

Standards for Shelter- Based Health Care

Authors:

Mary L. Tornabene, MS, APRN, FNP-BC, Heartland Alliance Health

Thomas Huggett, MD, MPH, Lawndale Christian Health Center

Editors:

Jess Lynch, MCP, MPH, Illinois Public Health Institute

Eric Tornabene, Editor

Contributors:

Angela Moss, PhD, MSN, APN-BC, RN, Rush University

Todd Stull, LCSW, Journeys The Road Home

Heather Duncan, PhD, MSN, APRN FNP, North Park University and Lawndale Christian Health Center

James Anderson

Luchata Batipe

Evelyn Figueroa, MD, UI Health

Sabina Wong, MD, PCC Wellness

Keiki Hinami, MD and Christine Haley, MSSA, Cook County Health

Nancy Heil, MD

Laura Pabalan, MD and Karen Lui, MD, Rush University Medical Center

Thank you all for your help and commitment to this project. We received a significant amount of rich information from this group. The scope of this project is aimed at primary health care teams going into shelters and starting to deliver care. It does not address the management of disease or age-related care. The amazing work completed by the pediatrics group will be housed electronically with this document, along with resources to manage disease.

The standards will be reviewed on a routine basis and new sections will be added.

The next section will be one on providing health fairs and mass immunizations

Please let me know if you have any questions

Introduction

For people experiencing homelessness, fragmented systems of care, limited access, and systemic racism create barriers to appropriate health care. Basic day-to-day survival often takes priority over health, causing delays in care and a decline in health and wellbeing. Clinical practice guidelines for providers working with people experiencing homelessness are essentially the same as for people who are housed—no person experiencing homelessness should receive a standard of care that is less. However, when addressing health and illness among persons experiencing homelessness, you have to take into account comorbidities, lack of housing and its impacts, lack of privacy, and societal barriers when planning care.

One way to improve access and diminish barriers is to provide care in shelters, recovery homes, and other congregate settings. There are many models that have been used by Health Care for the Homeless (HCH) agencies over the years. One of the most practical ways to initiate shelter health is shelter-based health care, including routine team shelter visits.

Shelter-Based Health Care – Benefits to Shelters and to People Experiencing Homelessness

Shelter-based health care provides our homeless neighbors with more direct and improved access to the health care system. It repairs a hole in our system, strengthens the relationship between the person experiencing homelessness and the health system and levels the playing field. Shelter-based care also helps to reduce individual barriers to health by acknowledging lack of mobility, the patient's hierarchy of needs, and potential inability or unwillingness to follow through.

When providers are present on-site where patients live, they can address medication safety and improve communication between health teams, clients, and shelter staff. On-site visits by an enthusiastic health care team eliminates the routine-degrading judgement homeless persons face when presenting for care. Health care providers can also work with shelter staff and increase their health literacy and support understanding that even in a housing-first environment, health is an equal priority.

Benefits to Shelter

On an agency level, partnerships between health care providers and shelter staff lead to long-term increases in housing occupancy and decreases in emergency service interventions. These partnerships can also be leveraged for grants to provide more resources for projects like enhanced health care services, infrastructure improvements at shelters, and permanent supportive housing beds. In the current funding climate, shelter agencies must have a robust partnership with a health care agency to provide

compelling data on health care outcomes, in order to garner funding and sustain community support.

Health care for people experiencing homelessness assists shelter staff meet client goals. Health care is the fundamental foundation for reaching these collaborative goals. Only once an individual feels more in-control can significant progress be made in case management. When the patient feels healthier and their symptoms decrease, it makes it much easier for them to do things like successfully complete SNAP benefit applications or engage in conversations about long-term housing options. Without quality health care provided by dedicated medical professionals, shelter staff struggle to meet even basic goals such as building rapport with patients.

Guiding Principles for Shelter-Based Health Care

- **Human rights-based.** Equality, respect, kindness, equal power, participant centered. Patients have the right to choose when, where, and how health care is delivered.
- **Low-barrier shelters and care:** Low-barrier services include housing first, harm reduction, and overall provision of services to people who have been marginalized by legal and social structures including people of color, LGBTQ+, people with disabilities, justice-involved individuals, survivors of domestic violence, and people who are undocumented.
- **Trust.** All team members continually work on trust-building. When serving patients experiencing homelessness, key aspects of trust are reliability, responsiveness, follow through and follow up.
- **Outreach:** Delivering care to the people where they are is incredibly important to the person and to healing homelessness.
- **Respect and engagement:** Engage patients in decision making, and respect their decisions
- **Strengths-based.** Identify and build on skills participants have; provide tools to move from illness to wellness; set realistic plans and expectations, and be willing to adapt to meet participant needs.
- **Trauma informed.** Homelessness is trauma, and there is trauma on the path to homelessness. Outreach in care works to avoid re-traumatizing. (<https://nhchc.org/online-courses/trauma-informed-care-webinar-series/>)
- **Harm reduction.** Reduces harm, provides services that do not condone or condemn behaviors. (https://nhchc.org/wp-content/uploads/2020/05/Healing-Hands-Harm-Reduction_FINAL2.pdf)
- **Goal-oriented.** The patient's goals in addition to our clinical goals (QI, standards, screens and shots, etc.) Given the level of acuity, we can't do it all at

once, but we can plan to do it. That is why every patient is given a follow up plan and follow up appointments at each visit.

Unhoused individuals and families are especially vulnerable to COVID-19

COVID-19

WHY HOMELESS POPULATIONS ARE A HIGH-RISK GROUP

POOR HEALTH
High rates of chronic medical conditions, behavioral health conditions, infectious illnesses, acute illnesses, & exposure to elements.

CONGREGATE SETTINGS
Shelters, public transportation, soup kitchens, health clinics & other service venues where this population receives care are large, crowded congregate settings.

AN AGING POPULATION
Many people experiencing homelessness are older, have limited mobility, & have even higher rates of poor health.

