Double Jeopardy

The Coronavirus & Homelessness in Ohio

March 24, 2020

About COHHIO

COHHIO is a coalition of organizations and individuals committed to ending homelessness and to promoting decent, safe, fair, affordable housing for all, with a focus on assisting low-income and special needs populations.

For over 25 years, COHHIO has been the voice of Ohio's underrepresented – the hundreds of thousands of Ohioans experiencing homelessness and housing insecurity. COHHIO is a statewide coalition consisting of hundreds of housing organizations and homeless service providers advocating for public policy solutions to ending homelessness and expanding access to affordable housing for Ohio's most vulnerable constituents. In addition to public policy advocacy, research and public education, COHHIO provides training and technical assistance to local homeless services and housing agencies and other nonprofit service organizations.

COHHIO
Coalition on Homelessness
and Housing in Ohio

175 S. Third St. Suite 580 Columbus, Ohio 43215 // Phone: (614) 280-1984

About the Authors

Barbara Poppe, M.S.

Barbara Poppe is the founder of Barbara Poppe and Associates and the former executive director of the United States Interagency Council on Homelessness. Ms. Poppe is a nationally recognized expert on homelessness and results-driven public-private partnerships. Ms. Poppe served as the Executive Director of the United States Interagency Council on Homelessness from November 2009 to March 2014. During her tenure, Poppe oversaw the Federal response to homelessness by working with 19 Federal agencies to create partnerships at every level of government and with the private sector to reduce and end homelessness. In June 2010, Barbara Poppe and four Cabinet Secretaries announced Opening Doors, the nation's first-ever comprehensive Federal plan to prevent and end homelessness.

Ms. Poppe served as the executive director of the nationally recognized Community Shelter Board (Columbus, Ohio) from October 1995 to November 2009. She holds a Masters of Science degree in Epidemiology from the University of Cincinnati.

Barbara Poppe and Associates, established in 2014, is an independent consulting firm that develops the capacity of communities and organizations to tackle complex issues using a collaborative systems approach to achieves results and impact.

Ms. Poppe serves on the national board of the Enterprise Community Partners and the national advisory board for the Center for Evidence-based Solution to Homelessness. Ms. Poppe donated her time and expertise for this project in support of the children, youth, and adults who are impacted by this crisis.

Angela Hetrick, MPH

Angela is a second-year Epidemiology PhD student at Ohio State University. She received her B.S. in Mathematics from North Carolina State University in 2011. Before beginning the MPH-Epidemiology program at the Ohio State University, she served as a Peace Corps Volunteer in Aboabo, Ghana from 2014-2016. Her experiences with HIV and malaria education laid the groundwork for pursuing a career in epidemiology. While pursuing her MPH, she had the opportunity to work as an intern for Barb Poppe on local and State-level housing plans, which entailed meeting and collaborating with every Continuum of Care team in Ohio. During her internship, she learned to navigate policy and advocacy of housing and homelessness in Ohio. Her research interests and experience lie in the intersection of infectious diseases (i.e., COVID-19), spatial analyses, substance use, and housing as healthcare.

Table of Contents

Executive Summary

Without immediate and decisive action, the collision between the COVID-19 pandemic and the homelessness crisis is likely to create an even more acute public health emergency for Ohio. This report documents a critical lack of guidance, resources, and capacity to meet the needs of Ohioans who are experiencing homelessness and are at risk of contracting COVID-19.

Through a review of recent literature, an online survey, conference calls with providers and community leaders, and consultation with national experts, we have concluded:

People who are enduring homelessness are at great risk due to

- Higher rates of morbidity and mortality resulting from pre-existing health conditions and lack of access to healthcare, and elevated rates of hospitalization with longer stays
- Need to go out into the community to fulfill basic needs in congregate facilities and public settings
- Lack of access to adequate hygiene and sanitation
- Over 2,100 Ohioans are living unsheltered in unsafe environments not fit for human habitation

Providers who serve people who are enduring homelessness are unable to adequately prepare and respond to COVID-19 due to

- Lack of resources to deconcentrate congregate facilities to comply with social distancing guidelines
- Lack of realistic guidance on how to screen and refer people who are symptomatic
- Lack of sufficient sanitation and hygiene supplies to prevent transmission of COVID-19
- Lack of sufficient capacity and space to quarantine and isolate symptomatic clients
- Gaps created when other community services and institutions shut down or shift to telework
- Severe staffing and resource shortages

Consequences to general public health are likely compounded by inadequate public health response for homeless population resulting in

- Increased spread of the Coronavirus
- Excess use of ER and hospitals
- Increased rates of morbidity and mortality

To avoid these consequences, immediate action is needed to

- Provide detailed, specific public health guidance on establishing, equipping and staffing shelter facilities
- Identify space and provide funding and clear guidance to secure additional shelter capacity, such as hotels and motels, to implement isolation and quarantine protocols
- Ensure programs are adequately staffed, supplied, and able to provide food for clients
- Fund emergency assistance to divert and rapidly move people from homelessness into housing
- Mitigate gaps created when other community services and institutions close or shift to telework

A strong public-private partnership which acts swiftly is critical to save lives and prevent the spread of COVID-19. COHHIO is working to partner with the State of Ohio, public health districts, healthcare systems, philanthropy, and homeless assistance providers to establish and implement a concrete set of actions to respond to the double jeopardy of Coronavirus and homelessness in Ohio.

Purpose of Report

As the State of Ohio confronts the COVID-19 pandemic, the state's homeless population and its safety net is emerging as a critical gap. COHHIO undertook a series of actions to understand the immediate, acute needs to address this public health crisis. Other work is underway to mitigate the impacts of the economic crisis on low-income Ohioans precipitated by the COVID-19 pandemic.

This report documents how the COVID-19 pandemic response is being hampered by inadequate preparedness and insufficient resources dedicated to meet the needs and prevent the spread of the virus among Ohio's homeless population. This report provides a snapshot of urgent needs from the viewpoint of community leaders who are tasked with managing Ohio's local and regional homeless assistance systems (known as as Continuums of Care or CoCs). Based on newly published research by a team of national experts, this report also provides cost estimates to meet the needs of single adults and other populations, including families with children.

Finally, the report lays out a call to action for philanthropy, business and government at all levels to implement a more comprehensive public health response to COVID-19 that accounts for Ohioans experiencing homelessness and housing insecurity.

---

[1] Dennis Culhane, Daniel Treglia, Ken Steif, Randall Kuhn, Thomas Byrne. (2020). Estimated *Emergency and Observational/ Quarantine Bed Need for the US Homeless Population Related to COVID-19 Exposure by County; Projected Hospitalizations, Intensive Care Units and Mortality*. Retrieved from Washington, DC: https://endhomelessness.org/wp-content/uploads/2020/03/COVID-paper_clean-636pm.pdf

Scope of Needs

The most recently available estimate of the number of people enduring homelessness comes from the 2019 Point-In-Time (PIT) study, which found that 12,100 Ohioans were homeless on the night of the count. Of these, 10,000 people were homeless and sheltered – residing in temporary quarters, predominately congregate facilities. 2,100 individuals were homeless and unsheltered, meaning residing in locations not intended for habitation, such as outdoor encampments or sleeping in cars or abandoned buildings.

As people are continuously entering and exiting homelessness, the actual number is far larger than the one-night PIT count. The annual estimate of homelessness in Ohio is at least 70,123 which represents the number of individuals who accessed homelessness services at some point during 2017 . This report noted the overall number was 20% higher in 2017 than in 2012, with the largest increases among young children and older adults.

