Recovery and healing are more difficult without housing

NATIONAL HEALTH CARE for the HOMELESS COUNCIL

## Homelessness & Health: What's the Connection?

FACT SHEET February 2019

Homelessness can take many forms, with people living on the streets, in encampments or shelters, in transitional housing programs, or doubled up with family and friends. While the federal government reports 1.5 million people a year experience homelessness, other estimates find up to twice this number of people are actually without housing in any given year. The connection between housing and homelessness is generally intuitive, but the strong link between health and homelessness is often overlooked. This fact sheet outlines how health and homelessness are intertwined—and why housing is health care.

**People who are homeless have higher rates of illness and die on average 12 years sooner than the general U.S. population.**

### Poor heath is a major cause of homelessness

An injury or illness can start out as a health condition, but quickly lead to an employment problem due to missing too much time from work; exhausting sick leave; and/or not being able to maintain a regular schedule or perform work functions. This is especially true for physically demanding jobs such as construction, manufacturing, and other labor-intensive industries. The loss of employment due to poor health then becomes a vicious cycle: without funds to pay for health care (treatment, medications, surgery, etc.), one cannot heal to work again, and if one remains ill, it is difficult to regain employment. Without income from work, an injury or illness quickly becomes a housing problem. In these situations, any available savings are quickly exhausted, and relying on friends and family for assistance to help maintain rent/mortgage payments, food, medical care, and other basic needs can be short-lived. Once these personal safety nets are exhausted, there are usually very few options available to help with health care or housing. Ultimately, poor health can lead to unemployment, poverty, and homelessness.

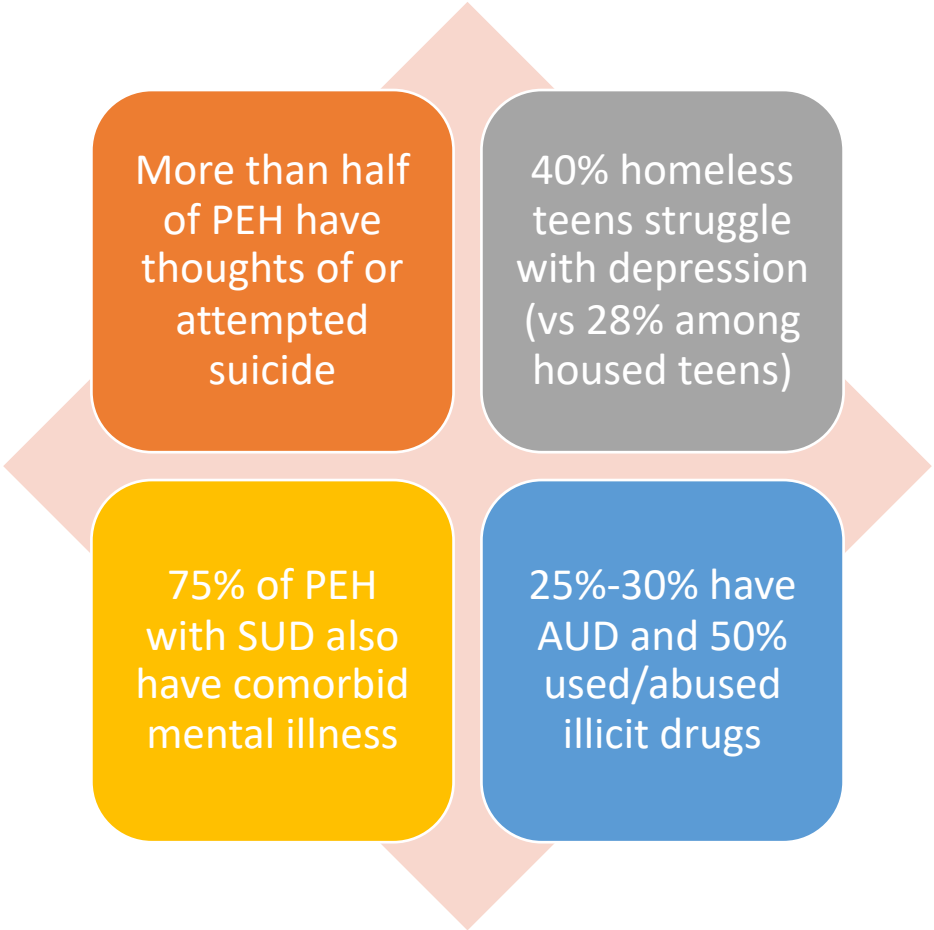
**Simply being without a home is a dangerous health condition.**

