Public Health and Homelessness in the United States: Findings from a Nationwide Landscape Assessment, 2023

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Prepared by The Cloudburst Group

Abstract

This white paper provides an overview of public health department activities for people experiencing homelessness in 2023. Drawing on interviews with 25 public health departments, surveys with 273 public health entities, and 116 survey responses from Health Care for the Homeless organizations, Continuums of Care, and Supplemental Security Income/Social Security Disability Insurance Outreach, Access, and Recovery partners, the analysis focuses on changes to the health-homelessness landscape since engaging in COVID-19 response. The findings show that the urgency of COVID-19 introduced new partnerships, programs, and resources into public health. However, many communities still struggle with adequate staffing and the long-term sustainability of these efforts.

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Executive Summary

The COVID-19 pandemic highlighted and exacerbated deeply rooted and long-lasting health disparities for people experiencing homelessness in the United States. Federal, state and territorial, local, and tribal (STLT) public health agencies were critical for preventing infection and promoting vaccination among people experiencing homelessness. STLT public health departments with existing homeless service provider partnerships were able to mobilize quickly to support the health of people experiencing homelessness; for others, the COVID-19 pandemic served as a catalyst for establishing new partnerships between public health and homeless services.

In 2021, the CDC Foundation launched a pilot program to establish Centers of Excellence in Public Health and Homelessness in three health departments. The CDC Foundation and the Centers for Disease Control and Prevention (CDC) purposely selected these health departments because of their extensive efforts and successes in bridging the gap between homeless services and public health. While these pilot sites are leaders in supporting the health of people experiencing homelessness in their jurisdictions, little is known about homelessness and health efforts at other health departments and public health organizations across the U.S. The CDC Foundation selected the Cloudburst Group (Cloudburst) to conduct a landscape assessment of health departments to understand their capacity and efforts to support the health of people experiencing homelessness in their jurisdictions.

Using web-based surveys and key informant interviews from March–May 2023, Cloudburst assessed public health department operations and structure, partnerships and partner communications, programs and activities, data and evaluation, and challenges and successes as they pertain to health and homelessness. Cloudburst also distributed surveys to Health Care for the Homeless (HCH) program contacts, Continuum of Care (CoC) points of contact, and government contacts of the U.S. Substance Abuse and Mental Health Services Administration's (SAMHSA's) Supplemental Security Income (SSI)/Social Security Disability Insurance (SSDI) Outreach, Access, and Recovery (SOAR) program to elucidate partner perceptions of public health partnerships.

Of the 273 health departments that completed the survey, 12 percent represented a state, territory, or tribal nation; 65 percent represented a county; and 22 percent represented a city or other locality. Cloudburst interviewed 25 health departments were interviewed, of which 40 percent represented a state or territory, 48 percent represented a county, and 12 percent represented a city or other locality.

More than half (55 percent) of the surveyed health departments indicated that there is no single point person for health and homelessness within their organization, but that many people do work related to homelessness within their methodological or disease-specific roles. Only 16 percent of health departments reported that they had a designated point of contact for health and homelessness activities.

Health department roles and levels of involvement in health and homelessness activities varied. In some jurisdictions, public health played a coordinating role, responsible for convening relevant health, homelessness, and other social services in their jurisdictions. Others described active

roles in hosting vaccination events, conducting infectious disease screening and testing within homeless service sites, and providing services to people living unsheltered or in homeless encampments.

Health departments described being understaffed and underfunded to do the health and homelessness work they felt was necessary. While there was an influx of funds and staffing during the COVID-19 pandemic, these funds are running out and leaving health departments without the necessary infrastructure to maintain new or strengthened partnerships and activities. If health departments had adequate and stable staffing and funding, they would strengthen existing partnerships, establish new partnerships, provide a wider range of health services for people experiencing homelessness, link public health and homeless services data to improve understanding of population-level health metrics, and expand opportunities to connect people to housing and other essential services.

Overall, participants described the COVID-19 pandemic as a significant facilitator of partnerships and efforts that were long overdue to support the health of people experiencing homelessness. As the future of public health continues to take shape after the emergence of COVID-19, embedding homelessness staff and resources within public health departments will be paramount to addressing homelessness as a health equity issue. In the meantime, health departments can consider identifying primary points of contact for homelessness activities among their existing staff. Health departments and homeless service providers together can work to establish new partnerships or formalize existing partnerships so that when the next public health threat emerges, jurisdictions are able to efficiently and effectively prevent disease and promote health among people experiencing homelessness.

Background

On any given night in the U.S. in 2022, the U.S. Department of Housing and Urban Development (HUD) estimated that there were more than 582,000 people experiencing homelessness *(see ref. 1)*. Most identified as male (61 percent) and were over 24 years of age (76 percent) *(see ref. 1)*. Significant racial disparities in those who experience homelessness persist. In 2022, people identifying as American Indian, Alaska Native, or Black or African American comprised 40 percent of the population of people experiencing homelessness, despite representing less than 20 percent of the total U.S. population *see refs. 1–2)*. Additionally, nearly one-third (30 percent) of all individuals experiencing homelessness had chronic patterns of homelessness, meaning they have a disability and have experienced homelessness for extended periods of time *(see ref. 1)*.

People experiencing homelessness are also more likely to experience early childhood adversity, live with complex trauma and experience traumatic events frequently, and have severe mental illness and substance use disorders *(see refs. 3–6)*. Research has shown that people experiencing homelessness are disproportionately affected by infectious and non-infectious diseases and are more likely to die at younger ages than their housed counterparts *(see refs. 7–15)*. Some drivers of these health disparities are due to stigma, discrimination, and inaccessible health care. People experiencing homelessness report experiences of stigma and discrimination in health care settings and find it challenging to navigate health care services that require numerous follow-up visits *(see refs. 16–17)*. They also face additional challenges around distance to services and transportation and financing health care and insurance coverage *(see refs.16–19)*. Inaccessible health care inhibits preventive screening as well as treatment and maintenance of health conditions.

A recent framework proposed by researchers from the CDC situates health care services, disease prevention, and wrap-around support services for people experiencing homelessness within the broader scope of homelessness prevention *(see ref. 20)*. This framework calls clinical groups, like HCH, other street medicine or backpack medicine teams, as well as public health agencies to the table as critical actors in preventing disease and homelessness. The field of public health, which is focused on preventing disease and promoting the health of populations and groups of people, is conceptually poised to support the health of people experiencing homelessness.

The COVID-19 pandemic exacerbated and illuminated health and social inequities faced by people experiencing homelessness. Across the United States, STLT public health agencies were called upon to support the prevention and amelioration of COVID-19 in congregate homeless service settings and among people experiencing homelessness broadly (see ref. 21). Facility-wide outbreaks of COVID-19 in homeless shelters, higher rates of hospitalization from severe COVID-19 illness, and lower vaccination coverage among people experiencing homelessness were reflective of inadequate investment in STLT public health infrastructure (see refs. 7, 12–14, and 21–26). Some STLT public health agencies were able to adapt more easily because of prior health and homelessness partnerships and activities. For others, the COVID-19 pandemic provided the platform to establish multi-sector partnerships between public health, homeless services, and other community support organizations (see ref. 21). Since the onset of the COVID-19 pandemic, federal programs were established to encourage collaboration between public health and homeless service agencies, though other types of coordination have happened organically in

communities and without dedicated funding. This white paper provides an overview of programs operating at the nexus of health and homelessness throughout the country, with a focus on conditions that have facilitated and challenged these partnerships and activities.

In 2021, a federal investment that allowed for COVID-19 testing and mitigation in homeless service sites and other congregate settings provided additional resources to bolster public health capacity for supporting the health of people experiencing homelessness. These resources, administered through the CDC's Epidemiology and Laboratory Capacity (ELC) cooperative agreement with all state and territorial health departments, are further supported by technical assistance providers from HUD (see ref. 27). In addition to joint assistance from the CDC and HUD on the implementation of the ELC COVID-19 detection and mitigation funds, the Peer-to-Peer Network on Public Health and Homelessness was established by the CDC Foundation and CDC to facilitate cross-jurisdiction sharing, learning, and problem-solving around a wide range of public health and homelessness. All ELC program contacts were invited to join the Peer-to-Peer Network, as well as other local contacts previously identified by the CDC Foundation, CDC, and HUD. This is evidence that across all levels of governance (local, state, and federal), the COVID-19 pandemic was a catalyst for joint public health and homelessness activities.

In 2021, the CDC Foundation launched a pilot program to establish Centers of Excellence in Public Health and Homelessness in three health departments. The CDC Foundation and CDC purposely selected these health departments because of their extensive efforts and successes in bridging the gap between homeless services and public health. While these pilot sites are leaders in supporting the health of people experiencing homelessness in their jurisdictions, little is known about homelessness and health efforts at other health departments and public health organizations in the U.S. The CDC Foundation selected Cloudburst to conduct a landscape assessment of health departments to understand their capacity and efforts to support the health of people experiencing homelessness in their jurisdictions. To understand the landscape of health and homelessness activities at STLT public health departments, this white paper addresses the following topics:

- Operations and organizational structure, including the level of state support to local health departments and communication between state and local health departments.
- Past, current, and planned capacity for staff dedicated to homelessness and health.
- Funding sources for staff and funding sources for programming for people experiencing homelessness.
- Partnerships and communication with organizations providing services to or collecting data on people experiencing homelessness.
- Past, current, and planned direct health department programming to support the health of people experiencing homelessness.
- Past, current, and planned indirect programming to support the health of people experiencing homelessness, such as through an HCH agency housed within a health department.
- Definitions of homelessness in data collection and data sources used for public health surveillance and disease tracking among people experiencing homelessness.
- Successes, challenges, and opportunities health departments have experienced/encountered working at this intersection.

Methods

The data collection strategy accomplished two goals. First, Cloudburst developed an internal-use directory of contacts for the CDC and the CDC Foundation using points of contact identified in survey responses. This directory will facilitate communication between federal and STLT public health agencies during public health emergencies and outbreaks that may affect people experiencing homelessness. Second, Cloudburst utilized quantitative and qualitative data to describe the breadth and depth of partnerships, activities, and opportunities at the nexus of public health and homelessness.

The following sections describe how Cloudburst identified participants for this work, the data collection process, and the methods of analysis.

Participant Identification and Recruitment

Surveys

Cloudburst used multiple strategies to identify and recruit potential survey participants. First, Cloudburst identified health department contacts through the list of known ELC program coordinators and the Peer-to-Peer Network listserv. During ELC check-in calls, the Cloudburst team asked recipients if they would be willing to participate in the survey and, if so, to provide the contact information of the appropriate respondent. These sources provided contact information for about 40 of the states, territories, and large cities representing the 64 ELC participants. The team also utilized publicly available contact information for each of the twelve Tribal Epidemiology Centers (TECs) to solicit feedback from tribal public health agencies.

Next, the Cloudburst team used publicly available information to gather contact information for HCH program coordinators in all jurisdictions with an HCH program, as well as contact information for CoCs, the coordinating body of homeless service responses in localities across the country. This was a manual process of identifying web pages and copying out contacts. The team emailed HCH and CoC partners an abridged survey asking them to provide contact information of who they collaborate with at their local health department and share brief information about their partnerships with public health. The team also identified government contacts of SAMHSA's SOAR program. In some jurisdictions, SOAR programs are led by local governments. The Cloudburst team invited over 250 HCH programs, over 425 CoCs, and over 100 SOAR programs to participate in either the abridged partner survey or the full health department survey, depending on their affiliation. This pathway identified 41 new or unique local health department contacts that the team invited to participate in the full survey for health departments.

A similar effort of manually identifying contacts was repeated for local health departments. Using the National Association of County and City Health Officials (NACCHO) public directory of local health departments, the team identified the names of local health departments from a diverse group of states that were either not already represented in participant identification or represented different geographic or population factors (e.g., states from all regions of the country, states with large rural populations, and states that may work with Tribal Nations). By searching local websites and internet archives, the team identified staff members at each public

health department who may have knowledge of, or interaction with, people experiencing homelessness or organizations that serve people experiencing homelessness. These staff included harm reduction specialists, behavioral health program managers, tuberculosis (TB) and sexually transmitted infections testing coordinators, and health equity specialists. The team documented contact information for these individuals and sent survey invitations to them on a rolling basis. When Cloudburst could not identify specialized staff, the team identified contact information for public health department administrators, directors, nursing supervisors, and other infectious disease directors and invited them to participate. Through this effort, Cloudburst invited contacts from over 1,400 local health department agencies to participate in the survey. This represents roughly half of the 2,800 local health departments that are NACCHO member organizations.

Interviews

Cloudburst's interview approach drew from collected survey responses. Within the survey, respondents indicated if they were interested in being interviewed or shared names of colleagues within their organization who would be appropriate to interview. This provided a list of 82 potential interviewees. The team reviewed the list and organized it to ensure the representativeness and diversity of interviewees across the country. For example, in several instances, multiple counties from the same state were willing to be interviewed; however, the team did not select all of them to ensure that the interviews were not heavily sampled from one location.

Additionally, if public health-specific teams were housed within a department of health and human services, the Cloudburst team did not interview individuals who worked within the human services division that had a public health division or team within their agency. After reviewing cross-country representativeness and public health-related work, the team reduced the interviewee sampling list to 57 individuals. From those 57 individuals contacted, the team completed 25 interviews. Individuals interviewed were from city/local, county, or state public health departments.

Data Collection

Data Collection and Analysis Plan

The team collected data using web-based surveys and virtual semi-structured interviews. At the beginning of this effort, a data collection and analysis plan included a draft survey instrument, an interview guide, and draft communication and outreach materials. The team identified topics to be assessed in data collection in consultation with the CDC Foundation and the CDC, and both agencies provided feedback on the draft data collection tools. The team designed the interview guides to explore organizational structure, partnerships, activities, successes, and challenges in more depth to provide context to the survey responses. The team conducted all data collection activities from March 27, 2023 to May 25, 2023.

Surveys

The health department survey tool uses a mix of new questions, questions adapted from other related efforts, and questions from validated scales to assess different elements of the topic

areas of focus. In the fall of 2022, Community Solutions administered surveys to CoCs participating in the “Built for Zero” movement to assess engagement between CoCs and local public health agencies (see refs. 28–29). The team adapted questions from this survey effort for public health participants as well as questions from the CDC Foundation’s Centers of Excellence in Public Health and Homelessness baseline survey of participating health departments. Lastly, the team included an existing scale for measuring the extent of partnership collaboration in the health department survey (see ref. 30).

The health department survey included branching patterns specific to different levels of governance, such as state or territory, city or county, and tribal entity for maximum relevance for different types of participants. Branching patterns were also used to separate participant responses based on their staffing for public health and homelessness efforts, past and present activities around public health and homelessness, and types of partnerships and data sources used. If health departments indicated that they did not have any staff or activities related to health and homelessness, they were directed to the end of the survey. Participating health departments that had either a single person dedicated to health and homelessness work or had multiple staff across multiple teams or divisions focused on homelessness were asked to provide the name of one individual who could be contacted by the CDC Foundation or the CDC during a public health emergency or outbreak to populate a directory of contacts.

Cloudburst then attempted to identify health department contacts from HCHs and CoCs. The team created an abridged survey tool for HCHs and CoCs to collect contact information from local public health partners and to assess HCH and CoC perspectives on collaboration and partnership with local public health using the same questions from the health department survey. All questions in both surveys were optional.

Interviews

Individual interviews were designed to gather information regarding public health and homelessness activities and capacity among public health organizations (see figure 1). Questions focused on organizational roles, partnerships and partner communications, and organizational activities and projects related to health and homelessness. The team used email outreach to recruit participants for the interview. Discussions lasted about 60 minutes each. Interviews were audiotaped with the permission of participants, and a verbatim transcript of each interview was produced solely to facilitate analysis.

Analysis

Surveys

Prior to analyzing health department survey data, the Cloudburst team reviewed responses to remove duplicate entries (five were removed as duplicates), entries with only location entered but no other questions answered (five failed to provide any information beyond location), or entries from entities that were not public health departments, such as a local federally qualified health center or housing and community development office (six responses were removed from non-public health entities). The final analytic sample included 273 health department survey responses. The final analytic sample for HCH, COC, and SOAR partners included 116 survey responses.

After cleaning data and removing respondent identifying data (such as contact information entered in response to survey questions) the team downloaded survey data as comma-separated value files (one for each survey) into the R statistical programming environment on a local workstation. The survey platform used for the study has its own graphics application programming interface and permits the creation of column or bar charts, which were used for some graphical depictions of summary statistics during exploratory data analysis. The team used the table() function in R to compile summary statistics for categorical variables in the survey data, as well as to perform selected cross-tabulations and Chi-squared tests of independence of pairs of categorical variables selected in consultation with the CDC Foundation and the CDC. The team entered results into table shells created with input and feedback from the CDC Foundation and the CDC.

Utilizing some of the same questions pertaining to partnerships in the health department survey and in the HCH and CoC survey allowed the team to compare how partnerships are viewed from both sides of the relationships (in the aggregate; the team did not attempt to cross-validate the viewpoints in any specific health department-homeless services organization dyad). For example, we presented the same lists of potential partnership activities (pre- and post-pandemic), as well as the same potential options for improving the performance of partnerships, to both health departments and selected homeless services organizations.

Interviews

All interview recordings and transcripts were stored on a secure drive. The team constructed a codebook with an analytical schema by utilizing early interview feedback, reading through several interviews, and reviewing the interview guide and overall research objectives. The team completed detailed coding of interview transcripts in NVivo, extracting passages from transcripts, applying a priori codes to interviews, and illustrating emergent codes and themes. The team cleaned the data by consolidating codes in alignment with identified themes. Coding was an iterative process that included the revision of codes and themes as a way to identify overarching categories that served as the backbone for data analysis.

Public Data Sources

The team utilized two public data sources to help contextualize the findings: the 2022 State and County Population Estimates from the U.S. Census Bureau, and the 2022 Point-in-Time (PIT) count from HUD, which estimates the population of people experiencing homelessness within each state and CoC *(see refs. 31–32)*. For large cities or metropolitan areas that may be situated in multiple counties, like Atlanta, Georgia, New York City, New York, or Boston, Massachusetts, the team used the 2022 Cities Population Estimates from the U.S. Census Bureau. For other cities or townships that participated in the data collection effort, the team reviewed the census estimate for their respective county. For identifying the population of people experiencing homelessness, the team identified the closest-aligning CoC estimates from 2022. For entire states or large cities and metropolitan areas, there was exact alignment. However, CoC boundaries do not always align exactly with city or county boundaries. As a result, many smaller jurisdictions have a population estimate for people experiencing homelessness that far exceeds their city or county limits.

Findings

Overview of Participants

Health department or HCH/CoC survey responses were received from most of the 59 U.S. states and territories (50 U.S. states, American Samoa, District of Columbia, Federated States of Micronesia, Guam, Marshall Islands, Northern Mariana Islands, Palau, Puerto Rico, and the Virgin Islands). Four states (8 percent) were not represented across either survey, two state agencies (4 percent) declined official participation but one or more of their local HCHs or CoCs participated in a partner survey, three additional states (6 percent) were only represented by an HCH/CoC survey. Six of the nine territories (67 percent) were not represented across either survey, and one territory (11 percent) was only represented in an HCH/CoC survey. Of the 12 TECs invited to participate, one (8 percent) participated in the health department survey. Two additional tribal public health representatives also participated; one representative was not from a TEC and the second respondent from a tribal affiliation did not provide demographic information. In total, every U.S. Department of Health and Human Services (HHS) region was represented in the health department survey at either the state, territorial, or local level, indicating strong geographic coverage (see ref. 33 and table 1). Of all health department survey participants who provided geographic information, 22 percent represented a city or other locality, 65 percent represented a county, and 12 percent represented a state, territory, or tribal nation (see figures 4–6).

Of the 25 health departments interviewed, ten (40 percent) represented states or territories, 12 (48 percent) represented counties, and three (12 percent) represented cities or other localities. Five interview participants (20 percent) were from Region 3 (Philadelphia/Mid-Atlantic), three (12 percent) were from Region 4 (Atlanta/Southeast), five were from Region 5 (Chicago/Midwest), one (4 percent) was from Region 6 (Dallas/Southwest), three (12 percent) were from Region 8 (Denver/Rocky Mountain), five (20 percent) were from Region 9 (San Francisco/West Coast and Island Territories), and two (8 percent) were from Region 10 (Seattle/Pacific Northwest).