LIMITED ABILITY TO FOLLOW PUBLIC HEALTH ADVICE
Washing hands, staying at home, & maintaining physical distance from others is often not possible for people without homes.

STIGMA & DISCRIMINATION
Communities regularly seek to block or remove people who are homeless. Laws often prevent housing & other services from being able to expand to meet the need.

www.nhchc.org
#VisualizeHomelessness

Source: www.nhchc.org/covidbrief
See our coronavirus resource page for more information and guidance on COVID-19: www.nhchc.org/coronavirus

NATIONAL HEALTH CARE for the HOMELESS COUNCIL

Many people experiencing homelessness are either living in congregate settings or encampments and have limited ability to follow public health guidance on social distancing. There is also a high proportion of the population of people experiencing homelessness that have risk factors for COVID-19 both in terms of age and underlying health conditions. People experiencing homelessness also face trauma, stigma and discrimination. In Chicago, as across the country, most people experiencing homelessness are people of color, and are at higher risk for COVID-19 due to systemic racism and limited access to care.

Specific unhoused populations with distinct needs (particularly during a pandemic)

- Medically and structurally vulnerable: those at high-risk for COVID, people with disabilities, people who are pregnant, etc.
- Persons with Serious Mental Illness (SMI) and/or Substance Use Disorder (SUD)
- Unsheltered homeless
- Families, including “doubled-up”
- School-aged children
- Unaccompanied minors/youth
- Postsecondary students
- Survivors of domestic violence
- Veterans
- Undocumented individuals and families
- Justice-involved individuals

Key Components of Partnerships between Health Care Providers and Shelters

Updated July 2020

Role of Shelter-Based Health Care Teams

- **Partner with the Chicago Department of Public Health (CDPH) and existing Healthcare for the Homeless (HCH) providers** (Heartland Alliance Health and Lawndale Christian Health Center).
- **Include People Experiencing Homelessness in planning.**
- **Outreach and engagement** with shelter residents and staff. Onsite work with the shelters is important for assuring staff and residents.
- **Assign a dedicated point of contact for the shelter's medical needs** and help to refer and connect residents to services.
- **Follow Healthcare for the Homeless Standards of Care** as presented in this document and at <https://nhchc.org/clinical-practice/>
- **Guidance on use of PPE and infection control.** Provide guidance and training to shelter staff about correct use of personal protective equipment (PPE). Deliver CDPH, DFSS, and CDC guidance on infection control, PPE, quarantine and isolation, etc.
- **Help to identify clients at increased risk of severe disease.**

When there are possible residents with COVID-19 symptoms:

- **Work with CDPH and existing testing teams** to test people with COVID-like symptoms who are not considered at high risk of severe illness and do not require hospitalization (anyone meeting either criteria should be transferred to the emergency department (ED) immediately).
- **Assist the Rapid Testing Team** in screening clients at your shelter if there is a case or cluster of cases detected.

When there are confirmed COVID-19 cases among residents or staff:

- **Clinically triage people** to City quarantine or isolation facilities if required.
- **Assess COVID-19 positive** clients regularly for signs of clinical deterioration.
- **Teach shelter staff** to look for signs of deterioration.

Checklist for Shelter-Based Care and Checklist for Shelter Staff

- ☐ Define Shelter Based Care team
 - ☐ Mental Health Team
 - ☐ Substance Use Disorders (SUD) team
 - ☐ Primary Care Team
- ☐ Meet with shelter staff and define their education needs and perception participant needs
- ☐ Complete Needs Assessment of shelter participants
- ☐ Define frequency of care and schedule
- ☐ Identify spaces at shelter for care
- ☐ Orient health care team to Healthcare for the Homeless model of care
- ☐ Define scopes of services and standards of practice
- ☐ Define processes for medically necessary services not performed on site (lab, pap smears, specialty referrals, etc.)
 - ☐ Order supplies
 - ☐ Define work flows including consent and registration
 - ☐ Medications:
 - ☐ Identify pharmacies
 - ☐ Identify stock meds and order
 - ☐ Define dispensing policies
 - ☐ Identify the SUD provider group and Mental health provider group for the shelter clients, Define linkages and legal collaborations (mutual ROI)
 - ☐ Train shelter staff on
 - ☐ Expectations of health team and scopes of services

- ☐ Trauma informed care
- ☐ Shelter Health Guidelines
- ☐ Plan initial on-site initiatives which may be health screens, immunizations, school physicals and should always include primary care
- ☐ Develop communication plan between all agencies serving shelter clients
- ☐ Plan ongoing engagement activities
- ☐ Define how to use students in Shelter Based Care
- ☐ Define and Redefine care flow
- ☐ Define processes for COVID-19 testing
- ☐ Help Shelter to define policies around infection control and disease prevention

Outreach and Engagement

Needs Assessment at the Shelter/ Consumer Involvement

Before you have a health team on-site at a shelter, you should conduct a needs assessment. Speak with shelter staff, management, and residents/consumers interested in collaboration. Find out:

- What population does the shelter serve?
- What housing resources are available to participants?
- What services persons experiencing homelessness desire?
- What services are available on-site, what agency provides them and how often are they available?
- Who are the shelter staff and what are their responsibilities?
- What times are the majority of guests or residents on-site?

