

Policy Brief:
Policies Protecting People Experiencing Homelessness during the COVID-19 Pandemic

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Executive Summary:

People experiencing homelessness are a uniquely vulnerable population during the COVID-19 pandemic, owing to their advanced age, comorbidities, and inability to “stay at home.” The health of homeless persons is intricately tied to that of the communities where they reside. Yet the impact of COVID-19 on homeless persons and the most effective policies to protect them remain unclear. This policy brief will synthesize the developing body of evidence on policy approaches to protect this population.

Based on our review, preliminary data suggests:

- (1) There is a high risk of infection, hospitalization, and death among people experiencing homelessness, especially in the congregate shelter setting.
- (2) Regular facility-wide testing of shelter residents and staff should be preferred over symptom screening and reactive testing, based on retrospective studies on shelter outbreaks
- (3) Non-congregate shelter may be effective in reducing infections, based on observational data from Seattle and a modeling study of the UK’s implementation of single-occupancy housing and alternative care sites for people experiencing homelessness.
- (4) Further studies are needed to evaluate patient and provider-centered outcomes of telehealth for people experiencing homelessness

As the pandemic continues, these interventions should be studied to inform how to best protect this population.

COVID-19 and People Experiencing Homelessness

During the COVID-19 pandemic, policies restricting non-essential business and activity outside one's home have been key to limiting spread of disease. But such measures do little to protect people experiencing homelessness, a uniquely vulnerable population.¹ Persons experiencing homelessness are at high risk for disease spread because they cannot practice social distancing while living in crowded shelters and lack consistent access to handwashing and shower facilities on the streets.² Compared to the general U.S. population, they are older and have a higher burden of comorbidities, including cardiovascular and lung disease³⁻⁵—features associated with more severe infection from COVID-19.⁶

Major outbreaks among homeless shelter residents and staff during the early months of the pandemic demonstrated the seriousness of the threat to this population.⁷⁻¹⁰ In early April 2020, mass SARS-CoV-2 PCR testing in a large homeless shelter in Boston found that 36% of residents tested positive, the majority of whom showed no symptoms.¹⁰ Similar testing events in nineteen shelters in four cities identified positive cases among 25% of residents and 11% of staff.⁸

Tracking and reporting of COVID-19 cases, hospitalizations, and deaths for people experiencing homelessness is still limited and varies across states. However, the available data paint a worrisome picture. A study conducted in Denver, Colorado from May-July 2020 reported a 24% seroprevalence of SARS-CoV-2 antibodies among shelter residents compared with 8% among people living in encampments.¹¹ For comparison, seroprevalence rates within the general Colorado population were less than 4%, and national rates less than 10%, during a similar timeframe (July-September 2020).¹² These findings suggest that congregate shelter residents may be at increased risk of infection compared to unsheltered individuals (and possibly the general population), but should be corroborated by seroprevalence studies in other locations. Other studies should also directly compare risks of infection for people experiencing homelessness and the general population.

Data on COVID-19 hospitalizations and deaths for people experiencing homelessness is also limited, but the few available data are concerning. One study found that persons experiencing homelessness accounted for over 22% of all adult patients hospitalized with COVID-19 infection at a Boston safety net hospital during the study period of March 1-May 18, 2020.¹³ A non-peer reviewed analysis by the New York Coalition for the Homeless reported that

the age-adjusted mortality rate for homeless residents living in New York City (NYC) shelters was 406 deaths per 100,000 people, compared with 231 per 100,000 among the general NYC population (as of October 30, 2020).¹⁴ These findings should also be investigated in larger populations and with more rigorous analysis for confounding variables.

Lastly, further studies are needed to better understand how the pandemic impacts the communities people experiencing homelessness are part of. First, studies should report healthcare utilization during the pandemic by people experiencing homelessness, as they have few options to self-isolate outside of the hospital.¹⁵ Second, the impact of pandemic-related disruptions to social services providing food, shelter, and employment on people experiencing homelessness should be examined. A majority of surveyed nonprofit community organizations in the U.S. have faced challenges in funding, staffing, and service delivery due to the pandemic.¹⁶ During a time when these services are most needed, disruptions to the safety net may pose a significant public health risk.

