

# Responding to COVID-19: Conversations with Homeless System Leaders

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Anti-poverty programs, including homeless services, are often on the frontlines of national crises. COVID-19 is no different. Homeless agencies serve one of the subpopulations facing the most significant barriers to self-isolation and other means of protecting one's health. These providers may also face an influx of new clients as the recession progresses, the national unemployment rate remains elevated, and evictions loom large for many individuals and families. Thus, the Alliance has been engaging in an ongoing effort to understand better how homeless service providers are managing in the current crisis.

The current publication is the third installment in a series highlighting provider responses to our survey project. It summarizes the responses collected through a series of phone interviews with 24 homeless Continuum of Care leaders from across the country during May and June.

Primarily, our interviewees learned that people of all stripes are working hard to aid people experiencing homelessness during these difficult times. This ranges from the outreach workers who never left the job (even if that meant going out to public spaces with limited PPE) to the system leaders exhausting every possible avenue of funding to protect their clients' health and get them housed. Together, workers and volunteers throughout systems are developing "promising practices" – we label them as such because they are emerging in a crisis and have yet to be formally evaluated.

Nevertheless, a long list of challenges remains. Some are rooted in the long history of systems being underfunded and generally lacking the community support to do the work expected of them.

## *Ensuring Healthy Conditions*

COVID-19 poses a risk to people experiencing homelessness. As a contagious illness, it could spread quickly in congregate settings like shelters and encampments. People in these locations often sleep in close quarters. Proper sanitation, especially in outdoor areas, is hard to maintain.

And shelter rules limiting stays to nighttime hours, law enforcement efforts to move people along, and personal habits often cause people experiencing homelessness to be mobile. This complicates plans to test people for COVID and serve their health needs.

To manage some of these issues, CoCs have been employing some promising practices that include:

- **Bringing Testing and Health Services to the People.** According to the Alliance's previous online survey, [28 percent](#) of CoC leaders reported conducting COVID-19 testing in places where homeless people live and congregate. Various types of professionals (doctors, nurse practitioners, health departments) are offering testing through shelters, hotels/motels, mobile testing units, and by accompanying outreach teams.

In some locations, health services (provided by Healthcare for the Homeless, health centers, and hospitals) are comprehensive and ongoing. These conveniently located health units treat the often-extensive medical needs of unsheltered, chronic, and older adult homeless people.

- **Randomized Testing.** Not having enough COVID-19 tests for all people experiencing homelessness is common. At least one of our interviewees addressed this challenge by conducting randomized testing on unsheltered people. This allows providers and health departments to estimate the spread of COVID-19 when they cannot get exact numbers.
- **Alert Systems.** [Twenty-eight percent](#) of participants in an Alliance online survey have adopted an alert system using cell phone to notify people experiencing homelessness of their potential exposure to COVID-19, test results, and general public health information.
- **Triaging People and Making Temporary Housing Placements.** Multiple communities have developed different approaches to triaging consumers and other community residents. For example, one CoC partnered with health experts (their local health and human services, the behavioral health department, and a healthcare provider) to create a joint operation center for this purpose. They opened a phone line staffed by nurses and experts from their local health and human services department. Callers are asked basic health questions and, based on CDC recommendations, are assigned a priority for hotel/motel rooms.
- **Making Shelter Available to Medically Impacted People.** Admitting known sick people into a shelter puts clients and staff at-risk. One of the leaders described daily wellness checks that involve taking temperatures and a questionnaire. The system does

not simply deny sick people shelter—they are placed in alternative housing while being referred to a medical provider and awaiting test results.

- **Providing Necessary Transportation.** Some service models include transportation to testing sites and hotels/motels used for social isolation and quarantine. For one CoC, this required newly retrofitting vans for this purpose.
- **Improving Sanitation.** Multiple communities have invested in sanitation improvements reaching unsheltered people. For instance, they have installed handwashing stations and outdoor bathrooms.
- **Securing PPE.** Shortages of personal protective equipment (PPE) have been common in America—especially at the very beginning of the COVID-19. Multiple sectors, including homeless services have felt the impact. Problem-solving has been creative—for example, sourcing masks through beauty supply stores. It has included private actors—donations from foundations and concerned citizens. And, for many CoCs, PPE has been secured through partnerships with state and local health departments.

## *Housing Placements*

Temporary housing placements are a central component of the homeless services system’s response to COVID-19.

