Community-level Responses of Homelessness Assistance Programs to COVID-19: Data from May 2020

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Introduction

In April 2020, the National Alliance to End Homelessness (NAEH) conducted a national survey of local homeless assistance coordinating agencies, or Continuums of Care, to understand the impacts of COVID-19 and how communities have responded to this unprecedented public health crisis. On January 30, 2020 the World Health Organization (WHO) declared the novel coronavirus outbreak a Public Health Emergency of International Concern and on February 11, 2020 the WHO announced the name of the new coronavirus disease: COVID-19 (WHO, 2020). By mid-March, starting with California, in almost every state in the United States, persons were encouraged to "shelter in place" and to practice "social distancing" to flatten the growth curve of infection to allow hospitals and emergency health care resources to adequately keep pace with those experiencing acute medical crises (Baral et al., 2020). Asking citizens to "shelter in place" and practice "social distancing" created an unprecedented urgency for communities across the country to respond to the needs of persons experiencing homelessness in the face of this crisis (Doran et al., 2020; Lima et al., 2020; Tsai & Wilson, 2020).

Primary concerns that quickly emerged across the nation were:

- How to provide shelter for people experiencing homelessness who become infected with COVID-19
- How to provide adequate shelter to prevent COVID-19 infection among medically vulnerable persons experiencing homelessness (over 65, underlying health conditions)
- How to address shelter density in existing congregate shelters to comply with CDC guidance for social distancing in shelters (110 sq ft per person)
- How to address the health and safety of unsheltered persons including people in encampments, in light of the crisis;
- How to protect staff who serve persons experiencing homelessness
- How to acquire financial resources and PPE supplies to address the needs of people who are homeless
- How to coordinate screening, testing, tracking and contact tracing with community partners.

The urgency for communities to address homelessness in the face of COVID-19 is aggravated by the fact that those who are most at risk for severe complications and death due to COVID-19 are often over-represented among populations of persons experiencing homelessness. Risk of severe complications and death is highest among older persons (age 65 and over among the general population, but extending to people

50 and over among persons who are homeless due to premature aging in this population) and persons of any age who have one of several underlying health conditions including: asthma , chronic kidney disease being treated with dialysis, chronic lung disease, diabetes, hemoglobin disorders, immune compromised, liver disease, serious heart conditions, and severe obesity (CDC, 2020).

These COVID-19 risk populations intersect in significant ways with the population of persons experiencing homelessness. First, there is an emerging "aging crisis" among persons experiencing homelessness, with a concentration of homelessness among people who are a part of the birth cohort of people born in the latter half of the post-War baby boom (1955-1965) (Culhane et al., 2019). Moreover, there are high levels of underlying health conditions for homeless persons and a lack of health care access which has led to a characterization of homelessness itself as a public health crisis (e.g. Donovan, & Shinseki, 2013; Hwang et al., 2013). Indeed, prior to COVID-19, the risk for premature mortality due to underlying medical conditions was well documented (e.g. Roncarati et al., 2018) and has been used to motivate prioritization of limited housing resources for persons living with homelessness (Rice et al, 2018).

Since 1994, communities in the US have created coordinating agencies called Continuums of Care (CoC), that act as intermediaries for federal homelessness assistance grants from the US Department of Housing and Urban Development. NAEH reached out to CoCs across the country to understand how communities were responding to the unique demands created by COVID-19, including the need to facilitate "shelter in place," isolation, quarantine and "social distancing" practices for persons experiencing homelessness in their CoC, in compliance with CDC guidelines.

The NAEH survey focused on the following domains:

- Screening and testing
- Estimates of COVID-19 case counts
- Data tracking practices in the CoC surrounding COVID-19
- Housing placements to address COVID-19
- Bed capacity changes to respond to COVID-19
- PPE issues for staff and consumers
- Staffing impacts
- Resource acquisition issues
- Agency assistance and partnerships to CoCs
- Access to services

The responses to this survey provide an understanding of how communities through their CoCs have responded to COVID-19 in the first 4-6 weeks of the crisis.

Methodology

The National Alliance to End Homelessness (NAEH) sent via email the "COVID-19 CoC Response Survey" to grantee contacts for every CoC in the United States on April 23, 2020. NAEH retrieved the list on the morning of April 23, 2020 from the US Department of Housing and Urban Development on their Grantee Contact Page. The list included multiple contacts for each CoC. While there are 397 CoCs, the survey went out to 861 unique email addresses. 48 emails bounced back as undeliverable (9.8%). Survey Monkey was the platform for data collection. The initial request provided a deadline of May 5, 2020 for completion of the survey. NAEH sent a reminder email on May 4, 2020 for communities to provide responses and extended the deadline to May 8, 2020. Surveys were submitted by 168 CoCs, representing 42% of all CoCs in the US, with a completion rate of 50%.

Response rates varied only slightly by CoC geography. Major city CoCs were the most likely to respond (46%) and other largely urban CoCs were the least likely to respond (35%), while rural and suburban CoCs fell in between.

The results of the online survey were supplemented with a round of phone interviews with a sampling of the CoC contacts. The selections were designed to ensure diversity according to region of the country, general population size, and HUD-defined CoC type (major cities, other urban, suburban, and rural).

Findings

Data Tracking

Collecting data on consumers and staff who have tested positive, or are symptomatic, for COVID-19 informs crisis management decisions. This includes temporary housing placements, supplemental service delivery, and staff assignments. HUD currently does not require such data collection.

CoCs were asked how they were collecting data about COVID-19. More than half of CoCs reported that information is being stored in HMIS, however, 12% reported that

data related to homelessness and COVID-19 status is not being systematically collected and stored.

Of those who are capturing COVID-19 data in HMIS:

- 73% are collecting data on sheltered people screened as symptomatic,
- 67% are collecting data on sheltered people testing positive,
- 57% are collecting data on unsheltered people screened as symptomatic
- 54% reported data was being collected on unsheltered people who tested positive

