



Issue Brief

Homelessness and Health Care: Lessons and Policy Considerations from the COVID-19 Pandemic

Introduction

The health, economic, and social impacts of COVID-19 have rippled across the globe. Nationally, there have been over 28 million infections since the pandemic erupted, and over 520,000 deaths.¹ COVID-19 has disproportionately impacted communities of color and continues to impact people living in poverty, older adults in nursing facilities, persons with disabilities, and people experiencing multiple chronic conditions. COVID-19 has presented an unprecedented challenge to federal, state, and local public health agencies, which have sought to contain virus spread through a mix of approaches, including social distancing, mask requirements, improved hygiene, and quarantine and isolation practices. For people experiencing homelessness, adhering to these protective measures has been even more challenging, putting them at greater risk for contracting COVID-19.

More than 150,000 people experience homelessness in California on any given day. People who are homeless have higher rates of illness and die on average 12 years sooner than the general US population.² People living in shelters are more than twice as likely to have a disability compared to the general population,³ and community survey data indicate that over one-quarter of people experiencing homelessness have severe mental illness and nearly 35% have a chronic substance use disorder.⁴ Chronic disease such as diabetes, heart disease, respiratory tract conditions, dental disease, and HIV/AIDS are found at high rates among the homeless population, placing people experiencing homelessness at higher risk of serious illness from COVID-19.⁵ Additionally, people experiencing homelessness who contract COVID-19 are two to four times more likely to require critical care and two to three times as likely to die compared to the general population.⁶

The saying goes that necessity is the mother of invention. This is illustrated by the COVID-19 pandemic and the innovative approaches developed by California's health care and homeless services providers and their partners. While much remains unknown at the one-year mark of the pandemic, California may consider how to strategically evaluate and advance some of the innovations that will continue to better serve this population beyond the pandemic.

While COVID-19 has strained communities and health care systems across the country, among the many challenges to emerge is how to best meet the health care needs of people experiencing homelessness during the crisis. In response to today's challenging environment, the California Health Care Foundation (CHCF) launched a portfolio to promote care for those experiencing homelessness that is responsive, person-centered, and focuses on their emotional, physical, and psychological needs. The Center for Health Care Strategies (CHCS), with support from CHCF, has produced a series of resources highlighting success stories, opportunities, and obstacles to improving care for people experiencing homelessness that have emerged during this public health crisis (see "About the Series.")

About the Series

This series focuses on the challenges of addressing the COVID-19- and non-pandemic-related health and health care needs of homeless individuals, and spotlights emerging care innovations, partnerships, and practices across the state. See the full series at www.chcf.org/collection/homelessness-covid-19.

This brief synthesizes innovative approaches and key lessons for supporting the health care needs of Californians experiencing homelessness during COVID-19. It presents the immediate public health challenges in responding to the pandemic and shares key programmatic efforts to support those experiencing homelessness. It also delves into considerations for California policymakers and stakeholders to leverage these lessons to prepare for the ongoing and continued impacts of the pandemic, and to inform future policy direction.

The Immediate Public Health Needs of People Experiencing Homelessness

ISSUE: Rapidly Respond to a Public Health Crisis

On March 19, 2020, California Governor Gavin Newsom issued shelter-in-place orders, directing all Californians to stay home except to go to an essential job or to shop for essential needs. For the nearly 150,000 people experiencing homelessness in California nightly, one-quarter of whom are experiencing chronic homelessness, complying with these orders has been nearly impossible. To make matters worse, the closure of public spaces, including parks and libraries, and limited access to hygiene and sanitation facilities, have made adherence to public health precautions all the more difficult.

Homelessness advocates declared the pandemic a “crisis on top of a crisis”: The vulnerability of living without shelter compounded by a high prevalence of comorbidities among people experiencing homelessness made the highly contagious and lethal virus a triple threat for people experiencing homelessness.⁷

Initial efforts for this population centered on the immediate public health imperative to contain the spread of COVID-19. County entities and community-based partners focused on procuring personal protective equipment (PPE), such as face masks, N95 respirators, eye protection, disposable medical gloves and gowns, and hand sanitizer for vulnerable residents and community service providers. Other priorities included establishing screening and testing procedures, providing isolation and quarantine options for people exposed to or testing positive for the coronavirus, and coordinating

and communicating the public health response for this population. In the early days of the crisis, addressing the existing medical and social needs of people experiencing homelessness took a backseat to the immediate public health efforts to flatten the infection curve.

