Responding to COVID-19

Operational Guidance and Considerations

March 2020

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Overview

Introduction

Communities across the US are coordinating efforts to slow transmission of COVID-19 and mitigate impacts of the virus on people experiencing homelessness. Over the last few weeks, federal partners including the US Department of Housing and Urban Development (HUD), the US Centers for Disease Control and Prevention (CDC), and the National Health Care for the Homeless Council (NHCHC) have published timely resources and guidance to support juridictions to respond to the unique needs of people experiencing homelessness during this crisis.

This document compiles existing local, state and federal resources on the COVID-19 pandemic. It shares examples and supports the rapid peer learning this threat requires. Information is changing quickly as the nature of the coronavirus is understood and additional resources become available. Content included here is current as of the time of publication/revision.

How to use this guide

Information gathered here assists local leaders in making decisions about COVID-19. This tool supports communities' navigation of response effort with best practices to prevent the spread of COVID-19 infections.

Definitions

See Appendix 1 for a list of definitions for key terms used throughout this document.

Shelter & Temporary Housing Models to be Considered in COVID-19 Response Efforts

Protecting highly vulnerable people, preventing a surge in hospital demand, and providing safe spaces for people who are symptomatic or positive is the current focus of all community members throughout the United States. HUD and CDC have published specific guidance to support communities to evaluate non-congregate shelter options, explore a harm reduction approach, and adjust outreach to unsheltered populations in this time of enhanced health risks due to infection.

To slow the spread of COVID-19 the CDC has recommended CoC's have non-congregate and congregate shelter and temporary housing capacity for a variety of needs including:

1. Overflow or auxiliary shelter space to account for beds lost when reconfiguring existing shelter space in accordance with social distancing guidelines
2. Isolation sites for people who are symptomatic
3. Quarantine sites for people who test positive for COVID-19

Sheltering approaches are either congregate (communal living spaces) or non congregate (private or semi private units). Coordination with public health partners and emergency operations officials is essential in designing local approaches. This section outlines CDC guidance and various models that are being implemented by communities.

Determining and Prioritizing Shelter/Temporary Housing Sites

Below are community guidelines for determining the most appropriate housing and shelter options needed for your COVID response effort and how they should be prioritized, which were recently published in the State of California's Recommended Strategic Approaches for COVID-19 response for Individuals Experiencing Homelessness and posted on the HUD Exchange.

The guidelines are included here for you to have an example, and your CoC should design your system in collaboration with your local public health partners.

1. Focus prevention efforts on those most likely to develop severe complications from COVID-19, including people who are currently in shelters and people who are currently unsheltered. The primary strategy for intensive infection prevention efforts is providing single-occupancy housing.
2. Reduce risk by decreasing density of existing congregate homeless shelters, which may require creating additional or overflow spaces to sustain bed numbers, increasing cleaning, and screening guests for symptoms.
3. Create isolation units (i.e. hotels, motels, trailers) for people who exhibit symptoms; separate people with symptoms quickly and ensure they wear facemasks.
4. Cohort individuals who test positive for COVID-19 together in group settings with appropriate healthcare personnel in place **OR** place them in individual isolation/quarantine units (i.e. hotel, motel, trailer) for the duration of quarantine.
5. Prioritize individual housing units (e.g. hotels, motels, and trailers) for unsheltered and sheltered individuals experiencing homelessness who are either (1) symptomatic or (2) at high risk of medical complications.
6. Consistent with CDC recommendations, unless individual housing units are available (i.e. hotel rooms) communities should not be clearing encampments and dispersing people throughout the community. If a community is unable to provide a hotel room or other single occupancy housing and client is asymptomatic, provide outreach services (screening, food, hygiene) and ensure that recommended social distancing is maintained where the individual is located, or determine if there is another appropriate shelter opportunity.
7. Create clear lines of communication so that homeless service providers and health systems have easy access to appropriate quarantine and isolation sites/resources. Ensure that health care providers are screening and triaging clients (see next section).

8. For every step of this process, para transit should be made available wherever transport is needed (See transportation section below). Durable Medical Equipment should be made available where needed at each site, and ADA compliant hotel rooms must be kept for those who require these accommodations.

The following are the State of California's recommended pathways for different target groups. Local responses should be designed in partnership with your public health partners.

Recommended Site: People who exhibit symptoms

1. Quarantine hotel/motel/trailer or other place where individuals can be isolated from others during investigation. (i.e. isolation hotel)
2. Alternative care settings: group facilities (i.e. shelters) separated from presumed COVID-19 negative individuals and staffed by healthcare professionals where individuals who exhibit symptoms can receive healthcare and assessments to see if they require a higher level of care (i.e. transfer to emergency department or inpatient).

Recommended Site: COVID-19 positive

1. Alternative care settings: group facilities (i.e. shelters) separated from presumed COVID-19 negative individuals and staffed by healthcare professionals where individuals who are COVID positive can receive healthcare and assessments to see if they require higher level of care (i.e. transfer to emergency department or inpatient).
2. Quarantine hotel/motel/trailers for those who could be safely isolated (e.g. those who are independent) and do not require extensive healthcare while contagious.

Recommended Sites:Presumed COVID-19 negative

1. Hotels/motels/trailers for High Risk Persons [to prevent infection for individuals at high risk of medical complications],
2. Shelters with appropriate social distancing, or
3. Remain unsheltered with appropriate outreach and social distancing.

See the State of California's flow chart which outlines the workflow for these recommended protocols which was recently published on HUD Exchange.

Non Congregate Settings

In addition to congregate sheltering options, communities are establishing non-congregate shelters which provide people with private or semi private temporary housing units. Examples of the types of locations being used include:

- Hotels/Motels
- University Housing and dormitories
- Repurposed buildings (i.e. service provider properties, closed jails, military properties)
- Trailers, RVs, Mobile Homes
- Individual tent structures and tiny homes

Sample resource: [Template Letter to Send to Local University/College Asking for Use of Dorms](#)

Guidance for Non Congregate Settings

CoCs considering non-congregate approaches to sheltering people who are homeless that are symptomatic or in high risk categories, such as seniors or people with chronic illness, [should consider the following guidance](#) released by HUD and the CDC that is highlighted in the section below. Coordination with public health partners is essential in design, resource investment and staffing considerations on these models.

