



COVID-19 RESPONSE: ISOLATION & QUARANTINE OF INDIVIDUALS EXPERIENCING HOMELESSNESS

APRIL 2020

▶ EXECUTIVE SUMMARY

- Conversations with 9 comparison jurisdictions suggests that **capacity forecasting for isolation and quarantine units has been largely reactive**. Most of those focused on capacity planning have relied on Culhane et al.
- While academic modeling presents some benchmarks, it doesn't yet account for room allocation choices / ISAQ withholds. Broadly speaking, however, modelers agree that **as total coverage of the vulnerable population increases, the proportion needed to be held for quarantine declines**.
- Though some critical health services must continue to be delivered in person, all jurisdictions have begun expanding telehealth. Experienced partners stressed that **telehealth approaches work best with established clients**. Jurisdictions are experimenting with video-enabled smart phones and tablets, disinfected and shared between sessions, and set up by on-site staff. One has reported that telemedicine for behavioral health has actually *decreased* no-show rates.
- Most jurisdictions are using incentives (e.g., motivational meals, access to tablets) to encourage quarantined individuals to remain in place. **Enforcement, though it may be permissible in some jurisdictions, has proven challenging**: police are unwilling to engage infected individuals; and there are a lack of reasonable enforcement options.
- **Most discharge procedures follow some small variant on a 14-day quarantine period**. Some jurisdictions are making earlier release decisions on the basis of testing.
- **Cities are taking a wide range of approaches toward securing additional beds**—from repurposing college dorms to providing housing vouchers to purchasing hotels outright.

“Preventing the spread of Covid-19 among people who live on the street is even more difficult.

They have inadequate access to basic hygiene facilities. Now that many food sites are closing their dining rooms, they are also closing access to bathrooms and sinks. Too few hand sanitizing stations (with dwindling supplies of sanitizer) are available to allow adequate disinfecting.

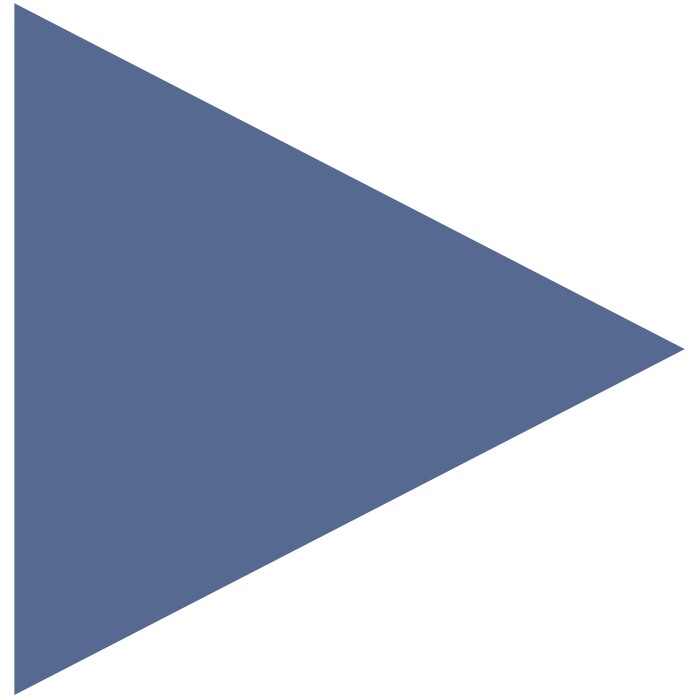
On the street, social distancing is impossible. People who are homeless have little choice but to congregate for safety; for shelter; and to share information, food, and consolation. And those who have untreated addiction often use substances together to prevent overdose death.”

– Mariam Komaromy & Michael Botticelli

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- II. Meeting mental, social, and medical needs in ISAQ settings
- III. Encouragement and enforcement of quarantine
- IV. Discharge criteria from COVID-19 quarantine
- V. Resources for securing beds

► I. PROJECTING NECESSARY ISAQ CAPACITY



▶ APPROACHES TO FORECASTING (I)

“We’re more or less flying by the seat of our pants”

- Given the unprecedented nature of this situation and this type of program, jurisdictions have found it **very challenging to forecast** the infection and hospitalization rates, the uptake rate of hotel housing, and the duration of stay.
- Informal conversations with comparison jurisdictions (n=9) indicate that **their strategies have been largely reactive.**
 - All intended to **maximize available units.**
 - Expectation is that **need is likely to outpace supply.** At the same time, concern that **HUD won’t reimburse for unoccupied beds.**
 - Some concern about **secondary influx of need** if hospitals begin releasing psychiatric patients to create space for COVID-19 patients.
- **Asymptomatic transmission may be more widespread than expected.** In Boston’s largest shelters, 600-700 people largely non-symptomatic people were tested for COVID-19, and 200 tested positive.¹

1. See, e.g., Lynn Jolicoeur et al., “[Surge In Coronavirus Cases In Boston's Homeless Population 'More Dramatic Than We Anticipated'](#),” WBUR, 6 April 2020.

