NATIONAL HEALTH CARE for the HOMELESS COUNCIL

COVID-19 & the HCH Community

Strategies for Proactive Universal Testing

Issue Brief | July 2020

As the response to the COVID-19 pandemic continues to evolve, there is an increasing focus on the need for universal testing (also called "facility-wide testing" or "point prevalence testing") of both symptomatic and asymptomatic people in greater numbers. This will allow public health authorities to better track the spread of the virus and take appropriate response measures. As the supply and capacity for testing expands, wider testing initiatives targeting vulnerable populations—such as people experiencing homelessness—are not only feasible, they are critical components of effective community response plans.

Many Health Care for the Homeless (HCH) programs have been partnering with their public health authorities to assist with broader-scale universal testing activities. To learn more about these experiences, Council staff conducted in-depth focus groups with five HCH programs, as well as shorter discussions with staff at 12 other HCH programs.

This issue brief complements the most recent CDC guidance on testing and provides public health authorities, emergency response systems, HCH programs, and other community providers with feedback about these experiences. It also offers lessons learned and strategies for conducting successful universal testing events among homeless populations. The goal of this brief is to inform subsequent local testing events with new federal guidance, as well as feedback from the HCH focus groups on what has worked well (and not worked well) in individual communities.

Federal Guidance

HHS: The U.S. Department of Health and Human Services (HHS) COVID-19 Strategic Testing Plan outlines three purposes of testing:

- **Diagnostic testing:** confirm individual cases of viral infection and inform subsequent treatment
- **Testing for contact tracing:** test and monitor persons in contact with infected individuals
- **Universal testing:** to limit the spread of disease and enable public health authorities to assess and manage the risks associated with COVID-19, including testing asymptomatic individuals. Objectives of universal testing include enabling rapid detection, isolation, and appropriate management of persons with viral infections; guiding the implementation of control measures; and detecting and containing outbreaks among vulnerable populations.

The HHS Strategic Testing Plan expects state and local governments to assume responsibility for planning and implementing COVID-19 testing activities, specifying that "State's plans should address how the jurisdiction will meet the testing needs for vulnerable populations,"

which include racial and ethnic minorities, populations living in underserved urban areas, **people experiencing homelessness**, and those with underlying conditions.

CDC: The Centers for Disease Control and Prevention (CDC) has published broad guidance on COVID-19 testing and more detailed guidance regarding who should be tested:

- **High priority:** "Residents in long-term care facilities or other congregate living settings, including prisons and **shelters, with symptoms**"
- **Priority:** "**Persons without symptoms** who are prioritized by health departments or clinicians, for any reason, including but not limited to: public health monitoring, sentinel surveillance, or screening of other asymptomatic individuals according to state and local plans."

Notably, the CDC indicates that this guidance "may be adapted by state and local health departments to respond to rapidly changing local circumstances." The newest CDC guidance offers further information for incorporating testing into a public health strategy for people experiencing homelessness.

HRSA: Because HCH programs are federally qualified health centers, guidance from the Health Resources and Services Administration (HRSA) at HHS has been especially important. In response to numerous operational issues, HRSA has published FAQs on many topics, to include funding availability, liability protection for external testing events, data collection and reporting, contact tracing, eligibility for reimbursement, temporary sites, and service delivery.

Importance of Proactive, Universal Testing in Homeless Populations

People experiencing homelessness are especially vulnerable to contracting COVID-19. Risk factors that contribute to high rates of COVID-19 illness include: having chronic health conditions; living in congregate settings like shelters and encampments; having limited ability to follow public health advice such as staying at home, washing hands, distancing from others; and generally being underserved in the health care system due to stigma and discrimination. Hence, it is especially important to prioritize this population due to their multiple risk factors and vulnerability to infection.