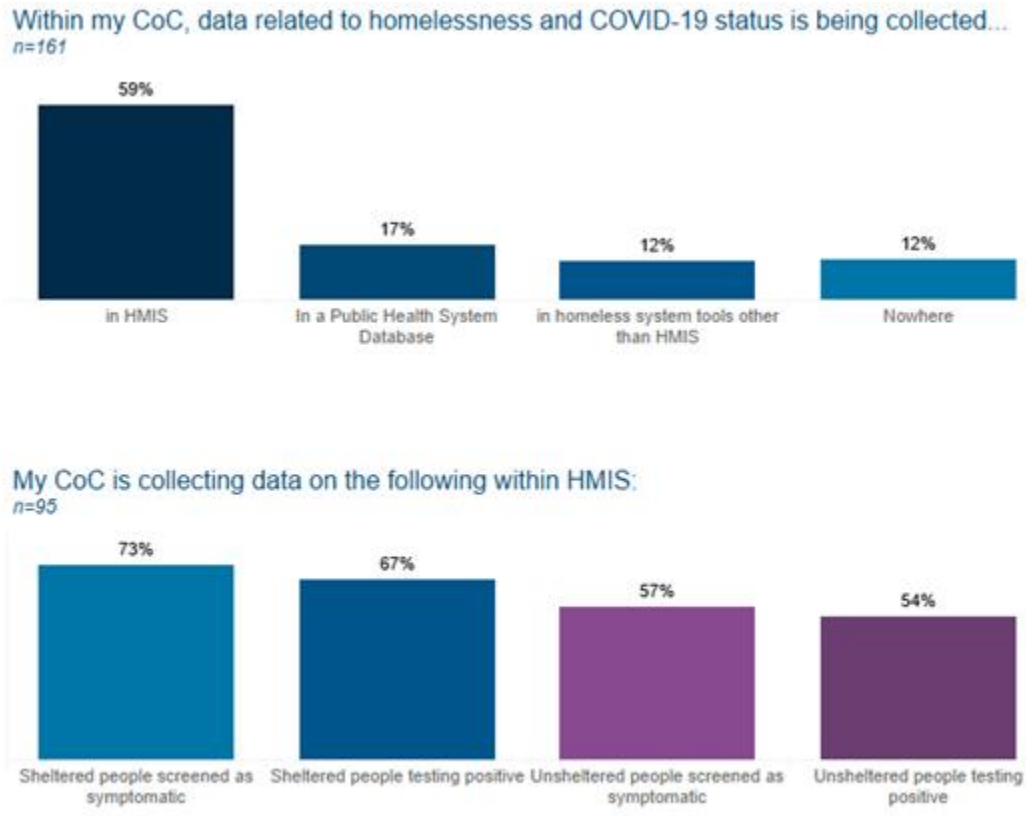

Figure 1

Interviews with a subset of CoCs suggest that some communities are postponing data collection for reasons that include a lack of data experts and training for frontline workers. The need to move people into healthier housing situations has been viewed as a bigger fire than data collection, distracting staff attention. Finally, some communities are delaying data collection activities because they have yet to have symptomatic or positively tested individuals. It is unclear if, in the interim, they are laying the groundwork for robust data collection.

COVID Case Counts

CoCs reported the number of homeless persons and staff who were symptomatic and untested and the number who tested positive, and whether those numbers were estimations or exact figures. As seen in Figure 2, at this early stage in the pandemic, most sites provided estimates, and symptomatic cases were reported at much larger numbers relative to confirmed cases from positive test results. Without knowing the total number of people screened or tested, these results provide little insight into infection rates among people experiencing homelessness but represent a starting point in this line of inquiry. Some participating sites have agreed to provide additional information through follow-up surveys, which we hope can shed more light on this question.

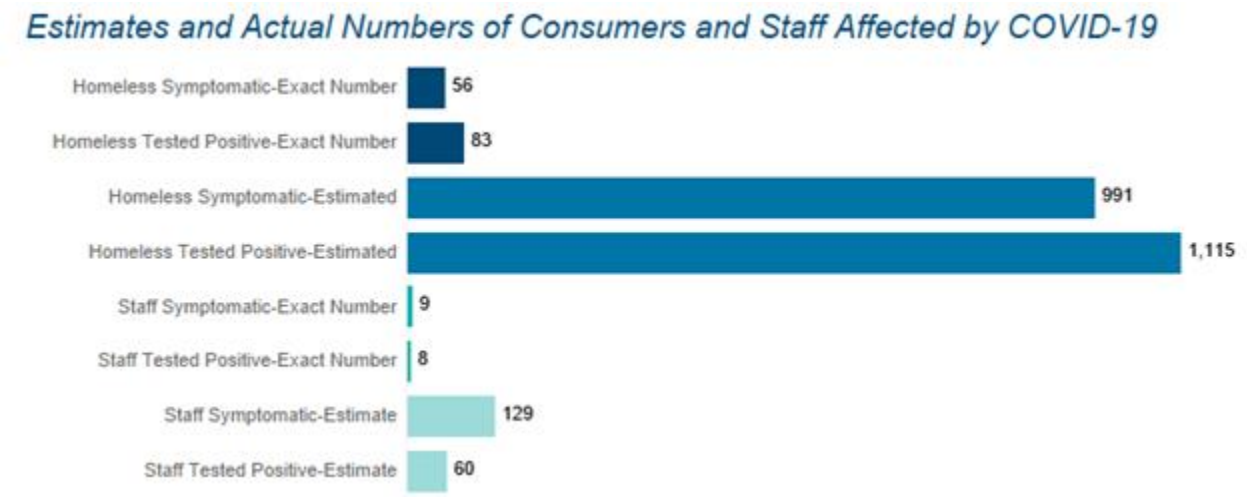

Figure 2

COVID Screening and Testing Capacity

CoCs also reported their weekly capacity to screen and test for COVID-19 among persons experiencing homelessness. 50% reported that they had no testing capacity. Symptom screening was slightly better, but the modal response category (25%) was still zero. 21% of responding CoCs reported that they could effectively screen between 100 and 250 persons.