	Best Practice Approach: Private Individual Rooms	**Better Approach:** Individual Rooms/ Semi-Private Spaces	**Good Approach:** Shared Spaces
Target Population	Individuals who are ● symptomatic after screening at shelter has been implemented ● pending testing or are close contacts of confirmed cases ● high risk with or without symptoms ● confirmed to be COVID-19 positive who do not need to be hospitalized	Individuals who are ● symptomatic after screening at shelter has been implemented ● confirmed to be COVID-19 positive who do not need to be hospitalized as long as all individuals in the space are COVID-19 positive	Individuals who are ● confirmed to be COVID-19 positive who do not need to be hospitalized as long as all individuals in the space are COVID-19 positive ● asymptomatic after screening at shelter has been implemented as long as all individuals in the space are asymptomatic.
Set-Up	● Individual bedroom (walls on all sides and a door) ● Individual bathroom ● Individual HCV ● Personal cleaning supplies for an ill person's room and bathroom	● Individual bedroom (walls on all sides and a door) ● If no existing walls, makeshift walls that are floor to ceiling should be created to create 6ft separation ● Limited shared bathroom with cleaning regiment ● Bathroom should be cleaned and disinfected	● Shared bedroom spaces with 6ft separation ● Makeshift walls that are floor to ceiling (if feasible) should be created ● Arrange all sleeping areas (including beds/cots) so that individuals are separated by putting a minimum of 6 feet between individual sleeping surfaces to

		after each use by an ill person ● Dedicate an entrance(s) or passageway(s) for infectious individuals when feasible.	prevent the spread of infections. ● Shared bathroom ● Bathroom should be cleaned and disinfected after each use by an ill person ● Dedicate an entrance(s) or passageway(s) for infectious individuals when feasible.
Staffing	● Onsite healthcare ● Transportation plan for closest hospital transport ● Staff shifts and crew configuration ● Cleaning schedules ● PPE available for staff ● Non-Congregate site management staff ● Case management staff ● Security	● Identifying dedicated staff to care for COVID-19 patients. ● Telehealth options ● PPE available for staff ● Non-Congregate site management staff ● Security	● Identifying dedicated staff to care for COVID-19 patients. ● Telehealth options ● PPE available for staff ● Non-Congregate site management staff ● Security

Community Examples - Non Congregate Options

Below are community examples of on-congregate shelter models being deployed by communities. See Appendix 2 for details on the program models and sample policies, procedures, and contracts.

- **King County:** Seattle/King county are operating isolation and quartitines units in hotels and trailers. Sites are coordinating services with onsite shelter managers, nurses, and behavioral health staff to provide substance use treatment, health care, supplies, and general support for other basic needs, including meals and transportation.
- **New Orleans Hotel:** State leased three hotels for people experiencing homelessness. New Orleans Health Department is providing behavioural health services; the state of Louisiana is providing management and operations staffing. The state of Louisiana is evaluating this approach to consider scaling it across the state to increase shelter capacity for people who are asymptomatic, symptomatic, or who have tested positive for COVID-19.

- **State Of California**: Under the Governor's disaster declaration, Los Angeles Family Housing was able to enter into emergency occupancy agreements with local hotels to procure 70 rooms.

Guests are screened and symptomatic clients are moved into isolation housing. Couples that are symptomatic may isolate together in this space and pets are allowed in the hotel rooms.

Congregate Settings

Several communities have configured congregate facilities or shelters to support COVID-19 response needs. Examples of the types of locations being used for congregate settings include:

- Civic centers
- Community recreation centers
- Stadiums
- Repurposed empty buildings/facilities

Guidelines for Congregate Settings

This section outlines guidance recently released on HUD Exchange for Shelter Management During an Infectious Disease Outbreak and the CDC's Interim Guidance for Homeless Shelters.

Maintaining Operations

Closing a community's homeless shelter without providing alternate housing or shelter leaves people experiencing homelessness vulnerable to unsheltered situations and decreased access to life-sustaining services. If a program is considering closing or not accepting new residents, immediately alert your local Continuum of Care (CoC), public health authorities, and emergency management officials and initiate planning for adding capacity.

Changing Intake Protocols

- **Screening**: Because test kits are limited, shelters should screen shelter residents for COVID-19 symptoms (i.e., recent/abnormal cough, fever, or shortness of breath) at intake and daily. There are many different community examples of screening tools. Some communities that have integrated public health services within their shelter system have more complex screening tools that are administered by medical/behavioral health personnel. Other communities do not have integrated public health services in shelters. In these communities screening tools may be completed by shelter staff. When developing or adapting an existing screening tool, communities should consider who will be completing the tool and consult with public health departments to approve the tool and process. (See screening section below)
- **Separating people with symptoms:** Where possible, shelter staff should separate residents into different areas of the shelter, if possible, based on whether they are showing symptoms of COVID-19 or not (see CDC's Interim Guidance for Homeless Shelters).
- **Alternate care sites:** Communities may establish alternate care sites for people exhibiting symptoms. Alternate care sites (ACS) are a way for healthcare providers to provide medical care for sick patients in non- traditional environments including locations that need to be converted (e.g., stadiums or hotels), or they may include facilities like mobile field hospitals.

Adjusting Operations

When people exhibiting symptoms of COVID-19 remain in shelter, shelters should enforce the following protocols to reduce the risk of disease spread:

- Placing masks on people with coughing symptoms;
- Encouraging frequent hand washing, cough etiquette, maintaining recommended social distancing, and reporting new or worsening symptoms to shelter staff;
- Implementing an intensive cleaning schedule;
- Taking regular stock of supplies: cleaning products, gloves, hand sanitizer, soap, and facemasks;
- If your shelter is running out of essential supplies, immediately inform your Emergency Operations Center, your CoC leadership and and/or public health partners so that they help you identify resources;
- Invite in healthcare partners, such as county public health and Healthcare for the Homeless providers, to provide regular clinic hours or wellness checks.

Modifying the Shelter Space

Bed spacing. Spread beds by at least 3 feet of space around each side of the bed for those who are not exhibiting respiratory symptoms (see Interim Guidance for Homeless Shelters). People exhibiting symptoms should be separated by 6 feet between beds and temporary barriers. Set up beds so that all clients sleep head-to-toe.

Make use of outdoor spaces. When the weather is temperate, expand use of outdoor spaces for socializing and eating to help meet social isolation requirements. For example, some programs are moving meals and case management services to outdoor spaces in an effort to maintain social distancing.

Plan for overflow accommodations. Shelters quickly reach capacity as a result of social distancing recommendations. Create a plan in coordination with public health departments and CoCs to identify sites for general overflow capacity. Establish a protocol for transporting or redirecting clients to those alternate accommodations once the shelter reaches capacity.

When setting up congregate facilities CoCs should follow the CDC's Interim guidance for homeless service providers to plan and respond to coronavirus disease 2019 (COVID-19).

Community Examples (Congregate Settings)

Below are community examples of congregate shelter models being deployed by communities. See Appendix 2 for details on the program models and sample policies, procedures, and contracts.