Conducting universal testing in a **proactive** manner—**before** a cluster of positive cases emerges—appears to offer the greatest potential for identifying early virus spread and effectively separating individuals before a broader community outbreak occurs. Especially given the high rates of asymptomatic spread of the virus, **relying on symptom screenings has shown to be ineffective in reliably identifying cases.**

The following operational strategies synthesize feedback from the leadership at numerous HCH programs that have participated in such testing events. See Table 1 for the specific experiences in five different cities.

Operational Strategies

- **Getting support for testing:** Most HCH programs report they were able to get support for universal testing initiatives only after finding clusters of positive cases in shelters. Once these responsive testing activities showed high rates of positive cases, they were able to make a public health case for more proactive, universal testing at numerous

sites. Some programs reported their Governor or Mayor had created a task force or working group focused on homeless populations, and testing initiatives grew from those planning efforts.

- **Partners:** The local public health authority was the primary partner with HCH programs for testing in many areas, with hospital systems, Continuums of Care (CoCs), other homeless services providers, local labs, and other community partners assisting in various capacities. City, county, and state governments have also been supportive, often actively collaborating and funding events. The CDC's presence in Atlanta was a unique advantage in that location.
- **Frequency of testing:** Previously there was no specific recommendation for how often staff and clients should be tested, and there were differing views expressed by HCH providers on this issue. However, the newest CDC guidance says: "*Repeat testing of all previously negative or untested clients, staff, and volunteers (e.g., once a week) is recommended until the testing identifies no new cases of COVID-19 for at least 14 days since the most recent positive result.*" The Boston HCH program is developing a simulation model that assesses ideal testing frequency to minimize cumulative infections, while Seattle is basing frequency on team assessments of risk factors (with monthly testing at high-risk sites). Individual communities should determine frequency based on community transmission rates, availability of testing, and public health goals.
- **Contact tracing and antibody testing:** Most HCH programs reported that the local health authority was leading the community contact tracing activities. Name-based contact tracing was not being conducted in this population but in some cities, location-based contact tracing was being implemented or considered. Very few programs reported including antibody testing in their activities.
- **Shelter characteristics:** Sites saw positive test results range from 0% to 66%. Some communities observed larger, more densely arranged shelters yielded higher positive test rates, while other communities found higher rates in similar, but smaller shelters. Even shelters that had good screening and shelter-in-place procedures have seen high positive rates. While more research is needed to determine which specific factors promote/slow the spread of the virus, a range of factors likely includes shelter density, program policies, infection control practices, screening protocols, and physical space layout.
- **Unsheltered/encampments:** Most HCH programs reported having some level of outreach, but there was wide variation in the success of testing events in these settings. Some experienced few clients wanting to be tested, while others had no problems with consent. Others reported doing only symptomatic testing to date. Several programs reported using mobile clinics, partnering with first responders or other community partners to help with logistics, and/or bringing food to help with engagement. Hygiene supplies are an especially important engagement tools given the lack of access to public restrooms.
- **Funding:** HCH programs reported a variety of sources to support universal testing activities, to include local health authority/city or county governments, private labs, philanthropic donations, hospital systems, and FQHC/health centers. To increase

testing, HHS issued $11 billion for testing and will reimburse health care providers for testing and treating uninsured individuals for COVID-19.

- **Services provided before/during:** Nearly all HCH programs reported doing some type of medical and/or behavioral health screening or group education at the time of testing or shortly thereafter once the client had been relocated to an alternate care site (ACS) for isolation/quarantine (I/Q). Some also provided food or conducted the testing event at a soup kitchen during meals.
- **Next steps:** Most HCH programs were planning to conduct more testing, especially in unsheltered locations using mobile teams. Some were developing different types of guidance to establish safer environments in encampments or to outline service provisions in ACS programs. Programs were also determining how testing results inform ACS discharge criteria and re-admission to shelters given that **CDC recommends not requiring a negative test result for shelter admission.**