### Homelessness creates new health problems and exacerbates existing ones

Living on the street or in crowded homeless shelters is extremely stressful and made worse by being exposed to communicable disease (e.g. TB, respiratory illnesses, flu, hepatitis, etc.), violence, malnutrition, and harmful weather exposure. Chronic health conditions such as high blood pressure, diabetes, and asthma become worse because there is no safe place to store medications properly. Maintaining a healthy diet is difficult in soup kitchens and shelters as the meals are usually high in salt, sugars, and starch (making for cheap, filling meals but lacking nutritional content). Behavioral health issues such as depression, alcoholism, or other substance use disorders can develop and/or are made worse in such difficult situations, especially if there is no solution in sight. Injuries that result from violence or accidents do not heal properly because bathing, keeping bandages clean, and getting proper rest and recuperation isn't possible on the street or in shelters. Minor issues such as cuts or common colds easily develop into -

# Mental Health & SUD

PEH = people experiencing homelessness
SUD = substance use disorder
AUD = alcohol use disorder



Research

JAMA Internal Medicine | Original Investigation

## Mortality Among Unsheltered Homeless Adults in Boston, Massachusetts, 2000-2009

Jill S. Roncarati, ScD, MPH, PA-C; Travis P. Baggett, MD, MPH; James J. O'Connell, MD; Stephen W. Hwang, MD, MPH; E. Francis Cook, ScD; Nancy Krieger, PhD; Glorian Sorensen, PhD, MPH

Invited Commentary

Supplemental content

**IMPORTANCE** Previous studies have shown high mortality rates among homeless people in general, but little is known about the patterns of mortality among "rough sleepers," the subgroup of unsheltered urban homeless people who avoid emergency shelters and primarily sleep outside.

**OBJECTIVES** To assess the mortality rates and causes of death for a cohort of unsheltered homeless adults from Boston, Massachusetts.

**DESIGN, SETTING, AND PARTICIPANTS** A 10-year prospective cohort study (2000-2009) of 445 unsheltered homeless adults in Boston, Massachusetts, who were seen during daytime street and overnight van clinical visits performed by the Boston Health Care for the Homeless Program's Street Team during 2000. Data used to describe the unsheltered homeless cohort and to document causes of death were gathered from clinical encounters, medical records, the National Death Index, and the Massachusetts Department of Public Health death occurrence files. The study data set was linked to the death occurrence files by using a probabilistic record linkage program to confirm the deaths. Data analysis was performed from May 1, 2015, to September 6, 2016.

**EXPOSURE** Being unsheltered in an urban setting.

**MAIN OUTCOMES AND MEASURES** Age-standardized all-cause and cause-specific mortality rates and age-stratified incident rate ratios that were calculated for the unsheltered adult cohort using 2 comparison groups: the nonhomeless Massachusetts adult population and an adult homeless cohort from Boston who slept primarily in shelters.

**RESULTS** Of 445 unsheltered adults in the study cohort, the mean (SD) age at enrollment was 44 (11.4) years, 299 participants (67.2%) were non-Hispanic white, and 72.4% were men. Among the 134 individuals who died, the mean (SD) age at death was 53 (11.4) years. The all-cause mortality rate for the unsheltered cohort was almost 10 times higher than that of the Massachusetts population (standardized mortality rate, 9.8; 95% CI, 8.2-11.5) and nearly 3 times higher than that of the adult homeless cohort (standardized mortality rate, 2.7; 95% CI, 2.3-3.2). Non-Hispanic black individuals had more than half the rate of death compared with non-Hispanic white individuals, with a rate ratio of 0.4 (95% CI, 0.2-0.7; $P < .001$). The most common causes of death were noncommunicable diseases (eg, cancer and heart disease), alcohol use disorder, and chronic liver disease.

**CONCLUSIONS AND RELEVANCE** Mortality rates for unsheltered homeless adults in this study were higher than those for the Massachusetts adult population and a sheltered adult homeless cohort with equivalent services. This study suggests that this distinct subpopulation of homeless people merits special attention to meet their unique clinical and psychosocial needs.

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*JAMA Intern Med.* doi:10.1001/jamainternmed.2018.2924
Published online July 30, 2018.





# Mortality Among 445 Unsheltered Adults in Boston: 2000-2009

- Average age: 44 (67% Non-Hispanic White, 72% men)
- 134 deaths
  - Average age: 53
- All-cause mortality rate nearly **10 times higher than MA** population and nearly **3 times higher than homeless** cohort
  - NCDs (cancer, heart disease), alcohol use disorder, chronic liver disease
  - Black/African American individuals had more than half the rate of death compared with White individuals

# Mortality & Behavioral Health: 28,033 Adults in Boston 2003-2008

ORIGINAL INVESTIGATION

## Mortality Among Homeless Adults in Boston

*Shifts in Causes of Death Over a 15-Year Period*

*Travis P. Baggett, MD, MPH; Stephen W. Hwang, MD, MPH; James J. O'Connell, MD; Bianca C. Porneala, MS; Erin J. Stringfellow, MSW; E. John Orav, PhD; Daniel E. Singer, MD; Nancy A. Rigotti, MD*

**Background:** Homeless persons experience excess mortality, but US-based studies on this topic are outdated or lack information about causes of death. To our knowledge, no studies have examined shifts in causes of death for this population over time.

