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Covid-19 Prioritization Triage Tool

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Abstract

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Smart Path to Housing and Health, an agency a part of the Santa Cruz County Department of Human Services is a local homeless action organization that specializes in a coordinated entry system that provides access to housing and service assistance to low income and people who are experiencing homelessness. Homelessness is a complex macro social and health issue that affects the quality of life because it increases unhealthy conditions for people living in poverty or who's neighborhoods surround these encampments. Contributing factors such as lack of affordable housing, eligibility requirements, poverty, poor physical and mental health, addictions, and broken family relationships have all stemmed from homelessness consequently resulting in chronic homelessness, emotional barriers, and trauma. Evidently, with the rise of Covid-19, homelessness has significantly been impacted due to greater risk of increased homelessness, limited shelter space, and limited social service resources being available during mandatory shelter in place orders. To help protect persons experiencing homelessness during Covid-19, Smart Path has implemented a new tool called the Temporary Permanent Housing Prioritization Tool which was used to prioritize persons who face increased risk of mortality from Covid-19 for rehousing programs. Furthermore, the agency has found that the tool was successful in providing housing opportunities to the individuals and families who went through the triage process of the project. One recommendation for the prioritization process would be to implement ways to prioritize not only elderly and high risk individuals during Covid-19, but to also give an equal opportunity to young adults so that they can also get rehousing opportunities.

Agency & Communities Served

Smart Path to Housing and Health is an agency a part of the County of Santa Cruz Department of Human Services. The agency is a project of the local Homeless Action Partnership (Smart Path, n.d.). Smart Path is a coordinated data entry system that assists a wide range of individuals and families who are homeless or experiencing homelessness with access to housing and services for their immediate needs. Their mission is to strengthen the community by protecting the vulnerable, promoting self-sufficiency, alleviating poverty, and improving the quality of life (Santa Cruz County, n.d.). Some of the programs provided through the County of Santa Cruz Department of Human Services include assistance with health insurance, non-cash benefits such as CalFresh, senior protective and dependent senior in home care services, child and family assistance with homelessness and child protective services, child adoptions, and veteran services. Smart Path to Housing and Health also manages up to 3 motels that provide temporary living to homeless individuals who currently reside in Santa Cruz. According to the United States Census Bureau (2019), Santa Cruz County has a population of 273,213 people. Of that current population, 87% are White, 1.5% are African American, 1.8% are American Indian, 5.3% are Asian, 0.2% Native Hawaiian and other Pacific Islander, 4.2% are two or more races, and 34.0% are Hispanic or Latino people. People who are living in poverty are 10.6% of the population, 7.3% living without health insurance who are under 65 years old, 8.8.% with a disability under the age of 65 years old, and 10,208 veterans residing in Santa Cruz County (Census, 2019.) According to the Census (2019) most of the population is made up of female individuals who account for 50.5% of the population, 4.9% are persons under 5 years old, 19% of persons under 18 years old, and 17.3% of persons are 65 years old and over.

Problem Description

Homelessness is a complex macro social and health issue that affects the quality of life for individuals and families. It is an issue that affects an entire community whether experienced or not. There are a variety of social and health issues that stem from homelessness such as economic factors of lack of affordable housing, poverty, poor physical and mental health, addictions, and broken family relationships. These all contribute to and affect human quality of life because it creates and increases unhealthy conditions for people living in poverty or who's neighborhoods surround these encampments. Evidently, it is a global issue that has continued to spike after recents events of Covid-19 creating more instability with mandatory lockdowns, loss of jobs, and inability to access resources.

Contributing Factors

Lack of Affordable Housing

Many American families and individuals struggle with maintaining permanent housing due to an increasing housing market across the country. According to the National Alliance to End Homelessness (2019), there is an immense gap between increased housing markets and underpaid jobs leaving more people homeless. This is significantly true due to families and individuals losing their jobs, getting pay cuts, and businesses closing down specifically due to Covid-19 stay in place orders which contributed to an increase in people becoming homeless.With a global pandemic as well as the lack of affordable housing, it has made it difficult for many people to obtain a stable livelihood and provide for their families or self. In addition, low income housing is extremely difficult to get with high volumes of individuals putting their name down on a waiting list. It can take up to 3 years to finally get the opportunity

to be housed for low income. According to The National Alliance (2019), affordable housing has decreased over time leaving many to become homeless if there is not a solution geared towards providing more affordable and low income housing opportunities.