- **Boston Tent Structures**: The City of Boston installed heated tents outside of homeless service providers for screening, testing, and for quarantine or isolation in the event that program participants in shelter test positive or exhibit symptoms.

- **Seattle/King County:** The Assessment Center / Recovery Center (AC/RC) is a large, congregate care facility designed to provide Public Health-supervised care to symptomatic or COVID positive adults who are not able to follow public health guidance for isolation, quarantine, or recovery in

their own home, or because they do not have a home. AC/RC facilities can serve as flex space for hospitals, making it possible to discharge non-serious COVID cases to the AC/RC, freeing hospital beds for the most acute cases.

- **Connecticut**: Connecticut Department of Housing (DOH) has partnered with CT Coalition to End Homeless to "decompress" the shelter population by contracting with area Hotels through the Department of Administrative Services (DAS) in order to comply with the recommendations from CDC of social distancing. An analysis of shelter square footage and census identified shelters that are too crowded by CDC standards for 6' of space between beds. DOH first moved elderly and medically fragile persons from shelter to hotels and are now focusing on shelter decompression overall. Efforts are also underway to identify and set up isolation/quarantine locations which will also be open to the homeless population. Some are specific to the homeless population while others are open to anyone who cannot go home and safely self-isolate.

- **Fort Worth Convention Center:** City and county collaborated to open shelter space at the local convention center; the county hospital is co-located on the first floor to provide clinical services and screening; clients are triaged to beds for asymptomatic or symptomatic clients and alternative spaces have been identified and are available for quarantine for those who have tested positive for COVID-19.

Policies and Procedures

Communities are currently drafting policies and procedures for non congregate sites that are opening as part of local COVID response efforts. Below is a list of the types of issues communities are exploring with local public health partners as they draft these policy manuals.

- ❏ Staffing and services
    - ❏ Staffing models and schedules (See 'staffing' section below)
    - ❏ Coordinating onsite services (medical services, behavioural health, case management, security, cleaning services)
    - ❏ Plans to ensure continuation of critical mental and behavioural health services at isolation, quarantine, and overflow sites (i.e. alternate forms of counseling over the phone, telemedicine considerations, and other adjustments needed to ensure continuity)
    - ❏ Distribution of supplies, food, and basic resources
- ❏ Screening, triage, and referral protocols, including recommended sites and transportation procedures (see 'transportation' section below)
- ❏ Roles and Responsibilities (hotel, homelessness services, public health, medical, behavioural health service system staff)
- ❏ Pet policy regarding whether pets are allowed on site
- ❏ Communications procedures -- consider information sharing across critical staff on important issues such as medication administration, behavioral health management
- ❏ Procedures for quarantine and monitoring health status among clients developed by local health partners
- ❏ Discharge protocols and procedures

- ❏ Site procedures
    - ❏ Smoking
    - ❏ Showers
    - ❏ Common areas
    - ❏ Hotel phones

Special Considerations for Policies and Procedures

Early feedback from communities operating COVID-19 isolation sites points to special considerations for communities when developing policies and procedures:

- ❏ Ensuring for continuation of critical alcohol use treatment and opioid replacement therapy
- ❏ Reducing risk of opioid related deaths - appropriate wellness checks (particularly in private rooms where client issues are less visible) and onsite overdose reversal resources and training
- ❏ Smoking breaks for people in isolation and quarantine - work with public health partners to develop procedures that will limit risk of exposure such as individualized smoking breaks and nicotine replacement therapy
- ❏ Laundry services - some communities are experiencing challenges to find services that will serve isolation or quarantine sites (engage laundry services by promoting the safety practices outline in the 'sanitation' section below or look at hospital laundry service options)
- ❏ Co-locate housing navigators at sites to start re-housing people as quickly as possible and when appropriate/possible in coordination with local coordination entry systems. We will highlight re-housing in the next edition of this guide.

MOUs for Operating Isolation and Quarantine Sites

Communities that are establishing additional shelter, isolation, and quarantine facilities are creating Memorandums of Understanding (MOUs) to support the provision and coordination of services for people experiencing homelessness residing at these sites. Communities are currently considering the following elements in these agreements:

Responsible Parties for the Following Activities

- **Securing Sites/Hotels**: contracting with hotel(s) or other facilities.
- **Screening:** screening people referred by hospitals, providers, and community based testing sites to determine the best location and approval of placements for designated sites.
- **Developing isolation and quarantine guidelines and protocols**: the public health district and health care partners should responsible for developing quarantine and isolation guidelines at each location
- **Staff Training:** training on quarantine guidelines, active monitoring of individuals' health status, and sanitation and cleaning practices
- **Personal Protective Equipment (PPE):** providing PPE to staff and individuals placed in isolation and quarantine units
- **Coordination of Services**: entity responsible for ensuring wrap around services are provided amd coordination across these providers (eg. onsite staffing, daily monitoring of symptoms in

accordance with public health guidelines noted above, social and behavioral health services, transportation, meals, and basic needs.)

Roles of Each Party Involved

Clearly define the specific role of each party. For example:

- State government agencies (Department of Public Health, Office of Emergency Management)
- Local municipalities (city and county government)
- Local public health district
- Local Emergency Management Agency
- Continuum of Care lead agencies, or other lead homelessness agencies or authorities
- Other local health care partners

In some locations state agencies / state public health departments are securing and contracting with facilities, designing quarantine practices and protocols, training, and supplying PPE, while local municipalities are coordinating operations and local wrap around services for sites in their respective jurisdictions.

Mutual Responsibilities of Parties

Any cross-cutting responsibilities are also noted, such as:

- Complying with isolation and quarantine guidelines
- Identification of project leads within each party who is empowered to make decisions
- Identification of sufficient resources in preparation for possible influx of new cases
- Establishing funding agreements to pay for leased spaces and services

Insurance

Communities are considering what types of insurance are needed leasing and contracted facilities and are exploring options for general liability insurance. This may include insuring the facility itself, any vehicles that will be used for transportation, or worker's compensation for employees. Key considerations for obtaining insurance include:

- State laws may permit self-insurance through existing policies with state agencies. You may contact your state office for workers compensation, office of risk and insurance, or general agency to explore self-insurance policies.
- Other jurisdictions have opted to contract for insurance coverage. In one community, the structure was set up as commercial liability coverage up to $1,000,000 per claim and $2,000,000 aggregate. The policy should cover the city government or other agency leasing the facilities and any independent contractors in their employ.
- Check with local supportive housing providers who operate project based or master leased sites to understand how they structure insurance for these types of sites.