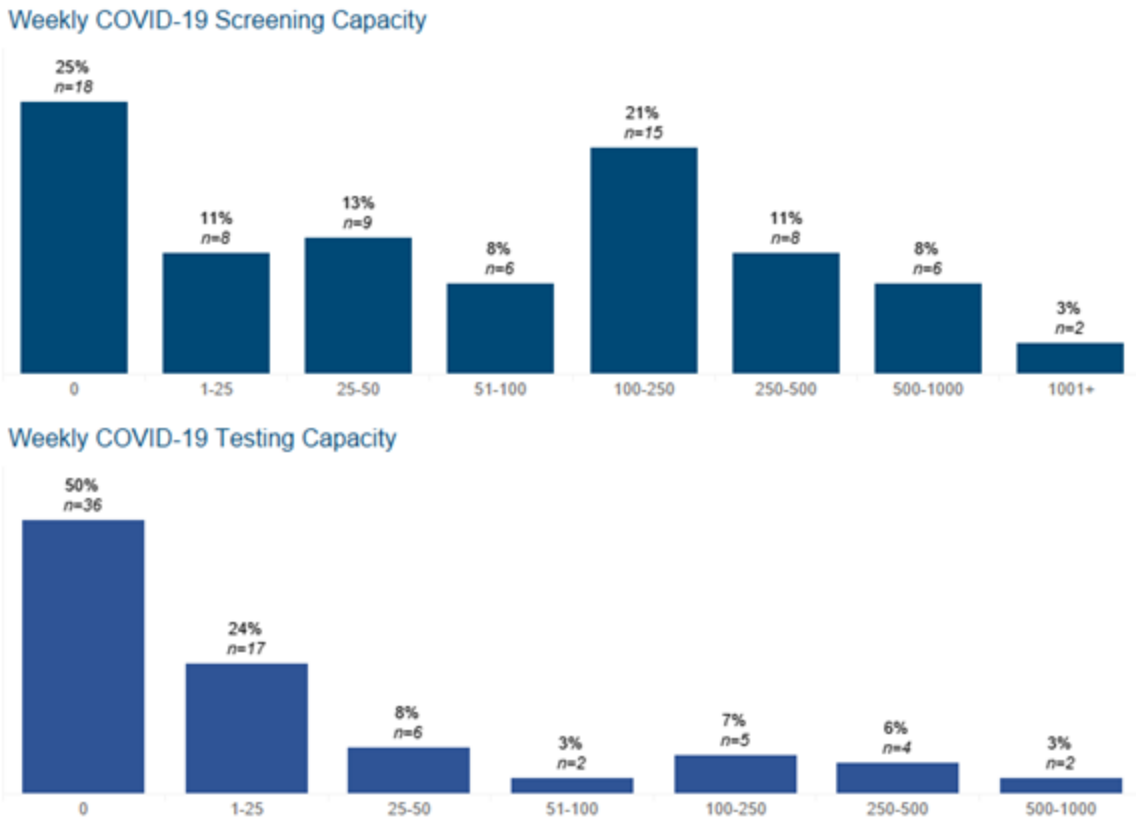

Figure 3

Screening and Testing Populations

CoCs were asked to provide details about screening and testing practices. As seen in Figure 4, 84% of CoCs reported that all sheltered persons were being screened. 59% of CoC reported that testing was being conducted for all or most people who were symptomatic, but only 14% reported sufficient capacity to test all persons in a shelter where someone tested positive.

86% of CoC reported testing outside of the shelter system in most CoCs. Only 28% of CoCs said that testing was occurring in locations where persons experiencing homelessness live and congregate. Moreover, only 28% of CoCs reported that they had a contact alert system to notify people of their potential exposure, test results or service announcements.

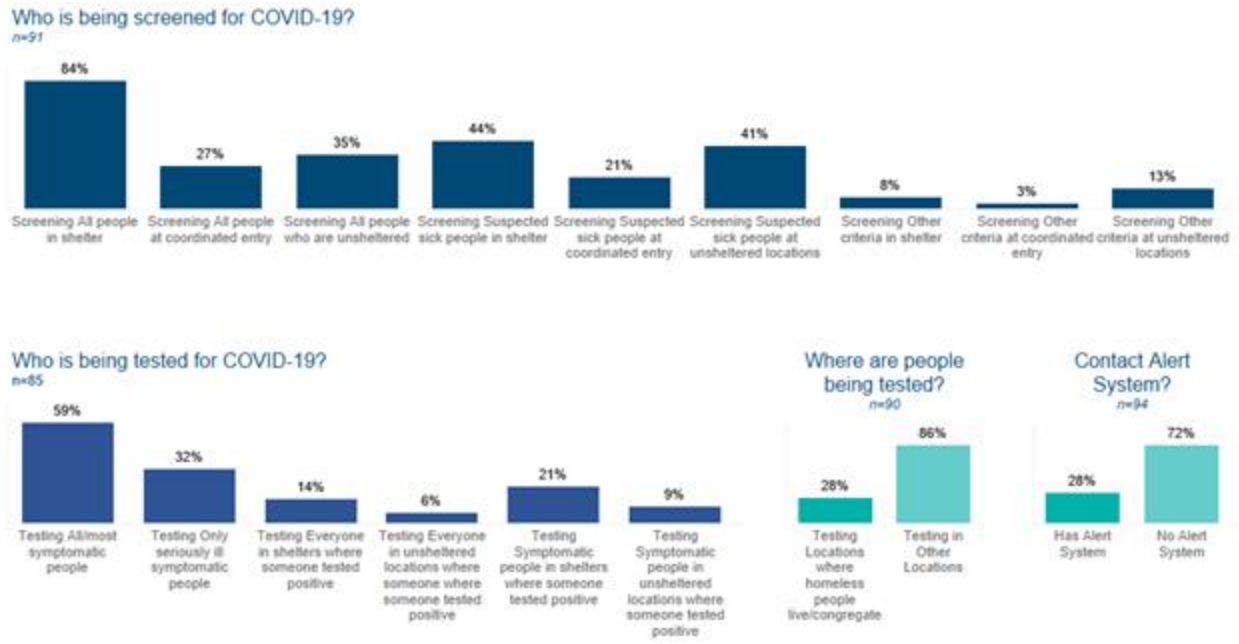

Figure 4

Temporary Housing Placements

CoCs reported on how COVID-19 impacted shelter services in their community. 83% of CoCs reported procuring hotel or motel rooms, and 92% reported implementing social distancing of 6 feet between beds (Figure 5). Conversely, 19% reported closing emergency shelters.

CoCs were also asked how they were handling unsheltered persons in their community. Procuring new hotel/motel rooms for unsheltered persons was endorsed by 74% of CoCs. Two noteworthy findings were that 22% of CoC reported bringing more people into existing shelters and 13% of CoCs reported sanctioning encampments.

In discussing hotel and motel rooms, CoC representatives commonly indicated prioritizing medically vulnerable (senior citizens and people with pre-existing medical conditions), symptomatic, and diagnosed people for those spaces. They have been experiencing some challenges with this approach. One of them is Nimbyism (residents resistant to having homeless individuals in their neighborhood). Some clients have had behavioral issues and/or have not wanted to stay at these locations and left. Extending support services to motels and hotels is not always easy with one community creating a Medical Volunteer Corps to help address the needs.

Interviewees noted the continued use of congregate shelter. Some were not using motels and hotels at all. Others could not secure enough rooms for everyone in need. Applying social distancing rules within shelters can be difficult. One community pointed out an issue within its shelters that could very well apply in other settings -- staff have not been adequately prepared to make what are essentially medical determinations about who can be released from quarantine and whose condition has advanced to a stage in which hospitalization is necessary.