Eligibility

Eligibility requirements are an immense barrier for a lot of people who are experiencing homelessness. One of the biggest eligibility requirements has to do with vital documentation such as an identification card, social security, birth certificate, and proof of income. However, being without a stable safe environment can play a huge role in not being able to have these vital documents on hand. Theft, misplacement, and no technology contributes to not being able to obtain vital documentation. In order to get housing, one has to have their vitals on hand with them. It is so essential in getting one thing after another in the process of getting an individual or family housed. Some may even have a hard time getting into shelters due to other eligibility requirements such as, lack of shelter space, demographics, medical, and dependent needs. This can cause an increase in homeless cases and prolong homelessness for individuals and families.

Relationships

Relationships are a beautiful and ever growing experience with the people we meet. Sometimes these relationships are intimate and often could just be a person's support system such as family. It is easy to only look at homelessness as an issue due to substance abuse, lack of affordable housing, or poverty, but damaged relationships have a lot to do with why individuals are or experience homelessness. Divorce, domestic violence, family conflict, and eviction because of a family member are all factors to be considered when identifying why some people have become homeless. According to the National Alliance to End Homelessness (2019)

domestic violence is a common contributing factor for youth, single adults, and families. For many it is the immediate contributor to why a person or family is homeless due to fleeing dangerous situations (The National Alliance to End Homelessness, 2019.) Frequently, homelessness can start because a client has experienced family conflicts resulting in a family member making them homeless. This can be due to someone not being able to pay their portion of the bill, violence, and conflicting disagreements. Divorce is also seen as a contributing factor of why families and single adults become homeless. In a divroce one or both parties have to pay out a lot of money to move forward with the legal separation. This could be a financial burden on each person which could result in one or both adults to experience poverty or homelessness. In addition, divorces break up a family unit causing each adult and sometimes children to figure out where they will create their new lives which can sometimes result in poverty or homelessness.

Consequences

Increase homelessness

Lack of affordable housing and accessible opportunities for low income housing due to waitlists is a primary cause of homelessness. This issue will be the cause of increased poverty, homelessness, and prolonged homelessness also known as chronic homelessness. The National Alliance to End Homelessness (2019) showed that this year has been one of the most severe affordable housing crises leaving people who live in poverty more affected. If the situation is not resolved with government assistance to provide more affordable housing and building more low income housing for single adults and families, many American individuals will be left with no choice, but to end up homeless in unsheltered environments such as places not meant for habitation.

Emotional Barriers

Homeless individuals already experience emotions that make them feel sad, hopeless, and embarrassed. Having to obtain all their vital documents and make it to an appointment is often very overwhelming for an individual who does not have the means of transportation. This can often lead many not moving forward in getting the help they need. The amount of time waiting to actually receive these services and documents can also cause emotional barriers such as losing faith or trust in programs or services which can cause stigmatization with the few sources that are available. As a result, the lack of services is related to the many emotional barriers that can be a roadblock between homelessness and case workers.

Trauma

Deeply distressing and disturbing experiences cause a lot of negative health conditions and coping mechanisms for a person. Some homeless individuals will result in substance abuse to cope with the trauma of domestic violence, a broken family relationship, trauma due to becoming homeless, mental health, and exposure to unsafe environments. Mental health is one of the leading outcomes of homelessness resulting in unstable lifestyles. Murray states (2017), **"**mental illness as another major cause of homelessness, which often leads to drug and alcohol abuse." Homelessness itself is traumatic and distills terror for many individuals and families. It creates more trauma as people who are homeless or experiencing homelessness have to combat personal challenges, unsafe and unhealthy environments, and mental health all in one.

