# COVID-19: A Framework for Health and Housing Partnership During the Pandemic

## INTRODUCTION

Collaboration and partnership between health and housing providers contribute significantly to effective service delivery of primary health care, mental health, substance use and housing with tenancy supports for individuals and families facing homelessness and housing instability. While most community service providers recognize the benefits of partnership in 'normal' times, creating and implementing these cross-sector partnerships can be complex and must be built from the relationships specific to a community. Community responses to the COVID-19 pandemic like shelter-in-place, quarantine, testing, and management of strained health resources have elevated the necessity and value of effective health and housing partnerships to address the needs of vulnerable populations. This brief highlights strategies for health centers, housing, and community service providers in leveraging partnerships to address a range of health and housing needs both during, and after the COVID-19 crisis subsides.

Reflecting on Corporation for Supportive Housing's (CSH's) Health and Housing Partnership: Strategic Guidance for Health and Housing Partnerships, the four stage process to create effective health and housing partnerships is applicable in the current emergency health environment, but at a more intentional and expedited pace. This brief will identify the stages and corresponding elements that are the most integral in the COVID-19 partnership context from the encompassing context below.

## KEY PARTNERS NECESSARY FOR AN EFFECTIVE COVID-19 PARTNERSHIP RESPONSE

**Housing:** Homeless housing and service providers have expertise connecting households facing homelessness and housing instability to community resources that meet a broad range of needs. Relying on this experience, housing providers have built partnerships across sectors by aligning goals, responsibilities and partner capacity. These housing providers are able to leverage established communication networks, access points and partners to connect vulnerable populations with information and resources during the emergency health crisis.

**Health Centers:** Health centers provide comprehensive primary care, preventive services, chronic disease management and support services to underserved populations. Health Care for the Homeless (HCH) grantees are also required to offer addiction services to address the importance of integrating of primary and behavioral health care for comprehensive care. Because health centers serve as safety net providers across the country they are uniquely positioned to provide testing and treatment to clients with complex needs and keep these clients connected to health care during the COVID-19 pandemic.

**Public Health:** Public health departments at the state, county and city levels are leading the response to COVID-19. Their guidance must be the primary driver for any health and housing response to the pandemic.

**Community Services**: Hospitals, behavioral health providers, including substance use disorder treatment providers, as well as workforce, education, legal services, public housing authorities, are all critical partners to have at the table for a coordinated response to the pandemic.

## MAKE THE CASE: *ENGAGEMENT WITH A COMMON CLIENT AND SHARED POPULATIONS THAT FACE INEQUITIES IN ACCESS TO QUALITY CARE*

People experiencing homelessness are at disproportionate risk of contracting COVID-19 and becoming seriously ill. Recent reports have found a high number of persons who are homeless, especially residents of emergency shelters, test positive even when they are asymptomatic.[1]

- Health Resources and Services Administration (HRSA) health center program grantees serve people with limited access to health care, including migrant and seasonal farmworkers and their families; persons experiencing homelessness; and/or residents of public housing. Health centers provide the link to primary care and related health services and supports for supportive housing tenants, many of whom have histories of chronic homelessness and complex health conditions.
- Supportive and affordable housing case managers and resident service coordinators are skilled at navigating community resources and building collaborative relationships. Individual service providers can create linkages and map out options for their clients to health centers and other resources for testing, primary care and other Social Determinants of Health (SDOH) community resources like food, equipment, and transportation.
- Both the scale and population risk factors evident during this current pandemic have accentuated existing inequities prompting some jurisdictions to examine and institute systemic approaches to increase efficiency and equity of access. Examples include distribution of personal protective equipment (PPE) and hygiene supplies, communication strategies that reach broad communities, and expansion of testing sites to diverse and accessible locations, including parking lots at community health centers.

## MAKE IT HAPPEN: *MAXIMIZE LEADERSHIP FOR EFFECTIVE COORDINATION*

Community organizations often focus on their respective roles, resources and performance obligations sometimes missing opportunities to leverage the expertise of potential partners and engage leadership to achieve common goals. In the emergency response to COVID-19, leaders across industries immediately recognized the necessity to fast track coordination.

- COVID-19 emphasized existing gaps in coordination of care, and the need for providers to work together to develop new protocols. Community partners must assess these gaps in the respective systems and determine existing expertise to address them.
- City, county and/or state public health departments are leading the efforts to address COVID-19. Most stay-at-home orders and other directives are issued by public health departments in coordination with elected officials. Public health departments are disseminating protocols to community partners for working with the broader community population, people who have COVID-19 symptoms, as well as people who have been tested positive for COVID-19.

