

# Standards for Shelter- Based Health Care:

## Outreach, Engagement and Providing Services

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*Thank you to all the contributors to this project. In particular, thank you to people with lived expertise for your input this year to enhance the standards and make them more person-centered.*

*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.*

*Please let us know if you have any questions or input. The Standards document will continue to be updated and revised, any suggestions for future revisions are very welcome.*

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*Footnote: \*Note that we have chosen to be expansive in the language we use in this document, so you will see the terms “consumers,” “participants,” “guests,” and “residents” used throughout the document to refer to people experiencing homelessness.*

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# 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 which can lead to delays in care and a decline in health and wellbeing. Clinical practice guidelines for providers working with people experiencing homelessness are 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 must consider 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 agencies over the years. One of the most practical ways to provide care and support 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 neighbors experiencing homelessness 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/participant's hierarchy of needs, and potential inability or unwillingness to follow through.

When providers are present on-site where participants 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 eliminate the routine-degrading judgment homeless persons face when presenting for care. Health care providers can also work with shelter staff to increase their health literacy—providing health information and resources to support health as an equal priority within a housing-first environment.

## Benefits to Homeless Service Providers and Shelter Staff

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 to garner funding and sustain community support.

Health care for people experiencing homelessness assists shelter staff to 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 (Supplemental Nutrition Assistance Program) 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 clients.

# Guiding Principles for Shelter-Based Health Care

- **Human rights based.** Equality, respect, kindness, equal power, participant- centered. People receiving services 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/participants 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/participants 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-traumatization. [Trauma-Informed Care Webinar Series](#)
- **Harm reduction.** Reduces harm, provides services that do not condone or condemn behaviors. [Key Strategies for Harm Reduction](#)
- **Goal-oriented.** The patient's goals in addition to our clinical goals (quality improvement, standards, screens, and shots, etc.). Given the level of acuity, we cannot 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.

*See Appendix for Checklist for Shelter-Based Health Care and Checklist for Shelter Staff*

# Health Care Provider Orientation

## Tips from Long-time Health Care for the Homeless Providers

- **Establish a regular schedule and stick to it.**

Do not rely on asking shelter staff if there is a need for you to go. If you call and ask if there is anyone to see who needs health care – Most of the time, staff will say no, and if you do not go, you will not have a chance to help. It is much better to go on a regular schedule.

- **Provide medications and treatments on the same day. Be prepared to test and treat on-site when possible.**

- **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 Disorders](#).

- **Be consistent: do not cancel sites.** People experiencing homelessness are consistently let down by the system. In truth, the system is overwhelmed and many agencies and providers over promise, while 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 for the next scheduled visit, offer telehealth, or send the nurse or case manager to gather information needed for follow-up. If care is canceled, then trust is broken. Repairing trust is difficult. At times you may not have the full team on-site, but if 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 the services differently.

# Needs Assessment at the Shelter, and Resident/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:

## Key Components of Shelter Health: Outreach and Engagement

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

Conduct a needs assessment, in collaboration with shelter staff, management, and residents/consumers.

## Find out:

- What populations does the shelter serve?
- What housing resources are available to participants?
- What services do people 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 most participants/guests/residents on-site?
- 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 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 health care, it breaks down barriers and brings people into the health care space and encourages engagement in care.

*\* Note that we have chosen to be expansive in the language we use in this document, so you will see the terms “consumers,” “participants,” “guests,” and “residents” used throughout the document to refer to people experiencing homelessness.*



# Outreach and Engagement

Engagement happens through successful outreach- participants/patients buy into primary care and behavioral health services through multiple, consistent encounters. All long-term sustainable efforts in shelter health are based on engaging participants in care. You cannot engage participants 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 people experiencing homelessness.

Outreach works to address health equity and human rights issues through participant- centered interventions and choice. In this way, the shelter-based care model provides patients the right to choose when, where, and how healthcare is delivered. Once the participant has engaged with the health team, that person can receive care in the shelter or schedule in the clinic.

Engagement involves multilevel commitment – collaborative engagement across shelter staff, health care providers, and participants/patients.

## 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 the trust of shelter guests.

- Get to know the case managers, shelter workers, etc. where you are. They will be your advocate for participants.
- Be gracious in understanding their limitations related to funding, shelter scopes of services, and workforce challenges.
- Shelter staff have historically high rates of turnover.
- Provide training for all levels of shelter staff: administrative workers, case manager, front desk, etc.
- Training should address their concerns and priorities first and then ongoing public health issues.
- The more shelter providers that are engaged in the physical and behavioral health of your participants, the more they will advocate and reinforce follow- through. You need to sell Health Care for the Homeless services to the shelter team and other 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 administer testing for tuberculosis (TB), even if the team is there to see guests. This is worth the time if it does not become too much.
- Collaboration with all agencies providing services at the shelter will benefit staff and participants 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.
- Health teams: you must OWN IT – As a provider in shelter-based care, you must 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 shelter health care staff must be trained in outreach and engagement principles and shelter policies.
- In certain instances, new health partners, whether in behavioral or primary care, may express an interest in collaborating with a shelter that already has established teams. In such situations, various factors should be considered. Although ongoing improvements are essential, the objective of shelter-based care is not to interfere with or displace existing partnerships, undermine trust and engagement, or disrupt the continuity of care. It is advisable for new collaborators to collaborate with established providers to identify underserved sites where they can contribute to providing care

