# A Qualitative Investigation into the Impact COVID-Era Telehealth Policies Had on Organizations Ability to Deliver Care to People Experiencing Houselessness in Seattle

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A thesis submitted in partial fulfillment

of the requirements for the degree of

Master of Public Health

University of Washington

2022

Committee

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Program Authorized to Offer Degree:

Health Systems and Population Health

**Abstract**

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As Covid-19 swept through the nation, many businesses and organizations moved to a remote setting where possible. While each business and organization, without a doubt, struggled to adapt, those who worked with vulnerable populations were disproportionately affected. Organizations with the goal of providing and connecting houseless individuals with medical care, mental health treatment, and more needed to find creative means to continue to provide those much needed services from a safe distance. This report aims were descriptive in nature, and aimed to learn more about how these organizations continued to provide services, and what lessons they are taking forward. Data was collected through semi-structured interviews with organization leaders and service providers as well as data provided by various state organizations to provide a scale for the issues raised in these interviews. The interviewees, or stakeholders, had all interacted with houseless clients via telehealth, either directly providing care, or managing staff who did. All organizations operated mostly in the greater Seattle Area, with some edge cases or clients being from elsewhere in the region. All organizations had performed a number of in person services before switching to primarily telehealth during the COVID-19 pandemic. Analysis suggests that telehealth was helpful for interacting with the houseless community however there were some important caveats. Firstly, telehealth was often aided by clients being able to use physical spaces provided by these organizations as well as access devices capable of engaging with services providers remotely while clients were at the facility. Second, some clients did not respond well to telehealth services or were unable to engage with them in a meaningful way. Thirdly, there are some real concerns with confidentiality that should be better addressed for this type of service. There are unique challenges to providing telehealth services to those experiencing houselessness that must be addressed, however, it is very much worthwhile to extend policies that allow for telehealth to continue in its current state while these issues are addressed. More research must be done to further understand the impact of these policies and on telehealth’s efficacy in this context.

## Executive summary

### Background and Purpose

In the U.S, the first case of COVID-19 was detected and confirmed on January 20th (CDC, 2020) and the first stay-at-home order issued by Washington State was on March 23rd (Inslee, 2020). In an effort to keep clients and staff safe, organizations offering health services for houseless individuals turned to telehealth options. This report explores the barriers and facilitators of telehealth among houseless folks and attempts to describe what may be needed going forward.

### Methods

This report used a qualitative approach to better understand the experience for these organizations delivering telehealth services in the Greater Seattle area and how it may be used going forward. Semi-Structured interviews were held via Zoom by a series of open-ended questions and follow-up questions for additional information. The sample consisted of five individuals from five separate housing organizations in total who worked with houseless individuals in the Greater Seattle Area.

### Key Findings

The themes were identified before the interviews based on previous research as well as the research question at hand. These themes were defined as Barriers, Facilitators, Concerns, Capacity, Needs, Policy, and Engagement. The most impactful, and most spoken about were the organizational barriers and facilitators.

*Facilitators*

- Additional flexibility in the Health Insurance Portability and Accountability Act (HIPPA), made it possible to implement telehealth services.
- Flexibility in scheduling
- Being able to offer a more times with shorter delays in care
- They also stated it was preferred by some clients.
- Telehealth required less rooms to operate

*Barriers*

- Client lacked devices or stable internet
- Lack of private spaces
- Organization had limited devices
- Client had difficulty engaging via telehealth
- Lack of guidance in best practices

## Recommendations

Moving forward, the best path appears to be a mix of telehealth and in person services, dependent on the individual situation. The information from stakeholders clearly details the usefulness of telehealth in this population. This report recommends the following changes be enacted. First, relevant policies should be maintained and updated to allow for these changes to take place. Second, further research should be done to investigate the efficacy of telehealth dependent on condition within this population. Lastly, guidance should be drafted to better protect confidentiality and instill best practices within housing organizations.

### *Policy changes*

Policies such as changes to the enforcement of HIPPA in relation to confidentiality of telehealth should be made to be more permanent as well as a continued effort by platforms such as Zoom to increase security measures to better align with HIPPA guidelines. Policies surrounding telehealth's ability to be charged to Medicaid and other insurance should be extended as more research is conducted on the efficacy of these services.

### *Guidance*

Guidance specific to organizations providing services to vulnerable populations and the organizations ability to conduct telehealth should be made. This guidance would include best practices for ensuring confidentiality via telehealth, information on billing resources, especially billing information specific to Medicaid and Medicare, and a clear depiction of policies that impact what can and cannot be discussed via telehealth. The last point will be especially important as efficacy reports come out surrounding telehealth.

## Conclusion

Organizations who deliver these crucial services are at cross-roads and are currently asking themselves, "How are we going to move forward". Much of that decision isn't up to them, as once the policies surrounding HIPPA confidentiality enforcement and Medicare reimbursement expire, they'll have no choice but to go back to only offering in-person services. This report suggests that the best path moving forward would require these policies to be extend, research surrounding efficacy be conducted, as well as guidance surrounding confidentiality and best practices for telehealth be created for these organizations. This would allow for a more equitable world in which care is expanded with our most vulnerable in the forefront of these policy decisions.