▶ APPROACHES TO FORECASTING (II)

Quarantine capacity modeling

Analysis of capacity needs (Culhane et al.¹)

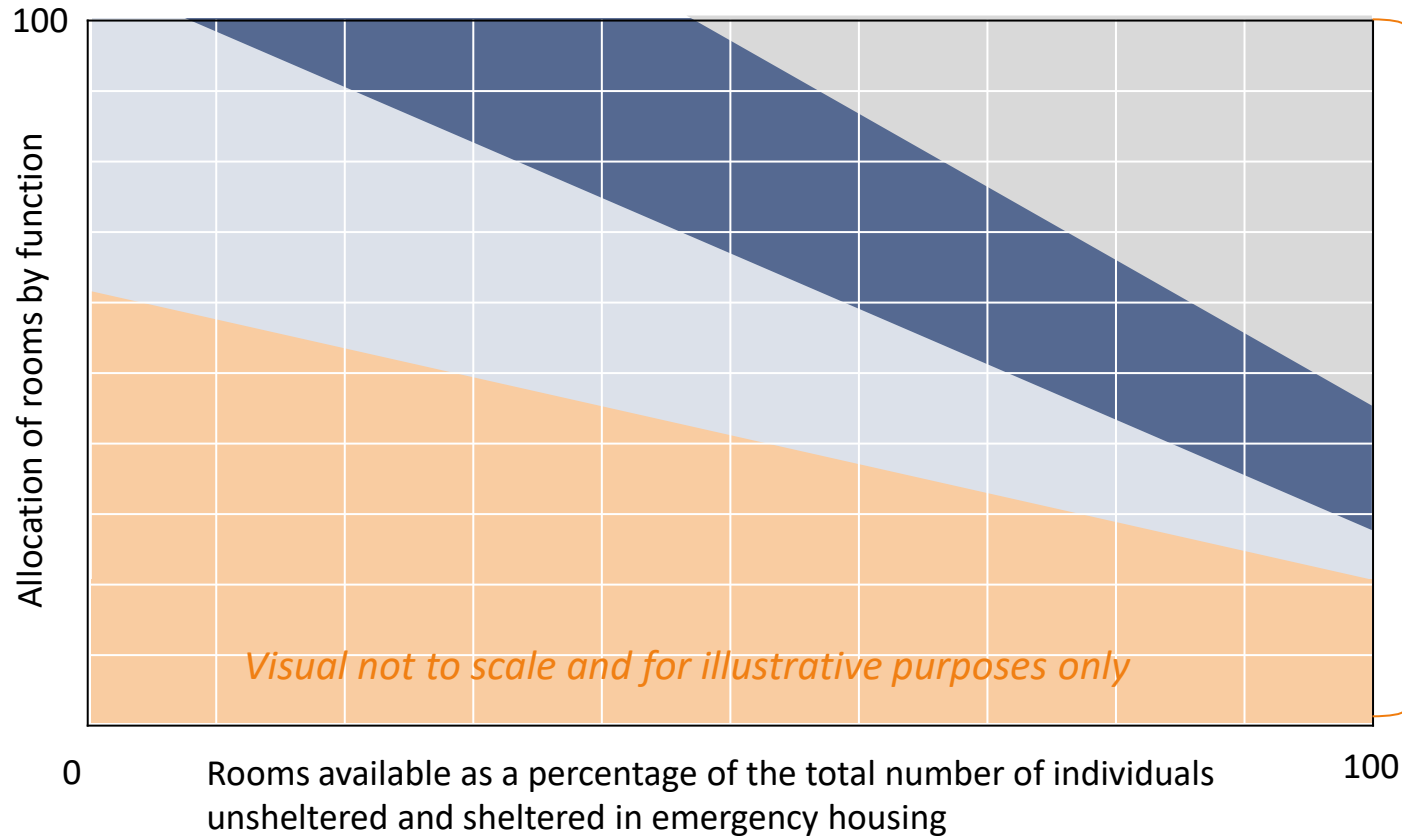
Principles driving need:

1. Emergency accommodations with private sleeping and bath space should be the **preferred option for all clients** and would be especially beneficial for individuals with known risk factors for COVID-19 complications.
2. **Individuals in urgent need of protection** – including the elderly, those with severe risk factors for COVID-19 complications, and those already presenting with respiratory symptoms – **must be accommodated with considerable haste**
3. **Individuals with known or suspected coronavirus infections must be accommodated in private sleeping and bathing quarters**, and such spaces should be made available well in excess of the likely number of infected individuals

¹Culhane, D., Treglia, D., Steif, K., Kuhn, R., & Byrne, T. (2020). Estimated Emergency and Observational/Quarantine Capacity Need for the US Homeless Population Related to COVID-19 Exposure by County; Projected Hospitalizations, Intensive Care Units and Mortality.

► POTENTIAL MODEL FOR ALLOCATING LIMITED ROOMS

As total coverage increases, proportion required for quarantine declines



Greater protection of vulnerable suggests fewer rooms need be reserved for quarantine

Color	COVID-19 Status	Risk factors
Orange	Tested positive	N/A
Light Blue	Known exposure; asymptomatic	N/A
Dark Blue	No known exposure; asymptomatic	High risk - 55+ and/or other factors
Grey	No known exposure; asymptomatic	Low risk

▶ ALTERNATIVE APPROACH TO ROOM ALLOCATION

- Another approach if adequate testing is available: Reserve hotel rooms ***for the isolation of those who are COVID-19 negative*** and have no known exposure.
- **Those with confirmed cases can be housed in congregate care** to preserve isolation spaces for those who are healthy and highly vulnerable.
- **Boston** is reserving 500 spaces in a convention center (pictured right) for people experiencing homelessness who have tested positive.¹



1. Boston University, "[Volunteers, Nurses Needed to Care for Boston's Homeless Who Have COVID-19](#)," 9 April 2020.

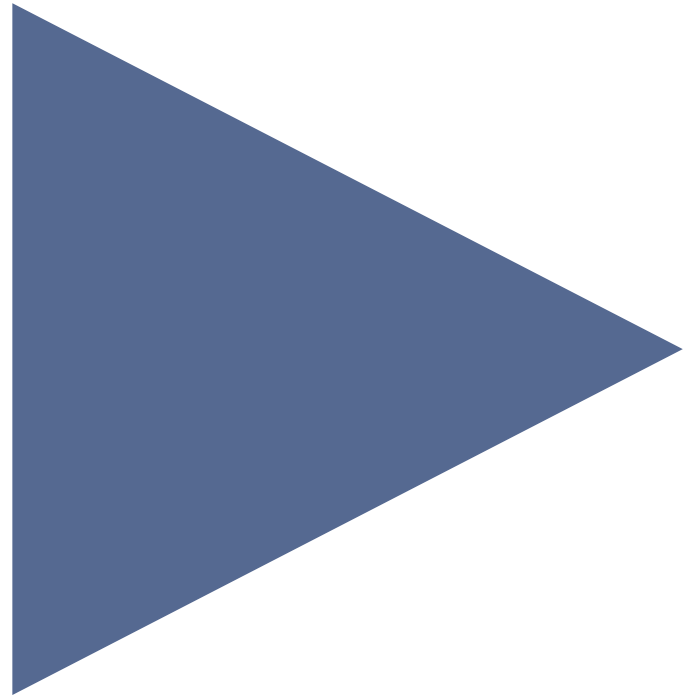
► CASE STUDY: LARGE-SCALE MANAGEMENT

Boston Health Care for the Homeless Program's emergency plan

- **Screening individuals** for COVID-19 at the entrance of shelters to identify patients with a potential positive diagnosis;
- Operating three **testing tents** at large-volume sites;
- Operating a newly-transformed wing of **respite program** as an isolation unit for patients diagnosed with the virus;
- Equipping and operating 24/7 the City's two **new medical tents** designed to accommodate the anticipated large volume of people who screen positively, giving a safe place to be isolated and receive care while test results are secured.
- Operating a **24/7 hotline and mobile service** to field concerns from shelter staff, particularly during off-hours, when a person arrives with suspected contact or symptoms.
- **Preparing for a shortage in PPE**, by creating a homemade prototype based on models created by other hospitals.

Source: Boston Health Care for the Homeless Program <<https://www.bhchp.org>>.

▶ II. MEETING MENTAL, SOCIAL, AND MEDICAL NEEDS



► EMERGING PRACTICES FOR DELIVERING VIRTUAL CARE

We spoke with five other jurisdictions to identify what's working so far. All emphasized that they are still in “experimental” stages.