The response to homelessness is organized and coordinated by a local Continuum of Care (CoC). The U.S. Department of Housing and Urban Development (HUD) requires the formation of these local planning bodies to organize and deliver housing and services to help people who are homeless move to stable housing and maximum self-sufficiency. CoC also refers to the system that coordinates programs to address and prevent homelessness within a geography. HUD's primary funding stream to address homelessness is also known as Continuum of Care funding. For the purposes of this report, we are using CoC to refer to the planning and coordinating body *(see map p. 8)*.
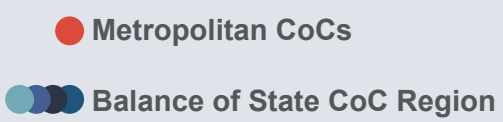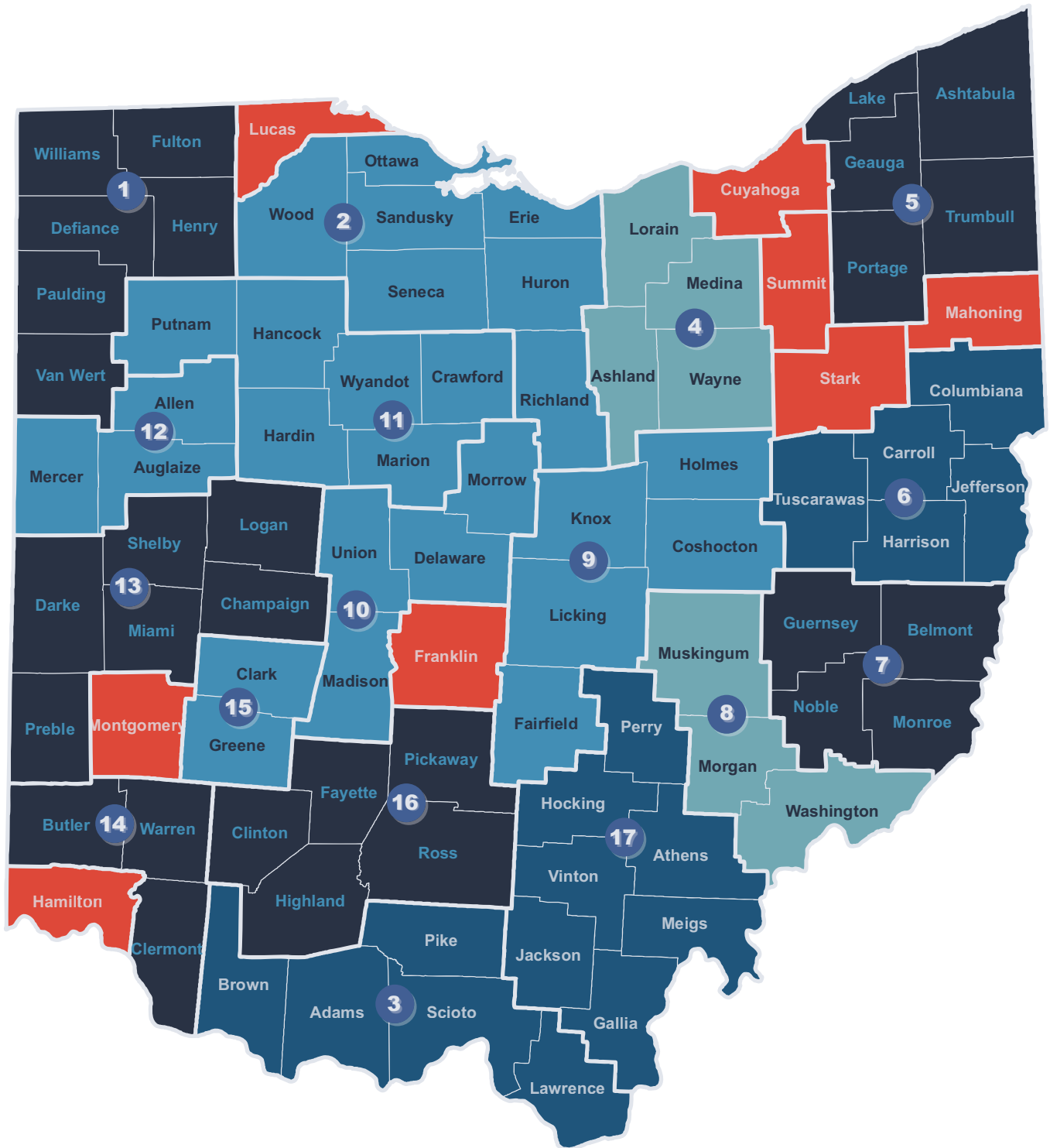
The inventory of temporary shelter/transitional space in Ohio is 10,400 beds across more than 300 congregate facilities statewide. [Download a listing](#) of homeless programs and their corresponding local health districts from COHHIO's website

---

[2] The Point-in-Time (PIT) count is a count of sheltered and unsheltered people experiencing homelessness on a single night in January. HUD requires that Continuums of Care conduct an annual count of people experiencing homelessness who are sheltered in emergency shelter, transitional housing, and Safe Havens on a single night. Continuums of Care also must conduct a count of unsheltered people experiencing homelessness every other year (odd numbered years). The Ohio report is found [here](#).

[3] From Culhane et al: Using estimates from Glynn and colleagues [Glynn, C. & Fox, E. B. Dynamics of homelessness in urban America. *Ann. Appl. Stat.* 13, 573–605 (2019)], the estimate of unsheltered homeless persons was modeled as 40% larger than is estimated by official HUD-mandated 2019 PIT counts to account for persons unobserved by enumerators and not incorporated through statistical modeling. The 2019 Ohio count of unsheltered persons has been adjusted to be consistent with this research.

[4] Ohio Housing Finance Agency. Revisiting the Silent Crisis: an Ohio human services data warehouse report, December 2018

Scope of Needs

Map of Ohio counties showing CoC regions:

- **Metropolitan CoCs** (red)
- **Balance of State CoC Region** (blue shades)

Region markers and counties:

1 — Williams, Fulton, Defiance, Henry

Lucas (Metropolitan)

2 — Wood, Ottawa, Sandusky, Seneca, Erie, Huron

Paulding, Van Wert

12 — Putnam, Hancock, Allen, Hardin, Auglaize, Mercer

11 — Wyandot, Crawford, Marion, Morrow, Richland

Cuyahoga (Metropolitan), Lorain, Medina

4 — Ashland, Wayne

Summit (Metropolitan), **Stark** (Metropolitan)

Lake, **5** — Geauga, Trumbull, Portage

Mahoning (Metropolitan)

Columbiana

6 — Carroll, Jefferson, Harrison, Tuscarawas

Holmes, Coshocton

9 — Knox, Licking

13 — Shelby, Miami, Darke

10 — Union, Delaware, Champaign, Madison

Franklin (Metropolitan)

15 — Clark, Greene

Montgomery (Metropolitan), Preble

Logan

Muskingum, **8** — Morgan

Guernsey, **7** — Belmont, Noble, Monroe

14 — Butler, Warren

Hamilton (Metropolitan), Clermont

Clinton, Highland, Brown

16 — Fayette, Pickaway, Ross

Hocking, **17** — Athens, Vinton, Meigs

Pike, Jackson, Gallia, Lawrence

3 — Adams, Scioto

Washington

Legend
- 🔴 Metropolitan CoCs
- 🔵 Balance of State CoC Region

Public Health Imperative v. Reality for Homeless Ohioans

The COVID-19 pandemic is an unprecedented public health crisis facing Ohio and the nation. There is a force multiplier when we think about how this public health crisis is playing out for people who endure homelessness and the people who work in programs that provide services to these people. Consequently, there is yawning gap between CDC guidance on COVID-19 and the reality of life for people who are homeless and the agencies that serve them.

People enduring homelessness are more likely to experience greater morbidity and mortality due to having more significant health problems than the general population, having to go out into the community to get their basic needs met, and the circumstances in which they end up living – unsheltered locations and congregate spaces. The potential for widespread transmission of COVID-19 within the homeless population due to inadequate access to hygiene and sanitation and the difficulty of early detection among a population isolated from health care also poses a threat to the general public.

Public Health Imperatives

Reduce Spread

Reduce Excess Hospitalization & ER Contacts

Reduce morbidity and mortality

Reality for Homeless Ohioans:

Shelters are not set up to accomodate social distancing

Lack of access to proper hygiene and sanitation and dependence on congregate settings to meet basic needs

People who are homeless must go out into community to get basic needs met and will come in frequent contact with other people.

Reality for Homeless Ohioans:

Extraordinarily high susceptibility to symptomatic infection, hospitalization, and fatality among the homeless population due not only to advanced age, but also the accelerated physical decline and mental weathering that frequently results from repeated exposure to harsh elements

Homeless patients stayed 36% longer per admission on average than the other patients, even after adjustments were made for differences in the rates of substance abuse and mental illness and other clinical and demographic characteristics.

Reality for Homeless Ohioans:

Individuals who are homeless are admitted to the hospital with medical-surgical conditions 10-15 years earlier than comparable, housed individuals, and with age-related impairments typical of stably housed individuals 20 years older.

Existing studies of homeless populations have observed obstructive pulmonary disease prevalence between 20 and 30%, compared to 10% for the general adult population.