## Patient/Participant Engagement

Participant engagement in health care for homeless services refers to the active involvement and collaboration of individuals experiencing homelessness in their own healthcare. It involves creating strategies and programs that encourage individuals experiencing homelessness to take an active role in managing their health, accessing healthcare services, and participating in interventions that address their unique needs. This approach recognizes the importance of treating individuals experiencing homelessness with dignity, respect, and involving them as partners in their journey. To achieve this the following should be in place:

- Human rights-based: Equality, respect, kindness, equal power, and participant- centered care. Participants/ patients have the right to choose when, where, and how healthcare is delivered.
- Strengths-based: Identify and build on skills they have, give tools to move from illness to wellness, and involve realistic plans and expectations.
- Trauma-informed: Homelessness is trauma, and there is trauma on the path to homelessness. Outreach in care works to avoid re-traumatization.
- Harm reduction, meaning care and services are provided in ways that reduce harm and does not condone or condemn behaviors. Provides education, and continually works on trust-building. Health care providers and case managers all do what they say, and continually look to follow up with the participant.
- Goal-oriented: A collaborative approach to engagement means prioritizing the patient's goals in addition to our goals (quality improvement, standards, screens, and

shots, etc.). Given the level of acuity, you may not be able to do it all at once, but you can plan to do it. That is why every patient is given a follow-up plan and follow-up appointments at each visit.

- Community-building, trust-building, and wellness: Sometimes activities that are not strictly medical can help to create staff and participant engagement. Holiday parties with practical gifts, foot-washing and giving out socks, and pizza parties are splendid examples of activities that create engagement.
- 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.
- Ask about and participate in the participant's housing plan. Encourage their follow-up and follow-through with their housing team.
- Do rounds in the gathering area and meet clients. Get out of the area where you see patients. You can learn so much more by not secluding yourself.
- **When a participant says no, it may not necessarily mean a rejection but rather an expression of mistrust.** In such instances, consider re-engaging later. Continuously communicate with individuals, making multiple attempts to understand their needs and concerns. This suggests a need for increased efforts in building trust and engagement.
- For people with serious mental illness, continue with friendly engagement – there is no need to ask about mental health symptoms every time. Find something in common to talk about, such as sports, weather, birthdays, or holidays. If you see them on the street, chatting people up and buying a meal can go a long way to engaging in care.

# Scope of Services

The scope of services provided to people who are homeless is comprehensive and aims to address the diverse and complex needs of this population. It involves a multi-faceted approach that goes beyond immediate shelter and food provision to address underlying issues contributing to homelessness. The scope of services should include:

- Wholistic and wrap-around care: 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.
- A well-trained care team for people experiencing homelessness includes:
  - People experiencing homelessness
  - Housing Specialists
  - Medical Doctor/Advanced Practice Registered Nurse/Physician Assistant: Physical Health, SUD, Psychiatry – Whole life cycle health care should be offered.
- Registered Nurse
- Behavioral Health – Mental Health and Substance Use Disorders
- Case Manager
- Benefits Enrollment Specialist
- Care Coordination
- Registration staff
- Medical or Outreach Assistants
- Community Health Workers (CHWs) and peer support specialists
  - 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 expertise 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, and 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 participants need all services, but participants should be evaluated for a full spectrum of services. Care coordination, clear assignments from shelter-based care teams, and clear linkages with shelters and other service providers can provide these essential services.
- Initiating care in a shelter should never be by telehealth because it puts up barriers. Shelter workers and participants will have an increase in anxiety when medical staff are not present, and telehealth is substituted. Telehealth can also set up a hierarchical system; **on-site care is needed to level the playing field and strengthen the relationship between healthcare and shelter teams. If telehealth is provided, all equipment should be supplied by the care provider, and they need to be face-to-face.**

## 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: [Creating a Culture of Safety at Health Centers](#).

## Service Delivery Models and Wrap-Around Services

All service delivery is multifaceted; however, some homeless service provider sites have more wrap-around services available than others. In a wrap-around approach, a team of professionals (e.g., service providers, educators, mental health workers) and key figures in a person's life (e.g., family, community members, etc.) create, implement, and monitor a plan of support. Wrap-around is a strengths-based intervention. Through collaborative implementation of shelter-based care in Chicago, we are striving to create more consistent availability and accessibility of healthcare and wrap-around services at different sites:

**A. Intensive sites:** Integrated teams with behavioral health and physical health providers, medical assistants, benefits enrollment, and case managers. 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 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:** This includes special event sites and/or special events within shelters, as well as 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, health fairs, and 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 and possibly psychiatry biweekly to monthly.
- Space will impact scope of services:
  - Comprehensive care
  - Physicals
  - Women's health exams
  - Urgent care
  - Management of chronic disease
  - Substance Use Disorders
  - Psychiatry
  - Rapid Testing: HIV (Human Immunodeficiency Virus), Hepatitis C Virus, Flu, Strep, pregnancy, hemoglobin A1C test, Urine Analysis, and Serum Blood Glucose
  - Screen for modifiable factors such as smoking. Cardiovascular disease, cancer, and chronic obstructive pulmonary disorder are still the biggest killer of people experiencing homelessness, and 50-80% of people smoke, so addressing smoking and cessation is important.
- Brick and Mortar health center for participants that is welcoming to persons who are experiencing homelessness
  - Some participants may prefer care off site, some guests think of the shelter as their safe place. For that reason, many want care on site, and others may want to receive care off site. Systems need to be able to accommodate this request. Not all shelters have the ability for women's health care or blood testing.
  - Open access scheduling or forgiving timed appointments are necessary.