**Methods:** We assessed all-cause and cause-specific mortality rates in a cohort of 28 033 adults 18 years or older who were seen at Boston Health Care for the Homeless Program from January 1, 2003, through December 31, 2008. Deaths were identified through probabilistic linkage to the Massachusetts death occurrence files. We compared mortality rates in this cohort with rates in the 2003-2008 Massachusetts population and a 1988-1993 cohort of homeless adults in Boston using standardized rate ratios with 95% confidence intervals.

**Results:** A total of 1302 deaths occurred during 90 450 person-years of observation. Drug overdose (n = 219), cancer (n = 206), and heart disease (n = 203) were the major causes of death. Drug overdose accounted for one-third of deaths among adults younger than 45 years. Opioids were implicated in 81% of overdose deaths. Mortality rates were higher among whites than nonwhites. Compared with Massachusetts adults, mortality disparities were most pronounced among younger individuals, with rates about 9-fold higher in 25- to 44-year-olds and 4.5-fold higher in 45- to 64-year-olds. In comparison with 1988-1993 rates, reductions in deaths from human immunodeficiency virus (HIV) were offset by 3- and 2-fold increases in deaths owing to drug overdose and psychoactive substance use disorders, resulting in no significant difference in overall mortality.

**Conclusions:** The all-cause mortality rate among homeless adults in Boston remains high and unchanged since 1988 to 1993 despite a major interim expansion in clinical services. Drug overdose has replaced HIV as the emerging epidemic. Interventions to reduce mortality in this population should include behavioral health integration into primary medical care, public health initiatives to prevent and reverse drug overdose, and social policy measures to end homelessness.

*JAMA Intern Med. 2013;173(3):189-195.*
*Published online January 14, 2013.*
*doi:10.1001/jamainternmed.2013.1604*

An estimated 2.3 to 3.5 million Americans experience homelessness annually,[1] and over 649 000 are homeless on a single night.[2] Homeless individuals have a high prevalence of physical illness, psychiatric disease, and substance abuse,[3-5] contributing to very high mortality rates in comparison with nonhomeless people.[6-17]

Despite the persistence of homelessness in the United States, the past decade has yielded few studies on mortality among homeless Americans, and information on causes of death in this population is sparse. In the most recent study that examined causes of death in a US-based homeless population, Hwang et al[7] analyzed data on 17 292 adults seen at Boston Health Care for the Homeless Program (BHCHP) in 1988 to 1993. This study documented the substantial toll of human immunodeficiency (HIV) infection, which was the leading cause of death among 25- to 44-year-olds and accounted for 18% of all deaths in the study cohort. Homicide was the principal cause of death for 18- to 24-year-olds, while heart disease and cancer were the leading causes among 45- to 64-year-olds.

*For editorial comment see page 178*

*CME available online at www.jamanetworkcme.com and questions on page 177*

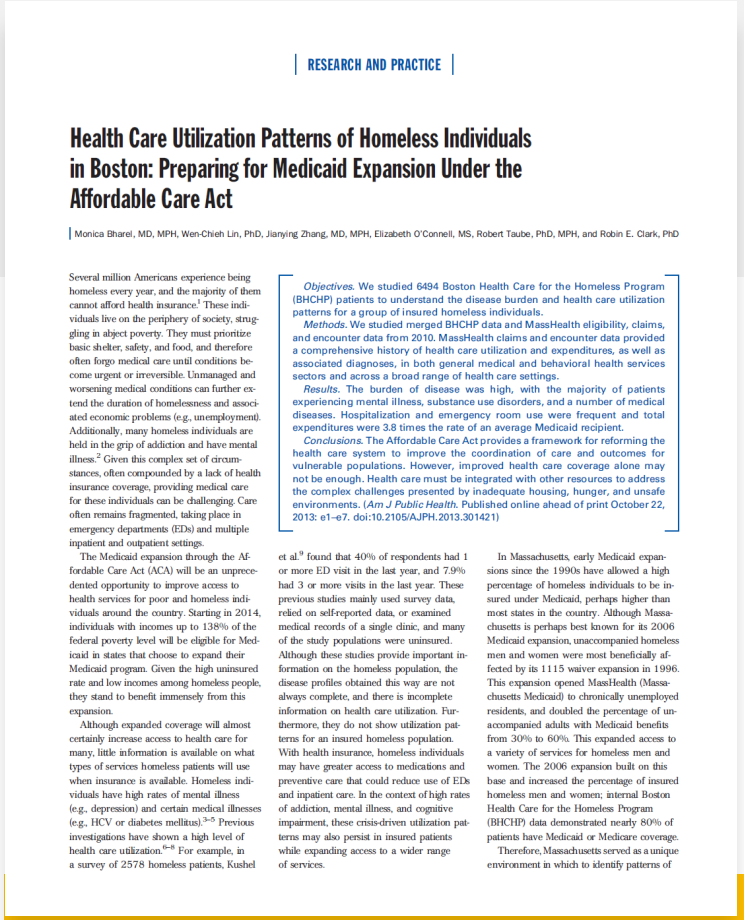
In view of interim advances in HIV treatment and expansion of federally funded Health Care for the Homeless clinical services, the mortality profile of homeless adults in the United States may have changed since 1988 to 1993; however, data to confirm this are lacking. A comprehen-