A newly released paper by Dr. Dennis Culhane and colleagues[5] , has noted "the extraordinarily high susceptibility to symptomatic infection, hospitalization, and fatality among the homeless population due not only to their advanced age, but also the accelerated physical decline and mental weathering that frequently results from

[5] Culhane et al, March 2020

repeat exposure to harsh elements." The author further notes that "concerns over chronological age are magnified by concerns over accelerated physical decline among homeless populations" and "existing studies of homeless populations have observed obstructive pulmonary disease prevalence between 20 and 30%, compared to 10% for the general adult population".
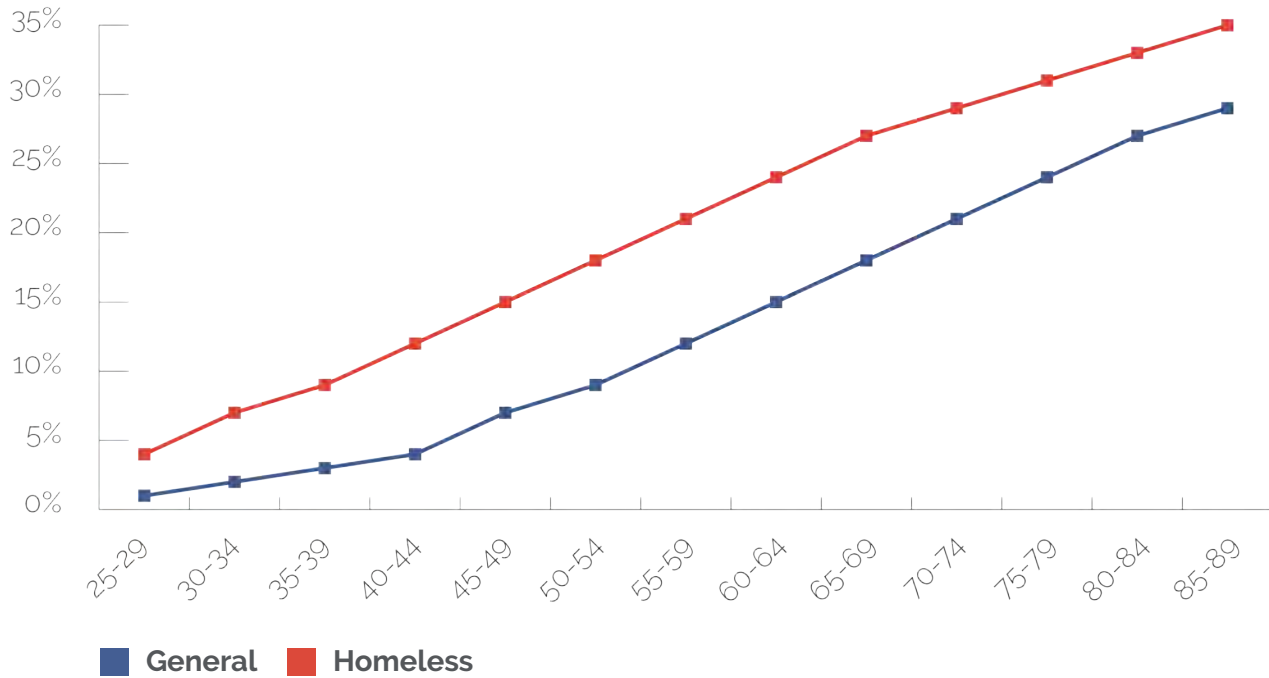
Included in the Culhane et al report, figure 1 compares the risk curves for homeless populations to the general population using a model that assumes infected homeless individuals would be twice as likely to be hospitalized, two to four times as likely to require critical care, and two to three times as likely to die.

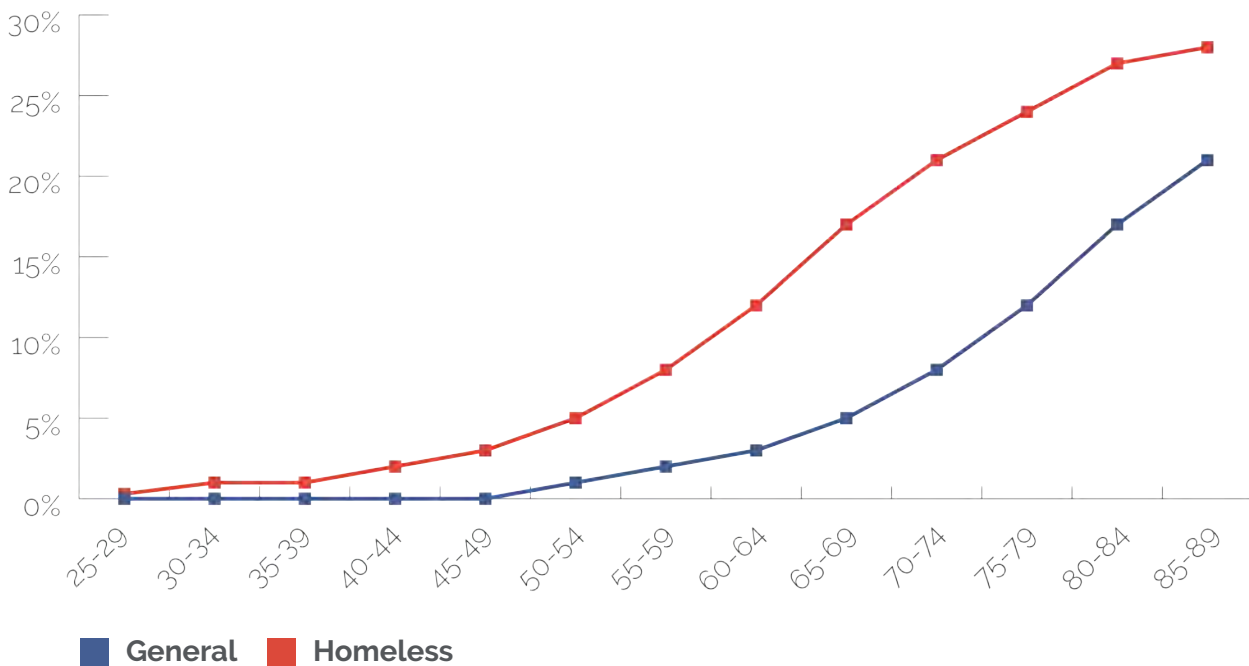[6] Brown, R. T., Kiely, D. K., Bharel, M. & Mitchell, S. L. Geriatric Syndromes in Older Homeless Adults. *J. Gen. Intern. Med*. 27, 16–22 (2012) and Landis, S. H. et al. Continuing to Confront COPD International Patient Survey: methods, COPD prevalence, and disease burden in 2012–2013. *Int. J. Chron. Obstruct. Pulmon. Dis. 9, 597* (2014).

[7] Landis, S. H. *et al.* Continuing to Confront COPD International Patient Survey: methods, COPD prevalence, and disease burden in 2012–2013. Int. *J. Chron. Obstruct. Pulmon. Dis. 9,* 597 (2014).

Figure 1: Age-specific risk for homelessness-adjusted scenarios in comparison to general population
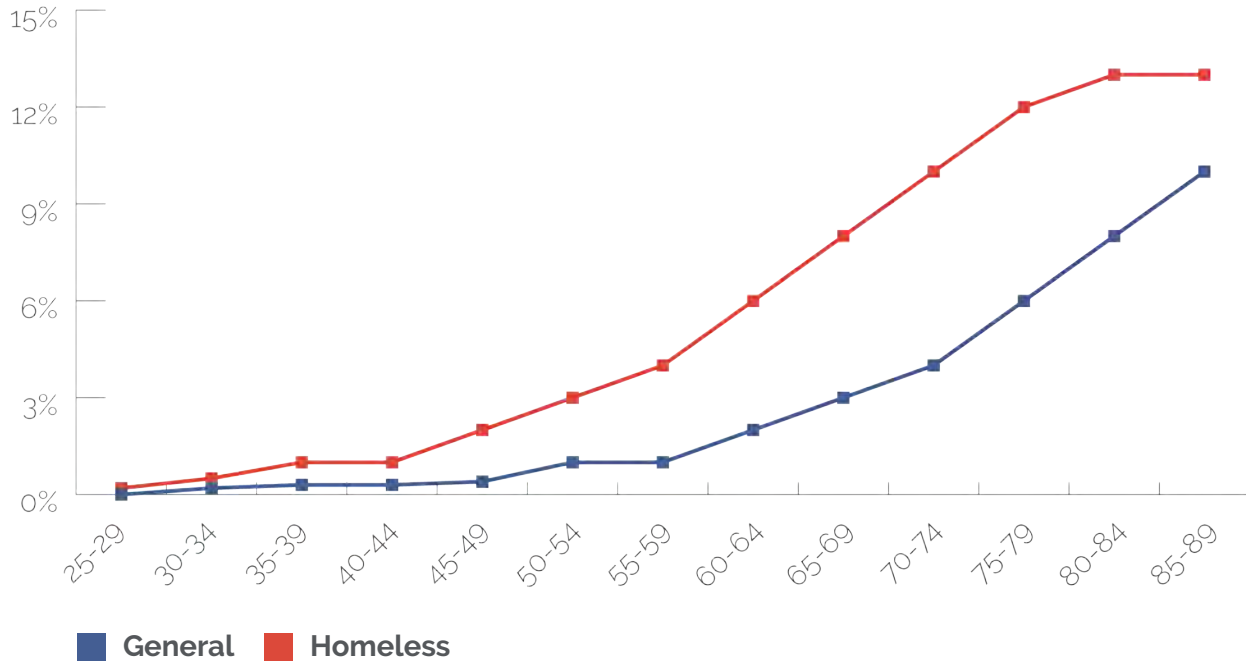
Panel A: Hospitalization