Some communities had already invested in disaster preparedness planning for health and safety concerns related to fires, hepatitis A, and other disease outbreaks among people experiencing homelessness. This planning allowed communities to build upon existing relationships and to lean in quickly to the COVID-19 pandemic at the beginning of 2020. San Diego County learned much about preparing for and responding to a crisis from the 2017 hepatitis A outbreak. A lack of strong communication pathways across the city, county, and community organizations was remedied by the development of a shared memorandum of understanding to support mobilization and coordination in the case of future emergencies.⁸ When COVID-19 struck, partners were able to activate a plan to use the convention center as a centralized, temporary shelter for people experiencing homelessness, called Operation Shelter to Home, as quickly as April 1.⁹ In Alameda County, the Health Care for the Homeless team was able to implement testing, tracing, and mitigation strategies quickly due to advance preparations. In a 2018 national presentation, the team shared insights on advance preparedness, including assessing severity of a disaster, partnership needs during a crisis, and considerations from the perspective of a person experiencing homelessness during such emergencies.¹⁰

Street medicine teams, such as the Roots Community Clinic’s Street Team Outreach Medical Program (STOMP) in Oakland, California,¹¹ pivoted their mobile outreach efforts to focus on providing hygiene kits and COVID-19 testing in the encampments they served. STOMP established an outdoor testing and treatment site when visits to the mobile van had to be curtailed to comply with social distancing orders. More often than not, however, the STOMP team found that people experiencing homelessness were more concerned with the threats associated with living outside, social needs such as access to food, and for those with substance use disorders, finding money to buy alcohol and drugs than they were about the potential exposure to the coronavirus.

STOMP outreach workers built on long-standing relationships with encampment members to encourage testing as well as uptake of referrals to isolation and quarantine hotels and motels. Across the county, street medicine teams balanced the need to screen and test at-risk individuals with the provision of health care services to meet existing needs out in the field. Alameda and other counties participating in the Whole Person Care program — a pilot program designed to improve care for Medi-Cal members through the coordination of health, behavioral health, and social services — also played a big role in street medicine efforts by leveraging their partnerships and infrastructure to respond to the urgent needs of people experiencing homelessness.¹²

Street medicine is the delivery of health care and social services specifically to address the unique needs and circumstances of people experiencing homelessness and delivered directly to them in their own environment.

In addition, the influx of Federal Emergency Management Agency (FEMA) funding during the initial wave of the pandemic enabled counties to quickly establish temporary housing solutions for at-risk people. Under FEMA guidelines, state and local governments were able to recoup 75% of room costs (now 100% of room costs under the Biden administration), as well as costs for essential wrap-around services — including daily meals and custodial, laundry, and security services — as well as site support staff. FEMA funds, however, cannot be used to reimburse homeless services providers for case management, a critical component of both helping people navigate barriers to tenancy and making necessary connections to community-based resources. Some homelessness advocates noted this prohibition is a lost opportunity, given that the temporary housing provides stability and mechanisms to provide care to people experiencing homelessness, creating an opportune time for case management.

As the pandemic continues to unfold, state, county, and local agencies are braiding and blending funding resources to establish new, creative ways to support people experiencing homelessness. Los Angeles County Department of Health Services staff noted that

emergency COVID-19 funding has bolstered the county's street medicine team's capacity to conduct enhanced medical surveillance and outreach. In the early days of the pandemic, street medicine team staff noted an increase in overdose deaths, rather than COVID-19 infections, and are taking advantage of the street medicine team's capacity to provide education and harm reduction approaches to address addiction.

LESSONS

The public health response is paramount. Despite the myriad health and social needs of people experiencing homelessness, mitigating the public health risks of the virus became the most immediate need. Limiting community spread has been especially important for them due to their higher risk factors and poor access to health care. Efforts centered on expanding screening and testing capacity of people experiencing homelessness and of frontline workers, including establishing standardized screening and testing processes, and ensuring that staff had adequate PPE to maintain their health and well-being. In addition, ensuring safe places for treatment and for isolation and quarantine were paramount. Public health efforts also focused on establishing protocols for providing safe transportation for asymptomatic people to isolation hotels, and coordinating medical care and wraparound services for those who were COVID-19 positive.

Building on existing relationships is essential. The rapid spread and impact of COVID-19 required that health and homeless service providers leverage existing partnerships with state and county partners to coordinate efforts for a more seamless response. To limit the spread of the virus, state and county agencies have had to coordinate the collection of data on positive or presumptive positive cases and to arrange for safe sheltering options, including in programs such as Project Roomkey.¹³ Destination: Home,¹⁴ a private-public partnership in Santa Clara County that promotes strategies for homelessness reduction and outcomes-driven housing and service models, worked to secure facilities and rooms for isolation and quarantine, and also leveraged relationships with local entities, such as hospitals, to quickly secure PPE for frontline homeless service providers.

“COVID-19 laid bare all of the challenges we already have — just at a much more rapid pace.”