Findings from surveys and interviews are presented together by theme. Themes include operations and structure of health departments, activities, programs, data and evaluation, and partnerships and partner communications in addition to barriers, facilitators, and opportunities for health and homelessness work. Each thematic topic area also includes sub-themes that provide additional nuance.

Operations and Structure of Health Departments

Staffing

Most health departments (55 percent) reported that there are multiple people within their agency or organization working on health and homelessness across different divisions, followed by 29 percent of health departments reporting that there were no designated contacts for health and homelessness. Fewer than forty (16 percent) health departments reported that there was a single point person within their agency designated for health and homelessness activities. Health department staff commonly encountered homelessness in their disease- or program-specific roles that were not exclusive to people experiencing homelessness. For example, staff hired for TB programming, COVID-19 mitigation, or the Women, Infants, and Children (WIC) program may

provide support or services to homeless service sites or people experiencing homelessness, even though their intended audience is more expansive than just homelessness. Designated points of contact for health and homelessness were often assigned to offices of health equity or special populations, teams focused on community-based settings, or generally situated at health department leadership levels. These staff discussed supporting cross-cutting health issues for people experiencing homelessness and were often responsible for providing internal coordination across disease or program-specific teams. Even health departments that have a designated point of contact for homelessness still described having other teams across their agency who encounter and work on homelessness. For example, one respondent from a Midwest health department stated:

> *"There's the COVID-19 team, and within that team, there's the 'highly impacted settings.' And that team has changed a little bit recently. But within that team, there's a couple of people who focus on working with shelters and other congregate settings like halfway homes, jails, and prisons. And then we have a lot of people across our agency who don't have homelessness in their title, but they work on issues related to homelessness because of their disease area, like hepatitis, HIV, syphilis, and our injury and violence prevention section, which deals with drug overdoses. So, it's kind of distributed, there's not a division. Other than me, there's not a lot of people who are kind of explicitly focused on homelessness, but I work with a lot of people who deal with homelessness in their day-to-day work."* ***—Midwest State Health Department Employee***

Positions with a primary role focused on health and homelessness mostly reported being funded by the ELC Detection and Mitigation of COVID-19 in Homeless Service Sites as project coordinators (a required position under the grant), contact tracers, and equity managers. Over a quarter (28 percent) of interviewed health departments were able to use this funding in conjunction with other external funding to create or expand offices of health equity for more homelessness support. However, ELC funding will end in 2024, potentially changing staffing arrangements from the current setup. Other interview participants were in more policy-focused roles, representing directors of community health improvement programs, chief strategists, and senior advisors to health department leadership. These policy-focused positions were mostly focused on special populations broadly, including people experiencing homelessness as well as refugees and migrants, correctional facilities, schools and institutes of higher education, tribal and rural populations, and other groups that face disproportionate risk or burden of disease.

Primary health and homelessness contacts have been in their roles for varying lengths of time. Just under 25 percent of health departments indicated that health and homelessness points of contact had been in their role for twelve or fewer months. The most common response (29 percent) was that health and homelessness contacts had been in their roles for one to three years, and 15 percent of health departments reported health and homelessness staff in their roles for ten or more years. City or other local health departments were more likely to report longer duration of time working on health and homelessness activities than county or state, territorial, or tribal health departments ($p=0.04$). Over 80 percent of city or local health departments had been working on health and homelessness issues for more than one year,

whereas over 60 percent of state and territorial health departments reported working on health and homelessness for less than a year. This finding could be the result of local ownership and varying local conditions pertaining to homelessness. Homeless service providers in a given locality may go to their city or local health department first during an outbreak or public health emergency, rather than their state or territorial health department. The increase in state and territorial health departments working on health and homelessness within the last year could also be the result of increased federal funding to state and territorial health departments through the CDC's ELC Detection and Mitigation of COVID-19 in Homeless Service Sites cooperative agreement. One respondent described this with:

> *"We had a number of unhoused individuals that had contracted mpox and there wasn't anywhere for them to go. And it was the classic problem of them not being ill enough to be hospitalized, but also being too ill or needing some type of specialized supportive care. And unfortunately, I think at least in one of those cases, the individual did eventually pass due to non-compliance with medication. So I think that that is an example of where I think there could have been an opportunity for outreach to occur between the [state] leadership teams that unfortunately didn't occur. And I think part of that is because homelessness is viewed as a local issue. So, you know, it's on the local health department to make those connections or to try to solve those sorts of problems."* ***—Midwest State Health Department Employee***

Similarly, another respondent stated:

> *"At the state level, housing is one of our priorities for our 2023 to 2027 plan for wellbeing. So, in the future, the requirement is that if it's a priority at the state level, it also has to be a priority at the local level so that local data and activities are feeding up. And so we would encourage them to adopt some of the strategies that we have laid out at the state level in their local areas, their local health districts."* ***—East Coast State Health Department Employee***

Over the past five years, 56 percent of health departments reported an increase in staffing to support health and homelessness activities in some capacity, while 7 percent reported a decrease in staffing and 37 percent reported that staffing capacity had stayed the same. Around one-third (34 percent) of health department survey respondents were not sure if their organization had ongoing or planned efforts to hire additional health and homelessness staff; 24 percent were aware of efforts to hire new staff and 43 percent indicated there were no plans to hire new health and homelessness staff. Participants largely attributed to the COVID-19 pandemic the changes they underwent in staffing and capacity for health and homelessness activities, and expressed concerns about what would happen once COVID-19-specific funding ended. One respondent from a southwest state health department said, "*I think that our position wouldn't exist if it were not [for] the pandemic.*"

Despite fewer than 25 percent of health departments reporting plans to hire additional health and homelessness staff, 60 percent of participants disagreed or strongly disagreed with the following statement: "*My organization has an adequate number of dedicated staff to health and homelessness activities*." This discrepancy also emerged during interviews with health departments. During interviews, many participants noted that staffing turnover within health departments and within community partner organizations, often due to term-limited funding, was a significant challenge for promoting health and well-being among people experiencing homelessness. One respondent stated:

> *"But we have also had staffing challenges with this position. [The current staff member] is the third person we've hired to do this position. I've been overseeing this position for about six months."**—Southwest State Health Department***

A rural health department described challenges with turnover:

> *"I'll just mention one of the challenges that I have, and this is probably not unique to me, but the turnover of those smaller nonprofit agencies and homeless providers is an ongoing challenge. We had everything stable for two or three whole years. I couldn't believe it. And we were really happy with the staff that were in place. But, whenever [a key staff member] leaves, you're kind of starting from scratch sometimes. So that is something that can be a challenge."**—Rural East Coast County Health Department Employee***

Similarly, a state health department employee stated:

> *"It's just been a little disruptive to have staff turnover. I think that's kind of common, but that's been challenging."**—West Coast State Health Department Employee***

Directly tied to staffing challenges were funding challenges. Interview participants expressed that they needed more funding and more staff to do the work they felt they needed to be doing. This pattern was also seen in health department surveys. Zero health departments strongly agreed that their organization had sufficient financial resources to conduct health and homelessness activities, and only 14 percent agreed. The rest (86 percent) disagreed or strongly disagreed, indicating that health departments do not have the necessary financial resources to conduct health and homelessness activities. A territorial health department respondent explained:

> *"So this ELC grant was funded for detection and mitigation of COVID-19 in homeless service sites, but this grant is only funded until July 31, 2024, which is next year. After that, there's no talk about [health and homelessness work] being regularly funded."**—Territorial Health Department Employee***

Similarly, a respondent from a rural health department added:

*"Funding is always going to be an issue. We got this influx of funding during COVID-19. There was a lot we needed to do. But there was also a lot we were able to do because we were able to hire so many staff. So to put it in numbers, my health district has about 90 full-time employees in steady state times. And we hired about 80 contractors during COVID. So we literally doubled in size. That's now like the perception that a lot of organizations have as far as our capacity. They worked with us when we had that many staff, but now that funding is drying up, our capacity is going way down. But we still have to do all of these required activities. And then we're getting asked to do a lot more. So funding is definitely going to be a challenge moving forward to carry out the work that we want and that we need to do and that's kind of expected of us."—**Rural East Coast Health Department Employee***

Health department interview participants also noted the complexity of homeless response systems and identified a need for specialized staff who can understand and exist in both public health and homeless service systems. So, having homeless response staff knowledgeable about public health and infection prevention and having public health staff knowledgeable about homeless response systems and experiences of homelessness would provide bidirectional benefits. For example, one respondent said:

*"I would love to see program supervisors trained on or aware of all of the services that are available for homeless clients."—**Urban Southern County Health Department Employee***

One health department staff member who has been in their role as the designated health and homelessness contact since before the COVID-19 pandemic even noted the challenge of operating in a boundary space:

*"I don't want to say that we're more complicated than anybody else, but a humongous challenge that I have come to appreciate in my role as the public health department lead for homelessness and homeless response is our field of homelessness services. They have acronyms and systems and funding streams that are highly nuanced and complex, and I know things about them. I've learned a lot about them. But there's a lot that I don't know. And I think trying to keep folks up to date on public health-related information is very difficult."—**Urban West Coast County Health Department Employee***

State and Local Relationships and Coordination

In the survey of health departments, 25 percent reported that decision-making, program planning, and other executive decisions around health and homelessness activities were primarily determined by the state or territorial health department. When asked about the implementation of programs and other health and homeless activities, 79 percent of health departments indicated that implementation happens by local health departments.

Only two of the 25 health departments interviewed reported that homelessness and health activities were centralized at the state health department. For most, states encouraged local health department autonomy on health and homelessness issues because of the local variation in responses to homelessness. Participants that typically operate with local public health autonomy noted that the dynamic with their state agencies changed during the COVID-19 pandemic to one of greater direction from the state, largely because of the flow of information and funding through state health departments. For example, one respondent stated:

> *"Well, I think it's still somewhat tenuous. As we move out of the pandemic, I think that we're still figuring out what [the state health department's] role will be and how we'll work with these different partners and what the relationship between [the state health department] and local public health and tribal health will be."* ***—Midwest State Health Department Employee***

State health departments often provided guidance on quarantine and isolation and general prevention strategies that local health departments were then responsible to implement and enforce in their jurisdictions. This became increasingly challenging as quarantine and isolation options changed and ended for people in congregate settings; in some cases, state-level guidance included quarantine and isolation for people experiencing homelessness, but not all local jurisdictions had the right support to continue quarantining and isolating clients. In the absence of state or federal guidance regarding alternative quarantine and isolation options, local health departments struggled to find strategies that balanced client needs and prevented transmission of COVID-19.

Roles and Responsibilities of Health Departments in Health and Homelessness

When asked how health department partnerships could be improved, over half (53 percent) of health departments identified that clearer roles and responsibilities of public health and community-based partners were needed. During health department interviews, the role of health departments emerged as a salient theme. Health departments talked about their role and purpose as a way to contextualize their activities, as well as how their roles and responsibilities were not always well known among partners or the community, creating challenges for health and homelessness work. One respondent from a rural health department described this challenge with:

> *"We already have our local federally qualified health center, and they have a mobile unit where they can go around and meet people where they're at for services. I think more structural change is needed to get people into homes. I think we're just kind of putting a band-aid on the problem. And that's why we kind of fumbled the money we did in the way that we did when we got that small grant from the state. I think it's hard for us to do this work sometimes because there are other agencies devoted to housing. It's hard to find or visually see big structural change and where we fit into this whole thing."—* ***Rural Midwest County Health Department Employee***

Health departments expressed that their primary responsibilities are focused on health promotion, disease prevention, and outbreak response. Health departments with larger population coverage reported having additional capacity to do more activities like data analysis and evaluation, but an underlying thread across all participants was the primary function of outbreak response and promoting/providing vaccination. Since January 2020, 37 percent of health departments doing activities related to health and homelessness reported doing general communication and information sharing with partners, 34 percent reported conducting or supporting vaccination clinics with the same percentage conducting health education and promotion, and 33 percent reported engaging in outbreak investigations with homeless service partners. HCH and CoC survey respondents reflected a similar pattern of programming in their engagement with health departments. Around one-third (36 percent) of HCH and CoCs partnered with health departments to conduct health education and promotion activities, 30 percent partnered for vaccination clinics, and 24 percent partnered in routine screening or testing for infectious diseases.

As part of disease prevention and outbreak responses, environmental health teams and divisions also played a role in supporting the health of people experiencing homelessness. Environmental assessments of homeless service facilities and homeless encampments were only reported by 23 percent of the surveyed health departments conducting activities with homeless service partners. While environmental health activities were only mentioned by a few participants during interviews, they noted that environmental health teams were crucial in supporting congregate shelters with infection prevention and control, inspecting and providing permits for interim housing sites, and supporting field-based work responding to homeless encampments. It is possible that environmental health plays a role in health and homelessness activities for many health departments, but few jurisdictions explicitly named these types of activities and could indicate an opportunity for expanding health and homelessness opportunities for public health organizations.

There was substantial variation in the governance of substance use and overdose prevention activities. Some states or localities had substance use and overdose departments analogous or parallel to the health department within their departments of health and human services. Other jurisdictions, mostly large metropolitan localities, situated substance use and overdose prevention as divisions or teams within the health department. Because people experiencing homelessness are disproportionately affected by substance use and overdose, the location and ownership over substance use and overdose activities influenced the extent to which health departments reported having staff designated for health and homelessness activities. For example, in a jurisdiction that separated substance use and overdose from the role of the health department, that health department might have reported fewer staff and programs for people experiencing homelessness within their agency. On the contrary, health departments whose responsibilities included substance use and overdose prevention were more likely to report more staff and activities within the health department focused on health and homelessness. The fragmentation of the health and homelessness portfolio across multiple agencies can translate into a resource challenge because of its relative inefficiency. One respondent from a suburban west coast health department said "*Our county is definitely under-resourced for behavioral health practitioners. So that is a big issue*," later adding:

*“Contracted service provider agencies know what they do, and they do it very well, but they're not going to know about how to access substance use treatment, for example. And that's a huge challenge that we are up against. Let alone accessing services for severe mental illness, which is in a different department with a different phone number. So, we have certain things going for us and we have some robust resources, but the cross-pollination among our systems is a challenge.”—**Suburban West Coast County Health Department Employee***

Public Health Departments and Public Health Divisions

An additional characteristic of public health agencies that influenced their staffing, programming, and capacity included where public health activities were situated within state or local governments. In more than half (56 percent) of the jurisdictions interviewed, public health departments operated as their own standalone entities within state or local government. In other jurisdictions, there were public health divisions within larger departments of health and human services. Participants reported strengths and limitations of both structures; standalone health departments had more robust staffing and increased autonomy, but experienced challenges coordinating with other departments across silos. Public health divisions within health and human service agencies were more likely to report that any homelessness-related activities fell within a sibling division, often housing and community services divisions. However, having both divisions embedded within a department of health and human services made it easier for cross-division collaboration and communication.

Activities, Programs, Data, and Evaluation

Across state and local public health, the level of direct engagement in health and homelessness activities varied widely. Health department interview participants prefaced their activities and programs by describing the perceived role and responsibilities of public health in their jurisdiction. The primary role and activities of some health departments included coordinating and managing grants. For others, public health staff reported being directly involved in outreach and connecting people experiencing homelessness to housing and other supportive services. However, there did not appear to be a clear or consistent relationship between the role of public health, the capacity of partners, and activities or programs. For example, one state with strong public health investment and leadership in public health and homelessness played a primarily coordinating role, while another state with similar public health investment and leadership in this space was more involved in direct client services and programs. Both states described strong partnerships with community-based groups, and both states classified themselves as “home-rule” states (i.e., local jurisdictions operate autonomously from the state). Another added:

*“Most of the work we do is supporting organizations within the community that are doing work surrounding homelessness. We don't have any direct programs or anything that [homelessness] is the focus of. It's more that our strategies overlap with organizations that are supporting those efforts.”—**Suburban Midwest County Health Department Employee***

Direct and Indirect Programming for People Experiencing Homelessness

An important distinction in programming emerged while conducting health department interviews: separating programs utilized by people experiencing homelessness from programs designed for people experiencing homelessness. This nuance was challenging to tease apart for some jurisdictions, and in some cases, these distinctions were layered. For example, in one suburban county health department, a team focused on TB described how a walk-in TB testing clinic was predominantly used by people experiencing homelessness since TB screening was a requirement for accessing homeless shelters. This health department activity (running a TB testing clinic) was not designed for or utilized exclusively by people experiencing homelessness. Within the TB testing program team, however, there were a few staff responsible for visiting homeless shelters in the county and providing mobile outreach services for TB, which represented an activity designed for people experiencing homelessness. When discussing health and homelessness programming, participants may not have made this delineation, but it is an important distinction to make since people experiencing homelessness may need tailored public health programming to meet their access and functional needs.

Data and Evaluation

There did not appear to be a single data source used by a majority of health departments to assess public health needs and outcomes among people experiencing homelessness. The most common sources of information for health departments to assess the health needs of people experiencing homelessness in their jurisdiction were informal sources, often relying on partner communication. Reports from homeless service providers were the most commonly used source of information, reported by 31 percent of health departments. This was followed by 30 percent of health departments reporting external meetings with other agencies and groups and 25 percent of health departments reporting first-hand accounts from non-clinical service providers as sources of information. This pattern was also observed during interviews; health departments noted that they would often receive reports from homeless service providers or other social service teams engaging with people experiencing homelessness. Only 16 percent of health departments reported successfully linking or integrating public health and homelessness data systems like the homeless management information system (HMIS). Most (67 percent) health departments had not tried to link public health and HMIS data, 7 percent had tried but were unsuccessful, and 10 percent were currently in the process of trying to establish data linkages at the time of the survey.

Data sources and data integration were common challenges and opportunities discussed during health department interviews. One respondent stated:

> *"Data. Better data sources, recent data, readily available data [is needed]. Technical assistance and working with other states or organizations that have really been creating and addressing this [data] issue. I think the understanding and the want is there. Or maybe, if we had some outside help, we may be able to succeed more on this."—**East Coast State Health Department Employee***

Not only are there limited and imperfect data sources, but trying to link data systems relies on trust between organizations and community members. For example, one respondent said:

> *"Data sharing moves at the speed of trust. And we had to work so much on building relationships and really understanding why folks, rightfully so, particularly talking about community members, may be reluctant to share information with the government."—* ***Urban West Coast County Health Department Employee***

Matching public health data with HMIS data was described as the next step for one state health department, but this was not highlighted as a next step for most due to limited staffing, funding, and the time and persistence it would take to actually conduct data matching. One respondent described this as:

> *"There's been lots of talk about HMIS matching. But the problem is related to data sharing. I don't know the specifics of the ins and outs of all the concerns...we only talk about it a little bit in our data group. So that's something that we're working on because one of our main items that's in our state's action plan is data related to mortality for people experiencing homelessness."—* ***West Coast State Health Department Employee***

Two county health departments interviewed described successful public health and homelessness data activities. The first described a multi-year investment from their local government to establish a shared data system that integrated public health, clinical, and homeless service utilization data. Even with the extraordinary financial and human resource commitment to establish this shared data system, there are still data challenges all along the spectrum of data collection to data analysis to data reporting. However, the integrated data platform has helped facilitate communication between public health, clinical, and housing partners about emerging trends or issues and allows for more timely identification of potential health threats or adverse health outcomes.

Partnerships and Partner Communication

Regardless of the types of activities and the role of public health in implementing those activities, all participants highlighted the importance of internal and external partnerships. Primary partners often included at least one other group or team internal to the health department and one external homeless services partner. Over 80 percent of health departments surveyed reported that they currently partner with homeless service and response programs in their jurisdiction; most (68 percent) reported having partnerships with emergency homeless shelters, and almost half reported partnerships with CoCs (46 percent) and permanent supportive housing programs (48 percent). Health departments that reported currently partnering with homeless service providers were more likely to have increased staffing over the previous five years and were less likely to have stable or declining staff ($p=0.02$). This association could indicate either direction; health departments may have been able to establish or strengthen partnerships with homeless service providers as a result of increased staffing, or they may have begun partnerships with homeless service providers and identified the need for more staffing related to health and homelessness activities.

