Date: October 8, 2020

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Subject: CDC/HUD field report on the response to COVID-19 among persons experiencing homeless in Anchorage, Alaska

BACKGROUND

In March 2020, the Municipality of Anchorage and local homeless service providers took steps to reduce the density of people staying in congregate shelters to reduce the risk of SARS-CoV-2, the virus that causes coronavirus disease 2019 (COVID-19), transmission in those facilities. They opened several temporary mass shelters with increased spacing and designated a primary shelter to remain at lower census to focus on serving people with disabilities and increased risk of severe COVID-19.

In mid-August, the Anchorage Health Department (AHD) identified the first cases of COVID-19 at that facility. Over the next 2 weeks, the number of COVID-19 cases among people experiencing homelessness in Anchorage increased and infections were identified among clients and staff at additional facilities. In response, several shelters further reduced the number of people staying within the facility, increased the spacing between people while sleeping and eating, encouraged existing clients to remain in the facility during the day, and closed admissions to new clients.

On September 4, AHD and the Alaska Department of Health and Social Services (ADHSS) requested technical assistance from CDC to help respond to the outbreak. On September 10, members of a federal field team traveled to Anchorage. The team included two epidemiologists and a medical toxicologist from CDC, and a lead for disaster technical assistance from Department of Housing and Urban Development (HUD). On September 11, the team met with staff from AHD and ADHSS to determine their objectives and activities. From September 12–21, the field team performed site visits at four shelters (Sullivan Arena, Brother Francis, Covenant House, and Gospel Rescue Mission) and the municipal COVID-19 isolation and quarantine facility. The team also had information gathering meetings with additional AHD and ADHSS staff, the Municipality of Anchorage (MOA) Emergency Operations Center, MOA Mayor's office, MOA Assembly's Committee on Homelessness, Anchorage Coalition to End Homelessness, and HUD and Federal Emergency Management Agency (FEMA) field offices.

OBJECTIVES

1. Strengthen case tracking and data sharing between public health and homeless services.
2. Streamline contact tracing for COVID-19 cases among people experiencing homelessness.
3. Evaluate isolation and quarantine facilities and services for people experiencing homelessness.
4. Assess the role of rapid testing for SARS-CoV-2 in homeless shelters.
5. Review systems and strategies for COVID-19 response among people experiencing homelessness to inform a plan for the next 6 months.

LOCATION

The Municipality of Anchorage is in southcentral Alaska. The city covers an area of 1,944 square miles and has an estimated population of 291,836. The population is 51% male. Overall, 24% of the residents are aged <18 years and 12% are aged ≥65 years. The racial distribution includes 64% White, 10% Asian, 9% Alaska Native/American Indian, 8% two or more races, 6% Black/African American, and 3% Native Hawaiian/Pacific Islander.

During August 2020, using data reported to the Homeless Management Information System (HMIS), a total of 1,394 unique individuals stayed one or more nights at an emergency shelter in Anchorage. Of those, 899 (65%) were male; 90 (6%) were aged <18 years, 68 (5%) were aged >65 years, and 19 (1%) were missing age data. Although 30% were missing data on race, 32% were reported as Alaska Native/American Indian, 19% were White, 9% were multiple races, 6% were Black/African American, 3% were Native Hawaiian/Pacific Islander, and 1% were Asian.

EPIDEMIOLOGY

From July 31–September 25, a total of 247 cases of COVID-19 associated with homelessness in Anchorage were reported to ADHSS; these cases include clients and staff of congregate and non-congregate shelters or transitional housing, and other people accessing homeless services (**Table**). Of the 247 cases, 183 (74%) were male and the median age was 51 years (Range 16–80 years). Race was missing for 84 (34%) cases but was reported as Alaska Native/American Indian for 102 persons (41%), White for 34 persons (14%), and multiple races for 11 persons (4%). Cases peaked in mid-August with 88 persons (40%) being confirmed during the week of August 23 and have declined over the past 4 weeks (**Figure 1**).

PRINCIPLES OF CDC GUIDANCE RELATED TO HOMELESSNESS AND COVID-19

CDC guidance to prepare for and respond to COVID-19 among people experiencing homelessness emphasizes decreasing crowding in homeless service sites in order to reduce the likelihood of disease transmission, in addition to measures like handwashing, wearing masks, using testing strategies, and other prevention activies. However, the decompression of homeless service sites increases the need for additional sites to open in order to continue serving the same number of individuals. Therefore, to continue homeless services in a manner that does not increase the risk of disease, a "whole community" approach is necessary to identify possible additional sites and services. The types of additional sites that are needed while COVID-19 is circulating include: 1) **overflow** sites to accommodate shelter decompression; 2) **isolation** sites for people who are confirmed to be positive for COVID-19; 3) **quarantine** sites for people who are waiting to be tested, or who know that they were exposed to COVID-19; and 4) **protective**

housing for people who are at increased risk of severe illness from COVID-19. Each of these sites needs to provide appropriate services, supplies, and staffing. Depending on resources and staff availability, non-congregate housing options with individual rooms should be considered for the overflow, quarantine, and protective housing sites.

PRIMARY RECOMMENDATIONS

1. Convene a multi-agency task force to coordinate the response to COVID-19 among people experiencing homelessness in Anchorage
2. Separate the isolation and quarantine locations, enhance the homeless services provided onsite, and facilitate access to different housing at the completion of isolation or quarantine
3. Prioritize moving people who are at the highest risk of severe illness from COVID-19 to non-congregate shelter options, which would allow more congregate shelter beds to be available during the winter months

DETAILED FINDINGS AND RECOMMENDATIONS

Case tracking

Tracking COVID-19 cases among persons experiencing homelessness is important to monitor trends in transmission and identify sites that may need additional public health intervention. ADHSS has identified two data entry staff to focus on positive COVID-19 laboratory test results for residents or other people tested in Anchorage. These staff will assign newly identified cases to the outbreak involving people experiencing homelessness based on the testing site (e.g., Visit Health collected the specimen at a shelter site), an address provided on the test request that correlates with a homeless shelter or other site that provides homeless services, or based on information gathered during the public health case investigation.