— Jennifer Loving, *Destination: Home*

POLICY CONSIDERATIONS

The pandemic has highlighted the critical role public health agencies serve during crises, including disease surveillance, implementing infection control measures, and coordinating a response across multiple partners and agencies. Investment in a robust public health infrastructure, however, has waned significantly in recent years. Public health agencies are underresourced, with significant declines in funding for state and local public health agencies in the past decade.¹⁵ Decreased resources have made responding to the public health crisis of COVID-19 that much more difficult, and has hampered the ability of some public health agencies to coordinate with community partners and health care providers serving people experiencing homelessness. Building the capacity of California’s public health agencies will enable them to share emerging evidence and data, align effective protocols and policies, and disseminate accurate information as it becomes available.¹⁶ In addition, California may want to consider opportunities to look at alternative payment models to incentivize Federally Qualified Health Centers (FQHCs) to do more street outreach, which would allow them to readily be on the front lines of future emergencies.

California’s Project Roomkey

ISSUE: Provide Critical Quarantine and Isolation Capacity for People Experiencing Homelessness

As one of the first states to see an outbreak of COVID-19 cases, California policymakers and public health professionals quickly recognized that people experiencing homelessness were extremely vulnerable to contracting the virus. Without adequate shelter or the capacity to self-isolate or have access to basic hygiene and sanitation, people experiencing homelessness were at heightened risk for COVID-19. In April 2020, Governor Newsom launched Project Roomkey to prevent the

community spread of the virus and to provide isolation and quarantine options for those without shelter. This initiative was designed to provide temporary housing while also generating revenue for hotels and motels across the state that were vacant as a result of the pandemic.¹⁷ The multi-agency, multi-community partnership started with an ambitious goal of securing 15,000 rooms in hotels and motels to allow for isolation and quarantining for people experiencing homelessness. The governor’s office also provided support to state and local governments to purchase 1,300 trailers to augment the hotel and motel room capacity. By the fall of 2020, the state had exceeded its goal — just as another surge was underway.¹⁸

The public health goals of the initiative are to:

- ▶ Offer self-isolation for people experiencing homelessness who are asymptomatic but high-risk, including those over 65 and those with underlying health conditions
- ▶ Provide quarantine capacity for people experiencing homelessness who have been exposed to COVID-19 and are awaiting test results
- ▶ Provide quarantine capacity for those experiencing homelessness who have tested positive for COVID-19 but do not require hospitalization

Project Roomkey, which is currently slated to phase out in September 2021, is partly funded through the federal CARES (Coronavirus Aid, Relief, and Economic Security) Act, which authorizes using FEMA funds to protect people experiencing homelessness from COVID-19. The California state legislature also initially earmarked \$150 million for emergency homelessness aid, which has been used to support local governments in identifying hotels and negotiating and executing contracts with hotel operators. State funds are also available to assist local providers with the documentation required for FEMA reimbursement, and additional state funds were allocated by the governor to keep rooms open during the late fall surge in infections.¹⁹

While the initial response to COVID-19 was rooted in public health and safety, it became clear that to manage the acuity of needs in the health care sector, there needed to be an active and engaged partner. Clinics,

health care providers, and managed care plans contributed to the provision of health care services at Project Roomkey sites, including physical health, behavioral health, and social needs.

Transition from Project Roomkey to a Long-Term Strategy

In September, the **Los Angeles Homeless Services Authority** (LAHSA) released a **COVID-19 recovery plan** to transition Project Roomkey residents into more sustainable housing solutions. The goal of the recovery plan is to rapidly move 15,000 high-risk, high-acuity people experiencing homelessness into permanent housing, including up to 4,000 people who were temporarily housed as part of Project Roomkey. Through June 2021, all 15,000 people will be moved into a “bridging unit,” where they will receive subsidized rent and wraparound services, depending on need. LAHSA officials note that the experience of rapidly housing significant numbers of people during the pandemic demonstrates that with adequate funding, finding housing solutions is feasible. The COVID-19 recovery plan includes different pathways for housing, depending on acuity, and an increase in funding for tenancy support services to keep people in their homes. LAHSA plans to transition 4,900 of the most vulnerable people experiencing homelessness out of emergency accommodation into newly leased “recovery housing” units. LA’s strategy is being supported by Coronavirus Relief Funds (\$80 million) and County Emergency Solutions Grants (\$15 million).