Despite the association between increased staffing and partnering with homeless service providers, health departments currently partnering with homeless service providers were significantly more likely to disagree with the statement that they had adequate staffing for health and homelessness activities ($p=0.03$). Health departments with inadequate staffing may need to rely on partnerships with homeless service providers more than health departments with adequate staffing. However, the large proportion of health departments with current homeless service partners indicates that health departments are likely understaffed to do health and homelessness work.

At the state level, interagency councils on homelessness and state-level housing government agencies were commonly cited as partners during interviews. For example, one respondent described:

> *"The other thing that's been really great is the [State] Interagency Council on Homelessness. They have an action plan to end homelessness. In the past, [the State Health Department] was not involved in the creation of the action plan and didn't have any objectives or activities that they were working on. The two staff members that were here before us actually got involved with the development of the plan and added activities that were specific to [our State Health Department agency]. And I think that that's really helped elevate the visibility of public health's role in addressing housing and homelessness, and also helped to have some accountability measures in place by saying 'this is what public health is doing.'"*—***West Coast State Health Department Employee***

At the local level, jurisdictions reported strong external partnerships with homeless shelters and organizations playing a leadership role in local CoCs (such as the collaborative or lead applicant for the CoC). Local health departments shared that homeless service partners were important for sharing data and information, especially during the COVID-19 pandemic. A rural respondent summarized this with:

> *"One thing that has worked very well is that several years ago, we decided that we needed at least one other agency to really be a key partner with the health department in addressing homelessness, and we were able to establish that with our public housing office. So their director actually co-chairs our local homelessness coalition with me. And it's just a really great partnership. And we appreciate them so much. And I think it's just critical to have them."*—***Rural East Coast County Health Department Employee***

The COVID-19 pandemic was mentioned as both a facilitator of collaboration between partners and a source of tension with partners. Jurisdictions with pre-existing partnerships and relationships with homeless service providers noted that having these relationships in place allowed them to more effectively and efficiently respond to COVID-19 among people experiencing homelessness. They also noted that their pre-existing partnerships were strengthened and solidified further during the pandemic. Uniquely, jurisdictions with pre-established homelessness partnerships noted that they thought communities without existing partnerships would struggle or have a more difficult time. However, jurisdictions without existing

partnerships indicated that the COVID-19 pandemic propelled the creation of new partnerships with homeless service providers out of necessity and reflected on the pandemic as a positive facilitator of their partnerships. For example, one interviewee stated:

> *"I think we worked fairly well together. And because we had to, I mean, there were a lot of different times at which guidance would change or evolve, understandings would change or evolve. And we just had to get information out, and we had to do it quickly. And so we would work very hard on producing the language and [our partners] would then disseminate it among their partners. So, I think that was helpful to have [our housing partners] and their intimate knowledge of the homeless service system, because they were out there providing technical assistance, providing infection prevention and vaccines in the community and all over the county. So, I think that worked really well."—* ***West Coast County Health Department Employee***

While another interviewee added:

> *"One of the lessons learned during the pandemic is that areas and localities that had established coalitions that had engaged in community engagement work were better. They had the infrastructure to rapidly respond to the pandemic because they had those relationships outside of the health department. And those coalitions are the backbone organizations that helped drive the pandemic response."—* ***East Coast State Health Department Employee***

A rural health department respondent said:

> *"There weren't a lot of positives to come out of COVID. But one positive was a lot stronger partnerships when it comes to government agencies, nonprofits, and these community partners."—* ***Rural Health Department Employee***

As the pandemic continued, and as the virus and guidance continued to change, some partnerships started to strain. Participants noted that as more protective measures became widely available and implemented, such as vaccination, boosters, natural immunity, and masks, some of their partners felt public health guidance was too restrictive while other partners felt public health was relaxing prevention measures too far. A respondent from an urban jurisdiction explained:

> *"It was a very rough time, you know, you're used to seeing these folks as your friends. But I think as the pandemic dragged on, after about a year, it became tense. I think, particularly given the nature of the homelessness crisis, people just began to get upset at any restriction that was in place. We evolved with time, just as everybody did, in our understanding of the illness, and I think as community protection increased with prior infection and with vaccination, and with boosters, the guidance and the required*

*protections changed. But we had a lot of tense conversations with some partners that we were way too assertive in providing required protection. For others, people didn't think we went far enough."—**Urban West Coast County Health Department Employee***

Participants also described how partnerships developed before and during the COVID-19 pandemic were able to be maximized in the summer of 2022 to respond to the emerging mpox outbreaks. Having these partnerships in place facilitated timely and effective action for people experiencing homelessness in ways that may not have been possible without partners. A participant highlighted the benefit of having established partnerships both with homeless service providers and with their state health department for other programming and funding opportunities, not just limited to COVID-19 or mpox. Additionally, one participant highlighted their ability to leverage existing partnerships for mpox as a success in their community:

*"Mpox was a particularly intense time because we had two public health emergencies at once, but luckily, we knew a lot of what we had to do. We leveraged all the same meetings and the same partners to do the work, like getting infection prevention guidance out there about how mpox is spread. In July of last year, we set up our own isolation housing site for people experiencing homelessness who had mpox, or who could not safely isolate at home, and it was mostly people experiencing homelessness, many of them engaged in sex work. And so we then began operating our own site on the public health side, which still continues to operate to this day. We didn't have many outbreaks because mpox is much more difficult to transmit than COVID. But we were able to leverage a lot of these partnerships and a lot of these meetings to launch a response very quickly for that, including vaccination."—**Urban West Coast County Health Department Employee***

Other Types of Partners

In addition to homeless response system partners, almost all (94 percent) health departments working on health and homelessness activities also reported partnering with other community-based organizations. Other types of partners in health and homelessness activities included: faith-based organizations (83 percent of health departments), community-based mental health service organizations (78 percent), other governmental agencies (78 percent), community-based substance use service organizations like safe injection sites and harm reduction centers (61 percent), law enforcement agencies or organizations (60 percent), and academic institutions or centers (34 percent). Of the 20 percent of health departments with known HCH programs in their jurisdiction, 63 percent reported partnerships with their local HCH prior to 2020, and 75 percent reported current partnerships with their local HCH. This indicates that some health departments were able to establish new partnerships with their HCH during the COVID-19 pandemic. Health departments that indicated current partnerships with HCH programs were also more likely to have indicated that their staffing had increased over the past five years (p=0.01). This association could indicate either direction; health departments may have been able to establish or strengthen partnerships with local HCH programs as a result of increased staffing, or they may

have begun partnerships with HCHs and identified the need for more staffing related to health and homelessness activities. In one case, the health department that the team interviewed was the lead of the local HCH.

Around 90 percent of health departments agreed or strongly agreed that their organizations would benefit by having both more partnerships as well as more diverse partnerships. Health departments disagreeing with the statement that they have adequate staffing for health and homelessness activities were more likely to disagree with the statement that they would benefit from more partnerships ($p=0.01$). This may indicate that health departments want to address their own staffing shortages before establishing new partnerships, or that limitations in health and homelessness activities are the result of being understaffed and not the result of the types and number of partner organizations. Considering the time and human resources required to cultivate trusting partnerships across sectors, it is plausible that health departments cannot appropriately build these relationships while understaffed. The relevance of staffing for partnership development was reiterated by respondents to the HCH and CoC survey, 30 percent of whom indicated that their relationship with health departments could be improved by "additional staff dedicated to partnerships and engaging in partner activities." In general, health departments indicated a much stronger interest in various options for improving partnerships with homeless services organizations than did their partners. For example, while the most frequently indicated options for improving partnerships for both groups were "Additional staff dedicated to maintaining partnerships and engaging in partner activities" and "Greater collaboration on shared goals and activities," more than twice as many health departments (74 percent and 75 percent) as HCH or CoC respondents (30 percent and 35 percent) agreed these could improve partnerships.

These results were confirmed during interviews with health departments; participants described how additional staff and extending COVID-19-specific staff would facilitate the establishment of new partnerships and improve the maintenance of existing partnerships. Ultimately, health department surveys and interviews indicated that health departments cannot establish new partnerships until their staffing capacity improves. One urban West Coast county health department described building partnerships with foundations of trust could be "*an entire body of work*." Similarly, a Midwest state health department noted that they were limited in the partnerships they could establish or strengthen because of limited staff capacity, particularly as COVID-19 funding dissipates: "*A lot of our non-COVID infectious disease teams are really understaffed. And so, it's hard to add anything to their plates*." Another urban West Coast county health department highlighted this theme:

> *"A lot of that money was really COVID-dependent. We're scaling back, unfortunately, a lot of those staffing services. The short answer is that staffing was a key piece to develop those relationships in particular."—**Urban West Coast County Health Department Employee***

Homeless service providers are also understaffed, further challenging opportunities for establishing or improving partnerships. An employee from a rural health department added how

both public health staff and homeless service providers have not been able to do much planning or vision-casting for their partnership because they were simply trying to maintain their activities:

> *"We feel like we're always being pulled in so many directions to just keep things going. I have to admit, there hasn't been a whole lot of forethought into what we can do. Because it feels like you're barely keeping your head above water sometimes. And I think our providers are feeling that way, too."*

When asked what opportunities health departments hope to see, 56 percent of interviewed communities described the desire for more and stronger partnerships. In one jurisdiction, a participant noted that by not having more community-based partners, the scope of services available to people experiencing homelessness was limited. A rural respondent described:

> *"Sometimes I wish that we had more nonprofit partners to pick from or to spread things out a little bit. We have a Department of Social Services and they are a key partner, especially in overnight emergency shelter needs, and there's already an after-hours system in place with our Department of Emergency Services, too. But sometimes, it's not the best to have a government agency be the point of contact because they just aren't as accessible. And there's a lot of people going to them for a lot of different things. And so, you have to get there, and you have to take a number with 50 other people. So, I really wish we had another agency that could do certain things. I think that's probably a product of being in a smaller jurisdiction, but those are some of the frustrations sometimes."—**Rural East Coast County Health Department Employee***

One health department interviewee shared that being able to provide funding to community-based partners helped facilitate the right partnerships to conduct health and homelessness work, but this was not expressed widely since most health departments reported not having enough funding or staffing. They stated:

> *"I think having funding available to give to community-based organizations is huge. Having a partner like [our homeless service partner] with that expertise to try to provide additional technical assistance and support has been really effective."—**West Coast State Health Department***

In fact, 74 percent of health departments surveyed noted that their partnerships would be improved by having additional health department staff dedicated to maintaining partnerships and engaging in partner activities, and 75 percent indicated that they saw a need for greater collaboration on shared goals and activities with health and homelessness partners.

As noted, these priorities were reflected by organizations partnering with health departments as well. Although the level of agreement was holistically lower from HCH and CoC survey respondents, the most frequent answers to "How could your organization's partnerships with health departments be improved?" were "Greater collaboration on shared goals and activities"

(35 percent) and “Additional staff dedicated to partnerships and engaging in partner activities” (30 percent). Meanwhile, no respondents indicated that “Less frequent meetings or communications” would improve their partner relationship.

Formalization of Partnerships

The role of public health departments and the work being conducted with and by partner organizations were more likely to influence the formalization of partnerships. Health departments whose primary role included grant administration and coordination were more likely to have formalized documentation of partnerships than health departments providing more direct services in their communities. The formalization of partnerships was also influenced by what programs fell under health department responsibility and if health departments operated as standalone entities. For example, substance use and overdose prevention activities housed within health departments may not need formal documentation of that partnership because they are both internal to the same agency. Similarly, public health divisions may not need formal partnership documentation with housing and community service divisions if they are both housed in a department of health and human services together. Less than a quarter (24 percent) of HCH and CoC survey respondents reported undertaking formal partnerships or agreements with health departments.

Most jurisdictions interviewed described strong, informal partnerships and did not necessarily express a desire or need to formalize partnerships through binding agreements. This was also evidenced in the survey responses; fewer than half (46 percent) of health departments thought their partnerships needed more formal partnership structures. An even smaller percentage (21 percent) of HCH and CoC survey respondents indicated that “more formal partnership structures, such as memoranda of understanding agreements or data use agreements” would improve their organization’s partnerships with health departments. For example, a respondent from a Suburban Midwest County health department said “*So we don't have [a memorandum of understanding] with anyone. It mainly just depends on what the partnerships look like*.”

However, health departments that reported having memoranda of understanding (MOUs) or other written agreements with partners were more likely to agree with the statement that they had sufficient resources for their health and homelessness programming ($p=0.03$). This association could be confounded by external forces such as prior investments from local governments. For example, localities with prior legislation that allocates funding and resources for health and homelessness activities may have more staff for longer durations which facilitated the opportunities for MOUs (which require time and staff to negotiate) and which ensures resources are allocated to this work.

Additionally, health departments with completed and signed MOUs with partners were more likely to report more frequent communication (mostly daily communication) with partners; health departments without MOUs reported communicating with partners less frequently. Health departments that had or were in the process of formalizing MOUs were also more likely to report having linked data with partner systems or being in the process of attempting to link data sources than those who do not have MOUs. It is possible that the desire to integrate, link, and share data and information across partners was a motivating factor for establishing MOUs. A Midwest State Health Department Employee described this with:

"We did have a contract in place [with a local research institute] for [a specific project] and then a contract in place for [another specific project]. We're currently working on getting a data sharing agreement directly between [our state health department] and our HMIS data to do some data matching for a drug overdose dashboard. Otherwise, you know, we don't have a lot of MOUs."

The few health departments that had been able to establish data sharing between public health and homeless services (such as immunization databases and HMIS) were more likely to have at least an MOU or a data sharing agreement in place to facilitate data sharing and system linkages. Some health departments did mention that data sharing between public health and homelessness was challenging and that documenting and formalizing data agreements were needed, even if a broader partnership agreement was not needed. For example, an East Coast State Health Department Employee stated:

"We have a data sharing agreement with local CoCs. They're required to allow us access to their deidentified data through the state data warehouse. So that's uploaded currently on a quarterly basis. And we're looking at whether or not with additional products, we can make that data identifiable so that we could do some data matching with [the state health department] and other departments to coordinate service delivery. But that's the vision, not the reality right now."

Another respondent added:

*"We have data sharing agreements with anybody who's using HMIS. And then the school system, we share our data, but I don't think that's formal. It's just the aggregate number of kids experiencing homelessness that are in public school, but we don't have a formal data sharing agreement with them."—**Rural East Coast County Health Department Employee***

Nearly a quarter (24 percent) of interviewed health departments acknowledged that establishing data sharing agreements can take a significant amount of time and coordination between staff from various divisions and organizations. Even within the same agency, it can take time to interpret various regulations and policies regarding data use and privacy to establish data sharing agreements. To assist in this process one health department created a performance measurement committee that brought together data stewards and privacy officers to actively problem-solve and overcome these challenges.

Proactive and Responsive Partner Engagement

Health department engagement with internal and external partners varied greatly. Some health department interviewees reported more proactive partner engagement, meaning that the health department sought out and invited partners to join in on health department-led activities. Other health departments described more responsive partner engagement, in which health department staff would join partner calls or attend partner-led activities in the community for

people experiencing homelessness. Even within health departments, there was a variation of proactive and responsive engagement, depending on the activities, partners, and health department staffing capacity at any given time. Health departments also expressed fluctuations in proactive and responsive engagement throughout the COVID-19 pandemic. Early on during the COVID-19 pandemic, health departments were playing a more proactive role by inviting partners to attend webinars and weekly calls and by offering technical assistance. As the pandemic continued and communities adjusted to COVID-19 mitigation strategies, health departments began taking a more responsive role, responding to partners who reached out for assistance or when alerted of an outbreak.

Barriers, Facilitators, and Opportunities for Health and Homelessness Work

In addition to the findings noted above, there were several barriers and facilitators to the successful completion of activities by health departments related to their work in health and homelessness.

Political Landscape and Local Conditions

External influences, such as the overall political environment and buy-in by local governments, did play a role in the amount of structural support that was available for health departments to complete their work. Strong support—such as mandating a specific office in the health department be established, prioritizing health equity, or requiring agencies to utilize a shared integrated data system—tended to lead to greater success. In addition, political leaders of some large metropolitan areas have declared homelessness a public health emergency, which has allowed access to additional funding, provided more resources, and implemented health and homelessness partnerships and activities. On the other hand, one interviewee indicated that "political" challenges can be a barrier to partnerships and efforts.

> *"[Another] challenge is that homelessness is a pretty political, politically sensitive topic. The work involves a lot of high-level leadership, which can slow things down because high-level leadership needs to review things and wants to make sure that they are kept aware of things. This is a really good example. A few months ago, in [a large urban city], there was a [public health need] that was tied to a homeless encampment. Anytime that happens, it always prompts politicians and leaders to start looking at sanitation and those types of issues. We were working with [an academic institution] to come up with a set of sanitation guidelines that would be statewide sanitation guidelines. And so, our [leadership] cautioned us on like, 'as these guidelines are being developed, we have to think about and be aware of this political sensitivity around local governments not wanting to feel like they're being mandated to do certain things and to make sure that their homeless populations have access to clean bathroom facilities and clean water' and all those things because of the political nature of it. So, I think that's another challenge."—**West Coast State Health Department Employee***

Housing Availability

One barrier illuminated during interviews included the decline in available and affordable housing. The inventory of housing is low and housing needs were amplified during outbreaks. Funding limitations prohibit health departments from paying above a certain rate for hotel rooms and as a result, temporary housing for patients who need to quarantine and recover from infectious diseases is more difficult to obtain. Health departments indicated that funding would often cover the quarantine period but not the recovery period. Additionally, funding may be limited in scope and only be available for COVID-19 but not other infectious diseases like mpox. To help support the needs of people experiencing homelessness who were hospitalized, one Southwest County Health Department created a discharge planning workgroup during the height of COVID-19 that was used to support and find housing. This workgroup has since been discontinued due to lack of funding.

When asked about future opportunities, more than half (60 percent) of interviewed health departments discussed the need to expand housing options and explore partnerships to increase affordable housing. Health departments discussed various housing options, including expanding cohousing and multi-generational housing as well as non-congregate shelters. One East Coast State Health Department discussed developing non-congregate shelters and associated policies and protocols that would allow for the isolation of sick individuals and prevent a broader outbreak.

Centralization of Services

When discussing service availability for people experiencing homelessness, 40 percent of interviewees described disjointed and decentralized services as a major challenge. Health and homelessness work is frequently completed by different divisions within a health department, making it difficult to find the correct contact person for specific services. Additional burden is placed on the coordination of care for people experiencing homelessness because services are located across a city or town. Health departments stated that there is a lack of knowledge regarding how and where to access services to assist people experiencing homelessness. One Urban Southern County Health Department described the desire to have health resources in one location in this way:

> *"In my experience working with clients who are homeless, it would be easier to have a one-stop shop for everything because transportation is always or many times an issue with clients. In working with these populations, they are sent to one place for one service, and then they have to go to another place far away for another service, etc. That complicates things that are already very complicated for clients. So having mental health services in one place, and housing, maybe a social worker for housing specifically, would be amazing if we had that here."*

Accessing needed services is a challenge when there is a lack of reliable and affordable transportation for people experiencing homelessness, as indicated by 28 percent of interviewees. One of the health departments that acknowledged this challenge partnered with other organizations to provide transportation assistance, while 40 percent of health departments

sought to overcome transportation challenges by utilizing mobile clinics that have the ability to "meet people where they are" or expanding case management to allow for more holistic care. Another 44 percent of interviewed health departments mentioned that they see an opportunity to have more health resources dedicated specifically to people experiencing homelessness, especially preventative health screenings and the provision of direct services (such as clinics or Narcan distribution). The capability of providing these additional opportunities is contingent upon capacity, which can be supported through partnership expansions, particularly with mental health and behavioral health organizations.