Public health partners should use standardized case definitions and unified data sources for internal communication and decision making, and reporting to community leaders and the public. Cases reported to the Alaska state National Electronic Disease Surveillance System (NEDSS)-based surveillance system (NBS) should be used by ADHSS, AHD, and the MOA Emergency Operations Center for epidemiologic analysis, updates to the MOA webpage and dashboard, and situational reports to community leaders and the public (**Figure 2**). Cases reported into NBS should meet the interim national surveillance case definition. For the purposes of this response, a person experiencing homelessness should be classified according to the HUD definition. Other cases may be included as being part of the outbreak (e.g., people in transitional housing or accessing other homeless services and shelter staff). However, the inclusion criteria should be clearly stated and, where possible, data should be stratified to define specify cases among people experiencing homelessness versus staff or other associates. If possible, routine testing at shelter sites should include data collection to capture whether the case is a person experiencing homelessness or a person otherwise affiliated with the outbreak (e.g., shelter staff, client who stayed previous night at the shelter site where testing is being performed, or client who stayed previous night at another location). This will assist with additional analysis and description of the outbreak to identify current issues that may need to be addressed.

Data sharing

Current information about people experiencing homelessness who should be in isolation or quarantine also should be shared with homeless shelter providers to temporarily restrict people

who might be infected from congregate housing and help public health locate people to provide results and complete the case investigation and contact tracing. The Homeless Management Information System (HMIS) is a local information technology system that is sponsored by HUD and managed by the Coalition to End Homelessness to collect client-level data and data on the provision of housing and services to homeless individuals and families and persons at risk of homelessness. COVID-19 variables have been added to HMIS and the system could be used to securely share information among shelter providers regarding clients who should be in isolation or quarantine. However, the data are not adequately updated or routinely used by all shelter providers to be useful for this purpose at this time. To facilitate sharing data with homeless shelter providers for people experiencing homelessness in isolation or quarantine, it has been proposed that the MOA Emergency Operations Center will provide a daily list of people staying in the isolation and quarantine facility to the MOA Housing and Homeless Services Coordinator who will then distribute the list via encrypted email to a limited distribution list (e.g., AHD, homeless shelter directors, shelter medical clinic director, Coalition to End Homelessness outreach teams) (**Figure 3**).

Contact tracing

Case investigation, contact tracing, and isolation and quarantine are essential public health tools to decrease the transmission of SARS-CoV-2. However, traditional, individual-based contact tracing among people experiencing homelessness requires a higher effort (i.e., more follow-up attempts) and has a lower yield (i.e., numbers of contacts identified) compared to the general population. The reasons for these differences include: 1) People experiencing homelessness with COVID-19 might be difficult to locate; 2) Homeless services often are provided in congregate settings where many people might be exposed to a single case and the individual who tested positive might not be able to identify every contact; 3) People who test positive might not be comfortable sharing the names of their contacts; and 4) Contacts might be difficult to locate and might not have consistent access to communication technology. Given these challenges, CDC guidance recommends a location-based contact tracing approach among people experiencing homelessness during the COVID-19 response.

Location-based contact tracing protocol includes the following elements and procedures:

1. Request information about recent locations from people who have tested positive
    a. Request in-depth information about locations visited by people who have tested positive between the current date and two days before their positive test, [Appendix A].
    b. Ask the most important questions (i.e., congregate shelters and other locations where the person spent time) first in case the interview is not completed.
    c. Provide information to the patient about how to self-isolate and seek medical care or other services as needed.
2. Fill in symptom information using screening data from contracted medics
    a. At intake, medics staffing the isolation site should request symptom information for the past 2 weeks.
    b. Using symptom data collected at intake will alleviate the need for contact tracers to collect the same information.
3. Determine where follow-up investigation or public health action is necessary
    a. Some locations identified by people who have tested positive may need additional

facility-wide testing and infection control measures, based on whether the location has a high transmission risk and whether it is it possible to conduct follow-up public health action.

4. Adjust procedures based on current conditions
    a. If there are high numbers of cases among people experiencing homelessness
        i. Request location information at the time of testing instead of after a positive result is received.
    b. If there are low numbers of cases among people experiencing homelessness
        i. Invest more time in thorough follow-up of cases using process described above.
    c. If transmission patterns are unclear
        i. Invest more time in thorough follow-up of cases using process described above AND request location information at the time of testing.

AHD has been using a location-based questionnaire since the beginning of September 2020. The following are opportunities to help further streamline the contact tracing process:

1. Partner with homeless service outreach providers to facilitate follow-up and enhance information gathering.
2. Decrease the amount of information requested through interviews to only that which is required to interrupt transmission of COVID-19 (i.e., primary locations where the person spent time, especially in congregate settings).
3. Identify other sources of data to complete case report forms (e.g., information collected at the time of specimen collection, HMIS, or intake data from the isolation and quarantine site).

Isolation and quarantine strategies

During the COVID-19 response, non-congregate isolation and quarantine sites (e.g., hotels) are used to facilitate public health isolation and quarantine for people experiencing homelessness throughout the United States. In Anchorage, the Emergency Operations Center established an isolation and quarantine space in a hotel that provides rooms, meals, and twice daily COVID-19 symptom screening. However, EOC and medical staff have described difficulty in convincing people to stay on site for the duration of their isolation or quarantine.

The following are recommendations to help improve the likelihood that people experiencing homelessness will be able to remain on site during their isolation or quarantine periods:

1. Separate isolation and quarantine locations to decrease risk of transmission from known cases to contacts pending test results and potentially allow for more congregate activities among people in isolation.
2. Designate an onsite manager for homeless service support and increase coordination with AHD, ADHSS Division of Behavioral Health, and the Coalition to End Homelessness.
3. Provide additional onsite services to meet specific needs of people experiencing homelessness and help them maintain isolation and quarantine. These might include:
    a. Transport personal belongings to the site
    b. Increase food and drink availability and options
    c. Improve access to entertainment and information (e.g., newspapers)
    d. Enhance communications capacity (e.g., use of hotel phone, cell phone chargers)

e. Assess family and childcare support needs
f. Provide mental health and remote interactive services (e.g., Listening Post)
g. Support ongoing substance use treatment
h. Facilitate linking people to housing directly from the isolation site
i. Provide a 24-hour contact number for homeless services and support

4. Inform further improvements to isolation and quarantine practices through data collection from clients staying at or recently discharged from the isolation site. A survey proposal and data collection and consent forms are provided in Appendix B. Findings from the survey are provided in a separate report.