Leasing Agreements and Contracts with Hotels

In addition to an MOU to support additional shelter, isolation, and quarantine facilities, communities are developing lease agreements or other contracts with the selected facilities (i.e. hotels). This is true even in states where governors have signed executive orders permitting the emergency use of such facilities. Communities may want to consider the following elements in these agreements:

Standard Lease Terms

- Description of the premises, including address, how many rooms you will occupy
- Duration of the lease and conditions of renewal
- Amount of rent (and security deposit, if required) that will be paid to the owner, including how and when funds will be delivered
- Facilities and appliances within the space you will use, including utilities, laundry, kitchen equipment, and parking spaces or structures
- Conditions for termination of the lease (written notice, 30 days)
- Responsibilities of the tenant and owner for maintenance of the facility
- Responsibility of services, utilities, supplies (e.g. trash disposal, water service, elevator service, electricity or gas, pool/pool equipment, linen/laundry service, hotel housekeeping or janitorial services)
- Assignment of lease (if one entity is leasing on behalf of another)
- Damage provisions

Employment Practices

State laws during this time may be suspended. Certain procurement requirements and other elements may be waived for a short period of time during this crisis. Some communities are considering enhanced payment for employees at shelters or other sites where people are being served.

If the state is a contracting entity for your leased premises, you may be obligated to comply with additional laws and regulations, depending on your jurisdiction. This may include:

- Fair hiring practices
- Prevailing wage laws
- Employee hazard protections
- Workers compensation

Insurance (see previous section)

The premises will need to be insured for the duration of the tenancy. The insurance information and coverage amounts should be included in the occupancy agreement or lease. This may include:

- General liability coverage
- Vehicle insurance for transportation

- Workers compensation insurance.

Leases and landlord/tenant law is state-specific. Depending on your state, there may be different requirements in addition to the above. Check your state Department of Housing for more information. In addition, if you are using federal funds, there may be specific federal requirements that will need to be included. Those requirements would be included in the funding mechanism (contract) awarding those funds.

Screening, Triage, and Referral Strategy

To slow the spread of COVID-19, the [CDC recommends](#):

- Screening for symptoms at shelter entry to help make decisions about how to separate those who could have COVID-19
- Directing symptomatic individuals to where they can stay, either within the shelter or at another location.
- Making decisions based on a predesignated plan (i.e workflow) developed with the local CoC, public health department, and community leadership.

Communities are developing trauma informed screening protocols to ensure all people who are living in shelters or unsheltered locations receive appropriate care and fully understand what is happening and to alleviate worries and fears, especially if they are identified as needing to move to another shelter or healthcare site.

Integrated Public Health or Community Based Organization

In many communities, Public Health agencies have led efforts or have become integrated into shelter screening, triage, and referral efforts. Some public health authorities are unaware of the specific steps necessary to support homeless serWhenever possible, having public health or other healthcare staff integrated at the beginning of the process is preferred as community based agency staff are not often equipped with knowledge or tools to address health and medical issues. However, in some communities, community based agency staff are handling the process of screening and ensuring people are separated by symptoms in order to reduce the spread of COVID-19.

In this section, we provide operational considerations and community examples of public health integrated and community based organization approaches.

Screening, Triage, and Referral Procedures

Screening, triage, and referral pathways ensure every person seeking help in the homeless services system receives appropriate shelter and care. Screening tools and triaging processes should be

designed with the staff administering the tool in mind. Some communities have well integrated public health or healthcare staff at the front door of the shelter system, while other communities rely upon front line staff to screen for symptoms.

Screening When Public Health Is or Is Not Involved

Where possible, Public Health or Health care officials should drive the design/implementation of the screening process.

In communities where public health, Healthcare for the Homeless, or other health care staff and supports are built into the client screening and triage process, a more thorough screening can be accomplished. San Diego, CA, and Seattle, WA, have fully integrated public health, and public health nurses perform screening for symptoms.

In other communities, where homeless service providers are taking the lead in the screening process, communities may want to consider a more basic screening tool.

Public Health Integration and Tool Selection

Community	Level of Public Health Integration in Screening Process	Link to Screening Tool
Atlanta	Limited - shelter staff are equipped to perform a simple screen, then refer to health care services when symptoms are indicated	Atlanta Screening Tool
Indianapolis	Somewhat Integrated - front line shelter staff are sometimes supported by public health staff. Either can perform a simple screening and refer to health care when indicated	Indianapolis Screening Tool and Workflow
San Diego	Fully Integrated - Public Health nurses perform screening of people coming to shelter. Nurses have closer connection to health care system to make referrals	San Diego Screening Tool and Workflow

How to Bring Health Care to the Table

Whether formally or informally, homeless service systems have some link to health care services. If your community is struggling to engage public health departments in this time of crisis, think about other health connections that could be leveraged. Some communities are working closely with public/county hospitals and local Health Care for the Homeless providers to ensure the needs of people experiencing homelessness are being met. Healthcare for the Homeless clinics are also a main connector between the homelessnes and health care systems and can be very helpful in making inroads to the broader health network.

What Happens When You are Unable to Screen at Intake

In communities where staff limitations, shelter design or other factors make it impossible to conduct screening at the front door of a shelter or agency, the importance of understanding where screening is

being conducted in your community and consider transporting clients to those sites prior to shelter entry. Make sure to have connections to public health and healthcare facilities where a client can go to be screened to ensure warm handoffs and referrals. Decide whether a person can be brought into the shelter without screening. Is there enough space between beds for appropriate social distancing? Are hygiene and cleaning practices being followed?

Operational Considerations During Screening and Triage

- Enforce social distancing for all staff and clients during screening and check in: In locations where people are waiting in line, tape off sections for standing 6 feet apart.
- Post signs discouraging person to person contact.
- Limit person to person contact during screening: pat downs, handshakes, fist bumps, hugs, etc. An agency wide protocol for screening people should be developed and communicated to all staff. This can be a simple document that outlines the process from a client's point of entry through each "station" or point of screening before being assigned a bed or room.
- Post signs in appropriate languages to communicate to people entering that they will be screened at entry in order to keep them safe, and then additional signs to communicate the process.
- Open a waiting area with social distancing considerations, even if the screening area is outside, for people to wait to be screened.
- Think through surfaces that need to be repeatedly sterilized in the screening and check in area: chairs, barriers, tabletops, etc.
- Consider where people will put their belongings during screening and make sure there is a place for belongings to be put down as check in will take longer than usual
- When possible, make restrooms available for people waiting to be screened and checked in, but such facilities will need to be regularly cleaned and sanitized.
- Consider how other check in and security screening such as wanding, bag checks, tool check ins, etc. should happen.
- If the shelter is separated into isolated is configuring separate areas in which people can be isolated, ensure a safe route for a person to get to their bed or room without exposing or being exposed to others
- Ensure that all staff know exactly where people will be sheltered based on screening outcomes, and ensure procedures for clearly communicating this information to clients to aleve worries/fears
- If a person is found to be symptomatic or has potential exposure and will be taken to another site, ensure an isolated place to wait for transport is provided
- Develop clear protocol for how to call transport to pick up people who will be cared for at different site (see 'transportation' section below)

Transportation Approaches

Transportation plays a vital role in supporting people who exhibit COVID symptoms to move between service providers and isolation/quarantine facilities. Many communities are thinking creatively about

transportation options and have retrofitted local buses and other public transport vehicles to enhance the safety of these vehicles and meet increased demand.