Supporting Successful Partnerships

Health departments have a variety of internal and external partnerships that vary by length of engagement. Individual interviews suggested that long-standing partnerships were more successful than newly formed relationships, partly because the timing allowed for the delineation of roles. Health departments indicated challenges would arise when it was not clear which organization should be doing certain activities or when roles were blurred. MOUs could facilitate communication about the roles and responsibilities of key partners in addition to formalizing the partnership. However, the process to establish MOUs with government agencies and organizations can be slow, resulting in more informal partnerships. Health departments that were able to identify specific individuals, such as a community engagement manager or racial equity manager, that focused specifically on developing relationships, identifying needs, and building bridges were more successful than smaller departments that did not have the resources available to designate those roles. Additionally, health departments with smaller jurisdictions may also have been limited in their partnerships due to the lack of available partners. One interviewee highlighted the possibility that the prominence and relatively greater resourcing of their state health department might make them a better lead agency for catalyzing relationships:

> *"I would like to see [the state health department] either be the backbone organization or help elevate another organization or state agency to be that backbone organization to just start thinking about creative solutions to homelessness. I think [our state health department] is perfectly situated to bring all our partners together, and not just external to the agency, but even internal as well. So, like chronic disease, but the maternal and child health team also, because they talk about housing, too. So, I think if we can figure out a way to just really pull our efforts and our resources around this, we would be so successful."—**East Coast State Health Department Employee***

Health departments identified future opportunities across a wide spectrum of topics, even things that may fall outside of traditional public health scope or role such as being a part of land zoning policy or helping connect people to housing. Future planned and ideated activities included strengthening and expanding partnerships across state and local public health, CoCs, and homeless service partners, as well as establishing mechanisms to incorporate the voices of people with lived experience of homelessness. A West Coast Department of Health employee stated

> *"The priorities that we will probably focus on would be supporting greater collaboration and coordination between local health jurisdictions and local continuum of care. That's a big one."*

One interviewee described their efforts to engage individuals with lived experience of homelessness as follows:

> *"We're working on developing a Lived Experience Advisory Board, which I think is also something that's going to be amazing when it gets off the ground. We are working with [our homeless service partners] to develop and launch it, and it's going to be made up of individuals that are currently experiencing homelessness, or recently experienced homelessness, for us to consult with on a regular basis around policies and issues related to homelessness, health in general, COVID-19. I think it's going to be a really great opportunity for us to hear the voices of people experiencing homelessness in our work. And I think that's a really important part of what we do—including the community in our processes and including them in the conversation. We're in the beginning stages to start recruiting, but in the next year, we're going to have lots of movement on that. And I think it's going to be very beneficial to us."—**West Coast State Health Department Employee***

Another community indicated they were recruiting people with lived experience to act as consultants for health-focused outreach as "there's a lot of important public health work that needs to be focused very explicitly and culturally specific to people experiencing homelessness, and [...] we don't have a lot of resources."

The Influence of COVID-19

COVID-19 is another area that acted as both a facilitator and barrier depending upon the community. The specific health needs of people experiencing homelessness during the pandemic propelled the formation of new partnerships or allowed existing partnerships to flourish. Funding specific to COVID-19 supported additional staff and provided health departments with a way to do additional activities specifically for people experiencing homelessness. One respondent described the impact of COVID-19 with:

> *"COVID-19 obviously brought in an enormous amount of resources that we were able to expand our staff with. And so, a quick example with COVID-19 is that we stood up this team, a homeless education awareness and response team, to respond to outbreaks and to support shelters. It became a team of community health workers, nurses, social workers, disease investigators, and response specialists. And that team also quickly became a communication arm on the ground for people experiencing homelessness and providers. So staffing was a key piece to how we were able to expand the number of people, both on the front and the back ends."—**Urban West Coast County Health Department Employee***

This phenomenon was also present in rural health departments. A rural East Coast county health department employee described: “We had a lot of work to do during COVID, but because of funding, we had more staff as well, so we were able to invest more resources.” One community was able to nearly double its programming in size due to an increase in funding during the pandemic and was able to expand its partnerships during this period. On the other hand, several jurisdictions that did not have well-established pre-existing partnerships struggled to quickly establish those connections and get funding out to address needs.

With the expiration of the COVID-19 Emergency in May 2023, there are several emerging challenges associated with funding. One challenge focuses on the perception that a health department’s increased capacity during the COVID-19 funding period is their normal capacity and partners therefore have higher expectations than can be maintained once that funding ends. Another barrier concerns COVID-19 and how the pandemic disrupted other operations. One Midwest County Health Department specifically spoke to this stating, “COVID disrupted so many other normal operations. So, we're certainly having to divert some activities to other things, and focus largely on COVID vaccinations for some of these populations, as opposed to some of the other things.”

Participants also described hopes for utilizing foundations built during the COVID-19 pandemic for additional health outcomes that are not limited to COVID-19, such as health education, vaccination, screenings, and other health care linkages, as well as surveillance, all of which were bolstered to support COVID-19 responses.

Overcoming Staffing Challenges

One of the most frequently cited challenges during the interviews was a lack of staff capacity due to the limited number of staff allowed because of funding limitations. Health departments and partner organizations are understaffed for the amount of work needing to be completed, which causes staff unavailability to attend all meetings. Several health departments noted being particularly under-resourced with behavioral health practitioners. Regardless of these challenges, the majority of staff indicated they were very committed to their work and that their level of passion and commitment was a strength. One interviewee illustrated this commitment:

> *“In our internal work group, I think a lot of what is driving it is that the people that show up want to be there. Part of the reason that it's been effective, even though we've had staffing changes, is that the members of the committee are very committed to keeping it going. So I think having regular communications and having regular standing meetings that are driven with goals in mind is the way that we've kept the work group going. Through all the ups and downs of staffing changes, all of that could have just kind of disappeared, but it's really a lot of internal staff. A lot of my colleagues care deeply about homelessness. And I think that that's part of the reason that internally, we are actually able to keep this going.”—**West Coast State Health Department Employee***

In addition to limited staff, staff turnover within public health departments and with partner agencies was a challenge. Training and onboarding new staff requires attention and time from existing staff, and there are natural transition periods where staff are adjusting to their roles and

learning about current processes, procedures, and recommendations. Frequent staff turnover also made it difficult to maintain an updated contact list or to have one reliable contact within each agency. This challenge of having a reliable contact is amplified when services are decentralized and there is no one place to go for comprehensive health and homelessness services. Cross-training homeless service providers on public health structures, systems, and roles, as well as training public health staff on homelessness response systems, daily lived experiences of homelessness, and housing pathways could be one way to minimize the disruption to operations from staff turnover.

Resources and Funding

The complexity and nuances of funding streams were stated as a challenge within the interviews. Many health departments noted the need for additional funding and resources to house individuals and to provide desired public health services. The management of multiple funding sources as well as the constraints and limitations imposed by a lack of flexibility in how funding could be used was also challenging. For example, ELC funds are limited to specific COVID-19-related activities. As funding runs out, health departments are forced to choose between activities. A Rural Midwest County Health Department Employee explained this issue:

> *"Additional funding would always be great. I'm on the team to look at our strategic plan and to look at our yearly goals. And all these entities have different pots of money. So, we're okay when it comes to working together, but every pot of funds is earmarked for certain things. You can only do certain things with that money. So, I think more funding where we can coordinate our response and have the freedom to do what we need with those funds."*

To combat the complexity of funding, one health department came together with its partners to understand funding differences and activities. From this effort, they were able to determine how to best allocate resources while also strengthening partnerships. As funding ends, staffing choices will also need to be made. Several health departments noted the desire to identify dedicated staff solely focused on health and homelessness efforts. A Suburban Midwest County Health Department put it in this way:

> *"In an ideal world, we would be able to hire someone that had a homelessness focus and that was what they were paid under. And they actually had a work plan or a grant or something where this was their focus. I mean, that would be nice so it wouldn't be just one of our staff members who are pulled in so many directions. But if we had one person that can really focus and support [health and homelessness] efforts, that could be beneficial."*

Future Data Collection Efforts

While most health departments mentioned some prior or ongoing data collection on the health of people experiencing homelessness, many communities aspire to dig deeper into data collection and integrate real-time data. Close to half (44 percent) of health department

interviewees provided ways in which they hope to use collected data, including to address social determinants of health, outbreak management, traffic-related injury and mortality, and violence prevention. Both large and small health departments propose the use of data to address mortality rates among people experiencing homelessness. Another health department sees an opportunity to match data in order to coordinate and expand services such as Medicaid.

Health departments discussed that data collection efforts vary across organizations and across data sources, which limits the usability of the data. Data sources may be limited in the questions that can be asked and the answer options available. For example, predefined data elements that require the selection of one single racial category may not accurately capture people who identify as multi-racial. Large public health surveillance systems may not be modifiable to add a question on housing or homelessness status. These discrepancies limit the extent of data integration across data sources and may result in missing data. Still, others discussed efforts taken to link across data sources to gain a complete picture of health among people experiencing homelessness. An Urban Southern County Health Department Employee stated:

> *"I'm in the process right now of trying to get HMIS data to be entered into our disease surveillance system. So when we get things like hepatitis or HIV, we can help get people back into care, or do some of the epidemiologic investigation and address clusters or outbreaks."*

Training Needs

More than a third (36 percent) of communities during the individual interviews stated that some level of cross-coordination or training of staff would be beneficial to holistically serve people experiencing homelessness. Several health departments discussed the benefit of cross-training in the areas of behavioral health services, infectious disease protocols, and other health and safety techniques. Health departments indicated that training would be beneficial to staff who operate as methodological or disease-specific subject matter experts, as well as training in general health and safety techniques for shelter or encampment residents.

Discussion

This analysis synthesized findings from a survey and interviews with public health departments regarding activities serving people experiencing homelessness. Operations within health departments to serve people experiencing homelessness often involve coordination across teams and departments. This was especially true when health departments were contained within departments of health and human services, in which case health and homelessness services were generally the responsibility of the human services division.

Public health programs and services for people experiencing homelessness also usually involve outside partners. COVID-19 presented both an impetus and resources to create these partnerships in communities, though many entities intended on maintaining lines of communication after the pandemic response was completed. This has left many public health departments better situated to respond to the emerging health needs of people experiencing

homelessness, activating many of the same partnerships for mpox response that were developed during COVID-19.

Despite strengthened partnerships, public health departments still face challenges serving people experiencing homelessness. Sometimes the role of public health within these partnerships is unclear or poorly defined. Additionally, many communities are not adequately staffed to maintain the depth of partnerships and programming that would be needed to fully serve people experiencing homelessness. Even in the face of these limitations, communities were still making progress in key areas such as joint training, increased outreach, data sharing, and the overall measurement of health and homelessness activities.

Correspondence with Prior Research

Built for Zero conducted an online survey of its affiliated homeless services organizations in 2022, and its results align with the present study's findings in several ways (see ref. 28):

- Of all Built for Zero's respondents, 87 percent indicated a "strong" or "some" relationship with their local health department and 86 percent of the respondents to this engagement indicated that they partnered with local health departments in their jurisdiction in at least some capacity.
- Built for Zero's respondents collaborated with their local health departments during the COVID-19 pandemic on vaccination (85 percent), testing (78 percent), outreach (83 percent), or education (85 percent); the current survey's results were, respectively, 56 percent, 35 percent, 65 percent, and 57 percent, indicating a somewhat lower level of collaboration against a comparable (but not identical) listing of activities; however, there were no respondents to the 2023 survey who indicated that they had not collaborated during the pandemic at all. Built for Zero's affiliated CoCs may also have a higher degree of programmatic sophistication than CoCs generally.
- Of all Built for Zero's respondents, 61 percent indicated that they had collaborated with local health departments on "over four" initiatives during the pandemic; the current survey found an average number of five collaborative activities with local health departments since January 2020.

Limitations

This project necessitated broad outreach to public health departments. While respondents from all 50 states, representing states and counties of all sizes, are included in this analysis, there are several important limitations to note. First, as previously described, many health and homelessness activities are being led by human services divisions of joint health and human services departments. Because of the focus of this paper, the Cloudburst team did not conduct outreach to staff who primarily served within the human service division, thus limiting the pool of potential respondents. The pool was further narrowed by the lack of public contact information for many health departments that could not be reached.

There was also some geographic overrepresentation of midwestern health departments in the health department survey. Of health department survey respondents, 124 (46 percent) worked in either the Chicago or Kansas City HHS region. The pool of respondents from the Chicago

region, in addition to respondents working in Illinois, Indiana, Michigan, Minnesota, and Ohio, was particularly robust. Of the health department survey respondents who provided their geographic location, 32 percent were working in the Chicago region.

Some of those who were included in the outreach did not participate. This included two states in which a centralized health department declined to participate, preventing the team from surveying localities in those states. In both cases, however, a CoC or HCH group did respond. Other reasons for nonresponse are not known but may include communities that were not undertaking health-homelessness work or organizations that were too busy to participate. Additionally, the response list included some undeliverable emails. In cases where there was an automatic reply providing an alternate contact, that contact was subsequently invited to participate. As the request to participate in the survey was distributed by Cloudburst and not the CDC Foundation or CDC, it is possible that potential survey participants believed the email to be illegitimate or fraudulent.

The team encountered significant challenges linking survey responses to PIT count or budget information to perform potentially useful analyses. The majority of survey participants were from county, city, or other local jurisdictions that did not align with PIT area estimates. PIT counts are reported at the CoC level, and CoCs do not always align with county or city borders or other census tract locations. Many of the localities that participated were represented by their Balance of State CoC, which are often combinations of multiple counties with smaller or more rural populations of people experiencing homelessness. Since only one population estimate is provided for the Balance of State CoC, the team could not determine meaningful associations or differences between counties in the same Balance of State CoC.

Opportunities

These findings highlight important opportunities for federal agencies, health departments, and local organizations to continue to partner within their communities in order to better serve people experiencing homelessness. For CoCs, this analysis shows a tremendous willingness on the part of public health departments to partner and participate as a member of the continuum. For CoCs that do not have a relationship with public health, leadership should conduct outreach and include health departments in program and service planning.

Given the benefits and opportunities illustrated through this project, it would be advantageous for federal agencies such as the CDC to encourage widespread deployment of health and homelessness work across the United States. Further, with current funding streams ending, critical next steps may include providing additional funding to state and county health departments to conduct this work.

Health departments at the state and county levels have the challenge of continuing to secure funding with the expiration of the COVID-19 pandemic. However, if they are able to creatively do so, there are numerous opportunities including adding additional staff and providing training to current staff. With limited funding, cross-training staff in multiple areas (including health and safety protocols) is one way in which health departments can stretch their funds and support the needs of people experiencing homelessness. Additionally, focusing on

increased comprehensive data collection will help ensure that appropriate programs are provided to marginalized populations that may surface during data analysis.

With an increased state and county focus on health and homelessness work, HCHs, CoCs, and community-based organizations should take advantage of the opportunities provided by health departments and partner with homeless service providers whenever possible. Partnering will benefit these organizations through the potential for additional funding, and it will also allow for better communication between parties. As they are the “boots on the ground” organizations, partnering with state and county health departments is one way to advocate for the people experiencing homelessness and to influence program deployment.

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Figures & Tables

Figure 1: Data Collection Process

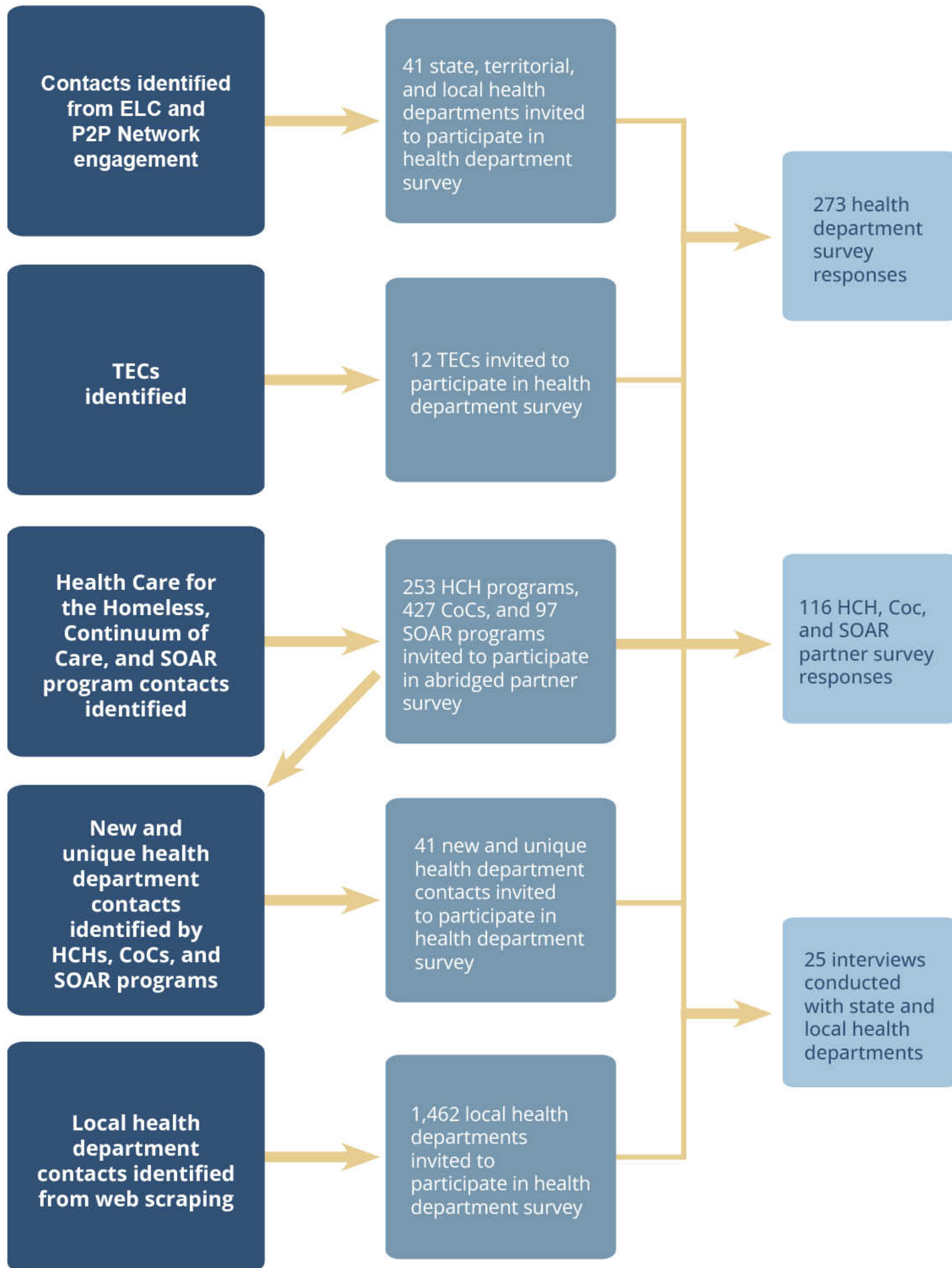


Figure 2: Project Timeline

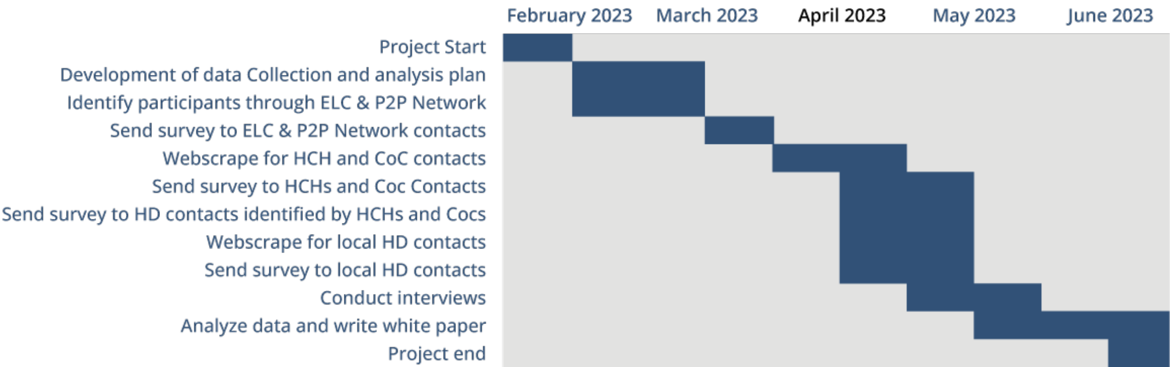
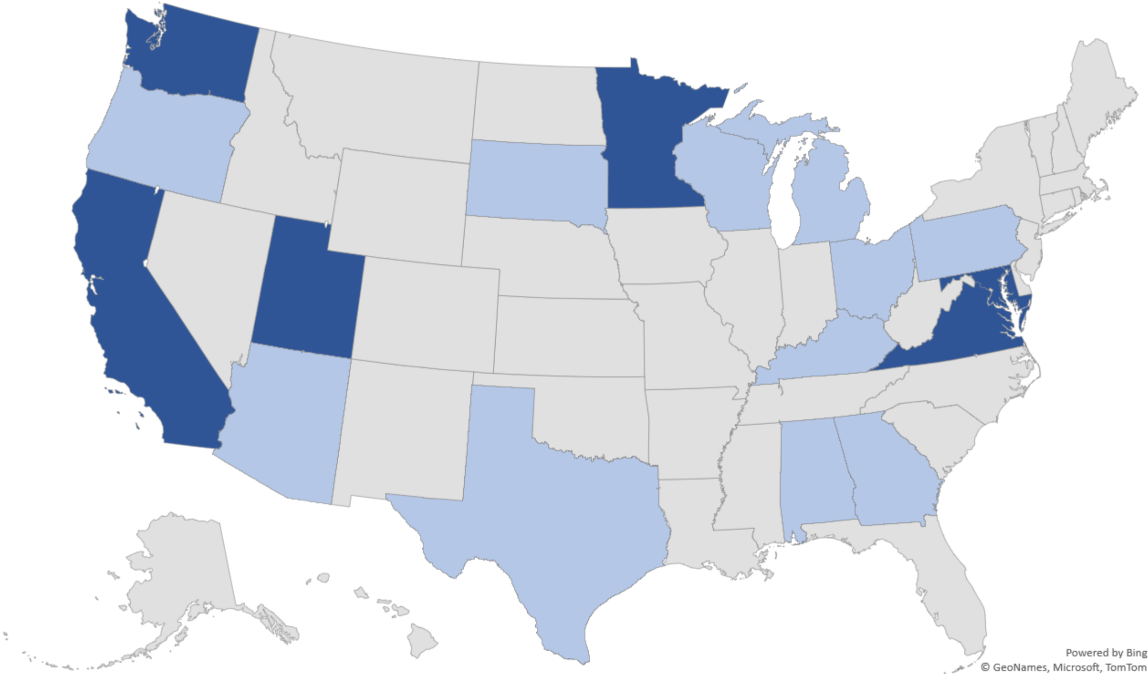


Figure 2 describes the schedule under which project activities have been undertaken to date.