Panel B: Critical Care

Panel C: Fatality

The emergent public health crisis is likely be further compromised by the demand that people who both contract COVID-19 and experience homelessness place on existing systems, unless measures are quickly put in place to reduce the spread and quickly identify and isolate persons who become symptomatic. It is in the interest of all Ohioans that quick decisive action is taken to fully implement a public health response for Ohioans who experience homelessness.

Critical Response Components

Responding to the public health crisis created by the COVID-19 pandemic requires immediate action in these three key areas:

1) Provide safe shelter to people who are unsheltered
2) Deconcentrate existing shelter programs to enable social distancing
3) Add quarantine and isolation capacity for those who are symptomatic and confirmed cases

These actions are critical to reduce the spread and flatten the curve, reduce excess hospitalization and emergency room admissions, and reduce the morbidity and mortality rates.

Provide safe shelter to people who are unsheltered

On any given day, more than 2,100 Ohioans live unsheltered on city streets and parks, in abandoned buildings and other places not meant for habitation. These individuals are even more vulnerable as many places they previously used to meet basic needs have closed.

It is critical that safe shelter be immediately provided to reduce the spread of the virus and reduce morbidity and mortality. This will require identifying new shelter spaces and equipping existing shelter spaces to meet these needs.

> Less widely known—but considerably more important—is the extraordinarily high susceptibility to symptomatic infection, hospitalization, and fatality among the homeless population due not only to their advanced age, but also the accelerated physical decline and mental weathering that frequently results from repeat exposure to harsh elements.
>
> **Culhane et al, March 2020**

Deconcentrate existing shelter programs to enable social distancing

More than 10,000 homeless Ohioans are residing in over 300 congregate facilities. These are primarily emergency shelters and transitional programs with congregate sleeping and day quarters and shared restroom and showers. Many facilities are over-crowded and unable to provide social distancing at recommended minimums of six feet. Since these programs operate on very lean budgets, with a strong dependency on volunteers and donated food and supplies, conforming to sanitary and hygiene protocols is extremely challenging.

There is an immediate need to create additional spaces at existing shelter and transitional programs by repurposing other parts of the facility or identifying alternative and additional shelter sites or spaces.

Add quarantine and isolation capacity for those who are symptomatic or have been confirmed

When an unhoused individual or family member is experiencing symptoms of a potential Coronavirus infection, immediate quarantine space away from other shelter residents is essential. Once Coronavirus infection is confirmed, shelter residents need to be in isolation.

There is an immediate need to create additional spaces at existing programs by repurposing other parts of the facility or identifying alternative sites to meet the distinct needs for people who require isolation and quarantine.

Current Level of Preparedness and Response

To better understand the homeless system's level of COVID-19 preparedness across Ohio, we surveyed the Continuums of Care (CoC), the key leaders overseeing the homeless system within each metropolitan county and the suburban/rural region of the state. See the appendix for methodology. Survey results reflect the status of preparedness as of Friday, March 20; it is possible that some situations are improving since that date.

CoC linkage with health departments

Overall, CoCs report established lines of communication and coordination with their local public health districts and departments. However, **only 46% of CoCs have established a joint response plan to COVID-19 with their local health department**. A joint response plan to COVID-19 between homeless service providers and local health departments and districts is critical to coordinate efforts and ensure an adequate and appropriate response.

COVID-19 preparedness and response

Communities are not prepared to prevent the transmission of COVID-19 within shelters and encampments or to assist people who are homeless experiencing COVID-19 symptoms. **Less than half (46%) of respondents reported that most or all of their homeless service providers had received training and education on COVID-19.** All respondents reported a necessity for further online training and education on COVID-19 protocols. Further, outreach providers in **only 22% of CoCs report sufficient equipment and training to support clients who are unsheltered to prevent and manage COVID-19**.

"In general, there is a lack of guidance on how to help persons experiencing homelessness who may be ill with COVID-19. In my conversations with our county, the commissioner is clearly looking for direction from ODH. And neither his office nor the local hospital has any extra thermometers, even though that's the first thing we're supposed to check when screening people from entering shelters. We don't really have a protocol or plan for what to do if we suspect an unsheltered homeless person may be ill, other than referring to the local hospital ER. Our county's health department has indicated they would like our assistance in securing a housing unit/motel if needed, but we don't have steps from here to there."

"We simply aren't sure how and where to quarantine them if it is more than a few people. We are also concerned about meal sites shutting down and our unsheltered homeless population not being able to access food."

"How to isolate/quarantine, what protocols should be used, what authority to enforce isolation, public health role and EMA role, responsibilities, vis-a-vis homeless systems/CoCs"

Deconcentrate existing shelter programs to enable social distancing

Only 17% of CoCs report having a written response plan for COVID-19, and 37% report updating their written infectious disease protocols to include COVID-19. Screening of staff, volunteers, and clients for COVID-19 has been implemented in fewer than half of CoCs (42%), and respondents report that providers can only conduct verbal screening for symptoms. **Just 51% of CoCs are aware of how to proceed when a possible COVID-19 case is identified.**