SARS-CoV-2 laboratory testing

Following the identification of COVID-19 cases among clients at a congregate shelter, MOA began offering periodic testing to clients and staff at all congregate shelter facilities in the city in August 2020. Testing is performed on a regular rotating schedule of 1–2 times per week at most facilities depending on the number of recent infections identified at the site. A contractor performs specimen collection of oral swabs at the shelter site and sends the specimen to an out-of-state contract laboratory for reverse transcription polymerase chain reaction (RT-PCR) testing. Despite the need for shipping, results are typically available within 2–3 days. Very limited data are obtained at the time of specimen collection and some issues were identified with the ability of the contract laboratory to provide a summary database of results as opposed to individual emails for each person tested. During the past 2 weeks, the state public health laboratory in Anchorage has begun testing of some specimens collected at the shelters. While this shift could further improve the time to reporting of results, the state public health laboratory has had some problems identifying specimens that were collected at shelter sites when reporting results.

AHD recently received two instruments to perform the Abbott Diagnostics ID NOW COVID-19 assay. The ID NOW COVID-19 assay is a rapid isothermal nucleic acid amplification test (i.e., a non-RT-PCR molecular test that detects SARS-CoV-2 viral RNA). Testing can be performed on nasal, nasopharyngeal or throat swabs from individuals with suspected COVID-19. It is not authorized for use in screening people without symptoms of SARS-CoV-2 infection. The test provides results in approximately 15 minutes but only one specimen can be run at a time. Testing is authorized for laboratories that are Clinical Laboratory Improvement Amendment (CLIA) certified to perform moderate to high complexity tests or in point of care settings operating under a CLIA Certificate of Waiver, Certificate of Compliance, or Certificate of Accreditation. The assay has an analytic limit of detection that is similar to RT-PCR; however, a recently published paper suggests the assay has substantially lower sensitivity than RT-PCR in a clinical field evaluation (Basu et al. J Clin Microbiol 2020).

Four SARS-CoV antigen tests have received FDA emergency use authorization (EUA), including the Abbott BinaxNOW COVID-19 Ag Card, LumiraDx SARS-CoV-2 Ag Test, BD Veritor System for Rapid Detection of SARS-CoV-2, and Sofia 2 SARS Antigen FIA. All of the tests provide results in approximately 15 minutes and are authorized for use on symptomatic people with suspected COVID-19; there are limited data on their use for screening asymptomatic

people. Although the antigen tests likely have lower sensitivity than RT-PCR[1], due to their low cost and simplicity, they could be used for frequent testing of people in congregate settings (e.g., long-term care facilities) to more quickly identify people who may be infectious and move them into isolation. Limited data suggest high specificity[1] but it is unknown how much cross-reactivity exists with human coronaviruses and the positive predictive value will depend on the pre-test probability (i.e., percent positive in the population being tested), especially when used for screening of asymptomatic people.

The following are further considerations for ongoing SARS-CoV-2 testing of people experiencing homelessness and homeless shelter providers in Anchorage:

1. Continue routine screening of clients and staff in congregate shelters to identify and isolate people with SARS-CoV-2 infection, and monitor trends in the outbreak. The frequency of testing can be adjusted based on number of positive tests obtained at a specific facility and the amount of ongoing transmission occurring in the community [Appendix C].
2. Consider obtaining additional information at the time of specimen collection to help determine whether the individual being tested is a person experiencing homelessness or a person otherwise affiliated with the outbreak (e.g., shelter staff, client who stayed previous night at the shelter site where testing is being performed, or client who stayed previous night at another location). If there continues to a be a high proportion of positives, consider requesting location information at the time of testing to facilitate contact tracing once results are available.
3. Optimize the efficiency of results reporting from the contract and state public health laboratory to the health department and homeless shelter providers. When feasible, results should be provided in a summary dataset for each facility to easily identify new cases among people staying in a congregate shelter and to distinguish staff from clients who spent the night at the shelter or others who are receiving homeless services but did not stay in a shelter.
4. Discuss the best use of the ID NOW COVID-19 rapid isothermal nucleic acid amplification test given its characteristics. One consideration may be placing the instruments in the clinics run by Southcentral Foundation at three shelter sites for testing of clients who present with respiratory symptoms. This could provide rapid evidence of SARS-CoV-2 infection without needing to send a patient or specimen to an outside laboratory. However, given the possible lower sensitivity, careful consideration would need to be given with how to manage a symptomatic person who tests negative on the ID NOW assay.
5. As data become available on the use of antigen testing for screening asymptomatic people and antigen test kits are more widely available, consider evaluating or implementing more frequent screening of people in congregate shelters using antigen testing with RT-PCR confirmation to more rapidly identify people who should be isolated.

[1] From https://www.cdc.gov/coronavirus/2019-ncov/lab/resources/antigen-tests-guidelines.html

Strategy and planning for the next 6 months.

The number of cases of COVID-19 per week among people experiencing homelessness in Anchorage has been decreasing since the end of August. However, further outbreaks and continued spread are likely to occur. Additionally, as the weather becomes colder, the number of people needing to access homeless services will increase. Finally, the economic conditions resulting from the pandemic may further increase the need for homeless services beyond typical winter baselines.