Problem Model

Contributing Factors	Problem	Consequences
Lack of affordable housing	Homelessness is a complex macro social and health issue that affects the quality of life for individuals and families.	Increase homelessness/chronic homelessness
Eligibility barriers		Stigma, embarrassment, unmotivation, and no trust in programs. Unable to get to services to get help.
Relationships		Trauma, mental health, and substance abuse

Capstone Project Description and Justification

Capstone Project

Covid-19 has significantly impacted the lives of everyone. It has specifically been worse for people who are experiencing homelessness due to economic consequences that posed greater risk of people becoming homeless, limited shelter space, and limited social service resources being available during shelter in place orders. Smart Path to Housing and Health seeks to prioritize persons considered to be the most vulnerable while providing shelter to individuals at motels they are contracted with. To help protect persons experiencing homelessness during Covid-19, Smart Path has come up with a new tool called the Temporary Permanent Housing Prioritization Tool which will be used to prioritize persons who face increased risk of mortality from Covid-19 for permanent housing programs.

Project Purpose

Smart Path to Housing and Health is embarking on a rehousing wave which will provide housing opportunities to as many people who are residing at the Covid-19 motel and shelters.

The purpose of the project is to obtain triage levels of participants to prioritize persons for limited motel and shelter openings, as well as, prioritize for available housing resources based on their vulnerability, triage level, and other factors. Eligibility criteria has been a barrier to many people experiencing homelessness due to age and or medical conditions. This tool is designed to specifically protect the vulnerable based on age and or medical conditions and helps to provide appropriate housing resources for at-risk persons of Covid-19 during a global crisis to be considered for the rehousing wave programs.

Project Justification

Some individuals are at an increased risk of more severe medical illnesses and fatality due to age and or medical conditions. This makes these individuals more at risk of Covid-19 and the severe illness that comes with it putting them in unhealthy circumstances or death. The triage prioritization tool is a project that helps to determine the level of vulnerability for each client who faces mortality and helps to prioritize their eligibility for Covid-19 motel/shelter spots, as well as, rehousing opportunities. According to the CDC the most vulnerable populations are people who are 65 years old or older. This population is at a higher risk for severe illness than people who are in their 50's and below (CDC, 2019.) Research shows that 80% of Covid-19 deaths occured in people over the age of 65 and 95% occurred in people who are older than 45 years old (CDC, 2019.) Within the agency, Smart Path services many adults who are 50 years old and over. Furthermore, people who have chronic medical conditions with their liver, heart, lungs, kidneys, and stomach (weak immune system) are deemed a high at risk population according to the CDC guidelines. This can put a lot of people in danger of Covid-19. In order to maintain and keep everyone safe, the triage tool is used to prioritize the most vulnerable to Covid-19 by

collecting triage levels so that they can be eligible for Covid-19 motels, shelters, and rehousing opportunities.

Project Implementation

The Prioritization Housing Tool has been implemented and revised in August of 2020. In order to help protect people experiencing homelessness who face increased risk of mortality from Covid-19, Smart Path will utilize this tool as a referral system to collect triage information and identify the most vulnerable to Covid-19. Furthemore, there is a ranking of each vulnerability to Covid-19. These rankings are P4 absolute, high, medium, and or low. For example, people who are identified as P4 absolute are deemed both highly vulnerable to Covid-19 and have medical conditions that make them extremely at risk outside of Covid-19. Absolute individuals will be prioritized first for assistance, while people in the P4 high category will be the next group to be prioritized, followed by medium, and low. Individuals who do not have any conditions that make them vulnerable to Covid-19 and who are not 65 years old or older will be prioritized by the usual Smart Path coordinated data entry assessment tool used to process participants and will be considered P5 or priority 5. Smart Path has developed a report in HMIS that prioritizes people in the motels and shelters based on their triage level and other factors. In order for individuals' triage level to be used for the report, it needs to be included in the Homeless Management Information System HMIS. The report later comes to me and I enter the triage information into HMIS which is a vital key piece for clients to be considered for rehousing wave programs and protected from Covid-19.

Assessment Plan

To determine the effectiveness of the triage data collected for the Temporary Permanent Housing Tool, data will be collected over time and entered into HMIS. When data is collected in HMIS for each client being processed through the triage data tool, the Coordinated Entry team from Smart Path to Housing Health will determine by triage vulnerability where a client and or family will be located based on how high the triage level is. There will be data recorded with the number of individuals and households at the end of the process and shown in a table to determine the effectiveness of the triage tool. This data will then be explained and determined if the tool was successful for its first run. No surveys were needed in this process because clients and families will either be moved into congregate shelter or Project Roomkey shelters.

