Housing as Health Care During and After the COVID-19 Crisis

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Abstract:

The COVID-19 crisis has illustrated clearly that "housing is health care." The 567,000 people experiencing homelessness in the U.S. face heightened risk for contracting COVID-19 due to the circumstances surrounding their lack of housing. Simultaneously, an outbreak of COVID-19 among people who are homeless could threaten already burdened health systems, showing the critical interconnections between housing and health care. We describe strategies to mitigate the impact of COVID-19 for homeless populations and for the health care system. Looking forward, we suggest that guaranteeing housing for all is an essential step toward reducing the societal burden of the next pandemic.

Keywords: COVID-19, coronavirus, homelessness, housing

Housing as Health Care During and After the COVID-19 Crisis

As public health authorities recommend stringent stay-at-home orders to reduce risk of COVID-19 spread, each night there are over 567,000 people in the U.S. for whom these recommendations are impossible because they are homeless—living in shelters, cars, or unsheltered environments.[1] People experiencing homelessness have always suffered from greater health risks and lower life expectancy than those who are housed, but the COVID-19 crisis makes clear how the conditions of homelessness present an immediate and grave threat to the health of homeless populations and create a potential tinderbox for the spread of the virus. If COVID-19 is not well-controlled in homeless populations, not only will those experiencing homelessness suffer, but so will the entire health care system.

For homeless individuals, admonitions to practice social distancing, to stay home, and to wash hands frequently are incongruent with their situation. Most homeless shelters consist of congregate dormitories, whose crowded conditions and shared bathrooms render social distancing challenging, if not impossible. Unsheltered homeless people have limited access to adequate resources for basic sanitation practices such as hand washing. As locations where unsheltered homeless people might have previously sought food or hygiene resources—such as fast food restaurants or libraries—adapt or close under local regulations, unsheltered people may face no choice but to use congregate meal programs or drop-in centers to meet their basic needs.

Compounding these challenges, the homeless population has aged over the past two decades. In Los Angeles County alone, over 4,700 homeless people were over the age of 65 in 2015.[2] Homeless individuals have a high prevalence of cardiopulmonary diseases, diabetes, and cancer. Therefore, not only are homeless people at higher risk for contracting COVID-19, they are at higher risk for having a

severe disease course requiring hospitalization, and for mortality. A largescale outbreak amongst the homeless population could further overwhelm the health care system and contravene efforts to "flatten the curve." COVID-19 has made evident what we have always known: homelessness is extremely dangerous to all who experience it, and has large societal costs.

Policy Makers Must Consider Homelessness in Emergency Management Plans

In the setting of widespread homelessness, emergency management plans must count not only hospital beds, ICU beds, and skilled nursing facility beds but also homeless shelter and medical respite beds, and devise rational strategies incorporating consideration of the best uses for all of these settings. Adequate consideration of homelessness in federal, state, and local emergency management plans is essential.

There are several potential strategies to mitigate the impact of COVID-19 for homeless populations. (Figure 1) These include setting up locations for isolation of homeless people with possible or confirmed COVID-19. Communities must also act urgently to protect people who are homeless by moving them out of unsheltered and congregate settings into locations that allow for appropriate self-care and social distancing, such as hotel rooms, which are newly available due to travel restrictions. California has negotiated to receive 75% reimbursement from FEMA for hotel rooms for priority populations.[3] While moving people experiencing homelessness into safe individual rooms is the hallmark of an effective response to mitigate COVID-19 transmission, other interim strategies include attempting social distancing in shelters and providing hygiene stations to unsheltered individuals.[4] Recent information suggests that screening people experiencing homelessness for symptoms of COVID-19 is

insufficient to identify all individuals who have COVID-19 and require isolation, as many people may be asymptomatic.[5]

While localities will implement these strategies, support from state and federal policy makers is instrumental. For example, Connecticut Governor Ned Lamont issued an Executive Order to provide "non-congregant" housing to vulnerable groups including people who are homeless during the COVID-19 crisis.[6] Virginia Governor Ralph Northam announced $2.5 million in funding to provide temporary housing for unsheltered homeless individuals, including spending for hotel and motel vouchers, case management, and medical transportation services.[7] At the federal level, the Department of Housing and Urban Development (HUD) issued a moratorium on foreclosures and evictions for certain types of homeowners for 60 days in the midst of COVID-19, which could help prevent some homelessness.[8]

Homelessness and the Health Care Sector: Limitations and Necessity

Hospitals throughout the country have long served as stopgap social, as well as medical, resources for people who are homeless, but COVID-19 has quickly limited their ability to fill these roles. In normal times, not only are homeless individuals sicker overall, but there is often a lower threshold for admitting them to the hospital due to their social circumstances.[9] Once hospitalized, some homeless patients spend longer in the hospital,[10] not because they require hospital-level medical care, but because there is no appropriate discharge location. Facing a dire shortage of hospital beds, COVID-19 has made our reliance on hospitals to fill other systems gaps for homeless patients a critical issue.