The following are recommendations to further enhance the current response to COVID-19 among people experiencing homelessness and assist with planning for the next 6 months:

1. Consider convening a multi-agency task force that meets regularly (e.g., weekly) to coordinate the response to COVID-19 among people experiencing homelessness in Anchorage.
    a. Proposed members could include a representative from:
        - AHD
        - ADHSS Section on Epidemiology
        - ADHSS Division of Behavioral Health
        - MOA Emergency Operations Center
        - Anchorage Coalition to End Homelessness
        - Southcentral Foundation
    b. The multi-agency task force would further coordinate with and obtain support from other state partners (e.g., Alaska Housing Finance Corporation, and Alaska Department of Commerce, Community, and Economic Development) and federal agencies (e.g., CDC and HUD). These state partners receive additional HUD funds that may be appropriate for allocation to the effort to limit the impact of COVID among highly vulnerable households. The HUD Community Planning and Development field office in Alaska can provide connections to these grantees; Carma Reed is the CPD Director for the Alaska HUD Field Office.
2. Prioritize moving people at increased risk for severe disease due to COVID-19 (e.g., persons aged ≥65 years or with significant underlying medical conditions) to non-congregate shelter options, which would allow more congregate shelter beds to be available during the winter months
    a. HUD and FEMA are working to add federal funds, reimbursement, and flexible programs to address the complexity of the COVID-19 response for people who have been marginalized and cannot access individual living situations. Given the specific risks for severe illness from COVID-19 among people aged ≥65 years or with certain underlying medical conditions, these funds are available to provide non-congregate shelter to protect individuals who are not in isolation or quarantine. Several other cities (e.g., Minneapolis) are utilizing these funds to provide non-congregate shelter.
    b. Congress has appropriated funds for communities to prevent, prepare for, and respond to COVID-19 among individuals and families accessing homeless services. Funds currently available for utilization include:
        a. Emergency Solutions Grant (ESG-CV)
            - State of Alaska allocation: $5.05 million
            - Municipality Anchorage allocation: $4.29 million

b. Community Development Block Grant (CDBG-CV)
    - State of Alaska allocation: $6.19 million
    - Municipality of Anchorage allocation: $3.06 million

c. Funds awarded to either the state or municipality that are currently unencumbered could be reviewed for possible use to further support the response to COVID-19 among people experiencing homelessness. Grantees and recipients can review the HUD Community Planning and Development Cross Program Funding Matrices available here. The HUD Community Planning and Development field office can help provide additional expertise to utilize funds to their best purpose.

d. HUD has assigned Julie McFarland (jmcfarlandconsulting@outlook.com) to provide ongoing technical assistance to support increased capacity among locally funded homeless organizations as they coordinate with emergency management and public health officials.

3. Offer influenza vaccine to people experiencing homelessness through shelters and community outreach programs. Begin planning for distribution of COVID-19 vaccine when it is available with prioritization of people at increased risk for severe disease and those staying in congregate settings.

SUMMARY

The COVID-19 pandemic is an extended, complex, and evolving crisis. The agencies involved in the COVID-19 response in Anchorage have adapted to the needs of the community and have created a foundation for future success in limiting transmission among people experiencing homelessness. Convening a multi-agency task force could help further coordinate the response. The recommended first tasks for this group are to: 1) separate the isolation and quarantine sites, 2) strengthen the homeless services provided onsite, and 3) facilitate access to housing after the completion of isolation or quarantine. To plan and prepare for the coming months, the task force should then prioritize moving people who are at the highest risk of severe illness from COVID-19 to non-congregate shelter options, providing more congregate shelter beds to be available during the winter. Influenza vaccine should be made available to people experiencing homelessness, and planning started for distribution of COVID-19 vaccine with prioritization of people at increased risk for severe disease and those staying in congregate settings. Further resources specifically related to the COVID-19 response among people experiencing homelessness are available in Appendix D.

Table. Characteristics of COVID-19 disease cases among people experiencing homelessness in Anchorage, Alaska (July 31–September 25, 2020)*

Characteristic	COVID-19 cases [N=247] No.	(%)
Male	183	(74)
Age group in years		
<20	1	(<1)
20–39	61	(25)
40–59	130	(53)
60–79	54	(22)
≥80	1	(<1)
Race		
Alaska Native/American Indian	102	(41)
White	34	(14)
Multiple races	11	(4)
Native Hawaiian/Pacific Islander	10	(4)
Black/African American	6	(2)
Unknown or other	84	(34)
Hospitalized	11	(4)
Died	1	(<1)

*Cases include staff of and clients in congregate and non-congregate shelters or transitional housing, and other people accessing homeless services.