Project Homekey. Building on the success of Project Roomkey, in July 2020, Governor Newsom announced the availability of \$600 million to launch **Project Homekey**.²⁰ Project Homekey is the next phase in the state’s response to protecting Californians experiencing homelessness who are at high risk for serious illness and COVID-19.²¹ Administered by the California Department of Housing and Community Development (HCD), Project Homekey provides grant funding to local public entities, including cities, counties, housing authorities, or federally recognized tribal governments within the state to purchase and rehabilitate existing housing stock (i.e., hotels, motels, vacant apartment buildings) and convert them into

interim or permanent long-term housing. Of the \$600 million in Homekey grant funds, \$550 million is from the state’s direct allocation of the federal Coronavirus Aid Relief Funds (CRF), and \$50 million is from the state’s general fund. All CRF funds were required to be spent by December 30, 2020, per federal funding requirements, while the state has until June 2022 to use the remaining \$50 million in state funds. HCD developed an accelerated application and award process to support this short timeline to expend federal funds.

LESSONS

County oversight can maximize local resource use to address needs. With administration and oversight for Project Roomkey at the county level, approaches to implementing the program have varied throughout the state. Most jurisdictions have used some combination of Centers for Disease Control and Prevention (CDC) criteria to identify those at higher risk for contracting COVID-19 (i.e., health vulnerabilities and age), as well as prioritization methods for shelter and housing, such as the Vulnerability Index — Services Prioritization Decision Assistance Tool.²² At the outset of the pandemic, some counties were slow to update prioritization lists, hampering efforts to connect eligible people to Project Roomkey rooms. The county connection, however, was important in the establishment of Project Roomkey sites. While state guidance was needed to streamline key functions of the program, cities and counties were better positioned to identify potential hotels and motels for the initiative, negotiate leases, and make connections with homeless services providers to deliver needed wraparound services for hotel residents.

Accelerated pace is possible when all partners share a common vision. Despite initial challenges, including matching people to rooms, trouble engaging a traditionally hard-to-reach population, assuaging hoteliers’ concerns about liability and insurance, and protracted contractual negotiations, the enrollment in Project Roomkey was fast paced. County agencies, along with community partners, acknowledge that establishing Project Roomkey was a huge lift, requiring coordination across government entities, community service providers, and hotel business operators. But the success of the program demonstrates that with the right resources and goal of collaboration, systems can move quickly.

Incorporate racial equity considerations into housing interventions. With Project Roomkey and other housing interventions, there is an additional layer to consider beyond availability and funding for housing: inequities caused by structural racism. In Alameda County, Black people and Native Americans are homeless at a rate four times higher than the county's general population, and twice as likely to be homeless among people experiencing poverty.²³ Alameda County is taking steps to reengineer the homeless response system using the lens of racial equity, with the goal of producing a homeless system that works better to end homelessness for all. Addressing inequities should be an explicit component of state and local health care and housing interventions to end homelessness.

A low-barrier enrollment process will contribute to success. Jurisdictions that have been more successful housing residents in Project Roomkey sites partnered with local service providers to create very low-barrier enrollment processes. They also leveraged these organizations' outreach expertise to engage individuals to participate. Los Angeles Family Housing, for example, successfully moved an entire encampment on the promise that all the residents could stay together and bring their pets and belongings. The Project Roomkey model also enabled local service providers to serve this highly vulnerable population in a personalized way, including through alcohol management programs and other harm reduction approaches.

Be creative about securing funding. California was the first state to secure FEMA approval for 75% federal cost share to support the Project Roomkey model. Counties were able to enroll people into the program quickly by using local resources to pay service providers and hoteliers, with the understanding that federal reimbursement would be forthcoming. In the early days of the pandemic, when FEMA designated the public health emergency period to be six months, there was the guarantee of FEMA reimbursement for Project Roomkey activities. However, as the pandemic has progressed, the emergency period has decreased to authorizations of one month at a time, resulting in financial uncertainty for county and community-based providers.

POLICY CONSIDERATIONS

Since Project Roomkey's inception, and now with Project Homekey, government entities and community partners have viewed these hotel and motel arrangements as a key component of a rapid rehousing model. While Project Roomkey initially served the immediate public health need of housing California's most vulnerable residents, the initiative is transitioning to becoming part of a long-term housing solution for people experiencing homelessness. The urgency of the pandemic environment accelerated new strategies to quickly house vulnerable residents while addressing their health and social needs. Sustaining investment in these sites, and permanent housing for residents, will be crucial, as will continued partnership between health care and homelessness sectors around data exchange, evaluation, and analysis to support coordination. COVID-19 further emphasizes the issues of health and racial inequity that disproportionately affect people experiencing homelessness, framing the pandemic as a "crisis within a crisis." As California considers its health and racial equity agenda, it will be important to consider how it protects and houses people who are homeless, and prevents more people from becoming homeless as part of its plan.