Key Components of Shelter Health: Outreach and Engagement

- Needs Assessment/ Consumer Involvement
- Healthcare Provider Orientation
- Safe, Private Space
- Consistent Service Delivery
- Engagement - Residents, Shelter Staff and Administration, and Healthcare Providers

- How have participants of their program been accessing care and at what sites, what has worked and what has not worked?
 - What are the specific needs for participants and/or staff?
 - Give Consumers a voice. Honoring the voice of those experiencing homelessness also gives dignity and acknowledges the rights we all have in planning our healthcare, it breaks down barriers and brings people into the health care space, and encourages engagement in care
-

Healthcare Provider Orientation:

Tips from long-time Health Care for the Homeless providers

- **Establish a regular schedule and stick to it.**
 - Don't rely on asking shelter staff if there is a need for you to go. If you call on the day you are to come and ask, "Is there anyone there who needs to be seen?" – Most of the time, staff will say no, and if you don't come, you won't have a chance to help. It is much better to come on a regular schedule.
Replace the last sentence with an explanation of benefits of regular schedule
- **Provide medication on the same day. Be prepared to test and treat on-site when possible.**
 - Don't just provide a written prescription for medication. Find processes to provide the medication immediately or to have it delivered the same day.
 - Even if the person is referred to the emergency room for a problem, always give medication that they might need. For example, always give antihypertensive medication (like amlodipine) even if you refer to the ED for a hypertensive urgency/emergency. Most EDs do not dispense medications, and the person will leave without the medication that they need.
 - Even if you refer to dental for pain or an abscess, start treating with an antibiotic/NSAID if indicated. Don't wait for the dentist to do it.
 - Do not refer a person with a urethral discharge to a clinic – Lawndale Christian Health Center did a study, and half never made it. Test and treat on-site immediately. Carry azithromycin, injectable ceftriaxone and lidocaine for reconstitution. Carry metronidazole with you to immediately treat trichomoniasis if person says their partner told them they had it.
- **Collaborate with providers with expertise in Mental Health and Substance Use Disorders**
 - Have ways to refer patients for substance use treatment including buprenorphine and methadone.
 - See Section *Addressing Mental Health and Substance Use Disorder*
- **Be consistent: there is no cancelling sites.** People Experiencing Homelessness are consistently let down by the system, in truth the system is overwhelmed and many agencies and providers over promise, others just do not

follow through. It is our charge to follow through. Health centers engaged in homeless services need to plan for time off, even unexpected time off. Never cancel, always reschedule. If you or your team is providing services every other week and there is no room for an extra day or extra team, add an hour the next scheduled visit, offer telehealth, send the nurse or case manager to gather information needed for follow up. If care is cancelled, then trust is broken. Repair is difficult. At times you may not have the full team on-site, as long as safety can be assured, care should be provided on-site. It is reasonable to limit services in low staffing situations but first try to do them differently.

Safety First – Providing Trauma-informed Care

Providing *Trauma informed care* in shelters respects the experiences that people may have had in their lives and provides for emotional, physical and psychological wellbeing.

- Are there spaces available that are respectful of patient privacy?
- Is it quiet enough for normal conversation?
- Is the space free of dim lighting, chemical smells, and disruptive behavior?
- Do proposed spaces have a clear exit?

Will efforts on site be collaborative and coordinated? Consider placing your registration person/medical assistant in view of people in the gathering area. This can be an effective way to have people wonder why you are there and what you are doing. It can also be helpful for the registration staff or medical assistant's feeling of safety if they are seen out in the open.

For more information see the following guide: <https://nhchc.org/wp-content/uploads/2019/08/creating-a-culture-of-safety-at-health-centers.pdf>

Engagement

Engagement happens through successful outreach- patients buy in to primary care, and behavioral health services, work with multiple, consistent encounters. All sustainable efforts in shelter health are based on engaging participants in care. You cannot engage them without laying the groundwork first. Outreach is the process of building connections that will improve the life and health of people experiencing homelessness and can occur in any setting where there are persons experiencing homelessness. Outreach works to address health equity and human rights issues through participant centered interventions and choice. In-shelter health patients have the right to choose of when, where, and how health care is delivered. Once a conversation is had

with the health team a person can receive care in the shelter or schedule in the clinic. Engagement involves multilevel commitment.

Shelter Staff Engagement Shelter staff are the key to getting participants in care, they are with the participants much more often than the health team and often have earned trust of shelter guests.

- Shelter staff have historically high rates of turnover
- Be gracious in understanding their limitations related to funding, shelter scopes of services, and individual education
- Provide training for all levels of shelter staff: admin, CM, Front Desk
- Trainings should address *their* concerns and priorities first then ongoing public health issues
- Get to know the case managers, shelter workers, etc. where you are. They will be your advocate with participants.
- The more shelter providers are engaged in the physical and behavioral health of your participants the more they will advocate and reinforce follow through- you need to sell healthcare for the homeless services to the shelter team and important stakeholders in their system
- Sometimes shelter staff are only a couple steps removed from the shelter guests they are serving and have similar traumas and needs. Occasionally it will be necessary to take a staff member's blood pressure or do their TB test, even if the team is there to see guests. This is worth the time if it doesn't become too much.
- Collaboration with all agencies providing services at the shelter will benefit staff and patients alike. Obtain a mutual release of information for each agency the participant works with
- Never divulge any protected health information, even when mutual release is active, until you have verbal permission from the participant. Grant them this control.

Health Team Engagement

Providers of services in shelters need to be supported, to have the tools and team members needed to deliver a consistently high standard of care. Be clear on expectations such as time on-site, productivity,

Health teams: you have to OWN IT – As a provider in shelter-based care you have to own the health of the community in your shelter. That does not mean you have to do all things for all people but you do have to see that every resident/patient/guest has access to services.