Implementing [CDC recommendations](#) to keep beds at least six feet apart often reduces shelter capacity. To continue serving as many people as possible, some CoCs elected to keep typically temporary winter shelters open through the spring and summer. They opened new auxiliary shelters in recreation centers, convention centers, and other locations. Brand-new safety precautions were instituted, including installing bed guards, replacing congregate eating sites with grab-and-go meals, and conducting regular health screenings. And many have expanded shelter hours—shifting from nighttime only to 24/7 shelter, allowing for a form of isolation from the broader public.

By far, the most common temporary housing response was to ensure quarantine and isolation through securing private hotel/motel rooms. Some health departments have taken the lead in providing these spaces for homeless and non-homeless people in need of quarantine. FEMA helped many CoCs to implement this solution directly. In some cases, this involved modifying existing hotel/motel programs—expanding their use and waiving typical requirements such as mandatory income contributions or refusals to rehouse based on behavior.

CoCs generally prioritized specific subpopulations for hotel/motel rooms—mainly older, medically fragile, and symptomatic or COVID-19 positive people. However, others targeted included unsheltered people and families. Providers have made efforts to staff up these new

service locations, managing hotel/client relationships and providing services (e.g., case management, behavioral health services, physical healthcare, food, and housing services).

Importantly, hotels/motels have not been the only approaches to non-congregate shelter. A couple of the CoCs we interviewed had (or were shifting to) these types of facilities before the crisis began. Other solutions included setting up quarantine and isolation sites in a state park and renting RVs in a campground.

System leaders are increasingly focusing on how to exit people from isolation and quarantine. Ideally, they want to shift them into permanent housing rather than into shelter or unsheltered homelessness. Some are ensuring that housing specialists are onsite at hotels/motels and other types of isolation and quarantine sites. And these workers are finding new ways to work with landlords and negotiate barriers erected by the pandemic (e.g., inability to get driver's licenses required for housing while a DMV is closed).

Finally, some systems have simply been unable to bring everyone inside. A subset is working with other community agencies to sanction encampments or otherwise prevent breaking them up. Other efforts include providing supplies and hand washing stations.

## *Data Collection*

System-wide data collection helps leaders identify challenges and opportunities to improve services. Within the current pandemic, it also has public health implications. It is useful to have knowledge of the number of people with symptoms or a diagnosis, the characteristics they share, and where their location is valuable. For example, such data could point to sources of community spread and inform decisions on who to prioritize for quarantine and isolation housing units.

Most CoCs ([59 percent](#)) are capturing COVID-19-related data within their existing Homeless Management Information Systems (HMIS). Interviews revealed they are asking a variety of questions that include:

- Are you experiencing symptoms consistent with COVID-19? What are they?
- Have you had contact with anyone infected with COVID-19?
- Have you been tested? When? What were the results?
- Have you ever been quarantined and/or spent time in isolation?
- Are you seeking assistance due to a COVID-19-related event?
- Which countries have you recently visited?
- Where were you recently staying? Hospital or hotspot location?

Successful data collection efforts require more than merely adjusting HMIS. Some leaders pair such changes with employee trainings, increasing awareness of the existence of new questions and preparing staff to collect the best possible information. CoCs reported gathering

information via coordinated entry (when people first enter homeless systems), street outreach teams, and frontline workers at temporary housing locations (shelters and hotel/motel sites).

Getting multiple employees to consistently fulfill their data entry duties proves difficult for some systems. Leaders discussed technology that is not user friendly, competing distractions in the form of day-to-day activities and crisis-related responsibilities, and other factors. One of the cited solutions was a robocall system. It dials all the shelters each night at 11:00 pm and allows workers to digitally enter the necessary information on their phones.

The interviews further revealed some ways in which data are processed and used. One CoC noted that COVID-19-related information is added to individual client dashboards, allowing service delivery to be based on a comprehensive view of the person. To help manage the current crisis, at least one leader reported putting together a system-wide daily situation report which tracks client numbers (people served at each site, testing positive, awaiting results), staff numbers (testing positive), meals served, and shelter capacity.

Finally, not all data collection is occurring through HMIS. A subset of CoCs is piloting a CDC tool. State and local health departments are also broadly collecting and keeping data related to the crisis. Some (but not all) ask questions about housing status—this allows them to study and report on people experiencing homelessness.

## *Staffing*

Within homeless services, COVID-19 is linked to employee shortages. Most CoCs (60 percent of survey question respondents) report experiencing this problem—most significantly among frontline shelter staff, street outreach workers, and volunteers.