Maintain in-person touch points where possible

- “**Telehealth is a tool that works best with established clients**” and “may be more challenging to establish with new clients” – especially those who are high acuity. “Relationships are invaluable currency for high-quality virtual delivery.”
- Some communities are following CDC guidance on **using and disinfecting PPE** to enable continued in-person treatment.

Leverage video through shared resources

- Access to mobile phones varies, but many clients experiencing homelessness have devices.
- “**Video-enabled smart phones and tablets strengthen delivery.**”
 - *Shared tablets can be disinfected and re-used.*
 - *On-site staff supporting technology solutions are critical.*
- Large CA county reports **decreases in no-show rates among telehealth clients**

Identify opportunities to integrate care

- Where possible, **take advantage of each medical touch-point** with a patient—where possible, ask trained professional to extend across physical and behavioral health needs (e.g., psychiatric checking blood pressure or re-prescribing diabetes medication)

▶ TELEHEALTH SURGE CAPACITY: A PROPOSAL FROM USC

- Telehealth clinic operated by the USC Suzanne Dworak-Peck School of Social Work, leveraging a cohort of **MSW students beginning a 12-week summer field placement.**
- **Initial evidence suggests impact** with adults who have transitioned from homelessness to permanent supportive housing. *(Note: Social Finance has not yet received and reviewed this evidence; we will follow up once we have.)*
- **Estimated cost \$35/session.**
 - Assumes clients have access to electronic devices.
 - Includes faculty supervision and project administrative support.

If you'd like to learn more,
happy to put you in touch

► BACKUP: MENTAL HEALTH SCREENING

Sample screening procedures from the UK

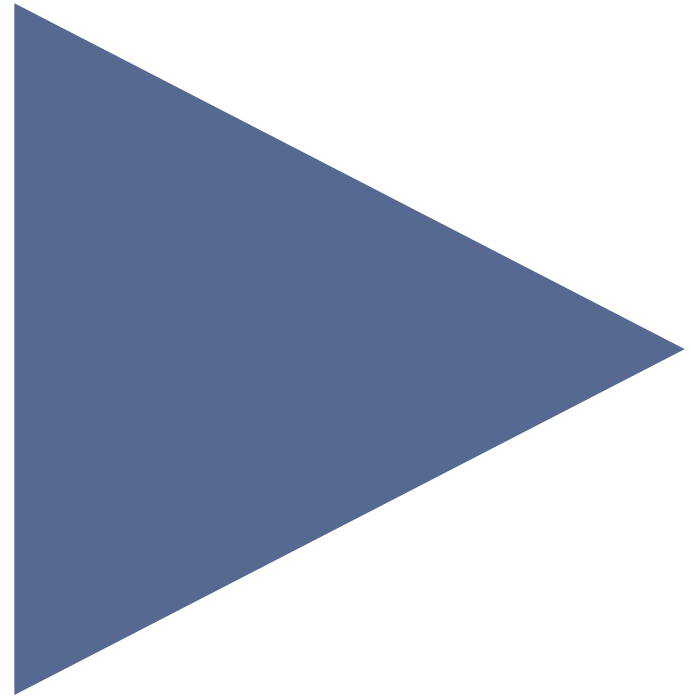
Conduct mental health survey upon arrival

1. Are they currently under the care of a mental health team?
 - If yes, contact current mental health team to plan continuing support, either virtually from current team or via local services
 - Ask if they have a care plan that they are willing to share with staff
2. Are they currently on any medication for their mental health?
 - If yes, ensure that this is confirmed with prescriber and continued
3. Do they feel they have any mental health problems?
 - If yes, ask for details & what support they feel they need

Ensure that staff engaging directly with guests are aware of monitoring guests

1. Ask residents how they are feeling/coping.
 - Have they had thoughts of self-harm/suicide?
2. Check their sleep patterns/eating patterns
3. Be alert to unusual behavior e.g.
 - shouting in room,
 - gesticulating when no one is around,
 - becoming distressed when interacting with others,
 - struggling to stay and wanting to leave,
 - becoming more withdrawn

▶ III. ENCOURAGEMENT AND ENFORCEMENT OF QUARANTINE



“This is a transient population. It’s difficult for them to quarantine. They’re attracted from the novelty perspective: a lot of people want a hotel. But some people, if they don’t have things like cigarettes, they roam.

We need to think about that on the front end. What would keep people in place? What would lead them to start roaming?”