Common Challenges

1. Gaining support from public systems to prioritize testing among homeless populations and allocate resources to testing activities
2. Lack of public health authority familiarity with homeless populations coupled with limited staff/resources meant some providers were left on their own to find solutions
3. Gaining trust from marginalized and/or undocumented people, especially when National Guard and/or law enforcement are present, as well as negative perceptions of COVID-19 testing and I/Q among a population with significant trauma histories, particularly for Black, Indigenous, and other People of Color
4. Limited access to sufficient PPE, tests, and testing supplies
5. Lack of confidence in test results given well-known flaws in the supply chain and/or multiple vendors/test types yielding varying results
6. Limited staff capacity and length of time for test results to come back (even when using rapid test machines, which still require patients to wait for results)
7. Providing sufficient services at I/Q programs to support vulnerable people, as well as appropriately supporting those who refuse to be relocated to an established I/Q program or have health care conditions too severe to be accommodated at I/Q programs
8. Public sector agency leadership changes
9. Lapses in transportation and/or confusion over the logistics of transporting clients to/from testing events and I/Q sites
10. Locating individuals who did not have a phone or email to convey test results
11. Unclear protocols guiding the exchange of individual client medical information to shelter providers in a manner that both complied with HIPAA/patient privacy laws but also informed an effective public health response

Recommended Actions for Successful Universal Testing Events

The following actions are based on lessons learned and advice from HCH leaders who have been part of numerous proactive, universal testing events. While aimed at public officials, many of these actions are intended to be conducted together with community partners. New CDC guidance gives more details as well.

1. **Prioritize population:** Prioritize homeless populations for COVID-19 testing, even if it falls outside official guidelines. Conduct proactive, universal testing at all shelter and encampment sites to better understand the spread of the virus and the resources needed to appropriately isolate/quarantine individuals, even if an established response plan is not finalized. If resources are severely limited, establish collective agreement on criteria for testing. Do not wait for a cluster of positive cases before doing universal testing, and do not wait for a perfect response system before testing.
2. **Maximize legal authority:** Public health authorities should assume a leadership role in the community's response and leverage the legal authority granted local and state governments to advance appropriate responses. Partner with providers, but recognize they do not have the same legal responsibilities or resources as public agencies.
3. **Educate stakeholders:** Educate public agency staff about homelessness, the local homeless services system, and the health care needs of this population.
4. **Set up provider/public information:** Establish a call line or website for shelter providers, outreach workers, and/or the general public to access information about how to refer clients for testing and where/when testing events will take place.
5. **Formalize partnerships:** Communicate regularly with all agencies and providers involved in coordinating the local response to homelessness. Formalize standing daily/weekly calls between partners to share information and thoughtfully plan next steps.
6. **Set up transportation:** Establish clear protocols for transportation to/from testing sites and I/Q sites, and ensure all providers are knowledgeable of this process.
7. **Conduct COVID-19 education:** Educate clients and staff about COVID-19 and their risk for contracting the illness, as well as social distancing, hand washing, and use of hand sanitizer. Communicate clearly with them about testing events, let them know what will happen after a positive or negative test result (especially if they will be moved to a new location), and gain informed consent to test and deliver services.
8. **Provide services at testing:** Ensure behavioral health providers are present at testing events to help de-escalate fears and engage people in the testing process. Respond to acute behavioral health emergencies that might be triggered by testing and help individuals process anxieties that may arise post-testing. If possible, conduct comprehensive health assessments to connect people to needed care and hold events at service sites like soup kitchens, shelters, or other places where people are congregating.
9. **Ensure safety of clients and staff:** Conduct testing outside whenever possible. Perform logistics planning ahead of time involving representatives from all coalition partners to

ensure the event goes smoothly. Create a backup plan for poor weather, and ensure all tents are fully secured from wind. Ensure sufficient PPE for testing conditions.