All staff in shelters need to be trained in outreach and engagement principals, and in shelter policies

Patient Engagement

- Human rights-based: Equality, respect, kindness, equal power, participant centered. Patients have the right to choose of when, where, and how health care is delivered.
- Strengths-based: Identify and build on skills they have, gives tools to move from illness to wellness, involves realistic plans and expectations
- Reduces harm, provides services that do not condone or condemn behaviors. Provides education, and continually works on trust-building. Providers, nurses, CM all do what they say, and continually look to follow up with the participant
- Trauma informed: homelessness is trauma, and there is trauma on the path to homelessness. Outreach in care works to avoid re-traumatizing.
- Goal-oriented: the patient's goals in addition to our goals (QI, standards, screens and shots, etc.) given the level of acuity, can't do it all at once but can plan to do it. That is why every patient is given a follow up plan and follow up appointments at each visit.
- Sometimes activities that aren't strictly medical can help to create staff and client/patient engagement. Christmas parties with practical gifts, foot-washing and giving out socks, pizza parties
- Never divulge a patient's protected health information, even when mutual release is active, until you have verbal permission from the participant. Grant them this control **YOU'VE ALREADY SAID THIS**
- **Ask about and participate in their housing plan. Encourage their follow up and follow through with their housing team**
- Do rounds in the gathering area, and meet and greet clients. Get out of the area where you see patients. You can learn so much more by not secluding yourself.
- **No does not mean no, it means I do not trust you when a participant declines a service or services in general, try to re-engage at a different time.** Keep doing rounds and speaking with people. It just means you need to do more work on engagement.
- For people with serious mental illness, continue with friendly engagement – no need to ask about mental health symptoms every time. Find something in common to talk about - sports, weather, birthdays, or even holidays. If you see them on the street, chatting people up and buying a meal can go a long way to engaging into care.
- Give all patients, especially those in shelters, follow up visits. Our patients have so many complex health issues that it is difficult to keep on top of them, so no one should get an RTC as needed. Most importantly, telling our patients, who are isolated and invisible that you want to see them again is giving them worth, and hope.

- Using wallet sized cards are more likely kept than 8.5 x 11 handouts. Business-sized cards can be used to record: TB test results; rapid HIV test results; blood pressure readings; (maybe SARS-CoV-2 test results?); stop smoking information; insurance information including ID numbers; clinic appointment cards. If you don't have one of these specialized cards, you can always write the information on the back of your personal business card.
 - Be consistent and keep your word. There are no cancelling sites, in emergencies reschedule, but being consistent is outreach. At times you may not have a medical assistant but that is ok as long as you can work on paper and fax or email forms. The alternative is an on-call assist.
 - If you run out of time at the shelter and you still have participants waiting to be seen, you need to address them and plan to meet them. If you do not address them word will get out within the **community**. It will be more difficult to engage participants in that shelter system.
-

Scope of Services

- Physical health, behavioral health, substance use disorder treatment, case management and most importantly housing- sometimes these are referred to as wrap around care. These are your essential services. Initiating care in a shelter should never be by telehealth, it puts up barriers.
- Health care workers are professionally trained in infection control techniques including proper use of PPE. This training does not extend to shelter workers. Shelter workers and participants will have an increase in anxiety when medical staff is not present and telehealth is substituted. Telehealth can also set up a hierarchal system; **on-site care is needed to level the playing field and strengthen the relationship between healthcare and shelter teams.**

The care team for persons experiencing homelessness includes:

- Persons experiencing homelessness
- Housing team
- MD/APRN/PA: Physical health, SUD, Psychiatry
 - Whole lifecycle health care should be offered
- RN
- Behavioral Health
- Case Manager
- Benefits Enrollment
- Care Coordination
 - <https://nhchc.org/wp-content/uploads/2019/08/healinghands-care-coordination-final-web-ready.pdf>
- Community Health Workers (CHWs)

- Community Health Workers in general are frontline public health workers who are trusted members of and/or have an unusually close understanding of the community they serve.
- *In homeless services, CHWs have lived experience of homelessness.*
- That shared experience is part of what makes CHWs unique in their ability to connect with clients in ways providers often cannot. Studies have shown that in programs serving individuals who are experiencing homelessness or struggling with substance use, shared life experience may be more important than shared personal characteristics. CHWs can provide education, reach out and bring participants to immunization-sites, accompany the health team to places where outreach-based health services are provided

Not all services need to be from the same organization and not all persons need all services, but they do need to be evaluated for them. Clear assignments from health centers on available staff and clear linkages with shelters can provide these essential services.

3 levels of service delivery

All service delivery is multifaceted. However, some shelter systems may provide wrap around services such as case management, housing, and substance use disorder counseling.

- A. Intensive sites: Integrated teams with behavioral health and physical health providers, medical assistants, Benefits enrollment, CM. At maximum this is a shelter-based clinic but could also be weekly or biweekly visits for a full or half day. Shelters with over 100 guests generally fall into this category
- B. Less intensive sites: Physical health provider, medical assistant, and ability to refer to behavioral health and other wrap arounds. Shelter would be connected to teams that provide other services
- C. Community engagement sites: In general, these are special event sites and/ or special events within shelters. One example is the St. Vincent DePaul Homeless Outreach Luncheon which occurs annually in November. Other shelters that would qualify under this would be smaller shelters with stable staff that are connected to health care and ensure patients have appointments and keep them. On site care for these sites includes Screenings and flu fairs, etc. Community Health Worker (CHW) visits.

Preparing for services to be offered in the shelter

- Always keep the completed needs assessment in mind when planning: What populations does the shelter serve and what will be needed to serve them
- Be clear but know that successful shelter care can evolve- start simple offering one time per week to every other week. The on-site team will also flux, with physical care weekly possibly psychiatry could be bi weekly to monthly
- Space will impact scope of services:
 - Comprehensive care
 - Physicals
 - Women's health exams
 - Urgent care
 - Management of chronic disease
 - SUD
 - Psychiatry
 - Rapid Testing: HIV, HCV, Flu, Strep, pregnancy, AIC, UA SBG
 - Screen for modifiable factors such as smoking. CV disease, cancer and COPD are still the biggest killer of persons experiencing homelessness, and 50-80% of people smoke, so addressing smoking and cessation is important

Supplies

The following list is a great place to start with stocking your shelter-based care kit. As time goes, kits become individualized by providers and needs within the specific shelter environment. Traditionally most healthcare for the homeless providers have used rolling suitcases, In the time of COVID-19 it is suggested to use plastic bins, rolling ones if available. They are easy to clean.