**Author Affiliations** are listed at the end of this article.





"The overall mortality pattern of homeless adults in this study demonstrates the substantial impact of substance abuse and mental illness, highlighting the **need for integrated systems of care** to address these complex issues."



RESEARCH AND PRACTICE

## Health Care Utilization Patterns of Homeless Individuals in Boston: Preparing for Medicaid Expansion Under the Affordable Care Act

Monica Bharel, MD, MPH, Wen-Chieh Lin, PhD, Jianying Zhang, MD, MPH, Elizabeth O'Connell, MS, Robert Taube, PhD, MPH, and Robin E. Clark, PhD

*Objectives.* We studied 6494 Boston Health Care for the Homeless Program (BHCHP) patients to understand the disease burden and health care utilization patterns for a group of insured homeless individuals.

*Methods.* We studied merged BHCHP data and MassHealth eligibility, claims, and encounter data from 2010. MassHealth claims and encounter data provided a comprehensive history of health care utilization and expenditures, as well as associated diagnoses, in both general medical and behavioral health services sectors and across a broad range of health care settings.

*Results.* The burden of disease was high, with the majority of patients experiencing mental illness, substance use disorders, and a number of medical diseases. Hospitalization and emergency room use were frequent and total expenditures were 3.8 times the rate of an average Medicaid recipient.

*Conclusions.* The Affordable Care Act provides a framework for reforming the health care system to improve the coordination of care and outcomes for vulnerable populations. However, improved health care coverage alone may not be enough. Health care must be integrated with other resources to address the complex challenges presented by inadequate housing, hunger, and unsafe environments. (*Am J Public Health.* Published online ahead of print October 22, 2013: e1–e7. doi:10.2105/AJPH.2013.301421)

Several million Americans experience being homeless every year, and the majority of them cannot afford health insurance.[1] These individuals live on the periphery of society, struggling in abject poverty. They must prioritize basic shelter, safety, and food, and therefore often forgo medical care until conditions become urgent or irreversible. Unmanaged and worsening medical conditions can further extend the duration of homelessness and associated economic problems (e.g., unemployment). Additionally, many homeless individuals are held in the grip of addiction and have mental illness.[2] Given this complex set of circumstances, often compounded by a lack of health insurance coverage, providing medical care for these individuals can be challenging. Care often remains fragmented, taking place in emergency departments (EDs) and multiple inpatient and outpatient settings.

The Medicaid expansion through the Affordable Care Act (ACA) will be an unprecedented opportunity to improve access to health services for poor and homeless individuals around the country. Starting in 2014, individuals with incomes up to 138% of the federal poverty level will be eligible for Medicaid in states that choose to expand their Medicaid program. Given the high uninsured rate and low incomes among homeless people, they stand to benefit immensely from this expansion.

Although expanded coverage will almost certainly increase access to health care for many, little information is available on what types of services homeless patients will use when insurance is available. Homeless individuals have high rates of mental illness (e.g., depression) and certain medical illnesses (e.g., HCV or diabetes mellitus).[3–5] Previous investigations have shown a high level of health care utilization.[6–8] For example, in a survey of 2578 homeless patients, Kushel et al.[9] found that 40% of respondents had 1 or more ED visit in the last year, and 7.9% had 3 or more visits in the last year. These previous studies mainly used survey data, relied on self-reported data, or examined medical records of a single clinic, and many of the study populations were uninsured. Although these studies provide important information on the homeless population, the disease profiles obtained this way are not always complete, and there is incomplete information on health care utilization. Furthermore, they do not show utilization patterns for an insured homeless population. With health insurance, homeless individuals may have greater access to medications and preventive care that could reduce use of EDs and inpatient care. In the context of high rates of addiction, mental illness, and cognitive impairment, these crisis-driven utilization patterns may also persist in insured patients while expanding access to a wider range of services.