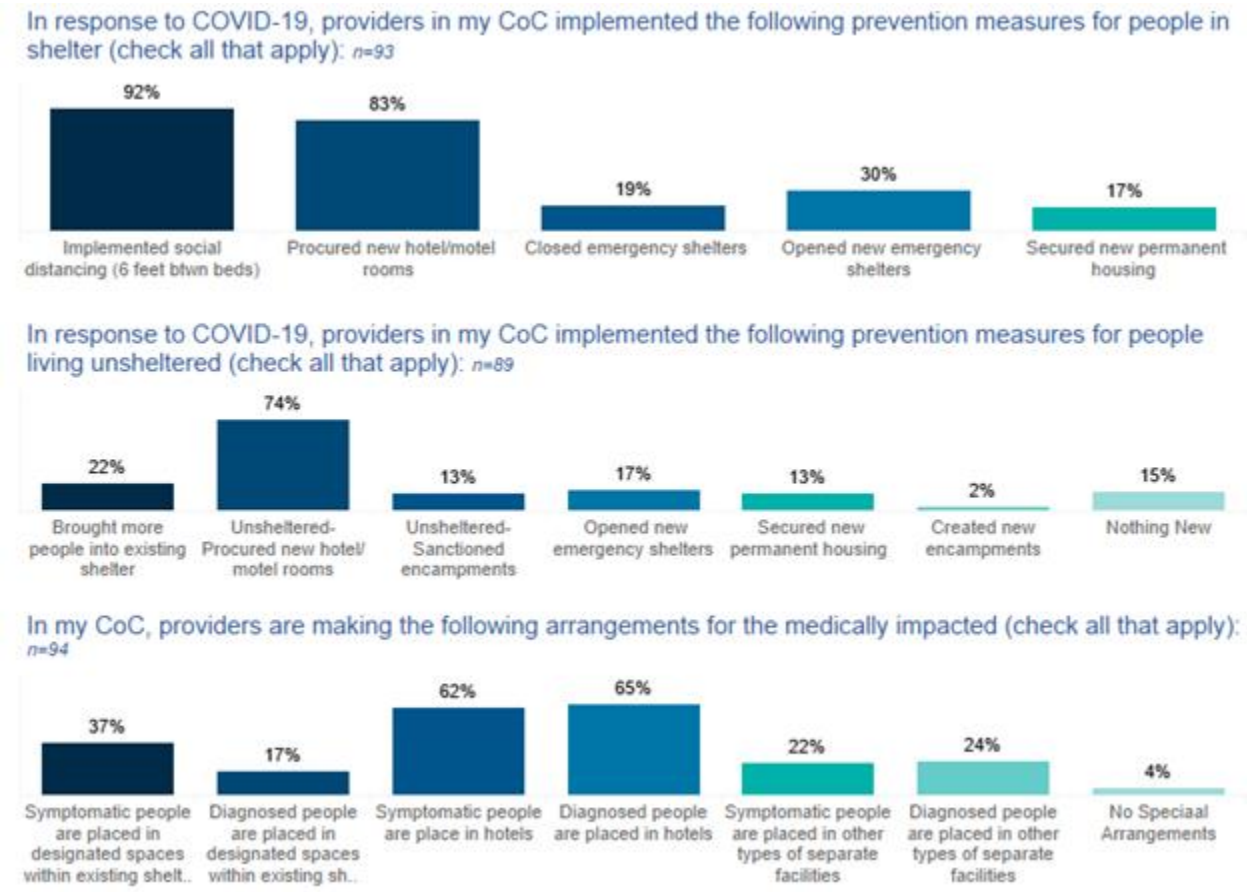

Figure 5

Beds Added

Figure 6 shows the total number of new beds made available by each CoC, differentiating between population and housing type. While the number of new shelter beds was high, totaling more than 2000 beds, the number of hotel or motel beds was much greater at 7000. This augments the prior result that reported hotel/motel beds being the modal response for how CoCs reported addressing COVID-19 with respect to

both sheltered and unsheltered persons.

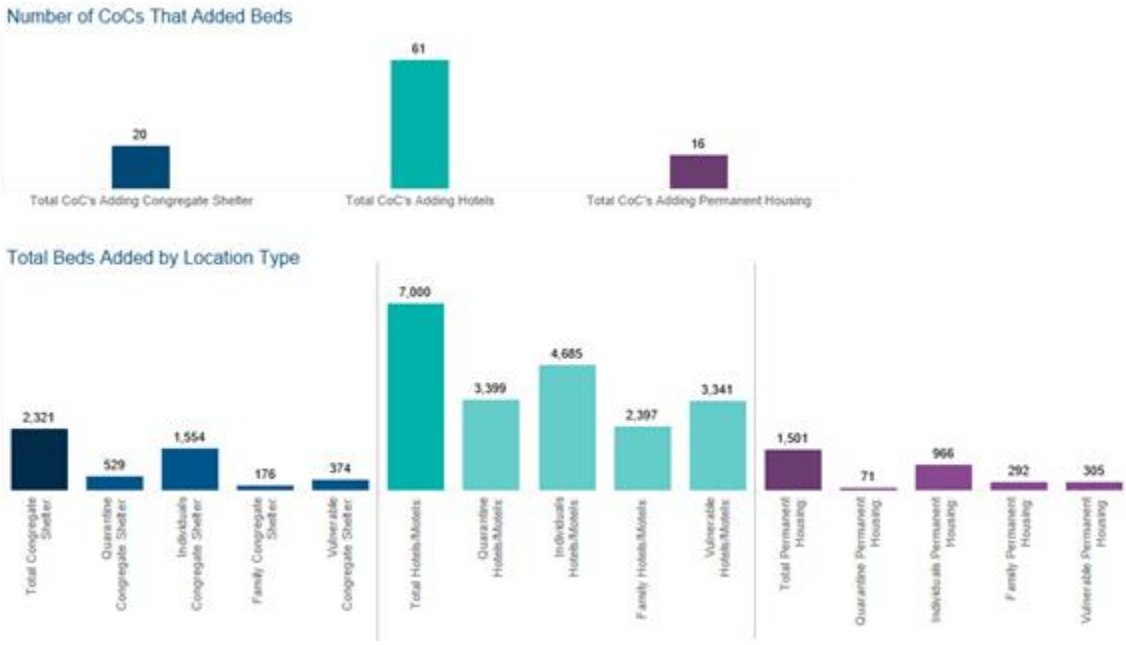

Figure 6

Supply Shortages

CoCs reported alarmingly high rates of PPE shortages. In particular, 49% reported shortages of masks for diagnosed/symptomatic consumers and 59% reported shortages of masks for staff.