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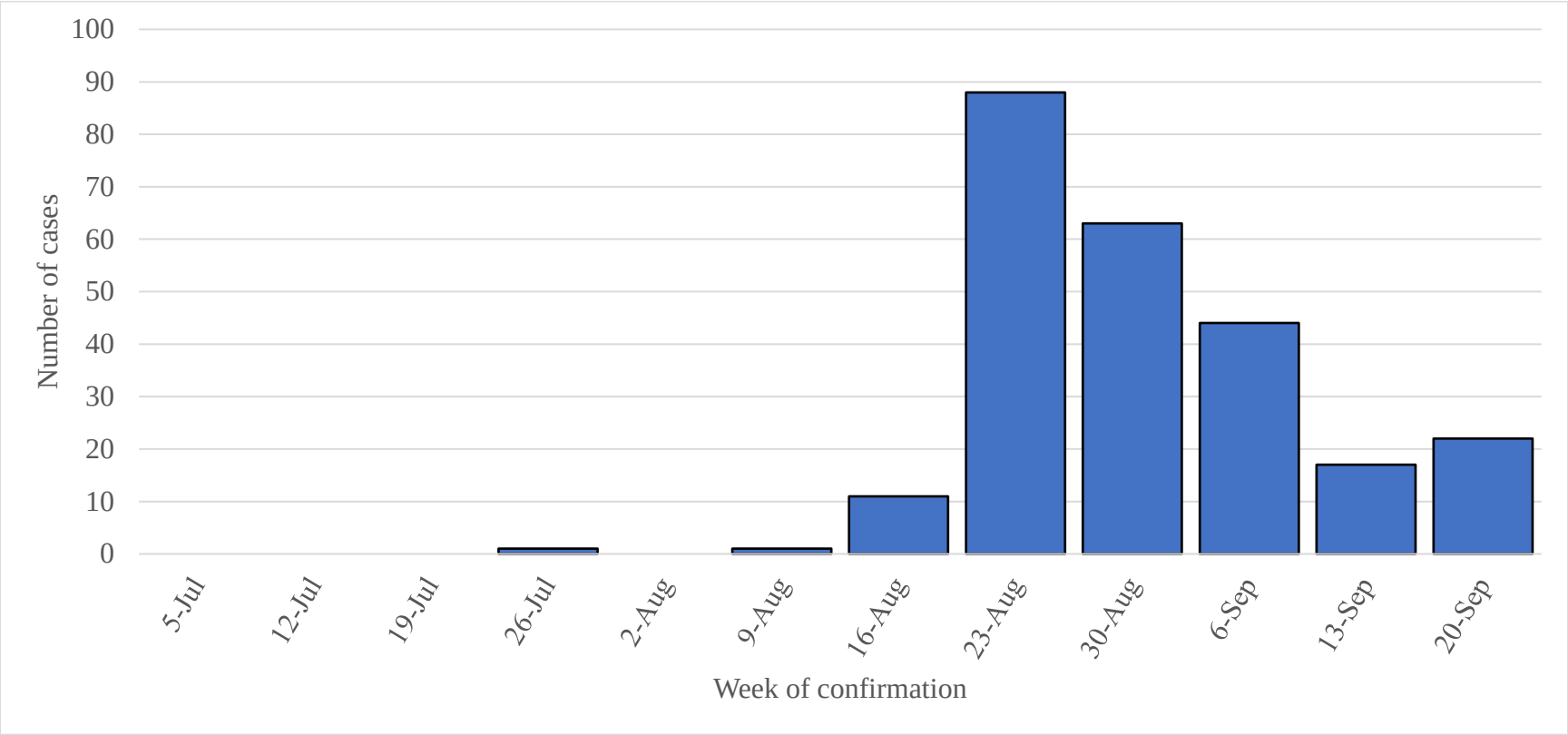
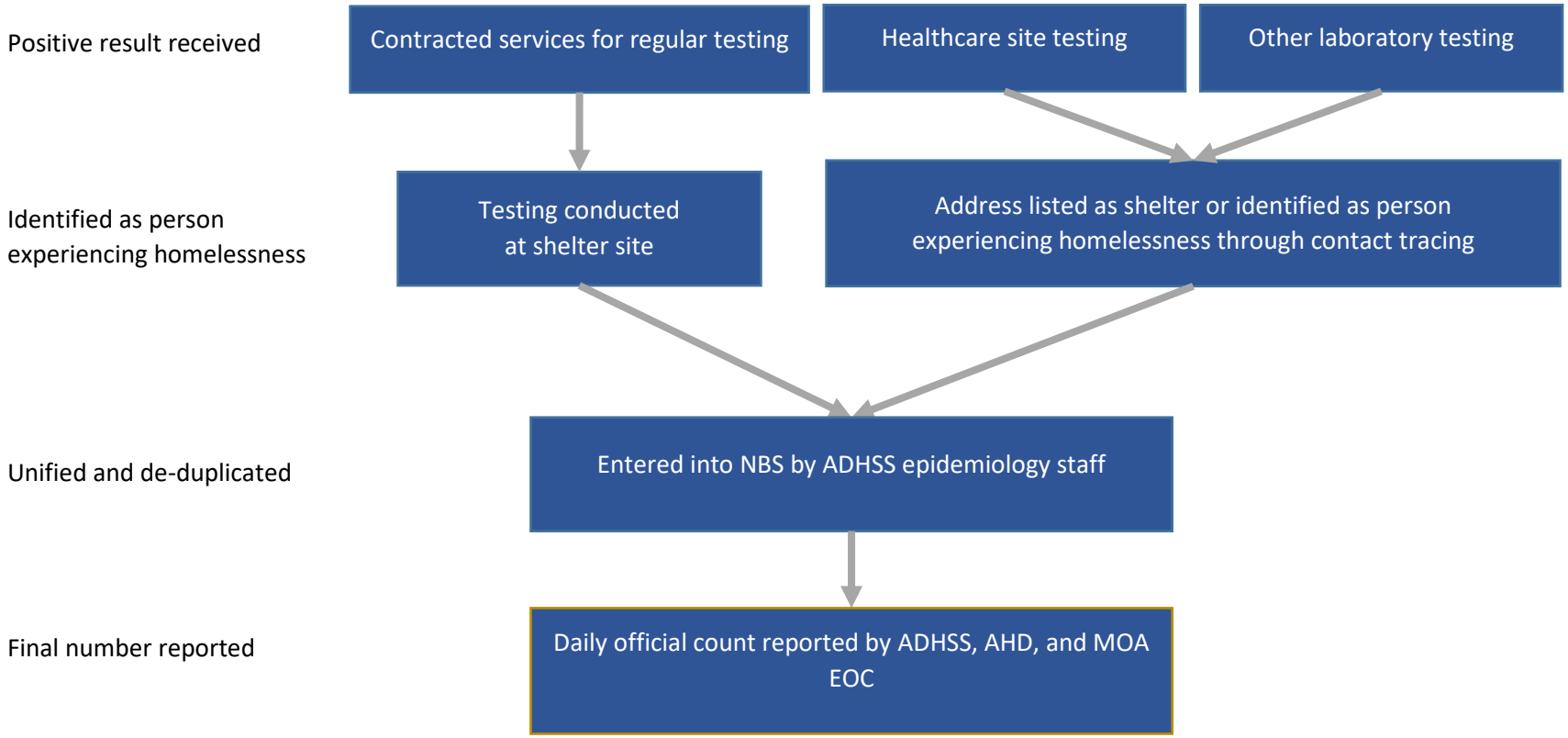
Figure 1. COVID-19 disease cases among people experiencing homelessness, by week of confirmation—Anchorage, Alaska (July 31–September 25, 2020)*



