# Rapid Creation of a Multiagency Alternate Care Site for COVID-19–Positive Individuals Experiencing Homelessness

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Cook County Health partnered with the Chicago Departments of Public Health and Family & Support Services and several dozen community-based organizations to rapidly establish a temporary medical respite shelter during the spring 2020 COVID-19 peak for individuals experiencing homelessness in Chicago and Cook County, Illinois. This program provided low-barrier isolation housing to medically complex adults until their safe return to congregate settings. We describe strategies used by the health care agency, which is not a Health Resource and Services Administration Health Care for the Homeless grantee, to provide medical services and care coordination. (*Am J Public Health*. 2021; 111(7):1227–1230. doi: https://doi.org/10.2105/AJPH.2021.306286)

Coronavirus disease 2019 (COVID-19) poses unique risks to individuals experiencing homelessness. Through collaboration among city, health care, and community partners, the Temporary Medical Respite Shelter provided a medically monitored isolation setting for people experiencing homelessness to complete COVID-19 isolation in May 2020.

## INTERVENTION

The Temporary Medical Respite Shelter ("the program") was part of a citywide, multiagency public health response to the convergence of two crises: homelessness and COVID-19.[1] Partly because of COVID-19 and its aftermath, the total homeless population of Chicago, Illinois increased in 2020, including the number of homeless individuals with physical disabilities and substance use, while racial disparities persisted.[2] Through a rapidly created responsibility-sharing framework, city agencies and Cook County Health, the framework's lead health care organization, worked with a consortium of community organizations to establish a medically supported alternate care site for COVID-19–confirmed homeless individuals. The program provided isolation housing for homeless clients from shelters and congregate settings that were unable to provide in-house isolation. Program clients received care coordination services, primary care, behavioral health, and addiction medicine services in addition to COVID-19 isolation.

## PLACE AND TIME

The program operated out of a community fitness center in a geographically underserved area of Chicago from May 1–30, 2020, during the first local peak of the pandemic.[3]

## PERSON

The clients were homeless adults with confirmed COVID-19. They were referred from emergency shelters undergoing facility-wide screening or from hospitals conducting testing in emergency departments or inpatient settings. Clients with substance use disorder, stable mental health disorder appropriate for outpatient treatment, history of criminal justice involvement, or requiring chronic hemodialysis were not restricted from the program. Our goal was to lower entry barriers into our program relative to existing COVID-19 isolation programs. The exclusion criteria pertaining to medically unstable conditions and mental health crises served to encourage conversation about appropriate levels of care and to prevent premature hospital discharges.

**BOX 1— Client Exclusion Criteria of the Temporary Medical Respite Shelter, Chicago, IL, May 2020**

1. Younger than 18 years
2. No laboratory-confirmed COVID-19
3. Unable to perform activities of daily living
4. Temperature > 103 degrees Fahrenheit, oxygen saturation < 92% on room air, respiratory rate > 30 breaths per minute, or increased work of breathing
5. Glucose readings > 300 mg/dL
6. Uncontrolled or symptomatic hypertension
7. Disorientation
8. Severe uncontrolled psychosis
   - Clients currently taking antipsychotic medications and clinically stable are not excluded
9. Current suicidal or homicidal ideation
10. Contact precautions for acute diarrheal illness, active extensively drug resistant organism infection, *Candida auris* colonization, or infection
11. Current diagnosis of acute tuberculosis
12. Lack of dialysis facility or routine transportation established for hemodialysis
13. Pregnant beyond 20 weeks gestational age
14. Current scabies or bedbug infestation
    - Clients who completed treatment are not excluded
15. Personality disorders that challenge the person's ability to abide by the rules of the shelter
16. Unwilling or unable to stay at the isolation facility through completion of the isolation period

## PURPOSE

Widespread testing of congregate settings was a part of the city's COVID-19 mitigation strategy.[3] This program provided medically monitored COVID-19 isolation to reduce transmission in congregate settings such as shelters and encampments. It also served as a discharge destination for hospitals to facilitate patient flow.

## IMPLEMENTATION

The program was operated jointly by Cook County Health, a large public safety-net health care organization; departments of the City of Chicago, including Family and Support Services, Public Health, and Emergency Management; and several dozen community-based organizations, including those providing shelters, behavioral health services, and other social services. Within the span of a few weeks in April 2020, partner agencies established an arrangement wherein the city provided the facility, shelter staff, and laundry and food services. The health care agency provided medical staff, coordinated medical services across organizations, and managed the day-to-day operations. A multiagency staff from health care, shelter service, security, and environmental service were trained in infection control, harm reduction, and trauma-informed care approaches.

Potential clients were referred either by the city's centralized intake, which triaged homeless individuals with COVID-19 based on medical complexity to isolation facilities in the city, or by local hospitals treating COVID-19 patients. The program medical director confirmed eligibility prior to accepting clients (Box 1).

Physicians and nurses, who were employees of the lead health care organization, volunteered to staff the site 24 hours a day, and they assessed clients daily by vital monitoring and physical exams. Clients who became clinically unstable were transferred to local emergency departments by ambulance. Real-time communication with hospitals facilitated transfers of patients back to the program upon discharge.

Telehealth visits were used for primary care, behavioral health, and substance use disorder. These visits also provided a technology-based solution to register patients in the health care organization. This qualified them for the Health Resources and Services Administration (HRSA) 340B Drug Pricing Program for no-cost prescription medications. Because the health care agency is not an HRSA-recognized provider of health care for the homeless, on-site physician services were located outside the usual place of care and so were not billable. However, on-site clinicians served an important role in building therapeutic trust to enable telehealth encounters, a format novel to most clients and providers.

Most clients (45 of 51) were able to establish relationships with care coordinators, who were able to assist with Medicaid application, stable housing applications, or identification of a primary care provider.