CoCs were asked to provide additional information as to the reasons for supply shortages. Mirroring supply shortages discussed across the country, 88% of CoCs reported that a lack of supplies available for purchase/requisition was an issue. In addition, it is noteworthy that 31% of CoCs cited supply shortages due to delays in the procurement process.

Interviews revealed ways in which shortages are being managed. Some CoCs are receiving donations of PPE such as cloth masks and hand sanitizer from their communities. At least one reported limiting the delivery of services to people experiencing homelessness due to a lack of PPE.

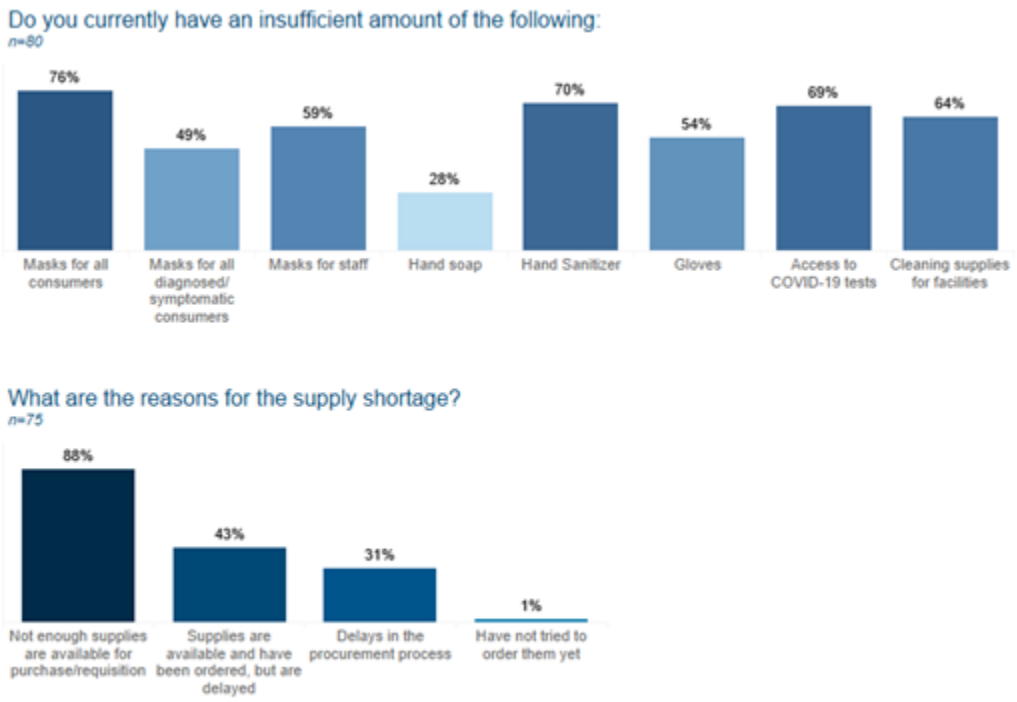

Figure 7

Staffing Issues

Of the 82 CoCs that provided staffing level information, 60% reported staff shortages. The challenges are significantly occurring among low-wage employees who are essential to keeping shelters and unsheltered services operating. Of CoCs, 88% reported COVID-19-related shortages in frontline shelter workers and 58% reported COVID-19-related shortages in street outreach workers. Additionally, 63% of CoCs reported volunteer shortages and 46% reported shortages in social workers.

The 49 CoCs reporting shortages were asked about the causes of staff shortages. 83% cited paid staff absent due to quarantine or social isolation and 77% reported similar issues with volunteers. Through interviews, some communities reported approaches to addressing these challenges--newly relying on remote communications tools to provide healthcare (telehealth), intake and assessment, and case management. Nevertheless, staffing shortages have contributed to cutbacks in services and reductions in shelter capacity.

It is noteworthy that individuals working in the homeless services system may share commonalities with other low-wage essential workers. As noted above, CoCs report a lack of PPE. Perhaps relatedly, 38% of CoCs reported staff resignations due to fears of

getting COVID-19 at work and 36% report staffing shortages due to employees being out sick.

CoCs were also asked to report on other COVID-19 related workforce issues. There was nearly universal endorsement of increased stress (96%), fears of contracting COVID-19 at work (91%), and exhaustion from longer hours and increased responsibilities (87%).

Figure 8

<u>New Resources</u>

On March 27, the CARES Act was signed into law. A large-scale Congressional response to COVID-19, it included $4 billion for homeless assistance through the Emergency Solutions Grant (ESG) program. During the survey period, the funds had yet to be distributed. Thus, existing activities (motel/hotel beds, PPE, staffing) have benefited from limited federal resources that include ordinarily awarded HUD grants and FEMA funds. Some jurisdictions have expended resources based on the promise of forthcoming CARES Act dollars.

Respondents were asked to report if they received new resources to address COVID-19 and from where these resources were procured. The modal response was state and local funds (66%), HUD homeless assistance was second (54%), followed closely by private

foundations at 51%. Receipt of FEMA assistance was reported by only 26% of CoCs.

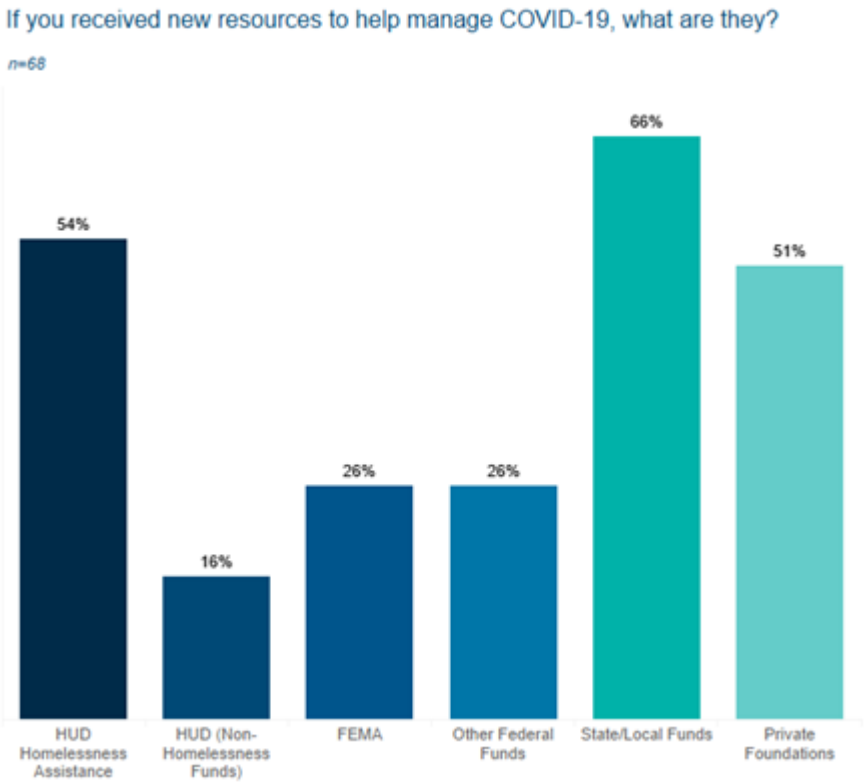

Figure 9

Resource Prioritization Ranking

The CoCs were asked to rank how their community is prioritizing the use of new resources. 51% ranked hotel/motel rooms as the number 1 priority and 76% ranked this either 1 or 2. It is noteworthy that permanent housing was the second priority with 32% of communities ranking it 1 or 2. PPE emerged as the third priority in the response to COVID-19. 35% reported this as priority 3, but it is important to acknowledge that 9% saw PPE as priority 1 and 14% saw it as priority 2.