Analysis of Policy Strategies

The following section will discuss policy responses implemented at the federal, state, and local level. The federal government has provided funding for homeless initiatives during the pandemic through two major sources. First, the CARES act, passed March 27, 2020, allocated \$4 billion in Emergency Solutions Grants through the Department of Housing and Urban Development (HUD) to local governments providing shelter and essential services for people experiencing homeless. Second, the Federal Emergency Management Agency (FEMA) Public Assistance Program Category B can be used by states to reimburse expenses including non-congregate shelter.¹⁷

With the available funding, state and local governments in partnership with homeless service providers have enacted a variety of strategies to protect their homeless populations. Below, we summarize the approaches and analyze the available evidence for the effectiveness of each policy.

Non-congregate housing

Non-congregate shelter is defined as housing where individuals have their own private rooms and restrooms. In principle, separate rooms provide a safer shelter option compared to

shared sleeping spaces by allowing a much greater degree of social distancing. Notable examples of non-congregate housing programs include California's Project Room Key¹⁸ and similar programs in New York City, Seattle, and Baltimore. An estimated 70% of Continuums of Care (CoC), local governing bodies for homelessness services, around the U.S. used this approach at some point between March and August 2020.¹⁹ Most of these programs utilized hotel and motels—largely empty in 2020 due to declines in travel—to house people who lack their own space to self-isolate. In the U.S., these programs tended to prioritize the most medically vulnerable, including homeless persons older than 65 and those with serious medical problems. While the hotel stays are meant to be temporary, some programs have used integrated case management to help transition residents to long-term stable housing.^{19,20} Programs may incorporate multidisciplinary teams and trauma-informed care to help address residents' complex medical and mental health needs.²⁰

Non-congregate housing programs face a number of challenges. First, they are expensive to implement. In addition to paying for rooms, the programs need to coordinate nursing, meals, laundry, and security for each site, adding expenses. Total costs for rooms in San Francisco's program reportedly amounted to \$260 per night, though FEMA covers 75% of the cost.²¹ Second, comorbidities such as substance use disorders can make compliance with quarantining in single-occupancy housing difficult for many individuals.²⁰ Third, securing rooms from private hotels and motels takes substantial time and resources. Nationwide, local CoC hotel programs housed 18% of their homeless populations on average.¹⁹ In California, it took Los Angeles' program 3 months to reach 25% of its goal of housing 15,000 people, peaking at 4,300 residents; ultimately, the number of people housed was limited by the number of hotel and motel owners willing to participate.^{18,22} California has since transitioned to providing funds for cities to purchase hotels and motels to be converted into permanent housing through its Project Homekey.²²

Despite these challenges, there is emerging evidence that non-congregate housing reduces infections. One observational study from Seattle followed 383 residents moved to hotels and 1,252 remaining in congregate shelters from February to August 2020.²³ The hotel cohort recorded about 24 positive cases from the two months prior to moving into hotels (March-April) and 6 cases in the four months afterwards (May-August). The congregant shelter cohort had about 9 positive cases between March-April and 64 cases between May-August including a

cluster of about 50 cases from July-August which was not mirrored in the hotel cohort (exact numbers not provided in report). However, this study did not describe how residents were assigned to the different cohorts and had limited reporting and analysis of their quantitative data. Another study examined the United Kingdom (UK)'s pandemic policy that consisted of non-congregate shelter in hostels and alternative care sites for symptomatic individuals. Using statistical modeling, it estimated that this approach prevented 21,000 infections, 1,100 hospitalizations, and 266 deaths during the first wave of the pandemic.²⁴ However, the U.K. program housed a much greater share of its homeless population compared to programs in the United States and was not limited to the medically vulnerable. Further studies should examine the costs, effectiveness, and equity of non-congregate housing programs in the U.S.