10. **Pursue permanent solutions:** Whenever possible, move clients into permanent housing once testing activities and I/Q stays are complete, rather than return them to homelessness.
11. **Actively reverse disparities:** Improve racial and ethnic disparities by targeting testing initiatives to historically underserved populations. Collect and regularly analyze race/ethnicity data to ensure equity in access to testing and follow up care. Amend testing strategies accordingly if analysis shows ongoing disparities. When possible, ensure the demographics of the testing teams reflect those of the population being tested.
12. **Share data:** Ensure robust data-sharing between health departments and CoCs to identify positive cases. Consider using the Homeless Management Information System (HMIS) to share relevant information that helps protect clients and staff while maintaining compliance with HIPAA/patient privacy.

Resources

Local Guidance/Research:

- **Mercy Care/Atlanta, GA:** Universal COVID-19 Testing for People Experiencing Homelessness.
- **Boston:** Addressing COVID-19 Among People Experiencing Homelessness: Description, Adaptation, and Early Findings of a Multiagency Response in Boston (*Public Health Reports,* June 9, 2020). See also: Prevalence of SARS-CoV-2 Infection in Residents of a Large Homeless Shelter in Boston (*JAMA,* April 27, 2020).

Federal Resources: HHS COVID-19 Strategic Testing Plan (May 24, 2020) and CDC Guidance for Health Departments: COVID-19 Testing Strategies for Homeless Shelters and Encampments (July 1, 2020).

For more resources, to include recent research on testing in homeless populations, see our COVID-19 Resource Page.
Contact us for technical assistance.

Table 1. COVID-19 Universal Testing of Homeless Populations in Five Cities

	Atlanta	Baltimore	Boston	San Fran	Seattle
Universal Testing Activities **Range of Positive Results as of May 29**	24 testing events ~3,000 tested (0% - 11%)	10 testing events ~1,000 tested (0% - 55%)	30 testing events ~3,000 tested (0% - 37%)	6 testing events ~450 tested (0% - 66%)	167 mobile testing events ~4,300 tested (0% - 48%)
Partners	CDC, Partners for Home (CoC), Mercy Care, Board of Health, Medical Resource Corps, Emory Medical School, and community volunteers	Mayor's Office of Homeless Services/CoC, Baltimore City Health Department, Mayor's Emergency Operations Center, Health Care for the Homeless, Johns Hopkins Hospital, University of Maryland Medical System, numerous homeless services providers	CoC, Boston Public Health Commission, Boston Health Care for the Homeless, Massachusetts Department of Public Health, two hospitals, three local laboratories	San Francisco Department of Public Health, community-based organizations, Homelessness and Supportive Housing	Local Health Department, Health Care for the Homeless, numerous homeless services providers
Funding/Resources for Universal Testing	Fulton County Department of Public Health, HRSA funding, United Way grants	Hospital partners, Baltimore City Health Department, and Health Care for the Homeless	Local labs, including the state lab, donated swabs, as well as two rapid testing machines	San Francisco Department of Public Health	Local, state and federal (including HRSA funding) sources
Process for Handling Positive Cases	DPH or Mercy Care contacts and arranges transportation Isolate positive cases at NCS	At first, isolated all shelter residents at NCS Now, only isolate positive cases at NCS	Isolate at one of three ACSs, one of which is the local medical respite program.	Isolate and quarantine close contacts at NCS	Isolate at one of four isolation and quarantine locations
Going Forward	Local health department conduct contract tracing on a county-by-county basis that has not included Fulton County (Atlanta) to date Additional targeted testing in shelters and in unsheltered populations More mobile testing in encampments once additional equipment is	Local health department conducting contract tracing, assisted by HCH and other providers HCH continuing to help shelter providers with screening, referral for testing, and treatment plan for positive cases Working with health department to evaluate	HCH conducting contact tracing Continuing universal testing at five largest shelters every 2 weeks Developing predictive model to determine ideal testing frequency	Local health department conducting case investigation and contract tracing for positive cases (focus on locations where clients previously visited) Additional testing in unsheltered population Establish safe outdoor spaces for isolation using new guidance	Based on team assessments; developing testing strategy that identifies risk levels. Possible monthly testing for high risk sites. Adding testing to HCH mobile services Create guidance for encampments to quarantine in place