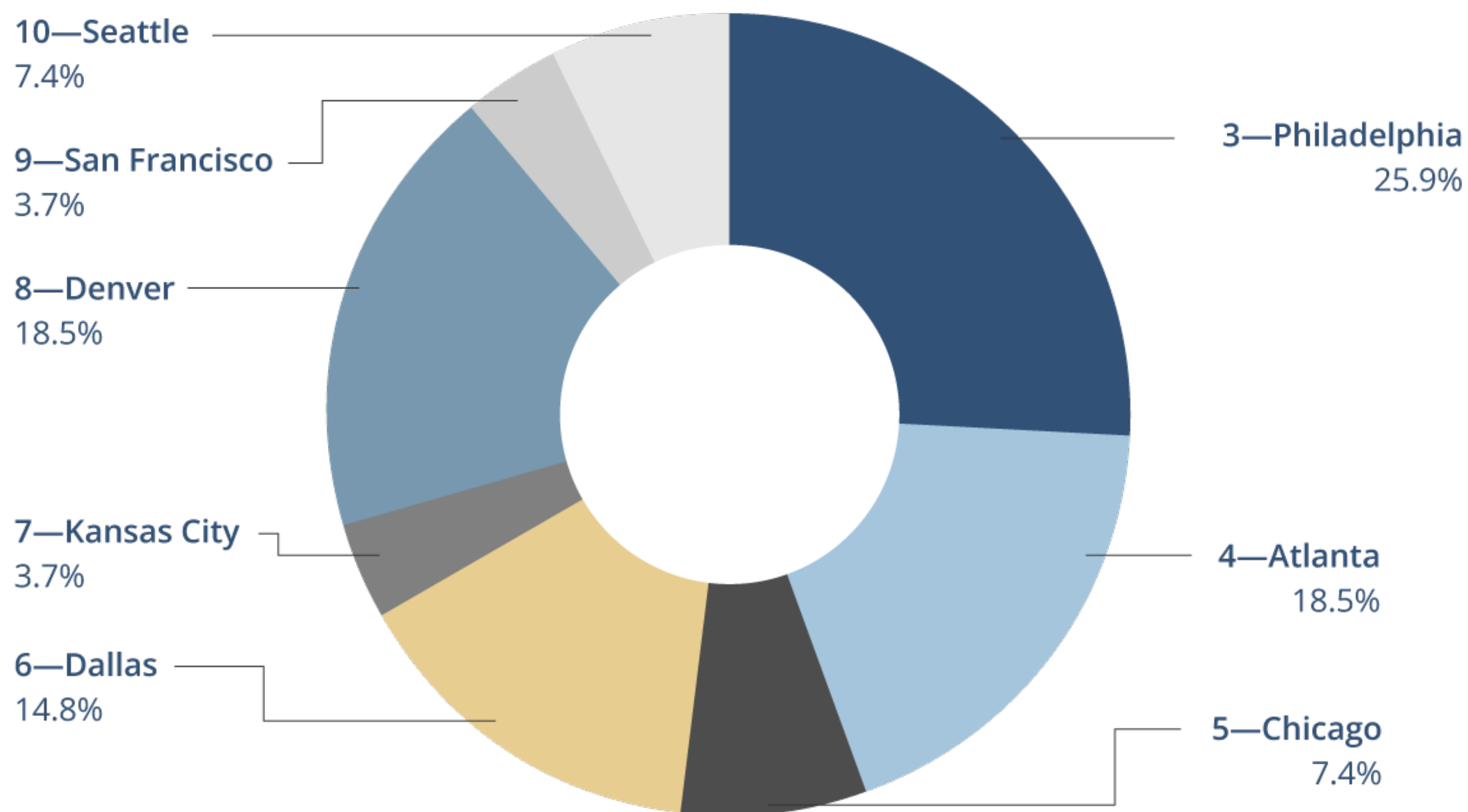
Figure 3: Map of Interviewees

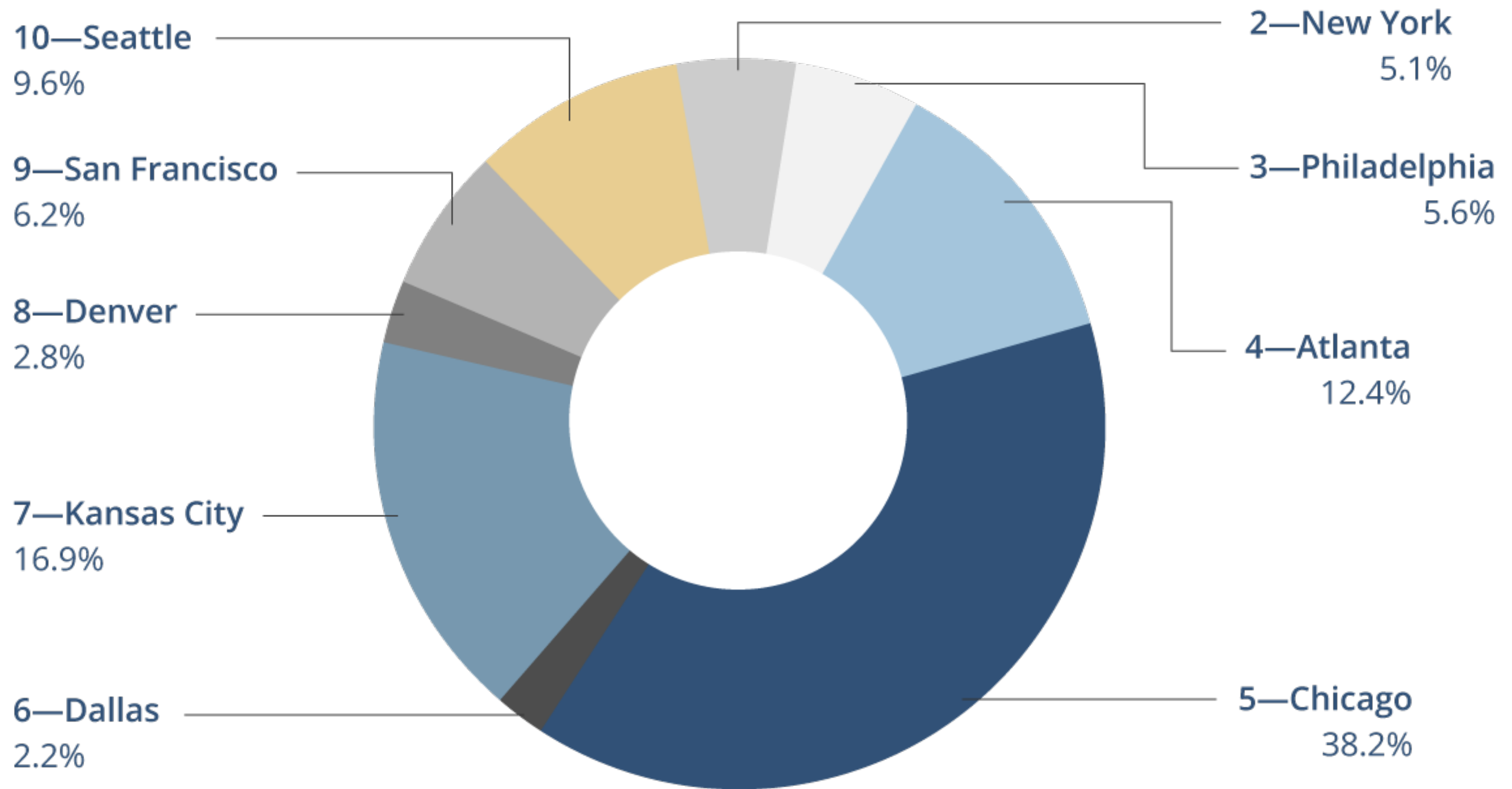
States in Which Health Department Interviewees' Jurisdictions Are Located



Note: Dark blue states had two or more interviewees and light blue states had one interviewee. One territory was also interviewed and is not pictured.

Figures 4–6. Breakdown of Survey Participants by HHS Region at State and Territorial, County, and City or Other Local levels




County Health Departments
by HHS Region
10—Seattle
9.6%
9—San Francisco
6.2%
8—Denver
2.8%
7—Kansas City
16.9%
6—Dallas
2.2%
2—New York
5.1%
3—Philadelphia
5.6%
4—Atlanta
12.4%
5—Chicago
38.2%

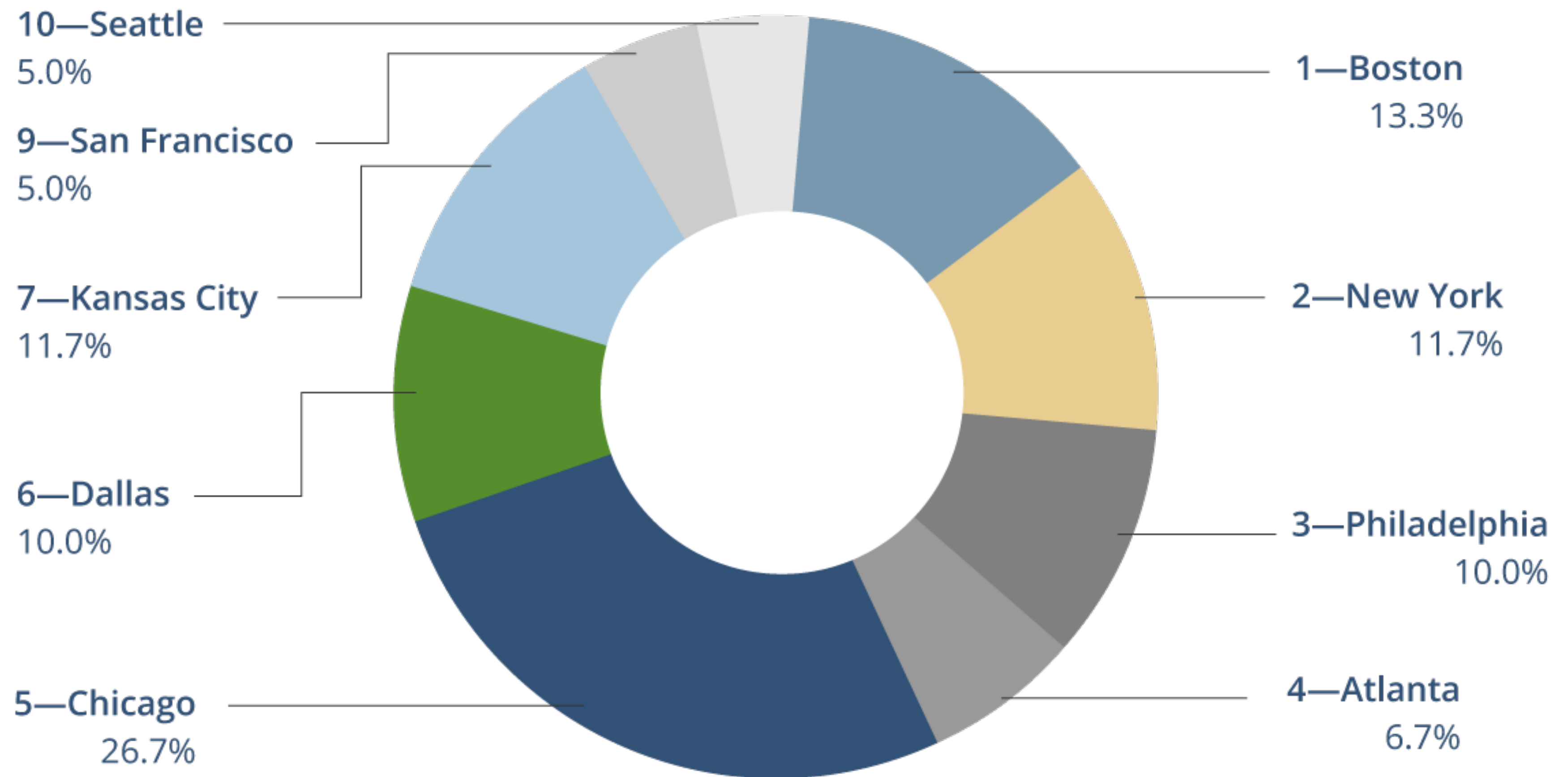

City or Local Health Departments
by HHS Region
10—Seattle
5.0%
9—San Francisco
5.0%
7—Kansas City
11.7%
6—Dallas
10.0%
5—Chicago
26.7%
1—Boston
13.3%
2—New York
11.7%
3—Philadelphia
10.0%
4—Atlanta
6.7%

Table 1. Characteristics of Health Department Survey Participants

	State or Territory Health Department		County Health Department		City or Local Health Department		Tribal Entity		Total	
	Count	Percent	Count	Percent	Count	Percent	Count	Percent	Count	Percent
HHS Region										
1—Boston		0%	2	1%	8	13%			10	4%
2—New York		0%	9	5%	7	12%			16	6%
3—Philadelphia	7	26%	10	6%	6	10%			23	8%
4—Atlanta	5	19%	22	12%	4	7%			31	11%
5—Chicago	2	7%	68	38%	16	27%			100	36%
6—Dallas	4	15%	4	2%	6	10%			14	5%
7—Kansas City	1	4%	30	17%	7	12%			38	14%
8—Denver	5	19%	5	3%		0%			10	4%
9—San Francisco	1	4%	11	6%	3	5%			15	5%
10—Seattle	2	7%	17	10%	3	5%			22	8%
Total	**27**		**178**		**60**		**2**		**267**	
Percent of Total Survey Responses (N=273)	**10%**		**65%**		**22%**		**<1%**		**98%**	

Table 2. Population Size of State, Tribe, or Closest Corresponding City or County Among Survey Participants

*Remaining survey participants did not provide sufficient geographic information for inclusion in this table

Population Size	State or Territory Health Department		County Health Department		City Health Department		Tribal Entity		Total	
	Count	Percent	Count	Percent	Count	Percent	Count	Percent	Count	Percent
<30,000	0		97	54%	20	33%	1	50%	118	44%
30,000–130,000	0		43	24%	23	38%	0		66	25%
130,001–700,000	0		26	15%	13	22%	0		39	15%
>700,000	27	100%	12	7%	4	7%	1	50%	44	16%
Total	**27**		**178**		**60**		**2**		**267**	
Percent of Total Survey Responses (N=273)	**10%**		**65%**		**22%**		**1%**		**98%**	

Appendices

Appendix A: Health Department Survey

Thank you for participating in our data collection effort that we are conducting with the CDC Foundation to assess health and homelessness activities within public health departments and organizations. Your participation will contribute to a greater understanding of health and homelessness activities and capacity within public health organizations across the U.S.

Your participation in this survey is completely voluntary, and the information you share will not impact your current projects, funding, and support from the CDC Foundation or the CDC.

Information collected through this survey will be used in two primary ways:

1. To identify a primary point of contact for health and homelessness activities at your organization. This information will be compiled into a directory of contacts for internal use only by the CDC Foundation and the Centers for Disease Control and Prevention to support outreach and emergency public health responses.

2. To develop a white paper that summarizes the breadth and depth of public health departments and organizational capacity and efforts for health and homelessness.

Individual names and contact information will only be provided to CDC and CDC Foundation for official duty-related activities. The white paper will not include the names of individuals who participated in this data collection effort. Responses may be characterized in the following ways: a) attributed to your organization with your permission (e.g., Minnesota Department of Health); b) regional or geographic descriptor (e.g., a Midwest State Health Department, a Tribal Epidemiology Center); c) a demographic descriptor (e.g., a large urban city health department); or by capacity descriptor (e.g., a health department with a strong history of effective public health and homelessness partnership).

Please do not hesitate to reach out if you have any questions, concerns, or difficulties completing this survey.

Ashley Meehan at ashley.meehan@cloudburstgroup.com.

#	Question	Field Type
Background Information		
Q1	Please enter the following information: • Full Name • Job Title • Email Address	Open-text
Q2	Which of the following best describes the governance level of your organization?	Select one: • City or Local • County • Tribal • State or Territory
Q2Sk1	In which state or territory is your organization located? Skip/Branching: only appears if "Tribal" was not selected. Tribal entities will be asked "Which tribe(s) does your organization support?"	Dropdown: AL AK AZ AR CA CO CT DE FL -- PR DC -- Etc.

