USICH and SARS-CoV-2[1] -- The Federal Response for Families and Individuals Experiencing Homelessness

This report is focused on USICH's efforts and national outcomes during the first six months of the COVID-19 and its impact on families and individuals experiencing homelessness January 1, 2020 through June 30, 2020.

Abstract

*Through the guidance of the U.S. Department to Health and Human Services (**HHS**) Centers for Disease and Control Prevention (**CDC**), the work of front-line emergency homelessness service providers and the support of many federal agencies, the incidence of positive COVID-19 cases and fatalities due to COVID-19 within the community of homelessness has been significantly lower than had been originally projected. Within the community of homelessness, the data indicates there have been 4,845 positive COVID-19 cases, and unfortunately, there have been 130 individuals who have died due to COVID-19 as of June 30, 2020.[2] Additionally, the rate of positive COVID-19 for families and individuals experiencing homelessness has been lower relative to respective general public rates as well as lower than the rates of other congregate living cohorts. The battle with COVID-19 is not over yet. Until a safe and effective vaccine and/or a therapeutic protocol are widely available, all agencies, organizations and individuals working to contain and mitigate COVID-19 within the community of homelessness must maintain extremely high levels of vigilance and make course corrections along the way as necessary.*

[1] SARS-CoV-2 (Severe Acute Respiratory Syndrome Coronavirus 2) is the name of the virus and replaced the prior name "2019 Novel Coronavirus." COVID-19 is the name of coronavirus disease caused by SARS-CoV-2. For the purpose of this report, COVID-19 is the term generally used.

[2] CDC data were compiled using the following sources: CDC's National Syndromic Surveillance Platform (NSSP), CDC's COVID-net, CDC's Data Collation and Integration for Public Health Event Response (DCIPHER) platform, CDC COVID Data Tracker United States COVID-19 Cases and Deaths by State and web scraping. Data reported from the CDC surveillance systems are provisional and subject to change.

United States Interagency Council on Homelessness (USICH)

USICH is an independent federal agency within the executive branch that is charged with:

- Coordinating the federal response to dramatically reduce family and individual homelessness.
- Creating national partnerships among all three-levels of government and with the private sector to drive the reduction of homelessness at the local level.
- Maximizing the effectiveness of the federal government in order to dramatically reduce family and individual homelessness.

USICH's vision to address homelessness is "*Trauma Informed Care + Affordable Housing = Housing Stability*."

USICH and the COVID-19 Response

The primary objective of **USICH** is to ***"save lives and avoid overwhelming local emergency rooms and departments due to medically compromised residents of homelessness facilities and encampments."*** **USICH** has led and coordinated the overall federal containment and mitigation response to the COVID-19 pandemic for families and individuals experiencing homelessness. Throughout the last six months, **USICH** has worked directly with a multitude of federal agencies, direct front-line homelessness service providers, public health authorities, health care providers, emergency response organizations and the White House on the COVID-19 response. At the outset of the pandemic in the United States, **USICH** took a proactive "emergency management incident command system" approach to the COVID-19 response -- which was informed by the unique characteristics of the homelessness community. Additionally, **USICH**'s strategies and tactics relied on information from data, doctors, epidemiologists and the scientific community.

From the onset, **USICH**'s leadership goal for the federal government's response to COVID-19 within the homelessness community has been to save lives and avoid overwhelming local emergency rooms and departments due to medically compromised residents of homelessness facilities and encampments. Because of **USICH**'s unique positioning within the homelessness space, **USICH** has been able to take fast and firm action.

From the outset of the COVID-19 pandemic, there were five congregate housing cohorts of utmost concern to the overall response effort:

- Nursing homes, long-term care facilities and assisted living facilities.
- People incarcerated in jails and prisons.
- Officers and enlisted personnel going through military training.
- University and college students.
- Families and individuals experiencing homelessness.

USICH has been immersed in addressing the federal response to families and individuals experiencing homelessness, and as necessary, has been also involved with issues regarding students and incarcerated individuals who also are experiencing homelessness.

