



The CHHRGE Report

Building an effective cross-sector partnership to address COVID-19
among vulnerably housed populations of Chicago

**Chicago Homelessness and Health Response
Group for Equity**



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EDITORIAL NOTE: The COVID-19 pandemic has forced many rapid responses in the past two months. During this time, our ad-hoc group has changed its name as the group's membership and scope of concern have grown. The careful reader will therefore note that some sections of the text reference the Westside COVID-19 Homeless Response Group, while most others use the current title, Chicago Homelessness and Health Response Group for Equity (CHHRGE). Both of these refer to the same organization, which going forward will operate under the name CHHRGE. We apologize for any confusion this may cause.

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Chicago Homelessness and Health Response Group for Equity (CHHRGE)

As of June 5, 2020

A Safe Haven

All Chicago

The Boulevard of Chicago

Breakthrough

Chicago Coalition for the Homeless

Chicago Department of Family and Support Services

Chicago Department of Public Health

Chicago Funders Together to End Homelessness

Chicago Department of Housing

Christian Community Health Center

Cook County Health

Cornerstone Community Outreach

Franciscan Outreach

Funders Together to End Homelessness

Haymarket Center

Heartland Alliance Health

Illinois Chapter, American Academy of Pediatrics

Illinois Public Health Institute

Lawndale Christian Health Center

Margaret's Village

Matthew House

Northwestern Medicine

Pacific Garden Mission

PCC Community Wellness Center

Primo Center for Women and Children

Rush University System for Health

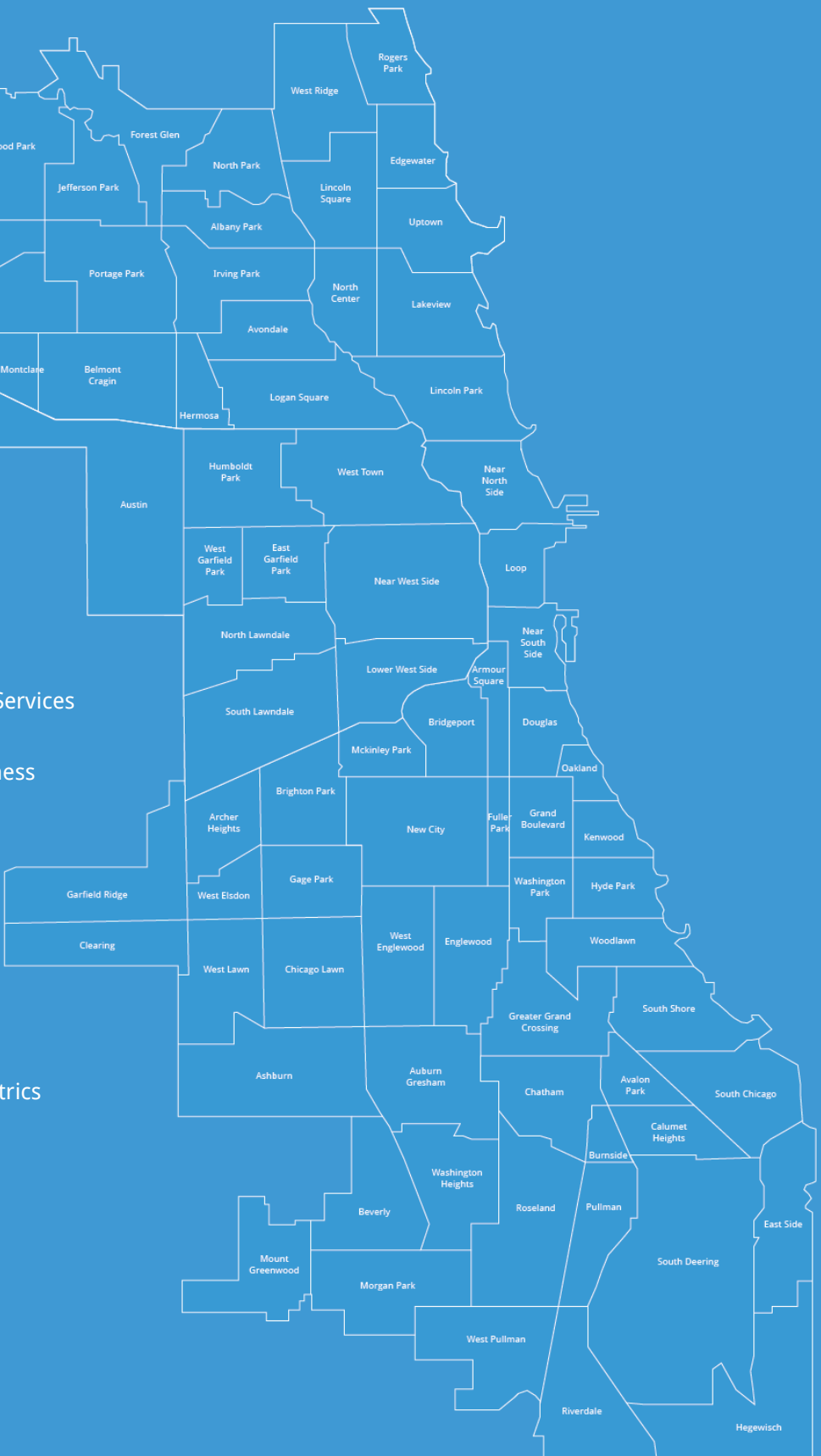
The Night Ministry

The Salvation Army Harbor Light Center

The Salvation Army Shield of Hope

Thresholds

University of Illinois at Chicago



Preface

In this report we share lessons learned and resources developed by a team of healthcare professionals and homeless service providers who convened in mid-March 2020 to address the impact of COVID-19 on the health of people experiencing homelessness in Chicago. The West Side Homeless Response Group, later renamed the Chicago Homelessness and Health Response Group for Equity (CHHRGE), grew from conversations at one institution into a twice daily meeting with up to 50 daily participants from multiple organizations. Together, the stakeholders of CHHRGE worked to address the devastating impact of COVID-19 across Chicago's entire vulnerably housed population. In this report we refer to CHHRGE as if it is a monolithic organization; it's not. It is a loosely coordinated but aligned multidisciplinary group of individuals and agencies working collaboratively to address this public health crisis. A series of ten questions were framed by the group which informed the work that followed:

1. How do we reduce the risk of spread of COVID-19 among the population of people experiencing homelessness in shelters?
2. How do we provide support for shelter staff and other agencies serving the vulnerably housed?
3. How do we screen the population of people experiencing homelessness and shelter staff for symptoms of COVID-19?
4. How do we isolate and test those with symptoms?
5. How and where should we safely isolate those experiencing both homelessness and COVID-19?
6. If a shelter experiences an outbreak of COVID-19, who should be tested?
7. How do we shield those who are experiencing homelessness and are high-risk for COVID-19 because of age or medical fragility?

8. What should be the standard of housing, medical, and behavioral healthcare for people experiencing homelessness in Chicago?
9. How can we contribute to accelerate efforts to permanently house this population?
10. How can we ensure that there is ongoing medical and behavioral health support for those experiencing homelessness as well as support for the congregate living staff?

Furthermore, the members of CHHRGE share the following guiding principles:

- **An Equity Framework:** We believe that everyone deserves a fair chance to achieve good health as a human right. Homelessness in Chicago is a matter of racial health equity as Black and Brown communities are disproportionately represented in this population.
- **Person-Centric Care:** We believe that our interventions must respect individual situations, autonomy, and decision making.
- **Standard of Care:** We believe that there should be a common standard of holistic medical, social, and shelter care across congregate living sites that include screening, testing, behavioral health, medical care services, and case management referral for permanent housing.
- **Integration and Care Coordination:** We believe that public health, medical, behavioral, and housing interventions must be integrated to achieve the outcomes we desire for people experiencing homelessness.
- **Collective Community Action:** We believe that we can accomplish more and achieve better outcomes together.
- **Housing is Health:** We believe that stable housing is a human right and foundational to good health.



CHHRGE reacted rapidly to COVID-19 among people experiencing homelessness and achieved the following milestones within a matter of months:

- A Safe Haven, Heartland Alliance Health, and RUMC collaborated to construct a medical respite unit for COVID-19 positive homeless guests; a facility with capacity for 100 individuals was opened within three weeks.
- A downtown hotel was repurposed to shield high-risk people experiencing homelessness from COVID-19. LCHC and UI Health partners coordinated testing of hotel staff and guests.
- Rapid response COVID-19 testing teams were created in partnership with CDPH, Heartland Alliance, RUMC, and UI Health.
- The South Side YMCA was repurposed by Cook County Health, CDPH, and DFSS to serve as a second COVID-19 isolation unit run by DFSS.
- Medical students distributed 25,000 masks to area shelters in partnership with CDPH.

We expect that this inter-institutional collaboration on behalf of the health and well-being of people experiencing homelessness will continue beyond the pandemic. It is our hope that this report will assist others in building similar long-term coalitions.

David Ansell, MD, MPH
Rush University Medical Center

I. Homelessness in Chicago

Chicago's 2019 Point in Time Annual Homeless Count found that, using the Department of Housing and Urban Development's (HUD) definition of homelessness, 5,290 Chicagoans are on the street, in encampments, or in shelters on any given night.¹ This number does not include the approximately 80,000 Chicagoans who were not captured in the survey and the tens of thousands of people living paycheck to paycheck, just one unexpected setback away from homelessness. For many, a single financial setback (e.g. job loss or unforeseen medical expenses) can become the catalyst for the eventual loss of their financial security and housing stability.

Homelessness does not impact all people equally. In Chicago, homelessness is a racial equity issue. Structural racism has created deep vulnerabilities and health inequities among African American people in Chicago in all matters of daily life from access to healthcare, food, education, and affordable housing. As a result, African Americans are disproportionately represented in the population of people experiencing homelessness and thus disproportionately impacted by COVID-19. 77% of people experiencing homelessness in Chicago are African American, compared to their less than 30% proportion in Chicago's population.²

For over a decade, the needs of individuals and families experiencing homelessness have been addressed by the HUD-chartered Chicago Continuum of Care, a group of more than 100 organizations. The Continuum housed over 2,840 households experiencing homelessness in 2019. The Chicago Cook County Housing for Health and Chicago Cook County Flexible Housing Pool have been leading efforts to combat homelessness for many years. This group of organizations also works to advocate for new resources, recognizing that there remain countless more individuals and families who need assistance than are currently being helped. In 2020, the difficulties that this vulnerable population faces became even more challenging as the COVID-19 pandemic spread to Chicago.



People experiencing homelessness also face other barriers to stable housing. Among Chicagoans experiencing homelessness in 2019:



27% reported receiving services for **mental health**



19% reported receiving services for **substance use disorders**



55% of men and 15% of women reported having been previously incarcerated



8% reported that they were fleeing a **violent relationship** or were being threatened

II. COVID-19 and People Experiencing Homelessness

Coronavirus Disease-19 (COVID-19) is caused by the novel coronavirus SARS-CoV-2 first noted in Wuhan, China at the end of 2019. While SARS-CoV-2 is a novel virus, the challenge it posed was not unexpected. In an era when over 100 million people travel internationally each year, public health scientists had been warning that a devastating global pandemic was not just likely, but inevitable.

Public health experts have also long warned that persons experiencing homelessness would be at particular risk for a pandemic flu. In December 2006, the Seattle-King County Health Department published guidelines for homeless service providers who may be responding to a pandemic. These guidelines identified the following reasons that people experiencing homelessness were at risk.³ Those experiencing homelessness often:

- Live in more crowded conditions, making social distancing difficult to achieve.
- Suffer from a variety of chronic and acute conditions which may affect their immune system response.
- Experience addiction and mental illness in rates disparate from the general population.
- May not seek care or isolation until they are very sick.

Because COVID-19 is spread person-to-person by respiratory droplets, individuals must take precautions such as self-isolating, wearing masks, limiting exposure in public, and avoiding cross-contamination of personal items. Risk of spread is highest when an individual is symptomatic, but even asymptomatic individuals can shed infectious droplets. To reduce disease transmission, experts recommend social distancing

(staying six feet apart) and quarantining (sheltering in place). The ability for those experiencing homelessness, living in encampments, or residing in congregate shelters to adhere to social distancing and sheltering in place recommendations is challenging if not impossible.

Chicago's per-capita funding for housing people experiencing homelessness has lagged that of other cities.⁴ Attempts to fund permanent housing have been limited and the quality of overnight congregate shelter space is highly variable. While it is estimated that 75% of people experiencing homelessness have insurance, access to medical care, particularly in shelters or encampments, is limited.⁵ Many people experiencing homelessness suffer from chronic medical and behavioral health conditions that make them vulnerable to premature mortality.⁶ Furthermore, those experiencing chronic homelessness have a life expectancy 17 years less than those with stable housing.⁷ Thus, when COVID-19 arrived in Chicago and began to spread across this population, the infection merely revealed the preexisting structural and social fault lines that all but guaranteed that this population would suffer at disproportionate levels.

CHHRGE goals for reducing the risk of COVID-19 amongst the homeless population:

- Reduce the risk of spread of COVID-19 among residents experiencing homelessness on the West Side, and agency staff providing care to this population.
- Provide supplemental support for Franciscan Outreach staff and other agencies serving people experiencing homelessness and the vulnerably housed.
- Sustain basic medical services for people experiencing homelessness on the West Side during the COVID-19 outbreak.

III. The Founding of CHHRGE

On March 13, 2020, a group of seven individuals consisting of homeless service providers, faculty, students, and staff from Rush University Medical Center convened to discuss the implications of COVID-19 on guests at Franciscan Outreach shelters on Chicago's West Side. The group recognized that public health guidelines for social distancing would put shelter guests at considerable risk unless urgent actions were taken. Seven priorities were identified as immediate actions for serving vulnerably housed individuals at Franciscan Outreach.

1. Allow for social distancing among guests.
2. Screen and test for COVID-19.
3. Quarantine symptomatic guests pending testing.
4. Isolate COVID-19 positive guests.
5. Protect high-risk individuals.
6. Support agencies serving this population.
7. Deliver routine and safe healthcare.

Within one month, daily calls included 100+ members from healthcare, service, and government agencies across the City of Chicago coming together to support vulnerably housed populations. The collaborative became known as the West Side Homeless COVID-19 Response Group and was later renamed the Chicago Homelessness and Health Response Group for Equity (CHHRGE). Over time, CHHRGE became more formalized. Daily stakeholder meetings began with a situational awareness report of the extent of the pandemic on the city, state, local health facilities, and shelters. The calls helped to identify challenges in the

system, resulting in the formation of multidisciplinary committees and partnerships charged with developing potential solutions.

Non-exhaustive list of multidisciplinary teams

- A workgroup of medical providers met daily to address healthcare problems in shelters.
- One team focused on issues of significant mental illness (SMI), substance use disorders (SUD), and other behavioral concerns.
- A rapid response team was formed to implement immediate testing at shelters.

Everyone worked together to address the same goals:

1) Reduce the risk of spread of COVID-19 among residents experiencing homelessness on the West Side, and staff providing care to this population, 2) Provide supplemental support for Franciscan Outreach staff and other agencies serving people experiencing homelessness, and 3) Sustain basic medical services for people experiencing homelessness on the West Side during the COVID-19 outbreak.

An unanticipated, but important benefit, of the daily calls was the development of a sense of community, built around a shared dedication to care for the vulnerably housed. Shelter operators and medical providers who, at times, felt overwhelmed by the challenges of COVID-19, observed that this multidisciplinary collaboration provided needed support to sustain their work through the crisis.



Social distancing



Screen/test for COVID-19



Quarantine individuals



Isolate COVID-19+



Protect the high-risk



Support shelters



Deliver healthcare

Student Leadership and Involvement

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In March 2020, to protect students from COVID-19, Chicago shut down its colleges and universities including all afterschool and volunteering activities. This was especially challenging for Rush University and University of Illinois at Chicago Health (UI Health) students, many of whom had been actively engaged in work with West Side communities, including many shelters. A small group of Rush and UI Health medical student leaders came together to support CHHRGE, becoming the workhorse of many CHHRGE initiatives. The Rush University administration supported the students by providing significant financial resources, guidance, and supplies for volunteering activities. Eventually this student leadership group grew significantly to include students from campuses across Chicago. Each time a volunteer opportunity was requested by a CHHRGE stakeholder, student liaisons contacted the student group to ask for volunteers to sign up and provided information to communicate directly with the opportunity manager. Students engaged in a large variety of projects including assembling 700+ care packages for the shelters, distributing personal protective equipment (PPE), packing lunches, and distributing informational flyers about COVID-19 to all of the Chicago shelters. Much of the necessary work to support CHHRGE could even be done remotely, or from the safety of students' homes. One of the significant contributions that students made to CHHRGE was advancements in communication via technology.