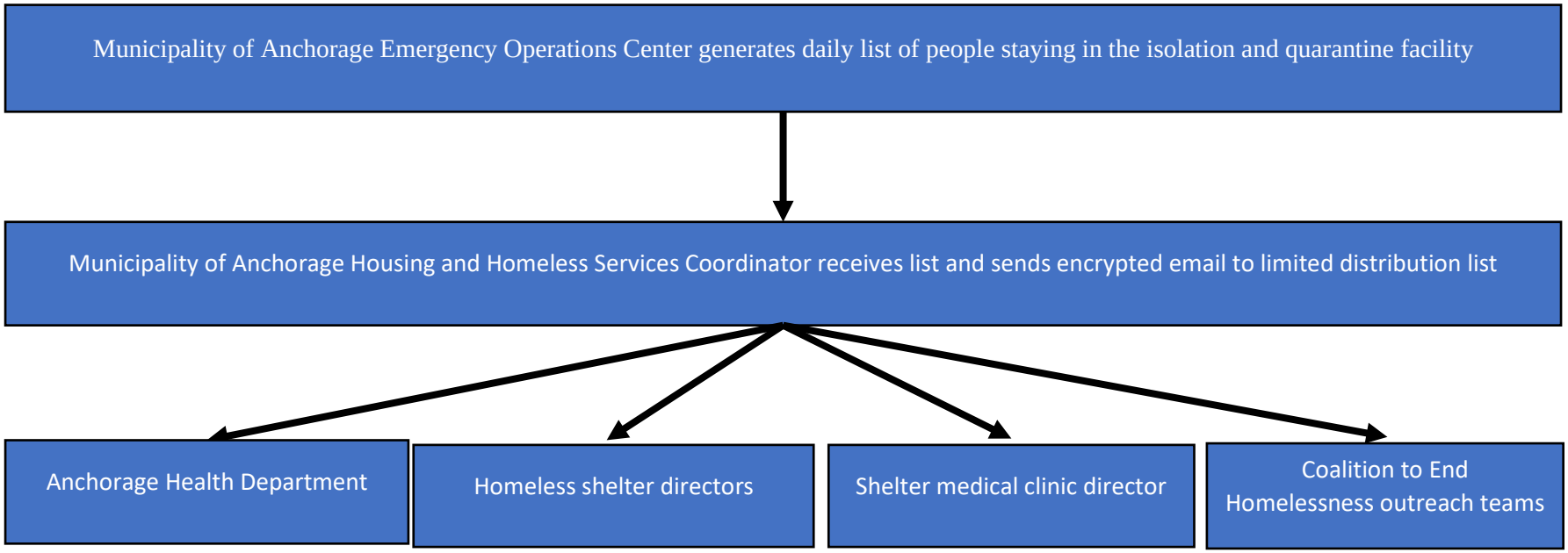
*Cases include staff of and clients in congregate and non-congregate shelters or transitional housing, and other people accessing homeless services.

Figure 2. Proposed case identification and reporting for COVID-19 cases among people experiencing homelessness in Anchorage, Alaska



NBS = NEDSS-based surveillance system; ADHSS = Alaska Department of Health and Social Services; AHD = Anchorage Health Department; MOA EOC = Municipality of Anchorage Emergency Operations Center

Figure 3. Proposed sharing of data with homeless shelter providers for people experiencing homelessness in isolation or quarantine for COVID-19—Anchorage, Alaska



Appendix A. Questionnaire for location-based contact tracing

Fill out this section before the interview if possible

Investigator Name:	*Date of Interview:*
Patient Name (Last, First):	Patient Date of Birth:
Current Sex: ☐ M ☐ F ☐ Other If F, are you pregnant? ☐ Y ☐ N	Patient Phone/email:
Current location: ☐ Homeless shelter/facility, name_____ ☐ Hospital, name_____ ☐ Other: _____	Spec collection date: ____/____/_____ Specimen collection location: _____ Initial infectious date: ____/____/_____ (2 days prior to start of symptoms. If no symptoms, then first positive test date)

Fill out this section during interview

Ethnicity:	Race (check all that apply):
☐Hispanic/Latino ☐Non-Hispanic/Latino ☐Unknown Tribal affiliation? ☐ Y ☐ N ☐ Unknown	☐Black ☐American Indian/Alaska Native ☐Caucasian ☐Native Hawaiian/Pacific Islander ☐Asian ☐Unknown ☐Other

You tested positive on _____(date/day)_____. Two days before that date would be ___(date/day)____. Please let me know if you have been to any of the following places between that time and now.

Where were you staying when you tested positive or became ill?
Did you attend school or daycare? List locations and dates.
Did you go to a job? List employer and locations.

Shelters			Estimated dates
Brother Francis Shelter	☐ Yes	☐ No	
Sullivan arena	☐ Yes	☐ No	
Gospel Rescue Mission	☐ Yes	☐ No	
Covenant House	☐ Yes	☐ No	
Clare House	☐ Yes	☐ No	
Other _____	☐ Yes	☐ No	
Camping			
Location _____	☐ Yes	☐ No	
Location _____	☐ Yes	☐ No	
Food			
Bean's Café	☐ Yes	☐ No	
Downtown Soup Kitchen	☐ Yes	☐ No	
Sullivan Arena	☐ Yes	☐ No	
Other _____	☐ Yes	☐ No	
Spending time			
Mental Health Consumer Web	☐ Yes	☐ No	
Park	☐ Yes	☐ No	
Other _____	☐ Yes	☐ No	
Other (e.g. jail, long term care facility, medical facility)			
Location _____	☐ Yes	☐ No	
Location _____	☐ Yes	☐ No	
Location _____	☐ Yes	☐ No	
Do you have a partner, family members, or other friends with that spend a lot of time with? Please provide name and contact information.			