In order to strategically address the needs of the possible effects of COVID-19 on the community of people experiencing homelessness, **USICH** divided the community of homelessness into four sub-cohorts in order to better customize COVID-19 containment and mitigation response initiatives:

- People receiving homelessness-based housing vouchers.
- People living in emergency centers, shelters and campuses.
- People living in encampments.
- Students, unaccompanied youth and families with children experiencing homelessness.

Each of these four homelessness sub-cohorts has unique characteristics that are associated with different medical acuity levels and varied likelihoods of exposure, transmission and spread:

Sub-cohort 1: People Receiving Homelessness-Based Housing Vouchers:
This sub-cohort has similar exposure and transmission risk levels to general population cohorts living in high-density apartments. In terms of medical acuity, the level of individual healthiness within this sub-cohort is generally slightly lower, relative to the general population living in apartment complexes. **CDC** guidance used for shared and congregate housing is useful in addressing COVID-19 for this homelessness sub-cohort.

Sub-cohort 2: People Living in Emergency Homelessness Centers, Shelters and Campuses:
Because of high contact levels between volunteers and staff members with residents experiencing homelessness, **USICH has made this sub-cohort a priority area**. There was a concern that staff and volunteers would transmit the coronavirus to those living in emergency shelters, centers and campuses. Individuals experiencing homelessness were not going to China for Chinese New Year, Italy for Spring Break, or New Orleans for Mardi Gras- whereas many staff and volunteers were frequent travelers. Simply put, **USICH has been, and continues to be, most concerned about the inward transmission of the Coronavirus through community spread**.

There are generally lower levels of medical acuity within this sub-cohort. Fortunately, staff members, volunteers, case workers, and medical care workers are embedded within emergency service shelters, centers and campuses and have thus been able to work proactively to contain and mitigate the Coronavirus within this community of homelessness. **CDC** has provided a series of guidance documents that are specific to the homelessness community that **USICH** has broadly and extensively promoted and disseminated to front-line service providers. **These guidance documents have elevated the importance of wearing masks, six-foot social distancing, isolation as needed, quarantine as needed, active hand washing, elimination of congregate meals, increased disinfection and "location tracing" (a form of contact tracing that is better suited for individuals experiencing homelessness).**

Sub-cohort 3: People Living in Encampments:
The risk of transmission into and within encampments has been generally much lower than in other identified sub-cohorts because of ultraviolet rays, natural outdoor air flow, existing social distancing and

a general aversion to interaction with the public. Individuals living in encampments have generally higher medical acuity levels. The **CDC** guidance for this sub-cohort has focused on the insertion of hygiene stations/supplies, improved hand sanitation and discouraging removing individuals from encampments (except when medically necessary for specific individuals).

Sub-cohort 4: Students, Unaccompanied Youth and Families with Children Experiencing Homelessness: The living circumstances of students, unaccompanied youth and families with children experiencing homelessness vary significantly across the country. It is therefore exceedingly difficult to generalize the risk of COVID-19 exposure and the level of medical acuity for this sub-cohort. Many within this sub-cohort have experienced elevated levels of domestic violence and abuse, higher levels of food insecurity, disconnection from services, increased levels of *learning-loss*, reduced childcare services and other work-related challenges. Youth within **this sub-cohort are likely to become victims of community spread and, in turn, unknowingly become vector transmitters themselves because of their constantly changing sleeping arrangements and locations.**

The approaches taken for the COVID-19 response within these four sub-cohorts were based on **CDC** guidance as well as lessons learned from our partners across the country. Lessons learned in Seattle and King County, Washington (the ground-zero epicenter for the outbreak in the U.S.) were particularly helpful during the initial onset of COVID-19.

Individuals and families experiencing homelessness require specific attention due to instances of relatively higher medical acuities that increase the risk of bad outcomes. Communities of color suffer relatively more from underlying chronic health conditions, such as diabetes, hypertension, obesity and chronic kidney disease, that are negatively affected after contracting COVID-19. Additionally, data show health disparities when it comes to Black, Latinx, Native American and other communities of color, including families and individuals experiencing homelessness.