#	Question	Field Type
Q2Sk2	Which [city/locality or county] is your organization located in?	Open-text
	Organizational Characteristics	
Q3	[Matrix] Please indicate if the following statements are true for your jurisdiction: "Decision-making, program planning, and other executive decisions around health and homelessness activities are primarily determined by the state or territorial health department in my jurisdiction." "Decision-making, program planning, and other executive decisions around health and homelessness activities are primarily determined by county, city, or other local health departments in my jurisdiction."	[Matrix] Select one: • True • Not true
Q4	[Matrix] Please indicate if the following statements are true for your jurisdiction: "Implementation of programs and other health and homelessness activities is primarily done by the state or territorial health department in my jurisdiction." "Implementation of programs and other health and homelessness activities is primarily done by the county, city, or other local health department in my jurisdiction."	[Matrix] Select one: • True • Not true
	Homelessness Point of Contact	
Q5	Which of the following best describes health and homelessness coordination within your agency?	Select one: • There is a primary point of contact for health and homelessness → Q5Sk1 • Multiple people work on health and homelessness within their respective topic

#	Question	Field Type
		areas with no single point of contact→ Q5Sk4 • No health and homelessness activities are coordinated within our agency → Q5Sk5
Q5Sk1	Who is the primary point of contact for homelessness in your organization? Another way to think about this is, if there were an outbreak of an infectious disease in a homeless shelter or among people experiencing homelessness, would you be the primary person that staff from CDC would be in contact with? This person may work on health and homelessness activities alone or may coordinate health-homelessness activities as well as activities for other congregate settings or special populations. Please list your name if you are the primary point of contact. Names and emails will only be shared with CDC staff to facilitate communication about outbreaks and emergency response and to provide other public health support for people experiencing homelessness. Skip/Branching: only appears if "There is a primary point of contact" is selected	Open-text: • Name • Email Address
Q5Sk2	How long has the primary point of contact for health and homelessness been in their role? This may be yourself, or another point of contact if you are not the primary point person for health and homelessness. Skip/Branching: only appears if "There is a primary point of contact" is selected	Dropdown: • Less than 6 months • 6–12 months • 1–3 years • 3–5 years • 5–10 years • 10 or more years
Q5Sk3	Which topic areas, divisions, offices, or bureaus in your organization have someone supporting health and homelessness? Skip/Branching: only appears if "Multiple people work on health and homelessness within their respective topic areas with no single point of	Open-text

#	Question	Field Type
	contact” is selected	
Q5Sk4	Who is one person who can be contacted regarding health and homelessness support? Skip/Branching: only appears if “Multiple people work on health and homelessness within their respective topic areas with no single point of contact” is selected	Open text: • Name • Organization/Job Title • Email Address
Q5Sk5	What other organizations or agencies coordinate health and homelessness activities in your jurisdiction? Skip/Branching: only appears if “No health and homelessness activities are coordinated within our agency” is selected	Open-text → [END OF SURVEY]
Staffing		
Q6	How many staff (including yourself) in your organization **currently** support activities related to health and homelessness in their official work capacity? This may include staff who work on homelessness alone or homelessness and other congregate settings or special populations.	Open-text
Q7	In the past 5 years, has the number of staff supporting health and homelessness in their official work capacity: This may include staff who work on homelessness alone or homelessness and other congregate settings or special populations.	Select one: • Increased • Decreased • Stayed the same
Q8	How long have there been staff or positions at your organization focused on addressing health and homelessness? This may include staff who work on homelessness alone or homelessness and other congregate settings or special populations.	Drop Down: • Less than 6 months • 6–12 months • 1–3 years • 3–5 years • 5–10 years • 10 or more years

#	Question	Field Type
		• Unsure
Q9	Are there ongoing or planned efforts to hire additional staff to support activities related to health and homelessness? This may include staff who work on homelessness alone or homelessness and other congregate settings or special populations.	Select one: • Yes • No • Unsure
Funding		
Q10	[Matrix] To what extent do you agree with the following statements? “My organization has an adequate number of dedicated staff to health and homelessness activities.” “My organization has sufficient financial resources, outside of staff, to conduct health and homelessness activities.” “My organization has the right amount of quality staff, funding, and partnerships to effectively promote health and well-being for people experiencing homelessness.”	[Matrix] Select one: • Strongly agree • Agree • Disagree • Strongly disagree
Q11	What funding sources currently support health and homelessness staff and activities within your organization? Some examples may include cooperative agreement funds from federal or state agencies, funds from non-governmental organizations, or other local funding streams.	Open-text
Partnerships and Communication		
Q12	Prior to January 2020, did your organization partner with homeless service programs or homeless response systems in your jurisdiction in any capacity? These might include Continuums of Care, task forces, working groups, specific facilities like homeless shelters, etc. Do not include partnerships	Select One: • Yes → Q12Sk1 • No • Unsure

#	Question	Field Type
	with Health Care for the Homeless here.	
Q12Sk1	What types of activities did your organization do in partnership with homeless service programs in your jurisdiction prior to January 2020? Skip/Branching: only if "Yes" to partnership prior to January 2020.	Select all that apply: • Outbreak investigations • General communication and information sharing • Data matching, linkages, or integration • Emergency preparedness planning • Natural disaster planning and response • Health education and promotion • Health clinics • Vaccination clinics • Environmental assessments of homeless service facilities • Environmental assessments of homeless encampments or outdoor sleeping • Routine screening or testing for infectious diseases (e.g., sexually transmitted infections, Tuberculosis) • Referrals or resources to care for chronic or disabling conditions • Referrals or resources to care for substance use disorder • Referrals or resources to care for severe mental illness • Naloxone distribution or other harm reduction service provision • General outreach to people experiencing unsheltered homelessness

#	Question	Field Type
		• Formalizing partnerships through memorandum of understanding or agreement, data use agreements, etc. • Other [open-text]
Q13	Since January 2020, what types of activities has your organization done in partnership with homeless service programs in your jurisdiction?	Select all that apply: • Outbreak investigations • General communication and information sharing • Data matching, linkages, or integration • Emergency preparedness planning • Natural disaster planning and response • Health education and promotion • Health clinics • Vaccination clinics • Environmental assessments of homeless service facilities • Environmental assessments of homeless encampments or outdoor sleeping • Routine screening or testing for infectious diseases (e.g., sexually transmitted infections, Tuberculosis) • Referrals or resources to care for chronic or disabling conditions • Referrals or resources to care for substance use disorder • Referrals or resources to care for severe mental illness • Naloxone distribution or other harm reduction service provision

#	Question	Field Type
		• General outreach to people experiencing unsheltered homelessness • Formalizing partnerships through memorandum of understanding or agreement, data use agreements, etc. • We did not conduct any activities during the COVID-19 pandemic with homeless service programs. • Other [open-text]
Q14	Does your organization currently partner with homeless service programs or homeless response systems in your jurisdiction in any capacity? These might include Continuums of Care, task forces, working groups, specific facilities like homeless shelters, etc. Do not include partnerships with Health Care for the Homeless here.	Select one: • Yes → go to Q14Sk1 • No • Unsure
Q14Sk1	Which of the following types of homeless service programs or response systems do you currently partner with? Skip/Branching: This question only appears if "Yes" is selected in Q14 regarding current housing partners.	Select all that apply: • Continuum of Care leadership • Local Emergency Solutions Grants Program Administration • Emergency homeless shelters • Permanent supportive housing programs • Rapid re-housing programs • Substance use treatment facilities for people • experiencing homelessness • Other [open-text]
Q14Sk2	How many other organizations does your organization currently partner with that provide services for or collect data from people experiencing homelessness?	Open-text with integer validation

#	Question	Field Type
	Skip/Branching: only if "Yes" to current partnership.	
Q14Sk3	What types of additional partners do you work with on health and homelessness activities? Skip/Branching: only if more than 0 "other organizations" are entered in Q179Sk3	Select all that apply: • Academic institutions or centers • Law enforcement agencies or organizations • Faith-based organizations • Community-based substance use service organizations (such as safe injection sites, harm reduction centers, etc.) • Community-based mental health service organizations • Other community-based organizations • Other governmental organizations
Q14Sk4	[Matrix] For each of the current partners below, please select the description that best captures your collaboration and partnership: • Homeless service providers or homeless response system • Academic institutions or centers • Law enforcement agencies or organizations • Faith-based organizations • Community-based substance use service organizations (such as safe injection sites, harm reduction centers, etc.) • Community-based mental health service organizations • Other community-based organizations • Other governmental organizations	[Matrix] Select one per partner group: 0. No interaction at all 1. Aware of these organizations; loosely defined roles; little communication; all decisions are made independently 2. Provide information to each other; somewhat defined roles; formal communication; all decisions are made independently 3. Share information and resources; defined roles; frequent communication; some shared decision making

#	Question	Field Type
		4. Share ideas; share resources; frequent and prioritized communication; all members have a vote in decision making 5. Members belong to one system; frequent communication characterized by mutual trust; consensus is reached on all decisions
Q14Sk5	Aside from COVID-19 work, what types of activities does your organization currently do in partnership with homeless service programs in your jurisdiction? Skip/Branching: only if "Yes" to current partnership.	Select all that apply: • Outbreak investigations • General communication and information sharing • Data matching, linkages, or integration • Emergency preparedness planning • Natural disaster planning and response • Health education and promotion • Health clinics • Vaccination clinics • Environmental assessments of homeless service facilities • Environmental assessments of homeless encampments or outdoor sleeping • Routine screening or testing for infectious diseases (e.g., sexually transmitted infections, Tuberculosis) • Referrals or resources to care for chronic or disabling conditions • Referrals or resources to care for substance use disorder • Referrals or resources to care for severe mental illness

#	Question	Field Type
		• Naloxone distribution or other harm reduction service provision • General outreach to people experiencing unsheltered homelessness • Formalizing partnerships through memorandum of understanding or agreement, data use agreements, etc. • Other [open-text]
Q14Sk6	Which of the following best describes the formality of your current partnerships with homeless service providers or homeless response systems? Skip/Branching: only appears if "Yes" to current partnership.	Select one: • Completed and signed memorandum of understanding or agreement • Currently in the process of finalizing a memorandum of understanding or agreement • Have discussed developing a memorandum of understanding or agreement, but have not started one • No plans to develop a memorandum of understanding or agreement
Q15	Does your jurisdiction have a Health Care for the Homeless program?	Select one: • Yes → Q15Sk1 • No • Unsure
Q15Sk1	Prior to January 2020, did your organization partner with Health Care for the Homeless programs in your jurisdiction in any capacity? Skip/Branching: only appears if "Yes" they have an HCH program in their jurisdiction.	Select one: • Yes • No • Unsure

#	Question	Field Type
Q15Sk2	Does your organization currently partner with Health Care for the Homeless programs in your jurisdiction in any capacity? Skip/Branching: only appears if "Yes" they have an HCH program in their jurisdiction.	Select one: • Yes • No • Unsure
Q16	[Matrix] To what extent do you agree or disagree with the following statements: "My organization would benefit from partnering with more partners providing services to or collecting data from people experiencing homelessness." "My organization would benefit from working with a more diverse group of partners (additional sectors, underrepresented groups, etc.) that provide services to or collect data from people experiencing homelessness."	[Matrix] Select one: • Strongly Agree • Agree • Disagree • Strongly Disagree
Q17	[Matrix] Rate your organization's overall communication efforts with partners providing services to or collecting data from people experiencing homelessness: • Overall effectiveness of communication with partners • Success communicating priorities with partners • Level of understanding of your partners' priorities	[Matrix] Select one: • Excellent • Good • Average • Below average • Poor
Q18	Which of the following best describes the frequency of your communication with homeless service providers in your jurisdiction?	Dropdown: • No regular interval, on an as-needed basis • Quarterly • Monthly • Every other week • Weekly

#	Question	Field Type
		• Daily
Q19	How could your organization’s partnerships with groups providing services to or collecting data from people experiencing homelessness be improved?	Select all that apply: • More frequent meetings or communications • Less frequent meetings or communications • Clearer roles and responsibilities • More formal partnership structures, such as a memorandum of understanding agreement or data use agreements • More accountability • Additional staff dedicated to maintaining partnerships and engaging in partner activities • Greater collaboration on shared goals and activities • Other [open-text]
Data & Information Sources		
Q20	What sources of information do you use to assess public health needs and outcomes among people experiencing homelessness?	Select all that apply: • Surveillance data • Medical records • Reports from homeless service partners • News media (journalistic sources) • First-hand accounts from medical providers • First-hand accounts from other service providers • Internal organization communications • External meetings with other agencies, groups, task forces, etc.

#	Question	Field Type
		• Other [open-text]
Q21	Does your organization have a definition of homelessness that is used to determine if someone is experiencing homelessness in your data system(s)?	Select one: • Yes → Q21Sk1 • No
Q21Sk1	Has your organization intentionally aligned its definition of homelessness with any of the federal definitions of homelessness? Skip/Branching: only if "Yes" is selected that the organization has a definition of homelessness	Select one: • Yes → Q24Sk2 • No
Q21Sk2	Which federal definition have you aligned your organizational definition with?	Open-text
Q21Sk3	Thinking about all of the data sources your organization uses, please select which of the following your organization uses to consider someone as "experiencing homelessness" Skip/Branching: only if "Yes" is selected that the organization has a definition of homelessness	Select all that apply • Person stayed in a homeless shelter • Person accessed other homeless services (e.g., meal services) • Person slept outside or in a place not meant for human habitation (e.g., tent, car, abandoned building) • Person stayed in transitional housing • Person stayed in permanent supportive housing • Person stayed with friends (doubled up or couch surfing) • Person stayed in hotel or motel • Person described as experiencing homelessness in medical record (either through ICD-10 code or open-text fields) • Person described themselves as experiencing homelessness (such as in a

#	Question	Field Type
		case interview, survey, or other interaction with data collection) • Other [open-text]
Q21Sk4	In your organizational definition, over what time period is a person considered to be experiencing homelessness? Skip/Branching: only if “Yes” is selected that the organization has a definition of homelessness	Select one: • At the time of data collection (survey, case investigation) or positive test result → Q22 • Over a time period (e.g., at some point in the past two weeks, at any point in the past year) → Q21Sk5
Q21Sk5	What type of time period? Skip/Branching: Only if “Over a time period” is selected for time frame of homelessness	Dropdown: • Days → Q24Sk6 • Weeks → Q24Sk7 • Months → Q24Sk8
Q21Sk6	How many days does a person have to be without housing to be considered experiencing homelessness? Skip/Branching: Only if “Days” is the selected time period	Open-text with integer validation
Q21Sk7	How many weeks does a person have to be without housing to be considered experiencing homelessness? Skip/Branching: Only if “Weeks” is the selected time period	Open-text with integer validation
Q21Sk8	How many months does a person have to be without housing to be considered experiencing homelessness? Skip/Branching: Only if “Months” is the selected time period	Open-text with integer validation

#	Question	Field Type
Q22	Has your organization linked or integrated public health and homeless service data systems (such as HMIS)?	Select one: • Yes → go to Q22Sk1 • Not yet—currently in the process of linking or integrating data • No—have been unsuccessful → go to Q22k2 • No—have not tried
Q22Sk1	What were the key facilitators to data linkage or integration in your jurisdiction? Skip/Branching: only if "Yes" was selected to successful data integration	Open-text
Q22Sk2	What have been key barriers to linking or integrating data in your jurisdiction? Skip/Branching: only if "No—have been unsuccessful" was selected for successful data integration	Open-text
Wrap-up and Interview Interest & Availability		
Q23	Would you be able and willing to meet with a member of our team virtually for approximately one hour to discuss these responses and this topic in more depth within the next few weeks?	Select one: • Yes • No • I am not the right person but would be glad to connect you with the primary contact for homelessness activities
Q24	Please provider the following information for the primary contact for homelessness activities: • Name • Organization/Job Title • Email Address	Open-text

Appendix B: Partner Survey

Thank you for participating in our data collection effort that we are conducting with the CDC Foundation to assess health and homelessness activities within public health departments and organizations. Your participation will contribute to a greater understanding of health and homelessness activities and capacity within public health organizations across the U.S.

Your participation in this survey is completely voluntary, and the information you share will not impact your current projects, funding, and support from the Centers for Disease Control and Prevention (CDC) or CDC Foundation.

Information collected through this survey will be used in two primary ways:

1. To identify a primary point of contact for health and homelessness activities at public health departments. This information will be compiled into a directory of contacts for internal use only by the CDC Foundation and the CDC to support outreach and emergency public health responses.

2. To develop a white paper that summarizes the breadth and depth of public health departments and organizational capacity and efforts for health and homelessness.

Individual names and contact information will only be provided to CDC and CDC Foundation for official duty-related activities. The white paper will not include the names of individuals who participated in this data collection effort. Responses may be characterized in the following ways: a) attributed to your organization with your permission (e.g., Minnesota Department of Health); b) regional or geographic descriptor (e.g., a Midwest State Health Department, a Tribal Epidemiology Center); c) a demographic descriptor (e.g., a large urban city health department); or by capacity descriptor (e.g., a health department with a strong history of effective public health and homelessness partnership).

Please do not hesitate to reach out if you have any questions, concerns, or difficulties completing this survey.

Contact Ashley Meehan at ashley.meehan@cloudburstgroup.com.

#	Question	Field Type
Background Information		
Q1	Please enter the following information: • Full Name • Organization • Email Address	Open-text
Q2	Which of the following best describes the governance level of your organization?	Select one: • City or Local • County • Tribal • State or Territory
Q2Sk1	Which state or territory is your organization located in? Skip/Branching: only appears if "Tribal" was not selected. Tribal entities will be asked "Which tribe(s) does your organization support?"	Drop down: AL AK AZ AR CA CO CT DE FL -- PR DC -- Etc.

#	Question	Field Type
Q2Sk2	Which [city/locality or county] is your organization located in?	Open-text
Health Department Partnerships		
Q3	Does your organization currently partner with local health departments in your jurisdiction in any capacity? Skip/Branching: only "Yes" responses will move on to complete the rest of the survey	Select one: • Yes • No • Unsure
Homelessness Point of Contact		
Q4	To the best of your knowledge, which of the following best describes health and homelessness coordination within your local health department?	Select one: • There is a primary point of contact for health and homelessness → Q5Sk1 • Multiple people work on health and homelessness within their respective topic areas with no single point of contact→ Q4Sk2 • No health and homelessness activities are coordinated within their agency → Q5
Q4Sk1	Who is the primary point of contact for homelessness within your local health department? Another way to think about this is if there were an outbreak of an infectious disease in a homeless shelter or among people experiencing homelessness, who would be the primary person that staff from the CDC would be in contact with at your local health department? This person may work on health and homelessness activities alone, or may coordinate health and homelessness activities as well as activities for other congregate settings or special populations. Names and emails will only be shared with CDC staff to facilitate communication about outbreaks, emergency response, and to	Open-text: • Name • Organization/Job Title • Email Address

#	Question	Field Type
	provide other public health support for people experiencing homelessness. Skip/Branching: only appears if "There is a primary point of contact" is selected	
Q4Sk2	Who is one person who can be contacted regarding health and homelessness supports within your local health department? Skip/Branching: only appears if "Multiple people work on health and homelessness within their respective topic areas with no single point of contact" is selected	Open text: • Name • Organization/Job Title • Email Address
Partnerships and Communication		
Q5	Prior to January 2020, what types of activities did your organization do in partnership with health departments in your jurisdiction?	Select all that apply: • Outbreak investigations • General communication and information sharing • Data matching, linkages, or integration • Emergency preparedness planning • Natural disaster planning and response • Health education and promotion • Health clinics • Vaccination clinics • Environmental assessments of homeless service facilities • Environmental assessments of homeless encampments or outdoor sleeping • Routine screening or testing for infectious diseases (e.g., Sexually Transmitted Infections, Tuberculosis) • Referrals or resources to care for chronic or disabling conditions

#	Question	Field Type
		• Referrals or resources to care for substance use disorder • Referrals or resources to care for severe mental illness • Naloxone distribution or other harm reduction service provision • General outreach to people experiencing unsheltered homelessness • Formalizing partnership through Memorandum of Understanding or Agreement, Data Use Agreements, etc. • We did not conduct any activities prior to the COVID-19 pandemic with homeless service programs. • Other [open-text]
Q6	Since January 2020, what types of activities has your organization done in partnership with health departments in your jurisdiction?	Select all that apply: • Outbreak investigations • General communication and information sharing • Data matching, linkages, or integration • Emergency preparedness planning • Natural disaster planning and response • Health education and promotion • Health clinics • Vaccination clinics • Environmental assessments of homeless service facilities • Environmental assessments of homeless encampments or outdoor sleeping • Routine screening or testing for infectious diseases (e.g., Sexually Transmitted Infections, Tuberculosis)

#	Question	Field Type
		• Referrals or resources to care for chronic or disabling conditions • Referrals or resources to care for substance use disorder • Referrals or resources to care for severe mental illness • Naloxone distribution or other harm reduction service provision • General outreach to people experiencing unsheltered homelessness • Formalizing partnership through Memorandum of Understanding or Agreement, Data Use Agreements, etc. • We did not conduct any activities during the COVID-19 pandemic with homeless service programs. • Other [open-text]
Q7	Aside from COVID-19 work, what types of activities does your organization currently do in partnership with homeless service programs in your jurisdiction?	Select all that apply: • Outbreak investigations • General communication and information sharing • Data matching, linkages, or integration • Emergency preparedness planning • Natural disaster planning and response • Health education and promotion • Health clinics • Vaccination clinics • Environmental assessments of homeless service facilities • Environmental assessments of homeless encampments or outdoor sleeping

#	Question	Field Type
		• Routine screening or testing for infectious diseases (e.g., sexually transmitted infections, Tuberculosis) • Referrals or resources to care for chronic or disabling conditions • Referrals or resources to care for substance use disorder • Referrals or resources to care for severe mental illness • Naloxone distribution or other harm reduction service provision • General outreach to people experiencing unsheltered homelessness • Formalizing partnerships through memoranda of understanding or agreement, data use agreements, etc. • Other [open-text]
Q8	Which of the following best describes the frequency of your communication with health departments in your jurisdiction?	Dropdown: • No regular interval, on an as-needed basis • Quarterly • Monthly • Every other week • Weekly • Daily
Q9	Which of the following best describes the formality of your current partnerships with health departments?	Select one: • Completed and signed memorandum of understanding or agreement • Currently in the process of finalizing a memorandum of understanding or agreement • Have discussed developing a memorandum of understanding or agreement, but have not started one

#	Question	Field Type
		• No plans to develop a memorandum of understanding or agreement
Q10	Has your organization linked or integrated public health and homeless service data systems (such as HMIS)?	Select one: • Yes • Not yet—currently in the process of linking or integrating data • No—have been unsuccessful • No—have not tried
Q11	How could your organization's partnerships with groups providing services to or collecting data from people experiencing homelessness be improved?	Select all that apply: • More frequent meetings or communications • Less frequent meetings or communications • Clearer roles and responsibilities • More formal partnership structures, such as a memorandum of understanding agreement or data use agreements • More accountability • Additional staff dedicated to maintaining partnerships and engaging in partner activities • Greater collaboration on shared goals and activities • Other [open-text]

Appendix C: Interview Guide

Name of Organization:

Name of Participant:

Title of Participant:

Date:

Interviewer Name:

Notetaker Name:

Good morning/afternoon. I am [NAME] and I am joined by [NAME] who will be taking notes during our discussion. Thank you for taking the time to speak with us today about your organization's efforts and capacity related to public health and homelessness. This is part of a voluntary project being conducted by the Cloudburst Group as part of a funded effort by the CDC Foundation to public health and homelessness activities and capacity among public health organizations.