## Supplies

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

PPE	Patient Care
Masks: surgical and N95	Wound Care Supplies
Face Shield	Ear irrigation Supplies
Gowns, Disposable lab coats	Point of Care Testing Supplies
Gloves	Blood Pressure cuff
Hand Sanitizer	Oto/ophthalmoscope
Cleansing Wipes	Pulse oximeter
	Thermometer
	CPR mouth shield
	Condoms
Engagement supplies	Technology
Socks	Laptop
Basic toiletries, lotions	WiFi
Nail Files	Cellphone
Emergency Medications	
Naloxone/NARCAN	
Nitroglycerin sublingual tabs	
Glucose Gel	
Chewable Asa	
Albuterol Inhaler	
Epi pen	

**Check expiration dates often**



## Medications

- **The ability to ensure access to medications and treatments near or where the patient is encountered is a top priority in providing care.** Do not just provide a written prescription for medication. Find processes to provide the medication immediately or to have it delivered the same day. This is inclusive of participants who are uninsured or underinsured. At each visit, and with each prescription assess:
  - Insurance/formulary status
    - If insurance is lapsed, how will they obtain meds?  
Having a contract with a pharmacy to provide medications free of charge for items you do not carry to site is necessary.
  - Is there a co-pay or limit to the number of prescriptions a person can have in one month
  - Safe use and storage
  - Do they have the ability to leave the shelter to go to the pharmacy
  - Will the chosen pharmacy deliver to the shelter? If so, who do they ask for?
  - Keep a small stock of medications on hand, see below
- Find ways to provide testing and initiate treatments on-site when possible.

### Some examples:

- If the person is referred to the emergency department for a problem, always give medication that they may need. For example, always give antihypertensive medication (like amlodipine) if you refer to the ED for a hypertensive urgency/emergency. Most EDs (emergency departments) do not dispense medications, and the person will leave without the medication that they need.
- If you refer to dental for pain or an abscess, start treating with an antibiotic/NSAID if indicated. Do not 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 a person says their partner told them they had it.

**Often participants experience lapses in insurance benefits or other barriers to pharmacy access, so 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	G.I. (Gastro-Intestine)
Acetaminophen NSAID	Docusate H2 blocker/Proton Pump Inhibitors Tums/Mylanta tabs Loperamide
Dermatology	Blood Pressure
Few categories, strengths steroid creams Antifungal	Calcium channel blockers (CCB), Angiotensin-converting enzyme (ACE) inhibitors hydrochlorothiazide (HCTZ) Beta blockers (BB)
Antibiotics	Vitamins/Others
STI Treatment As appropriate	Multivitamin infusion/injection Folic Acid Thiamine Prednisone Sugar Free/Alcohol Free Cough Syrup
Allergies/Asthma	Prevention/Emergency
Diphenhydramine Loratadine Albuterol MDI	NARCAN/Naloxone

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

## Care flow

- Shelter teams should try to arrive together. This works to break down the 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 the shelter participants and also the staff and team at the shelter. Walk around and introduce yourselves to the entire team for the first few minutes.
- Patient flow: It will take time to iron out the details of care flows and depend on the shelter's physical space and layout. 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 on-site 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. Community Health Workers (CHWs) can have an impact on follow through with referrals, so it is important to have them in the loop.

## Additional Guidance for Special Populations:

- **Pediatric Care for Children and Adolescents:** [Supplemental Guide](#)
- **Preventative Care for Persons Experiencing Homelessness:** [Supplemental Guide](#)
- **End of Life Care:** [Supplemental Guide](#)

# 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 scope of services, and how to refer to them. For shelters that do not have a behavioral health partner, there are some resources available as noted here.

## Substance Use

Shelter-based care primary care and psychiatric providers provide access to MAR. When a shelter's SBC partner is not onsite, participants can access same day treatment Through the MAR NOW Program, callers can speak immediately to a provider and receive a prescription over the phone or transportation to a clinic for same-day in-person treatment. Transportation is provided, and the program is available to all Chicagoans regardless of income, insurance status, or ability to pay. CALL 833-234-6343 BETWEEN 6AM AND 10PM 7 days per week.

## Narcan

Shelters should have a supply of Narcan on site, and all staff and volunteers should be trained in its use. Narcan is available from CDPH, Shelter-Based Care Teams, and IDHS Drug Overdose Prevention Program (DOPP). More information about DOPP can be found [here](#).

Nasal Narcan training is available from both CDPH and SBC teams.

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.