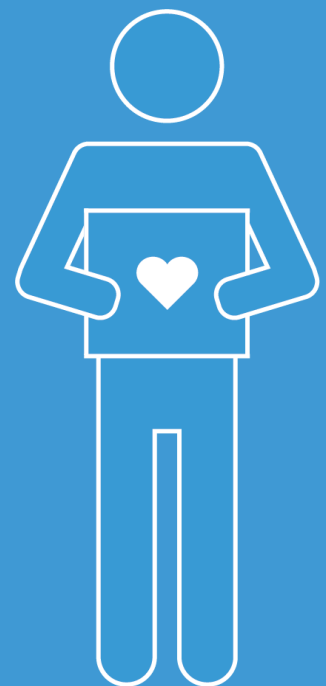
Homelessness is a very important issue for our family, and so it was a joy to be able to give to our West Side brothers and sisters. We were able to make 143 bags with the supplies we purchased. So glad people will be benefiting from them soon!

Orrianne Morrison, M2

.....

The Role of Students in CHHRGE

- Student volunteers can be extremely useful in minimizing the spread of COVID-19.
- Student leaders can create a coalition of volunteers by drawing from their student body.
- Remote volunteering is possible.
- Protocols for marketing, signing up for, and participating in activities must be put in place for volunteering to run smoothly.

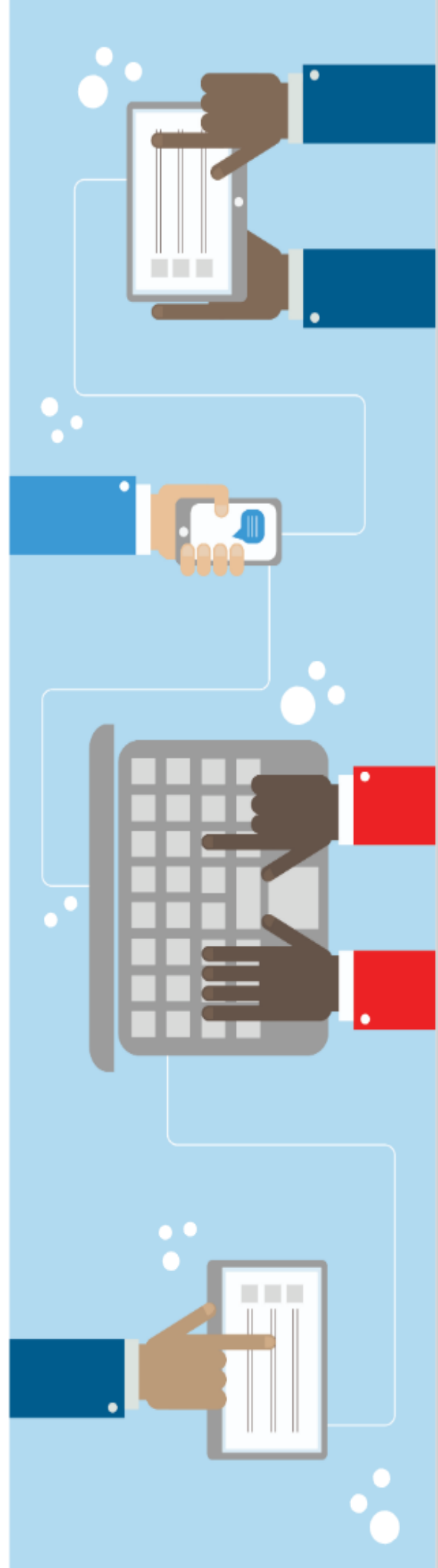


Technology as a Collaborative Tool

From the outset, CHHRGE implemented systems to communicate, share resources, and maintain documentation virtually. Initially, these strategies included WebEx conference calls, emails, and a shared Google Drive. As the group rapidly expanded, these tools became unwieldy, and student volunteers worked with faculty to develop two additional platforms: a Slack Workspace and a Bitrix24 portal. Students created training videos and served as technical support for members transitioning to the platform. Eventually, a Bitrix24 “intranet” for CHHRGE was born, including messaging, cloud storage for resources, policy and procedures, and user management systems. Through this portal, CHHRGE could classify stakeholders into “departments” (i.e. medical providers, social workers, students) and give each department specific privileges, significantly decreasing time needed for administrative duties. For example, the “Medical Providers” department was granted permission to edit the medical documents folder on the cloud storage. These features ensure that stakeholders only have access to the resources necessary for their tasks. This platform also enables easier contact management so that email lists can be instantly generated based on roles and departments. CHHRGE’s adoption of a Slack Workspace and a Bitrix24 portal provided the coalition with the means to efficiently coordinate and communicate. However, the rapid increase in new coalition members, unfamiliar with the technology, prevented the platforms from being fully integrated into organizational workflows. Despite the powerful tools available for collaboration, it was difficult to develop a platform that was utilized regularly, and the most effective tool of communication became daily stakeholder phone calls.

Considerations When Using Technology to Collaborate

- Select technology solutions that work on different operating systems (i.e., Mac, Windows, etc.).
- Onboard new members to technology and resources.
- Technology should make it easy for people to collaborate.
- Have a technical support team, even if it is student volunteers.
- Educate new group members of communication platforms and their corresponding protocols.



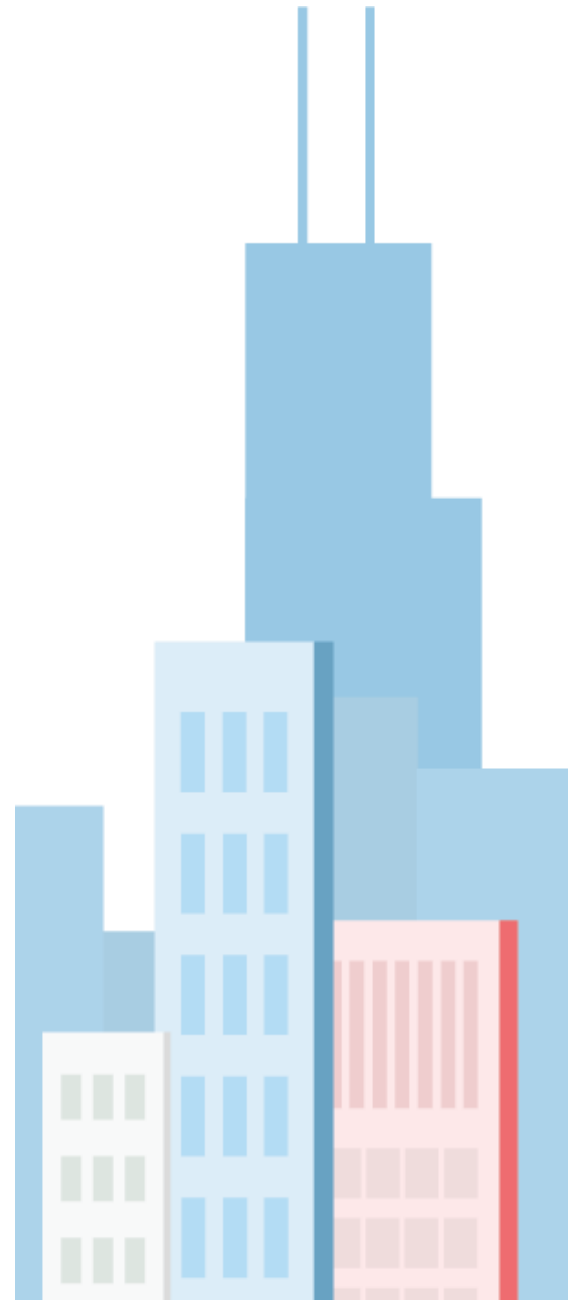
CHHRGE Relationship with the City of Chicago

As noted earlier, CHHRGE grew quickly from a partnership between one medical school and one shelter, to an ad hoc group of over 100 members from various sectors: healthcare, housing, social services, and others. Advocates for people experiencing homelessness were sought within the first week, and several agencies attended daily group calls. However, differing roles had to be acknowledged within this work. City agencies have formal responsibilities as part of Chicago's governance and, as outlined in Section IV below, have a unified command structure through the City's Incident Command Center.

The City's administrative roles kept them at arm's length from the day-to-day operations of service providers. As a group of established providers, the members of CHHRGE have a much more local view of day-to-day challenges in an effective COVID-19 response; this coupled with the providers' direct work with vulnerable populations established these providers as ideal people to identify emerging problems, or where systems are not functioning as intended. Advocacy by an ad hoc group like ours, coming from a grassroots perspective, can at times lead to tensions with City agencies. Several factors have maintained effective working relationships:

- City agencies were invited to the CHHRGE table from the onset.
- The participation of major Chicago healthcare institutions served to increase the trust and confidence of the City.
- All communications have been transparent among CHHRGE members and with the City.
- The willingness of CHHRGE partners to not only identify problems, but to work with City agencies to implement solutions, solidified relationships.

CHHRGE Chicago continues to operate without a formal charter. When possible, members speak with one voice about policies and initiatives; at times, however, organizations will have different opinions. Where we agree, we function as advocates, informing City agencies of conditions impacting the people experiencing homelessness in the community, identifying problems and barriers to solutions, and making recommendations for changes in City policies and procedures. At the same time, CHHRGE functions as a partner with the City in working toward solutions, as described in the following section (IV), in which the City of Chicago lays out its official COVID-19 response strategy.



IV. The City of Chicago's COVID-19 Response

Introduction

From the earliest days of the COVID-19 crisis, the City of Chicago began planning for how to protect its most vulnerable residents and sustain essential social services. The Chicago Department of Public Health (CDPH) first began monitoring the progression of COVID-19 in mainland China in early January 2020. The City began reviewing guidance, inventorying local resources, assessing needs, and sharing information among national, state, and local agencies as well as healthcare providers – all in preparation for a possible outbreak within the U.S. Based on the City's previous experiences responding to H1N1, Ebola, and CDPH's facilitation of a national emergency preparedness training exercise in 2019 ("Crimson Contagion"), the City understood that early planning is essential to mobilize and bring interventions to scale. Indeed, within a week of these early actions, the first travel-related COVID-19 case was identified in Chicago and by late February the first case of local transmission within Chicago had been identified.

City of Chicago Organizational Structure for COVID-19

During the COVID-19 response, the City of Chicago has organized into a Unified Command Structure under the Incident Command System (ICS). ICS is a nationally recognized hierarchical management system which allows various agencies and organizations to operate under a common structure during emergencies. Broadly, the structure is broken up into Unified Command and Operations, Planning, Logistics and Finance sections. Under this structure, leaders from various agencies set objectives, make decisions and solve problems collaboratively. Chicago's Unified Command is composed of the Mayor's Office, CDPH, Office of Emergency Management and Communications

(OEMC) and various other City agencies. CDPH is the lead agency and has command staff onsite daily. OEMC is the main coordinating body and has set up the Unified Command Post. Multiple local, state, and federal partners are working within the various sections of the organization in order to effectively collaborate. This structure allows the City of Chicago to have a united coordinated response to COVID-19.

The Operations Section is responsible for establishing the methodology and tactics of the response. Under this response, the City of Chicago has grouped the Operations Section into four branches: Health and Medical, Public Safety & Personal Protective Equipment (PPE), Feeding, and Housing. The Health and Medical Branch is led by CDPH and is coordinating the operations associated with surging and protecting the healthcare system, COVID-19 testing and epidemiological surveillance. The Public Safety & PPE Branch, led by OEMC, coordinates the distribution of PPE to public safety agencies and other essential workers providing guidance to those entities. The Feeding branch is led by Chicago Public Libraries and focused on providing food to various vulnerable groups such as Chicago Public School students, older adults, and people experiencing homelessness while they shelter in place. The Housing Branch, under the leadership of the Department of Family and Support Services (DFSS) and Department of Housing (DOH), is responsible for providing temporary housing as well as isolation and quarantine for people experiencing homelessness, first responders, and healthcare workers.

The Planning, Logistics, and Finance sections provide support to the operations branches by managing tasks including but not limited to: supporting long range and contingency planning, managing resource requests, coordination of supplies, and tracking financial costs. In addition, within the Unified Command Post is an

Emergency Operations Center where individual agency and organization representatives are available to answer questions, solve problems and ensure that incident information is disseminated to their respective stakeholder agencies and organizations.

The City's Community Mitigation Strategy

Upon the first signs of community-based transmission occurring in Chicago, City leadership identified – among many pressing concerns – the need for a city-wide system for prevention of COVID-19 within congregate settings and provision of compassionate care for people experiencing homelessness. To meet this need, the City identified three clear goals of a Community Mitigation Strategy:

1. **Prevent:** Take steps to stop or slow the spread of COVID-19 within congregate shelters and encampments and mitigate potential adverse health impacts by removing high-risk residents to shield them from exposure.
2. **Identify:** Identify confirmed cases and close contacts through screening, testing, and investigations.
3. **Respond:** Provide quarantine and isolation housing options for suspected and confirmed cases.

Within these goals, the City identified a number of potential strategies, each of which is discussed below.

PREVENT: CDPH medical directors, in collaboration with DFSS, developed guidance documents for shelters and other congregate settings and outreach workers and routinely updated these documents to reflect current CDC recommendations. These guidance documents, as well as daily COVID-19 data, external resources, and live feeds of Mayoral announcements and CDPH Commissioner Arwady's daily Q&A sessions were housed on the City's dedicated COVID-19 website (www.chicago.gov/coronavirus).⁸ Every week, DFSS and CDPH, with support from All Chicago, provided

webinars to shelter providers on public health guidance, how to manage symptomatic clients, and updates to the City's community mitigation strategy.

Building off of the guidance documents, DFSS and CDPH worked with shelter providers to implement CDC-recommended social distancing measures within congregate settings. To facilitate social distancing by decompressing the system, the City reached agreements with the YMCA of Metro Chicago and the Salvation Army to secure temporary capacity at five new sites with 699 beds to accommodate the entirety of clients that had to be moved from existing shelters through decompression. These sites include facilities for women, children and families; residents returning from incarceration; as well as those that require isolation. As of the date of publication of this paper, the City continues to identify further sites to accommodate overflow from the shelter system.

DFSS' Homeless Outreach Prevention team, in coordination with outreach delegate agencies, regularly visits encampments to assess safety and nutritional needs, identify locations that require cleaning, and responds to requests for shelter. While canvassing in response to COVID-19, outreach workers provide education about preventive best practices and distribute hand sanitizer, in accordance with CDPH guidance. In order to promote good hand hygiene and sanitation, the City worked with Chicago Coalition for the Homeless to bring portable toilets and hand washing stations to 14 encampments across the city.

The City continues to engage the philanthropic community for donation of PPE, in supplement to the City's own procurement and distribution channels. On April 3, in response to updated federal guidance, CDPH issued guidance for universal masking in congregate shelters and began working with medical students and philanthropists to source cloth masks for use by congregate setting clients. That same week, CDPH, DFSS

and partners from Chicago Homelessness and Health Response Group for Equity (CHHRGE) – most notably Public Health Institute, Health & Medicine Policy Research Group, and dozens of RUSH medical students – distributed more than 25,000 pieces of PPE to all congregate settings in the Chicago. Additional donated PPE was distributed on April 18th and May 2nd. While the City developed and implemented these prevention strategies, it also had to remain nimble enough to respond to emergency situations. For example, as a few large, congregate shelters across the city began reporting outbreaks, the City rapidly evolved its mitigation strategy.

An Evolving Mitigation Strategy

On April 2, 2020, Lawndale Christian Health Center (LCHC), in collaboration with UI Health and Lurie Children's Hospital, started to accept people who had symptoms of COVID-19 disease at a 190-bed hotel. This action was performed to remove them from very large congregate setting shelters, where there might be 200-300 people in a single room. Six days later, testing expanded and identified that, through a sample, it was estimated that more than 60% of large shelter residents were positive for SARS-CoV-2 despite lacking symptoms. On April 9, 2020, CDPH redirected the mission of the hotel, shifting focus to shielding asymptomatic high-risk persons. That same day, asymptomatic high-risk persons were accepted at the hotel.