Strategic USICH COVID-19 Initiatives and Activities

USICH, in partnership with other federal agencies, has conducted a variety of strategic initiatives and tactical activities including, but not limited to, the following:

Coordinated the Federal COVID-19 Response for People Experiencing Homelessness: USICH has been coordinating the overall federal response to COVID-19 relating to families and individuals experiencing homelessness, including two **USICH** Council meetings at the principals' level chaired by Department of Labor (**DOL**) Assistant Secretary John Pallasch.

Chaired the COVID-19 Homelessness Interagency Work Group: Since the presidential declaration regarding the COVID-19 pandemic, **USICH** Executive Director Dr. Robert Marbut Jr. has chaired the COVID-19 Homelessness Interagency Work Group working within the Department of Homeland Security Federal Emergency Management Agency (**FEMA**) command structure of the Emergency Determination under the Stafford Act. This work group has been integral in the coordination of federal partners and initiatives. The work group has enabled collaboration between federal partners and non-governmental

organizations and has met one to three times per week -- every week -- in order to coordinate strategies and tactics, foster information sharing, improve situational awareness and proactively plan for the longer-term effects of COVID-19.

COVID-19 Homelessness Interagency Work Group Participating Agencies and Organizations:

- Department of Agriculture (USDA),
- Department of Education (ED),
- Department of Health and Human Service:
  - i. Assistant Secretary for Planning and Evaluation (HHS/ASPE),
  - ii. Assistant Secretary for Preparedness and Response (HHS/ASPR),
  - iii. Centers for Disease and Control Prevention (HHS/CDC),
  - iv. Health Resources & Service Administration (HHS/HRSA),
  - v. Substance Abuse and Mental Health Services Administration (HHS/SAMHSA),
- Department of Homeland Security Federal Emergency Management Agency (DHS/FEMA),
- Department of Housing and Urban Development (HUD),
- Department of Labor (DOL),
- Department of Veterans Affairs (VA),
- Small Business Administration (SBA),
- U.S. Interagency Council on Homelessness (USICH),
- American Red Cross
- Citygate Network
- Salvation Army

Additional federal agencies have been included on an as-needed basis.

Hosted State and Local Official Webinars: USICH has been hosting a series of webinars for state and local government officials that have been focusing on real-time lessons learned. The first webinars were primarily based on lessons learned in the response of COVID-19 in Seattle and King County, Washington. Representing the area of initial impact of the Coronavirus in United States, these two jurisdictions have had impactful observations and useful lessons learned that **USICH** has helped share nationally. Key topics of these webinars have included critical issues of response systems as well as isolation and quarantine operations. These webinars included **USICH** staff, **CDC** epidemiologists, local officials from Seattle and King County and subject matter experts from other federal agencies on an as-needed basis. These webinars allowed local officials in communities to better prepare for COVID-19 before the virus reached their respective homelessness shelters, centers and campuses. Beyond the workshop conference calls with state and local officials, **USICH** hosted workshops with the Women of Color Network and the Women Veterans United Committee. **These webinars have reached approximately 13,385 individuals in communities across the country.**

Provided COVID-19 Hot Spot Surveillance Support: USICH supported **CDC** with surveillance and identification of potential hot spots. This has proved to be especially important because the direct emergency homelessness service agencies have used leading indicators to warn of "possible" COVID-19 outbreaks before testing was conducted and/or test results were completed. This provided a critical early warning system in which to contain and/or mitigate the spread of COVID-19 within local

communities of homelessness. Beyond the preemptive and rapid identification of potential hot spots, this surveillance network of direct emergency service providers has proven to be more sensitive and robust than existing surveillance systems.