## EVALUATION

The program received 69 client referrals, about half from hospitals and half from shelters, and 51 clients arrived at the program. In most cases, accepted clients who did not arrive found alternate housing themselves. Most accepted clients were male (82%) and Black (69%), reflecting the demographics of Chicago's homeless population. Median length of stay was seven days (Table 1). Most clients had mental illness (88%), similar to the broader population of homeless patients served by the health care system. All clients completed the full isolation period recommended by the Centers for Disease Control and Prevention.

Telehealth encounters (n = 75) consisted of 36 visits for primary care, 27 for substance use disorder, and 12 for

mental health care. Prescribed medications were delivered for 23 clients. Successes in substance use treatment services included on-site recovery support, initiation of buprenorphine therapy via telehealth, methadone delivery from a community treatment provider, naloxone training, and assistance with entering residential drug treatment. Accomplishments in care coordination included facilitating transportation of clients to and from outpatient hemodialysis.

Client satisfaction was high, with most clients rating their stay as "excellent" (74%); some clients were reluctant to leave the program. Most clients returned to the same congregate settings from which they were referred. A minority went to stay temporarily with friends or family or in a street encampment. On the basis of formal and informal feedback involving a satisfaction questionnaire or interview, our service-orientation and trauma-informed care approach fostered a program that clients and shelter staff reported as unique among shelters in the city.

## ADVERSE EFFECTS

To help manage stress levels among clients and staff, we deliberately discouraged characterizing our work as heroic. Instead, we were guided by kindness as the organizing principle and a trauma-informed approach to addressing conflicts. However, several incidents illustrated how on-site security's disciplinary approach to behavioral health contrasted with health care staffs' de-escalation approach. The need to negotiate these differences in organizational culture among participating

**TABLE 1— Characteristics of Clients Accepted at the Temporary Medical Respite Shelter: Chicago, IL, May 2020**

| | No. (%) or Median (IQR) |
|---|---|
| Total sample | 51 |
| Gender | |
| Male | 42 (82.4) |
| Female | 8 (17.6) |
| Other | 1 (2.0) |
| Age, y | |
| 18–24 | 2 (3.9) |
| 25–34 | 3 (5.8) |
| 35–44 | 11 (21.6) |
| 45–54 | 10 (19.6) |
| 55–64 | 22 (43.1) |
| ≥ 65 | 3 (5.8) |
| Race | |
| White | 5 (9.8) |
| Black | 35 (68.6) |
| Latino | 11 (21.6) |
| Other/unknown | 0 (0.0) |
| Insurance status | |
| Insured | 37 (72.5) |
| Uninsured | 12 (23.5) |
| Unknown | 2 (3.9) |
| Clinical characteristics | |
| Diabetes | 6 (11.7) |
| Heart condition[a] | 6 (11.7) |
| HIV/AIDS | 4 (7.8) |
| Other immunosuppressing condition | 2 (3.9) |
| Mental illness[b] | 45 (88.2) |
| Duration of homelessness, months | 12 (8–33) |
| Length of stay, days | 7 (6–10) |
| Disposition following isolation at TMRS | |
| Shelter | 31 |
| With friends or family | 5 |
| Substance use disorder treatment program | 1 |
| Street encampment | 1 |
| Hospitalized | 1 |
| Transferred to other isolation facility | 1 |
| Missing/unknown | 7 |

*Note.* IQR = interquartile range; TMRS = Temporary Medical Respite Shelter.

[a]Heart condition includes heart failure, arrhythmia, and coronary artery disease.
[b]Mental Illness detected by self-reported diagnosis, pharmacologic treatment history, psychiatric hospitalizations, illicit drug use, substance use or behavioral health visit onsite or telehealth, or observed behavioral dysregulation.

agencies posed a challenge to the program's multiagency leadership.

## SUSTAINABILITY

The program was supported financially by medical billing, grant support from charitable organizations, and public emergency funds. By the end of May, demand for isolation beds decreased as COVID-19 cases temporarily declined and the program closed after one month. Thereafter, the program served as a template for the health care agency to establish a separate medical respite program that met isolation needs during the winter peak of COVID-19 and various post–acute care needs of a medically complex homeless population. Our adaptive approach to the provision of medical respite care has attracted ongoing funding from county government, Medicaid managed care, and charitable foundations.

## PUBLIC HEALTH SIGNIFICANCE

As an example of a collaboration by city government, community organizations, and safety net health care system to serve a high-risk homeless population, this program adds to existing models of alternate care sites.[4–6] It was a collaborative, low-barrier public health intervention in which homeless individuals with medical and behavioral health comorbidities completed COVID-19 isolation. Our ability to care for complex clients was possible because of innovative aspects of the program, including our hybrid model of on-site health care and telehealth that allowed uptake of telehealth for primary and specialty care without compromising quality of care, qualification of patients for 340B Drug Pricing for discounted medications, and care coordination to facilitate housing after respite care. The rapid and successful implementation of this project by a health care agency operating outside of its usual care settings may encourage other health care providers to participate in health care for the homeless. AJPH


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## PUBLICATION INFORMATION

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## CONTRIBUTORS

C. Y. Wang wrote the initial draft of the article. K. Hinami, M. L. Palma, and C. Y. Wang collected and analyzed the data. All authors contributed to the study conceptualization, revised drafts, and approved the final version.

## CONFLICTS OF INTEREST

M. L. Palma's spouse is a cofounder of and holds equity in Satellite Biosciences Inc, which is an early-stage life sciences company focused on liver disease. The remaining authors have no conflicts of interest to disclose.

## HUMAN PARTICIPANT PROTECTION

This project was approved by the Cook County Health institutional review board.

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