Figure 2: Frequency of COVID-19 training completion for frontline staff across CoC and BoS regions
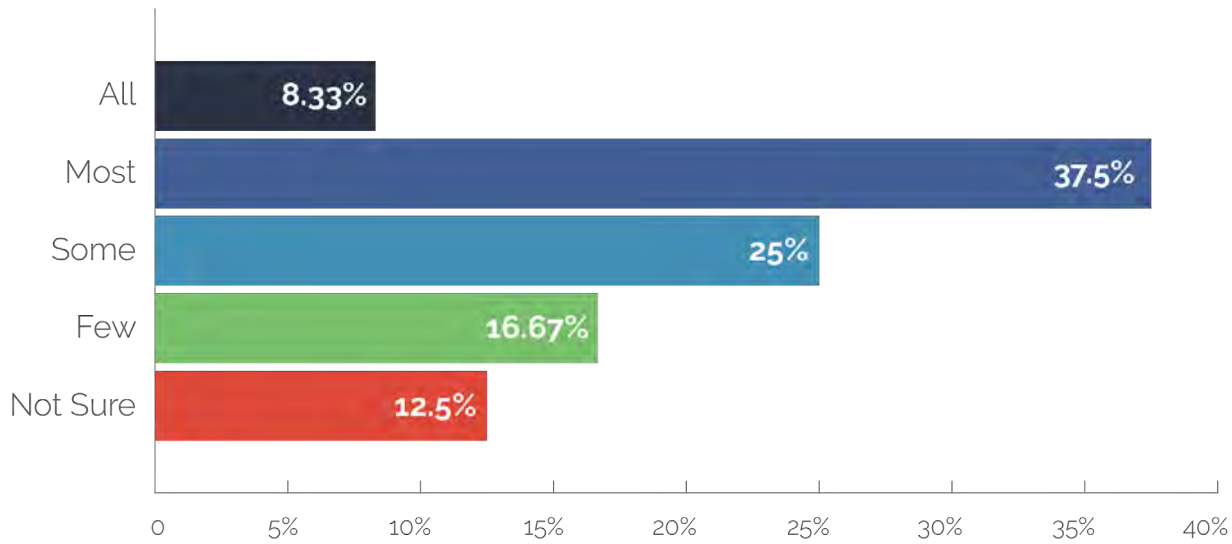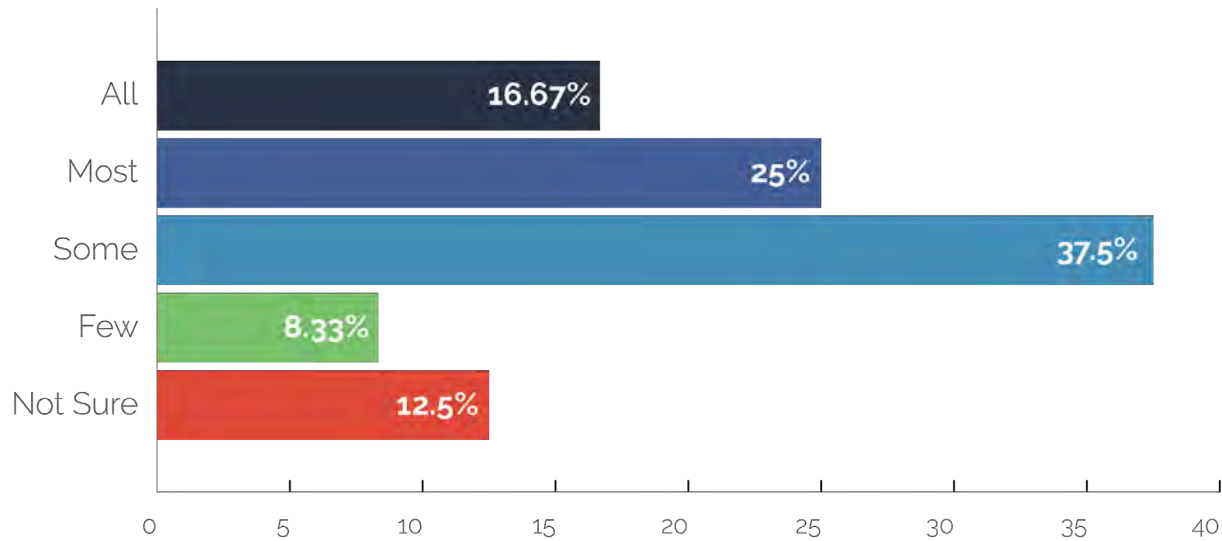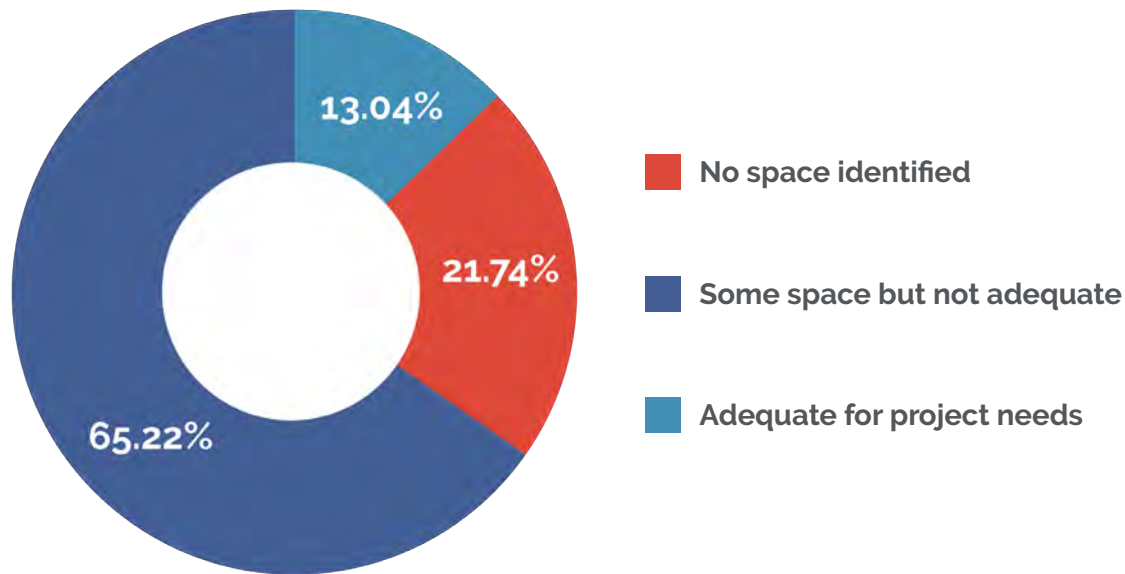

Figure 3: Percent of homeless service providers that have instituted COVID-19 screening within CoCs and BoS Regions

A critical need for addressing COVID-19 among people experiencing homelessness is isolation and quarantine space. **Only 13% of CoCs reported having adequate space options for people and families with mild COVID-19 symptoms**. Emergency shelter space remains insufficient to follow the recommended CDC guidelines of social distancing; **only 25% of CoCs report that emergency shelter capacity within their region has been reconfigured to accommodate recommendations**. Approximately half report using motel and hotel vouchers as an option for isolation and quarantine within their regions, and a smaller proportion (22%) report using alternative temporary facilities.

Figure 4: Percent of CoCs and homeless service providers that secured isolation/quarantine space for people/families with mild COVID-19 symptoms

No space identified

Some space but not adequate

Adequate for project needs

"A major problem is the configuration of the shelters themselves - there is no place to isolate or quarantine. The hope is to identify a sick person before they enter a shelter, but even though some try to take temperatures, what to do if discovered? Health department says if 100.4, don't allow person into the shelter. Then what is the person to do?"

"At this time, shelters anticipate they will have to quarantine in place, as it's likely someone will be identified with COVID-19 after entry, not before. None of our local shelters has the capacity to isolate or quarantine a space within the shelter. The entire shelter would need to be quarantined. If the health department identifies a COVID-19 case in a homeless person, the department indicated they can pay for a motel stay but there is no immediate plan in place."
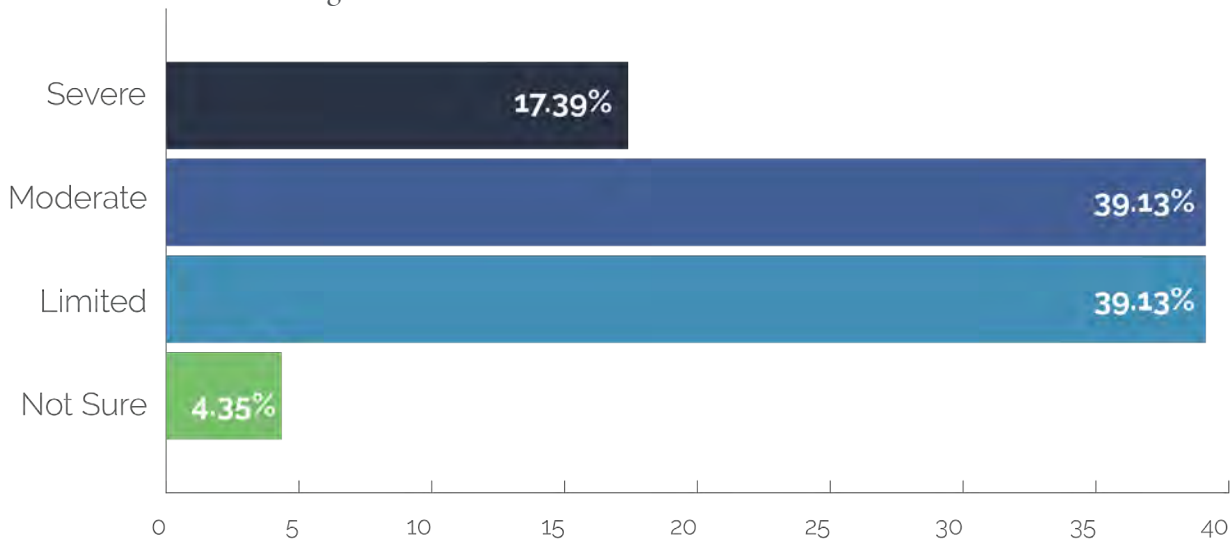
Usual shelter procedures, supplies, and staff are insufficient to address COVID-19 needs. To reduce isolation, quarantine, and social distancing needs, 50% of CoCs report most or all of their shelters are increasing diversion strategies to reduce shelter admissions. However, financial gaps remain; **just 21% of CoCs have the ability to provide the financial assistance necessary to reduce admission and minimize shelter crowding.**

Nearly half of providers are experiencing severe or moderate disruptions in staffing and volunteer support due to concerns of COVID-19 exposure, and even more are struggling to identify sufficient supplies. **Only 29% report having sufficient sanitation and hygiene supplies on hand to prevent transmission of COVID-19.**

Impact of COVID-19 on program operations

Over half of all respondents noted severe (17%) or moderate (39%) disruptions in staffing and volunteer support. Given that homeless assistance programs operate leanly during usual times, reduced staffing can result in unsafe operating conditions, reductions in operations, and even program closures. **65% reported that services for people experiencing homelessness have been reduced in their region.**

Figure 5: Extent of volunteer and staff disruptions that homeless service providers are experiencing within CoCs or BoS Regions

Concerns for family shelters include addressing the impacts of school and childcare closures and decreased access to community services for children, e.g. access to public libraries, parks and recreation centers, food pantries, WIC, healthcare centers, etc.