Proactively Led and Conducted Hot Spot Containment and Mitigation: Before any positive COVID-19 cases had been reported within the homelessness community, USICH set up a 24/7/168 emergency rapid response protocol that was led by the **USICH** Executive Director and the Chief Operating Officer. This rapid response team worked directly with potential hot-spot homelessness shelters, centers and campuses to contain and/or mitigate the spread of the virus within and between emergency facilities. In addition to the facility program operators, **USICH**'s rapid response team generally has worked with CDC, local authorities and staff from national network organizations proactively to address critical issues.

Led the Effort to Include Homelessness and Food Bank Providers as Critical Infrastructure: In partnership with the White House, **DHS/FEMA** and **HHS**, **USICH** worked with the Department of Homeland Security's Cybersecurity and Infrastructure Security Agency (**DHS/CISA**) to formally include language designating homelessness and food bank services and workers as official essential critical infrastructure within the "*Updated Memorandum on Identification of Essential Critical Infrastructure Workers during COVID-19 Response*." This guidance enabled direct emergency homelessness service agencies to source Personal Protective Equipment (PPE) more readily and encouraged state and local authorities to keep emergency homelessness service providers and food banks open.

Provided Technical Assistance: USICH provided a wide range of technical assistance (TA) to Congressional Members, Congressional staff members and federal agencies on the COVID-19 response for those experiencing homelessness. **USICH** TA addressed issues ranging from critical gaps within The Coronavirus Aid, Relief, and Economic Security (CARES) Act, to the inclusion of non-profits within the Payroll Protection Plan, to student food distribution processes.

USICH also provided technical assistance to state and local officials throughout the United States on the COVID-19 response regarding people experiencing homelessness. Additionally, **USICH** provided an extensive amount of TA to direct front-line emergency homelessness service providers on a wide range of issues.

Proactively Disseminated Updated Federal Guidance and Information: **USICH** distributed updated guidance regarding the Coronavirus and COVID-19 impacting people experiencing homelessness through a variety of **USICH** communication platforms. Guidance and information were produced by **CDC, ED, FEMA, HHS, HUD, SBA, USDA** and **VA**, and subsequently has been widely disseminated by **USICH**.

USICH Staffed Numerous Response Task Forces and Work Groups: USICH staff members have served on formal and ad-hoc response work groups including, but not limited to, Alternative Care Sites, **FEMA** Emergency Support Function (ESF) #6 (mass care, emergency assistance and human services), ESF #6 Policy Cell, financial assistance and food insecurity. Additionally, many **USICH** staff members have been involved with a wide variety of special projects and issues relating to COVID-19 and homelessness.

Conducted Virtual-Workshop Conference Calls with Direct Front-Line Emergency Homelessness Service Providers: Of all the initiatives undertaken, the most productive and powerful **USICH**-led activity has been a series of interactive virtual-workshop conference calls in partnership with the **CDC** and other necessary federal agency experts for the direct front-line emergency homelessness service providers across the country. The sharing of guidance, followed by extensive two-way Q&A sessions, occurred during every conference call. The Q&A focused mostly on **CDC** protocols, the CARES Act, the Paycheck Protection Program, Economic Impact Payments, the Coronavirus Food Assistance Program and **HUD** Emergency Solutions Grants (ESG).

CDC guidance has focused on the importance of wearing masks, six-foot social distancing, isolation as needed, quarantine as needed, active hand washing, elimination of congregate meals, increased disinfection and "location tracing."

These proactive and timely conference calls built on the concepts of D2C (direct-to-consumers) by bypassing intermediaries, which allowed front-line emergency homelessness service providers to interact directly with **CDC** doctors and epidemiologists. This provided real-time, two-way information flow between federal subject matter experts and front-line homelessness service providers. **CDC** has reported that this direct contact with front-line service providers allowed them to develop higher quality guidance over a shorter period.

USICH also learned from a majority of front-line direct service providers that, at the outset of the pandemic, service providers were having difficulty connecting with their respective local health authorities who were overwhelmed at that time due to the increased workload resulting from COVID-19. Providers reported their local health authorities' phones were repeatedly busy, voice mailboxes were full, and emails were not being answered. Yet, because of the connection made between the front-line providers and the **CDC** via **USICH**'s work in the space, service providers were able to talk directly with high-level **CDC** epidemiologists and other federal experts in real time.