-Response coordinator (small state)

▶ ENCOURAGEMENT AND INCENTIVIZING TO REMAIN IN QUARANTINE

In the absence of forcing individuals to remain in quarantine, jurisdictions are seeking to incentivize them to do so

JURISDICTIONS FACING DIFFICULT ISOLATION & QUARANTINE ISSUES

- Most are experimenting with **incentives to encourage individuals to remain** in hotels or other temporary locations to prevent the risk of community spread.
- Includes: motivational meals; private mail services; access to tablets (some that disconnect if removed from site) and high-speed internet; 24/7 hotline to address concerns and complaints as they arise.
- Some sites have **24/7 security**; others have **outreach teams** that work to track down individuals who leave.
- In some cases, **individuals sign “safety” contracts** when arriving.

MANY ARE ALSO TESTING ALTERNATIVE ARRANGEMENTS

- *Major California county 1:* In process of developing a **non-secure 24-hour residential treatment facility** specifically for clients with SMIs.
- *Major California county 2:* Converting a wing of a crisis residential program into **new locked care facility**.
- *Large midwestern suburban county:* Experimenting with county-funded **“Room & Board”¹** arrangements for those evicted from congregate living facilities.

1. Typically unlicensed room rentals from private landlords; may have shared restrooms and kitchens.

► ENFORCEMENT OF QUARANTINE (I)

What we've heard: While some jurisdictions may resort to enforcement, doing so may be challenging

Quarantine orders are likely enforceable...

- Four jurisdictions report challenges with individuals under quarantine leaving quarantine early.
- In one state, the Public Health Director has the authority to mandate compliance but has not yet done so. In many cities, shelter-in-place orders are legally enforceable through citations.
 - E.g., Washington D.C.: ***“Any individual who willfully violates the stay-at-home order may be guilty of a misdemeanor and, upon conviction, subject to a fine not exceeding \$5,000, imprisonment for not more than 90 days, or both.”***¹

...but challenging to implement, and of unclear value

- Police officers are reticent to engage with COVID-19-positive individuals due to the risk to their own health.
- Unclear what type of consequence would be appropriate for violation given inability to pay fines and that jails are attempting to de-densify.
- As long as need remains significantly higher than capacity, it does not seem like a good allocation of resources to force individuals to remain in places that others also infected would happily accept.

1. Government of the District of Columbia, “Mayor Bowser Issues Stay-At-Home Order,” 30 March 2020
<<https://mayor.dc.gov/release/mayor-bowser-issues-stay-home-order>>.

► ENFORCEMENT OF QUARANTINE (II)

Sample language regarding enforcement

King County¹

Isolation and quarantine mean that the guests stay away from the general public. Every person will have a 24/7 phone number they can call if they need anything, or if their condition changes. In addition, staff will check in with every patient multiple times per day to identify any needs and deliver supplies to their door. They will have no need to go out to get anything. Every guest will be strongly advised as to the importance of remaining for the full length of time to recover. **However, their stay is voluntary.**

Alameda²

Guests of Operation Comfort are there because they are acutely sick and therefore potentially infectious to others. **The Alameda County Health Officer's order of March 16, 2020 has the force of law and can be enforced by local police if necessary, including detention or arrest if indicated to protect the health of the community.**

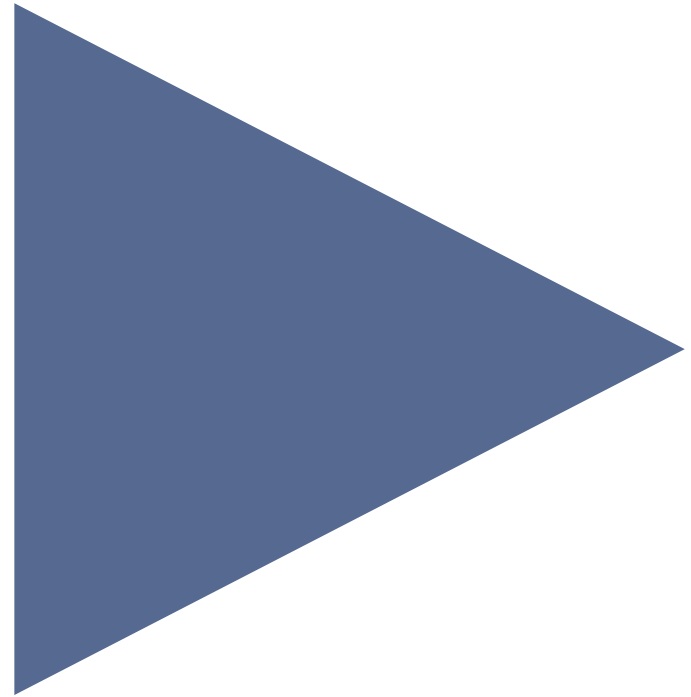
- The Referral Information and Participation Agreement signed by the guest before entering states very clearly that they are agreeing to stay in their room and not to leave for any reason until medically cleared.
- If guests leave without authorization, law enforcement may be notified, and the guest's prior housing may be advised not to allow the guest to return.