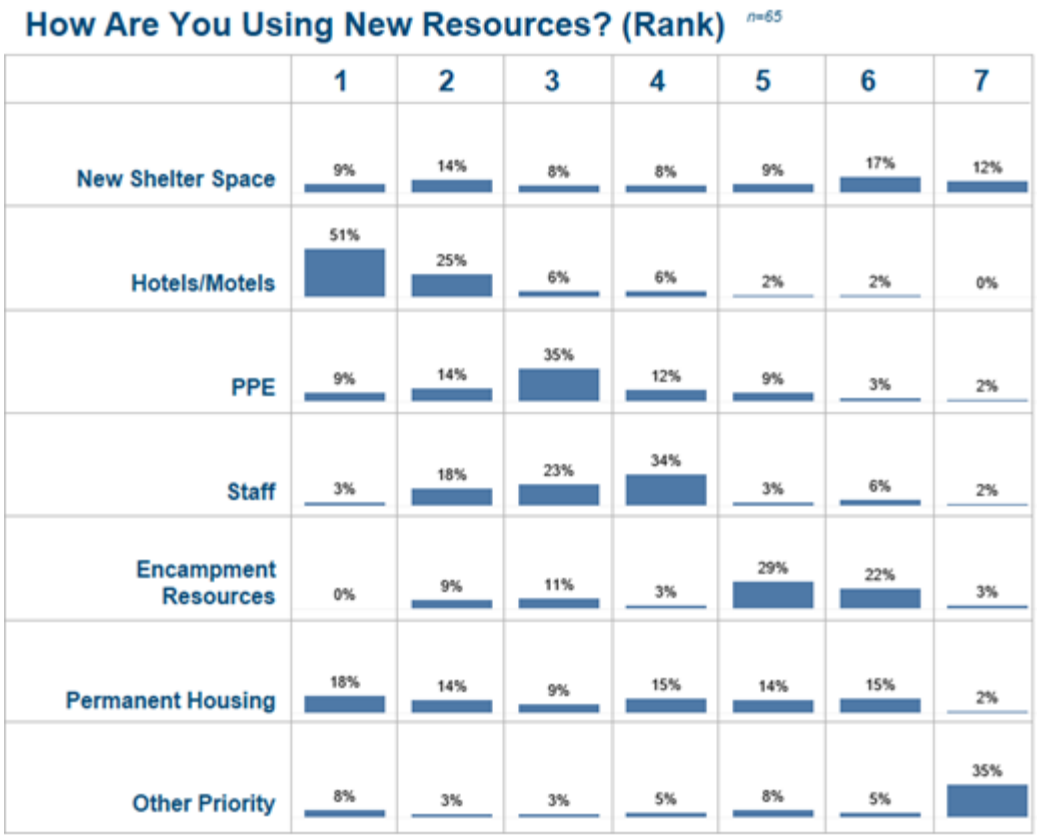

Figure 10

Future Funding Prioritization

We asked communities to rank how they would use any future funding that becomes available. In contrast to how new funds have been spent to date, CoCs were very clear that permanent housing was the priority for any future funding, with 56% reporting this as their first priority and 74% reporting this as either priority 1 or 2. Through our interviews, communities expressed concerns about finding housing placements for vulnerable clients (elderly and/or with pre-existing medical conditions) once funds for hotels and motels expire.

Hotel and motel acquisition, which was ranked first in the prior question surfaces as the second most common future priority on the online survey with 39% of CoCs ranking this as either priority 1 (16%) or priority 2 (23%). Staffing needs was the third priority, with 52% cumulatively ranking PPE as 1st, 2nd or 3rd, slightly ahead of PPE (49%).