The following national organizations and networks of direct front-line emergency homelessness service providers have participated in these conference calls, including numerous, regular conference calls throughout the duration of the COVID-19 Emergency:

- Catholic Charities.
- Citygate Network.
- Family Promise.

- National Network for Youth.
- Salvation Army.
- School House Connection.
- Society of St. Vincent de Paul.
- Volunteers of America.
- YUSA.
- Large independent homelessness centers and campuses (an ad hoc group organized by USICH).

To date, an estimated **4,580 individuals from the above national networks have participated in these USICH-led workshops, representing approximately 96.8% of the emergency beds in the U.S.** As the pandemic spread, it became clear that **having shelter, center and campus staff members who were vigilant in promoting and maintaining CDC protocols within facilities and programs was a critical success factor** for better outcomes.

In each of these conference calls, **USICH** and other federal partners focus on the following critical issues:

- **CDC** guidance and protocols.
- Hot spot containment and mitigation as well as quarantine and isolation.
- Personal Protective Equipment (PPE) and cleaning supplies.
- Increased demand for services.
- Staffing and staff fatigue.
- Volunteer levels and at-risk volunteer sub-groups who were in their 60s and 70s.
- Donations and financial stability of local affiliates and agencies.
- Food supply to centers, shelters and campuses, as well as pantries and feeding centers.
- Physical plant and facility layouts.

Most local affiliates and agencies report a 25-75% increase in demand for services; meals and food services represent the highest increase. These increases in demand have led to additional operating costs for food, PPE, cleaning supplies and linens. Additionally, many agencies have had to pay to modify their physical plants to meet the six-foot social distancing guidelines and improve their sanitation and hygiene systems.

In terms of staffing and volunteers, many organizations have lost and/or chosen not to use their volunteer corps, because most of their volunteers have been in the high-risk 60-70 age group. Recently some agencies have had limited success in recruiting college-age volunteers.

Proactively addressing these items both strategically and tactically before the Coronavirus presented in local communities helped in reducing the likelihood of hot spots that could have overwhelmed and crashed local emergency medical facilities. **It was critical to move early, swiftly and firmly.** Collaboration throughout the federal government with local entities and non-governmental organizations has been instrumental in helping to save lives by lessening the demand on local

emergency health systems and thus not overwhelming emergency rooms and departments with medically compromised people experiencing homelessness.

Emergency homelessness shelters, centers and campuses realized many improvements that helped the families and individuals that these organizations serve. Additionally, **CDC** and other federal agencies benefitted from the questions and feedback on these conference calls in three ways:

1. Provided better and more robust situational awareness.
2. Expedited learning curves.
3. Created efficient and unfiltered connections with direct emergency service providers.

Note: This report focuses on the activities of **USICH**. There are many federal agencies that have implemented major departmental programs and initiatives to assist the community of homelessness during the COVID-19 pandemic, including the CARES Act that contains **HUD**'s ESG and Community Development Block Grant Programs initiatives.

Data on COVID-19 and the Homelessness Community

As of June 30, 2020, within the general public in the United States, there have been 2,581,229 total positive COVID-19 cases in the U.S., and sadly 126,739 deaths have been caused by COVID-19. In comparison, within the community of homelessness, the **preliminary data indicates that there have been 4,845 positive COVID-19 cases, and unfortunately there have been 130 individuals who have died due to COVID-19.**

The number of positive cases and fatalities within the community of homelessness is dramatically and significantly lower than originally predicted. It is relatively lower than local general public populations and other congregate housing cohorts. The rate of impact within the homelessness community could have been much higher and more devastating than it has been to date, had early and firm action not been taken. **This early collaboration with federal agencies, front-line providers, and local authorities made a significant difference in reducing the number of positive cases and fatalities of people experiencing homelessness.**

It is especially important to note that in most local communities, individuals experiencing homelessness have been tested on a wider basis and at significantly higher rates than the general public.