Guests of Operation Protection who are present due to being members of vulnerable groups are permitted to leave if they wish to do so.

¹King County Frequently Asked Questions: COVID-19 Isolation, Quarantine, and Recovery Sites

²Operation Comfort: Alameda County Emergency Hotel Shelter Handbook

▶ IV. CRITERIA FOR DISCHARGE



► CRITERIA FOR DISCHARGE

As identified in informal interviews

For individuals quarantined due to positive COVID-19 test results:

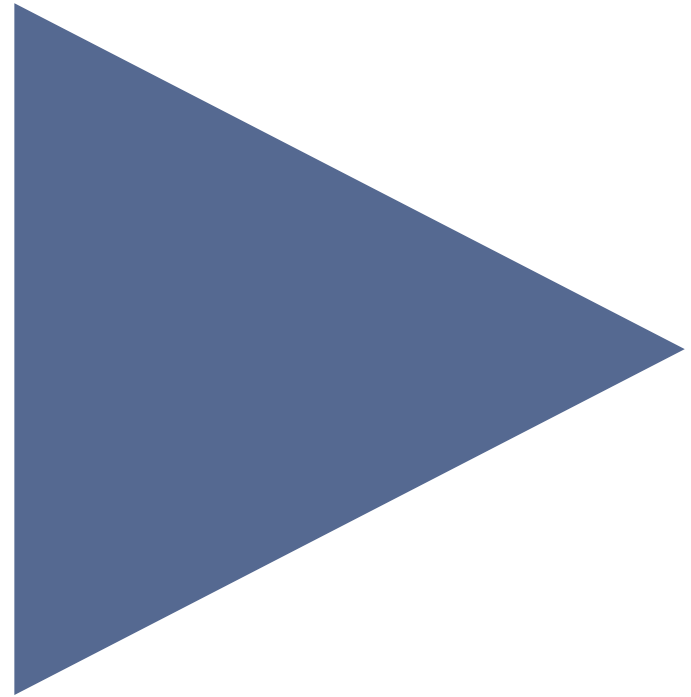
- *The most common approach seems to be that individuals are held for a minimum of 14 days.*
- A large county also requires that the individual additionally be symptom-free for seven days.
- A small state also requires that the individual additionally be fever-free for three days.
- In a large city, individuals are isolated until 7 days following the onset of the illness or 72 hours fever-free without fever-reducing medication and client indicates that they are feeling better.
- In two jurisdictions, individuals were discharged after a single negative test.
- In the UK, 7 days following onset is the typical guidance, but they are choosing between 10 and 14 days for individuals experiencing homelessness due to the risks associated with potentially returning to an institutional setting. They are not requiring negative tests because PCR can remain positive for a long time.

For individuals isolated due to membership in a vulnerable group:

- Individuals are advised to remain as long as they are healthy and the COVID-19 risk persists at a level warranting such guidance. Individuals are free to leave at any time.

Best practice: Housing navigators connecting with clients upon entry to being discharge planning

▶ V. RESOURCES FOR SECURING BEDS



▶ NEGOTIATING TERMS WITH HOTELS

Concerns of hotels	Potential mitigating measures
Damage to the facility. Reduced business once the hotel returns to normal operations due to negative associations / fear .	Hotel damage mitigation fund. Develop communications plan to generate positive media surrounding social responsibility of hotel; publicize plans to clean and disinfect in accordance with CDC standards.
Risk of infection among hotel workers; provision of services including security, housekeeping, and cooking.	Minimize or avoid usage of hotel staff; use experienced social services professionals to fill relevant roles, especially cleaning..
Validity of current insurance coverage (e.g., general liability and workers comp) when the primary use of the facility changes.	Offer alternative insurance through FEMA or another agency.
Triggering unintentional default due to violation of covenants and restrictions contained in franchise agreement, financing documents, management agreement, ground lease and any other encumbrances.	<i>[tbd – learning more]</i>

“It’s an easier decision [to agree to allow a hotel to be used for COVID-19 related activities], though still not without risk to the hotelier, if the third-party has good insurance, takes full indemnity, leases the facility from the owner, and agrees to make sure it’s cleaned and disinfected afterwards.” - Sean Murphy, senior director and vice president of the hospitality practice at Arthur J. Gallagher

▶ ALTERNATIVE STRATEGIES TO SECURE BEDS

- I. Purchase **hotels** or other vacant buildings (Austin).
- II. Invoke **temporary eminent domain**.
- III. Purchase or rent large **AirBnB properties**.¹
- IV. Purchase **campers and RVs**.
- V. Repurpose **college dormitories** (ex: North Carolina).
- VI. Provide additional **vouchers** that families can use to obtain market-rent apartments and open up places in shelters (ex: Boston).
- VII. Utilize **National Guard & quarantine tents** (ex: under active consideration in one small state).