Providing services to individuals experiencing homelessness can be difficult due to the many barriers to care that this population faces. These barriers can negatively affect treatment initiation, adherence, and retention. Additionally, as stated in the [guidance provided by SAMHSA](#), the supply of affordable housing is still inadequate to meet the needs of those experiencing homelessness and wait times for placement into permanent housing can be long, ranging from a few months to several years. This can result in a period during which people are on the street and in shelters, during which their physical and mental health conditions often worsen.

# Understanding Needs, Risks, Common Conditions, Barriers, and Special Considerations

People who are experiencing homelessness often face challenges with alcohol, drugs, and mental health. Studies show that many individuals experiencing homelessness that struggle with substance use issues also deal with complicated problems like trauma, physical health, legal issues, and finding work.

Individuals experiencing homelessness with substance use or mental health problems have three main needs: specific help for the person, support for their family to prevent problems from passing to the next generation and understanding and respecting diverse cultures. The most urgent problems for individuals experiencing homelessness include dealing with both short-term and long-term medical issues (like diabetes, HIV, heart and breathing problems), getting help for drug issues, and stabilizing mental health. Some people also have untreated disabilities, such as problems with hearing, vision, balance, or moving around.

There are obstacles to getting medical help, like not having transportation, lacking insurance, and not trusting healthcare providers. Special things to consider are creating ways to reach out to and connect with individuals experiencing homelessness based on their unique needs, providing care that understands and addresses past traumas, and giving care that respects diverse cultures.

## Service Needs – Wrap-around services for people with behavioral health needs

In our community, we see the effects of systemic racism in how people move through different systems. These systems include places like shelters, hospitals, and the Cook County Jail. When we look at the people moving through all three of these places, we notice something important: 84% of them are Black, and 79% are over the age of 45. Half of these individuals are under the age of 35 and move between the Cook County Jail and emergency shelters. For the approximately 1,200 people caught in this cycle, they spend about one out of every five days in locations like jails, hospitals, or shelters. The cost of providing services for these individuals amounts to \$300 million over four years. Consistently accessing all three of these places is not easy for people experiencing homelessness, but when they do, the expenses

add up. For instance, four out of ten individuals using homeless services have had hospital or jail stays lasting over four years. The challenges intensify, particularly as 84% of those cycling through these systems are Black, and half of those moving between the Cook County Jail and shelters are under 35. When these high users end up in jail, detox becomes necessary due to alcohol-related issues, often leading to hospitalization. Additionally, securing a stable place to live poses a significant challenge for these individuals. Only 15% of them find permanent homes in the continuum of care, underscoring the continued need for efforts to ensure people have safe and stable living conditions.

Having a place to live is crucial for good health in the United States. But the systems that respond to mental health crises and homelessness usually work separately, making it hard to take care of a person's overall well-being. This separation can lead to unnecessary problems like trauma, getting arrested, going to jail, ending up in the hospital, not getting proper care, and sometimes even death. Also, being homeless can make mental health issues and substance use problems worse, turning them into a crisis.

**Wrap-around services** are a complete way to take care of someone, including their physical health, mental health, help with substance use, managing their situation, and finding a place to live. These services are important for people without homes and should be given in a coordinated way, often by teams with different experts, to handle all the unique needs these people have. Using the internet for health services (telehealth) is not the best idea for this group because they might not have the things they need, like a phone or a stable place to live. However, if someone prefers it, telehealth can be used. It is important to provide care right where people are to make the relationship between healthcare and shelters stronger.

## For Further Reading and Resources:

Explore a more comprehensive guide at [Expanding Access to and Use of Behavioral Health Services for People Experiencing Homelessness](#) (Page 32)

## Key Providers and Support Services for Homeless Individuals

- Healthcare providers can best approach and engage with individuals experiencing homelessness by:
  - Working collaboratively with the client and others.
  - Recognizing and accepting the client as an active participant in prioritizing needs.
  - Developing an empathic relationship that respects the client's wishes and creates opportunities to help the person become housed and enter treatment.
- When approaching an individual experiencing homelessness, it is important to:
  - Approach respectfully.
  - Offer safety-related items that he or she appears to need.
  - Utilize engagement strategies that invite the person to discuss their needs as they desire.
  - Keep interactions brief (about 2 minutes) unless the individual indicates a willingness to have a longer conversation, to help build trust, confidence, and tolerance of support.
- The types of providers and compilation of services needed for people experiencing homelessness with substance use and/or mental disorders include:
  - Outreach workers.
  - Case managers.
  - Peer support specialists.
  - Primary care providers.
  - Psychiatrists.
  - Psychologists.
  - Nurses.
  - Social workers.
  - Substance use disorder treatment providers.
- Services needed include:
  - Outreach and engagement.
  - Assessment.
  - Treatment planning.
  - The treatment processes.
  - Care coordination.
  - Continuing care.
  - Preventive services.
- Preventive services may include:
  - HIV testing and counseling.
  - Hepatitis B and C testing and vaccination.

- Tuberculosis screening.
- Immunizations.
- Services will need to be tailored to the needs of the population and conducted in various settings and/or in the community to ensure adequate touch points occur.