PPE	Patient Care	Engagement supplies
Masks: surgical and N95	Wound Care Supplies	Socks
Face Shield	Ear irrigation Supplies	Basic toiletries, lotions
Gowns, Disposable lab coats	Point of Care Testing Supplies	Nail Files
Gloves	BP cuff	
Hand Sanitizer	Oto/ophthalmoscope	Emergency Medications
Cleansing Wipes	Pulse ox	Naloxone/NARCAN
	Thermometer	NTG SL
Technology	CPR mouth shield	Glucose Gel
laptop	Condoms	Chewable Asa
MiFi		Albuterol Inhaler
Cellphone	Check expiration dates often	Epi pen

Medications

The ability to ensure access to medications near or at where the patient is encountered is a top priority in providing care. Prescribing medications to the homeless is more complex and the issues to consider and discuss with your participant include paying for medication, insurance status, safe medication storage and use. Do they have the ability to leave the shelter to go to the pharmacy or can the pharmacy deliver? Often participants experience lapses in insurance benefits, it is important to have a small stock on hand to give to them. Consider using pre-packaged medications from companies such as DirectRX. Follow all applicable state laws for documenting. The following is a good list to start on stock medications.

Pain Acetaminophen NSAID	G.I. Docusate H2 blocker/PPI Tums/Mylanta tabs Loperamide	Derm Few categories, strengths steroid creams Antifungal
Blood Pressure CCB, ACE HCTZ, BB	Antibiotics STI Treatment As appropriate	Vitamins/Others MVI Folic Acid Thiamine Prednisone
Allergies/Asthma Diphenhydramine Loratadine Albuterol MDI	Prevention/Emergency NARCAN/Naloxone	Sugar Free/Alcohol Free Cough Syrup

- Linkage for lab testing, EKG, spirometry, immunizations
- Ensure access to immunizations, have supplies to carry them if needed including coolers, digital thermometers with alarms
- Be prepared for emergencies and frequently check expiration dates: Narcan, epinephrine SQ; nasal or injectable naloxone; diphenhydramine for acute allergic reaction; glucose gel for hypoglycemia; chewable aspirin 325 for acute chest pain; NTG SL for acute chest pain (but expires quickly); albuterol inhaler for asthma attack; captopril or amlodipine for hypertensive urgency; mouth shield in case rescue breathing needed; if with a clinic room within a shelter site, consider access to AED

Care flow

- Shelter teams should try to arrive together. This works to break down stigma of hierarchy and helps participants to see that all members of the team are equally important,
- During the first few weeks, get to know patients. Walk around and introduce yourselves to the entire team for the first few minutes. Get to know the shelter participants

- Patient flow: it will take some time to iron out the details and also depend on shelter layout. For the most part, flows in shelter health closely follow flows in most clinics. All patients must give consent for care. Obtaining insurance information for billing supports future efforts. It is important to note that if persons are successfully connected to a primary care provider, the onsite provider team should work to support that relationship and not interrupt the relationship.

Follow up care


Work out the details on lab testing and referrals before you start. Have a plan and options to get people there. Be certain your care coordinators and referral coordinators are connected to shelter staff for patients that may need assistance with follow up plans.

Be aware of special populations/health management issues

- Children /pediatric care:INSERT PEDS LINK HERE
 - Preventative Care for Persons Experiencing Homelessness
 - <https://nhchc.org/wp-content/uploads/2019/08/healing-hands-preventative-care-finalized.pdf>
 - End Of life Care
 - <https://nhchc.org/wp-content/uploads/2019/08/2018-end-of-life-care-guidelines.pdf>
-

Addressing Mental Health and Substance Use Disorders

Providing Behavioral Health Services and Collaborating with Behavioral Health Teams

- Shelters often have behavioral health partners, find out who they are, their scopes of services and how to refer to them. If the shelter you are providing services at does not have a behavioral health partner contact  _____
- Primary care providers providing care in shelters need to be intimately familiar with assessing and diagnosing behavioral health disorders, basic treatments, and have a psychiatrist to speak with and schedule participants with.
- PHQ-2, GAD should be administered as they would be in a clinic setting
- Trauma causes homelessness and homelessness is trauma. Assess for PTSD (post traumatic stress disorder)
- Asking about hearing voices outside of you that bother you, or seeing things that really aren't there (AH, VH) are high-yield questions when doing the review of systems

- For people with psychosis who could really benefit from taking an antipsychotic, find the hook or the symptom that is really bothering them and propose that medication may help to decrease that symptom. The symptom could be problems with sleep, with voices that are too loud and bother them, problems with concentrating on getting things done, problems with finding housing, etc. Less helpful is medicalizing/labeling the person's symptoms as hallucinations, etc. "What do you think I am, doc, crazy??"
- With psychiatry input, strongly consider initiation and use of long-acting injectables on-site at shelters for those with psychosis who have difficulty taking PO meds – keeping clinic appointments to receive IM injections can be a challenge for those who need LAIs

Assessment and Treatment of Substance Use Disorder in the shelter

- Primary care provider teams should do SBIRT for all, even at first visit. Assessing for substance use disorder (SUD) and alcohol use disorder (AUD) is important.
- Shelter based teams must have access to low barrier Medication Assisted treatment (MAT) teams, *It is best to have all providers trained and credentialed to offer MAT services., and coaches or case managers available for the participants* Have a very low barrier for starting medication assisted treatment/recovery; don't just refer to the clinic; carry rapid urine toxicology cups with you, but urine testing is NOT required for the diagnosis of OUD; Schedule soon 2-3 day follow-up after starting. Word will get around if you are low-threshold OR if you put up a barrier such as making people see a counselor or go to clinic first.
- Emphasize motivational interviewing techniques for all team members, and model techniques for all staff
- Harm Reduction for everyone those with OUD (prescribe naloxone, don't use alone, don't go to pass outs, needle exchange);
- Train shelter staff on naloxone use and ensure they have a supply available
- It should be a very rare exception to prescribe a controlled substance other than buprenorphine/naloxone in large congregate settings. This pertains especially to benzodiazepines. Word gets around quickly and meds are easily stolen.
- **Don't give up on someone who is under the influence or nodding off. Gently say we can talk later, and give your business card so the person knows where they can get help.**
- For more information
 - <https://nhchc.org/wp-content/uploads/2019/08/healing-hands-treatment-models-for-non-opioid-substance-use.pdf>
 - <https://nhchc.org/wp-content/uploads/2019/08/healing-hands-non-opioid-substance-use-mental-health-and-homelessness-rev.pdf>
 - For more information on treating Opioid Use Disorder in the shelter see <https://www.quantumunitised.com/get-material.php?id=605>