IDENTIFY: Along with guidance documents and training webinars, CDPH medical directors also developed symptom screening tools for both shelter staff and DFSS outreach workers. Knowing that the majority of shelters in the city lacked dedicated medical staff or clinical linkages, CDPH also mobilized more than a dozen volunteer medical professionals on March 23 to assist with screening via telemedicine and make

recommendations to shelter staff on how to manage symptomatic clients. The City also contracted 40 nurses to visit shelters and provide in-person consultation on infection control.

Containment strategies depend on the ability to rapidly identify and address cases in congregate settings. While the demand for testing has exceeded capacity, both nationally and locally, CDPH collaborated with local health systems, including CHHRGE members, and medical supply distributors to provide testing in shelters and encampments. CDPH has collaborated closely with a team from Rush University Medical Center (Rush) and University of Illinois Health (UI Health), along with other external partners who provide routine clinical care in these settings, to organize testing in homeless shelters. The rapid testing team responds to outbreaks in homeless shelters that are reported to CDPH by performing mass testing of symptomatic and asymptomatic clients to detect cases early, perhaps before symptoms show, and separate COVID-19 positive clients from COVID-19 negative clients. With support and leadership from the UI Health and Rush, more than 700 shelter residents and staff can now be tested for COVID-19 each week. This expansion of testing capability helps enable CDPH to intervene and halt further spread within congregate settings. As of May 1, the rapid testing team has performed more than 1,400 tests across 18 programs.

As mentioned above, while implementing many of the strategies discussed herein, many congregate settings in the City began noting clusters of symptomatic clients. CDPH's investigation team of medical staff and epidemiologists has investigated all reported cases of COVID-19 within congregate settings. Reporting could occur either by a congregate setting directly to a CDPH Medical Director, or via an online reporting form which would automatically trigger an investigation. As part of the outbreak response, CDPH's investigation team and

medical directors provide tailored, situation specific guidance to facility's staff on establishing cleaning protocols, whether to stop/continue referrals for new clients, and how to properly manage both COVID-19 positive and exposed individuals.

RESPOND: Perhaps the most critical and most challenging need for the City was to locate appropriate sites for quarantine of persons with close contact to known cases and isolation of persons confirmed to be COVID-19 positive. Multiple City Departments, healthcare institutions, homeless services providers, behavioral health providers, advocates, aldermen, members of the hospitality industry, and temporary support staff worked around the clock for weeks to bring to life these facilities for which there was no preexisting model.

Many COVID-19 positive clients are isolating in their usual place of residence. This has benefits such as providing continuity of care for clients, but also introduces a huge burden on shelters that are very short on appropriate isolation space and may not have clinical expertise on site. Through coordination with CDPH and DFSS, partners from UI Health, Rush, and Heartland Alliance Health have provided clinical and infection control advice to shelters to identify appropriate isolation space, and in some shelters experiencing large outbreaks, the City has deployed clinical staff to support existing clinical teams.

One of the tremendous successes of the City's response efforts and collaboration with the Chicago Homelessness and Health Response Group for Equity (CHHRGE) members was the opening of a 100+ bed isolation facility with wraparound services for individuals experiencing homelessness and positive for SARS-CoV-2 or COVID-19 disease on April 11, 2020. (A Safe Haven, discussed in Section [V: Symptom Screening in Shelters](#) and [V: Medical Respite and Isolation Centers](#)). Likewise, the City partnered with Cook County

Health and YMCA of Metro Chicago to open a second isolation facility with 132 bed capacity, which can take referrals direct from shelters. In addition, the City is operating a 200-bed hotel isolation of low-acuity, low-risk patients without safe home environments in which to self-isolate as well as two hotels for quarantine of first responders and frontline healthcare workers. ER discharge staff and shelters were notified of intake procedures for these settings through the City's HAN Alert system and tailored webinars.

While the establishment of dedicated quarantine and isolation housing, including sites with wraparound support, are notable successes amidst a crisis, there continue to be needs that the City and its partners are unable to meet due to site limitations, staff capacity, and shortages of resources. The City is continuing to work with providers to set up sites that can serve COVID-19 positive persons experiencing severe mental illness. In addition, as of the date of publication, the City and partners are finalizing details to open similar isolation facilities to serve people experiencing homelessness and unstably housed persons with enhanced behavioral health needs in geographically representative sides of the city.



Planning Beyond COVID-19

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The breakneck speed at which the COVID-19 situation escalated necessitated strong central leadership and unprecedented coordination of City departments and local partners, including healthcare systems, social service providers, the hospitality business community, philanthropy, the medical supply industry, and advocates. One of the fortuitous features of the West Side COVID-19 Homeless Response Group was having an organically occurring framework to assist the City to build upon its Community Mitigation Strategy, understand current conditions on front lines, establish new community linkages, and secure resources. For these reasons, the City's Community Mitigation Strategy can remain a working document that can evolve in near real-time as needs are met and new needs are identified. The City and its vast array of partners will continue to provide education and resources, identify and respond to cases, and work to ensure an equitable, compassionate response to COVID-19 in Chicago's homeless population.

Beyond enabling quick, yet thoughtful responses to COVID-19 issues among the City's homeless and unstably housed residents, the West Side structure also provides a framework for building towards long term change beyond COVID-19. A public health emergency like COVID-19 magnifies what we already knew: that health requires a home, and the holes in our social safety net have real impact on health outcomes. The COVID-19 response has driven considerable innovation, producing new partnerships and housing models that can inform how we support people experiencing homelessness, long after the immediate threat of coronavirus is behind us.

Some initial actions in recent weeks have sown the seeds of this lasting change. First is filling the need of

clinical linkages for all shelters and congregate settings in the city. While some shelters have strong relationships with providers, this is not the case for the majority of shelters in the city. This problem is exacerbated by lack of medically trained staff or volunteers on site at the shelters. As of publication of this paper, the City and West Side partners are actively working to build relationships between shelters without established clinical linkages and the city's network of Federally Qualified Health Centers (FQHCs).

Secondly, and perhaps most importantly of all, the current COVID-19 pandemic, like the opioid overdose epidemic, has accentuated the need for supportive housing to improve the health of those experiencing homelessness. The City, West Side partners, and the Chicago Continuum of Care (the federally mandated local body responsible for planning and coordination of both housing and services for homeless families and individuals in Chicago) are actively collaborating to streamline the permanent supportive housing placement process and establish new pathways to this evidence-based model of care that combines affordable housing with healthcare and supportive services.

As a city, we can learn from this moment about how to build a more equitable, compassionate system of housing and care. Thank you to the West Side partners for your countless contributions to the response effort and sharing our vision for lasting, positive change.

V. CHHRGE Initiative

Primary Prevention in Shelters and Congregate Living Facilities

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When the COVID-19 pandemic arrived, shelters in Chicago sought to limit viral spread through improved hygiene, PPE utilization, and social distancing within their normally dense living spaces.

Hand Hygiene: Along with social distancing, maintaining hand hygiene is essential to reduce the spread of COVID-19, but difficult to enforce in shelters. Many shelters have limited bathroom facilities, which introduced hygiene challenges and required improvisation. For example, staff at a Franciscan Outreach shelter noticed that when guests checked-in at night, there were numerous touchpoints where germs could spread before guests had a chance to wash their hands. The Chicago Homelessness and Health Response Group for Equity (CHHRGE) recommended that the entrance be rerouted, suggesting that guests enter the shelter in such a way that the bathroom was the first stop upon entry. Franciscan Outreach staff encouraged handwashing and sanitized bathroom surfaces regularly. Other shelters had similar challenges and solutions. Healthcare partners were able to provide disinfectant and sanitizers for these shelters.

Social Distancing in Shelters: Bed layouts also needed to be moved from their typical high-density format to provide social distancing. Guidance for this effort was provided by the DFSS, CDPH, and CHHRGE. Some shelters started by encouraging guests to sleep in alternating directions from head to foot and began to limit shelter capacity by as much as 50%. Concurrently, the City moved to identify and approve additional space for existing shelter beds. For example, the 270 nightly census of a Franciscan Outreach shelter was reduced to 90, and 180 beds were relocated to a much larger space

in a nearby YMCA. The City reported at the end of April that these efforts enabled social distancing with a loss of only 80 overnight beds across the city. However, at the same time, demand for shelter space increased as more individuals experiencing homelessness sought shelter from the street.

Education: In order to have guests follow the above guidelines, clinicians from CHHRGE met regularly with shelter staff to keep them informed and answer questions about evolving recommendations. Brochures (in English, Spanish, and Polish) on precautions against COVID-19, hand washing, social distancing, and other precautions were distributed to shelters throughout the city [[Appendix 1](#)].

Universal Masking: Reducing spread from respiratory droplets became the next prevention opportunity. As it became apparent that there were many shelter residents with COVID-19 symptoms, CHHRGE made a recommendation for universal masking of clients and staff in shelters (this was prior to the CDC and CDPH policies on universal masking). CHHRGE and CDPH partnered with Project Hope to obtain 25,000 surgical masks, which were distributed by student volunteers from Rush and UIC to shelters across Chicago. With extended wear, the mask supply could last at least one week, during which time new cloth masks could be produced or other supplies obtained. Simultaneously, UI Health and several of the partners in the CHHRGE led an initiative to provide cloth masks to shelters as a more permanent solution to universal masking. It was determined that the best masks to provide in congregate settings were special masks with a three-layer design [[Appendix 2](#)]. It was estimated that 10,000 masks would be necessary so that every person in Chicago experiencing homelessness would have two masks (one could be washed nightly). Volunteer groups of seamstresses (i.e., local bridal shops) were given instructions and began making these masks.

Symptom Screening in the Shelters



Along with primary preventative measures, it was recognized that shelter guests must be screened for COVID-19 symptoms to identify high-risk individuals for isolation. Screening protocol includes temperature and symptom checks to identify fevers and flu-like symptoms. Diagrams of screening area layouts can be found in [Appendix 3](#). CHHRGE began to focus on screening in larger congregate settings, including the following sites.

A Safe Haven: A Safe Haven maintained a 400-unit transitional housing facility and other supportive housing sites. Preexisting strict infection control policies were strengthened to respond to COVID-19 CDC protocols, thus successfully preventing infections among staff and residents. Early response included education, public notices, and enforcement of CDC-recommendations including frequent handwashing, social distancing, universal masks, and daily screenings. A Safe Haven's unique semi-private accommodations required no need for decompression, closed campus, or mandatory isolation of symptom positive and newly referred individuals. Out of 1,400 clients served at three locations, only four have tested positive for COVID-19 as of the end of May 2020; all four individuals contracted the virus in the community, and there was no documented spread within A Safe Haven's programs.

Haymarket Center: Haymarket Center added twice daily temperature screenings for all staff and guests. Staff who screened positive were given a mask and gloves, then asked to go home and self-quarantine for 14 days and be tested by their own medical providers.

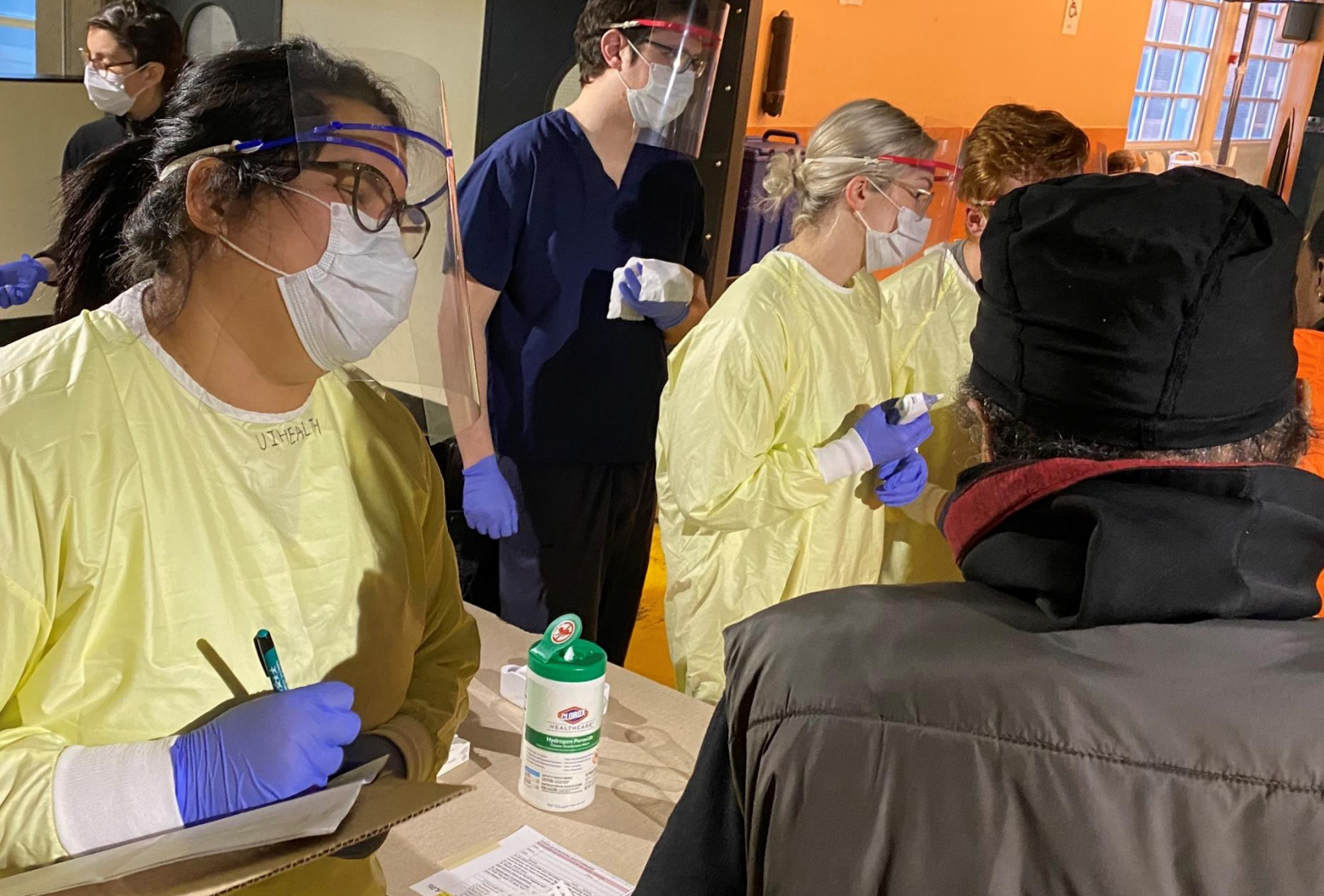
Pacific Garden Mission: The main supportive efforts at Pacific Garden Mission (PGM), one of the largest shelters in Chicago, were to provide daily symptom screenings and clinical support to over 300 guests and

PGM staff. Screening teams consisted of 5-10 student volunteers accompanied by 1-2 physicians to evaluate positive screens. Screenings were a crucial component of managing the COVID-19 outbreak at PGM and preceded implementation of rapid testing, isolation, and acute care for COVID-19 positive guests. As the needs at PGM expanded, the team adjusted their services to accommodate the 140-person COVID-19 isolation unit onsite as well as provide wraparound services to guests. Clinicians from UIC began rounding daily to care for COVID-19 positive patients and provide primary care, while student volunteers rotated between symptom screenings and general support services such as medication packaging and supplies preparation.

Franciscan Outreach: At Franciscan Outreach, guests who screened positive were directed to the attending physician for further evaluation. If the physician felt that the guest was unlikely to have COVID-19, they were permitted to return to their bed. If the physician believed the guest may have the virus, the guest was isolated. For full details of screening logistics, see the attached training manual sent to all student volunteers [\[Appendix 4\]](#). Every day there was at least one student site coordinator to ensure that screening ran smoothly, track equipment usage, and report back observations or needs to the rest of the team. Eventually the team began expanding to other sites around the Chicagoland area in order to provide needed support.