Fill out this section using data from medics at the isolation hotel

Date of entry into isolation _____/_____/_____			Date of release from isolation: ____/_____/_____		
Underlying medical conditions? (prompt: heart disease, diabetes, lung disease or asthma, immunocompromised, etc.)					
Did the person have any of the following symptoms in the 2 weeks prior to isolation or at any point during isolation?					
Fever >100.4F (38C)	☐ Yes	☐ No ☐ Unk	Cough (new onset or worsening of chronic cough)	☐ Yes	☐ No ☐ Unk
Subjective fever (felt feverish)	☐ Yes	☐ No ☐ Unk	Wheezing	☐ Yes	☐ No ☐ Unk
Chills	☐ Yes	☐ No ☐ Unk	Shortness of breath (dyspnea)	☐ Yes	☐ No ☐ Unk
Rigors	☐ Yes	☐ No ☐ Unk	Difficulty breathing	☐ Yes	☐ No ☐ Unk
Muscle aches (myalgia)	☐ Yes	☐ No ☐ Unk	Chest pain	☐ Yes	☐ No ☐ Unk
Runny nose (rhinorrhea)	☐ Yes	☐ No ☐ Unk	Nausea or vomiting	☐ Yes	☐ No ☐ Unk
Sore throat	☐ Yes	☐ No ☐ Unk	Abdominal pain	☐ Yes	☐ No ☐ Unk
New olfactory and taste disorder(s)	☐ Yes	☐ No ☐ Unk	Diarrhea (≥3 loose stools per day)	☐ Yes	☐ No ☐ Unk
Headache	☐ Yes	☐ No ☐ Unk	Others	☐ Yes	☐ No ☐ Unk
Fatigue	☐ Yes	☐ No ☐ Unk	If yes, specify:		
Additional comments					
Onset of first symptoms reported____/_____/_____			Last date symptoms reported____/____/____		
☐ No symptoms reported 2 weeks prior or during isolation (asymptomatic)					
Hospitalized at any point during isolation? ☐ Y ☐ N; Location_____Dates____/____/_____					

Appendix B. Informing COVID-19 quarantine and isolation among people experiencing homelessness

Background and rationale

Homeless services are commonly provided in congregate settings, increasing the risk of spread of COVID-19 among people experiencing homelessness. Furthermore, people experiencing homelessness have a higher burden of underlying medical conditions that are associated with severe illness from COVID-19 and have been shown to be hospitalized more often than people in the general population. Therefore, public health measures to prevent spread of COVID-19 are necessary to protect people experiencing homelessness. For example, effective isolation of infectious cases of COVID-19 is imperative to decreasing transmission of disease. Throughout the United States, communities have set up alternate care sites for people who are not able to isolate or quarantine in a residence, such as people experiencing homelessness. However, encouraging people to stay in isolation or quarantine consistently has been identified as a problem at these alternate care sites. We propose to collect information from people experiencing homelessness who have been recommended to stay in public health isolation or quarantine to help inform barriers to remaining on site.

Objectives

1. Describe the barriers to public health isolation or quarantine at alternative care sites for people experiencing homelessness, including the role substance use disorder may play in behaviors associated with breaking isolation or quarantine protocols.
2. Describe opportunities to improve services to help individuals remain in public health isolation and quarantine.

Methods

We propose to conduct a mixed methods assessment of barriers and facilitators to public health isolation and quarantine among people experiencing homelessness who are COVID-19 positive or recently medically cleared. We will enroll up to 50 people, over the age of 18, experiencing homelessness at the isolation and quarantine site in Anchorage, Alaska. All participants will be asked to complete a brief survey (Question 1-6 in Appendix A). Approximately 25 of the participants will be asked to complete an additional short qualitative interview (Question 7-9 in Appendix A). Topic areas will include barriers to maintaining isolation, including probes for issues around perceived unfilled needs (e.g., food and social activity) and substance use, and ideas for enhancing isolation services [**Qualitative survey and interview form**]. Analysis will be performed on the survey and field notes from the interviews. Field notes and survey results will be transcribed to a secure computer and then shredded. The data obtained will be presented in a descriptive fashion so no statistical analysis will occur. Written consent will be obtained from all participants prior to the interview [**Consent form**].

Collaborators

- Anchorage Health Department
- Alaska Department of Health and Social Services
- Centers for Disease Control and Prevention
- Anchorage Coalition to End Homelessness

Qualitative survey and interview

Questionnaire: Barriers and facilitators of public health isolation												
Section 1: Complete as much of this section as possible prior to the interview. If client declines to complete the survey please note their age, sex and mark "No" under "Consented to Survey".												
Introduction: "Hi my name is _____. I am here to conduct an interview to help the Anchorage Health Department learn how we can help people stay in insolation or quarantine in this hotel. I would like to ask you a few questions about your stay, which should take less than 15 minutes. Your answers will be completely confidential, and we won't write down your name or other identifying information. I will be writing down your answers on this paper which will be shredded once we summarize the results. You don't have to participate and can choose not to answer any questions at any time. If this sounds ok to you, please read through this consent form and sign at the bottom."												
Interviewer name:							**Interview date**:	/ /				
1. Patient age							**Interview site:**					
2. Current sex:	Male	☐	Female	☐	Other	☐	**Consented to Survey:**	Yes	☐	No	☐	
Completed Survey?	Yes	☐	Refused	☐	Not Present (after 2 attempts)	☐						
Section 2: In-person survey (*Ask questions in past tense if you are talking with someone who was recently discharged from the hotel)*												
3. I'm going to ask you a few questions about leaving your room. Do you leave your room during the day for any of the following reasons:												
	a.	To get food?						Yes	☐	No	☐	
	b.	To see your friends or family?						Yes	☐	No	☐	
	c.	To see a spouse or partner?						Yes	☐	No	☐	
	d.	To take care of children or dependents?						Yes	☐	No	☐	
	e.	To seek medical care?						Yes	☐	No	☐	
	f.	To get mental health treatment?						Yes	☐	No	☐	
	g.	To go to work?						Yes	☐	No	☐	
	h.	To spend time outside?						Yes	☐	No	☐	
	i	To smoke or use tobacco/nicotine products?						Yes	☐	No	☐	
	i.	To drink alcohol or use drugs?						Yes	☐	No	☐	
4. Would you be willing to stay in your room more often if there were:												
	a.	Different food options?						Yes	☐	No	☐	
	b.	Different entertainment options?						Yes	☐	No	☐	
	c.	Your friends or family were here?						Yes	☐	No	☐	
	d.	Different medical care available here?						Yes	☐	No	☐	
	e.	Mental health treatment available here?						Yes	☐	No	☐	
	f.	A space to spend time outside?						Yes	☐	No	☐	
	g.	Housing and case management services here?						Yes	☐	No	☐	
	h.	Substance use treatment available here?						Yes	☐	No	☐	
5. Do you currently use any of the following substances on a regular basis (more days than not)?												
	a.	Alcohol						Yes	☐	No	☐	
	b	Marijuana						Yes	☐	No	☐	
	c.	Opioids						Yes	☐	No	☐	
	d.	Stimulants (cocaine, amphetamines etc)						Yes	☐	No	☐	
	e.	Sedatives or Tranquilizers (Benzodiazepines, sleeping pills etc)						Yes	☐	No	☐	
6. Since you've been at this hotel, have you had any symptoms that you feel were from withdrawal from drugs or alcohol?												
								Yes	☐	No	☐	
7. Are you currently undergoing any medical treatment for use or addiction to a drug or alcohol?												
								Yes	☐	No	☐	
8. Are you currently undergoing any counseling for drug or alcohol use or addiction?												
								Yes	☐	No	☐	