> "We are concerned about meal sites shutting down and our unsheltered homeless population not being able to access food."

Adding the anxiety created by COVID-19 to the stress inherent to homelessness, all shelter residents are struggling. Staff report concerns about rising conflicts that can lead to domestic and interpersonal violence,

relapses for people who are trying to manage their substance use disorder, and additional mental health crises. Further exacerbating this is the shift to telemedicine for behavioral health service and medical care. Without access to personal phones and confidential space, it is unlikely that homeless people will receive the care they need.

Many CoCs are concerned about how decisions being made by other institutions will increase demand on homeless programs. For example, the release of jail inmates without appropriate discharge options will likely result in many vulnerable people seeking shelter. In fact, it was reported that in some communities, jails are conducting mass release procedures in response to COVID-19 and simply discharge

> "We have clients who have been approved for permanent supportive housing, but we can't move forward with moving into an apartment since our housing authority is not processing vouchers."

inmates with a listing of the local shelters. It is unknown how limiting new admissions to nursing homes, treatment programs, and residential care programs will increase demand on shelters. Shifts in congregate feeding programs, food pantries, and other resources that address food insecurity may also put more households at risk of losing their current housing.

Many CoCs are reporting that public housing agencies are closed and therefore no longer processing vouchers, conducting inspections, or other essential activities for housing placement. Additionally, many landlords are no longer accepting applications or filling vacant units. This means that many people cannot exit emergency shelter. The consequence is shelters either must turn new requests for shelter away or further over-crowd their facilities.

> "Schools and other places are providing meals but we are concerned about those that aren't being reached due to various limitations. Checkpoints for households with high concerns like domestic violence and substance use. Some households are having trouble navigating homeschooling. Ability to teach the material and also lack of electronics, lack of internet. Lack of childcare. Some parents can't go to work because the kids are home from school with no childcare options available."

> "Need for additional childcare support for shelters and housing programs while children are out of school. The need for appropriate and adequate spaces with internet access and computers/technology for children in shelter to stay caught up on learning."

Financial Needs

CoCs confirmed they are facing critical funding gaps. Nearly all reported a financial need for shelter operating costs to implement COVID-19 protocols (74%), outreach operating costs to implement COVID-19 protocols (48%), and diversion and homelessness prevention financial assistance (83%). Over half requested rapid exit financial assistance to expedite persons exiting shelters (57%). CoCs listed hotel and motel vouchers, among other financial needs (39%).

> "Donations are down and expenses up. Need to be able to request an advanced draw in funding in lieu of waiting for all reimbursements since payrolls are going to be higher because volunteer numbers are down, and more staff are being utilized."

Immediate Needs

The highest priority needs are to:

1) Identify spaces and hotels for additional shelter capacity to deconcentrate existing facilities and expand shelter options to accommodate unsheltered individuals – funding will be required

2) Identify and set up spaces and hotels for isolation and quarantine – funding will be required

> "PPE equipment is needed at all shelters in our region. Hand sanitizer is nearly gone at all shelters as well, so large containers and at least a few for each location would be great. Masks are very limited at all shelters as well, so any would help."

3) Provide public health guidance and protocols for establishing, equipping and staffing shelter, quarantine, and isolation spaces for people enduring homelessness

4) Provide guidance on how to connect the homeless assistance system with the medical response to COVID-19 – both physical and behavioral health resources are needed

5) Expand efforts to provide emergency assistance to divert from shelter and rapidly exit people from homelessness – funding will be required

6) Ensure every facility and program has:
   a. sufficient coverage by appropriately trained staff – funding will be required

   b. adequate hygiene, sanitation, PPE (personal protective equipment), and basic medical supplies – funding will be required

   c. adequate food and related items to ensure nutritional needs are met consistent with COVID-19 distribution restrictions – funding may be required

7) Advance and align improved coordination and communication about homeless-specific responses to COVID-19 across state agencies and with local public health districts, emergency management agencies, and healthcare systems

> "Local hotels/motels are hesitant to take this on. Getting food and supplies to quarantined people has created extra work, and this all costs money that we didn't plan for and don't have readily available."

> "Available space, and hotels/motels aren't always an option in our region."

Cost Estimates

Culhane Report

A just published study by Culhane et al used national data to assess additional capacity required to address the acute effects of the COVID-19 pandemic on single adults who were enduring homelessness. The analysis considered the need to reduce density in current programs and meet the needs of unsheltered people for both safe shelter that conforms to social distancing and specialized spaces for quarantine and isolation. The researchers estimated the cost to add capacity based on a 40% infection rate, cost estimates for shelter based on a 2020 study , and a $7,500 per bed estimate to accommodate partitions and added non-Medicaid funded support services. They estimated nationwide, CoCs need an additional 400,000 shelter beds to manage the COVID-19 pandemic for the current estimated homeless population (300,000 beds to accommodate homeless persons living unsheltered (including unsheltered families) and 100,000 beds to increase social distancing within existing shelter facilities for single adults.

CoC Name	Total New Shelter Beds Required	Total Additional Cost for New Capacity, including quarantine and isolation
Ohio Balance of State	1,832	$53,360,800
Columbus/Franklin County	1,026	$30,195,400
Cleveland/Cuyahoga County	689	$20,926,200
Akron, Barberton/Summit County	280	$8,323,900
Dayton, Kettering, Montgomery County	317	$9,608,800
Cincinnati/Hamilton County	409	$12,545,700
Canton, Massillon, Alliance/ Stark County	76	$2,278,400
Toledo/Lucas County	185	$5,693,900
Youngstown/Mahoning County	66	$2,011,300
Statewide	**4,880**	**$144,944,400**

[8] Culhane et al, March 2020

[9] U.S. Department of Housing and Urban Development's 2019 Annual Homelessness Assessment Report (AHAR)

[10] Using estimates from Glynn and colleagues [Glynn, C. & Fox, E. B. Dynamics of homelessness in urban America. *Ann. Appl. Stat.* 13, 573–605 (2019)], the estimate of unsheltered homeless persons was modeled as 40% larger than is estimated by official HUD-mandated 2019 PIT counts to account for persons unobserved by enumerators and not incorporated through statistical modeling.

[11] Culhane, D. & An, S. *A statistical profile of the "homelessness industry" in 2015: Revenues, expenditures, employment, volunteers, fundraising and executive compensation.* (2020)

The Culhane report identified cost estimates for additional capacity for all Ohio CoCs as well. In total, the researcher estimated that an additional 4,880 beds at an annual cost of $144 million would be required to address the acute needs (see appendix for complete table) in the state.

Barbara Poppe and Associates estimate

Building off the methodology developed by Culhane et al, the author of this report created cost estimates for a 90-day and 180-day acute response that was **comprehensive of all populations**, not just single adults which was the primary focus of the Culhane report, and incorporated features to meet **dynamic needs**. This approach accounts for the reality that households will continue to fall into homelessness during this acute phase.

- Costs for basic shelter through hotel/motel space were estimated to be $50/day rather than $68.50 per night
- Peak infection rate of 40% (same as Culhane)
- Additional $7,500 per bed to accommodate non-Medicaid funded support services (same as Culhane)
- Incorporating diversion assistance to help reduce new shelter admissions ($1,500 per household)
- Incorporating rapid exit assistance to help unsheltered households and the households with the greatest vulnerabilities exit homelessness ($4,000 per household)
- Estimated costs for providing food and supplies for existing and additional shelter was not included. These costs will need to be provided either through funding or direct provision on a donated basis.

Based on these estimates, approximately 5,000 additional beds are immediately needed to address acute needs to prevent the spread of COVID-19 among the general population and among homeless people, reduce impact on hospitals and emergency rooms, and reduce morbidity and mortality among homeless populations due to COVID-19 infections. Diverting 1,476 households from the shelter system and helping 844 households exit more quickly will help to mitigate the impact of new requests for shelter assistance (the usual rate of new cases and the potential for new cases due to the economic impacts of the pandemic) on the existing and additional shelter capacity. These estimates are likely to understate the demand for this type of assistance if the economic crisis is swift and severe such that evictions increase dramatically. The cost estimates for a 3-month acute response are estimated to be $41 million, and $108 million if the acute phase stretches to 6-months.