- Model and practice de-escalation techniques. Get on the side of the patient and fight with them against the system. “You are right, it isn’t fair, but we will fight along with you.”
 - Consider crisis prevention training for staff (Crisis Prevention Institute)
 - Telehealth can be incorporated as a part of behavioral healthcare but establishing an on-site presence is the core approach.
 - Community Health Workers and Recovery Support Specialists: utilize your CHWs to fill gaps and create an entry to behavioral health care for those who are resistant.
 -
-

Supporting access to disability, public benefits and housing

Documenting Disability and completing forms Many individuals and families experiencing homelessness may need assistance in accessing available housing and public benefits options. Documenting health and abilities will assist with ending an individual or family’s homelessness. Being familiar with physical and behavioral health disability standards, and documentation required for local and federal programs breaks down barriers for patients and supports engagement. Know the coordinated entry processes in your community and connect with case management, housing service and Legal service providers versed in Housing First. Work to remove unnecessary barriers in program policies and practices that prevent individuals and families from accessing permanent housing.

- For further information on coordinated entry: https://nhchc.org/wp-content/uploads/2020/02/HealingHands_USE_020620.pdf
 - Documenting Disability: <https://nhchc.org/online-courses/documenting-disability/>
 - Disability letter checklist: https://nhchc.org/wp-content/uploads/2019/08/Letter-Writing_Checklist.pdf
-

Health education

Note that educational level/reading level should be at the 3rd grade level. Very simple understandable education.

- Pay close attention to literacy level of any handouts and make them brief. Vague education about reducing cardiovascular disease or a diabetic diet makes little sense if a person has little to no control over their diet or exercise. One proven technique on diet is to walk the food line with participant, helping them to make better choices when there is very little choice in food.
- Link education to what is happening in the shelter – if many of the kids have diarrhea, do education about that.

- Try to coordinate very brief (10 minutes max) health education with a specific service that happens immediately thereafter, such as flu shots, TB testing, Hep A immunization, coronavirus testing? Pay close attention to literacy level of any handouts and make them brief. Vague education about reducing cardiovascular disease or a diabetic diet makes little sense if a person has little to no control over their diet or exercise. Link education to what is happening in the shelter – if many of the kids have diarrhea, do education about that.

Roles for Students

Students can take on several roles. Providers often have relationships with universities to precept students within their specialties in clinics. It is also appropriate to have them precepted by experienced shelter care staff if it is ok with the shelter administration and staff

Consider adding students for immunization fairs, COVID-19 testing, health screenings, community assessments and shelter staff training.

Don't put students (nursing, medical or other) in a position to do health education all by themselves. A seasoned staff member/provider is needed to "rescue" the student from too personal questions (What's your phone number? Are you married?) or to answer questions that the student may not have the answer to.

Students have a presentation on COVID-19 for shelter participants, if your team would like to have this available for the shelter, please contact:
covid19healtheducation@gmail.com

COVID-19: Providing Care During a Pandemic

COVID-19 Testing on Shelter Intake – NOT recommended

CDPH, CHHRGE and NHCHC do NOT recommend testing for COVID-19 on intake to shelter. All persons entering (staff, volunteers, residents) should be assessed for exposure, symptoms, and temperature upon entering. If the screen is abnormal or temperature exceeds 100.4 F, isolate the guest or staff member in an empty room, if possible, and call the aligned FQHC or, in Chicago, call 872-558-3304 to access the testing team at Lawndale Christian Health Center.

There is more information and guidance from the Chicago Department of Public Health:

Guidance for Congregate Living:

<https://www.chicago.gov/content/dam/city/depts/cdph/HealthProtectionandResponse/COVID-19%20Guidance%20for%20Congregate%20Living%20Facilities.pdf>

Guidance for Homeless Shelters:

<https://www.chicago.gov/content/dam/city/depts/cdph/HealthProtectionandResponse/Homeless%20Shelters%20Reopening%20Guidance%2006.26.2020.pdf>

Health teams working in shelters should have adequate PPE

- For general care, a surgical mask and face shield is required
- Running water and soap or Alcohol based hand sanitizer
- Gloves
- Consider use of disposable lab coats
- Antibacterial wipes, as available
- It is recommended to bring supplies in a wipeable or cleanable container such as a plastic storage bin so that the exterior of what you take out of the shelter is cleaned as you leave


Health teams will work with shelters staff on infection control


Shelter providers have been put in the position of being health care workers and they have not had the training to do so. Kindness matters so much. Educate shelter staff on infection control, and donning and doffing PPE. Give them your number and be available for questions. Remember health teams have training and are in a trusted position to help shelter providers through this pandemic.

- PPE – not all shelters will need to know full PPE but some may, tailor your education appropriately. This is a great place for students to help


How to Use Personal Protective Equipment: A Quick Reference Guide for Frontline Clinical Providers

Frontline clinical providers should wear the following personal protective equipment (PPE) when treating individuals confirmed or suspected to be infected with COVID-19.