### For Further Reading and Resources:

Explore a more comprehensive guide at [Expanding Access to and Use of Behavioral Health Services for People Experiencing Homelessness](#) (Page 27)

## Coordination of Care

Coordinating Systems of Care means putting together and organizing different services for people without homes and those going through tough times with their mental health. This includes making sure homeless services, mental health crisis help, and other important services like Medicaid, housing help, and corrections departments work together. The idea is to create a better and complete response for people facing homelessness and mental health challenges. These individuals often deal with many complicated systems, and we want to avoid unnecessary problems like trauma, getting arrested, going to jail, ending up in the hospital, or even losing lives.

### For Further Reading and Resources:

Explore a more comprehensive guide at: [Coordinating Systems of Care to Provide a Comprehensive Behavioral Health Crisis Response to Individuals Experiencing Homelessness](#).

## Tips For Working with Individuals Experiencing Homelessness

- **Building Trust and Rapport:**
  - Be respectful, non-judgmental, and empathetic.
- **Trauma-Informed Care:**
  - Use principles of trauma-informed care to create a safe and supportive environment.
- **Flexible and Individualized Services:**
  - Provide services that are flexible and tailored to the unique needs and preferences of each person.
- **Engagement in Care Plans:**
  - Involve individuals in the development of their own care plans and treatment goals.



- **Access to a Range of Services:**

- Ensure access to diverse services, including housing, healthcare, substance use treatment, and mental health services.

- **Harm Reduction:**

- Offer harm reduction tools and education, such as naloxone, fentanyl test strips, and safer smoking kits.

- **Culturally Competent Workforce:**

- Recruit diverse, culturally competent workers who reflect the communities being served and bridge cultural gaps that can deter engagement.

- **Feedback and Improvement:**

- Solicit feedback from individuals with lived experience and those using services to evaluate and improve interventions

### For Further Reading and Resources:

Explore a more comprehensive guide at: [Expanding Access to and Use of Behavioral Health Services for People Experiencing Homelessness](#) (Page 20).

Four ways to Limit Use of Force in Care of Persons Experiencing Homelessness. <https://edhub.ama-assn.org/ama-journal-of-ethics/module/2785189>

## Co-occurring Behavioral Health and Chronic Medical Conditions – Vulnerability Factors

- **Vulnerability Factors:**

- Individuals experiencing homelessness with substance use and/or mental disorders face vulnerability factors.

- **Chronic Medical Conditions:**

- Common chronic medical conditions among individuals experiencing homelessness include diabetes, HIV infection, heart, and respiratory conditions.

- **Co-Occurring Disorders:**

- Individuals experiencing homelessness also have high rates of co-occurring disorders, including substance use disorders and mental illnesses.

- **Increased Risk for Homelessness:**

- People with mood disorders, schizophrenia, antisocial personality disorder, or any substance use disorder are at least two times more likely to have experienced homelessness than those without these diagnoses.

- **Untreated or Inadequately Treated Disabilities:**

- Individuals experiencing homelessness may have untreated or inadequately treated disabilities, such as hearing and/or vision impairment, lack of balance, or mobility impairments.

- **Impact on Access to Care:**

- These vulnerabilities can make it more difficult for individuals experiencing homelessness to manage their symptoms and access the care they need.
- **For Further Reading and Resources:** Explore a more comprehensive guide at: [Expanding Access to and Use of Behavioral Health Services for People Experiencing Homelessness](#) (Page 19).

- **Effective Behavioral Health Crisis Response:**

- The most effective crisis response for individuals experiencing homelessness with substance use and/or mental disorders is one that is tailored to their unique needs.

- **Consideration of Complex Issues:**

- It considers the complex issues related to trauma, physical health, justice, and employment.

- **Variety of Crisis Response Strategies:**

- Effective crisis response may involve street outreach, mobile crisis teams, drop-in centers, shelters, assertive community treatment (ACT) teams, permanent supportive housing programs, criminal justice environments, healthcare facilities, and other community behavioral health prevention and treatment programs.

### Comprehensive Assessment:

- Crisis response should include a comprehensive assessment of the individual's needs and strengths.

### Tailored Treatment Plan:

- Care for individuals experiencing homelessness should involve the development of a treatment plan that is tailored to the individual's unique needs and goals. Patient Health Questionnaire-2, Generalized Anxiety Disorder tool should be administered as they would be in a clinic setting.
- Trauma causes homelessness and homelessness is trauma. Assessment for PTSD (post-traumatic stress disorder).
- Asking about hearing voices outside of you that bother you, or seeing things that really are not there (auditory and visual hallucinations (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 the medication may help to decrease that symptom. The symptoms could be problems with sleep, 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 medications orally – keeping clinic appointments to receive intramuscular (IM) injections can be a challenge for those who need LAIs (long-acting injectables).

## Assessment and Treatment of Substance Use Disorders in the shelter

- Primary care provider teams should do SBIRT (screening, brief intervention, and referral to treatment) for all, even at the first visit. Assessing substance use disorder (SUD) and alcohol use disorder (AUD) is important.
- Shelter-based care 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 an extremely low barrier for starting medication assisted treatment/recovery; do not just refer to the clinic; carry rapid urine toxicology cups with you, but urine testing is NOT required for the diagnosis of OUD;
- Schedule a two-to-three-day follow-up soon 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 a clinic first.
- Emphasize motivational interviewing techniques for all team members, and model techniques for all staff.