Expected Outcomes

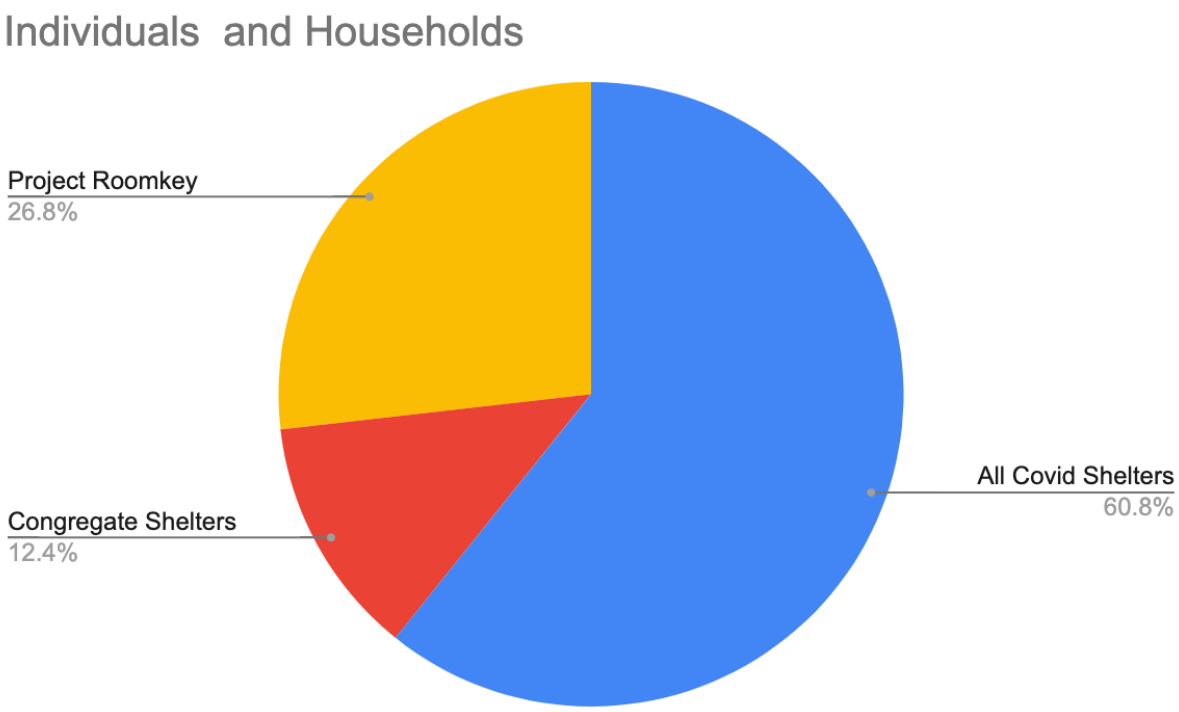
The main outcome of the project is to get the most vulnerable population who are at high risk to Covid-19 and provide rehousing opportunities to them. The project will shed light on how to better protect vulnerable individuals and protect the health of others by prioritizing their needs first. Homelessness is a macro level problem for a lot of communities. It takes a village in decreasing it and providing reliable and effective services to the homeless population. This project will help to ensure that people who are the most vulnerable due to Covid-19 and other medical factors will be steps further in their goal to a stable and protective healthy environment. With the continuation of this tool, it can be the blueprint for other organizations to use in the future should there be a global pandemic where prioritization in getting people off the streets and into a safe environment to stop the spread of any global virus is needed. It can also be a helping tool to provide new ways to provide rehousing opportunities to families and individuals using the tool for general usage within the community and for other agencies.