The Los Angeles County Department of Public Health provides the following transportation protocols to prevent the spread of COVID-19 which could be considered when designing protocols with local public health partners.

- Limit transport of all clients to essential purposes only. Non-essential transportation should be postponed or cancelled.
- When transportation of symptomatic clients is necessary:
- Symptomatic clients should NOT be transported with non-symptomatic clients.
- Have symptomatic clients wear facemasks.
- Avoid transporting multiple symptomatic clients together.
- When multiple clients need to be transported simultaneously, appropriate social distancing (> 6 feet) should be practiced both for clients and the driver.
- The client should be placed on the opposite side of the car farthest away from the driver's seat.
- Vehicle windows should be rolled down to improve ventilation in the car.
- Transporting vehicles should be outfitted with plastic tarps or coverings that can be cleaned and appropriately disinfected after each transport.
- Include supplies for good hygiene, including tissues, trash cans or trash bags for disposal of used tissues, and alcohol-based hand sanitizer.
- If you plan to transfer the client to a higher level of care due to worsening respiratory status, notify EMS or other transporters that the client has an undiagnosed respiratory infection.

See the CDC's Interim Guidance for Emergency Medical Services (EMS) Systems for more information about recommended PPE for transporting clients with possible COVID-19 and cleaning transport vehicles.

Drivers should be trained on COVID-19 recommendations, how to wear PPE, and how to sanitize their vehicles after each transport. Drivers should also receive training on how to avoid bringing the virus home with them.

Staffing Models and Considerations

Several communities are currently designing new staffing structures to meet the needs of local COVID response efforts in partnership with local public health and emergency management partners. This includes staffing:

- For existing services (shelters, outreach, etc) as shelters reconfigure and axillary shelters are stood up to meet growing demand
- For new congregate and non-congregate isolation and quarantine facilities, in coordination and partnership with local health partners

- To backfill staff who are unable to work due to caretaking responsibilities or illness

Identifying Staffing Needs

To assess staffing needs, communities are considering these types of factors:

- **Space**: Size and configuration of the facility has implications for the number of staff needed.

- **Services Required**: To fully operate the facility, a range of services may be needed such as screening (at intake and ongoing); symptom/Medical monitoring to identify if/when a lower or higher level of care or different type of setting is needed; non medical services (e.g., food, hygiene, laundry, mental health, substance use services/treatment); medication management services; site monitoring and/or security; janitorial services; transportation services; adn rehousing services.

- **Skills, Training, and Cultural Competencies**: What training or education is needed to perform the required activities? What languages will need to be spoken on-site or available via real-time translation services? What training is needed if staff recruited do not have backgrounds in homeless services? What are opportunities for leveraging people with lived expertise?

- **Gaps and Needs**: Which activities can be performed by existing on-site staff (e.g., shelter staff, motel staff, convention center staff) and which will require supplemental staffing? What activities can be done virtually and what must be done on-site? Which staff needs will require new hiring and which entity(ies) will do the hiring?

Filling Staffing Needs

Securing staff needed to operate new facilities has been a challenge for many communities. Public health and emergency management staff should be employed to the fullest extent possible, however it is likely that supplemental staffing will be needed. Communities are exploring the following sources to meet staffing needs:

- Non-essential city or county positions that can be repurposed/re-assigned temporarily
- Health Care for the Homeless or other Federally Qualified Health Center staff
- CoC or Coordinated Entry staff who may have had their hours reduced due to COVID impacts
- Other community- and faith-based organizations
- Peer experts/people with lived experience of homelessness, who may be particularly valuable candidates for many needed positions
- Graduate students, especially in social work or medicine-related fields.
- Managed care organization housing navigators or housing specialists
- County mental health staff
- University partners
- National Guard humanitarian support
- Medical Reserve Corps
- Red Cross staff/volunteers

- Volunteers

It may also be necessary to hire for new temporary positions. (See example job listing for temporary emergency shelter staff positions.)

Staffing Models

The precise configuration of staffing will vary depending on type of site (congregate or non-congregate) and purpose (overflow shelter or isolation/quarantine/recovery center) of the facility. Below are staffing considerations and models from communities currently operating quarantine and isolation sites.

New Orleans Isolation and Overflow Shelter Capacity

The City of New Orleans is moving people experiencing homelessness into hotels as quickly as possible as part of their COVID-19 response efforts. See the City's Staffing and Location Plan for more information about their staffing mode, which includes:

- Program manager and program supervisors
- Resident advisors
- Case managers
- Security and safety coordinators

King County Example

King County is operating Isolation & Quarantine Sites. More information about their staffing structure can be found here.

Congregate Assessment and Recovery Centers

AC/RC sites are emergency mass care facilities aimed at reducing hospital overcrowding. In King County, the following staffing structures are being used:

- Public Health-supervised care supports patients in recovery
- At a minimum, each site has an onsite director and physician, clinical staff and non-medical professionals, with numbers of staff based on the numbers of patients admitted (i.e., using one structure or two)
- 24/7 on-site health care staff and 24/7 on-site behavioral health staffing via combination of on-site and telemedicine
- 24/7 onsite security personnel, monitoring both interior and exterior
- On-site pharmacy staff
- Non-medical staff to check in with patients multiple times per day to identify any basic need
- Supplies delivered to the door; no person-to-person contact between patients/delivery persons
- Social worker or coordinator for discharge planning.