- Harm Reduction for everyone those with opioid use disorder (OUD) (prescribe naloxone, do not use alone, do not go to pass outs, needle exchange);
- Train shelter staff on naloxone use and ensure they have a supply available.
- Prescribing controlled substances, particularly benzodiazepines, in large congregate settings should be an extremely rare exception, with buprenorphine/naloxone being the preferred choice. Rapid dissemination of information and the ease of medication theft necessitate a cautious approach

Do not give up on someone who is under the influence or nodding off. Gently say we can talk later and provide them with your business card so the person knows where they can get help.

### For more information

- Healing Hands: [Treatment Models for Non-Opioid Substance Use Amongst Populations Experiencing Homelessness Guide](#)
- Healing Hands: [Non-Opioid Substance Use, Mental Health, & Homelessness](#)
- For more information on treating Opioid Use Disorder in the shelter see: [Quantum Units Education® A Trusted Online CE \(Coordinated Entry\) Provider](#)
- 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.

**Tip: Community Health Workers (CHWs) and Recovery Support Specialists: use CHWs and peer support to create behavioral health care entry for those who have faced barriers or resistance to care and treatment.**

# 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: [Coordinated Entry Systems, Assessment of Vulnerability, and Housing Prioritization for People Experiencing Homelessness](#)
- Documenting Disability: [Documenting Disability Simple Strategies for Medical Providers, Password Protracted Training Information](#).
- Disability letter checklist: [Letter-Writing Checklist](#)

# Health Education

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

- Pay close attention to the 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 the 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 (ten minutes max) health education with a specific service that happens immediately thereafter, such as flu shots, TB testing, Hep A immunization, and coronavirus testing.

# 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 okay with the shelter administration and staff.

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

Do not 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 is your phone number? Are you married?) or to answer questions that the student may not have the answer to.



# Leadership From People with Lived Experience

Consumer Advisory Boards (CAB) provide people experiencing homelessness with 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 like health fairs, holiday events, developing educational materials, and contacting shelter guests to help with engagement.

## Information on Consumer Advisory Boards:

- [The National Consumer Advisory Board \(NCAB\)](#) is a committee of people who have experienced homelessness and been participants in Health Care for the Homeless projects across the country and who are involved in the governance of those HCH projects.
- [Operating Guidelines of the National Consumer Advisory Board \(NCAB\) and the NCAB Steering Committee](#)

## 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 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, [Membership Details](#).

## Health Education Resources

### Learning Modules

- Health Care for the Homeless 101: [HCH 101](#)

### Additional Adapted Clinical Standards

- [Interdisciplinary Care](#)
- [Organizing Health Services for Homeless People A PRACTICAL GUIDE](#)
- [COVID-19 and People Experiencing Homelessness RESOURCES AND GUIDANCE](#)

# Outbreaks and Infectious Disease Care

**NEW COVID-19 GUIDANCE FOR SHELTERS; NEW ISOLATION FACILITY; TB SCREENING QUESTIONS; MENTAL HEALTH TRAINING FOR SHELTERS (August 3, 2023)**

## COVID Updates

The Illinois Department of Public Health (IDPH) has released **new COVID-19 guidance**, considering the end of the federal public health emergency. The Chicago Department of Public Health has told us that they will issue guidance that will align with IDPH guidance, and we will share this CDPH guidance when it is received.

Shelters should monitor the **CDC (Centers for Disease Control) COVID-19 Data Tracker** weekly and implement enhanced infection prevention and control measures based on the **level of new COVID-19 hospital admissions** over the past week in their county.

## If we are at **LOW** risk, assessed weekly, we follow this guidance:

- Shelters no longer must screen people entering the building for symptoms of COVID-19.
- We should offer high-quality masks to staff and clients based on risk.
- Routine physical distancing is no longer emphasized.
- Testing persons with symptoms of COVID-19 and acting based on that test result has not changed, with an emphasis on early treatment of COVID-19 for those most at risk.


## COVID-19: Providing Care During a Pandemic

COVID-19: Testing on Shelter Intake is 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


# 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](http://www.nhchc.org/covidbrief)  
See our [coronavirus resource page](http://www.nhchc.org/coronavirus) for more information and guidance on COVID-19: [www.nhchc.org/coronavirus](http://www.nhchc.org/coronavirus)

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abnormal or temperature exceeds 100.4 F, isolate the guest or staff member in an empty room if possible, and call the aligned FQHC (Federally Qualified Health Centers) or, in Chicago call 872-588-3304 to access the testing team at Lawndale Christian Health Center.

There are specific unhoused populations with distinct needs (particularly during a pandemic).

**They include:**

- Medically and structurally vulnerable: those at high-risk for COVID-19, people with disabilities, people who are pregnant etc.
- Persons with Serious mental Illness (SMI) and/or substance use disorder (SUD)
- Unsheltered homeless individuals
- Families, including those “doubled-up”
- School-aged children
- Unaccompanied minors/youth
- Postsecondary students

- Survivors of domestic violence
- Veterans
- Undocumented individuals and families
- Justice involved individuals

## Unhoused individuals and families are especially vulnerable to COVID-19

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.