As states across the country see the emergence of variant strains, measures to stem the spread of the virus will remain in place, further impacting joblessness, particularly among low-wage workers. Homelessness advocates point out that California is on the verge of what has been dubbed the "eviction cliff." When protections against eviction expire, as many as one million families across the state — roughly 365,000 in Los Angeles County alone — could be at risk of being forced out of their homes.²⁴ From a racial equity perspective, these statistics are even more stark: Latinx, Black, and Asian households are nearly three times as likely as White households to be behind on rent as of December 2020.²⁵ In January, Governor Newsom extended the eviction moratorium to the end of June 2021.²⁶ Continued efforts to safeguard against eviction and to provide rent support will be critical to avoiding new homelessness as the pandemic drags on.

Medical Respite for People Experiencing Homelessness

ISSUE: Expansion of Medical Respite Care Due to Isolation and Quarantine Needs

Medical respite programs are intended as a safe option for people experiencing homelessness to receive ongoing medical care and support services (e.g., care coordination, medication management, and connection to behavioral health care and substance use services) and provide an alternative to extended, and more expensive, hospital stays. Medical respite is time-limited, thus distinct from nursing homes, supportive housing programs, and other longer-term care facilities, and is offered in a variety of settings including freestanding facilities, homeless shelters, and transitional housing. Over the last few years, California's Whole Person Care pilot has catalyzed the growth and development of these programs.

Medical respite, also known as recuperative care, is acute and postacute medical care provided to people experiencing homelessness who are not sick enough to stay in the hospital, but are too sick to return to a shelter or the streets, given their health needs.

Illumination Foundation in Orange, California, provides housing and a range of services to adults and children to help disrupt the cycle of homelessness. Its recuperative care program has six sites with 250 recuperative care beds across Southern California. The program is funded primarily by the county's Whole Person Care pilot,²⁷ provides medical care coordination, case management, mental health counseling, food, hygiene, transportation, access to a community clinic, and housing connections. The program's impact is illustrated by 69% fewer hospitalizations, an 83% reduction in inpatient care costs, and a 46% reduction in emergency department visits, resulting in a 36% decrease in related costs.²⁸ This success is attributed to the model, which at its core is based on respect for patients and strong relationships and connections across the community.

During the COVID-19 pandemic, medical respite care sites in California²⁹ and across the country have played an important role in supporting the homeless population as well as alleviating the burden on hospitals preparing for or experiencing a surge in capacity. For people who experience homelessness, the COVID-19 pandemic elevated the need for more medical respite in light of isolation and quarantine requirements. Medical respite centers had to determine how to handle admissions from hospitals either by creating a separate ward for people who tested positive for COVID-19, or by not accepting those who tested positive and potentially opening more beds to accept additional patients from hospitals to offload them when capacity is strained.

In addition, medical respite programs were well-positioned to also support the larger community response to COVID-19. For example, Illumination Foundation was selected by the Orange County Health Care Agency to operationalize local Project Roomkey efforts. Building on its recuperative care program experience, Illumination Foundation established a plan to contract with six motels, two of which would temporarily house people who tested positive for COVID-19, and the remaining four for people experiencing homelessness with the highest vulnerability to the virus due to age or chronic conditions. This approach created opportunities to safely house people from shelters and the street, as well as provided space for patients to recuperate outside of the hospital to increase hospital capacity. Overall, Illumination Foundation has served 1,570 people, 205 of whom were COVID-positive, using 780 Project Roomkey motel rooms.

In the Illumination Foundation's approach, medical respite center staff provided necessary health screenings and transportation to the appropriate site based on results and completed on-site intake and referral processes. Medical respite center staff also joined the community response by providing training to volunteers in patient-centered, trauma-informed care at Project Roomkey and other COVID-19 alternative care sites to help support necessary services. Medical respite programs are based on strong relationships and communication pathways: with hospitals that refer patients to care, and with shelters and community resources used to support people when they leave medical respite. Illumination Foundation, when selected to lead the Project Roomkey efforts, was able to

build upon these relationships and with the public health authority to quickly develop, communicate, and implement plans to support people through Project Roomkey.

The Santa Clara Medical Respite Program, part of the Valley Homeless Healthcare Program in San Jose, California, also adapted during the pandemic to provide necessary services for isolation and quarantine. First, they doubled their bed capacity from 20 to 40, in anticipation of the surge in infections and to maintain capacity in hospitals. They also experienced challenges in monitoring patients' needs behind closed doors, given the infrastructure of the hotel rooms as well as social distancing requirements throughout their respite center facilities, necessitating new protocols around monitoring and overall safety. Adapting to COVID-19 also meant providing additional flexibility for people and enhancing existing community partnerships. For example, during COVID-19 someone in isolation or quarantine could bring partners and caregivers to the site with them, decreasing their apprehension to enter the temporary housing. Nutrition and food access were enhanced, and some medical respite sites were able to provide medically tailored meals for diabetics. Further, COVID-19 created an impetus to further lean into efforts to work with community partners to find housing for those transitioning out of alternative care sites. Medical respite centers' philosophy — to provide a safe and dignified space for people to recover — coupled with the unique position that centers have in their communities, serve as a useful model for isolation and quarantine during the pandemic.