Screening stations had the following supplies:

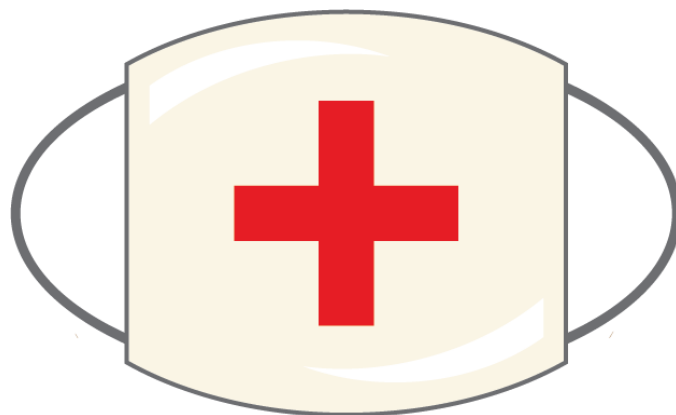
- Thermometers and ear probe covers.
- Clipboards, paper, and pens for recording.
- Stickers to mark those who had been screened.
- Alcohol wipes, hand sanitizer, and garbage bags for disinfecting between guests.
- All volunteers were supplied with PPE: face mask, gloves, full-length gown, eye protection.



COVID-19 Testing in the Shelters

Primary prevention practices are proven to reduce disease spread; however, guests still face the risk of being exposed to COVID-19 and falling ill. A congregate environment, such as those found in most shelters, increases the risk of super-spreading of the virus. CDPH understood that widespread testing around shelter outbreaks would be necessary to control community spread but lacked the staff to field a mobile testing team. Institutional partners including Heartland Alliance, LCHC, RUMC, and UI Health began to respond to outbreaks occurring across many congregate sites. Partnered with the Epidemiology and Infection Surveillance (EIS) unit of CDPH, these testing teams began field testing daily.

Between March 15 and April 30, 2020, 2,146 individuals in 16 congregate facilities were tested with an overall COVID-19 positivity rate of 26%. Test positivity rates in early April were as high as 50%, but the rates dropped as the testing teams responded more rapidly to outbreaks.



Temporary Shield Housing

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Along with screening for individuals with flu-like symptoms, CHHRGE began to screen for another group: those who were at high-risk for COVID-19 complications and mortality. It was determined that these individuals should be shielded from potential exposure by removal from congregate settings and placement in safer housing. High-risk individuals were identified as meeting any of the following criteria:

- Above the age of 60
- Smoker
- Comorbid conditions (cardiovascular disease, diabetes, pulmonary disease, kidney disease)
- Immunocompromised

Research has shown that people experiencing homelessness have an accelerated rate of aging, often involving early geriatric syndromes and premature death.⁹ The appropriate cut-off for shielding this group may actually be lower than age 60, but this threshold was set pragmatically given a finite housing resource.

One method of providing temporary shield housing was the use of hotel rooms. Initially, Hotel One-Sixty-Six in Chicago was rented by the City of Chicago and staffed by LCHC to offer voluntary quarantine in the hotel for those experiencing homelessness and exhibiting symptoms of COVID-19. Staff at LCHC have over 25 years of experience providing medical and behavioral healthcare for individuals experiencing homelessness. Testing was conducted as individuals arrived at the hotel. As testing by CDPH and CHHRGE uncovered that 40-60% of positive COVID-19 tests were in asymptomatic people, the strategy of only isolating COVID-19 positive individuals shifted. Hotel One-Sixty-Six was then used to remove vulnerable, *asymptomatic*, high-risk individuals from shelters to shield these individuals from contracting COVID-19 at a shelter. As

of May 10, 2020, there were 159 guests at Hotel One-Sixty-Six from 19 different Chicago shelters, with a total of 239 persons served by the hotel program.

Hotel Protocols: When a person enters the hotel, they are provided a handout outlining what to expect during their stay [[Appendix 7](#)]. A medical provider then obtains a medical history and performs an initial COVID-19 screening. The intake process also screens for necessary wraparound services (i.e., care management, behavioral healthcare, medications.). Guests are seen every day by a medical provider. Testing for COVID-19 is performed by clinical partners from UI Health and Lurie Children's Hospital at the threshold to the patient's hotel room (test results are returned in 24-72 hours). During their stay, guests are advised to wear a face mask when opening the door to their room, such as greeting staff or picking up medication deliveries. They must remain isolated in their hotel rooms and cannot leave to go to the hallway or lobby. Because these high-risk SARS-CoV-2 negative individuals have a high COVID-19 morbidity risk, it is not possible to discharge them from shield housing back to the shelter during the pandemic. Coordination with the Continuum of Care has led to prioritizing these guests for permanent supportive housing placement or transitional housing.

Providing Amenities: Establishing how to adequately provide for the residents of the hotel has been a constantly evolving process. CHHRGE communicated with the hotel kitchen staff about the need for healthy foods as many of the guests suffer from diabetes and hypertension. LCHC staff made efforts to cater to guests' needs, including daily trips to the local convenience store for specific food items, laundering clothing, and finding activities for residents while isolating. Around Easter, small bags of candy were distributed to residents to keep spirits up. Small incentives, such as \$25 Walgreens gift cards, were given to guests when leaving the hotel after successful

completion of isolation/quarantine. This incentive program is being replicated at other sites providing quarantine or isolation care for people experiencing homelessness. Amenities are also important for the staff providing care for people experiencing homelessness. Providing staff with courtesy meals, parking, shuttle bus transportation, appropriate time off and scheduling, consistent pay, communication of mission, uplifting patient stories and reflections, shared data drives, and adequate PPE are all as critical as the incentives for guests experiencing homelessness.

Medical Care: Clinicians provided daily rounds for high-risk guests. Having medications for immediate use in an accessible cabinet has been critical. Same-day prescription delivery became possible with twice daily deliveries from LCHC's own pharmacy. Delivery of methadone to the hotel was arranged in collaboration with Family Guidance Centers, a Chicago-based behavioral health organization, regardless of where the person's home methadone program might be. Daily monitoring, with special attention to oxygen saturation, has been very important for COVID-19 positive guests.

Transportation: One significant challenge was the arrangement of transportation between sites. LCHC was able to provide transportation consistently for shield housing. Other sites that did not have 7-day van coverage required problem solving with the City. In one case, drivers from the Chicago Public Library vans were recruited to transport people experiencing homelessness to a respite unit (isolation for COVID-19 positive persons experiencing homelessness).

Temporary Shield Housing Considerations

- Isolation centers may need to evolve to fit the growing needs of the pandemic.
- Exceptional care for residents should be the number one priority in isolation centers, even if it means going above and beyond to make residents comfortable.
- Providers must also be supported. Many are volunteering their time to serve the community during a high-stress situation.



Medical Respite and Isolation Centers

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Most shelters do not have space to effectively isolate individuals with COVID-19 and prevent spread. Additionally, hospitals sought locations to discharge stable COVID-19 positive individuals experiencing homelessness. Sites for these patients to receive respite care before returning to shelters became an early priority for CHHRGE and the City.

A Safe Haven, an established transitional housing provider with a four-acre campus in North Lawndale on Chicago's West Side, stepped up to provide isolation space. In addition to comprehensive services (i.e., life skills, employment training, job placement), A Safe Haven has a record of housing guests in semi-private rooms. Having demonstrated success in controlling the spread of COVID-19, they were confident in their ability to add an isolation unit and set aside a 7,000 square-foot wing. Within two weeks, the facility modified the space to create the City's first 100-bed Isolation Medical Respite Center. Building on a relationship with Rush University's College of Nursing, A Safe Haven created a partnership with Rush, Heartland Alliance Health, and the City. On April 11, 2020, the space opened for recuperating COVID-19 positive individuals ages 2+. The CDPH A Safe Haven Rush Respite Shelter (CARReS) unit is staffed by onsite nurses and lay monitors. The medical team are present onsite seven days weekly. Extensive operating procedures have been created to guide care in the facility, including intake, discharge, medical care, and behavioral health management.

Behavioral Health: SUD patients are managed in partnership with A Safe Haven Tele-Behavioral Health and specialists in Medication for Addiction Treatment (MAT; previously known as Medication Assisted Treatment); other mental health issues are managed by Rush Psychiatry. Additional strategies in Section [VI: Behavioral Health](#).

Medical Care: Medical, psychiatric, and SUD management care is provided during guest convalescence from COVID-19 at CARReS, utilizing a trauma-informed care model. The medical team supports guest recovery from COVID-19 illness and manages chronic medical conditions. The team collaborates with A Safe Haven staff for admission and discharge processes, including transfer to ED if clinical condition deteriorates, and transfer to non-COVID-19 housing once the isolation period has been met, according to current CDC and CDPH guidance.



Features created for the Isolation Medical Respite Center included:

- Specialized negative air pressure isolation space.
- Individual showers and bathroom stalls.
- Private tele-behavioral health services room.
- A 'clean area' nursing station.
- A medication room.
- Ample sized bed bug resistant mattresses.
- 4-6 bed pods separated by partitions.
- Dining room serving three hot nutritious meals catered daily by onsite A Safe Haven catering.
- Community area with big screen television.
- Outdoor sitting and smoking area.
- 24-hour resident comfort and medical assistance monitors.
- Deep cleaning housekeeping.
- Transportation services.
- Electronic camera security system.
- 24/7 in-person security guard.
- Discharge services to hospital.
- Community homeless network and to A Safe Haven transitional and supportive housing programs.



Facility Operations: A Safe Haven works to accommodate guests' needs over the course of their stay. Staff provide guests with breakfast, lunch, and dinner in the shelter's cafeteria; self-serve food and refreshments are also available. Shower times are posted at breakfast each day and are available to all guests who sign up for a time slot. Guests must keep prescriptions, including narcotic medications, in the shelter's locked medication cabinet. Monitors help in many ways including assistance for the many disabled or impaired to go to the rest room and showers. We also provide case management, discharge and housing planning to move many of our guests to other programs, putting them on a path to self-sufficiency. All guest activities that require use of facilities outside a Safe Haven's entrance door including smoke breaks and shower times are monitored in order to ensure the safety of its guests and others.

A second respite unit was opened through a partnership between Cook County Health and the City of Chicago on May 1, 2020, adding capacity for an additional 132 COVID-19 positive individuals aged 18 and over to recover with supportive respite care and clinical monitoring. Both sites initially planned to consider discharge after three consecutive asymptomatic days at least seven days after the onset of symptoms; as of May 4, 2020, CDPH issued a new guidance extending length of stay to at least 10 days after onset of symptoms.



A Safe Haven's Model of Care

Caring in Place

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Implementing Isolation in a Shelter or Other Congregate Site

Guests experiencing homelessness who have a fever over 100°F, or who appear acutely unwell, should receive prompt medical care, with consideration of sending the guest to the nearest emergency department for evaluation and possible hospitalization. Afebrile guests with more subtle symptoms of possible COVID-19 may not require such urgent care but should be tested for COVID-19 or isolated until asymptomatic for at least three consecutive days. This becomes extremely challenging in congregate living shelters. As discussed previously, initial plans called for symptomatic individuals to be isolated at Hotel One-Sixty-Six. When strategy called for this to become shield housing, shelters were asked to isolate in place. Shelters were recommended to make any possible building modifications to accommodate quarantining in place [\[Appendix 6\]](#). Additionally, CHHRGE provided the following guidance to the shelters:



Sleep space: If possible, each symptomatic individual should have their own room.

Grouping all symptomatic persons together in a common space is not optimal; while this would remove them from the asymptomatic population, it would risk that a symptomatic person who does not have COVID-19, but whose symptoms are due to another condition (i.e., allergies, upper respiratory infection, strep throat, etc.) could be exposed to someone who does have COVID-19. These individuals must be given masks and should continue social distancing from each other. If there are no isolating rooms, consider if the person can be moved into a hallway, away from traffic, or at the end of a corridor. If the only place available is in the same space, move all other beds back at least six feet or greater. Use a

divider around the bed to reduce the spread of airborne droplets. This can be a sheet pulled taut between two chairs, tables or other cots stood on end, a sheet tent with a clothesline. Keep the ill person's belongings in airtight containers, such as a plastic storage box or a large trash bag with a zip tie.



Restrooms: As with sleeping spaces, a private bathroom is best. If not possible, label one stall in the restroom for symptomatic persons only. Instruct anyone with symptoms to use only that stall. They must wear a face mask to go to the bathroom. Give the sick person a container of sanitizer wipes and make them responsible for wiping the door handles, toilet handle, sink faucets, paper towel dispenser, or anything they touch both before and after use. Additionally, schedule regular staff cleaning of the restrooms.



Meals: Meals need to be delivered to the person in the sleeping area via a disposable container with disposable silverware. The person providing the meal should set it down at least three feet away and let the sick person pick it up. Once it is consumed, the ill person should place all disposable items in a bag and then place the bag three feet away. A staff person with gloves and a face mask should then take it and dispose of the bag.



Contact: Many people, including the people experiencing homelessness, have cell phones. Give the sick person a number to call when they need assistance so they will not need to get up and find someone. If they do not have a phone, something else like a bell will work.



Amenities: It is helpful to provide the sick person with a water bottle, a small trash can, tissues, sanitizing wipes, cough drops, and other basic amenities that they may need throughout the day. This minimizes the frequency that these people will need to get up during isolation.



Support and Considerations for Staff

The COVID-19 pandemic has been stressful for everyone, and the presence of even one individual with non-specific symptoms can trigger anxiety for frontline shelter staff. For shelter staff with little or no medical background, training and support from health professionals on proper use of PPE, contact precautions, and hand hygiene can be invaluable in maintaining calm. For example, infectious disease specialists from UI Health and representatives from CDPH visited Haymarket Center to meet with staff, answer questions, and make recommendations.

Staff need to be assured that they have PPE, education, and the ability to remain safe. They should be given the opportunity to express their fears, and leadership should address these concerns respectfully. Appreciation for their work and dedication to others should be expressed. Failure to address these issues

may result in staff calling off work due to fear, and the facility not having sufficient personnel to operate safely.

Addressing the Concerns of Guests

Staff and health professionals can support successful quarantine by providing education and making frequent visits to answer questions. Define expectations up front so that guests in quarantine know how they will be cared for and how long they will be expected to remain separate from the general population. Prompt testing should be arranged when possible. Signs should be posted, reminding guests of the need for handwashing, wearing masks, and sanitizing surfaces.

Unless under official public health order, guests have the right to leave a facility even when they are symptomatic and quarantined. Addressing comfort, providing MAT for substance use disorder, nicotine replacement for tobacco users, and giving small incentives encourage adherence with quarantine.

VI. Challenges

Isolation and Medical Challenges



Maintaining a person in isolation in a hotel room for a prolonged time period can be a challenge which demands flexibility and an ability to respond to the person's needs. As isolation time has extended, staff have had to obtain clothes, arrange for laundering of patient clothing, and accommodate guest smoke breaks.

Many providers working at Hotel One-Sixty-Six had prior experience caring for people experiencing homelessness and other people at high-risk for COVID-19. These experienced providers are able to mentor and show providers with less experience how to do more traditional nursing roles (i.e., taking temperatures, oxygen saturation readings, common wound dressing changes), and how to gain trust and engage patients by serving their immediate needs.

Furthermore, rounding on a large number of guests can be a challenge. To address this, Hotel One-Sixty-Six instituted a low acuity rounding system. In this system, those who are stable are rounded on by non-adult providers (such as pediatricians) who do a quick visual check-in with the patient and ask about symptoms and how they are doing; these providers only perform temperature screenings and pulse oximeter readings on those who are COVID-19 positive. Low acuity rounders, who can see up to 40-50 guests a day, report to a rounder assigned specifically to the patient.

Finally, Hotel One-Sixty-Six partnered with UI Health infectious disease attendings for staff instruction on how to appropriately use and conserve PPE while upholding the highest safety standards. This allowed staff to remain patient-centered, an ideal that sometimes means creatively working around systems that are not responsive while staff advocate for systemic changes.



Behavioral Health

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Management of Behavioral Health and Substance Use Disorders in Isolation Units

Providing supportive and collaborative services during a national crisis, such as the COVID-19 pandemic, for those who are unsheltered and have SMI and/or SUD needs poses many challenges. Shelters feel like a secondary home to many guests experiencing homelessness. Sheltering together symbolically serves as support, while social distancing implies rejection of others in their community. This is especially isolating for individuals with SMI and SUD, as individuals are already ostracized by greater society. Adhering to social distancing parameters for this population becomes almost impossible, conceptually. One must also consider that guests with limited resources adopt a harm reduction model. Given these complexities, a behavioral health (BH) model in a non-medical setting was devised to facilitate a streamlined screening process (See [Appendix 5](#) for an outline of the behavioral health model). This BH model focused on establishing screenings that recognized two key concepts:

1. Guests with SMI/SUD often have needs that need to be met immediately.
2. Shelters are running above capacity without the necessary staff to support the increased burden.