COVID-19 mitigation strategies in congregate shelters

As noted previously, there have been numerous examples of the capacity for COVID-19 to spread rapidly in congregate shelters.^{10,25} Despite the heightened risks, congregate shelters fill unmet needs for shelter, food, and bathrooms for many people experiencing homelessness—especially during the winter. To reduce harms from this approach, the CDC has published guidance for congregate shelters on facility layout, protocols for staff use of personal protective equipment (PPE), and procedures for symptom screening and isolation.²⁶ The guidance includes spacing beds at least 6 feet apart and aligned head-to-toe, disinfection of frequently touched surfaces, using physical barriers to protect screening staff, and requiring clients to wear provided masks. There are limited data on the effectiveness of these mitigation strategies in the shelter setting, though these measures are low cost and easy to implement.

In addition to implementing these measures, some cities, such as San Diego, have converted large spaces such as convention centers into shelters.²⁷ These larger shelters have higher capacity of beds and centralize resources such as food distribution and case management. Within 4 months of opening, San Diego's shelter program moved 400 residents into permanent housing, with plans to transition remaining convention center residents to a city-run hotel in 2021.²⁸ However, costs are significant—in the month of November 2020, total costs of San Diego's convention center shelter amounted to \$210 per resident per day, far exceeding its initial estimates.²⁹ From April until November 2020, facility-wide testing showed only 27 positive

cases out of over 9,000 tests; however, an outbreak of at least 120 cases was identified in December 2020, demonstrating the continued risks associated with large shelters.³⁰

Universal testing for shelter residents and staff

Another key policy aimed to make congregate shelters safer is implementing regular COVID-19 testing of residents and staff. The CDC currently recommends regular facility-wide testing in shelters based in areas with moderate community transmission.³¹ The evidence for this policy comes from cross-sectional studies showing the potential for rapid disease spread among residents despite symptom-based screening and testing procedures. In a large Boston shelter, mass testing revealed a large outbreak of 147 cases; of those testing positive, 88% had no symptoms at the time of testing.¹⁰ Another study of 19 shelters in four cities corroborated these findings—mass testing triggered by a few symptomatic cases identified larger outbreaks including 25% of residents and 11% of staff.²⁵ These data support the use of regular universal testing in shelters for early detection and isolation of persons with pre-symptomatic or asymptomatic disease.

Regular testing in shelters also allows for better collection of data on prevalence in the population at various points of time. A surveillance study of 14 shelters in King County, Washington between January-May 2020 using routine and surge testing found a 2% positivity rate among residents and staff—lower than the 8.8% laboratory rate during that period.³² This difference in rates could be partly attributed to the higher percentage of symptomatic persons seeking care within the general testing population. Data collected by the National Healthcare for the Homeless Council on universal testing events of shelters and encampments found a 7.8% positivity rate among residents and 4.0% among staff as of December 3, 2020.³³ This data is currently limited to self-reported events in 21 states, and further studies should include more representative samples.

Alternative care and Medical respite care sites for isolation and recovery

Many areas hard-hit by the pandemic have utilized alternative care sites to provide extra capacity to meet the surging demand for healthcare resources.³⁴ These are sites apart from hospitals (such as mobile medical units or converted motels) where patients with COVID-19 can safely recover under medical monitoring.