Note: A multistate partnership with a national hotel chain could maximize efficiency in obtaining beds across geographies. The chains below already have at least one location participating in housing individuals experiencing homelessness:

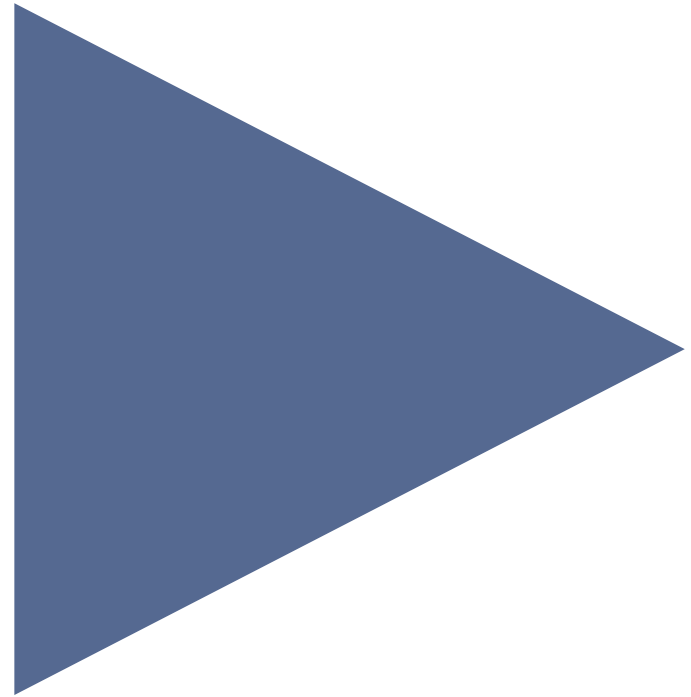
Chain	Location(s)
Comfort Inn & Suites	Oakland
Courtyard by Marriott	Marriott Edina Bloomington
Crowne Plaza	North Central Austin
DoubleTree	Augusta, GA
Fairfield Inn & Suites	Shakopee
Hilton Garden Inn	New Orleans
Holiday Inn Express & Suites	Mall of America
Radisson Hotel	Oakland
Quality Inn	New Orleans

1. AirBNB has a system in place for owners to offer space in emergencies <<https://www.airbnb.com/openhomes/disaster-relief>>.

► COORDINATION AMONG AGENCIES

- Given the increasing availability of funding streams to support quarantine and isolation of homeless population, at least one jurisdiction has encountered problems with multiple agencies simultaneously booking rooms at the same hotels.
- The problem of **competition among agencies** (and between government and non-profit service providers) can potentially cause serious consequences:
 - **Inadvertent mingling of populations** with different statuses in relation to COVID-19 (e.g., those who have tested positive and those who have tested negative and require protection due to status in a vulnerable group).
 - Hotels desperate for revenue may **drive up prices** when multiple entities are bidding.
 - Anticipated rooms **may not be available**.
- Communication is critical: Even as local, state, and governments issue restrictions, it is critical that hotels and other partners understand that **they may continue to serve homeless populations** even if other operations are prohibited.
- In order to mitigate these problems, it may be helpful to have **a single lead agency** in each jurisdiction handling negotiations with hotels or to set up shared documents to track all rooms available by type, managing organization, eligibility, and funding source.