LESSONS

Creative adaptability in the face of urgency is key. Medical respite centers were an ideal model for standing up short-term isolation and quarantine sites for people experiencing homelessness during the pandemic based on their structure, approach to care, and training. Furthermore, medical respite centers adapted their models to address new issues brought on by COVID-19. They set up new staff safety protocols and PPE inventory, adapted to new facility infrastructure, and developed new processes and protocols focused on COVID-19 testing and screening, and a 24-hour intake process. They also established or modified existing communication loops with public health, hospitals, shelters, and homeless outreach street teams.

Counties, cities, and health care and homeless service providers noted that the urgency of the pandemic created the will and opportunities to move people indoors. The Santa Clara Medical Respite Program moved approximately 2,000 people out of shelters and off the street in just a few months. This flexibility and ability to mobilize is valuable during the pandemic and beyond as localities continue to address long-term homelessness.

Expanding and building on existing models is often the best first step. COVID-19 highlights the need for a safe place for people experiencing homelessness to go when they are sick, injured, or recovering. It also emphasizes the positive impact medical respite can make by partnering with hospitals and the health care system to address capacity issues. With approximately 100 medical respite centers across the country, one quarter of them in California,³⁰ there is much opportunity for hospitals, managed care organizations, and other organizations at the nexus of homelessness and health care to expand this model of care. Additionally, further increasing community partnerships can have a long-term effect on people in medical respite by connecting them to resources they need.

“The COVID-19 pandemic recalls the old truism attributed to Winston Churchill, ‘Never let a good crisis go to waste.’ We may now have the opportunity to reform a flawed health care system that made COVID-19 far more damaging in the United States than it had to be.”

— Pooja Bhalla, Illumination Foundation

POLICY CONSIDERATIONS

During the pandemic, medical respite programs helped people experiencing homelessness safely quarantine and isolate by leveraging or expanding existing medical respite beds. Given their deep experience caring for this population, medical respite programs also provided implementation support and training to new local initiatives such as Project Roomkey. Medical respite programs also serve a critical role in helping to decrease hospital surges during the pandemic. While the health care system may not yet understand the value of medical respite programs, many of the Whole Person Care counties have seen the benefits of providing Medi-Cal members experiencing homelessness access to medical respite beds while they are sick or injured. As the Whole Person Care pilots begin to wrap up at the end of 2021, new options for supporting medical respite will be required to meet the health care needs of people experiencing homelessness. Fortunately, there is already a potential pathway for supporting these programs in Medi-Cal beyond the Whole Person Care pilots. The California Advancing and Innovating Medi-Cal (CalAIM) proposal includes medical respite as an optional, or in-lieu-of service, that managed care plans can choose to offer their members, thus providing an opportunity to expand access to medical respite programs in California.³¹

Health Care Innovations in Response to COVID-19

ISSUE: Rethinking Staffing Models and Advancing Harm Reduction and Telehealth

Staffing models. Staffing adaptations occurred across many institutions after the pandemic hit to address COVID-19-related medical needs, as well as to continue public health activities such as screening, infection control, and surveillance in both the sheltered and unsheltered populations. Los Angeles County Department of Health Services (LADHS), which operates hospitals and clinics across LA County, responded by developing a specialized team made up of newly hired staff to expand outreach efforts into homeless shelters. The COVID Response Teams (CRTs) are composed of nurses, emergency medical technicians, program managers, and administrative assistants who work together to offer education on infection control, monitor clients for symptoms, and provide

guidance to shelter staff on mitigation strategies. CRTs help shelters refer both COVID-positive residents and vulnerable residents with chronic conditions to alternative care sites. CRTs also conduct weekly surveillance testing and screening of asymptomatic clients and staff in shelters to assess if COVID-19 is in the facility. If so, the public health department is alerted to handle outbreak management, but the CRT role is critical in identifying the problem.

LADHS was able to create the CRTs quickly due to the availability of federal disaster funding. Since this funding is short-term, the CRTs are also working to build up shelter staff capacity to conduct these activities in the future. LADHS has eight CRTs working in shelters and nine working with the unsheltered population in partnership with street medicine programs. Though more challenging without the shelter infrastructure, these encampment CRTs focus on the same activities of education, infection control, and surveillance testing and response. LADHS's existing staff — including multidisciplinary teams that already worked with people experiencing homelessness before COVID-19 hit — are also being trained by the CRTs so they can incorporate these activities into their work when disaster funding is no longer available.