SUD Evaluation During Intake

There is a significant amount of anxiety for patients with opioid use disorder (OUD) who are entering a shelter for quarantine. Specifically, people who are actively using opioids prior to coming to the site are at risk for experiencing uncomfortable, and sometimes dangerous, withdrawal symptoms. Furthermore, once patients with OUD enter the shelter, they may encounter difficulty in obtaining medication to treat OUD, specifically buprenorphine/naloxone and

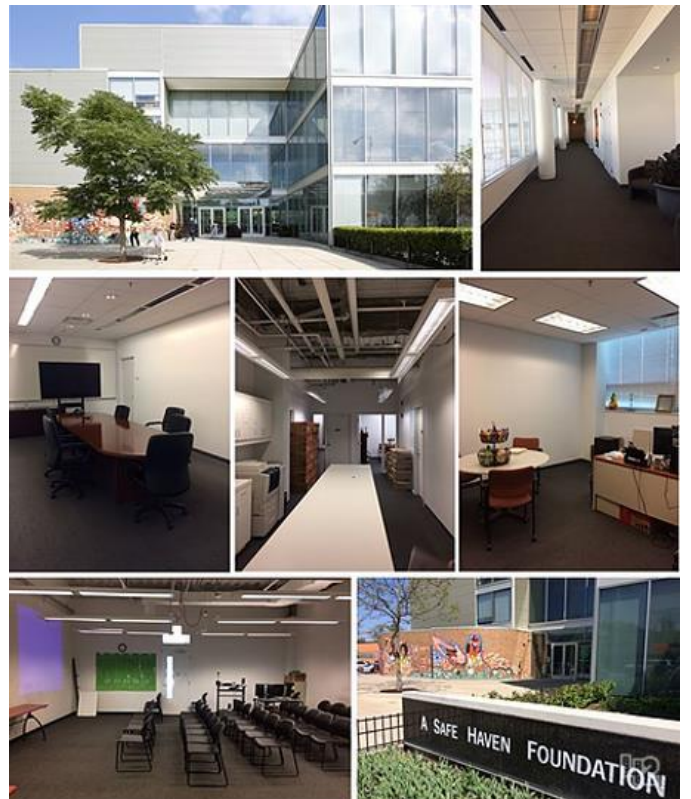
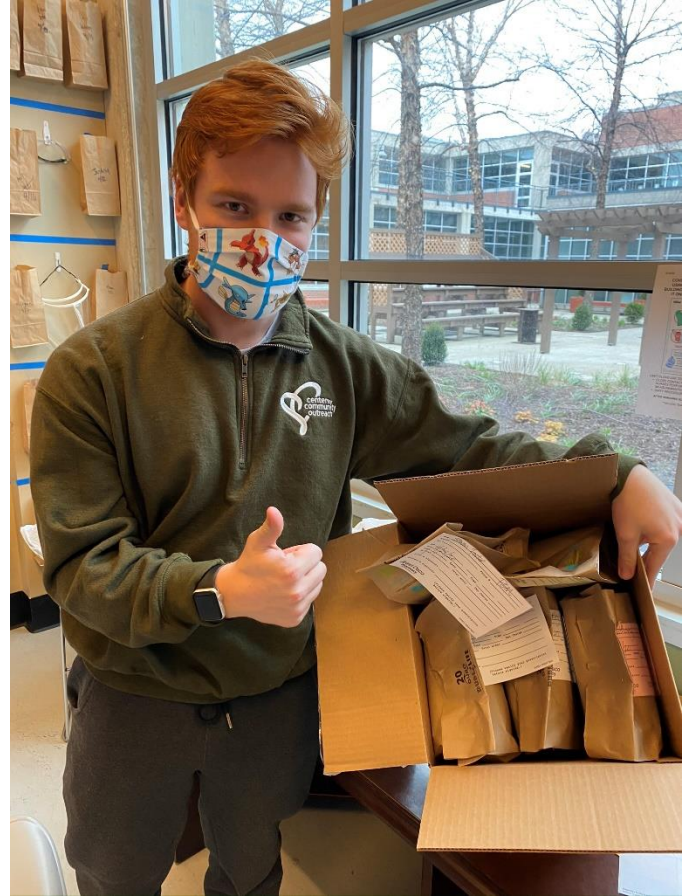
methadone, as well as storing their medications safely. To overcome these issues, CHHRGE encouraged screening for SUD or OUD during intake. For patients entering a shelter with a history of OUD and who were currently in treatment, shelter staff worked with the patient and treatment program to organize methadone delivery or buprenorphine/naloxone prescription pick-up and to support the storage of these medications onsite. Those that were identified as having an SUD or OUD, were not actively in treatment, and who expressed interest in treatment were either connected to services by the onsite provider, a partner who could dispense buprenorphine/naloxone, or an outpatient treatment program for intake/counseling services. Any type of withdrawal that was unable to be managed onsite was brought to the hospital for medically supervised withdrawal. When medically appropriate, these people were discharged back to the shelter.

Medication Needs

Part of providing appropriate services was accounting for the pharmaceutical needs of patients with both chronic health conditions, including mental illness and SUD. At Salvation Army sites, patients who needed to take medications regularly were able to lock their medications in a cabinet and access them upon request. Another concern was the maintenance of controlled substances, including MAT for patients with OUD. A “methadone workflow” was established for this purpose, including establishing methadone deliveries from opioid treatment programs. Additional courier services were utilized for the delivery of buprenorphine/naloxone and other medications. Grant funding has been secured that will enable Rush Medical College students to distribute naloxone kits to guests at Franciscan Outreach and to train recipients on kit use.

VII. The Role of Funders

Philanthropy plays a key role in supporting both basic services and civic innovation. Chicago Funders Together to End Homelessness (CFTEH) is the local chapter of the national Funders Together to End Homelessness organization, and currently includes 16 Chicago-area funders of the housing and homeless services sector. CFTEH's role within CHHRGE includes advocating for a coordinated city-wide response and mitigation strategy while leveraging its collective relationships with city leaders and agencies to facilitate information sharing. CFTEH engaged other key stakeholders from the housing and homeless response ecosystem, including All Chicago and the Continuum of Care. CFTEH also plays a role in elevating the on-the-ground experience of the CHHRGE providers and institutions to inform and coordinate advocacy efforts at the state level. Lastly, in an effort to support scaling and replication of the efforts, CFTEH is strengthening key cross-sector collaborations to better coordinate and align relationships and resources with healthcare funders, funders of domestic violence programs, and funders working to support justice-involved populations.





VIII. Conclusion

Policy and Systems Change to Address Homelessness in the City

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COVID-19 has highlighted the systematic underfunding and de-prioritization of homeless services in the nation and in Chicago. This crisis has provided much needed urgency and pressure to address these wrongs and ensure that homelessness becomes a brief occurrence.

Homelessness is a multifaceted problem occurring at the intersection of many systems: healthcare, behavioral health, education, justice, child welfare, living-wage employment, and affordable housing. The failure is not of the individual, but of the public sector systems that fail to recognize and intervene early in life. Thus, homelessness must be addressed collectively by the systems that contribute to it. The healthcare partnerships detailed above must be sustained and expanded so that all people experiencing homelessness have access to comprehensive healthcare. Partnerships must also be expanded to incorporate education and employment opportunities to support people experiencing homelessness and to help prevent additional people from becoming homeless. Similarly,

the justice and child welfare systems must be engaged to address the bidirectional relationship between homelessness and involvement in these systems.

Lastly, there must be robust housing pathways to ensure that people experiencing homelessness can obtain and maintain housing. Chicago needs to invest in expanding housing with individually tailored supports and affordability across income levels in the community. Homelessness is a symptom of the absent safety net in this country. It is only through the development of intentional cross-sector partnerships that we will be able to end homelessness.

CHHRGE appreciates and respects the tireless efforts of the City of Chicago and our colleagues at CDPH, DFFS, and the Department of Housing in the COVID-19 crisis. We also acknowledge that our understanding of these systems is limited. None-the-less, it is clear that while the current system is broken and places individuals at risk, there are ways to rapidly improve.

CHHRGE has identified ten policy areas to address both short-term vulnerabilities of people experiencing homelessness in the COVID-19 pandemic and long-term housing, healthcare, and economic development needs of people experiencing homelessness in Chicago.

Chicago Homelessness and Health Response Group for Equity's Working List of Policy Issues

(Note: The Sequence of Issues Does Not Reflect Prioritization)

- Maintain the number of shelter beds that existed in Chicago pre-COVID, with additional space to social distance.
- Shield high-risk individuals and families in hotels and apartments. Broaden the definition of high-risk to include medically and structurally vulnerable individuals. We estimate that at least 400 additional high-risk individuals and families could immediately benefit from shielding by opening more hotels or through subsidized housing units.
- Shield high-risk individuals and families in apartments, funding at least 1,750 rental subsidies with supportive services, bridging to permanent solutions, allowing high-risk individuals and families to move from congregate settings into their own units and reduce the risk of infection.
- Create medical partnerships for every shelter in the city to ensure that guests have access to timely, high-quality medical and behavioral care, and shelter staff have access to information and resources to operate safely.
- Create a Chief Homelessness Officer within the Mayor's office to coordinate a homelessness strategy across multiple departments in the City of Chicago.
- Conduct ongoing COVID-19 testing and surveillance screening across the population of the homeless and vulnerably housed to monitor true disease prevalence and recovery, in order to create an early warning system of a second wave. Apply a racial equity analysis to this data to help inform city priorities.
- Define standards of medical and housing care for the homeless population including performance measures and provide sufficient funding to shelter and medical providers to meet those standards.
- Implement Illinois's 1115 waiver to pay for wrap-around services. Amend the current waiver to include funding for housing the homeless.
- Expand system capacity for providing key behavioral health services by working with State and local community mental health agencies and outpatient treatment providers.
- Fund housing subsidies and other supports to create 2,000 additional units of non-time-limited housing by the end of 2021 including permanent supportive housing to reduce the number of individuals and families dependent upon the overnight shelter program. Use rent supports, housing set-asides, and other strategies to expand affordable housing across the city.

Epilogue

In the current climate of homelessness, the COVID-19 pandemic, and social injustice, CHHRGE has been able to bundle these issues and create a platform of leadership to address them, boldly calling out the problems and taking precise aim at providing solutions. CHHRGE took on the problems of homelessness, which I believe is a social injustice that is experienced by many in our society but ignored by most.

The recent protests surrounding the killing of George Floyd highlights how much work is still ahead to confront inequality, racism, and social injustice. Although homelessness issues have often been ignored, CHHRGE has stepped up and become a pillar in our communities, lifting the voices of the homeless and changing the lens and perceptions in our society. CHHRGE shined a glaring light on this issue by exposing the problems of the homeless and working through our blinders about systemic racism and the health disparities impacting black and brown communities.

But what to do about it and where do we to begin? Let's start with its origins. The concept of homelessness is deeply embedded in discriminatory practices, even beyond the confines of systemic racism. Through the bravery to acknowledge the problems, CHHRGE did not shy away from understanding these challenges but instead responded to them by convening service providers, community agencies and key stakeholders to address the everyday struggles of our homeless that were exacerbated during the pandemic.

Providing necessary shelter for our infected brothers and sisters was the first act of humanity with built-in measures to protect and prevent the spreading of the virus. The second act was lifting the veil of racism and exposing the key indicators that influence the wellbeing of our community, the social determinants of health, including lack of housing, lack of employment, food insecurities, education, and access to healthcare.

CHHRGE developed the dialogue around homelessness by educating and confronting the inequalities as they exist. CHHRGE opened discussions with local, state and governmental elected officials to build and promote new avenues for change, and new policies to improve the lives of the homeless. We are working for both immediate and long-term solutions to be sustained beyond the current COVID-19 pandemic. CHHRGE advances solutions by utilizing data-driven information to help shift cultural attitudes and challenge the status quo. We welcome all to the table: key stakeholders, community service providers, medical providers, agencies, long-term homeless experts, and those with lived experiences. As a result, a movement of advocacy has been created which will ultimately fuel the actual change CHHRGE seeks to accomplish. No longer will the homeless be treated with neglect or disdain, but instead with dignity and respect. George Floyd changed the lens of social justice; CHHRGE is changing the conceptual and societal views of the homeless.

From the call to action at the start of the COVID-19 pandemic to the current protests for social justice in our black and brown communities, the CHHRGE mission has never been clearer, nor our efforts more decisive. CHHRGE embodies the old South African concepts of **UBUNTU** which means **HUMANITY**.

*I am because You are because We are because
Of the energy of God.
There's oneness in humanity.*

My humanity is caught up and bounded in your humanity through our interdependence, "a person is a person through other person(s)." You have gifts that I don't have. I have gifts that you don't have. We achieve ourselves by sharing ourselves with others and caring for the ones around us.

Diane Washington, MD
Executive Director of Behavioral Health, Cook County
Health

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CHHRGE Partners



A Safe Haven: A Safe Haven Foundation is an innovative, vertically integrated ecosystem that helps people aspire, transform and sustain their lives as they transition from homelessness to self-sufficiency with pride and purpose. A Safe Haven provides the tools for each individual to overcome the root causes of poverty and homelessness through a holistic and scalable model. A Safe Haven supports individual adults, families with children, youth, including Veterans and non-violent re-entry, with individualized case management, shelter, food, treatment, education, job training, access to employment & affordable housing. Through A Safe Haven's social services and portfolio of owned and managed social business enterprises, and affordable, senior and veteran housing and vast network of referral and partner organizations, and employers it provides a seamless continuum of care, housing and employment and/or resources including funding to help 5,000 individuals annually achieve social, financial and housing stability in a sustainable manner since 1994 Housing is Healthcare®



All Chicago: All Chicago is a charitable organization whose mission is to unite the Chicago community and resources to provide solutions that ensure and sustain the stability of home. All Chicago works to prevent and end homelessness by providing critical financial assistance to people experiencing an emergency that could lead to homelessness or other crises. All Chicago convenes key stakeholders and provides partners with training and data on people experiencing, or at risk of, homelessness.



The Boulevard of Chicago: The Boulevard of Chicago is a charitable organization dedicated to providing high quality, cost-effective medical respite care, holistic support and housing services to ill and injured homeless adults in order to break the cycle of homelessness, restore their health, and rebuild their lives. It works to give men and women on the road to medical recovery a place to restore their health and rebuild their lives. Boulevard residents receive care from PCC Wellness physicians and nursing staff, receive coaching and education, and employment assistance. Once residents have completed their medical recovery the Boulevard of Chicago helps residents find safe stable housing and provides them with ongoing support.



Breakthrough: Breakthrough is a faith-based, non-profit organization based in East Garfield Park that partners with those affected by poverty to build connections, develop skills, and open doors of opportunity. With a hyper-local, 40-block focus, Breakthrough provides a myriad of services such as housing, health & wellness, and workforce development focused on the simple formula of “people first”.



Chicago Coalition for the Homeless: Organized in 1980, Chicago Coalition for the Homeless (CCH) is the only non-profit in Illinois solely dedicated to advocating for and with people who experience homelessness. The organization’s mission is to organize and advocate to prevent and end homelessness, because housing is a human right in a just society. Staffed by public policy specialists, legal aid attorneys, and community organizers, CCH advocates for and with people impacted by homelessness – families, unaccompanied youth, returning citizens, and low-wage workers. Together, we advocate to develop affordable housing, preserve a shelter safety net, and protect access to public schools and school services, health care, fair wage jobs, and basic human rights and services.



Chicago Department of Family & Support Services (DFFS): The Chicago Department of Family & Support Services (DFFS) is an administrative unit of the City of Chicago’s Government Working with community partners, to connect Chicago residents and families to resources that build stability, support their well-being, and empower them to thrive.