In Massachusetts, early Medicaid expansions since the 1990s have allowed a high percentage of homeless individuals to be insured under Medicaid, perhaps higher than most states in the country. Although Massachusetts is perhaps best known for its 2006 Medicaid expansion, unaccompanied homeless men and women were most beneficially affected by its 1115 waiver expansion in 1996. This expansion opened MassHealth (Massachusetts Medicaid) to chronically unemployed residents, and doubled the percentage of unaccompanied adults with Medicaid benefits from 30% to 60%. This expanded access to a variety of services for homeless men and women. The 2006 expansion built on this base and increased the percentage of insured homeless men and women; internal Boston Health Care for the Homeless Program (BHCHP) data demonstrated nearly 80% of patients have Medicaid or Medicare coverage.

Therefore, Massachusetts served as a unique environment in which to identify patterns of

# Service Utilization of 6,496 Adults in Boston: 2010

- "…a **majority of individuals have mental illness and SUDs**, either alone or co-occurring. Approximately one third of ED visits and half of hospitalizations were attributable to behavioral health disorders."

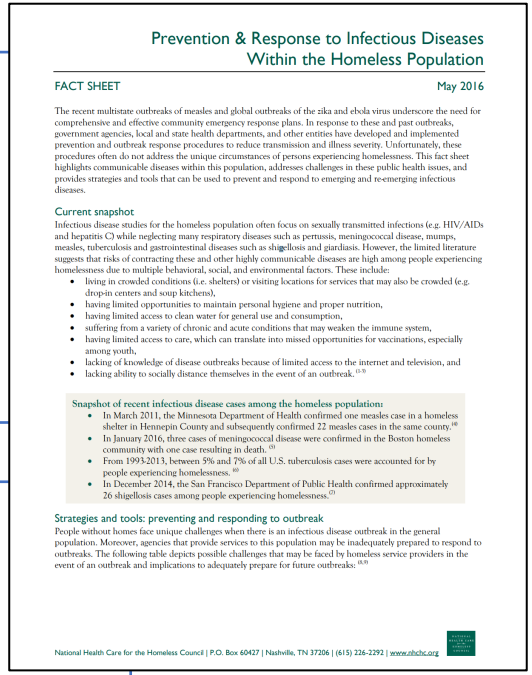
- Burden of disease is higher in this population, so costs are higher, but "states are already likely to be **paying for services for homeless individuals in less effective and fragmented systems**."

## Prior Epidemics Among Individuals Experiencing Homelessness

- HIV
- TB
- Hepatitis A & C
- Meningitis
- Norovirus
- Opiate use

## Risks Related With

- Sharing needles, unprotected sex
- Crowded conditions and inability to adhere to social distancing guidelines
- Limited access to hand hygiene, clean water, food safety
- Limited access to vaccinations
- Immune status: underlying disease, poor nutrition, chronic stress
- Increased involvement with criminal justice system (greater risk of certain infections related to incarceration)
- Lacking knowledge because of limited access to internet, media outlets, TV
- Histories of trauma, poverty, lack of social supports, mental health



Prevention & Response to Infectious Diseases Within the Homeless Population

FACT SHEET May 2016

The recent multistate outbreaks of measles and global outbreaks of the zika and ebola virus underscore the need for comprehensive and effective community emergency response plans. In response to these and past outbreaks, government agencies, local and state health departments, and other entities have developed and implemented prevention and outbreak response procedures to reduce transmission and illness severity. Unfortunately, these procedures often do not address the unique circumstances of persons experiencing homelessness. This fact sheet highlights communicable diseases within this population, addresses challenges in these public health issues, and provides strategies and tools that can be used to prevent and respond to emerging and re-emerging infectious diseases.

Current snapshot

Infectious disease studies for the homeless population often focus on sexually transmitted infections (e.g. HIV/AIDs and hepatitis C) while neglecting many respiratory diseases such as pertussis, meningococcal disease, mumps, measles, tuberculosis and gastrointestinal diseases such as shigellosis and giardiasis. However, the limited literature suggests that risks of contracting these and other highly communicable diseases are high among people experiencing homelessness due to multiple behavioral, social, and environmental factors. These include:

- living in crowded conditions (i.e. shelters) or visiting locations for services that may also be crowded (e.g. drop-in centers and soup kitchens),
- having limited opportunities to maintain personal hygiene and proper nutrition,
- having limited access to clean water for general use and consumption,
- suffering from a variety of chronic and acute conditions that may weaken the immune system,
- having limited access to care, which can translate into missed opportunities for vaccinations, especially among youth,
- lacking of knowledge of disease outbreaks because of limited access to the internet and television, and
- lacking ability to socially distance themselves in the event of an outbreak. [4-9]