Modeling Cost Estimates for Addressing Acute Needs of Homeless Ohioans during COVID-19 Pandemic

Expanding Shelter Opportunities During COVID-19 Crisis	Need	Costs 3 months	Costs 6 months
Additional Emergency Beds in Hotel Settings for Currently Unsheltered Homeless Individuals	2,110	$ 9,494,100	$ 19,304,670
Additional Emergency Beds in Hotel Settings to Reduce Density at Existing Shelters and Support Social Distancing	2,953	$ 13,287,600	$ 37,285,006
Quarantine/Isolation Beds Needed, at Additional Cost	4,772	$ 8,947,350	$ 17,894,700
		$ 31,729,050	**$ 74,484,376**
Other activities to meet acute needs			
Diversion assistance to reduce shelter admissions or shorten stays	1,476	$ 6,643,800	$ 13,287,600
Rapid Exits from Emergency System	844	$ 3,375,680	$ 20,254,080
Total Estimated Cost		**$ 41,748,530**	**$ 108,026,056**

COHHIO response

As the COVID-19 outbreak began to spread into Ohio, COHHIO refocused the entire work of the organization to respond to the urgent needs facing the state's homeless population and the people who serve them. COHHIO took a lead role in coordinating communications among CoCs and frontline providers throughout Ohio.

COHHIO ramped up outreach and communications to local homeless services agencies throughout the state, scheduling regular conference calls to update CoC lead staff on coronavirus-related developments. COHHIO launched a dedicated COVID-19 webpage, and distributes regular email alerts about emerging guidance. COHHIO staff have hosted online training sessions on COVID-19 preparedness for local homeless services agency staff.

> **In an effort to respond directly to shortages of desperately needed supplies at emergency shelters, COHHIO started purchasing gloves, thermometers, cleaning products, and other items to help equip frontline staff.**

COHHIO developed a series of specific policy recommendations for the state and federal governments to better support Ohio's over-burdened homeless system. Gov. DeWine has appointed a work group to address the challenges the pandemic poses to Ohio's homeless population, and state agencies have started taking action.

COHHIO Pandemic Emergency Fund
While emergency state and federal funding for homeless services agencies is in the pipeline, it will take weeks or more before these desperately needed dollars reach frontline responders. In order to fill the gap during this critical time period, COHHIO created the Pandemic Emergency Fund to help local agencies obtain the cleaning supplies, medical equipment, extra staffing and additional space they need to prepare and respond to the outbreak.

COHHIO diverted $250,000 from the organization's own resources to establish the Pandemic Emergency Fund on Mar. 18. COHHIO thanks Ohio Capital Corporation for Housing, which has pledged $100,000, and our other philanthropic supporters – The George Gund Foundation, The Sisters of Charity of Cleveland Foundation, and The Char and Chuck Fowler Family Foundation, which have contributed a combined total of $55,000. COHHIO also appreciates our many individual donors, whose contributions have brought the Pandemic Emergency Fund's total balance to over $410,000 in less than one week.

Working with Ohio's CoC leads to determine the highest priority needs, COHHIO directs 100% of these donations to local emergency shelters and other congregate programs around the state. Nonprofit agencies can use an expedited application process to request mini-grants of up to $10,000 to help them prepare for and limit the spread of the coronavirus among people experiencing homelessness.

Given the urgent and widespread needs among homeless services agencies throughout Ohio, COHHIO will continue raising money from private, corporate, and foundation sources to replenish the Pandemic Emergency Fund until the crisis subsidies or adequate public resources become available.

Call to Action

Dr. Amy Acton, Director of the Ohio Department of Health, recently noted with regard to the Coronavirus pandemic :

"This is a war on a silent enemy," Acton said. "I don't want you to be afraid. I am not afraid. I am determined, but I need you to do everything. I want you to think about the fact this is our one shot in this country. All of us are going to have to sacrifice, and I know someday we will be looking back and wondering what it was we did in this moment. There will be so many heroes."

"Everyone is being heroic right now, and I can tell you that every action you take is mattering, but this is that moment. It is our one shot," she added.

This report lays out the opportunity to pull together across sectors – business, government, philanthropy, faith-based, civic, nonprofit – and across disciplines – public health, disaster response, healthcare, social services, housing, public service – to defeat this silent enemy. An all hands-on deck approach is essential as we set aside our other priorities and focus on reducing the spread of the virus, saving lives, and making Ohio healthier for everyone.

People who are enduring homelessness are very diverse, from pregnant women with young children fleeing domestic violence, to middle aged workers who lost their jobs due to injury, to older women with histories of depression and mental illness, to young people struggling to free themselves from opioid addiction, to Vietnam-era Veterans who lost their homes in a recent divorce. Yet they all share the lack of a safe, stable place to call home and are trying to get by depending on the charity of emergency shelters or sleeping in abandoned buildings.

The dual catastrophes of homelessness and the Coronavirus pandemic requires each sector to rise up and offer its expertise and resources to stand up a more comprehensive and integrated statewide response.

> "This pandemic affects all of us around the globe. But just imagine if you were trying to ride this out with your family and had nowhere to call home."
> **Bill Faith**
> **COHHIO Executive Director**

---

[12] March 22, 2020 https://www.businessinsider.com/ohio-orders-residents-to-stay-at-home-for-2-weeks-2020-3

We need significant government response at all levels – local, state, and federal – to redeploy existing resources with flexibility and haste. The appendix includes a summary of ways key state and federal partners could provide some regulatory relief. Importantly, an effective response will require significant new funding that is swiftly deployed to implement the actions described in this report. Governments can also take the lead to coordinate, communicate, and collaborate with other sectors.

Philanthropy can also provide flexibility for their grantees to redeploy grants already in place and reprogram pending grant awards to support the nonprofit organizations that need to scale up to respond to the pandemic. New philanthropic funding could be used flexibly to fill gaps not covered by government grants. Philanthropy could play a catalytic role by advancing funds quickly so nonprofit partners have the frontloaded cash to begin acting now as government goes through its contracting processes.

Businesses and employers can also step in by mobilizing healthy employees to volunteer at homeless assistance programs. The hotel and restaurant sector can also be key partners to help make available space and meals as part of efforts to expand and serve more people through dedicated spaces for shelter, quarantine, and isolation.

Faith-based organizations, civic groups, and general public also have a role to play in mobilizing volunteers and supporting local relief campaigns and the COHHIO Pandemic Emergency Fund.

This mobilization is just the acute phase – we know that there are looming economic impacts, especially unemployment, that will have a negative impact on a family's ability to keep a roof overhead. We will need significant investment in rental assistance, as moratoriums only defer an eviction – the landlord will still need to be paid. We know that the homeless response system will also feel the pain of an economic downturn – demand for assistance will go up – so we need to be prepared to sustain their efforts.

We must believe that we will get through this if we all work together. This report lays out the many ways we can come together to defeat the virus and save lives.

Appendix

Methodology

CoC Lead and Ohio BoSCoC Regional COVID-19 Needs Survey

COHHIO administered a cross-sectional survey to a total of 25 Continuum of Care (CoC) and Balance of State regions on March 18, 2020. Survey collection closed on March 21, 2020. The survey had a response rate of 93% (n=25). The non-respondents consisted of two Balance of State Regions that included Adams, Ashtabula, Brown, Geauga, Lake, Lawrence, Pike, Portage, Scioto, and Trumbull counties. All eight metropolitan regions in Ohio completed the survey (Cuyahoga, Franklin, Hamilton, Lucas, Mahoning, Montgomery, Stark, and Summit counties).

The survey consisted of COVID-19 planning with local health departments, homeless shelter provider preparedness of COVID-19, and gaps and needs to address COVID-19 prevention in shelters. COHHIO administered the survey using SurveyMonkey (SurveyMonkey Inc., San Mateo, CA, USA).

Additional Needs Captured through COHHIO Conference Calls with CoC Leads and Providers

COHHIO hosted informational webinars and conference calls with CoC and BoS regional leads on March 16, 17, and 20 to provide updated guidance on COVID-19, as well as the response and needs of providers as the COVID-19 outbreak in Ohio progresses. During these calls, COHHIO administered polls to collect COVID-19 information from CoC and BoS regional leads. These polls included questions regarding COVID-19 protocols, isolation and quarantine space needs, supply needs, and more. A question and answer panel was added at the end of each call for CoC and BoS regional leads to ask questions specific to the situations they were addressing on the ground.