Chicago Department of Public Health (CDPH): The Chicago Department of Public Health (CDPH) is an administrative unit of the City of Chicago’s Government which works to promote and improve health by engaging residents, communities and partners in establishing and implementing policies and services that prioritize residents and communities with the greatest need. CDPH respects and appreciates Chicago residents’ diversity and seeks to affirm their range of experiences, values, traumas and strengths over the course of its public health work.



Chicago Funders Together to End Homelessness (CFTEH): Is a branch of the national philanthropic membership organization Funders Together to End Homelessness which utilizes its members’ voices, influence, and expertise of philanthropy to advance lasting solutions to ending homelessness, including addressing its underlying causes like structural and racial inequities, and helping create policies and systems that center people with lived expertise. CFTEH works to bring awareness to homelessness and its causes through advocacy and programming.



The City of Chicago Department of Housing: The City of Chicago Department of Housing (DOH) is an administrative unit of the City of Chicago's Government committed to ensuring that Chicago's housing resources and policies address the needs of residents of all income levels.



COOK COUNTY HEALTH

Cook County Health: Cook County Health and Hospital System is a public health system comprised of John H. Stroger Jr. Hospital of Cook County, Provident Hospital of Cook County, and several related centers which serves the people of Cook County. It aims to elevate the health of Cook County, secure the future of the health system and build a place where everyone will want to receive care regardless of a patient's ability to pay.



Cornerstone Community Outreach (CCO): Cornerstone Community Outreach is a Chicago based non-profit that provides shelter for families, women, and men experiencing homelessness. Cornerstone offers individualized case management services for shelter guests and support for neighbors as well as a wide range of services and assistance. Cornerstone is honored to be working for decades with CDFSS and many partner organizations to provide the best way to be welcoming, assisting and supporting people who are experiencing homelessness and on the path to housing and independence.



Franciscan Outreach: Franciscan Outreach is a provider of homeless services in Chicago that operates as a system of support for men and women who are marginalized and homeless, empowering people to gain the stability they need to transition into permanent housing. Through five service sites, Franciscan Outreach provides a diverse array of programs and services to those in need.



Haymarket Center: Haymarket Center is a non-profit organization which works to aid people with substance use disorders in their recovery by providing comprehensive behavioral health. Haymarket Center provides this aid through its evidence-based interventions and state of the art programming geared towards strong outcomes. Haymarket provides comprehensive clinical substance abuse treatment and supportive services to Chicago's vastly ignored and underserved populations regardless of their ability to afford services.

HEARTLAND ALLIANCE

HEALTH

Heartland Alliance Health: Heartland Alliance is an anti-poverty organization, serving those who are homeless, living in poverty, or seeking safety. It provides a comprehensive array of services in the areas of health, housing, jobs and justice – and leads state and national policy efforts, which target lasting change for individuals and society. Heartland Alliance Health is a Federally Qualified Health Center that has designation as a healthcare for the homeless site, as designated per HRSA.

Illinois Chapter

INCORPORATED IN ILLINOIS

American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN®



Illinois Chapter, American Academy of Pediatrics: The Illinois Chapter, American Academy of Pediatrics (ICAAP) is an organization of approximately 2,000 pediatricians in Illinois. Primary activities include advocacy on behalf of children, families, and health professionals in Illinois; the provision of continuing medical education and other resources for pediatricians, pediatric specialists, and other child health care providers; and collaboration with state, city, and local organizations and agencies on programs and projects improve the health and well-being of children.



Illinois Public Health Institute: The Illinois Public Health Institute is an organization dedicated to mobilizing stakeholders, catalyzing partnerships, and leading action to improve public health systems to maximize health, health equity and quality of life for people in communities across Illinois. It works to improve the physical, mental and social well-being of all people in Illinois by developing a high-functioning public health system comprised of active public, private and voluntary partners.



LAWNDALE CHRISTIAN
HEALTH CENTER
Loving God. Loving People.

Lawndale Christian Health Center: Lawndale Christian Health Center is a non-profit organization based in North Lawndale that works to show and share the love of Jesus by promoting wellness and providing quality, affordable healthcare for Lawndale and the neighboring communities via its six clinics. With its more than 100 medical providers Lawndale Christian Health Center works to address the lack of affordable, quality healthcare services.



Margaret's Village
Strengthening Families. Building Communities. Opening Doors.
MARIA SHELTER • BELIEVE SHELTER • VINCENNES SENIOR CENTER

Margaret's Village: Margaret's Village is a non-profit that advocates for underserved communities on Chicago's south side. It provides transitional housing for homeless women and families through the Maria and Believe shelters offering supportive services to residents in order to empower them and lift them out of poverty. On-site case managers provide holistic and individualized services such as care coordination and referrals for legal assistance. Margaret's Village operates the Vincennes Senior Center to provide activities and emotional well-being to its residents. Margaret's Village works to engage with the community to reimagine Chicago's south side as a resilient and safe neighborhood. Program participants enjoy music and art therapy as well as writing workshops which promote healing and improve communication skills. Through partner

agencies, Margaret's Village facilitates job training, coaching and employment placement. Margaret's Village also coordinates with the UChicago Medical Center and Goldie's Place to provide free medical and dental services.



Northwestern Medicine: Northwestern Medicine is an academic health system comprised of ten hospitals and outpatient care facilities whose mission is to provide premier integrated care where the patient comes first. The Northwestern Medicine clinical and administrative staffs collaborate with the Feinberg School of Medicine which aims to transform the practice of medicine and profoundly impact human health.



Pacific Garden Mission: Pacific Garden Mission is a rescue mission, based in Chicago's Near West Side which works to reach the lost with the Gospel of Christ and minister with the transforming message of the Gospel. Pacific Garden Mission's facility which has 950 beds provides men, women, and children with housing, daily training in vocational skills and life skills, and access to a variety of supportive programs.



PCC Community Wellness Center: PCC Community Wellness Center is a Federally-Qualified Health Center serving the West Side of Chicago and western suburbs. PCC's mission is to improve health outcomes for the medically underserved community through the provision of high quality, affordable, and accessible primary health care and support services. Anchored with family medicine, we are committed to serving the needs of all people in all stages of life. PCC currently serves almost 50,000 patients at twelve sites, with over one-hundred health care providers. In addition to outpatient primary care, PCC's service lines include integrated behavioral health program, dental care, and inpatient adult medicine and OB care at two partner hospitals. PCC is committed to training the next generation of health care providers for the underserved, through Fellowships in Maternal-Child Health and Community Medicine, partnerships with two family medicine residency programs, and training nurse practitioner, nurse midwife, and social work students.



Primo Center for Women and Children: Primo Center is a non-profit organization that works to empower families to become productive, responsible, and independent members of their community by providing family shelter and permanent supportive housing, integrated physical, dental, and mental health care, early childhood development, and supportive services to families experiencing homelessness in Chicago. Primo Center works in high-need communities across Chicago, operating facilities in North Lawndale and West Humboldt Park, in Auburn Gresham and Englewood, and in Hermosa.



Rush University System for Health (RUSH): Rush University System for Health (RUSH) is an academic health system comprised of Rush University Medical Center, Rush Copley Medical Center and Rush Oak Park Hospital, as well as numerous outpatient care facilities whose mission is to improve the health of the individuals and diverse communities it serves through the integration of outstanding patient care, education, research and community partnerships. The RUSH system also includes Rush University a health sciences university with more than 2,500 students comprised of Rush Medical College, the College of Nursing, the College of Health Sciences and the Graduate College.



The Salvation Army Harbor Light Center: The Salvation Army Harbor Light Center is a faith based organization, providing a 200 bed substance use treatment facility and community center. Its message is based on the Bible and its ministry is motivated by the love of God. The Salvation Army is made up of thousands of officers, soldiers, adherents, employees, volunteers and other individuals all working together to holistically meet the spiritual, emotional and physical needs of those less fortunate.

The Salvation Army Shield of Hope: The Salvation Army Shield of Hope is the nation's first emergency's homeless assessment and rapid-response center (EHARC) to provide families facing homelessness personalized service and support. The facility Shield of Hope is an integral part of the City's broad-ranging, multi-year action plan to address homelessness in partnership with the Chicago Continuum of Care. The Shield of Hope has 90 beds available for vulnerable families on a nightly basis, can accommodate up to 142 beds in emergency shelter situations and provides private rooms and restrooms. EHARC has provides shelter to over 4000 clients annually since opening. Families staying at The Shield of Hope/EHARC have access to an array of services through The Salvation Army's network which include; job training, recreational and educational programs for the entire family and treatment for substance abuse.



University of Illinois at Chicago (UIC): University of Illinois College (UIC) of Medicine is one of the largest medical schools in the country with a diverse student body of over 1,300 students. The College's four campuses located in Chicago, Peoria, Rockford, and Urbana take advantage of the state's urban and rural environments and offer numerous opportunities for clinical training and research. It strives to advance health for everyone through outstanding education, research, clinical care and social responsibility. UIC is associated with UI Health's Mile Square Health Center, a Federally Qualified Health Center which has health clinics located in many neighborhoods across Chicagoland to care for individuals at every stage of life, whether or not they can pay for it.

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Appendices

Appendix 1: COVID-19 Education Brochures

Guide to COVID-19 the new virus in town



Protect yourself and others!



Don't touch your face.



If you need to touch your face,
wash your hands first.

Wash your hands often.



Count to 20 slowly while you make soapsuds.

Or use hand sanitizer.

Keep rubbing your hands together until dry.



page 1

When you cough...
cover your nose and mouth!

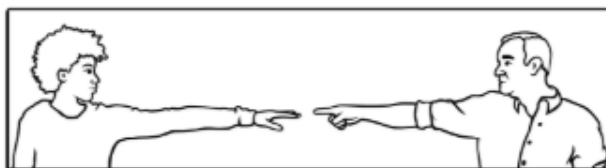
Use a tissue.



Or use your elbow.



Whenever you can,
stay at least **6 feet** away from others.

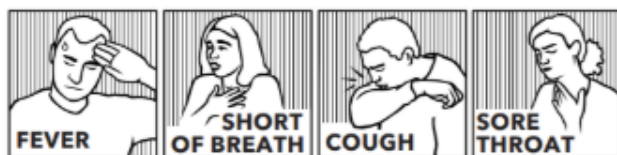


Enjoy some alone time!

page 2

Most people with the virus just have a cold.
But, some people can get *very sick*.

Do you feel sick?



- ✓ Tell the people working at your shelter or go to the nearest hospital.
- ✓ Ask for a mask to wear.
- ✓ Keep doing everything on pages 1 and 2.

If you think you are getting *very sick*, call 911.

Questions?

1-800-889-3931

Illinois Department of Public Health

Other important phone numbers:

page 3 v.1.1; 04/06/2020; send requests to darcie.moeller@cookcountyhhs.org

Guía de COVID-19

el nuevo virus en la ciudad



¡Protéjase usted mismo y a los demás!



Cuando tosa...

¡cúbrase la nariz y la boca!

Use un pañuelo descartable.



O use su codo.



Siempre que pueda, manténgase al menos a **6 pies** de distancia de los demás.



¡Disfrute de un tiempo a solas!

página 2

No se toque la cara.



Si necesita tocarse la cara,
primero lávese las manos.

Lávese las manos con frecuencia.



Cuente hasta 20 lentamente mientras hace espuma con el jabón.

O use desinfectante para manos.

Siga frotándose las manos hasta que se seque.



página 1

La mayoría de las personas con el virus solo tienen un resfriado.

Pero algunas personas pueden *enfermarse mucho*.

¿Se siente enfermo?



- ✓ Dígame a las personas que trabajan en su albergue o vaya al hospital más cercano.
- ✓ Pida una máscara para usar.
- ✓ Siga haciendo todo en las páginas 1 y 2.

Si cree que se está muy enfermo, llame al 911.

¿Preguntas?

1-800-889-3931

El Departamento de Salud Pública de Illinois

Otros números de teléfono importantes:

v.S1.2; 04/09/2020; Enviar solicitudes a darci.moeller@cookcountyhhs.org

Poradnik COVID-19

nowy wirus w mieście

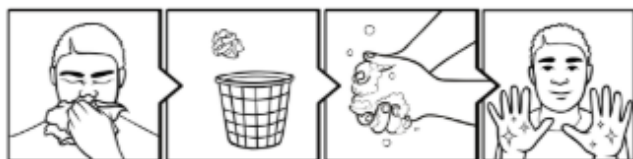


Ochroń siebie i innych!



Jak kaszlesz zasłoń nos i usta!

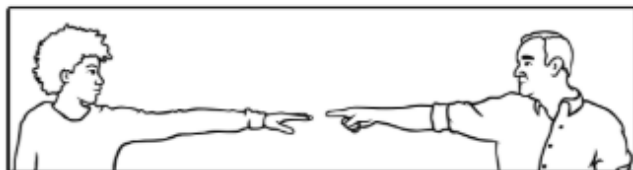
Używaj chusteczki.



Lub swojego łokcia.



Jak tylko jest to możliwe, zachowaj dystans **6 stóp** (ok. 2 metrów) od innych.



Ciesz się samotnością!

page 2

Nie dotykaj twarzy.



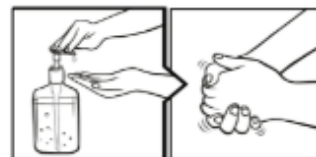
Jeżeli musisz dotknąć twarzy,
umyj najpierw ręce.

Często myj ręce.



W czasie mydlenia powoli policz do 20-u.

Lub używaj żelu do dezynfekcji.
Proszę nacierać ręce aż wyschną.



page 1

Większość ludzi
z tym wirusem ma objawy przeziębienia.
Ale niektórzy mogą poważnie zachorować.

Czy czujesz się chory?



- ✓ Poinformuj pracowników w schronisku.
- ✓ Poproś o maszkę.
- ✓ Wykonuj czynności z pierwszej i drugiej strony.

Jeżeli uważasz, że twój stan się pogarsza,
zadzwoń pod 911.

Pytania?

1-800-889-3931

Departament Służby Zdrowia stanu Illinois

Ważne numery telefonów:

page 3

v.P1.1; 04/05/2020; darcie.moeller@cookcountyhhs.org

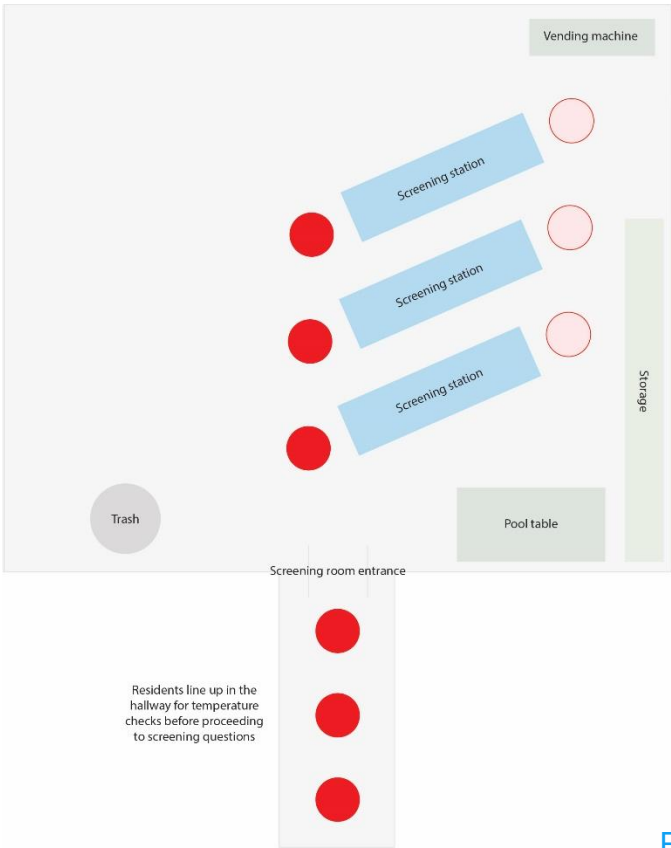
Appendix 2: Three-Layer Cloth Mask Design Specifications