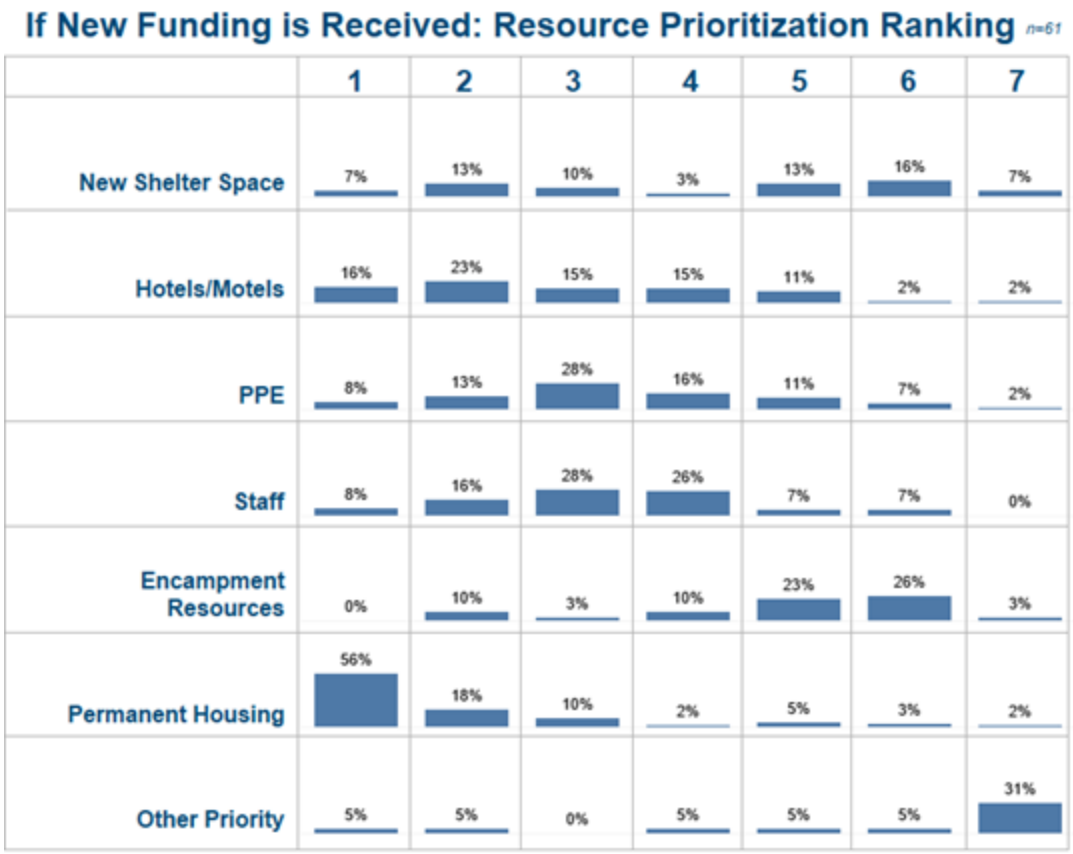

Figure 11

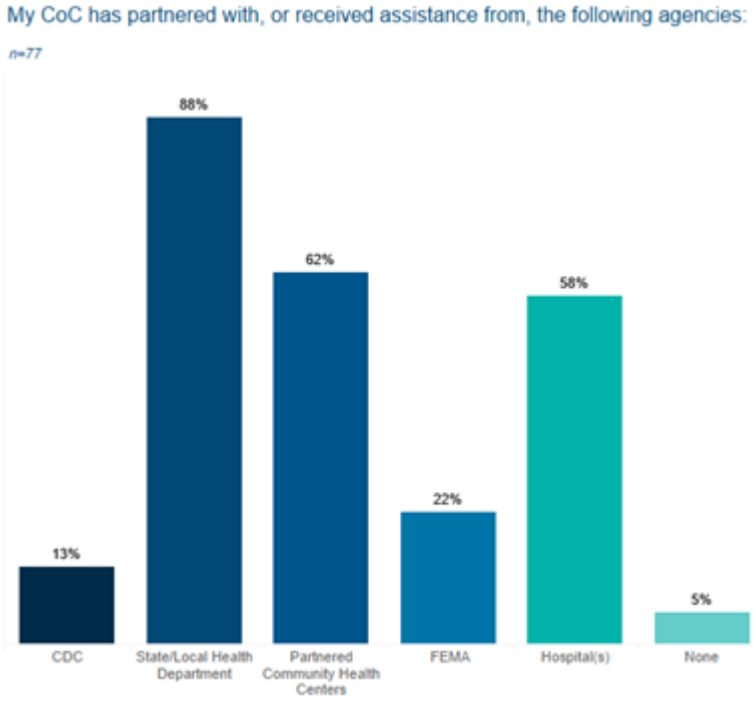

Figure 12

Partnerships

The final item in the survey asked CoCs about partnerships they formed in their initial response to COVID-19. Nearly every CoC (88%) reported a partnership with state or local health departments. Connections to federal agencies were more rare--only 13% reported a partnership with the CDC and 22% with FEMA. Hospitals and community health centers were also endorsed at high rates.

Discussion

This survey provides the first systematic insight into the ways in which local communities are addressing COVID-19 for people experiencing homelessness. We see a relatively clear picture emerging from the answers provided by the 168 CoCs participating in this study. Communities are prioritizing health and housing to the extent possible, but with serious material constraints that hamper their ability to act.

Communities are extremely limited in their ability to test, with most saying they have no capacity for testing and therefore rely on screening of symptoms. While 86% of communities said that they are screening everyone in their shelters, studies from Boston and San Francisco showing the prevalence of asymptomatic infection suggest that this approach is inadequate. Moreover, many communities expressed insufficient capacity to test people even if there is a positive confirmed case. Nearly all CoCs also expressed severe constraints in their housing options, personal protective equipment (PPE), and staff capacities, limiting their ability to conduct fundamental elements of their work that keep clients safe and moving toward permanent housing in the community.

Communities are continuing to perform and even add capacity despite these new challenges. More than 1,500 permanent housing units have been added and more than 7,000 hotel and motel rooms have become available. The number of hotel and motel rooms is about 3.5 times larger than the number of congregate shelter beds created over the same period. That permanent housing, the ideal outcome for all people experiencing homelessness in all circumstances and especially at this moment, continues to be a priority is a testament to the dedication of homeless service providers across the country. Beyond permanent housing, private spaces available through hotel and motel rooms are preferable to congregate settings. While most are attempting social distancing measures, communities should continue to push for more as they continue to reduce crowding in existing shelters.

As governments and foundations look to help homeless service providers, they should take into account the ways in which communities have used new resources to date and how they would use additional resources in the future. Safe, non-congregate housing capacity was the clear priority for current and anticipated spending. Second was internal capacity - resources to retain and hire staff and PPE to ensure the safety of staff and residents alike.

Limitations

There are some notable limitations to the analysis and generalizability of this survey. Fewer than half of all CoCs responded to the survey at all, and only half of those completed the survey. Survey and item nonresponse is unlikely to be random, with factors such as staff time, ability to gather requested data items, and political considerations likely influencing completion rates. Therefore, we cannot generalize findings from this survey to other communities. In addition, all data are self-reported. Beyond removing obvious data entry errors, we were unable to validate the responses. Thus, in a few instances, the answers to different questions may appear inconsistent. Despite these limitations, these data provide a unique picture of the first weeks of the COVID-19 pandemic response in communities in the United States, with respect to issues facing persons experiencing homelessness. The findings here show a clear commitment by communities to the health and safety of persons experiencing homelessness as well as nearly universal challenges with respect to finding adequate resources to meet all the needs posed by the pandemic.

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Appendix 1: Survey Document

CoCs and COVID-19: Online Survey Questions

CoC Number:____
CoC Name: _____
Survey Completion Date:
Name of Person Completing Survey:
Email Address:

Intro

The National Alliance to End Homelessness is conducting surveys of homeless service providers across the country to understand the impacts of COVID-19 and your responses to it. We thank you for taking a couple of moments to complete this survey during this challenging time. Your responses will ensure our ability to inform policymakers (and others who can help) of your needs and those of people experiencing homelessness.

DATA TRACKING

1. Within my CoC, data related to homelessness and COVID-19 status is being collected . . .

☐ in HMIS ☐ in a public health system database
☐ in homeless system tools other than HMIS ☐ Nowhere

2. My CoC is collecting data on the following within HMIS (check all that apply):

☐ Sheltered people screened as symptomatic☐ Sheltered people testing positive
☐ Unsheltered people screened as symptomatic ☐ Unsheltered people testing positive

COVID-19 CASE COUNTS

(If your CoC is collecting data on COVID-19 cases, please answer the questions in this section. If your CoC is not collecting such data, please skip this section and move on to the next one.)