We expect this interview to last approximately one hour, and if you think of any information after we conclude our conversation today, please do not hesitate to reach out to us. There are no reimbursements or financial incentives for your participation in this interview.

Information collected through this interview will be used in two primary ways:

1. To identify a primary point of contact for health and homelessness activities at your organization. This information will be compiled into a directory of contacts for internal use only by the Centers for Disease Control and Prevention to support outreach and emergency public health responses.

2. To develop a white paper that summarizes the breadth and depth of public health departments and organizational capacity and efforts for health and homelessness.

Individual names and contact information will only be provided to CDC and CDC Foundation for official duty-related activities. The white paper will not include the names of individuals who participated in this data collection effort. Responses may be characterized in the following ways: a) attributed to your organization with your permission (e.g., Minnesota Department of Health); b) regional or geographic descriptor (e.g., a Midwest State Health Department, a Tribal Epidemiology Center); c) a demographic descriptor (e.g., a large urban city health department); or by capacity descriptor (e.g., a health department with a strong history of effective public health and homelessness partnership).

With your permission, we would like to audio-record this interview so that we can ensure our notes are complete and accurate. Interview recordings will not be shared with the CDC Foundation or the CDC, and will be stored on Cloudburst's internal drive until the project is completed.

Do you have any questions about the scope of this effort, or about how your information will and will not be used?

Do we have your permission to audio record this interview to ensure the completeness and accuracy of our notes?

→ If yes, start recording. If no, continue with as robust notes as possible.

Part 1: To get started, I have a few questions about your role and your organization:

1) Tell me a little bit about your role and where you sit within your organization.
    a) Is this where all homelessness and health activities are housed within your organization?
    b) What other teams/offices do you work with within your organization on homelessness and health activities or programs?
2) [For state and local health departments] Can you describe the relationship between the state and local public health departments as it pertains to health and homelessness?
    a) Does the state health department defer to local health departments for decision-making and implementation, or are these things centralized at the state level?
3) [For tribal epidemiology centers] Can you describe your relationship with state or federal tribal health agencies?
    a) What about with other local tribal public health organizations?

Part 2: Now, I would like to learn more about your partnerships and partner communications to conduct health and homelessness work:

1) Who are your organization's primary partners regarding public health and homelessness activities?
    a) How long have you had these partnerships?
2) Can you tell me more about the nature of these partnerships?
    a) Do you have a memorandum of understanding or agreement in place?
    b) Do you have data sharing or data use agreements in place?

    c) Are these partnerships characterized by sporadic communication as needed, regular and often co-implementation of activities, or somewhere in between?

3) What does communication look like between you and your key homelessness partners?
    a) How often do you join partner meetings, calls, or events?
    b) What are your reflections on the quality and effectiveness of these communications?
4) How has the COVID-19 pandemic affected your organization's partnerships and communications with homeless service partners?
5) Overall, what has worked well in your partnerships for health and homelessness work?
6) Overall, what could be improved in your partnerships for health and homelessness work?

Part 3: For the next set of questions, I will be asking about your organization's activities and projects related to health and homelessness:

1) What projects is your organization currently supporting related to health and homelessness?
    a) For each of these projects, is your organization the primary lead or implementer of this project, or is the CoC/a homeless service provider the lead?
        i) From your perspective, when would it be appropriate for your public health organization to take the lead on homelessness and health activities? When would it be most appropriate for the homeless service system to take the lead on homelessness and health activities?
    b) [ASK ONLY IF THIS PERSON DID NOT COMPLETE A SURVEY] What funding sources are supporting these projects—both staff for the project as well as actual implementation?
    c) How has the COVID-19 pandemic affected your organization's programming or participation in programming for people experiencing homelessness?
2) How is your organization evaluating the implementation and impact of these projects or efforts?
    a) What data systems are used to track information?
    b) How is homelessness defined in your organization's tracking?
    c) Does your organization currently have any data sharing or data linkages with homeless service data such as HMIS?
        i) If your organization has tried to pursue data integration and been unsuccessful, can you share more about what the barriers have been?

ii) If your organization has been successful at integrating and sharing data, can you share more about what has facilitated that?

d) How has the COVID-19 pandemic influenced data sharing between partners?

3) What projects, efforts, or activities does your organization want to be doing more of related to health and homelessness? (Another way of asking: "If resources were not a concern, what would you like to see happen within your organization or within your partnerships related to health and homelessness?")
   a) Is your organization on track to achieve these goals?
   b) What additional resources or support are needed in order for your organization to achieve these goals?

Part 4: I'd like to wrap up our conversation today with one success and one challenge story:

1) Can you share one example of a successful partnership and implementation between your public health organization and a homeless service partner? (This might be a successful data sharing and analysis effort, a successful outbreak response or vaccination campaign, or another implemented project.)
2) Can you share one example of a challenge your public health organization and homeless service partner have encountered? (This could be a challenge related to the partnership itself, a challenge related to data sharing, or a challenge implementing a project.)
3) Is there anything else that you would like to share with us about your organization's efforts to support the health of people experiencing homelessness?

Please do not hesitate to reach out if you think of additional questions, comments, or concerns. Thank you for sharing your time and expertise with us!

Appendix D. Questions by Theme Across Data Collection Instrument

Operations and Structure		
Health Dept Survey	**HCH & CoC Survey**	**Interviews**
Q7. Please indicate if the following statements are true for your jurisdiction: (Multiple responses allowed)	6. To the best of your knowledge, which of the following best describes health and homelessness coordination within your local health department?	1. Tell me a little bit about your role and where you sit within your organization? 1. Is this where all homelessness and health activities are housed within your organization? b. What other teams/offices do you work with within your organization on homelessness and health activities or programs?
Q6. Which of the following best describes the governance level of your organization? (Select one)	2. Which of the following best describes the governance level of your organization?	
Q8. Which of the following best describes health and homelessness coordination within your agency? (Select one) Q18. Does your jurisdiction have a Health Care for the Homeless program? (Select one)		2. [For state and local health departments] Can you describe the relationship between the state and local public health departments as it pertains to health and homelessness? a. Does the state health department defer to local health departments for decision making and implementation, or are these things centralized at the state level? 3. [For tribal epidemiology centers] Can you describe your relationship with state or federal tribal health agencies? What about with other local tribal public health organizations?

Operations and Structure		
Q8Sk3. How long has the primary point of contact for health and homelessness been in their role? This may be yourself, or another point of contact if you are not the primary point person for health and homelessness. Q10. In the past 5 years, has the number of staff supporting health and homelessness in their official work capacity (This may include staff who work on homelessness alone, or homelessness and other congregate settings or special populations) (Increased/Decreased/Stayed the Same) Q11. How long have there been staff or positions at your organization focused on addressing health and homelessness? This may include staff who work on homelessness alone, or homelessness and other congregate settings or special populations. (Select one) Q12. Are there ongoing or planned efforts to hire additional staff to support activities related to health and homelessness? This may include staff who work on homelessness alone, or homelessness and other congregate settings or special populations. (Select one)		

Operations and Structure		
Q24. Does your organization have a definition of homelessness that is used to determine if someone is experiencing homelessness in your data system(s)? Q24Sk1. Has your organization intentionally aligned its definition of homelessness with any of the federal definitions of homelessness? Q24Sk3. Thinking about all of the data sources your organization uses, please select which of the following your organization uses to consider someone as "experiencing homelessness" Q24Sk5. In your organizational definition, over what time period is a person considered to be experiencing homelessness? Q24Sk6. What type of time period? (Experiencing Homelessness)		11b. How is homelessness defined in your organization's tracking?

Activities, Programs Data, & Evaluation		
Health Dept Survey	**HCH & CoC Survey**	**Interviews**
Q15Sk1. What types of activities did your organization do in partnership with homeless service programs in your jurisdiction prior to January 2020? (Select all that apply)	8. Prior to January 2020, what types of activities did your organization do in partnership with health departments in your jurisdiction?	10c. How has the COVID-19 pandemic affected your organization's programming or participation in programming for people experiencing homelessness?
Q16. Since January 2020, what types of activities has your organization done in partnership with homeless service programs in your jurisdiction? Q17Sk6. Aside from COVID-19 work, what types of activities does your organization currently do in partnership with homeless service programs in your jurisdiction?	9. Since January 2020, what types of activities has your organization done in partnership with health departments in your jurisdiction? Select all that apply: 10. Aside from COVID-19 work, what types of activities does your organization currently do in partnership with health departments in your jurisdiction?	10. What projects is your organization currently supporting related to health and homelessness?
Q23. What sources of information do you use to assess public health needs and outcomes among people experiencing homelessness? Q25. Has your organization linked or integrated public health and homeless service data systems (such as HMIS)?	13. Has your organization linked or integrated public health and homeless service data systems (such as HMIS)?	11. How is your organization evaluating the implementation and impact of these projects or efforts? 11a. What data systems are used to track information? 11c. Does your organization currently have any data sharing or data linkages with homeless service data such as HMIS? 11c (i). If your organization has tried to pursue data

Activities, Programs Data, & Evaluation		
		integration and been unsuccessful, can you share more about what the barriers have been? 11c (ii) If your organization has been successful at integrating and sharing data, can you share more about what has facilitated that? 11d. How has the COVID-19 pandemic influenced data sharing between partners?
		10a. For each of these projects, is your organization the primary lead or implementer of this project, or is the CoC/a homeless service provider the lead? 10a (i). From your perspective, when would it be appropriate for your public health organization to take the lead on homelessness and health activities? When would it be most appropriate for the homeless service system to take the lead on homelessness and health activities? 10b. What funding sources are supporting these projects - both staff for the project as well as actual implementation?

Partnerships and Partner Communications		
Health Dept Survey	**HCH & CoC Survey**	**Interviews**
Q17. Does your organization currently partner with homeless service programs or homeless response systems in your jurisdiction in any capacity? These might include Continuums of Care, Task Forces, Working Groups, specific facilities like homeless shelters, etc. Do not include partnerships with Health Care for the Homeless here. (Select one) Q17Sk1. Which of the following types of homeless service programs or response systems do you currently partner with? Q17Sk3. How many other organizations does your organization currently partner with that provide services for or collect data from people experiencing homelessness? Q17Sk4. What types of additional partners do you work with on health and homelessness activities? Q15. Prior to January 2020, did your organization partner with homeless service programs or homeless response systems in your jurisdiction in any capacity? These might include Continuums of Care, Task Forces, Working Groups, specific facilities like homeless shelters, etc. Do not include partnerships with Health Care for the	5. Does your organization currently partner with local health departments in your jurisdiction in any capacity?	4. Who are your organization's primary partners regarding public health and homelessness activities? How long have you had these partnerships? 5. Can you tell me more about the nature of these partnerships?

Partnerships and Partner Communications		
Homeless here. (Select one) Q18Sk1. Prior to January 2020, did your organization partner with Health Care for the Homeless programs in your jurisdiction in any capacity? Q18Sk2. Does your organization currently partner with Health Care for the Homeless programs in your jurisdiction in any capacity?		
Q17Sk5. For each of the current partners below, please select the description that best captures your collaboration and partnership: Q17Sk8. Which of the following best describes the formality of your current partnerships with homeless service providers or homeless response systems? Q21. Which of the following best describes the frequency of your communication with homeless service providers in your jurisdiction? (Select one)	11. Which of the following best describes the frequency of your communication with health departments in your jurisdiction? 12. Which of the following best describes the formality of your current partnerships with health departments?	5a. Do you have a memorandum of understanding or agreement in place? 5b. Do you have data sharing or data use agreements in place? 5c. Are these partnerships characterized by sporadic communication as needed, regular and often co-implementation of activities, or somewhere in between? 6. What does communication look like between you and your key homelessness partners? 6a. How often do you join partner meetings, calls, or events?

Partnerships and Partner Communications		
Q19. To what extent do you agree or disagree with the following statements: (rating partnerships) Q20. Rate your organization's overall communication efforts with partners providing services to or collecting data from people experiencing homelessness: Q22. How could your organization's partnerships with groups providing services to or collecting data from people experiencing homelessness be improved?	14. How could your organization's partnerships with health departments be improved? Select all that apply	6b. What are your reflections on the quality and effectiveness of these communications? 7. How has the COVID-19 pandemic affected your organization's partnerships and communications with homeless service partners? 8. Overall, what has worked well in your partnerships for health and homelessness work? 9. Overall, what could be improved in your partnerships for health and homelessness work?

Barriers and Facilitators for Health & Homelessness Work		
Health Dept Survey	**HCH & CoC Survey**	**Interviews**
Q13. To what extent do you agree with the following statements? (adequate staffing) Q19. To what extent do you agree or disagree with the following statements: (rating partnerships)		7. How has the COVID-19 pandemic affected your organization's partnerships and communications with homeless service partners? 9. Overall, what could be improved in your partnerships for health and homelessness work? 11c (i). If your organization has tried to pursue data integration and been unsuccessful, can you share more about what the barriers have been? 11d. How has the COVID-19 pandemic influenced data sharing between partners?

Opportunities		
Health Dept Survey	**HCH & CoC Survey**	**Interviews**
Q22. How could your organization's partnerships with groups providing services to or collecting data from people experiencing homelessness be improved?	14. How could your organization's partnerships with health departments be improved? Select all that apply	12. What projects, efforts, or activities does your organization want to be doing more of related to health and homelessness? (another way of asking: "If resources were not a concern, what would you like to see happen within your organization or within your partnerships related to health and homelessness?") 12a. Is your organization on track to achieve these goals? 12b. What additional resources or support is needed in order for your organization to achieve these goals?

Success Stories & Challenges		
Health Dept Survey	**HCH & CoC Survey**	**Interviews**
		8. Overall, what has worked well in your partnerships for health and homelessness work? 9. If your organization has been successful at integrating and sharing data, can you share more about what has facilitated that? 13. Can you share one example of successful partnership and implementation between your public health organization and a homeless service partner? (This might be a successful data sharing and analysis effort, a successful outbreak response or vaccination campaign, or other implemented project) 14. Can you share one example of a challenge your

Success Stories & Challenges		
		public health organization and homeless service partner have encountered? (This could be a challenge related to the partnership itself, a challenge related to data sharing, or a challenge implementing a project) 15. Is there anything else that you would like to share with us about your organization's efforts to support the health of people experiencing homelessness?

Appendix E. Health Department Survey Top-Level Results

Q6. Which of the following best describes the governance level of your organization? (Select one) N=267	
Level	**Percent**
City or Local	22.8
County	67.0
State or Territory	10.1

Q7. Please indicate if the following statements are true for your jurisdiction: (Multiple responses allowed; N varies)	
Response	**Percent True**
"Decision-making, program planning, and other executive decisions around health and homelessness activities are primarily determined by the state or territorial health department in my jurisdiction."	24.5
"Decision-making, program planning, and other executive decisions around health and homelessness activities are primarily determined by county, city, or other local health departments in my jurisdiction."	72.9
"Implementation of programs and other health and homelessness activities is primarily done by the state or territorial health department in my jurisdiction."	17.4

Q7. Please indicate if the following statements are true for your jurisdiction: (Multiple responses allowed; N varies)	
"Implementation of programs and other health and homelessness activities is primarily done by the county, city, or other local health department in my jurisdiction."	79.1

Q8. Which of the following best describes health and homelessness coordination within your agency? (Select one) N=267	
Response	**Percent**
There is a primary point of contact for health and homelessness → Q8Sk1	16.3
Multiple people work on health and homelessness within their respective topic areas with no single point of contact→ Q8Sk4	54.5
No health and homelessness activities are coordinated within our agency → Q8Sk5	29.2

Q8Sk3. How long has the primary point of contact for health and homelessness been in their role? This may be yourself, or another point of contact if you are not the primary point person for health and homelessness. Skip/Branching: only appears if "There is a primary point of contact" is selected N=34	
Response	**Percent**
Less than 6 months	14.7
6–12 months	8.8
1–3 years	29.4
3–5 years	14.7
5–10 years	11.8
10 or more years	14.7

Q10. In the past 5 years, has the number of staff supporting health and homelessness in their official work capacity (This may include staff who work on homelessness alone, or homelessness and other congregate settings or special populations): [Select one] N=134	
Response	**Percent**
Increased	56.0
Decreased	6.7
Stayed the same	37.3

Q11. How long have there been staff or positions at your organization focused on addressing health and homelessness? This may include staff who work on homelessness alone, or homelessness and other congregate settings or special populations. (Select one) N=132	
Response	**Percent**
Less than 6 months	4.5
6–12 months	7.6
1–3 years	21.2
3–5 years	12.1
5–10 years	11.4
10 or more years	23.5
Unsure	19.7

Q12. Are there ongoing or planned efforts to hire additional staff to support activities related to health and homelessness? This may include staff who work on homelessness alone, or homelessness and other congregate settings or special populations. (Select one) N=134	
Response	**Percent**
Yes	23.9
No	42.5
Not sure	33.6

Q13. To what extent do you agree with the following statements? N=133				
Statement	**Strongly agree**	**Agree**	**Disagree**	**Strongly disagree**
"My organization has an adequate number of dedicated staff to health and homelessness activities."	0.8	39.1	44.4	15.8
"My organization has sufficient financial resources, outside of staff, to conduct health and homelessness activities."	0.0	14.4	49.2	36.4
"My organization has the right amount of quality staff, funding, and partnerships to effectively promote health and well-being for people experiencing homelessness."	0.0	17.6	57.3	25.2

Q15. Prior to January 2020, did your organization partner with homeless service programs or homeless response systems in your jurisdiction in any capacity? These might include Continuums of Care, Task Forces, Working Groups, specific facilities like homeless shelters, etc. Do not include partnerships with Health Care for the Homeless here. (Select one) N=132	
Response	**Percent**
Yes	60.6
No	16.7
Unsure	22.7

Q15Sk1. What types of activities did your organization do in partnership with homeless service programs in your jurisdiction prior to January 2020? (Select all that apply) *Skip/Branching: only if "Yes" to partnership prior to January 2020.* N=80	
Response	**Percent**
Outbreak investigations	52.5
General communication and information sharing	73.8
Data matching, linkages, or integration	20.0
Emergency preparedness planning	57.5
Natural disaster planning and response	30.0
Health education and promotion	65.0