For example, in an effort to better understand the nature and spread of the Coronavirus and COVID-19 within the community of homelessness, Mercy Care of Atlanta Georgia was asked by **CDC** and Fulton County to work with local homelessness service providers to comprehensively test as many as possible individuals experiencing homelessness within Atlanta. COVID-19 testing was conducted at 23 sites (within homelessness congregate shelters, service centers, clinics, encampment outreach sites, and a COVID-19 isolation hotel) in Atlanta, over a five-week period ending on May 15, 2020. **At least 75% of all individuals experiencing homelessness in Atlanta received tests, and people experiencing homelessness had a 1.2% COVID-19 positive rate.** This included individuals who were symptomatic and

asymptomatic. This is estimated to be a lower positive rate than within the general public in Atlanta.

It is also informative to review data from Los Angeles County, since it has the highest local population of people experiencing unsheltered homelessness in the U.S. The 2019 Point-in-Time Count reported 42,471 individuals as unsheltered with 58,936 individuals experiencing overall homelessness. As of June 28, 2020, there were 642 reported **positive COVID-19 cases which represents 1.1% of the 2019 homelessness count**. Additionally, the Los Angeles Medical Street Surge initiative has been conducting extensive testing at clinics, shelters, interim housing sites and pop-up sites in and around encampments. As of June 24, 2020, the Medical Street Surge initiative had reported 69 positive tests and 3,397 negative tests, which represents **a COVID-19 positive test rate of 1.9%**.

On a national level, there have been only nine local communities to report more than 100 confirmed positive cases of COVID-19 within the community of homelessness. Of these nine, approximately five have had 100-499 positive cases, three have had 500-999 positive cases and one has had over 1,000 positive cases. Furthermore, of the largest 1,250 emergency shelters, centers and campuses in the U.S., approximately 24 have approached becoming a potential hot spot that needed to be contained and/or mitigated. Of these 24, less than a handful needed to be temporarily closed.

An even more important metric than the rate of positive tests is the rate of emergency room and department visits. During the last eight weeks, **the emergency room and department visit percentage-rate has dropped seven of the last eight weeks on a week-over-week basis for individuals experiencing homelessness,** for both "ICD Code U07.1" (emergency code for confirmed COVID-19) and for "CLI, CC, or COVID DD" (COVID-like illness chief complaint or diagnoses of COVID-19).

Through the efforts of **CDC**, the broad support of many federal agencies and the front-line emergency homelessness service providers, **the incidence of positive COVID-19 cases and deaths caused by COVID-19 within the community of homelessness has been significantly lower than predicted, and has been lower than estimated rates relative to the general public and other congregate living cohorts.** The battle with COVID-19 continues, and the situation could change quickly. It is therefore critical to remain vigilant and continue with the efforts that have led to these better-than-projected outcomes. Until a safe and effective vaccine is widely administered, all the agencies, organizations and individuals working to contain and mitigate COVID-19 within the community of homelessness must remain vigilant.

Data Sources

CDC data were compiled using the following sources: **CDC**'s National Syndromic Surveillance Platform (**NSSP**), **CDC**'s COVID-net, **CDC**'s Data Collation and Integration for Public Health Event Response (DCIPHER) platform, **CDC** COVID Data Tracker United States COVID-19 Cases and Deaths by State, and web scraping. Data reported from the **CDC** surveillance systems are provisional and subject to change. Additional data came from City of Los Angeles, County of Los Angeles and Mercy Care COVID-19 Testing. **USICH** expects that some of the reported data above may increase slightly, mostly due to timing of reporting.