Section 3: In person qualitative interview. Reminder to interviewers: Asking the prompts is not required. Use them if warranted by the conversation. **"Thank you for your answers. Would it be ok to ask you just a few more questions?"**
8. Can you tell me why you are staying in this hotel? **Prompt: Do you know why people with COVID-19 (also called the coronavirus) are supposed to stay here?**
9. Can you tell me more about the reasons you leave the room? **Prompt: Earlier you mentioned X; can you tell me more about that?** **Prompt: Can you tell me how alcohol or drug use might contribute to you leaving your room.**
10. What are some things or services that would help you stay in your room? **Prompt: Earlier you mentioned X; can you tell me more about that?** **Prompt: If you were able to quarantine with a spouse or family would that make you more likely to stay in your room? Explain.**

Barriers and facilitators of public health isolation among people experiencing homelessness
Consent form

Purpose
The Centers for Disease Control and Prevention and community partners are conducting interviews with men and women experiencing homelessness to learn about their experience with isolation and quarantine during the COVID-19 pandemic. These interviews will help us determine what factors contribute to people leaving isolation and quarantine and help give the health department recommendations on resources to provide clients while under isolation and quarantine. We expect this interview to take no more than 30 minutes. In the interview we will discuss behaviors associated with leaving quarantine and what resources that you the client would need in order to comply with isolation procedures.
You are the expert on your experience, and your thoughts and opinions are greatly valued and appreciated. We want to learn from you. We encourage you to speak openly and honestly about your experience. There are no right or wrong answers. Should you agree to participate, here are some points you should know.

- **Rights regarding participation**. This interview is completely voluntary. You may choose not to participate or not answer any question at any time for any reason.
- **Privacy**. We will take every precaution to protect your identity and ensure your privacy unless otherwise determined by law. These interviews are anonymous, and we will not be collecting your name. All responses will be summarized anonymously. We will never use your name or the facility's name in any reports.
- **Benefits**. Your participation in these interviews will not result in any direct benefits to you. However, your input will help to develop strategies to better help people staying in isolation.
- **Risks**. These interviews pose minimal, if any, risks to you. You are free to not answer any questions that you find too intrusive or sensitive.
- **Compensation**. You will not receive monetary compensation for your participation.
- **Notes**. We will take notes to help us keep track of your responses. No quotes or comments you make will be linked with your name in any way. We will keep all information and locked in a file cabinet or a secure computer file. Only project staff will be able to access the information. These notes will be destroyed upon conclusion of the project.
- **Questions**. We will answer any questions that you have about this interview before we begin.
- **Contact Numbers**. If you have any questions about this interview, please contact Dr. Matthew Eisenstat 803-292-3952.

Your Consent
The above document describing the benefits, risks, and procedures for this project has been explained to me. I had a chance to ask questions, and my questions were answered. I was given a copy of this consent form. I agree to participate.

_____ _____
Participant **Date**

_____ _____
Interviewer **Date**

Appendix C. Identifying when facility-wide testing in homeless shelters or encampments is indicated

	None to minimal	Minimal to moderate	Moderate to Substantial
Community Transmission Description	Isolated cases or limited community transmission; case investigations under way; no evidence of exposure in large communal setting	Sustained transmission that is not large-scale but with high likelihood or confirmed exposure in communal settings and with the potential for rapid increase in cases	Large-scale, uncontrolled or controlled community transmission, including in communal settings
Baseline Activities	Conduct regular case identification and investigation*	Increase access to testing at the site according to designated criteria**	Consider initial and regular facility-wide testing
When to conduct facility-wide testing	A laboratory-confirmed case is identified at the site, or A laboratory-confirmed case is identified in a sentinel site***, or A cluster of probable cases at the site exceeds a pre-determined threshold, or A site is identified in location-based contact tracing		No trigger needed; follow-up testing triggered if cases are identified

***Passive surveillance.**
****Active surveillance**
*****Sentinel site is a site that provides a signal for whether outbreaks might be occurring at adjacent sites**

Appendix D. CDC COVID-19 Response guidance related to homelessness

Interim guidance for homeless service providers (Aug 5)

Interim guidance on people experiencing unsheltered homelessness (Aug 6)

Investigating cases in homeless shelters (Aug 6)

Testing in homeless shelters & encampments (Aug 3)

Performing broad-based testing for SARS-CoV-2 in congregate settings (Jun 27)

Universal COVID-19 Testing at Homeless Service Sites (National Healthcare for Homelessness Council)

COVID-19 and homelessness services training for homeless shelter workers

Youth experiencing homelessness (Aug 1)

People experiencing homelessness (Aug 10)

Checklist for homeless service providers during community re-opening (May 16)

Screening clients for COVID-19 at homeless shelters or encampments (Aug 3)