Communities have faced challenges adjusting to this new reality, due in large part to longstanding systemic disinvestments in housing and homeless services systems. While many

communities have created alternative settings—hotel rooms, isolation rooms in shelters, isolation tents—for those who are suspected of having COVID, these do not yet meet the scale of the need in all localities. Hospitals are left to determine whether to admit homeless patients with mild symptoms of possible COVID to the hospital—taking up a scarce hospital bed—or to take a risk in discharging them into congregate or unsheltered settings. Homeless patients with mild COVID-19 symptoms are in some cases being referred or showing up at crowded emergency departments, further illustrating the interconnectedness of the health care system, the homeless services system, and emergency planning.

Some communities have medical respite facilities, which provide housing and care for people who are homeless and too sick to be in the shelters or unsheltered but not sick enough to need a hospital bed; such medical respite facilities may be particularly valuable during the COVID-19 crisis. To reduce avoidable hospitalizations, public health officials could use the medical respite model to create settings with health care services to care for homeless individuals who are infected, but do not require hospitalization.

Health care and homeless services are locked together with shared fates. COVID-19 has demonstrated both the limitations and the necessity of the health care sector when it comes to addressing homelessness. Health care alone cannot solve the nation's housing and homelessness crisis, and the same is true as it pertains to COVID-19. Planning and action to prevent spread of COVID-19 among people who are homeless are ultimately multi-sectoral and multi-level governmental responsibilities. Yet at the same time, health care must be part of the conversation to implement COVID-19 plans for homeless individuals, who jointly touch both health care and social service systems.

COVID-19 May Create Homelessness. Can It Also Push Us Toward Ending It?

Ironically, without aggressive preventive action, the widespread economic disruptions caused by COVID-19 could lead to dramatic increases in homelessness, which will further widen health disparities. Due to the effects of structural racism, Black and Native Americans are at dramatically increased risk for homelessness.[11] It is unacceptable that over half a million people in the U.S.—disproportionately members of minority groups—face higher risks from COVID-19 due to homelessness, and that millions more face risks of newly becoming homelessness related to COVID-19.

The COVID-19 pandemic has laid bare the myriad ways in which homelessness affects health, both for people experiencing homelessness and for everyone. The needed large, structural changes to fix the housing crisis have come too late for this pandemic. However, once the COVID-19 crisis resolves, let us not forget that society must solve the homelessness crisis that before the next pandemic reminds us of the impossibility of achieving a healthy society without adequate housing for everyone.

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Figure 1. Strategies to mitigate the impact of COVID-19 for homeless populations

Summary of several key strategies recommended for implementation by local emergency management response systems, public health authorities, and/or homeless services agencies, in collaboration with the health care sector.

- **Protect.** Individuals who do not yet have COVID-19 should be moved from congregate shelters or unsheltered locations to private rooms, such as in motels, with appropriate supervision and support services. Older individuals (aged 50 and older) and those with high risk chronic medical conditions are particularly vulnerable to poor COVID-19 outcomes and could be prioritized to move to private rooms first.
- **Isolate.** Set up isolation locations for people who are homeless and who have possible or confirmed COVID-19. If local testing capability allows, people with confirmed COVID-19 should be isolated separately from those with suspected COVID-19. Those with confirmed COVID-19 can be cohorted in a congregate setting (apart from anyone without confirmed COVID-19). Ensure close monitoring for deterioration / progression of symptoms.
- **Quarantine.** Set up appropriate quarantine accommodations for those who are asymptomatic but have had close contact with someone with confirmed COVID-19 (applicable in localities in which there is not yet widespread community transmission, or post-widespread community transmission of COVID-19).
- **Socially distance.** Encourage social distancing within encampments and all locations serving people who are homeless, including shelters, drop-in centers, and meal programs. Be aware that social distancing is important but unlikely to be adequate to fully prevent spread of infection in congregate settings.
- **Ensure good hygiene and other infection control practices.** Set up handwashing stations and other hygiene facilities for unsheltered individuals. Practice good hygiene and cleaning in all locations serving people experiencing homelessness.
- **Screen.** Because neither COVID-19 testing nor screening based on symptoms is perfect, ideally a combined approach should be used. Homeless populations in congregate and unsheltered settings should be prioritized for COVID-19 testing to allow appropriate triage to isolation or other sites. Also actively screen all individuals in or entering shelters or in unsheltered environments for symptoms of COVID-19. Identify protocols for immediate masking, isolation, and further triage for symptomatic individuals. Work with homeless-tailored primary care resources including street outreach teams and use telehealth for triage and ongoing monitoring.
    - Hospitals (inpatient and emergency departments) and ambulatory care facilities must ask all patients with confirmed or possible COVID-19 about housing status, and follow local protocols for discharge of well-appearing homeless patients who do not require hospital admission.
- **Communicate.** Ensure all area hospitals and community providers have a clear referral and transportation protocol in place for when they identify homeless individuals in need of isolation or quarantine. Work closely with local substance use and mental health providers to ensure needs are met for this population. Communicate plans with people experiencing homelessness.

More information on these and other strategies are available online from the CDC, the U.S. Department of Housing and Urban Development (HUD), the National Health Care for the Homeless Council, the National Alliance to End Homelessness, and others.