[1] *COVID-19 & the HCH Community: Comprehensive Testing & Services for People Experiencing Homelessness*. Issue Brief April 2020. National Health Care for the Homeless Council

- Health centers working with public health departments are leading the development of community-wide mitigation strategies to engage, educate and support vulnerable populations to prevent transmission, identify confirmed cases and close contacts, and respond to suspected and confirmed cases across community service and homeless systems. These responses include standing up isolation/quarantine sites for people experiencing homelessness who are COVID positive, are experiencing symptoms and awaiting testing, or who are particularly high risk of contracting the virus.
- Early in this health crisis, homeless and housing leaders leveraged their coordinated assessment access points to incorporate COVID-19 pre-screening to identify symptoms, access to shelter, and alternate housing locations to de-densify congregate shelter housing. Cross-sector leadership teams need to understand their roles and develop partnerships to communicate regularly to review, refine, and train on protocols for care provider across systems.

## MAKE IT WORK: *COMPLEMENTARY ROLES AND EFFECTIVENESS OF CARE COORDINATION*

Care coordination in COVID-19 involves a concerted effort between health care and housing staff to work together to meet client needs with the right intervention, in the right place, at the right time. In this arrangement, housing and health care providers work together as a team with common goals to improve health outcomes for tenants/patients in the community.

- Care Coordinators working at health centers and in supportive housing help vulnerable populations navigate the health care system and boost broader understanding and adherence to protocols and best practices in times of health crisis. These same staff are working to assess patients and community members for COVID-19 symptoms, provide testing, and assess the need for quarantine, or for hospitalization.
- In the context of COVID-19, health center care coordination is particularly important with case managers in shelters and supportive housing who may have residents who are being directed to, or may be leaving hospitals or isolation facilities. Case managers at housing locations must have access and training to local public health department protocols for people who have COVID-19 symptoms as well as people who have been tested and are COVID-19 positive.
- Health and housing care coordination can ensure health risk assessments happen, appropriate care plans are developed, and communication among different providers on the care team.
- Health and homeless services coordination can ensure the health and safety for those without permanent housing by providing transportation to and from quarantine sites, educating emergency shelter staff and residents on infection control, create hand-washing stations and physical distancing protocols, arrange for PPE, and supply other hygiene products for going in and out of emergency shelters. Health center staff also can provide health care services to emergency shelter residents at quarantine sites.
- Vulnerable populations, including those with permanent housing and those without, leaving a hospital post COVID-19 treatment will rely on care coordination between hospital staff, their case manager, their care coordinator and any other relevant team member to coordinate care for the patient back in the community. Discharge planning should produce a care plan that includes:

- Instructions regarding ongoing COVID-19 contagion and home care;
- Linkages for access to food, household supplies, transportation and other necessities;
- Instructions for ongoing health care treatment, medications and symptom monitoring;
- Linkages to behavioral or mental health care required and recommended;
- Plans for cleaning and safety procedures.

## MAKE IT WORK: *ACCESS TO QUALITY CARE*

In a time of crisis like COVID-19, other health concerns may be neglected as the focus is public health and individual safety. However, primary health care, behavioral health care, and chronic conditions are still ever present. Health and housing partnerships can work to ensure vulnerable patients and tenants have access to the health care and support services they need.

- ***Chronic disease management***
  Health centers can be key partners in helping supportive housing tenants manage chronic diseases such as asthma, hypertension, kidney disease, diabetes and heart disease. Primary care needs should not be neglected during the pandemic. Tenants need on-going medication and maintenance supplies for many conditions, as well as routine lab tests. The health center can provide these important health services either through on-site health center visits or virtual/telemedicine visits and housing case managers can ensure those connections happen.
- ***Delivery of behavioral health, SUD and OUD services***
  Health Care for the Homeless (HCH) grantees are required to offer addiction services and the HCH model of care incorporates harm reduction, low barrier access to treatment, integrated care, a comfort level with behavioral health issues and substance use disorders, and familiarity with trauma. Health centers can collaborate with supportive housing providers who may struggle with providing this care to high-need clients. Supportive housing staff can employ harm reduction models to ensure those with substance use issues are remaining safe, housed and connected to addiction treatment. Many health centers are continuing to provide medication assisted treatment to individuals with opioid use disorder during the pandemic. Tenants who are sent to isolation/quarantine locations must have access to addiction treatment and medications as well as counseling services. Coordination between housing and health is key to ensure safety for the tenants who are still engaged and need this treatment as there are ways to continue with it during COVID-19.[2]
- ***On- going primary care***
  As with chronic disease, on-going primary care needs do not go away during a pandemic. Health centers and housing case managers can work to ensure that tenants still access limited primary care visits, medication monitoring and routine lab tests.

[2] *Reducing Harm for People Using Drugs & Alcohol During the COVID-19 Pandemic: A Guide for Alternate Care Sites Programs.* Issue Brief April 2020, National Health Care for the Homeless Council.

- ***Telehealth***
  The U.S. Department of Health and Human Services (HHS) has issued new guidance[3] around virtual and telehealth options and many health centers have moved quickly to provide these options. Housing case managers can help tenants make those connections by telephone or computer for on-going primary and behavioral health treatment.