Q15Sk1. What types of activities did your organization do in partnership with homeless service programs in your jurisdiction prior to January 2020? (Select all that apply) ***Skip/Branching: only if "Yes" to partnership prior to January 2020.*** **N=80**	
Health clinics	23.8
Vaccination clinics	51.3
Environmental assessments of homeless service facilities	20.0
Environmental assessments of homeless encampments or outdoor sleeping	16.3
Routine screening or testing for infectious diseases (e.g., sexually transmitted infections, Tuberculosis)	36.3
Referrals or resources to care for chronic or disabling conditions	36.3
Referrals or resources to care for substance use disorder	42.5
Referrals or resources to care for severe mental illness	35.0
Naloxone distribution or other harm reduction service provision	51.3
General outreach to people experiencing unsheltered homelessness	42.5
Formalizing partnership through memorandum of understanding or agreement, data use agreements, etc.	25.0

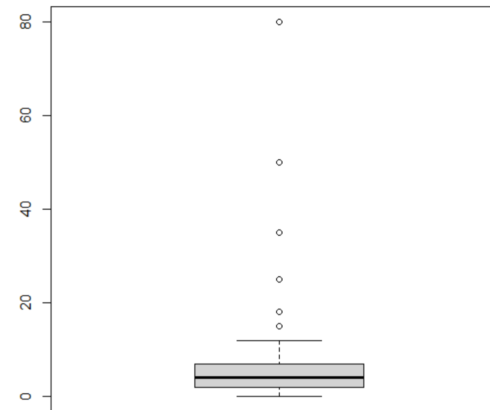
Q16. Since January 2020, what types of activities has your organization done in partnership with homeless service programs in your jurisdiction? N=267	
Response	**Percent**
Outbreak investigations	32.6
General communication and information sharing	36.7
Data matching, linkages, or integration	12.0
Emergency preparedness planning	27.0
Natural disaster planning and response	14.2
Health education and promotion	34.5
Health clinics	16.1
Vaccination clinics	34.1
Environmental assessments of homeless service facilities	13.5
Environmental assessments of homeless encampments or outdoor sleeping	9.4
Routine screening or testing for infectious diseases (e.g., sexually transmitted infections, Tuberculosis)	19.5
Referrals or resources to care for chronic or disabling conditions	18.7
Referrals or resources to care for substance use disorder	22.8
Referrals or resources to care for severe mental illness	20.2
Naloxone distribution or other harm reduction service provision	27.7

Q16. Since January 2020, what types of activities has your organization done in partnership with homeless service programs in your jurisdiction? N=267	
General outreach to people experiencing unsheltered homelessness	23.6
Formalizing partnerships through memorandum of understanding or agreement, data use agreements, etc.	16.1
We did not conduct any activities during the COVID-19 pandemic with homeless service programs.	1.9

Q17. Does your organization currently partner with homeless service programs or homeless response systems in your jurisdiction in any capacity? These might include Continuums of Care, Task Forces, Working Groups, specific facilities like homeless shelters, etc. Do not include partnerships with Health Care for the Homeless here. (Select one) N=129	
Response	**Percent**
Yes	80.6
No	7.8
Unsure	11.6

Q17Sk1. Which of the following types of homeless service programs or response systems do you currently partner with? (Select all that apply) *Skip/Branching: This question only appears if "Yes" is selected in Q17 regarding current housing partners.* **N=104**	
Response	**Percent**
Continuum of Care leadership	46.2
Local Emergency Solutions Grants Program Administration	21.2
Emergency homeless shelters	68.3
Permanent supportive housing programs	48.1
Rapid re-housing programs	29.8
Substance use treatment facilities for people experiencing homelessness	40.4
Other: please specify	26.0

Q17Sk3. How many other organizations does your organization currently partner with that provide services for or collect data from people experiencing homelessness?
Skip/Branching: only if "Yes" to current partnership.
N=80




```
> summary(cdcf$q17sk3.how.many.partners)
  Min. 1st Qu.  Median    Mean 3rd Qu.    Max.    NA's
 0.000   2.000   4.000   7.025   7.000  80.000     187
```

Q17Sk4. What types of additional partners do you work with on health and homelessness activities? Skip/Branching: only if more than 0 “other organizations” are entered in Q179Sk3 (Select all that apply) N=77	
Response	**Percent**
Academic institutions or centers	33.8
Law enforcement agencies or organizations	59.7
Faith-based organizations	83.1
Community-based substance use service organizations (such as safe injection sites, harm reduction centers, etc.)	61.0
Community-based mental health service organizations	77.9
Other community-based organizations	93.5
Other governmental organizations	77.9

Q17Sk5. For each of the current partners below, please select the description that best captures your collaboration and partnership: N=97						
Response	0. No interaction at all	1. Aware of these organizations; loosely defined roles; little communication; all decisions are made independently	2. Provide information to each other; somewhat defined roles; formal communication; all decisions are made independently	3. Share information and resources; defined roles; frequent communication; some shared decision making	4. Share ideas; share resources; frequent and prioritized communication; all members have a vote in decision making	5. Members belong to one system; frequent communication characterized by mutual trust; consensus is reached on all decisions
Homeless service providers or homeless response system	3.1	15.5	24.7	35.1	15.5	6.2
Academic institutions or centers	42.6	22.3	24.5	6.4	3.2	1.1
Law enforcement agencies or organizations	16.8	23.2	27.4	13.7	12.6	6.3
Faith-based organizations	10.4	24.0	28.1	21.9	13.5	2.1

Q17Sk5. For each of the current partners below, please select the description that best captures your collaboration and partnership: N=97						
Response	0. No interaction at all	1. Aware of these organizations; loosely defined roles; little communication; all decisions are made independently	2. Provide information to each other; somewhat defined roles; formal communication; all decisions are made independently	3. Share information and resources; defined roles; frequent communication; some shared decision making	4. Share ideas; share resources; frequent and prioritized communication; all members have a vote in decision making	5. Members belong to one system; frequent communication characterized by mutual trust; consensus is reached on all decisions
Community-based substance use service organizations (such as safe injection sites, harm reduction centers, etc.)	19.1	14.9	22.3	25.5	13.8	4.3
Community-based mental health service organizations	3.2	12.8	26.6	30.9	16.0	3.2
Other community-based organizations	7.4	17.9	28.4	26.3	14.7	5.3

Q17Sk5. For each of the current partners below, please select the description that best captures your collaboration and partnership: N=97						
Response	0. No interaction at all	1. Aware of these organizations; loosely defined roles; little communication; all decisions are made independently	2. Provide information to each other; somewhat defined roles; formal communication; all decisions are made independently	3. Share information and resources; defined roles; frequent communication; some shared decision making	4. Share ideas; share resources; frequent and prioritized communication; all members have a vote in decision making	5. Members belong to one system; frequent communication characterized by mutual trust; consensus is reached on all decisions
Other governmental organizations	12.1	12.1	27.5	20.9	20.9	6.6

Q17Sk6. Aside from COVID-19 work, what types of activities does your organization currently do in partnership with homeless service programs in your jurisdiction? ***Skip/Branching: only if "Yes" to current partnership.*** **(Select all that apply)** **N=104**	
Response	**Percent**
Outbreak investigations	59.6
General communication and information sharing	76.0
Data matching, linkages, or integration	23.1
Emergency preparedness planning	53.8
Natural disaster planning and response	33.7
Health education and promotion	64.4
Health clinics	26.9
Vaccination clinics	56.7
Environmental assessments of homeless service facilities	25.0
Environmental assessments of homeless encampments or outdoor sleeping	17.3
Routine screening or testing for infectious diseases (e.g., sexually transmitted infections, Tuberculosis)	33.7
Referrals or resources to care for chronic or disabling conditions	37.5
Referrals or resources to care for substance use disorder	47.1

Q17Sk6. Aside from COVID-19 work, what types of activities does your organization currently do in partnership with homeless service programs in your jurisdiction? ***Skip/Branching: only if "Yes" to current partnership.*** **(Select all that apply)** **N=104**	
Referrals or resources to care for severe mental illness	45.2
Naloxone distribution or other harm reduction service provision	56.7
General outreach to people experiencing unsheltered homelessness	52.9
Formalizing partnerships through memorandum of understanding or agreement, data use agreements, etc.	34.6
Other: please specify	9.6

Q17Sk8. Which of the following best describes the formality of your current partnerships with homeless service providers or homeless response systems? **Skip/Branching: only appears if "Yes" to current partnership.** **(Select one)** **N=104**	
Response	**Percent**
Completed and signed memorandum of understanding or agreement	22.9
Currently in the process of finalizing a memorandum of understanding or agreement	7.3
Have discussed developing a memorandum of understanding or agreement, but have not started one	19.8
No plans to develop a memorandum of understanding or agreement	50.0

Q18. Does your jurisdiction have a Health Care for the Homeless program? (Select one) N=124	
Response	**Percent**
Yes	19.4
No	50.8
Unsure	29.8

Q18Sk1. Prior to January 2020, did your organization partner with Health Care for the Homeless programs in your jurisdiction in any capacity? (Select one) Skip/Branching: only appears if "Yes" they have an HCH program in their jurisdiction. N=24	
Response	**Percent**
Yes	62.5
No	20.8
Unsure	16.7

Q18Sk2. Does your organization currently partner with Health Care for the Homeless programs in your jurisdiction in any capacity? (Select one) Skip/Branching: only appears if "Yes" they have an HCH program in their jurisdiction. N=24	
Response	**Percent**
Yes	75.0
No	16.7
Unsure	8.3

Q19. To what extent do you agree or disagree with the following statements: (Select one) N=123				
Response	**Strongly agree**	**Agree**	**Disagree**	**Strongly disagree**
"My organization would benefit from partnering with more partners providing services to or collecting data from people experiencing homelessness."	38.2	52.0	8.9	0.8
"My organization would benefit from working with a more diverse group of partners (additional sectors, underrepresented groups, etc.) that provide services to or collect data from people experiencing homelessness."	38.5	51.6	9.0	0.8

Q20. Rate your organization's overall communication efforts with partners providing services to or collecting data from people experiencing homelessness: N=122					
Response	Excellent	Good	Average	Below average	Poor
Overall effectiveness of communication with partners	12.3	43.4	32.0	9.8	2.5
Success communicating priorities with partners	12.3	41.0	34.4	9.8	2.5
Level of understanding of your partners' priorities	9.0	39.3	39.3	10.7	1.6

Q21. Which of the following best describes the frequency of your communication with homeless service providers in your jurisdiction? (Select one) N=121	
Response	Percent
No regular interval, on an as-needed basis	36.4
Quarterly	10.7
Monthly	24.8
Every other week	7.4
Weekly	13.2
Daily	7.4

Q22. How could your organization’s partnerships with groups providing services to or collecting data from people experiencing homelessness be improved? (Select all that apply) N=104	
Response	**Percent**
More frequent meetings or communications	38.5
Less frequent meetings or communications	1.9
Clearer roles and responsibilities	52.9
More formal partnership structures, such as a memorandum of understanding agreement or data use agreements	46.2
More accountability	27.9
Additional staff dedicated to maintaining partnerships and engaging in partner activities	74.0
Greater collaboration on shared goals and activities	75.0
Other	16.3

Q23. What sources of information do you use to assess public health needs and outcomes among people experiencing homelessness? (Select all that apply) N=267	
Response	**Percent**
Surveillance data	22.8
Medical records	7.1
Reports from homeless service partners	30.7
News media (journalistic sources)	6.4
First-hand accounts from medical providers	15.4
First-hand accounts from other service providers	24.7
Internal organization communications	14.6
External meetings with other agencies, groups, task forces, etc.	30.0
Other	5.6

Q24. Does your organization have a definition of homelessness that is used to determine if someone is experiencing homelessness in your data system(s)? (Select one) N=119	
Response	**Percent**
Yes	38.7
No	61.3

Q24Sk1. Has your organization intentionally aligned its definition of homelessness with any of the federal definitions of homelessness? Skip/Branching: only if "Yes" is selected that the organization has a definition of homelessness (Select one) N=46	
Response	**Percent**
Yes	71.7
No	28.3

Q24Sk3. Thinking about all of the data sources your organization uses, please select which of the following your organization uses to consider someone as "experiencing homelessness" Skip/Branching: only if "Yes" is selected that the organization has a definition of homelessness (Select all that apply) N=46	
Response	**Percent**
Person stayed in a homeless shelter	91.3
Person accessed other homeless services (e.g., meal services)	26.1
Person slept outside or a place not meant for human habitation (e.g., tent, car, abandoned building)	93.5
Person stayed in transitional housing	63.0
Person stayed in permanent supportive housing	30.4
Person stayed with friends (doubled up or couch surfing)	58.7
Person stayed in hotel or motel	54.3
Person described as experiencing homelessness in medical record (either through ICD-10 code or open-text fields)	47.8
Person described themselves as experiencing homelessness (such as in a case interview, survey, or other interaction with data collection)	71.7
Other	13.0

Q24Sk5. In your organizational definition, over what time period is a person considered to be experiencing homelessness? Skip/Branching: only if “Yes” is selected that the organization has a definition of homelessness (Select one) N=46	
Response	**Percent**
At the time of data collection (survey, case investigation) or positive test result	46.3
Over a time period (e.g. at some point in the past two weeks, at any point in the past year)	53.7

Q24Sk6. What type of time period? Skip/Branching: Only if “Over a time period” is selected for time frame of homelessness (Select one) N=22			
Response	**Percent**	**How many (Average response)**	**How many (Median response)**
Days	54.5	7.3	1.0
Weeks	27.3	2.3	2.0
Months	18.2	7.8	9.0

Q25. Has your organization linked or integrated public health and homeless service data systems (such as HMIS)? (Select one) N=111	
Response	**Percent**
Yes	16.2
Not yet—currently in the process of linking or integrating data	9.9
No—have been unsuccessful	7.2
No—have not tried	66.7

Q26. Would you be able and willing to meet with a member of our team virtually for approximately one hour to discuss these responses and this topic in more depth within the next few weeks? (Select one) N=112	
Response	**Percent**
Yes	58.6
No	19.0
I am not the right person, but would be glad to connect you with the primary contact for homelessness activities	22.4

Appendix F. COC/HCH/SOAR Survey Top-Level Results

Note: In the tables below, the question numbers from the corresponding questions in the Health Department survey have been prepended to question text to simplify comparisons between the surveys.

Q6. Which of the following best describes the governance level of your organization? (Select one) **N=112**	
Level	**Percent**
City or Local	34.8
County	49.1
State	16.1

Q8. To the best of your knowledge, which of the following best describes health and homelessness coordination within your local health department? (Select one) **N=95**	
Response	**Percent**
There is a primary point of contact for health and homelessness → Q8Sk1	21.1
Multiple people work on health and homelessness within their respective topic areas with no single point of contact→ Q8Sk4	65.3
No health and homelessness activities are coordinated within our agency → Q8Sk5	13.7

Q15Sk1. Prior to January 2020, what types of activities did your organization do in partnership with health departments in your jurisdiction? (Select all that apply) N=99	
Response	**Percent**
Outbreak investigations	19.2
General communication and information sharing	55.6
Data matching, linkages, or integration	10.1
Emergency preparedness planning	30.3
Natural disaster planning and response	16.2
Health education and promotion	43.4
Health clinics	23.2
Vaccination clinics	29.3
Environmental assessments of homeless service facilities	9.1
Environmental assessments of homeless encampments or outdoor sleeping	6.1
Routine screening or testing for infectious diseases (e.g., sexually transmitted infections, Tuberculosis)	32.3
Referrals or resources to care for chronic or disabling conditions	24.2
Referrals or resources to care for substance use disorder	23.2
Referrals or resources to care for severe mental illness	19.2
Naloxone distribution or other harm reduction service provision	18.2
General outreach to people experiencing unsheltered homelessness	23.2

Q15Sk1. Prior to January 2020, what types of activities did your organization do in partnership with health departments in your jurisdiction? (Select all that apply) N=99	
Formalizing partnerships through memorandum of understanding or agreement, data use agreements, etc.	24.2
None	5.1
Other	9.1

Q16. Since January 2020, what types of activities has your organization done in partnership with health departments in your jurisdiction? (Select all that apply) N=99	
Response	**Percent**
Outbreak investigations	37.4
General communication and information sharing	64.6
Data matching, linkages, or integration	23.2
Emergency preparedness planning	47.5
Natural disaster planning and response	22.2
Health education and promotion	56.6
Health clinics	35.4
Vaccination clinics	55.6
Environmental assessments of homeless service facilities	19.2

Q16. Since January 2020, what types of activities has your organization done in partnership with health departments in your jurisdiction? (Select all that apply) N=99	
Environmental assessments of homeless encampments or outdoor sleeping	12.1
Routine screening or testing for infectious diseases (e.g., sexually transmitted infections, Tuberculosis)	35.4
Referrals or resources to care for chronic or disabling conditions	28.3
Referrals or resources to care for substance use disorder	29.3
Referrals or resources to care for severe mental illness	21.2
Naloxone distribution or other harm reduction service provision	29.3
General outreach to people experiencing unsheltered homelessness	32.3
Formalizing partnerships through memorandum of understanding or agreement, data use agreements, etc.	33.3
We did not conduct any activities during the COVID-19 pandemic with homeless service programs.	0
Other	11.1

Q17. Does your organization currently partner with local health departments in your jurisdiction in any capacity? N=110	
Response	**Percent**
Yes	86.4
No	10.0
Unsure	3.6

Q17Sk6. Aside from COVID-19 work, what types of activities does your organization currently do in partnership with health departments in your jurisdiction? Select all that apply: ***Skip/Branching: only if "Yes" to current partnership.*** **N=99**	
Response	**Percent**
Outbreak investigations	15.2
General communication and information sharing	52.5
Data matching, linkages, or integration	16.2
Emergency preparedness planning	27.3
Natural disaster planning and response	16.2
Health education and promotion	36.4
Health clinics	22.2
Vaccination clinics	30.3
Environmental assessments of homeless service facilities	9.1
Environmental assessments of homeless encampments or outdoor sleeping	8.1
Routine screening or testing for infectious diseases (e.g., sexually transmitted infections, Tuberculosis)	24.2
Referrals or resources to care for chronic or disabling conditions	23.2
Referrals or resources to care for substance use disorder	20.2
Referrals or resources to care for severe mental illness	17.2
Naloxone distribution or other harm reduction service provision	20.2

General outreach to people experiencing unsheltered homelessness	24.2
Formalizing partnerships through memorandum of understanding or agreement, data use agreements, etc.	24.2
Other: please specify	8.1

Q17Sk8. Which of the following best describes the formality of your current partnerships with health departments? Skip/Branching: only appears if "Yes" to current partnership. (Select one) N=68	
Response	**Percent**
Completed and signed memorandum of understanding or agreement	42.6
Currently in the process of finalizing a memorandum of understanding or agreement	1.5
Have discussed developing a memorandum of understanding or agreement, but have not started one	22.1
No plans to develop a memorandum of understanding or agreement	33.8

Q21. Which of the following best describes the frequency of your communication with health departments in your jurisdiction? (Select one) N=70	
Response	**Percent**
No regular interval, on an as-needed basis	34.3
Quarterly	7.1
Monthly	32.9
Every other week	4.3
Weekly	12.9
Daily	8.6

Q22. How could your organization's partnerships with health departments be improved? (Select all that apply) N=116	
Response	**Percent**
More frequent meetings or communications	9.5
Less frequent meetings or communications	0
Clearer roles and responsibilities	14.7
More formal partnership structures, such as a memorandum of understanding agreement or data use agreements	21.6
More accountability	7.8
Additional staff dedicated to maintaining partnerships and engaging in partner activities	30.2
Greater collaboration on shared goals and activities	35.3
Other	12.1

Q25. Has your organization linked or integrated public health and homeless service data systems (such as HMIS)? (Select one) N=69	
Response	**Percent**
Yes	36.2
Not yet—currently in the process of linking or integrating data	5.8
No—have been unsuccessful	8.7
No—have not tried	49.3