Snapshot of recent infectious disease cases among the homeless population:

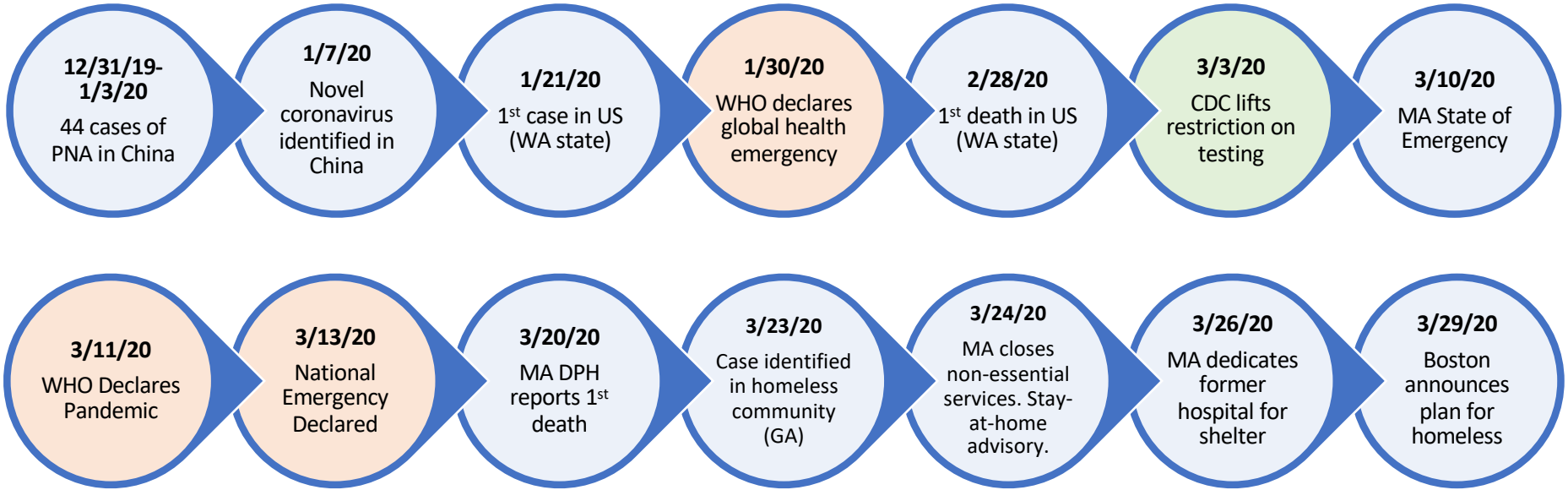
- In March 2011, the Minnesota Department of Health confirmed one measles case in a homeless shelter in Hennepin County and subsequently confirmed 22 measles cases in the same county. [8]
- In January 2016, three cases of meningococcal disease were confirmed in the Boston homeless community with one case resulting in death. [5]
- From 1993-2013, between 5% and 7% of all U.S. tuberculosis cases were accounted for by people experiencing homelessness. [6]
- In December 2014, the San Francisco Department of Public Health confirmed approximately 26 shigellosis cases among people experiencing homelessness. [7]

Strategies and tools: preventing and responding to outbreak

People without homes face unique challenges when there is an infectious disease outbreak in the general population. Moreover, agencies that provide services to this population may be inadequately prepared to respond to outbreaks. The following table depicts possible challenges that may be faced by homeless service providers in the event of an outbreak and implications to adequately prepare for future outbreaks: [8,9]

National Health Care for the Homeless Council | P.O. Box 60427 | Nashville, TN 37206 | (615) 226-2292 | www.nhchc.org

# Timeline of Key Events: COVID-19



# COVID-19 by the Numbers

*(as of early 4/2/20)*

| Region | Cases | Deaths |
|---|---|---|
| Global | 956,588 | 48,583 |
| US | 216,722 | > 3,603 |
| Massachusetts | 7,738 | 122 |
| Boston | 1,057 | 7 |

Cases among people experiencing homelessness have been reported in several states, including CA, CO, GA, MA, NV, NY