3. Among people experiencing homelessness in your CoC . . .
   ____ (total number) have ever been symptomatic but never tested (¨ Exact Number ¨ Estimate)
   ____ (total number) have ever tested positive for COVID-19 (¨ Exact Number ¨ Estimate)

4. Among staff of your CoC . . .
   ____ (number) have ever been symptomatic but never tested (¨ Exact Number ¨ Estimate)
   ____ (number) have ever tested positive for COVID-19 (¨ Exact Number ¨ Estimate)

5. At the height of our CoC's capacity, we were able to ensure an estimated
   ____ people were screened for COVID-19 each week

____ people were tested for COVID-19 each week

6. If you are willing to provide greater information about your data (including demographic information), please share the name of an individual with whom we can follow-up: _____

SCREENING and TESTING

7. Screenings for COVID-19 include activities such as taking temperatures or asking about people whether they have experienced certain symptoms. Who is your CoC screening for COVID-19? (Check all that apply).

☐ All people in shelter☐ Suspected sick people in shelter
☐ All people at coordinated entry☐ Suspected sick people at coordinated entry
☐ All people who are unsheltered ☐ Suspected sick people at unsheltered locations

☐ Other criteria in shelter _____
☐ Other criteria at coordinated entry _____
☐ Other criteria at unsheltered locations _____

8. Who is being tested for COVID-19? (Check all that apply).

☐ All/most symptomatic people
☐ Only seriously ill symptomatic people
☐ Everyone in shelters where someone tested positive
☐ Everyone in unsheltered locations where someone tested positive
☐ Symptomatic people in shelters where someone tested positive
☐ Symptomatic people in unsheltered locations where someone tested positive

9. Where is COVID-19 testing occurring? (Check all that apply).

☐ Locations where homeless people live/congregate ☐ Other

10. Do you have a system (e.g., cell phone alerts) for contacting homeless people about health alerts, test results, housing placements offers, or other COVID-19 related issues?

☐ Yes☐ No

HOUSING PLACEMENTS

11. **In response to COVID-19**, providers in my CoC implemented the following prevention measures for people in shelter (check all that apply):

☐ Implemented social distancing (6 feet btwn beds in all directions)
☐ Opened new emergency shelters
☐ Procured new hotel/motel rooms
☐ Secured new permanent housing
☐ Closed emergency shelters
☐ Other _____
☐ Nothing new

12. **In response to COVID-19**, providers in my CoC implemented the following prevention measures for people living unsheltered (check all that apply):

☐ Brought more people into existing shelter☐ Opened new emergency shelters
☐ Procured new hotel/motel rooms☐ Secured new permanent housing
☐ Sanctioned encampments☐ Created new encampments
☐ Nothing new☐ Other _____

13. In my CoC, providers are making the following arrangements for the medically impacted (check all that apply):

☐ Symptomatic people are placed in designated spaces within existing shelters
☐ Diagnosed people are placed in designated spaces within existing shelters
☐ Symptomatic people are place in motel/hotel rooms
☐ Diagnosed people are placed in motel/hotel rooms
☐ Symptomatic people are placed in other types of separate facilities
☐ Diagnosed people are placed in other types of separate facilities
☐ No special arrangements are made

BED CAPACITY CHANGES

14. If your system has added beds in the wake of COVID-19, please track them below.

	Congregate Shelter	Hotel/Motels	Permanent Housing
Total Beds Added			
Quarantine/Isolation			
Individuals			
People in Families			
Youth			
Identified Vulnerable (Older Adults, Underlying Health Conditions)			

PPE

15. Do you currently have an ***insufficient*** amount of any of the following? (Check all that apply)

☐ Masks for all diagnosed/symptomatic consumers☐ Hand Sanitizer
☐ Masks for all consumers☐ Gloves

☐ Masks for staff☐ Access to COVID-19 tests
☐ Hand soap☐ Cleaning supplies for facilities

16. If you have insufficient supplies, what are the reasons? (Check all that apply)

☐ Not enough supplies are available for purchase/requisition
☐ Supplies are available and have been ordered, but are delayed
☐ Delays in the procurement process
☐ We haven't tried to order them yet

STAFFING

17. Are you experiencing COVID-19-related staffing shortages?

☐ Yes | ☐ No

18. If you are experiencing COVID-19-related staffing shortages, in what areas are they occurring? (Check all that apply)

☐ Frontline Shelter Staff☐ Social Workers☐ Physical Health Specialists
☐ Street Outreach Workers ☐ Behavioral Health Specialists☐ Food prep workers
☐ Facilities Maintenance ☐ Volunteers ☐ Other _____

19. If you are experiencing staffing shortages, what caused them? (Check all that apply)

☐ Volunteers absent due to quarantines, social isolation☐ Volunteers out sick
☐ Paid staff absent due to quarantines, social isolation☐ Paid staff out sick
☐ Increased staffing needs but delays/inability to make new hires☐ Other _____
☐ Paid staff resignations (due to fears of getting COVID-19 at work)
☐ Paid staff resignations (other reasons)

20. What other staffing related challenges, if any, are you experiencing? (Check all that apply)
☐ Increased stress☐ Exhaustion from longer hours, increased responsibilities
☐ Decreased Morale☐ Fears of contracting COVID-19 at work
☐ Insufficient training☐ Other _____

RESOURCES

21. If you have received new resources to help manage COVID-19, what are the sources? (Check all that apply)

☐ HUD Homelessness Assistance☐ Other Federal Funds
☐ HUD (Non-Homelessness Funds)☐ State/local Funds
☐ FEMA
☐ Private foundation
☐ N/A
☐ Other _____

22. How are using new resources? Rank the below according to your priorities, labeling your most significant priority as a "1" and leaving non-priority items blank.

__ New shelter space__ Staffing__ Other _____
__ Hotel/motel rooms__ Resources for Encampment
__ PPE__ Permanent housing

23. If additional funds become available, how will you use them? Rank the below according to your priorities, labeling your most significant priority as a "1" and leaving non-priority items blank.

__ New shelter space __ Staffing __ Other _____
__ Hotel/motel rooms __ Resources for Encampment
__ PPE __ Permanent housing

AGENCY ASSISTANCE/PARTNERSHIPS

24. My CoC has partnered with, or received assistance from, the following agencies to help manage health issues (check all that apply):

☐ CDC
☐ FEMA
☐ None
☐ State/local health department
☐ Hospital(s)
☐ Other _____
☐ Community Health Centers