▶ APPENDIX: USEFUL RESOURCES



► RESOURCES: PROJECTING CAPACITY NEEDS

- Culhane paper explaining methodology for projecting necessary room capacity for isolation and quarantine; includes table with specific estimates for each county - https://endhomelessness.org/wp-content/uploads/2020/03/COVID-paper_clean-636pm.pdf
- Culhane online planning & response tool for forecasting necessary isolation and quarantine capacity - https://tomhbyrne.shinyapps.io/covid19_homeless_dashboard/
- “Boston Homeless Advocates Say Asymptomatic Virus Spread Shows 'Urgent' Need For Universal Testing” - <https://www.wbur.org/commonhealth/2020/04/15/boston-homeless-population-coronavirus-asymptomatic-universal-testing>

► RESOURCES: COMPREHENSIVE ISAQ GUIDES

- Infectious Disease Toolkit for Continuums of Care: Preventing & Managing the Spread of Infectious Disease for People Experiencing Homelessness -
<https://files.hudexchange.info/resources/documents/Infectious-Disease-Toolkit-for-CoCs-Preventing-and-Managing-the-Spread-of-Infectious-Disease-for-People-Experiencing-Homelessness.pdf>
- Seattle/King County
 - FAQ regarding Isolation & Quarantine sites -
https://www.usich.gov/resources/uploads/asset_library/FAQs_IQR_Sites_March_24.pdf
 - Early Learnings from Seattle/King County; compiled by the US Interagency Council on Homelessness, details specific best practices based upon the plans that have been executed to date in Seattle – https://www.usich.gov/resources/uploads/asset_library/COVID-19-Response_Ealy_Learnings-from-Seattle-King-County-041020.pdf
- International Street Medicine Guide, which includes guidance regarding how to approach isolation and quarantine -
<https://stmi.memberclicks.net/assets/docs/COVid19%20SM%20Guidance%203-20-20.pdf>

► RESOURCES: MEETING MENTAL, SOCIAL, AND MEDICAL NEEDS

- **The American Psychiatric Association has compiled resources for mental health professionals responding to the COVID-19 outbreak.** Link to resources page can be found [here](#).
- **The American Psychological Association had partnered with some of the largest mental health providers to develop the “COVID-19 Mental Health Resource Hub”.** Link can be found [here](#).
 - *May not provide adequate detail – but good resources for mental health professionals that are transitioning care for the first time.*
- **Healthy London and The UK Command Centre** have compiled comprehensive guidelines surrounding [monitoring mental health needs](#) (link can be found [here](#)), [managing alcohol withdrawal while in COVID-19 temporary housing](#) (link can be found [here](#)), [managing nicotine dependence](#) (link can be found [here](#)), and [managing opioid dependence](#) (link can be found [here](#)).
- Technical Assistance Center’s resource library - <http://www.tacinc.org/knowledge-resources/covid-19-resources/>
- Overdose prevention and harm reduction guidelines from King County - https://www.kingcounty.gov/depts/health/locations/homeless-health/healthcare-for-the-homeless/~/_media/depts/health/homeless-health/healthcare-for-the-homeless/documents/covid/overdose-prevention-harm-reduction-covid-19.ashx

► RESOURCES: ENCOURAGEMENT & ENFORCEMENT OF QUARANTINE

- “Can Local Governments Enforce Quarantines? Should They?” An NPR article looking at quarantine enforcement options by state - <https://www.npr.org/2020/03/18/816630364/can-local-governments-enforce-quarantines-should-they>
- “Casper Shifts toward Rules Enforcing COVID-19 Quarantine, Self-Isolation Directions” <https://oilcity.news/community/health/covid-19/2020/04/14/casper-shifts-toward-rules-enforcing-covid-19-quarantine-self-isolation-directions/>

► RESOURCES: CRITERIA FOR DISCHARGE

- CDC guidance for termination of isolation for individuals with COVID-19 outside medical settings - <https://www.cdc.gov/coronavirus/2019-ncov/hcp/disposition-in-home-patients.html>
- European Centre for Disease Prevention and Control guidance for ending isolation in the context of community transmission - <https://www.ecdc.europa.eu/sites/default/files/documents/covid-19-guidance-discharge-and-ending-isolation-first%20update.pdf>

► RESOURCES: SECURING BEDS

- RFP from MaineHousing to secure hotel blocks for COVID-19 positive individuals, individuals awaiting testing results, and individuals experiencing homelessness - https://mainehousing.org/docs/default-source/rfps/rpf---hotel-rooms-4-8-20.pdf?sfvrsn=a40e8f15_0
- RFP from San Francisco to secure hotels for isolation and quarantine as well as for first responders - <https://www.scribd.com/document/452563018/SFHSA-Request-for-Hotel-Room-Price-Quotes>
- RFP Columbia, MO for homeless encampment - <https://www.documentcloud.org/documents/6837844-Camp-Rfp.html#document/p2>
- “When Hotels Become Hospitals: A New Set of COVID-19 Risks,” an analysis of potential risk from the perspective of the hotel industry - <https://riskandinsurance.com/when-hotels-become-hospitals-a-new-set-of-covid-19-risks/>