	Atlanta	Baltimore	Boston	San Fran	Seattle
	procured (mobile vans, etc.)	further universal testing activities Providing NCS for all vulnerable populations (e.g., not just people experiencing homeless)	Testing those leaving incarceration and entering shelters Additional testing in unsheltered population		
Challenges	Loss of CDC support to do the testing Redeploying staff to conduct testing Finding the right strategy for repeat testing Reopening of shelters	Data sharing Testing capacity, overcome by help from hospital partners Inconsistent tests Lack of familiarity with homeless services system and health care needs of population within health department Inconsistent direction between city and state authorities Responding to outbreaks diverts testing resources, limiting more proactive testing Change in CoC leadership disrupted partnerships Length of time for state to approve testing in congregate settings other than nursing homes	Multiple labs employed different versions of the test, creating discrepancies in results and variable turnaround times Skepticism among staff/clients on test accuracy Waxing/waning testing resources impact testing frequency Client reluctance to be tested caused by loss of service access While rapid tests give results in 15 minutes, two machines can only do eight tests an hour, creating wait times when testing hundreds Cold and wet weather has inhibited testing	Shelter staff deployed to hotels, reducing staff availability at shelters for testing Limited capacity for testing; changing offers from private labs created confusion Unsheltered clients not wanting to test because do not want to go to ACS programs Informed consent for testing is not clear to clients Implementing risk mitigation/harm reduction for unsheltered people	Clients not wanting to test because do not want to go to ACS programs
Lessons Learned/ Advice	Work with churches and other agencies that serve food during testing activities Rely on street medicine teams, HMIS, and EHRs to	Test proactively in all shelters before clusters appear to prevent virus spread Educate public health agencies and private partners about health care	Communicate clearly with clients so they understand the implications of a positive test Establish a team to manage tracking results, collaborating with partners	Implement clear informed consent protocols with clients so they understand what will happen Do not rely on symptom screening to characterize COVID-19 prevalence	Send an outreach team to encampments ahead of time to educate clients about the virus and the testing process

	Atlanta	Baltimore	Boston	San Fran	Seattle
	find clients to deliver testing results Conduct logistics planning ahead of testing event with partners and identify back up plans Pick the right partners so you don't "trip over each other." Having CDC located in Atlanta a key benefit Create a backup plan for poor weather, and secure testing tents firmly or they will blow away Educate clients about testing to engage them as partners in this work Establish clear, regular communication channels between public agencies and service providers Set up a website to publicly announce when/where you are testing so your events are more efficient	needs of homeless population & build support for testing (even if outside official testing guidelines) Identify strong public sector leaders with the authority to make decisions, working together with broad provider coalitions. Hold regular meetings (daily/weekly) with all those coordinating local homeless response Communicate plans clearly with clients in shelters, especially if they will be moved to another location Screen for other illnesses and ensure access to ongoing chronic disease management, especially if staff at ACS are not comfortable with high-need patients Isolate clients with a plan for housing permanency and service provision	to find people with positive results, triaging people to appropriate ACS Plan transportation ahead of time and know which cab companies are participating Strongly secure tents with sandbags to prevent blowing away Establish protocol for whether and when to retest people with previously positive result who have already completed isolation Centralize tracking of test results so trends are immediately clear and clusters are seen early, and analyze testing opportunities and results with an equity lens	(high proportion of asymptomatic cases in large shelter outbreak)	Set up testing sites at places where people are already gathering

Notes:

- ACS = Alternate Care Sites: where patients with COVID-19 can remain and receive medical care for the duration of their isolation period
- CoC = Continuum of Care
- NCS = Non-congregate sites, such as hotels/motels
- This issue brief focuses on universal testing activities, not individual patient tests in response to positive screens