N95 RESPIRATOR



GOWN



GLOVES



**FACE SHIELD/
EYE PROTECTION**

How to properly use protective equipment

PPE TYPE	DONNING PPE	REMOVING PPE
N95 RESPIRATOR (AS AVAILABLE)	<ul style="list-style-type: none"> Secure ties or elastic band at middle of head and neck Fit flexible band to nose bridge Fit snug to face and below chin Fit-check respirator 	<ul style="list-style-type: none"> Front of respirator is contaminated – DO NOT TOUCH! Grasp ONLY bottom then top ties/elastics and remove Discard in waste container
GOWN	<ul style="list-style-type: none"> Fully cover torso from neck to knees, arms to end of wrist, and wrap around the back Fasten in back at neck and waist 	<ul style="list-style-type: none"> Gown front and sleeves are contaminated! Unfasten neck, then waist ties Remove gown using a peeling motion; pull gown from each shoulder toward the same hand Gown will turn inside out Hold removed gown away from body, roll into a bundle and discard into waste or linen receptacle
GLOVES	<ul style="list-style-type: none"> Use non-sterile for isolation Select according to hand size Extend to cover wrist of isolation gown 	<ul style="list-style-type: none"> Outside of gloves are contaminated! Grasp outside of glove with opposite gloved hand; peel off Hold removed glove in gloved hand Slide fingers of ungloved hand under remaining glove at wrist
FACE SHIELD / EYE PROTECTION	<ul style="list-style-type: none"> Put on face and adjust to fit 	<ul style="list-style-type: none"> Outside of goggles or face shield are contaminated! To remove, handle by "clean" head band or ear pieces Place in designated receptacle for reprocessing or in waste container

Wash hands or use an alcohol-based hand sanitizer immediately after removing all PPE!

N95 Respirator Usage and Care

N95 respirators must only be used by a single wearer. Use labels to reduce accidental usage of another person's respirator.

Existing CDC guidelines recommend a combination of approaches to conserve supplies while safeguarding health care workers in such circumstances.

- Minimize the number of individuals who need to use respiratory protection through administrative controls;
- Use alternatives to N95 respirators (e.g., other classes of filtering facepiece respirators, elastomeric half-mask and full facepiece air purifying respirators, powered air purifying respirators) where feasible;
- Implement practices allowing extended use and/or limited reuse of N95 respirators, when acceptable;
- Prioritize the use of N95 respirators for those personnel at the highest risk of contracting or experiencing complications of infection.

Extended use is favored over reuse because it is expected to involve less touching of the respirator and therefore less risk of contact transmission. A key consideration for safe extended use is that the respirator must maintain its fit and function.

Homeless shelter facilities should develop clearly written procedures to advise staff to take the following steps to reduce contact transmission:

- Discard N95 respirators following use during aerosol generating procedures.
- Discard N95 respirators contaminated with blood, respiratory or nasal secretions, or other bodily fluids.
- Discard N95 respirators following close contact with, or exit from, the care area of any patient co-infected with an infectious disease requiring contact precautions.
- Consider use of a cleanable face shield (preferred) over an N95 respirator and/or other steps (e.g., masking patients, use of engineering controls) to reduce surface contamination.
- Perform hand hygiene with soap and water or an alcohol-based hand sanitizer before and after touching or adjusting the respirator (if necessary for comfort or to maintain fit).

If reusing respirators is necessary because of limited supplies:

- Hang used respirators in a designated storage area or keep them in a clean, breathable container such as a paper bag between uses. To minimize potential cross-contamination, store respirators so that they do not touch each other and the person using the respirator is clearly identified. Storage containers should be disposed of or cleaned regularly.
- Clean hands with soap and water or an alcohol-based hand sanitizer before and after touching or adjusting the respirator (if necessary for comfort or to maintain fit).
- Avoid touching the inside of the respirator. If inadvertent contact is made with the inside of the respirator, discard the respirator and perform hand hygiene as described above.
- Use a pair of clean (non-sterile) gloves when donning a used N95 respirator and performing a user seal check. Discard gloves after the N95 respirator is donned and any adjustments are made to ensure the respirator is sitting comfortably on your face with a good seal.

Use masks not evaluated or approved by NIOSH or homemade masks as a last resort.

NATIONAL
HEALTH CARE
for the
HOMELESS
COUNCIL

For more information visit the Coronavirus Resources of the National Health Care for the Homeless Council's website: www.nhchc.org/coronavirus
Sources: Information in this document came from the Centers for Disease Control and Prevention and other sources available at www.nhchc.org



Screening

Shelter staff should be educated on the signs, symptoms and screening for COVID-19. Clients should be evaluated routinely. The questionnaire below is easy to use and comprehensive for daily screening. Some shelters may prefer a flow sheet which is fine as well

When a shelter guest has symptoms of COVID-19 Help shelter staff identify isolation space at facilities, if possible and review PPE and Isolation precautions with them. There is a rapid testing team available in the City of Chicago through Lawndale Christian Health Center. Shelter Staff can call 872-558-3304 to access the testing team.

COVID-19 SCREENING QUESTIONNAIRE			
To be performed upon entrance to the shelter and daily			
Date		Time	
Name			
Birth Year			
Gender	male	female	other
In an effort to provide you the safest possible sleeping and living conditions, we want to screen you for symptoms of COVID-19. We will help you have a safe place to stay regardless of COVID-19 risk or not.			
A. Please perform hand hygiene with hand sanitizer (if supplies allow) and answer these questions			
B. MEASURED TEMPERATURE		C	F
C. Over the past 14 days, have you had ANY of these symptoms?			
	YES	NO	DID NOT ANSWER
1 Dry cough (change from baseline)			
2 Shortness of breath (change from baseline)			
3 Muscle aches (myalgias)			
4 Sore throat			
5 Headache (influenza like illness)			
6 Fatigue (influenza like illness)			
7 Have you had close contact with anyone who has COVID-19? (close contact is defined as <6ft for >10 minutes)			
If yes to 1-7 with T>37.8 please apply 3-layer mask and direct to isolation area; if yes to any questions 1-4 without T>37.8 (100F) or T>37.8 without symptoms please direct to health care on duty			
Notes:			

Work flow:
A. Name collected by line monitor(s);
B) 2-person team to collect info (one to ask questions, one as recorder; C. Third person taking temperature; D) Sticker given at conclusion

Ongoing Infection Control Assessment Health teams are encouraged to develop a routine where shelters they served are monitored for ongoing infection control measures. At the end of this document is a risk assessment tool to assist with this task.