    This charts depicts King County's staffing model for its assessment and recovery centers:

AC/RC Staffing Model
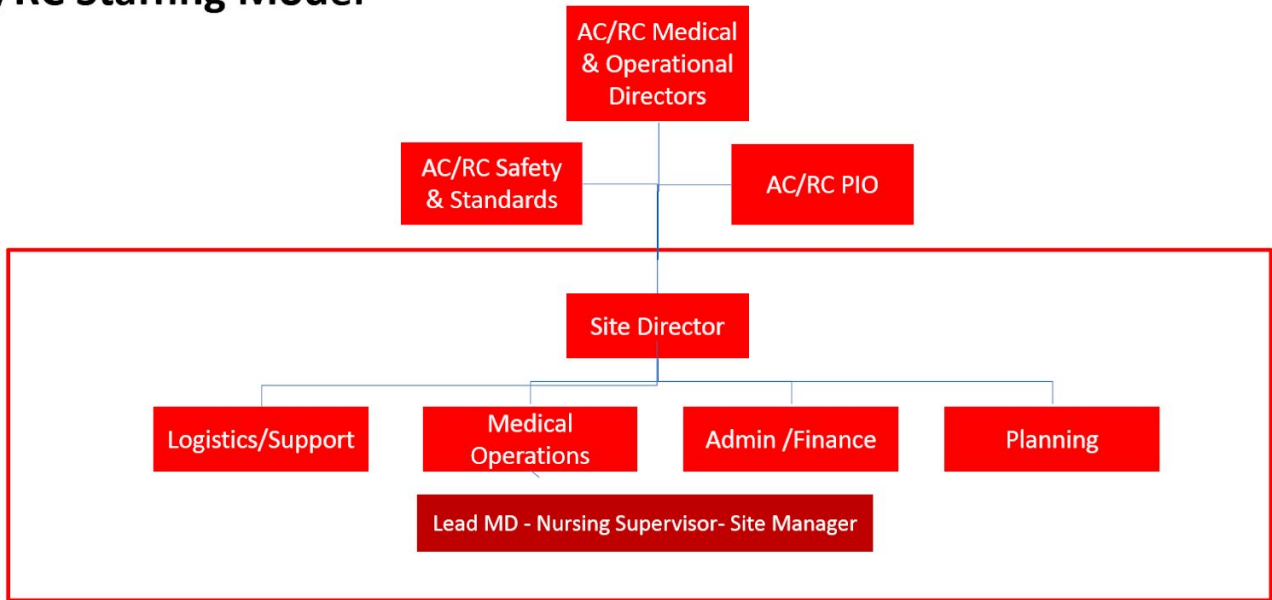
AC/RC Staffing Model

	Health	Day	Night		Admin/Ops	Day	Night		Security	Day	Night
Fixed Number per site	Nursing Supervisor	1	1		Administrative Support	2	0				
	Discharge Planner	1	0								
Scalable Per 70 Patients	ARNP/NP/PA	1	1		Operations Staff	7	5		Site Security	3	3
	RN/PHN	13	7								
	CAN/LPN	6	3								
	Bevahioral Health Provider	2	1								
	Behavioral Health Specialist	4	2								

	Day	Night		Day	Night		Day	Night		Total Staff Day	Night
Staff for a 140 Bed AC/RC	54	29		16	10		6	6		76	45
Staff for a 350 Bed AC/RC	132	71		37	25		15	15		184	111

Sanitation Considerations

CDC recommendations regarding Cleaning and Disinfection for Community Facilities are aimed at limiting the survival of COVID-19 in non-healthcare facilities, and provide guidance for employees regarding sanitation, handwashing, and cleaning laundry. Similar recommendations were recently provided to homeless service providers in Washington DC which includes guidance about:

Housekeeping

- Clean facilities routinely and effectively.

- Clean frequently touched surfaces, such as doorknobs, door handles, handrails and telephones, as well as non-porous surfaces in bathrooms, sleeping areas, cafeterias and offices (e.g., floors), using an EPA-registered hospital disinfectant that is active against viral pathogens.

- Place waste baskets in visible locations and empty regularly.

- Ensure that waiting areas, TV rooms and reading rooms have adequate ventilation (e.g., open windows if practical).

- Linens, eating utensils and dishes belonging to those who are sick do not need to be cleaned separately, but should not be shared without thorough washing. Instruct cleaning staff to avoid "hugging" laundry before washing it to avoid self-contamination. Instruct cleaning staff to wash their hands with soap and water or an alcohol-based hand sanitizer immediately after handling infected laundry.

Keeping clients and employees informed

- Describe what actions the facility is taking to protect them, including answering their questions and explaining what they can do to protect themselves and their community.
- Provide educational materials and information to clients and visitors in a way that can be understood by English and non-English speakers.
- Post flyers and have credible educational information clearly visible and available to staff and clients:
    - [Symptoms of COVID-19](#)
    - [Stop the Spread of Germs](#)
    - [Stop the Stigma](#)

Medical Waste

Based on [CDC Waste Management guidance](#), medical waste (trash) coming from facilities treating COVID-19 patients is no different than waste coming from facilities without COVID-19 patients. CDC's guidance states that management of laundry, food service utensils, and medical waste should be performed in accordance with routine procedures. There is no evidence to suggest that facility waste needs any additional disinfection

Daily Sanitation Checklists

The following checklists have been adapted from [HUD's Infection Disease Toolkit](#). Checklists are a useful way to ensure cleaning and sanitation tasks are done correctly and at the right time. The checklists in this section can be modified to suit your needs and procedures.

[Checklist #1](#): General Sanitation Checklist for Shelters

Shelter staff can use this checklist to implement sanitation guidelines at key operational intervals, such as before daily entries/exits, in between staff shifts, and before and after mealtimes.

Checklist #2: Operational Checklist Example: Staff and Shift Assignments for Kitchen

Create an operational procedure checklist such as the example shown below for each area of the shelter such as common areas, bathrooms, dining areas, kitchens, and sleeping areas. Note subtasks and procedures specific to each area.

Checklist # 3: Daily/Weekly Cleaning Schedule

Checklists, such as the example below, should be kept in plain view on a clipboard or bulletin board to ensure all areas are cleaned as needed and assigned. Ensure the list includes all areas needing cleaning and the appropriate frequency for each cleaning. Staff members should initial the corresponding box once the task is completed and record the time completed.

Front Line Staff Training Resources

In a public health emergency, it is important to ensure staff are fully trained on strategies for preventing and slowing the spread of the disease. The following training resources are targeted staff providing direct services.

Managing and Slowing Spread of COVID-19

UC Berkeley released this video series by the COVID-19 Community Action Team. It was developed for youth providers, but the information is more broadly applicable.

The videos can be played as a playlist or individually

- The first video is an orientation to the series.
- The second video is an orientation to symptoms of COVID-19 and the screening process.
- The third video is an orientation to triage of clients after they are screened.
- The fourth video is an introduction to personal protective equipment (PPE) and guidelines for PPE use for staff.

The CDC also released targeted guidance for key actions local and state health departments, homelessness service systems, housing authorities, emergency planners, healthcare facilities, and homeless outreach services can take to protect people experiencing homelessness from the spread of COVID-19.