## MAKE IT LAST: *SUSTAIN CARE POST COVID-19*

Communities are slowly reopening as the crisis stage of the pandemic abates at different rates across the country. It is apparent that a "new normal" will require greater collaboration between public health, health care and supportive housing providers to ensure ongoing health and safety of communities in the initial phase and during anticipated resurgence of the virus that may occur. Below are partnership areas that can help sustain care post COVID-19.

- Recent guidance[4] has given new flexibility to sharing data for COVID-19 response efforts. During a health crisis, it is important for Continuums of Care (CoCs) to share their homeless systems data with health care and public health on individuals testing positive, symptomatic but not tested, and high risk individuals who are more vulnerable to the virus so appropriate care responses can be employed.
- In order to prepare for future infectious diseases, there should be a memoranda of understanding between health centers, housing and homeless services providers to identify roles and protocols for addressing the health needs of staff and residents in housing and education, infection control, PPE supplies, testing, isolation/quarantine, transportation and re-housing strategies.
- To ensure continued partnership and care coordination, health and housing partners should leverage current cross-sector workgroups to advance on joint projects and funding requests that could support and maintain care coordination successes.
- Health and housing partnerships can support efforts to transition special and vulnerable populations to telehealth for primary care and behavioral health. Instituting promising practices like the three step workflow; triage, intervention, and management for clients in isolation units.[5]

[3] https://www.telehealth.hhs.gov/providers/policy-changes-during-the-covid-19-public-health-emergency/#telehealth-waivers-and-other-flexibilities-from-the-centers-for-medicare--medicaid-services-cms
[4] https://www.hhs.gov/about/news/2020/03/24/ocr-issues-guidance-to-help-ensure-first-responders-and-others-receive-protected-health-information-about-individuals-exposed-to-covid-19.html
[5] https://d155kunxf1aozz.cloudfront.net/wp-content/uploads/2020/04/CSH-on-Triage-and-Telehealth-Support-Plan-for-Isolation-Units.pdf

## Health and Housing Partnership Examples

**Atlanta, GA** – St. Joseph's Health System, the Health Care for the Homeless (HCH) grantee in Atlanta, quickly deployed their outreach teams in collaboration with Partners for Home (PFH) the local homeless continuum of care to screen for fever and symptoms in homeless encampments. These teams are coordinating communications and transportation to send symptomatic individuals to hospitals or isolation in hotels for those awaiting testing results, in collaboration with the local public health, the mayor's office, the CoC and the public hospital on the COVID-response.

**Boston, MA** – Boston HCH rapidly developed a screening tool for entry to shelters and set up outdoor testing tents at three shelter locations. They worked with the city and public health to identify spaces for isolation and quarantine in hotels, dorm rooms and large open spaces such as gyms. Transportation was coordinated with Boston Medical Center for patients, utilizing two designated vehicles dispatched through a command center. Recognizing addiction risks for individuals during the crisis, HCH prioritized medications for opioid use disorder as critical intervention to continue at their clinic sites. They adopted strategies to make it possible to include longer prescription intervals and continue their mobile unit for needle exchanges and subcutaneous injections for people who do not, or cannot come to their health center.

**Chicago, IL** – The Chicago Department of Public Health and the City of Chicago worked with Lawndale Christian Health Center (LCHC) to make temporary housing available for people experiencing homelessness whose age and/or underlying health conditions place them at higher risk of severe COVID-19 associated illness. The intent is to remove high-risk individuals from congregate shelters and encampments to protect them from exposure to COVID-19. A clinical evaluation is recommended to determine whether individuals meet high-risk criteria.

**Yakima, WA** –Yakima Neighborhood Health Services is a health center and HCH grantee serving the chronically homeless through street outreach, primary care, permanent supportive housing and medical respite. The center engaged their long standing community partnerships to develop a coordinated COVID-19 response, utilizing a state provided COVID emergency housing grant, FEMA funds, and a consolidated homeless grant. The county board, department of human services and health district/office of emergency management also worked together with the city, providers and foundations to bring resources to the efforts. The health center tests persons experiencing homelessness living in encampments and the emergency shelter. The community has created an isolation and quarantine facility for individuals who were COVID-19 positive. When anyone tests positive they can enter the health center's medical respite program, with the capacity to house 15 COVID-19 positive individuals. There are also five slots for non-COVID-19 patients who may have been exposed or showing symptoms in another medical respite facility.[6] The county will provide hotel/motel vouchers if there are more than 15 who need isolation and quarantine. The center received funding to adapt their mobile

[6] The medical respite set up is classified as an alternative care setting under CDC guidelines, so staffing, PPE and infection control comply with those guidelines.

vans to add plastic barriers for the drivers so they can safely transport individuals to the medical respite locations.

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