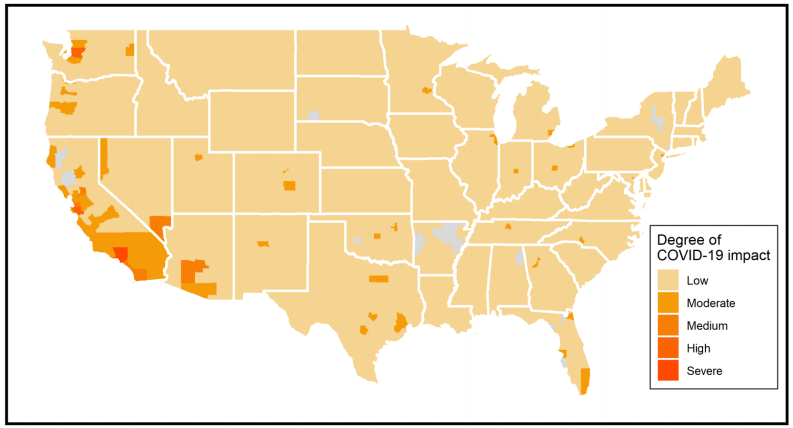
# COVID-19 Considerations for Homeless Populations

- Space: proximity to others, little control over cleaning measures
- Less access to sinks/running water, soap and hand sanitizers
- Prevalence of underlying comorbidities
- Higher rate of tobacco use
- Lower average age expectancy
- Less access to reliable and accurate information

# Projected COVID-19 outcomes for US homeless population (assuming peak 40% infection rate)

Proportionate distribution of hospitalizations, ICU, and mortality among homeless individuals due to COVID-19 pandemic

*Estimates based on 40% infection rate and 15-year accelerated aging*




Source: Age distribution from Los Angeles Homeless Services Agency HMIS 2018;
New York City Department of Social Services HMIS 2017;
CoC data from U.S. Department of Housing and Urban Development 2019 Point-in-Time Estimates of Homelessness;
U.S. Department of Housing and Urban Development 2019 CoC GIS Geodatabase.
Grey areas indicate counties where no data is available.

Table 1: Projected COVID-19 outcomes for U.S. homeless population assuming peak 40% infection rate at a given time

| | Number of cases | Percent of total population | Range across scenarios |
|---|---|---|---|
| Hospitalization | 21,295 | 4.3% | 2.4%-10.3% |
| Critical Care | 7,145 | 1.4% | 0.6%-4.2% |
| Fatality | 3,454 | 0.7% | 0.3%-1.9% |

Map 1 depicts the proportionate distribution of hospitalizations, ICU admissions, and mortality among homeless individuals across the United States as a result of the COVID-19 pandemic. It is largely reflective of the distribution of the homeless population generally, with cases concentrated in urban areas and most regions seeing very few COVID-19 cases and low mortality.

# HCH Program Interventions

Goal to shrink existing services (routine and non-urgent care) to slow transmission

## Healthcare Workforce

- Anticipate drop
- Task-shifting for staff > 65 and with medical conditions
- Transparent prioritization of PPE during shortages
- Childcare for essential staff
- Mental health support
- Frequent staff communication

## Social Distancing

- Defer routine and non-urgent medical visits
- Increase use of telehealth
- Wellness check-in phone calls
- Decrease number of patients in waiting area
- Support delivery of medications
- Limit size of support groups and meetings
- Stagger mealtimes and clothing distribution

## Screening

- Establish and update protocols for symptoms and exposure
- Screen outside prior to entry
- Call patients proactively to screen prior to clinic arrival
- Work with shelter staff to screen widely at shelters

## Testing

- Widespread shortage of swabs and testing kits
- Some labs may be able to prioritize rapid testing for vulnerable populations
- Expansion of commercial testing

## Quarantine & Isolation

- Repurpose old and allocate new spaces
- Maintain capacity to practice hand-hygiene and toilet facilities
- Increase cleaning facility measures
- Post clear, multi-lingual and low literacy information on prevention
- Low-threshold considerations for patients with mental health conditions or active substance use disorders

# Policy & Public Health Interventions

Food Access

Shelter & Housing

Law & Immigration Enforcement

Health Systems

Economic Relief

2020 Census Count

# Implications

**Patients**
- Decreased access to routine medical care, urgent care (overburdened system) and support/recovery groups
- Interrupted relationships with service providers and staff
- Isolation, loneliness, anxiety, uncertainty
- Higher vulnerability to illness and death

**Staff**
- Stress, fatigue, anxiety, burnout
- Increased exposure to COVID-19

**Program**
- Increased demands for quick synthesis of information, innovation and iteration, new processes and protocols, partnerships
- Changes to core programming
- Reduction in staffing
- Loss of revenue
- Low supply of PPE

# Patient Considerations

- Welcoming spaces and dignified treatment
- Increase education, information and communication for patients with limited English proficiency
- Focus on trauma-informed approaches where possible
- Focus on behavioral strategies for prevention and de-escalation in settings of high stress
- Access to pastoral care
- Engage behavioral health staff for messaging