Alternative care sites play an essential role for people experiencing homelessness with COVID-19, who do not otherwise have a safe place to self-isolate outside of the hospital. They function similarly to a model of care that predates the pandemic known as medical respite care, defined as care for the unstably housed whose needs fall in between inpatient and outpatient care.³⁵ Sites may be used as a discharge destination for homeless patients who have been hospitalized and may allow those who test positive with mild symptoms to avoid hospitalization altogether. Alternative care sites can build upon medical respite model of connecting patients to primary care and support services including housing, insurance and mental health care.^{35,36} This approach has been implemented and described by practitioners in Boston's Healthcare for the Homelessness Program, though they have not yet reported on comparative outcomes or costs.^{36,37} Alternative care sites may have contributed to the reductions in hospitalizations and deaths estimated in a study of the UK policy, discussed above.²⁴ There is a need for further study of efficacy, cost-effectiveness, and associated healthcare utilization in the U.S. context, building on pre-pandemic data showing reductions in hospitalizations and readmissions.³⁸

Telehealth for people experience homeless

Emergency authorizations by the Center for Medicare and Medicaid Services (CMS) in March 2020 allowed for the expanded use of telehealth services across the U.S.³⁹ Before the pandemic, telehealth benefits tended to be limited to patients living in rural areas with already established relationships with their physician. These federal changes granted flexibility to providers and allowed all patients to access telehealth during the pandemic. Importantly, CMS also allowed states to waive similar restrictions for Medicaid programs.

These changes allowed the rapid development and use of telehealth by health centers providing care for people experiencing homelessness.^{40,41} Temporary State Medicaid waivers were key to this growth; among patients seen at federally-funded Healthcare for the Homeless Programs, Medicaid was the most common form of insurance coverage (51%), followed by no insurance (34%) and Medicare (9%).⁴² The National Health Care for the Homeless Council (NHCHC) interviewed representatives of 17 programs around the U.S. delivering telehealth to people experiencing homelessness, compiling their experiences as case reports.⁴¹ Among the common themes noted was the successful uptake of audio-only telephonic visits, which reduced transportation barriers to care and were more accessible than video visits for those without

smartphones, cellular data, or private areas to talk. This is consistent with surveys showing access to cell phones among the vast majority of homeless adults,^{43,44} but low rates of internet connectivity among those older than 50 years old.⁴⁴ However, a challenge with telephonic visits is low reimbursement rates in many states. An important policy issue for telehealth programs going forward is whether states choose to make some temporary changes to their Medicaid programs permanent, including paying for audio-only visits and not requiring prior authorization or an existing relationship with the patient and provider to engage in telehealth.⁴⁰

Overall, telehealth is a promising strategy to increase access to care for people experiencing homelessness during the pandemic. However, available evidence is limited to qualitative case reports. Further studies should assess patient and provider-centered outcomes, such as emergency department visits and provider satisfaction.

Moving Forward: Conclusions and Areas for Further Study

Almost a year into the pandemic, the impacts of COVID-19 on people experiencing homelessness are still not well understood. This issue has renewed relevance in the ongoing winter months, in which community rates of infection have dramatically increased, and people experiencing homelessness face dual threats of exposure to the harsh elements and to the virus. Furthermore, the profound impact of job and wage losses caused by the pandemic may lead to a growing number of individuals and families experiencing homelessness; expiring eviction restrictions may put an estimated 30-40 million Americans at risk of eviction, barring intervention.⁴⁵

Our review of the literature can be summarized as follows. First, preliminary studies suggest **there is a high risk of infection, hospitalization, and death among people experiencing homelessness, especially in the congregate shelter setting.** Further studies should directly compare these risks to that of the general population. Second, **regular facility-wide testing of shelter residents and staff should be preferred over symptom screening and reactive testing,** based on retrospective studies on shelter outbreaks. Third, **non-congregate shelter may be effective in reducing infections,** based on observational data from Seattle and a modeling study of the UK's implementation of single-occupancy housing and alternative care sites for people experiencing homelessness. Fourth, **further studies are needed to evaluate**

patient and provider-centered outcomes of tele-health for people experiencing homelessness.

A sustained partnership between policymakers, healthcare and service providers, and researchers is needed to protect the lives of people experiencing homelessness during the COVID-19 pandemic. As the pandemic continues, research should inform better policies to address the problem of homelessness itself.

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