Sanitation Training

King County released a sanitation and hygiene webinar for homeless service providers.

Los Angeles released this Public Health Preventing the Spread of Respiratory Illness Poster.

Use of PPE

Sequence for Putting on and Removing Personal Protective Equipment (PPE) from the CDC

How to Care for Someone with Symptoms

Interim Guidance on How to Care for Someone with Symptoms Consistent with COVID-19

Disaster Response for Homeless Individuals and Families: A Trauma-Informed Approach from the U.S. Department of Health and Human Services

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Appendix 1: Definitions and Context

Asymptomatic: People who are exhibiting no symptoms of COVID-19. People who are asymptomatic may continue to reside in a shelter.

Symptomatic: People who are exhibiting new symptoms associated with COVID-19 which include: fever, cough, shortness of breath. People who are symptomatic may continue to reside in a shelter and be monitored for worsening conditions.

Screening: The CDC has recommended that shelters screen people when entering a program every day. Screening should include checking if people entering a program are exhibiting recent symptoms for COVID-19. Symptom screenings include checking for fever, cough and shortness of breath.   Screenings will determine if people are symptomatic or asymptomatic. Examples of community screenings can be found on the HUD exchange.

In some communities, shelter managers are screening for COVID-19, in other communities DPH staff or Healthcare for the Homeless staff complete screenings.

Testing: People tested should be isolated until results are received. Testing is often conflated with screening-know the difference. Testing will likely not be a significant component for the majority of cases. Several health systems are only testing when the result will impact

Overflow: To accommodate social distancing guidance from the CDC, many communities have reduced capacity in homeless shelters. Many CoCs are establishing overflow sites. These overflow sites are providing critical capacity to maintain beds in the community or to expand bed availability. These overflow spaces are a critical part of the response in many communities.

In some CoCs, overflow spaces have been easy to find and communities have used available winter emergency shelter space. In other communities these spaces have been more challenging to identify.

Social Distancing/Social Isolation/Quarantine -These words are being used interchangeably. Maintaining distance from others in order to slow disease spread. Social distancing can be practiced at hotels/motels, shelters and outside in encampments. Some communities are using these terms rigorously, consistent with their public health definition, and others are using the clinical context.

Isolation: Isolation is also the technical term when healthcare professionals instruct someone who is confirmed positive and/or presumptive positive to separate from others to limit the spread of the virus. This can happen in hotels/motels.

Emergency Management Agency: County Emergency Management agencies are responsible for leading community responses to disasters. Increasingly County and State Emergency Management Agencies are coordinating COVID-19 responses. Many communities have started planning for quarantine and/or isolation spaces. These spaces should be available to anyone who needs these services. CoCs should be included in these planning discussions. If Emergency Management Agencies are leading planning on issues like quarantine/isolation, help the CoC establish a relationship with this department by reaching out to the Director's office.

Department of Public Health: In a public health emergency like COVID-19, County Departments of Public Health (DPH) lead the community response. CoCs should have a point of contact in this department to provide them with guidance and support. If they do not have this relationship in place, HUD TA should help them establish this connection.

DPH are set up differently throughout the country and there is often no established point of contact for homeless planning. Typical points of contact for the CoC can be Policy Advisors, Infectious Disease Coordinators and Epidemiologists. DPH should be guiding the homeless response as a component of the overall effort and be available for questions and problem solving.

Departments of Health should be concerned about the homeless response to COVID-19 because it is a vulnerable population. As TA providers we want to support grantees' access to DPH resources and ensure awareness of HUD and CDC resources to help frame the conversation.

Healthcare for the Homeless and other community based health clinics-Important partners that locally can have differing levels of involvement. CoCs should be maximizing this relationship to support shelter and street outreach teams.   National Health Care for the Homeless Council has been a vital partner assisting HUD and CDC to develop targeted guidance for local communities.

HUD Policy Positions

HMIS: CoCs should use HMIS to track COVID-19 data if it makes their workflow easier. Communities should focus on collecting the information they need to save lives or quantify need

Encampments: Communities should not be closing encampments unless there are better housing solutions being offered. Outreach to people in encampments should continue abiding by CDC guidelines.

Shelter: Shelters can be reconfigured to serve both asymptomatic and symptomatic people.   CoCs should work with the community to determine how each shelter in the portfolio will respond to COVID 19. Shelters should not close without planning contingencies.

Appendix 2: Community Examples

(Section in development)

Congregate

Fort Worth, Texas	
Overview	The CoC, City and County Hospital collaborated to open shelter space at the local convention center as overflow space to allow appropriate social distance in current shelters. The convention center can house up to 355 people each night. Clinical services and screening are provided. Alternative spaces are available for symptomatic clients and RVs in the parking lot of the convention center are used to shelter COVID-19 positive guests.
Facilities	Convention Center and Isolation RVs Provided Onsite
Funding Source(s)	City reserve funds approved under emergency designation, with anticipated Federal backfill; and County Hospital Funds Diverted from closed School Clinics and reduced hours at the clinic that typically serves persons experiencing homelessness
Operational Roles and Services Provided	The JPS County Hospital screens guests for placement at the convention center. Testing is available onsite and all symptomatic and positive guests are provided PPE. The county hospital is co-located on the first floor to provide clinical services and screening and triage guests. MedStar Mobile Healthcare is providing transportation to the convention center from hospitals, clinics, and other designated transport sites. The CoC holds a daily morning conference call with key community and service provider agencies and closes the day with an email update. The county hospital supports screening, training, medical street outreach, medical observation, and hospitalization as needed with connection to the department of public health for specific needs. All meals are provided to guests during their stay.
Additional Resources	Coronavirus Resources

Seattle and King County, Washington	
Overview	Assessment Centers/Recovery Centers (AC/RC) are large, congregate care facilities designed to provide Public Health-supervised care to symptomatic or COVID positive adults who are not able to follow public health guidance for isolation, quarantine, or recovery in their own home, or because they do not have a home. These can serve as flex space for hospitals, making it possible to discharge non-serious COVID cases to the AC/RC, freeing hospital beds for the most acute cases. AC/RC can serve up to 350 per location. Transportation to and from the centers is provided by the city and/or county.
Facilities	Hotels, Vacant Land and Properties, Parking Structures; More facilities are currently being identified (to maximize staffing and equipment resources, the city and county are focused on larger sites as opposed to a greater number of small sites).
Funding Source(s)	The county is seeking reimbursement though state and federal funds.