Harm reduction. New harm reduction innovations for addressing behavioral health needs are also being piloted during the pandemic, particularly as people experiencing homelessness move into quarantine and isolation rooms, where they are at higher risk for overdose because of social isolation, stockpiling of drugs, and other issues. Along with Narcan kit and fentanyl testing strip distribution, hotel staff are being trained to urge their clients to never use alone; there is even a tollfree phone number³² available to people who prefer or need to phone a friend. And while opioid and stimulant use is prevalent, alcohol is the most commonly used substance. San Francisco and Alameda Counties are piloting alcohol management programs in Project Roomkey hotels to avoid complications related to abrupt alcohol withdrawal resulting from limited access during isolation and quarantine.³³ In these pilots, clients in the hotels are provided a medically supervised supply of alcohol along with supportive services. Specifically, the pilot includes an intake assessment at the hotel, a recommended daily dosage of alcohol to be delivered and monitored, and interim

case management to support referrals to services and treatment upon request or discharge from the Project Roomkey site. The University of California San Francisco Center for Vulnerable Populations is conducting an evaluation of the pilots to assess outcomes such as emergency department and jail cost avoidance. Project leaders hope that positive outcomes will result in wider-scale implementation of the model.

Harm reduction is a set of principles focused on reducing negative consequences related to substance use. Harm reduction is also a social justice movement, built upon the respect for the rights of people who use substances such as drugs and alcohol.

Telehealth. The use of telehealth visits is another innovation that has been catalyzed by the pandemic. While for the general population, telehealth has grown exponentially in uptake and acceptance by providers and patients alike, clinics have struggled with this strategy for people experiencing homelessness during the pandemic. Not surprisingly, the homeless population has limited access to devices, charging stations, and Wi-Fi. Given these limitations, the hybrid visit, during which a patient can participate in a physical or behavioral telehealth visit from inside a clinic, has quickly evolved as a workaround for some health centers. There, the patients have access to a clean, safe, private space, use of technology such as an iPad or phone provided by the clinic, and most importantly, a continued connection to their health provider.

LA Christian Health Center — an FQHC with multiple locations and street outreach teams, including one on LA's Skid Row, a 54-block area of Downtown LA associated with poverty and homelessness — has incorporated the hybrid telehealth visit into its practice. After identifying an interest in trying out this approach, it quickly set up workflows and infrastructure changes, such as installing landlines to the exam rooms that would be used for hybrid telehealth visits to minimize contact, exposures, and risks of in-person, face-to-face visits. For about 40% of LA Christian Health Center's clients, visits are now hybrid. The FQHC would like to continue to offer this option even beyond the pandemic to support the

behavioral health needs of people experiencing homelessness, as funding allows, given that it provides another pathway to care for those who prefer an alternative to in-person visits.

“What has been really interesting for us is there are a lot of things that we have wanted to do for years that just somehow get delayed or pushed back. And the COVID-19 response is making us do things really, really fast that have always made sense, but we just didn't take the time to make it happen. And so even though it's been really hard, we have had to do a lot of things very quickly that we have wanted to do for a long time. And we were able to do it because of the urgency of the situation, broad support, and the influx of disaster funding.”

— Leepi Shimkhada, LADHS

LESSONS

Leverage temporary disaster relief funding and momentum with a focus on sustainability. Disaster relief funding is a critical tool that helps states meet their immediate needs in a major crisis, such as the COVID-19 pandemic. These resources are limited and should be used as strategically as possible, even during times of emergency, to achieve a longer-term impact. Providing training to staff, modifications to facilities, and adjustments to processes and workflows can have potential impact beyond the immediate crisis. Staff training in safety practices in clinics and trauma-informed care at isolation and quarantine units will have lasting effects on staff as well as patients. Further, the urgency and motivation born out of a crisis, coupled with the influx of short-term resources, can ignite innovation and momentum to continue those efforts after the emergency abates. This momentum can potentially create a new approach to care such as the alcohol management program piloted in Project Roomkey, produce additional options for patients such as the hybrid telehealth visit, or amplify the impact that can be made with more funding

and more staffing. While it may be difficult to be strategic in the face of an emergency, considering how to leverage the resources and ideas may prove fruitful in effecting longer-term, more systemic change.