# Key Components of Partnerships between Health Care Providers and Shelters

(Updated October 2023)

## Role of Shelter-Based Health Care Teams

- Partner with the Chicago Department of Public Health (CDPH) and existing Health Care for the Homeless providers. Do not attempt to set up services at places where there are existing relationships with health teams. Some teams receive local city funding, others private and some are designated Health Care for the Homeless by the Human Resource Service Administration (HRSA).
- Include People Experiencing Homelessness in planning.
- Outreach and engagement with shelter residents and staff. Onsite work with the shelters is important for ensuring staff and residents.
- Assign a dedicated point of contact for the shelter's medical needs and help to refer and connect residents to services.
- Assist with Housing applications. Support for disability determinations can end homelessness for the person in front of you.
- Follow Health Care for the Homeless standards of care as presented in this document: [Clinical Practice: Assisting Health Care for the Homeless Clinicians and Staff](#)
- 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 (Department of Family and Support Services), and CDC guidance on infection control, PPE, quarantine, and isolation, etc.
- Help to identify participants at increased risk of severe disease.

When there are residents with COVID-19 symptoms:

- **Work with CDPH and existing testing teams** to test people with COVID-19- like symptoms who are not considered at high risk of severe illness and do not require hospitalization (anyone meeting either criterion should be transferred to the emergency department (ED) immediately).
- **Assist the Rapid Testing Team** in screening participants at your shelter if there is a case or cluster of cases detected.

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

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

## Additional Guidance from the Chicago Department of Public Health

- Guidance for Congregate Living: [Chicago Department of Public Health COVID-19 Guidance for Congregate Living](#)
- Guidance for Homeless Shelters: [COVID-19 Guidance for Homeless Shelters as Chicago Cautiously Reopens and Gradually Resumes](#)

**Health teams working in shelters should have adequate PPE for use during times of increased respiratory illness.**

### General Guidelines:

- For general care, a surgical mask is required.
- Running water and soap or alcohol-based hand sanitizer
- Gloves
- Consider use of disposable lab coats
- Antimicrobial/antiviral 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 local health authority infection control guidelines 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, so tailor your education appropriately. This is a suitable place for students to help.

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

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

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.



**For more information visit the Coronavirus Resources of the National Health Care for the Homeless Council's website: [www.nhchc.org/coronavirus](http://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](http://www.nhchc.org)*

# Screening

Shelter staff should be educated on the signs, symptoms, and screening for COVID-19, influenza, varicella, and gastrointestinal illness. Clients should be evaluated routinely. The COVID-19 questionnaire below is easy to use and comprehensive for daily screening during times of increased shelter or community infections. 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.

**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.

# New Isolation Resource for the City of Chicago

## The Quarantine and Isolation - Hotel Housing Services program

In collaboration with Heartland Alliance Health, 10 rooms are available for people experiencing homelessness (sheltered and unsheltered), mental illness, substance-abuse, and other behavioral health issues that need isolation and quarantine space for various communicable diseases, such as COVID-19 and Monkeypox.

The following is the referral procedure and protocol for Quarantine & Isolation Housing Program:

### REDCap

All referrals must be submitted through the [REDCap referral link](#)

**All requests will be reviewed by CDPH Quarantine & Isolation Housing Program team (Dr. Michelle Funk, Ernie Brown-Gomez, Divya Ramachandran, Anne Schultz).**

## Eligibility criteria

The Case must be infectious communicable diseases AND either diagnosed or of high clinical suspicion from medical provider:

Please use the point of contacts listed below to refer people that are in need for isolation:

**Divya Ramachandran**

([divya.ramachandran@cityofchicago.org](mailto:divya.ramachandran@cityofchicago.org)) or 312-805-7600

**Anne Schultz**

([anne.schultz@cityofchicago.org](mailto:anne.schultz@cityofchicago.org)) or 312-742-0846

**Ernest Brown-Gomez**

([Ernest.Brown-Gomez@cityofchicago.org](mailto:Ernest.Brown-Gomez@cityofchicago.org)) or 312-744-7513

