

NATIONAL
HEALTH CARE
for the
HOMELESS
COUNCIL

September 4, 2020

To the Committee on Equitable Allocation of Vaccine for the Novel Coronavirus:

Thank you for emphasizing the importance of equity when distributing a COVID-19 vaccine, and for the opportunity to provide comments on your draft report, *Discussion Draft of the Preliminary Framework for Equitable Allocation of COVID-19 Vaccine*. We appreciate the attention given to equity as a fundamental value, and the inclusion of several ethical frameworks for consideration.

The National Health Care for the Homeless Council (NHCHC) is a membership organization representing HHS-funded Health Care for the Homeless (HCH) health centers and other organizations providing health care to people experiencing homelessness. Nationally, 300 HCH programs served over 1 million patients in 2,000 locations across the country last year, providing a wide range of services to include comprehensive primary care, mental health and substance use treatment, medical respite care, supportive services in housing, case management, outreach, and health education—all regardless of an individual's insurance status or ability to pay. Most of our patients live on the streets and in shelters, transitional programs, and other congregate settings.

As a network of health care providers serving very vulnerable adults, we are writing to share comments on two issues: the seeming exclusion of frontline health care workers who treat high-risk patients in outpatient community health center settings, and the prioritizing of older adults in nursing homes over homeless populations.

Issue 1: Why are many frontline health care workers left out of Phase 1a? (pp. 58-59)

We are very concerned that Phase 1A (the highest priority group) only acknowledges health care workers in hospitals, nursing homes, assisted living facilities, group homes, and skilled nursing facilities. We also note that morticians, undertakers, and funeral directors are included in this category. The rationale section acknowledges that these workers are important to stem the pandemic and prevent death and severe illness. It also notes that these workers are working in environments where they are exposed to the virus and provide essential care, whereas a vaccination would allow them to

continue services while at the same time not spreading the infection to patients or their own families.

Response: There does not appear to be another category of health care workers listed in the report, yet thousands of clinical and support staff at community health centers, medical respite programs, and other outpatient, community-based settings are on the frontlines every day providing care to people experiencing homelessness. The points raised in the rationale also describe the risks for this workforce as well.

Our HCH programs see 23,000 people every day, with over 5.6 million visits a year. About one-third of our patients have a respiratory illness or cough on any given day and it is common that they do not notice new symptoms that may appear. Many of our services are delivered on a walk-in basis, which puts our primary care providers at regular risk for COVID-19 infection given that basic primary care involves looking into mouths, listening to lungs, and doing a lot of talking with patients about health education. Our pediatric and family population often live in crowded, multi-generational households (which brings unique risks) and our behavioral health providers and case managers are talking together with clients for extended periods of time. The broad—and general—nature of COVID-19 symptoms makes it especially easy for both staff and clients to pass through standard screening protocols. All this is to describe an unpredictable clinical environment where staff are at high risk of COVID-19 infection, and should be included in a Phase 1 priority along with their hospital and nursing home peers.

Further, the description of “critical risk workers” (described in Phases 2 and 3) does not capture the high workplace risk that is currently occurring in these health care settings, nor does it acknowledge the significant contributions that these health care workers have made in keeping very vulnerable patients connected to care and out of the hospitals and emergency departments. Hence the need to clarify that workers in these outpatient clinical venues are included in Phase 1A.

Recommendation: Ensure that Phase 1A specifically includes health care staff working in outpatient settings such as community health centers, medical respite care programs, and other health care settings where high-risk, vulnerable patients receive care. This staff is not only comprised of clinical providers, but also of support staff such as case managers, community health workers, security guards, front desk staff and others who are in direct patient-facing positions with populations that are high-risk.

Issue 2: Why are people experiencing homelessness in Phase 2, behind lower risk populations? (pp. 64-65, 71)

We are concerned that older adults in congregate or overcrowded settings have been prioritized over people experiencing homelessness—to the degree that they are in different phases of vaccine distribution (Phase 1B v. Phase 2). Further, we note that

Draft Table 2 (included below) assesses people experiencing homelessness at a higher level of risk (differences in Criterion #4), which makes the lower priority assessment especially confusing. In our discussion below, we explain why these populations should be considered together as part of the same, high-risk category.

DRAFT TABLE 2 Applying the Allocation Criteria to Specific Population Groups

Phases	Population Group	Criterion 1: Risk of Acquiring Infection	Criterion 2: Risk of Severe Morbidity and Mortality	Criterion 3: Risk of Negative Societal Impact	Criterion 4: Risk of Transmitting Infection to Others	Mitigating Factors for Consideration
1a	High risk workers in health care facilities	H	M	H	H	High risk of acquiring infection due to no choice in setting but may have access to personal protective equipment. Essential to protecting the health care system.
1a	First responders	H	M	H	H	High risk of acquiring infection due to no choice in setting but may have access to personal protective equipment. Essential to protecting the health care system.
1b	People with significant comorbid conditions	M	H	M	L	High risk of severe morbidity and mortality, but may be able to social distance and isolate.
1b	Older adults in congregate or overcrowded settings	H	H	L	L	High risk of acquiring infection due to lack of choice in setting.
2	Critical risk workers (part 1)	H	M	H	M	High risk of acquiring infection due to no choice in setting, but may have access to personal protective equipment.
2	Teachers and school staff	H	M	H	H	High risk of loss to an essential service, but there are alternative choices such as online schooling (lower grades should be given priority).
2	People with moderate comorbid conditions	M	M	M	L	Moderate risk of severe morbidity and mortality, but may be able to social distance and isolate.
2	All older adults	M	H	L	L	High risk of severe morbidity and mortality, but may be able to social distance and isolate.
2	People in homeless shelters or group homes	H	H	L	H	High risk of acquiring infection due to lack of choice in setting.
2	Incarcerated/detained people and staff	H	M	L	M	High risk of acquiring infection due to lack of choice in setting.
3	Young adults	H	L	M	H	Low risk of severe morbidity and mortality, high risk of transmission, but may be able to social distance/isolate/close bars, etc.
3	Children	M	L	M	H	Low risk of severe morbidity and mortality
3	Critical risk workers (part 2)	M	L	M	L	Moderate risk of acquiring infection due to lack of choice in setting.