Meet people where they are to address COVID-19 and general health education. Addressing health care needs is one of many competing priorities and typically not the most pressing one to deal with for people experiencing homelessness. Especially during the pandemic, homeless service providers, health care providers, and outreach workers need to employ a relationship-based, responsive, and multifaceted approach to engage with clients. One way to do this is to employ innovative approaches to address a patient's most urgent issues — from getting shelter, food, alcohol or drugs, behavioral health services, or immediate care such as wound treatment — while also educating on COVID-19 as part of continuous outreach. And the reverse is true as well: Addressing a request for a COVID-19 test is also an opportunity to engage on other unmet health and housing needs. Focused approaches to meet people where they are to provide what they need, when they need it can be demonstrated in street medicine programs that regularly work to build trust in the community. This outreach is arguably even more important with the additional need to address COVID-19 education. For example, by offering a snack or toiletries packet as part of trust and relationship-building, a patient may be more receptive to hearing a provider talk about good hand hygiene or accepting a mask. Further, securing temporary housing for isolation and quarantine may jump-start a patient's engagement in new or additional behavioral health care services. By meeting people experiencing homelessness where they are — in the figurative sense of their health care needs and in the literal sense of the environment (street, shelter, clinic, food pantry, etc.) in which they can be engaged — there is increased opportunity to provide the necessary public health response and education for bending the infection curve for people experiencing homelessness.

POLICY CONSIDERATIONS

During the pandemic, rapidly emerging health care delivery innovations may be time-limited — such as a COVID Response Team established to respond to immediate needs. Others born out of the COVID-19 response, like managed alcohol programs for people experiencing homelessness in isolation and quarantine sites, will likely have ongoing application postpandemic. For these innovations with more long-term potential, there is an opportunity to evaluate their impact, and determine if and how they can be refined to improve health care delivery going forward for people experiencing homelessness. Lessons can be drawn around financing for staff and services, and identifying and better meeting patients' needs. At the national, state, and county/local level, the response to COVID-19 will continue to shape the future of health care for the homeless population well beyond the pandemic. CalAIM is one vehicle in California that can be leveraged to support this progress.

What's Next for California?

Even as the COVID-19 infection rate begins to fall and vaccine distribution increases, several unknowns exist. In addition to the question of how long the pandemic will persist, California — like many states — is grappling with the realities of an economic and budget crisis. In January 2021, Governor Newsom introduced his budget proposal. For Medi-Cal, one highly anticipated component of this budget was the funding and vision for the CalAIM proposal, which remained on track and intact in its funding and support. Other potential sources of support include the American Rescue Plan Act, which provides \$5 billion to help those experiencing homelessness and \$510 million for the Federal Emergency Management (FEMA) Emergency Food and Shelter Program (EFSP), which supports homeless services providers, and the Street Medicine Act (AB369), which was introduced to the California legislature and seeks to add street medicine as a Medi-Cal benefit.³⁴ Going forward, it is important to assess the impact of the lessons from COVID-19 to apply a strategic lens to state and local approaches to enhance health care for people experiencing homelessness, and to look at opportunities for additional investments in homelessness response statewide.

In early 2021, the **California Health Care and Homelessness Learning Community**, supported by CHCF, was launched to share innovative approaches to improve health services for homeless populations. The year-long learning community will support peer learning with stakeholders across the state and the nation, foster opportunities to support the scale and spread of promising practices, educate participants regarding policy levers to address the health care needs of those experiencing homelessness, and identify priority areas for the field to meaningfully meet the health care needs of this population.

Finally, after a year of responding to COVID-19, there is new hope around slowing and ending the spread of the virus through recently available vaccines. California's Homeless Coordinating and Financing Council is working with key state and national partners to prepare and implement a strategy for vaccinating homeless services workers and people experiencing homelessness across the state.³⁵ The strategy will require coordination with multiple agencies, and successful efforts will need tailored strategies that build confidence, deliver clear and accurate information from trusted messengers, and meet people where they are. California's health care and homeless services providers and their partners have had to come together to address the public health, safety, and health care needs of people experiencing homelessness in new and innovative ways during the pandemic. Through further evaluation and the advancement of key innovations, state and local efforts that were born out of necessity may inform ongoing strategies to better serve people experiencing homelessness.

About the Authors

The **Center for Health Care Strategies** (CHCS) is a non-profit policy center dedicated to improving the health of Americans with low incomes through partnerships that promote innovations in publicly financed health care, especially for individuals with complex, high-cost health care needs. Anna Spencer, MPH, is a senior program officer and Kathy Moses, MPH, is senior fellow at CHCS.

About the Foundation

The **California Health Care Foundation** is dedicated to advancing meaningful, measurable improvements in the way the health care delivery system provides care to the people of California, particularly those with low incomes and those whose needs are not well served by the status quo. We work to ensure that people have access to the care they need, when they need it, at a price they can afford.

CHCF informs policymakers and industry leaders, invests in ideas and innovations, and connects with changemakers to create a more responsive, patient-centered health care system.

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