Work to Be Done

Address the Compounding Issues Between COVID-19 and the Upcoming Seasonal Flu:

Dealing simultaneously with two different viral respiratory diseases that have similar and overlapping symptoms is going to require a highly-structured strategic response. There are at least four compounding factors that make dealing with the seasonal flu and the Coronavirus at the same time particularly challenging:

1. It will be difficult, especially in the early stages of infection, to distinguish between the seasonal flu and COVID-19.
2. The addition of tens of thousands of seasonal flu cases into local emergency room and departments will add to the overloading of the medical system.
3. With weakened immune systems, it is likely that some individuals could contract both the seasonal flu and COVID-19 at the same time.
4. It is likely that some symptomatic seasonal flu patients who have not been tested will falsely think they have COVID-19 and present themselves at local emergency rooms and departments, thus adding to already overloaded emergency rooms and departments.

The best way to fight these two-front wars will be to widely administer the seasonal flu vaccine within the community of homelessness as well as within the general public as soon as the seasonal flu vaccine is ready to administer. Planning efforts are underway to promote, distribute and administer the seasonal flu vaccine within the homelessness community. This effort also will be an excellent pilot prep run for the COVID-19 vaccine when it is ready to be administered. **Having a singular multiplex assay test for Influenza Type A, Influenza Type B, Respiratory Syncytial Virus (RSV) and COVID-19 also would be an excellent tool to help battle these diseases.**

Families with Children and Youth Need Focused Attention:

So far during the COVID-19 pandemic, **children, youth and families experiencing homelessness**, as defined by the **ED**, **have received significantly less homelessness assistance because most of these populations have not been eligible for ESG homelessness assistance provided through the CARES Act**. This group of 1,508,265 individuals does meet the **ED** definition, but most of the individuals are not covered under **HUD**. As a result, families and youth experiencing homelessness continue to experience instability.

School closures caused by the pandemic have created significant challenges, such as keeping in communication with families and youth, and identifying youth and families who have recently started experiencing homelessness. This loss of contact means that families and youth may not receive critical wraparound services. Children and youth experiencing homelessness face significant barriers to distance learning due to lower levels of access to the internet and electronic device ownership. Further, "*learning-loss*" is likely to be exacerbated with additional face-to-face school closures. It is therefore critical to focus attention on this issue and to close any learning gaps as a result of COVID-19.

Relieve Staff Fatigue Among Homelessness Services Providers:

Most front-line emergency service staff members within shelters, centers and campuses have been working significant amounts of overtime since the outbreak of COVID-19. The stress on staff has been exacerbated by the fact that many organizations have chosen to stop or limit volunteers from helping, since so many of the volunteers are in their 60s and 70s, thus adding to the workload of the staff. Additionally, many staff members have had to quarantine and isolate, which has added to the workloads of the remaining staff members on duty. All of this is occurring in an environment in which most homelessness service providers have seen a 25-75% increase in demand for services. Unfortunately, most organizations do not have available funding to add staff.

The front-line homelessness emergency service staff members across the U.S. have been doing an amazing job despite such challenges, but they are fatigued and need relief. It is difficult to be vigilant while exhausted. The passion and efforts of these front-line emergency workers need to recognized and honored. **Allocating resources to expand staff capacity would be extremely helpful.**

Address the Need for Scalable and Flexible Isolation and Quarantine Areas and Sites:

Affected communities and agencies realized during the initial outbreak of COVID-19 that it was critical not to overload and crash the emergency rooms and departments. It is thus essential to have scalable and flexible isolation and quarantine areas within shelters, centers and campuses that act to contain and/or mitigate the spread of the Coronavirus. This is especially important with the rise of community spread. If locations are not available within shelters, centers and campuses, formal offsite alternative care sites need to be stood up. Beyond containment and mitigation, these alternative care sites provide the critical function of diverting individuals away from emergency rooms and departments, thus reducing the demand on emergency rooms and departments.

Looking to The Future

The battle is not over yet, and we need to maintain vigilance as the situation could change quickly. It is therefore critical that we remain vigilant and continue with efforts that have led to the better-than-predicted outcomes experienced thus far within the community of homelessness. Until at least one safe and effective vaccine and/or therapeutic protocol is widely available, all the agencies, organizations and individuals working to contain and mitigate COVID-19 within the community of homelessness must maintain an extremely high level of vigilance and make course corrections as needed.

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