Increased need is one of the causes. Systems are taking on more significant duties that include implementing social distancing recommendations, placing people in quarantine and isolation sites, and monitoring client symptoms. But another cause of shortages is lost staff time. Some employees self-isolate due to their age, health conditions, or being a caretaker over others who are COVID-19 vulnerable. Leaders further note staff resignations and people calling in sick. They believe some portion of employees are fearful of contracting COVID-19 at work, are experiencing increased on-the-job stress, and/or must take care of children at home.

CoCs are managing staffing shortages via a variety of strategies. Examples of gap-filling measures include:

- **Reallocating responsibilities.** Systems have shifted existing employees into new roles, and asked them to take on different responsibilities to fill coverage gaps. A side effect has been less time spent on previous activities such as coordinated entry.

- **Hiring workers from other agencies.** One leader onboarded laid off and furloughed employees from other city departments. Similarly, another was able to take advantage of a Conservation Corps program that closed, hiring its youth workers. Disaster agencies, non-profits, and perhaps others have also lent some of their talent to homeless services.
- **Hiring temporary workers.** Temporary workers are helping at shelters, with rehousing efforts, and possibly other tasks.

Leaders are also actively trying to prevent gaps from developing and growing.

Multiple communities implemented (or are considering implementing) increased financial compensation to keep their employees on the job. This has taken the form of hazard pay and bonuses for good attendance at work.

Systems are also implementing safety measures that help address employee concerns. For instance, they are keeping high-risk staff at home as much as possible. Some have alternated staff schedules—e.g., expecting each employee to be at a shelter one week and at home the next. Thus, exposure to other staff and clients is reduced along with the risk of contracting COVID-19.

## *Partnerships*

Responding to a crisis is typically not a single person or single agency activity. Homeless service providers have been working with partners, either deepening existing relationships or building new ones.

Their most-cited partners are public health departments. These agencies have helped to:

- Reconfigure shelters, implementing social distancing recommendations.
- Institute cleaning procedures.
- Advise on the proper use of equipment.
- Train outreach workers, shelter providers, and hotel/motel staff.
- Completely oversee individuals who test positive for COVID-19, maintaining quarantine housing and ensuring their care.

However, efforts to collaborate have extended far beyond health departments to include:

- **Healthcare providers.** These agencies are providing testing, street outreach, transportation to hospitals, and patient care.
- **Colleges and universities.** Academic experts in epidemiology are also testing people and tracking positive cases.
- **Unsheltered people and people with lived experience.** At least one CoC reported working with unsheltered people and others with lived experience to develop a 12-18 month plan to manage the COVID-19 crisis.
- **Legal Services.** Lawyers are helping to remove barriers to stable housing.
- **Social Services.** These partners can ensure that clients enroll in public benefits programs that address needs such as healthcare, food, and income.

Keeping these various partnerships alive and thriving requires effort. Within their interviews, the CoC leaders highlighted various activities that feed their connections.

Some were able to create designated staff positions for this purpose—for example, a liaison between the health department and homeless services and new roles within the health and human services department to oversee a region’s entire COVID-19 response. Pre-existing structures have also been of benefit. For instance, one leader already had healthcare leaders serving on his/her board—they have been helpful during the crisis. Other providers are located within health departments, making collaboration much more straightforward.

Leaders are utilizing other standard tools to maintain communication with partners. They have established regular meeting schedules—twice weekly, weekly, or monthly. E-mail chains and blog posts targeting community partners also work to improve coordination among agencies.

## *Common Challenges*

The primary aim of this publication is to uplift promising practices emerging from the current crisis, which encompasses both a global pandemic and an economic recession. However, difficulties are inevitable amid such unusual circumstances. Our interviews certainly reflect some common challenges experienced by homeless services systems, which generally fall into five categories.

### **1) Resource Constraints**

System leaders described multiple challenges that seemed rooted in having insufficient resources, including:

- Inability to collect COVID-19-related data
- Failure to test everyone experiencing homelessness
- Insufficient numbers of case managers to help people connect to telehealth and other services
- Limited PPE which, for some, is resulting in a reduction in services
- Inability to provide isolation space
- Unmet needs for staff to cover hotels/motels
- Inability to make up for shelter capacity losses caused by [CDC guidelines](#) on social distancing
- Fears of not being able to serve a potential influx of clients from upcoming evictions
- Failure to extend shelter hours to allow for 24/7 operations
- Inability to provide transportation to healthcare and housing services
- Insufficient permanent housing options once isolation ends
- Failure to meet consumer demand for hotels/motels
- Inability to properly treat consumers with substance abuse disorders, including being able to provide medications that prevent overdoses

In some areas, homeless services providers are competing for resources with other groups. Hotels/motels can be in high demand. Health departments place non-homeless people in these rooms if they need to be isolated and regularly live in overcrowded spaces. Housing unstable people, who are not in the homeless system, were already renting rooms before the crisis. And some healthcare providers and other essential workers are staying in hotels/motels to protect their families from contracting the virus. Similarly, there are resource competitions for PPE—mainly with essential workers.