Not only do many people experiencing homelessness have high-risk comorbid conditions and also live in congregate settings—like nursing homes—but they interact with the community much more frequently, engage in work activities on a regular basis, and have greater “touch points” throughout the services sector. Why is one congregate, high-risk population important enough to categorize in Phase 1, but other congregate, higher-risk populations have to wait until Phase 2?

Response: We strongly disagree that people experiencing homelessness are at lower risk than older adults in nursing homes, and assert they actually are a higher risk group that is more appropriately assigned to Phase 1. To date, we are aware of 226 large-group testing events at homeless shelters and encampments and have test results from nearly 10,000 people—with [a COVID-19 positive rate of 8.37%](#). However, this represents only a portion of testing, so we suspect that the rate may be higher if testing were to be conducted and reported more systematically.

[Research](#) shows that this population has poorer health and greater rates of premature mortality, which increases their risk of infection and illness. Older homeless adults have [even higher levels of geriatric conditions](#)—similar to those found in housed adults 20 years older. Many of our patients meet criteria for skilled nursing and/or nursing home placements, however, they are often not accepted into these settings for various reasons (usually having to do with insurance status, behavioral conditions, or other factors). Our patients have high levels of diabetes, asthma, cardiovascular disease, respiratory illnesses, and other chronic medical conditions—often coupled with mental health or substance use disorders that compound their risk for COVID-19.

We also point out that while both these populations live in congregate settings where they are unable to socially distance, we are unaware of any nursing home that has 60 people sharing a bathroom, 100 people sleeping in a single room, or the level of chaos regularly associated with services. Yet this is the reality of many homeless shelters. Further, encampments often have no hygiene facilities at all, meaning there is no opportunity to wash hands or meaningfully keep a clean environment. Again, we see many factors that increase risk for this population that is not applicable in a controlled nursing home environment. (These same factors likely extend to the staff who work in homeless services settings as they are also exposed to this same environment.)

We also provide comment on the estimated size of homeless population (page 71, lines 1616-1634). There were 568,000 people experiencing homelessness documented at [the last annual point in time count](#), but nearly [1.4 million people were estimated to have used shelters in 2017](#) (the last estimate available, though this is considered a conservative estimate). With unemployment high and an unknown number of evictions occurring in many communities (in spite of the recent CDC order on a moratorium), rates of homelessness are likely to be higher than in previous years. Hence, higher numbers of vaccines likely need to be reserved for this group.

Recommendation: Assess people experiencing homelessness at the same level of risk as older adults in congregate settings, placing BOTH populations in Phase 1. We do not believe splicing these populations apart serves the equity framework that had been described previously in the report. It also raises concerns about differentiating between “the deserving” v. the “undeserving,” which is a long-standing issue in how resources are allocated in the United States.

Finally, we would like to add several comments about distribution of a vaccine that would be important to consider in order to ensure a smoother implementation:

- We whole-heartedly agree with the Framework's recommendation that it is in the national interest that Medicare and Medicaid provide free vaccine administration (p. 77), that those who are uninsured should get access to the vaccine as well (p. 78), and that all individuals in the United States, regardless their immigration status, receive the vaccine (p. 79).
- We recommend developing guidance that allows HUD homeless services providers to better understand how they can facilitate access to and/or promote the availability of a vaccine (and/or partner with a health care provider) in order to better protect a high-risk group that can be challenging to reach.
- We encourage making it a requirement that jurisdictions identify specific goals for reaching vulnerable populations, and to report demographic information such as race/ethnicity, housing status, and general income levels. This would allow the public health community to understand how well it is reaching specific populations and adjust its approach if needed. We also encourage requiring regular data analysis and timely corrective action plans in response to disparities in vaccine distribution.
- We recommend developing an outreach campaign that is culturally competent and specifically designed to educate those experiencing homelessness about the importance of a vaccine. This would be very helpful to service providers, who otherwise are on their own to determine how to best discuss the vaccine with their clients, which is likely to have wildly disparate results.
- Finally, we need to emphasize the critical importance that the COVID-19 clinical trials for a vaccine be conducted safely and with integrity. We are very concerned that short-cuts and expedited schedules for production will not only compromise the quality of an initial vaccine, but will undermine the acceptance of any vaccine that is made available—especially among vulnerable people. This jeopardizes all the goals of producing a vaccine.

Thank you for the opportunity to comment on the *Discussion Draft of the Preliminary Framework for Equitable Allocation of COVID-19 Vaccine*. We appreciate your considering our perspectives, and welcome an opportunity to talk further with you about issues related to homelessness.