Operational Roles and Services Provided	Up to 80 staff per site, including clinical staff and non-medical professionals, depending on the facility size.
	Each site will have an onsite director and physician. These centers are designed for recovery and no procedures beyond basic care will be performed. Anyone needing acute care or medically necessary procedures will be transported to a licensed medical facility.
	Public Health workers and nursing staff will provide basic care and monitoring.
	Three security personnel are onsite at all times, monitoring both interior and exterior.
	Support staff provide meals for all guests via bedside delivery. No congregate meals are severed. Support staff also provide onsite laundry services.
	Remote pharmacist available for medications not carried onsite.
	In addition to providing testing for high-risk populations, each facility will provide separate isolation spaces for people awaiting test results and for those who test positive. All laboratory analysis will be done off site.
	Partnership with local animal shelters to board pets offsite. Staff will provide reunification and other discharge planning.
Additional Resources	AC/RC Center Announcement COVID-19 Webinar AC/RC Fact Sheet COVID-19 Response Presentation

Connecticut	
Overview	The Connecticut Department of Housing has partnered with CT Coalition to End Homeless to "decompress" the shelter population by contracting with area Hotels through DAS. An analysis of shelter square footage and census identified shelters that are too crowded by CDC standards for 6' of space between beds. DOH first moved elderly and medically fragile persons from shelter to hotels and are now focusing on shelter decompression overall.
	Efforts are also underway to identify and set up isolation/quarantine locations which will also be open to the homeless population. Some are specific to the homeless population while others are open to anyone who cannot go home and safely self-isolate. These sites are being coordinated through local municipalities, the regional Department of Emergency Management and Homeland Security and local hospitals. The CT Hospital Association is also playing a role in coordination with the homeless providers.

Facilities	Hotels and Motels, Churches, Unused Dormitories,Closed nursing homes, Community Facilities (e.g., YMCA, Armory buildings)
Funding Source(s)	State funds through the Office of Policy and Management; Federal funds through the stimulus package and existing Housing and Urban Development (HUD) grants.
Operational Roles	**Department of Housing (DOH)** is overseeing and co-leading the effort to obtain additional housing. **CT Coalition to End Homelessness** is overseeing and co-leading the effort to obtain isolation and overflow shelter. They are providing staff support, troubleshooting logistics, communication, data and tracking, and municipal communication. Shelter staff have been spread to new sites, supplemented with temps from a staffing agency. At this time, volunteer operations have been suspended due to increased risk. Meals are served by staff onsite. **CAN regional leaders** areIdentifying shelter decompression needs, developing a plan for transportation, staffing, and meal delivery to relocated residents, as well as tracking data and costs. **Department of Administrative Services (DAS**) is responsible for hotel outreach, negotiation, and contracting. **Department of Emergency Management and Homeland Security (DEMHS**) is providing legal support, oversight, interagency coordination, regional coordinators assisting with logistical support and municipality communication as needed. Janitorial staff have been contracted to clean all sites. Medical professionals are available through telehealth options.
Additional Resources	Executive Order COVID-19 Resource Guide

Non Congregate:

New Orleans, Louisiana	
Overview	Local public health officials directed the City to move all unsheltered people into sheltered locations as quickly as possible, as increasing numbers of rodents in encampments may exacerbate current public health risks. City and County partnered to lease multiple floors in hotels to temporarily house 150 people experiencing homelessness. These locations will also be used for isolation and quarantine units.
Facilities	Hotels

Funding Source(s)	Housing and Urban Development (HUD) grants, local and state funds, non-profit contributions
Operational Roles and Services Provided	Security is assigned to every floor to encourage compliance with quarantine. Services are provided by contracted private agencies and the **Fire Marshall**. **The National Guard** has been deployed to assist with equipment and supplies. **New Orleans Health Department** is providing behavioural health services. **Unity of Greater New Orleans, local nonprofits** and the **state of Louisiana** is providing management and operations staffing. There is one program manager, two program supervisors, and numerous resident advisors at each site. Program managers and supervisors oversee operations, make referrals for behavioral health interventions, and are responsible for escalations and evictions. Resident advisors monitor floor activity, coordinate with security, and ensure distribution of clothing and other personal supplies to residents. Case managers vary by location, but are available to assist with housing plans, HMIS data entry, and other support functions. All guests are provided meals and have access to cleaning and laundry services. Local police, the National Guard, and shelter staff screen clients for COVID-19 symptoms upon entry.
Additional Resources	[Unity of New Orleans COVID-19 Updates](#)

Seattle and King County, Washington	
Overview	To increase the safety of shelters, Seattle and King County are screening guests for COVID-19 symptoms. Symptomatic guests awaiting test results are moved into isolation housing.
Facilities	Hotels, Trailers
Funding Source(s)	The county is seeking reimbursement though state and federal funds.
Operational Roles and Services Provided	Onsite nurses and behavioral health staff are available 24 hours to conduct symptom monitoring and support other health needs. Substance abuse support, including methadone, is available to support harm reduction and disincentivize leaving isolation. An onsite shelter manager coordinates logistics and supplies needed. Support coordinators and general staff assist with other basic needs, including meals, and coordinating transportation. These staff also open doors and place needed items in rooms, but do not have any face-to-face contact with guests.

	Healthcare providers coordinate discharge. If a guest is positive and requires continued care, appropriate arrangements are made and travel is provided. If a guest is negative and asymptotic, they are discharged back to their community or a shelter.
Additional Resources	COVID-19 Webinar Isolation and Quarantine Policies Video: Inside Quarantine Facility COVID-19 Response Presentation

Los Angeles, California	
Overview	Under the Governor's disaster declaration, Los Angeles Family Housing was able to enter into emergency occupancy agreements with local hotels to procure 70 rooms. Guests are screened and symptomatic clients are moved into isolation housing. Couples that are symptomatic may isolate together in this space and pets are allowed in the hotel rooms.
Facilities	Hotel Rooms
Funding Source(s)	Office of Emergency Management, County of Los Angeles
Operational Roles and Services Provided	Shelter intake and Public Health staff screen guests for COVID-19 symptoms. **LA Metro** has retrofitted public busses to transport guests safely. Onsite nurses and behavioral health specialists are available to monitor symptoms and support health needs. Substance use support and overdose prevention is available onsite. Telehealth is available for psychiatry and prescriptions. **Office of Emergency Management** staff act as site and facility managers, coordinating janitorial needs, security, and maintenance. Guests are allowed to visit an outside space when accompanied by a coordinator with 6 feet of social distance. Movement inside the hotel is limited. Non-profit shelter staff are purchasing agents for all supplies, including food. Guests are provided three meals per day. Discharge coordinators monitor guests and plan for release into vetted housing situations or shelters when symptoms are no longer present.
Additional Resources	LA Family Housing COVID-19 Response