Glossary of Terms

Chronic homelessness: Experience by an individual or family with a disabling condition who has been continuously homeless for a year or more or has had at least four episodes of homelessness in the past three years.

Continuum of Care (CoC): A regional or local planning body required by HUD to organize and deliver housing and services to meet the specific needs of people who are homeless as they move to stable housing and maximum self-sufficiency. CoC refers to the system coordinating programs that address and prevent homelessness within a geographical region. The primary HUD funding to address homelessness is also known as Continuum of Care funding.

Coordinated Entry System (CES): CES is an integrated, community-wide process to provide outreach to and identify households experiencing homelessness, assess their needs, and prioritize access to programs and resources to end their homelessness. An effective coordinated entry process includes prioritization, a Housing First orientation, emergency services, standardized assessment, referral to housing, outreach, and use of HMIS. Diversion: Aimed at helping households stay safely in current housing or, if that is not possible, move to other housing without requiring a shelter stay first. Priority is given to households who are most likely to be admitted to shelters or be unsheltered if not for this assistance.

Emergency Shelter: A facility designed to provide temporary or transitional shelter for people who experience homelessness, typically (but not exclusively) for a period of 90 days or less. Housing-focused supportive services provided in addition to the provision of shelter. HUD encourages average length of stay to be less than thirty (30) days.

Homelessness Management Information System (HMIS): HMIS is a computerized data collection tool designed to capture client-level and services-level information over time on the characteristics and service needs of men, women, and children experiencing homelessness. These data may be used for recordkeeping, coordinating services for households, and assessing system performance.
Homelessness (as defined by U.S. Department of Housing and Urban Development HUD): Households who lack a fixed, regular, and adequate nighttime residence and are living in temporary accommodations such as shelter or in places not meant for human habitation; or families who will imminently lose their primary nighttime residence; or families who are fleeing, or are attempting to flee, domestic violence, dating violence, sexual assault, stalking or other dangerous or life-threatening conditions that relate to violence against the individual or a family member (sometimes referred to as "literal homelessness").

Housing Inventory Count (HIC): An inventory of beds and units dedicated to persons experiencing homelessness. This is completed each year during the last week in January, coinciding with the Point-in-Time Count.

Permanent supportive housing (PSH): Decent, safe, affordable, community-based housing that provides tenants with the rights of tenancy and links to voluntary and flexible supports and services for people with disabilities who are experiencing chronic homelessness.

Point-In-Time (PIT): A snapshot of the homeless population taken on a given day. Since 2005, HUD requires all CoC applicants to complete this count every other year in the last week of January. This count includes a street count in addition to a count of all clients in emergency and transitional beds.

Rapid Re-housing: Interventions that prioritize moving a family or individual experiencing homelessness into permanent housing as quickly as possible, ideally within 30 days of a client becoming homeless and entering a program. Time-limited services may include housing identification, rent and move-in assistance, and case management. Rapid Re-housing is considered permanent housing since the tenant obtains a lease in their name.

Transitional Housing: A type of temporary housing and appropriate support services to homeless persons to facilitate movement to independent living within 24 months. HUD encourages that this be a limited portion of the community inventory and reserved for specific sub-populations (e.g. youth or domestic violence victims) or for purposes like short-term interim housing.

Unsheltered Homelessness: Individuals or families living in places not meant for human habitation, i.e. tents, cars and RVs, abandoned buildings, encampments, or sleeping on sidewalks, doorways, etc.

Estimated Emergency and Observational/Quarantine Bed Need for the US Homeless Population Related to COVID-19 Exposure by County; Projected Hospitalizations, Intensive Care Units and Mortality

Dennis Culhane, Dan Treglia and Ken Steif, University of Pennsylvania, Randall Kuhn University of California Los Angeles and Thomas Byrne, Boston University

March 20, 2020

CoC Name	Estimated Total Unsheltered	Sheltered Homeless Individuals	Density Reduction Bed Need	Total New Shelter Beds Required	Cost of New Capacity	Cost of Quarantine Beds	otal Additional Cost
Ohio Balance of State	1,140	1,384	692	1,832	$45,790,000.00	$7,570,800.00	$53,360,800.00
Columbus/Franklin County	535	982	491	1,026	$25,645,000.00	$4,550,400.00	$30,195,400.00
Cleveland/Cuyahoga County	148	1,082	541	689	$17,235,000.00	$3,691,200.00	$20,926,200.00
Akron, Barberton/Summit County	122	317	159	280	$7,007,500.00	$1,316,400.00	$8,323,900.00
Dayton, Kettering, Montgomery County	69	496	248	317	$7,915,000.00	$1,693,800.00	$9,608,800.00
Cincinnati/Hamilton County	43	731	366	409	$10,222,500.00	$2,323,200.00	$12,545,700.00
Canton, Massillon, Alliance/Stark County	24	104	52	76	$1,895,000.00	$383,400.00	$2,278,400.00
Toledo/Lucas County	17	337	169	185	$4,632,500.00	$1,061,400.00	$5,693,900.00
Youngstown/Mahoning County	13	107	54	66	$1,652,500.00	$358,800.00	$2,011,300.00
Statewide	**2,111**	**5,540**	**2,772**	**4,880**	**$121,995,000.00**	**$22,949,400.00**	**$144,944,400.00**

Federal and State Regulatory Relief

HUD
- Cancel Annual CoC NOFA competition and replace it with a streamlined renewal/grant amendment process
- Expedite and streamlining grant amendments from the Field Office
- Unit Inspections
    - Permission to conduct unit inspections via landlord or client self-certification, to be followed up by agency verification after the crises has passed
    - Permission for lead-based paint inspections to be done via landlord or client self-certification, to be confirmed by agency verification after the crises has passed
- Eligibility
    - Waive the requirement that current forms of Primary Identification are needed to be eligible and receive program services due to offices being closed. Only has to include one form of ID
- Forms of ID are allowed to be expired and can be photocopy (i.e. expired state ID)
- Social security card and birth certificate not be required
- Secondary forms of ID are allowed and acceptable forms of documentation (prison ID, medical records, voter registration, library card, police record)
    - For households reporting being currently unsheltered, self-certification is sufficient to document homelessness, third party verification or documentation of due diligence to obtain third party verification should not be required or encouraged
- Lease Terms
    - Relax requirement that initial lease term for CoC Program-funded RRH and PSH programs be one-year – allow for minimum one-month lease term
- Budget and Amendments
    - Programs can utilize funds from any BLI in advance of requesting and being approved for a grant amendment to move money into Supportive Services BLI to provide services under necessary BLI categories (Outreach, Food, Medical)
- Projects are able to spend money now without having to wait for approval for an amendment as long as they maintain documents and records.
    - Allow CoC lead agencies to approve grant amendment requests to streamline approval process
    - Waive the requirement that projects can only move 10% of each BLI within grant period and allow projects to move necessary amount of funds from whatever BLI to provide services.
    - Waive that moving 10% of a BLI into a new category is consider a significant and/or permanent change in the grant.
    - Waive match requirements for projects
    - Programs with unspent funds at the end of the grant cycle can request that the underspend funds be rolled over and used within the first 6 months of the grant renewal and can be added to any BLI including new BLI without a grant amendment.
- Eligible Costs
    - Projects can pay for phones and phone services in order to maintain contact with clients.
    - Single-site housing facilities can pay for the cost of INTERNET in order for program participants to make calls, access important information, participate in tele-psych, and case management sessions virtually.

ODSA

- Cancel competition and replace it with a streamlined renewal/grant amendment process
- Unit Inspections
    - Permission to conduct unit inspections via landlord or client self-certification, to be followed up by agency verification after the crises has passed
    - Permission for lead-based paint inspections to be done via landlord or client self-certification, to be confirmed by agency verification after the crises has passed
- Documenting Eligibility
    - For households reporting being currently unsheltered, self-certification is sufficient to document homelessness, third party verification or documentation of due diligence to obtain third party verification should not be required or encouraged
- Payment Standards
    - ODSA allows more flexibility to pay rent above local FMR (you can already do this in CoC Program, provided rent is reasonable)
    - Ease up on rent reasonableness requirements
- Income Limits
    - ODSA programs relax income eligibility requirements
- Lease Terms
    - Relax requirement that initial lease term for CoC Program-funded RRH and PSH programs be one-year - allow for minimum one-month lease term