# HCH Program: Essential Partnerships

# Discussion

- *Will all individuals in shelters be exposed? Will more individuals choose to sleep outside?*
- *Will there be/how much of an increase in the numbers of homelessness as a result of COVID-19?*
- *How sustainable are new programmatic efforts?*
- *What are the trade-offs of redirection away from other acute and chronic conditions, redirection away from quality of care, etc.?*
- *How will the opioid epidemic be impacted by the COVID-19 pandemic?*
- *What are the implications of all the variability of containment strategies and practice?*

# Suggested Resources

**Interim Guidance**

- CDC: Interim guidance for homeless service providers to plan and respond to coronavirus disease 2019 (COVID-19)
- CDC: Responding to Coronavirus Disease 2019 (COVID-19) among People Experiencing Unsheltered Homelessness
- Seattle-King County DPH: Interim Guidance on COVID-19 for Homeless Service Providers
- CA DPH: Flow Chart: COVID-19 Recommended Protocol for People Experiencing Homelessness
- CA DPH: Recommended Strategic Approaches for COVID-19 Response for Individuals Experiencing Homelessness
- LA County DPH: Guidance on Congregate Living Facilities: COVID-19
- NYC Health: COVID-19 Interim Guidance for Homeless Shelters
- HUD: Specific Considerations for Public Health Authorities to Limit Infection Risk Among People Experiencing Homelessness
- Harm reduction guideline

**Resources**

- NHCHC: The State of COVID-19 and Homeless Health Care and COVID-19 Resources
- NHCHC: Needed Policy Responses for a High-Risk Group
- NHCHC: hosting regular townhalls starting 03/27/2020
- Homeless Hub: Pandemic Planning: How Can My Agency Prepare?
- HUD: Infectious Disease Prevention & Response Resources (daily digest)
- HUD:Infectious Disease Toolkit for Continuums of Care: Preventing & Managing the Spread of Infectious Disease for People Experiencing Homelessness
- National Low-Income Housing Coalition: Coronavirus and Housing/Homelessness
- HHS: U.S. Department of Health and Human Services (HHS): COVID-19 Updates
- VA: U.S. Department of Veteran Affairs (VA): COVID-19 Resources
- VA: VA COVID-19 Response Plan
- PartnersHealth Care, BHCHP: established Hotlines, Telemedicine

# Suggested Resources

**Webinars**

- NHCHC: Coronavirus and the HCH Community: Status Updates, Available Guidance, Local Preparations, and Outstanding Issues 3/20/20
- NHCHC: People Without Shelter & COVID-19: Reaching People Where they Are in a Pandemic (4/3/20)
- HUD: Infectious Disease Preparedness for Homeless Assistance Providers and Their Partners (webinar 3/10/20, slides here; webinar 3/13/20)
- Homelessness Learning Hub: Pandemic Preparedness (2015 re H1N1 in Canada)
- Various Grand Rounds: MGH Medical Grand Rounds "A Coordinated, Boston-wide Response to COVID-19" Livestream available here (03/12/2020)

**Peer-Reviewed Articles**

- Lancet: COVID-19: a potential public health problem for homeless populations by Tsai & Wilson. (3/11/20)
- Lancet: Efforts escalate to protect homeless people from COVID-19 in UK by Kirby (3/26/20)
- BU, Penn, UCLA: Estimated Emergency and Observational/Quarantine Bed Need for the US Homeless Population Related to COVID-19 Exposure by County; Projected Hospitalizations, ICU and Mortality by Culhane et al. (3/24/20)

**News Media**

- Reuters: Homeless shelters, programs ill-equipped for coronavirus, U.S. cities warned by C. Biron (3/10/20)
- NYT: Coronavirus Outbreak Has America's Homeless at Risk of 'Disaster' by T. Fuller (3/10/20)
- ABC News: Coronavirus and the homeless: Why they're especially at risk, ways to stop a spread 'like wildfire' by E. Shapiro (3/11/20)
- Daily Beast: Will Coronavirus Make America Finally Care About the Homeless by B. Nelson (3/11/20)
- Huff Post: Homeless People Are Especially At Risk Amid Coronavirus Pandemic by Ruiz-Grossman (3/11/20)
- WBUR: Tent Medicine to Treat Those with Coronavirus in Boston's Homeless Community by M. Bebinger (3/23/20)
- New Yorker: Coronavirus spurs a movement of people reclaiming vacant homes by D. Goodyear (3/28/20)
- Boston Magazine: Boston Coronavirus News: Suffolk Dorm to Shelter the Homeless by A. Vaughn (3/30/2020)
- City of Boston press conference: Boston Mayor Walsh Press conference (03/29/2020)
- CNN: How do you stay home when you're homeless? (4/2/20)