1. Please make masks for donation with safe sanitary practices in mind. We will wash them again at our pantry before donation. Do **NOT** donate masks if you are ill or have been in contact with a sick individual.
2. Any pattern may be used or designed that includes at least three layers. Outer layers of 100% cotton, tight weave (cannot see light through it, i.e., quilting fabric). Inside layer is non-woven fabric (i.e., dryer sheets, baby wipes, non-woven quilter's interfacing). Integrate a twist tie for nasal bend option.
 - a. Wash fabric before sewing (shrinkage!).
 - b. We recommend the outer cloth layers be different in appearance (different colors, pocket on one side, etc.) so mask users can always identify which side goes against their face.
3. If you cannot obtain elastic, please create ties (sewn over ribbon since ribbon will fray).
4. Video tutorials (please make sure to integrate non-woven layer; no pockets!) (links updated May 4, 2020)
 - a. <https://vimeo.com/user11252937/review/399305630/8e27c1181c>
 - b. <https://www.asiaone.com/lifestyle/taiwanese-doctor-recommends-making-your-own-cloth-face-mask-air-filter-heres-how-do-it>
 - c. <https://www.youtube.com/watch?v=aHvghyn314U>

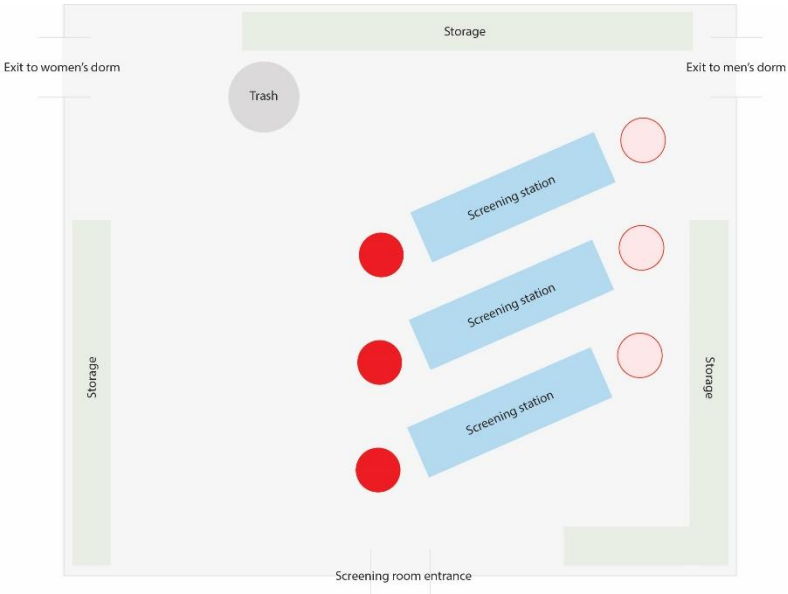


Appendix 3: Shelter Screening Layouts

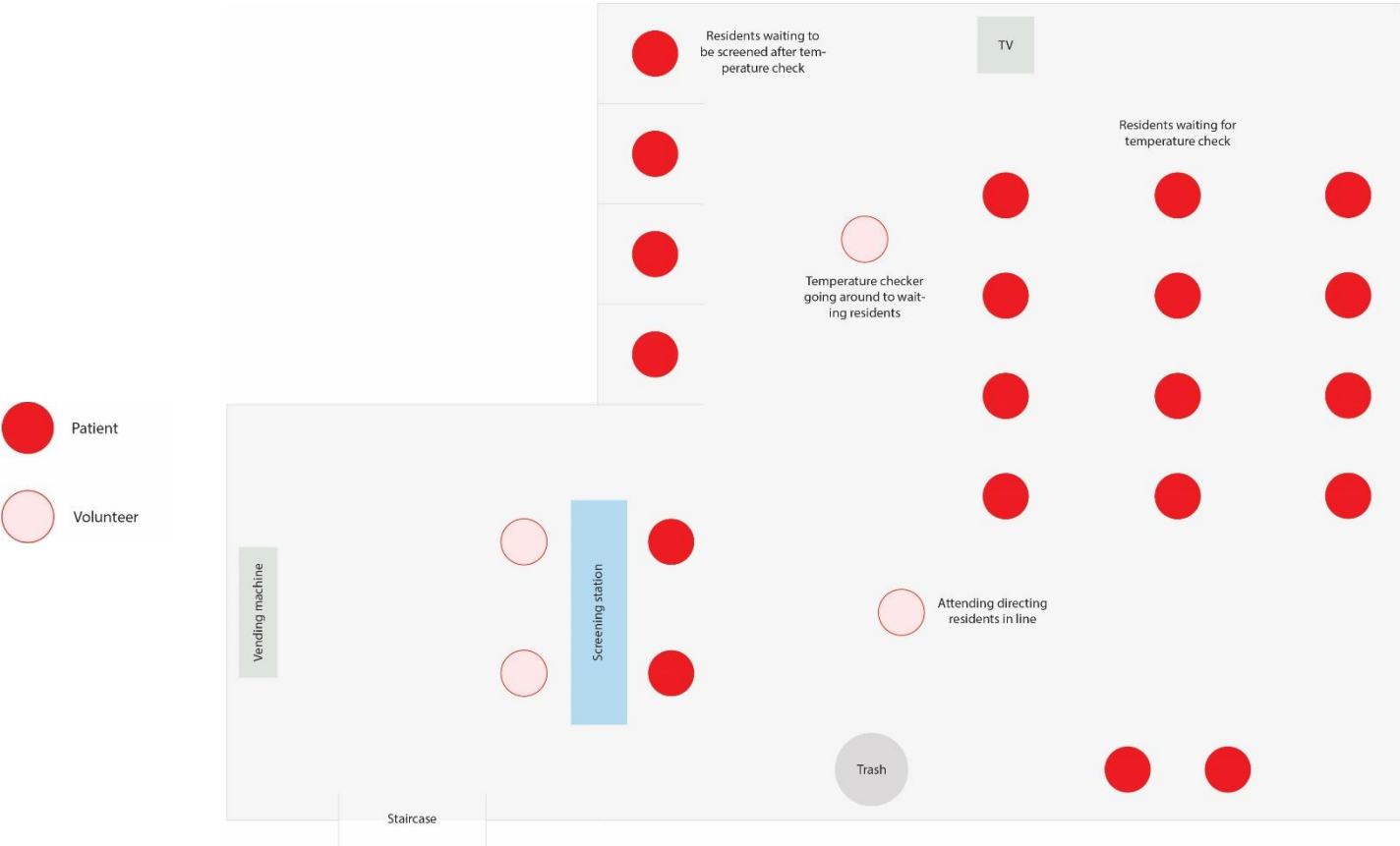
YMCA



Franciscan Outreach – Harrison St.



Franciscan Outreach – Sacramento Blvd.



Appendix 4: Student Volunteer Training Manual

Original manual developed by Taylor Vandenberg, M1 - University of Illinois College of Medicine and was adopted by CHHRGE

Volunteer Screening Training Manual

Site: Franciscan Outreach

2715 W Harrison St, Chicago, IL 60612

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Volunteer Safety & General Information

I. Volunteer Safety Affirmation

- A. Your safety is our top priority.
- B. As a volunteer, you will have access to all PPE necessary to perform your work, in accordance with CDC recommendations.
- C. You will **NOT** be asked to perform any tasks without the proper PPE supplied to you.
- D. You may choose to not participate in your shift if you feel that you have not been supplied the proper PPE.
- E. If you feel uncomfortable at any time during your shift, you have the right to leave after notifying the site coordinator.

II. Volunteer Expectations

- A. Screenings will last between 1-3 hours.
- B. Please wear comfortable clothing that has adequate coverage; for example, long pants, gym shoes and a t-shirt are acceptable. If you have scrubs you would like to use, that is also allowed.
- C. **You will receive ALL required PPE** necessary to perform these screenings. See IV.A for more details
- D. You will be expected to **read this manual in its entirety** and **perform any required trainings** prior to your volunteering shift

III. General Safety Guidelines

- A. Volunteers should be ***masked and gloved at all times while on site***
- B. It is recommended that masked volunteers stay a minimum of **3 feet** away from guests' faces when interacting to minimize risk
- C. Hand sanitizer will be available to volunteers at all times

IV. Guest Interactions/Screening Exposure

- A. While working in shelters, you will be fitted with all equipment necessary for droplet precautions

- B. All screening components will be performed across the table at your station
- C. There is no physical interaction necessary in this screening process apart from inserting thermometers
 - 1. Aural, Infrared, and Contact (forehead) thermometers have low droplet risk
 - 2. Oral thermometers have heightened droplet risk

V. Who can I reach out to with questions?

- A. Your Specific Site Coordinator for that day

Roles, PPE, Equipment

I. Roles:

A. Volunteers:

1. Perform initial screening questions and temperature check
2. Determine if guest has a "positive" screen

B. Attendings:

1. Perform more comprehensive examinations of guests who are flagged by preliminary screen
2. Provide support and communication to volunteers in a need-based capacity

II. Personal Protective Equipment (PPE)

A. All volunteers will wear PPE that is in accordance with current CDC guidelines:

1. **Surgical grade face mask**
2. **Gloves**
3. **Full length gown**
4. **Eye protection** (goggles/face shield)

B. **How to properly put on and remove your PPE**

1. Please view this [short video on how to don and doff your PPE](#)
2. Pay attention to **order**:

a) Donning (putting on) PPE:

- (1) Gown
- (2) Face mask
- (3) Eyewear
- (4) Gloves

b) Doffing (removing) PPE:

- (1) Gloves
- (2) Gown
- (3) Eyewear
- (4) Face mask



III. Equipment/Supplies At Your Station

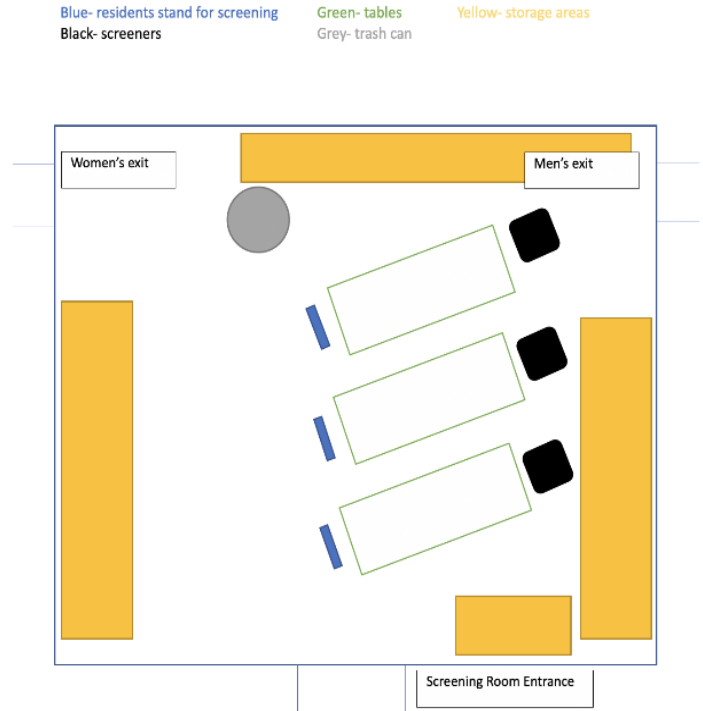
- A. Thermometers: per station for temperature checks. Can be infrared or aural.
- B. Ear probe covers (for aural thermometers): 15-20 per station. Will be sanitized and reutilized.

- C. Clipboard, paper, pens: for recording # of people screened, # of "positive" screens
- D. Stickers: to mark guests who pass screening
- E. Cavi wipes: 1 container per station
- F. Hand sanitizer: 1 container per station
- G. Garbage bags: to collect gloves/used wipes/etc.

Screening Instructions and Workflow

1. Meet in the main office to the left of the Franciscan Outreach entrance door.
2. Volunteers and attending physician don PPE together in the office, ensuring compliance and proper technique.
3. Bring clipboards, documentation sheets, pens, thermometer, probe covers, sticky notes, Lysol wipes, gloves, and hand sanitizer to the clinic space after donning.
4. Setup in the back room of the clinic:
 - a. Clear the center of the room by placing tables to the side and upside down on top of others tables to create more space.
 - b. Three thin, long tables (2ft x 5ft) should be used as the screener stations. Set them up diagonally so screeners are sitting at the head of the table, nearest the wall away from the door residents will be exiting out of.
 - i. The female residents exit out of the left door.
 - ii. Tables will need to be moved to other side of the room after completing the screening of women.
 - iii. Men exit out of the right door.
 - c. Three plastic chairs can be set up at head of tables for screeners to use.
 - d. Blue tape markings designate positions for residents to stand at the other end of each screener table, as well as at 6-foot increments leading back to the main room for the residents to wait in line awaiting screening.
 - e. Position a trashcan adjacent to exit doors for residents to dispose of post-it notes after negative screening.
 - f. Prop exit door open (only one at a time: men's door for men screenings, etc.)
5. Temperature taker and scribe stand at the entrance door to the clinic (after the office space). They have a trashcan behind them to dispose of thermometer tips. Temperature taker uses aural thermometer and dictates the number to the scribe, who writes it on a post-it note and hands to patient.
6. After temperature measurement, residents line up on markings leading to the screening area indicated in "Setup".

7. Three screeners are seated at the head of the tables in the back room of the clinic, wearing PPE. Residents wait on designated areas demarcated by blue tape on the ground before entering back room to talk to an available screener.
8. The attending physician stands in the back room behind the residents being screened and helps to direct them into the screening positions as well as being readily available for further screening.
9. Negative screenings can dispose of post-it notes in the provided trash can as they exit the clinic space. Positive screens are referred to the attending physician for further screening, who determines the resident as OK or recommended for isolation and transport.



Screening Questions

I. Components:

- A. What are we using to screen?
 - 1. Y/N Symptom Screening
 - 2. Temperature
- B. Screening Questions:
 - 1. Do you have a **NEW cough, or a cough that is WORSE than your baseline?**
 - 2. Do you have **shortness of breath that is changed from baseline?**
 - 3. Do you have muscles **aches?**
 - 4. Do you have a **sore throat?**
 - 5. Do you feel **more fatigued than usual?**
 - 6. Any **new headaches?**
 - 7. Have you had any known contact with someone that has tested positive for COVID-19?
- C. Temperature:
 - 1. All temperature will be taken in °Fahrenheit
 - 2. **Any temperature > 100°Fahrenheit will be considered a fever**

****What constitutes as a positive screening**

Post-Shift Cleanup & Sanitization

XV. Face Shield Sanitization Area Set-Up

- A. One of the coordinators will set up the Face Shield Sanitization Area.
- B. **Gloves** should be worn during this procedure.
- C. Place the three buckets in numerical order for the sanitization steps:
 - 1. Enzymatic Bucket
 - 2. Water Only
 - 3. 10% Bleach Solution
- D. Fill the Enzymatic Bucket with **dish soap** (about 2 ounces) and water, until bucket is about ⅓ full.
- E. Fill the second bucket with **water only**, until about ⅓ full.
- F. Fill the **10% Bleach Solution** bucket as follows:

1. Using the plastic measuring cup, measure out 48 ounces (1.5 quarts) of bleach. Add bleach to the third bucket.
 2. Using the 11-quart gray bucket, measure 13.5 quarts of water. Add water to the third bucket.
 3. The 10% Bleach Solution bucket will have 15 quarts of water total.
- G. Return bleach and measuring cup to the gray bucket.
- H. Close door during the screening shift.

XVI. Station Cleanup

- A. ALL materials and equipment must be sanitized:
- B. Sanitize all probe covers and place into "ready" containers. Allow to dry and close lid.
- C. Wipe down all other equipment/supplies with Cavi wipe
- D. Return to marked storage bins

XVII. PPE Disposal/Sanitization Instructions

- A. Gloves and masks are disposable
- B. **Gowns:** after properly removing gown, you will discard into a bag for laundering.
- C. **Eyewear:** all volunteers are responsible for sanitizing their own eyewear. See below.

XVIII. On-Site Eyewear Sanitization Instructions

GOGGLES:

1. Place goggles on a flat surface.
2. Spray goggles thoroughly with *quaternary compound solution* (pink solution) to ensure that all parts of the goggles have been saturated.
3. Let rest for 1 min
4. Dry goggles thoroughly with a paper towel. Return goggles to the eyewear bin.

FACE SHIELDS:

1. All buckets will be located in the janitor's closet across from the men's bathroom. You must have gloves on to clean the face shield.
2. One volunteer will collect all dirty face shields and complete the sanitization process.
3. Place the face shield into first bucket labeled *enzymatic cleaner* (we use dish soap). Use gloved hands to swish shield around in soapy water.
4. Remove shield and place in second bucket of *water*, to rinse. Make sure shield has been completely rinsed before moving it to third bucket.