Project Results

The Covid-19 triage was successful in providing rehousing opportunities to individuals and families. The tool was organized to prioritize the most vulnerable groups of people by categorizing them by level of high risk during the pandemic. Age and medical history were a determining factor of how at risk an individual is due to Covid-19 and CDC guidelines. Many of the individuals who were triaged were able to be determined for congregate and non-congregate rehousing opportunities. All Covid shelters within the Santa Cruz jurisdiction had a total of 1,079 individual clients and 928 households that were either placed in congregate shared living shelters, Project Roomkey/Isolation (p1-p3), or Project Roomkey/shelters. Over the span of one year, many clients were triaged for rehousing opportunities by entering a single triage level for each client into a shared datasource called the Homeless Information Management System, also known as HMIS. The data was then assessed by collaborating agencies and staff to determine rehousing status. Clients that went through the triage system were considered for the congregate shelters and Project Roomkey/shelters. According to the data, out of the individual clients, 221 went to congregate shelters and 476 went to Project Roomkey/shelters. Out of households 204 went to congregate shelters, while 390 went to Project Roomkey/shelters. Furthermore, 697 individuals and 594 households successfully received rehousing which determined the effectiveness of the Covid-19 triage system during the pandemic with an overall success rate of 1,291 clients rehoused in congregate/non-congregate shelters.

Covid Shelter Type	Individuals	Households
All Covid Shelters (total)	1,079	928
Congregate Shelters	221	204

Project Roomkey/Shelters	476	390



Conclusion & Recommendations

The Covid-19 Prioritization Tool was developed to provide rehousing opportunities to vulnerable homeless individuals and families who are at high risk for Covid. In determining who was the most vulnerable, prioritization levels were recorded and inputted into the shared database based on age and medical history. Furthermore, it allowed many elderly individuals to be processed as the prioritization since they were deemed the most vulnerable due to age and medical history using CDC guidelines. Although this was a success in identifying the most vulnerable to Covid-19, one recommendation was to find ways to prioritize young adults as well

so that they may get an equal opportunity for rehousing waves. Should the agency keep the triage tool as a source to continue to prioritize clients into rehousing opportunities, the agency should look more outside of Covid-19 and more into socioeconomic issues such as health outcomes in demographics and not just in age, whether or not a client's environment is health or not, is a client dealing with addiction or discrimination, income and occupation issues, education, and measure inequities to resources. All these social determinants are things that play a huge role in the status of an individual's livelihood. There should be added categories to the triage tool to determine the at risk a population is due to their situations they face on a daily basis to help clients achieve not just rehousing, but to maintain their home and stability to their livelihood. This would open the age gap up between elderly and young adults so that everyone can get a chance to be prioritized in the process outside of Covid-19. In closing, the triage tool was a successful implementation and addition to the agency. It did exactly what it was intended to do and rehoused individual and family clientele during one of the Nation's most severe crises witnessed. The Covid-19 triage tool will be a stepping stone for Smart Path in continuing to grow and rehouse more clients as time goes on.

Personal Reflection

During my time interning for Smart Path to Housing and Health, I grew more knowledgeable and even more passionate about working in the Human Services field. The amount of experience retained while interning over the course of three semesters had opened up many doors leading to serving the homeless population with the knowledge I gained. Some of the skills that I learned was mainly how coordinated entry data systems work and how it funnels clients through a system where they can get the shelter and health services they need. Another

big part of my capstone was understanding and learning more about how a crisis such as the Covid-19 pandemic can heavily impact the homeless population. There were extensive procedures that took place between the agency and other collaborating agencies in creating and managing emergency shelters during the pandemic for people experiencing homelessness. In efforts to protect people experiencing homelessness, the agency created a new way to prioritize high at risk clients incorporating health and age. What I learned most about being a part of the process of this project was how essential it is to involve a whole community of shelter and health providers to better assist people experiencing homelessness connecting them to a healthy environment of shelter. The triage tool was a success in providing shelter for those experiencing homelessness. One of the limitations or challenges to this project design was being remote. Only being able to zoom made it more difficult not getting hands-on experience in the process. I was only able to enter data during this time because of limitations to being on sight with my agency. The significance of this project really pinpointed the social issue of homelessness and how health can be directly impacted. More specifically, it addresses how tools such as this project can make a difference in connecting clients to housing in the event of emergency shutdowns due to a pandemic. Something that this project highlights is how vital it is to work together in protecting one another in trying times using new technology tools to continue working towards protecting the quality of life for people who are experiencing homelessness. For future Smart Path to Housing and Health interns, one piece of advice I can give is to work onsite if that is an option through the agency because you will get more hands-on experience than what you can gain being remote.

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Appendix A

Scope of Work

Activities	Deliverables	Timeline/Deadlines	Supporting Staff
Entered triage data from April and ended the project in October.	None	April 15, 2021/October 12, 2021	Mentor