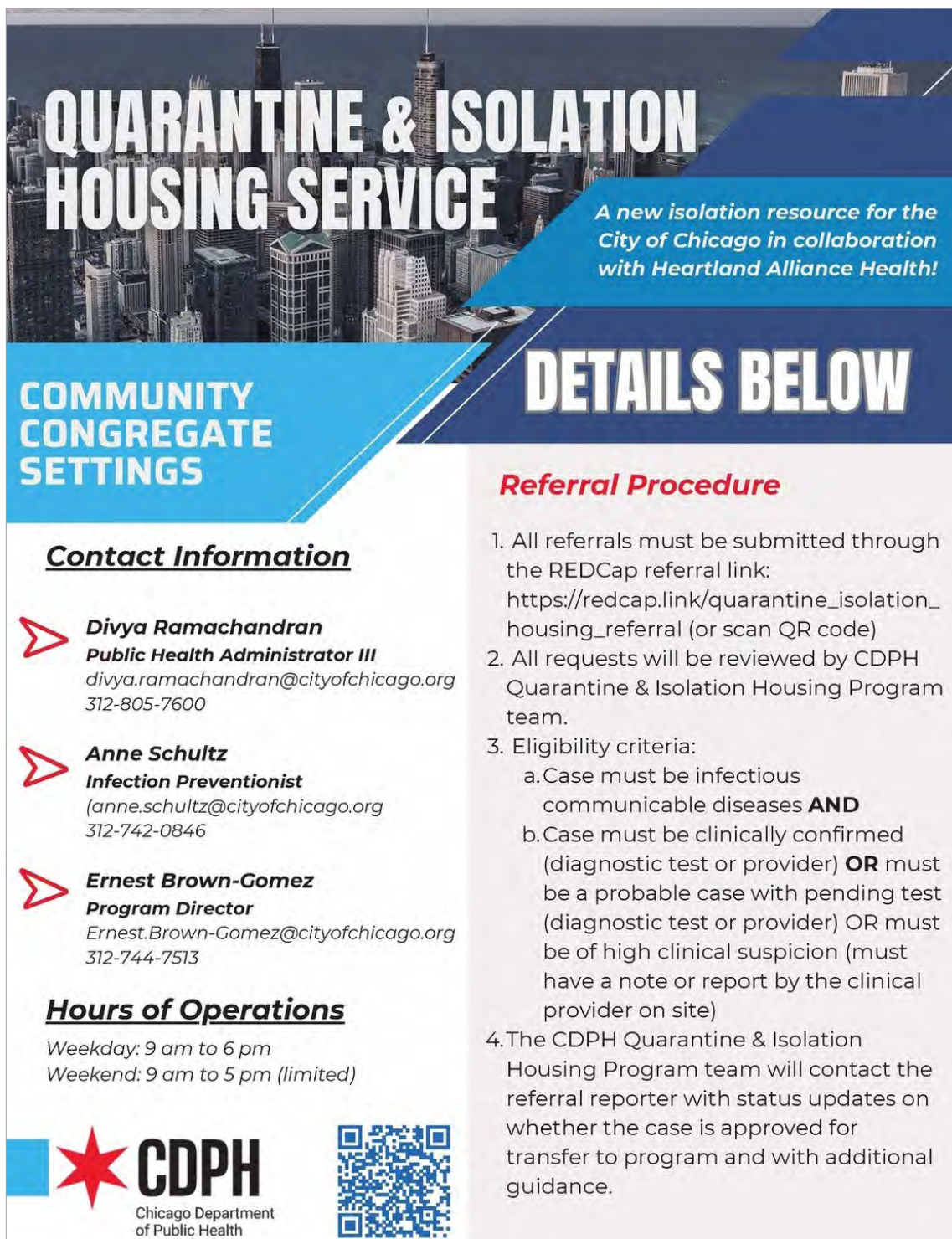
## Hours of operations:

**Weekday hours:** Referrals are available until 6 pm so that the cases can be placed into rooms by 8 pm at the latest.

**Weekend hours:** Referrals are available from 9 am to 5 pm.

# Appendix

## Quarantine & Isolation Housing



**QUARANTINE & ISOLATION HOUSING SERVICE**

*A new isolation resource for the City of Chicago in collaboration with Heartland Alliance Health!*

**COMMUNITY CONGREGATE SETTINGS**

**DETAILS BELOW**

**Contact Information**

➤ **Divya Ramachandran**  
**Public Health Administrator III**  
divya.ramachandran@cityofchicago.org  
312-805-7600

➤ **Anne Schultz**  
**Infection Preventionist**  
(anne.schultz@cityofchicago.org)  
312-742-0846


➤ **Ernest Brown-Gomez**  
**Program Director**  
Ernest.Brown-Gomez@cityofchicago.org  
312-744-7513


**Hours of Operations**

Weekday: 9 am to 6 pm  
Weekend: 9 am to 5 pm (limited)

**Referral Procedure**

1. All referrals must be submitted through the REDCap referral link:  
[https://redcap.link/quarantine\\_isolation\\_housing\\_referral](https://redcap.link/quarantine_isolation_housing_referral) (or scan QR code)
2. All requests will be reviewed by CDPH Quarantine & Isolation Housing Program team.
3. Eligibility criteria:
  - a. Case must be infectious communicable diseases **AND**
  - b. Case must be clinically confirmed (diagnostic test or provider) **OR** must be a probable case with pending test (diagnostic test or provider) **OR** must be of high clinical suspicion (must have a note or report by the clinical provider on site)
4. The CDPH Quarantine & Isolation Housing Program team will contact the referral reporter with status updates on whether the case is approved for transfer to program and with additional guidance.

 **CDPH**  
Chicago Department of Public Health



# COVID-19 Transmission Shelter Risk Assessment Tool

## Facility Prep

**All identified at risk areas are points of education and intervention signs are posted at shelter entrances instructing all persons to wear masks before entering.**

- 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 (PPE) by staff and volunteers
- Proper cloth mask washing

## Sanitation

- OSHA (Occupational Safety and Health Administration) 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 (PPE) 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

## Checklist for Shelter-Based Health 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 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 Health Care 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 workflows including consent and registration.
- Medications:
  - Identify pharmacies.
  - Identify stock medications and order if needed.
- Define medication dispensing policies.
- Identify the SUD provider group and mental health provider group for the shelter participants.
- Define linkages and legal collaborations (mutual return on investment)
- 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, or 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 implement health authority guidance around infection control and disease prevention