Respite Programs In Chicago, there is an isolation respite center for people recovering from COVID-19. The respite center, CARReS (CDPH A Safe Haven Rush Respite Shelter), is a partnership where clinical care is provided by the Rush College of Nursing and Heartland Alliance Health provides treatment for Substance Use Disorder and psychiatry. Referrals can be made through <https://www.chicago.gov/city/en/sites/health-care-workers/home/chicago-covid-19-isolation-facilities.html>

Testing The link below summarizes universal testing recommendations for persons experiencing homelessness. As noted above, CDPH, CHHRGE, and NHCHC recommend against universal testing upon intake.

<https://nhchc.org/wp-content/uploads/2020/07/Issue-brief-6-COVID-19-Homelessness-Universal-Testing-Strategies.pdf>

Outbreak response each shelter is aligned with a CDPH disease outbreak investigator. With a few exceptions, Andrew Weidemiller is assigned to shelters with names starting with the letters A-L and Divya Ramachandran is assigned to shelters M-Z.

- Andrew Weidemiller's number is (773) 405-6745
- Divya Ramachandran's number is (312) 805-7600.

Contacting the disease outbreak investigator when a case in a shelter is identified should trigger universal testing. You can also contact Heartland Alliance Health's COVID-19 RN Greg Bowman at gbowman@heartlandalliance.org

Leadership from people with lived experience

A Consumer Advisory Board (CAB) is the only way to understand the needs of those experiencing homelessness is to give them a voice in planning, implementing, and evaluating services. People experiencing homelessness should be involved at all levels of new projects. **Consumers can also work on special projects such as health fairs, and holiday events, develop educational materials, and reach out to shelter guests to assist with engagement**

- **Information on Consumer Advisory Boards**
<https://nhchc.org/consumers/ncab/>
- **National CAB operating guidelines:** <https://nhchc.org/wp-content/uploads/2019/08/ncab-operating-guidelines-updated-june-2019.pdf>

Join the Health Care for the Homeless Clinicians' Network



The Health Care for the Homeless Clinicians' Network is the nation's leading membership group that connects hands-on providers from many disciplines who are committed to improving the health and quality of life of people experiencing homelessness. The HCH Clinicians' Network fosters networking and professional growth among a diverse membership comprised of nurses, physicians, social workers, nurse

practitioners, physician assistants, outreach workers, case managers, substance abuse counselors, mental health therapists, dentists, pharmacists, psychologists, and students.

The Clinicians' Network provides a forum for its members to share the latest information and research, review and make recommendations about clinical practice, and network with peers. It provides valuable resources that can help you excel in your work. The network's educational offerings and communications will connect you to the best practitioners and models of care.

<https://nhchc.org/clinical-practice/hch-clinicians-network/membership/>

Resources

Learning modules, including: HCH 101 <https://nhchc.org/online-courses/hch-101/hch-101-course/>

Adapted clinical standards

- <https://nhchc.org/clinical-practice/homeless-services/interdisciplinary-care/>
 - <https://nhchc.org/clinical-practice/homeless-services/case-management/>
 - <https://nhchc.org/clinical-practice/diseases-and-conditions/influenza/>
-

COVID-19 TRANSMISSION SHELTER RISK ASSESSMENT TOOL

All identified at risk areas are points of education and intervention

Facility Prep

- ☐ Signs are posted at shelter entrances instructing all persons must wear masks to enter
- ☐ Signs are posted throughout facility depicting proper wearing of masks
- ☐ Signs are posted listing symptoms of COVID-19, and prevention of COVID-19
- ☐ Symptom screenings and temperature checks are performed for all persons entering the shelter daily
- ☐ In all places where people may line up, 6 feet social distancing marks are in place, and easily identifiable
- ☐ Counters have signs that discourage leaning
- ☐ Staff/volunteer desks have barriers to prevent aerosolized particles from hitting staff/volunteers

- ☐ Signs are posted encouraging social distancing
- ☐ Hand washing stations are visible
- ☐ Proper hand hygiene infographics are posted at hygiene stations

Written Policies Being Followed On:

- ☐ How participants and staff are educated about COVID-19 prevention
- ☐ How symptomatic persons are isolated, referred to medical treatment, and what community linkages are used
- ☐ How staff exposure to COVID-19 is responded to, according to latest health department guidelines
- ☐ How staff confirmed COVID-19 infection is responded to, according to latest health department guidelines
- ☐ Proper usage of protective personal equipment by staff and volunteers
- ☐ Proper cloth mask washing

Sanitation

- ☐ OSHA approved COVID-19 disinfection products are in use
- ☐ Frequency and monitoring of cleaning surfaces that are touched are defined and followed
- ☐ Cleaning product stock is monitored
- ☐ Hand washing stations are monitored and re-supplied regularly
- ☐ Trash cans are located near exits and transition spaces for disposal of contaminated items
- ☐ Areas for donning and doffing personal protective equipment are identified

Participant Related Risks

- ☐ Mask wearing infographics are visible
- ☐ Masks are available for all participants
- ☐ Cloth masks are washed routinely
- ☐ Participants are educated on infection control practices

- ☐ Isolation areas for symptomatic participants are clearly identified
- ☐ Daily rosters and bed maps are kept
- ☐ Mattresses are 6 feet apart, and head to foot if barrier walls are not in place
- ☐ Multiple trash cans are located in sleeping areas
- ☐ If linen is collected in a laundry bag, there is a hand washing station next to the laundry bag
- ☐ Meals are timed so that guests can be 6 feet apart while eating, and no self-serving is allowed

Staff Related Risks

- ☐ Participant-facing staff wear masks and face shields properly
- ☐ A daily roster of staff and volunteers is kept