Finally, some CoCs report not fully using available resources. In particular, some have empty hotel/motel rooms due to rules established by FEMA or other agencies that narrowly define who is eligible for them.

As these interviews were being conducted, participants were informed of regional subgrant awards under the CARES Act. Congress passed this comprehensive COVID-19 response in March, providing \$4 billion in new dollars to homeless service providers across the country. It is unclear the degree to which those funds will address identified challenges and how long such funds will last during a crisis with no foreseeable end in sight. CoCs have expressed that the uncertainty of future funding impedes planning. How can they hire staff, contract for new spaces, or resolve other matters without knowing how long they can pay for them?

## **2) Organizational Growing Pains**

Crisis response requires executing new plans and activities—often very quickly.



CoCs were experiencing some growing pains in areas such as establishing MOUs with hotels/motels, bringing services (e.g., behavioral health, transportation, food) to new sites, and setting up new HMIS data entry locations.

Systems are quickly adjusting how they manage different types of people. Staff have fears of contracting COVID-19 that must be addressed. Some systems are hiring and training new people, some of whom lack experience in social services. Consumers require effective communication about test results and health information. There have also been challenges with ensuring some consumers to stay inside, getting others to leave hotels/motels when their time in isolation ends, and addressing security/safety issues at hotels/motels. And providers are adjusting to working remotely with other relevant parties (e.g., landlords and housing inspectors).

Further, CoCs are confronting the need to overcome the ramifications of historical challenges quickly. For instance, an overreliance on volunteers meant the loss of significant human resources during the crisis as many began isolating.

### **3) Unmet Needs for Guidance**

CoCs are regularly grappling with questions that realistically don't have easy answers. At the time of their interviews, they appeared to require greater guidance on issues such as the following:

- How should they estimate their PPE needs?
- How should they be managing the flow of people in and out of quarantine and isolation rooms (significantly in motels/hotels)? What community and personal factors should guide when to use these spaces? How long should people stay in them?
- How can they prevent homelessness?
- What is the best strategy for managing the needs of unsheltered people, many of whom are being underserved during the crisis?
- How should they determine when and what employees should stay at home in isolation?
- How should Balance of State rural CoCs manage the crisis when much of the available guidance seems more appropriate for urban areas?

### **4) Discrimination**

Discrimination against people experiencing homelessness, people of color, and/or poor people is often a barrier in addressing homelessness. This continues to be true even during this unprecedented crisis. System leaders report that some hotels/motels are unwilling to serve the population. Neighbors of these businesses have been guilty of NIMBY-ism, protesting the idea of homeless people being offered shelter that could protect their lives and the lives of others. One state-run quarantine and isolation location would not allow people with criminal records

to have a room. Finally, multiple leaders indicated that it is simply difficult to get their communities or other government agencies to care about unsheltered and other homeless people.

## 5) Interagency Fractures

Partnerships with other agencies can be tough to navigate. Multiple homeless services providers are operating in communities where health departments (and other entities) oversee testing and/or quarantine/isolation sites but are not sharing information with them. HIPAA concerns are often assigned the blame, leaving agency partners with the task of finding useful ways to collaborate that do not unlawfully violate individuals' privacy. Otherwise, health departments could be doing more to properly account for homelessness in their work, tracking information about the housing status of all the people they reach.

Other agencies are directly interfering with homeless services objectives without consulting with them—for example, some police departments continue to break up encampments, which is contrary to [CDC guidance focused on unsheltered homelessness](#).

Finally, there can be disagreements among agencies about who oversees specific aspects of a community's response or who is responsible for paying for certain services.

## *Conclusion*

COVID-19 and the recession are putting enormous pressure on homeless services systems. They are responding in various promising ways that could inform one another but also other providers reaching people living in poverty. Nevertheless, they still have a list of challenges that they need to overcome—many are related to the availability of resources and technical assistance. Others, including Congress, can and should step in to assist. The best possible response will not only benefit people experiencing homelessness, but everyone in communities focused on their physical and economic health.