5. Remove shield and place in third bucket of **bleach solution**. Make sure the shield is completely covered by the solution. **LET THE SHIELD SIT FOR 5 MINUTES**. Two face shields can simultaneously sit in the bleach solution bucket.
6. Remove shield from bleach solution and place wet shield into clean plastic bin for drying. One of the coordinators will bring the clean shields to the Prayer Room to dry overnight.
7. When finished, dump all solutions into the sink. Stack buckets and place under the sign.

Volunteer Post-Shift Hygiene and Sanitization

- XV. It is important to have a plan for how to clean yourself and your belongings at home, especially if you live with others. Make sure you have cleaning materials ready (alcohol wipes, Clorox wipes, diluted-bleach solution, etc.).
- XVI. Example Plan:
- A. Have someone there to let you in or let yourself in (be sure to go back and clean any doorknobs or handles you may touch)
 - B. Have a disposable bag ready to receive all **clothing items** you wore to your shift
 1. If possible, strip by the door
 2. Gently place clothing into the bag
 3. Note: Do not stuff clothing down into bag, as this may cause a burst of air containing the virus to billow back out
 4. Seal the bag (until ready to wash clothing)
 - C. Have a container (ex: Tupperware) in which to place **non-clothing items** for later cleaning
 1. Keys, Phone, ID badge, Pen
 - D. Take off **shoes** and either place in the bag or put aside for later cleaning
 1. Use a spray (ex: Lysol) on shoes
 - E. Take a shower and thoroughly wash with soap
 - F. Clean non-clothing items

- G. Use alcohol wipes, Clorox wipes, or diluted bleach solution to clean phone, keys, ID badge.
- H. If you haven't already, ***clean doorknobs or handles*** you touched to get into the building
- I. Wash your hands with soap and water after final cleaning

Mental Health Resources

- XVII. Mental Health America: resources to help deal with anxiety and frustration surrounding COVID-19 <https://mhanational.org/covid19>
- XVIII. CDC information on Daily Life and Coping: <https://www.cdc.gov/coronavirus/2019-ncov/daily-life-coping/managing-stress-anxiety.html>
- National Institute for Mental Illness: Guide to COVID-19 <https://www.nami.org/covid-19-guide>

Appendix 5: SMI and SUD Triage Plan Protocol for Non-medical Settings

Initiatives should focus on establishing behavioral health teams (BHTs) to provide behavioral health services to organizations at a distance. While developing these BHTs, CHHRGE recommends leveraging existing partners.

- Create 5-10 BHTs (consisting of 4-5 providers each) specializing in SMI or SUD.
- BHTs should consist of psychiatrists, psychologists, psychiatric APRNs, LCSWs, and CADC Recovery coaches.
- Develop protocols to support these guests in collaboration with internal and external partners. All services will be provided via telehealth seven days a week.
- Hire Virtual Project Coordinators.
- Identify pharmacies to manage costs for medications for the uninsured. Resourced by IA or 340B. Required centralized pharmacy delivery service: Prime Rx or utilize courier services.
- 10-15 electronic tablets to support telehealth visits at the various sites.
- Utilize cloud-based HIPAA compliant media (UPdox) to store data from guest information and allow sharing with other health providers.

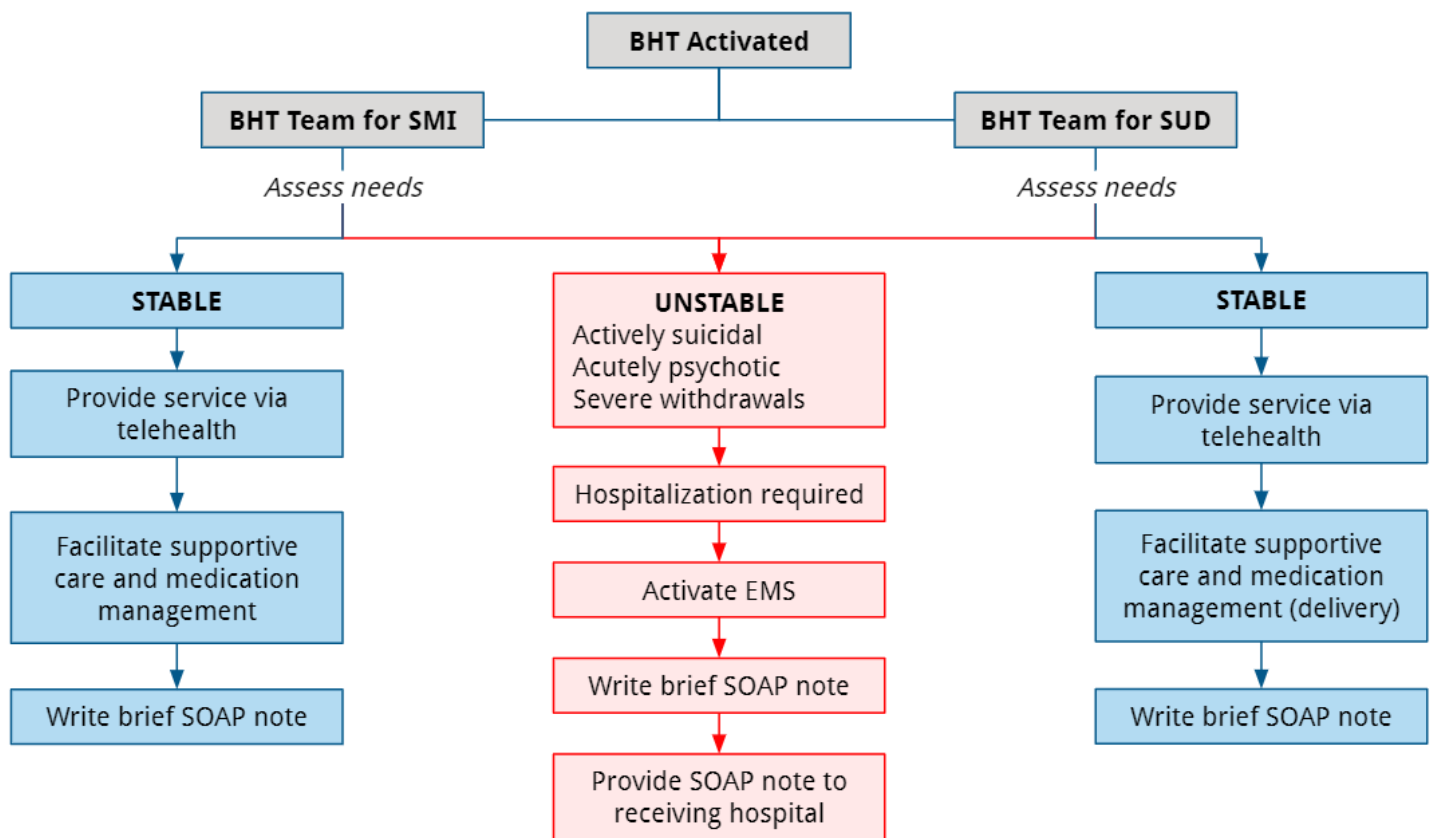
BHT's detailed tasks would include:

1. Providing BH services via telehealth to the people experiencing homelessness housed in shelters and isolation sites.
2. Support shelters and isolation sites in triage dispositions of BH guests that fall into the category of unstable and might need additional support or hospitalization.
3. Provide services for SMI/SUD guests in conjunction with external partners' support during surges of patients.
4. Share collaborations with the shelters to identify and manage acutely unstable guests identified as: actively suicidal, psychotic, or demonstrating active withdrawal signs and symptoms.
5. Collaborate with hospitals to provide potential inpatient bed capacity.
6. Identify future hospitals to support the BH inpatient hospitalization needs.

This plan is informed by the consensus statement created by the American Association for Emergency Psychiatry (xfS1) and the Mental Health Triage Scale developed by David Smart et al. (2)

| | |
|----------------------------|---|
| Level 1: Emergency | The patient is violent, aggressive, or actively suicidal (has a plan and/or intent) <i>OR</i> The patient is suspected to be actively withdrawing from alcohol and/or benzodiazepines |
| Level 2: Urgent | The patient is very distressed or acutely psychotic, likely to become aggressive, or may be a danger to self or others <i>OR</i> The patient is at high risk of severe withdrawal from alcohol and/or benzodiazepines |
| Level 3: Non-urgent | All others, including patients with long-standing or non-acute mental health disorders |

Proposed workflow draft: central command center 1-800 or 1-877 number set-up



Appendix 6: Building Modifications for Infectious Disease Control

Restrooms

- Avoid the need for a door into the bathroom by creating a turning hallway to prevent viewing the restroom. If there is already a door to the restroom, prop the door open to avoid the use of a handle.
- If possible, use automatic equipment that does not require human touch: hand air dryers, automatic sinks, and automatic flush toilets.
- Designate one stall in each restroom for those who are ill.
- Have instructions for handwashing by sinks.

Dining areas

- Use prewrapped silverware and disposable trays, plates, etc.
- Use packets of salt, pepper, sugar, and condiments. Remove pre-filled condiment containers.
- Keep trash cans covered.
- Sanitize tables and chairs between uses.
- Reduce chairs at each table to keep social distancing.
- Vary eating times to reduce the number of people eating at once.
- Ensure areas are thoroughly cleaned between each eating time.
- Have hand sanitizer available in the area.
- Close all open food areas: salad bars, beverage stations, buffets.
- Have all food served by licensed food handlers.

Recreation & living areas

- Reduce chairs to encourage social distancing.
- Have sanitizer available.
- Increase the cleaning schedule of the space.
- Only have washable surfaces, leather or vinyl furniture, and no cloth. Remove any cloth furnishing or cover with plastic.
- Leave sanitizing wipes for board games; remove games that can't be sanitized. Create signage that instructs people to clean these items before and after use.
- Prevent eating in recreation areas since people cannot use a mask.
- Utilize artificial walls to create separation of space (as shown in the above image by A Safe Haven)

General

- Limit the number in the elevator to no more than three people.
- Display signage for safety protocols. Develop signage that utilizes images with predominance over words (thenounproject.com).
- Limit visitors to the facility.

Appendix 7: What to Expect During Hotel Isolation

It is important to remember that this hotel has been converted to a quarantine and isolation facility. Some typical amenities will not be available or allowed. In order to ensure safety, Hotel One-Sixty-Six asks that guests remain in their rooms for their entire stay. No visitors are allowed, although guests can use phones to speak with family and friends.



What to Bring

Clothing for a few days, personal care items, and medications

Phone and phone charger (if available)

Excessive items may be labeled and stored. All items will be returned at the end of your stay.



Banned Items

Cigarettes

Illegal items

Weapons



Arrival and Check In

A driver wearing a mask will drop guests off at the rear entrance of the hotel. An escort and security staff wearing masks will greet guests. Staff will inspect guests' bags for any banned items. Guests will then be taken to their designated rooms where they will remain for the rest of their stay.



Included Items & Services

Comfortable bed, TV, free Wi-Fi

Three daily meals and drink choices: orange juice or coffee for breakfast, soda or coffee in the evening

Soap and shampoo: these will be replaced as needed

Face masks and trash bags. Trash will be picked up daily.

Room phone: Family and friends may call guests. However, the hotel operator does not have names of guests. Callers will need to ask for a guest's room number, not a guest's names.

Phone numbers for our staff, who are available to talk if guests have questions or concerns

Providers and staff on call for guest medical needs

Medication management and support. Nicotine patches or gum if needed.



Not Included

Room key

Room service

Clothes washing

Outside food may not be ordered



How Long Will Guests Stay?

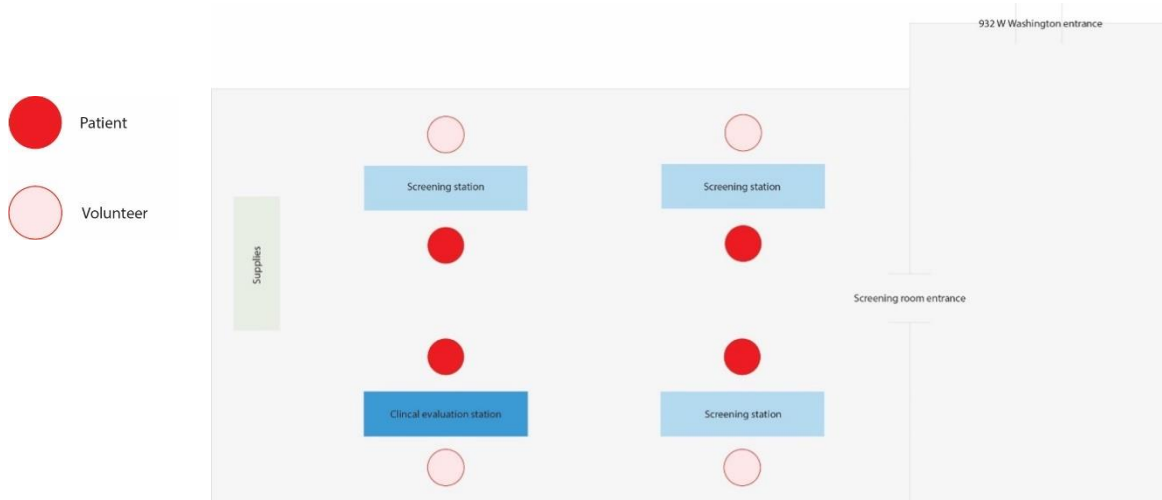
Your stay will last until you receive a test result for COVID-19, usually less than a week. From there, we work with guests to make sure they have care, whether this means returning to the shelter, staying put, moving to another care facility, or going to a hospital. We provide transportation if needed.

Appendix 8: Haymarket Workflow

Team Members: three student volunteers (temperatures and screening) and one clinician (attending physician, PA)

Workflow

1. Screening takes place from 6:30 a.m. - 9:00 a.m. during the largest shift change at Haymarket. Team members arrive by 6:15 a.m. to set up.
2. Screening is located in the chapel which is the first door on the right when you enter the Haymarket Center at 932 W Washington Blvd, Chicago, IL 60607.
3. Our Haymarket contact stores our supplies in her office overnight and will bring supplies down to the screening space each morning. We are working on getting a locked storage box for our supplies to be kept in the screening space.
4. In the chapel there are four long tables: one at the back of the room for supplies and three set up on the sides of the room for screening. There is tape on the floor indicating 6-foot spacing for staff as they wait in line to be screened.
5. Each screening table should be set up with one forehead thermometer, one box of alcohol pads, hand sanitizer, gloves, a pen, and screening sheets.
6. Staff will filter in as they are coming onto shift or leaving to go home for the day. The biggest rush of staff is from 6:45 a.m. - 7:45 a.m. surrounding the 7 a.m. shift change.
7. When staff enter the room, they will be directed to a free screening table where the screener will take their temperature from behind the table and ask questions.
8. Negative screenings are free to start their shift or leave to go home. If a patient has a temperature $>100^{\circ}\text{F}$ or there is concern for a positive screen based on positive screening questions, the clinician will take the person aside for a brief clinical evaluation. If the clinician decides the patient is a presumed positive, they will be informed they need to call their supervisor, HR, and their PCP and return home without stopping along the way. Haymarket will also be notified at that time.
9. At the conclusion of the screenings, Haymarket staff will take over to continue screening staff. Clean tables and supplies and remove PPE. Clean reusable PPE (face shields) and return all Rush equipment (face shields, unused gowns, masks, gloves) to the Rush box. Haymarket will store the equipment for you.



Appendix 9: COVID-19 Screening Questionnaire

COVID-19 Symptoms

If any symptoms are reported or observed, the client should be escorted to the designated area and informed about social distancing measures.

| | | | |
|--|-----|----|-------------------|
| Do you feel like you have a fever? | Yes | No | Observed by staff |
| Do you have a cough? | Yes | No | Observed by staff |
| Are you experiencing difficulty breathing? | Yes | No | Observed by staff |

COVID-19 Risk Factors

If any risk factors are reported, call your clinical contact with the client to determine next steps.

| | | |
|--|-----|----|
| Are you over the age of 60? | Yes | No |
| Do you have an underlying health condition such as diabetes, heart disease, or cancer? | Yes | No |

If yes, what is the condition?

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