## Introduction

### Covid-19 and Telehealth

In January of 2020 the first case of COVID-19 was confirmed in Washington State and by March of that same year, the first stay-at-home order was issued (CDC, 2020). Quickly, people found themselves facing the unprecedented challenge of navigating the new world and the limitations COVID-19 wrought. Organizations were forced into a “build it as you fly” mentality when it came to continuing their work and this was especially true for organizations working with vulnerable populations. When it comes to organizations such as the Cocoon House, Compass Health, or the Downtown Emergency Services Center, the critical services they offered were often face to face, either in an office or in an outreach capacity. These organizations offer a great array of services, but this report will only be exploring their physical and mental health services they provide to houseless individuals. This includes case management, counseling sessions, and medical check-ups. The term “houseless” will be used in place of the term “homeless”, as to better reflect the resilience of the people experiencing unstable housing’s ability to make anywhere a home. This report will also be focusing on the organizations that provide these services to houseless individuals rather than houseless individuals. It is important to note that this is a limiting factor, and further research should seek to include their valuable insight as they both experienced houselessness and a global pandemic. This made the work the organizations did that much more essential. These organizations were faced with the challenge of performing their jobs with a vulnerable population while implementing Covid-19 safety precautions in a fast-paced and often changing world. For those who offered services or engaged with

houseless people, continuing to offer their services in the safest manner possible often meant turning to telehealth options.

The term “Telehealth services” covers the range of concepts from mental health treatments to physical health exams performed over the internet through applications such as Microsoft Teams or Zoom (HHS, 2022). Telehealth can also be performed via phone either through calling or texts. While far from perfect, telehealth services provided a way for people to continue to seek care during the Covid-19 pandemic in a safe manner. While more research needs to be done on the efficacy of remote care versus traditional in-person care specific to houseless individuals before any stalwart conclusion can be drawn in that regard, there must also be work done to better understand the feasibility of what implementing telehealth services means for our most vulnerable populations.

When examining telehealth during the pandemic, the question needs to ensure that our most vulnerable populations are at the forefront of research, not an afterthought. This research aims to expand upon the growing literature to better understand the impact telehealth has had on organizations ability to deliver telehealth care to houseless individuals. A collection of case studies was reported on by the National Health care for the Homeless Council (NHCHC) in 2020. One of these studies examined the Health Care Centers for the Homeless here in Seattle, Washington. They noted successes such as higher patient satisfaction and a quick transition to virtual care. They also noted challenges such as issues with access to device and data plans. As a part of their general recommendations for providing healthcare to those experiencing houselessness, they fail to mention any guidance as to how telehealth can

be used or where it can be used. Telehealth options aren't always the answer, the NHCHC list's recommendations for diseases in which telehealth options may be inadequate. Including telehealth in an evidence-based capacity could be beneficial for removing known barriers to, healthcare options, as the NHCHC mentioned.

Many of these people depend on these services for regular care and treatment. A study from the U.S Department of Human and Health services found a 63-fold increase in telehealth utilization, nationally, during the pandemic with a 32-fold increase in telehealth for behavioral options (HHS, 2021). The organizations offering these services to houseless individuals did not experience such exponential growth as to normally handle this. Rather, according to this report's stakeholders, telehealth offered an increase in efficiency in their ability to hold visits, maintain schedules, and save time such as travel. Telehealth also has the advantage of being logistically sound during the pandemic. People are able to distance themselves and still give clients the crucial care they need.

**Houselessness by the Numbers**

In 2017, there were around 23,000 people experiencing houselessness in Washington State with about half of those being in King County (DOH, 2017). People experiencing houselessness are more likely to suffer from poor health for a multitude of reasons. The National Institute of Medicine's Medline lists the contributing factors as "Limited access to healthcare, problems getting enough food, trouble staying safe, Violence, Stress, Unsanitary living conditions, and exposure to severe weather" (NIH, 2021). When compared to the general US population, houseless individuals are more

likely to have HIV (20% versus 1%), Depression (49% versus 8%), and Substance Use Disorders (58% to 16%), there is a clear disparity that must be addressed (NHCHC, 2019). In 2017, an article examined the usage of the emergency department by houseless people. This article interviewed houseless individuals with one person stating they had been to the Emergency department “Twenty-seven times since January” (McGuire, 2017). Emergency departments have a legal obligation to treat patients who need immediate care, but after that acute care has been received, they are often released (CMC, 2021). For houseless individuals with many barriers to regular primary or follow-up care, these repeat visits are often to seek treatment for the same previous issue. With roughly 11,500 people experiencing houselessness in King County, there is a clear need to increase access to care to reduce this disparity.

This report further explores an organization’s ability to conduct telehealth aimed supporting our houseless population here in King County via a mixed methods approach. Qualitative interviews were held with employees of organizations that either connected people experiencing houselessness to services or conducted telehealth services aimed at supporting people experiencing houselessness. This report aimed to answer the research questions: What were the facilitators and barriers to implementing telehealth? How was engagement impacted? Lastly, how should telehealth be implemented moving forward?

**Telehealth Concerns**

Switching over to a telehealth model does not come without its consequences. The most apparent issue with this population is how someone experiencing

houselessness might not have regular access to a device that can access telehealth. The Veteran's Administration (VA) recently did a study involving houseless veterans looking to improve care management through integrating telehealth options; they cited a "digital divide" for participants that we're less technically savvy and thus less likely to engage with telehealth options (Gabrielian, 2013). For the organizations, they may not have the budget or the capacity to offer these devices. There is also the logistical issue of having and maintaining access to a device and services that can utilize telehealth platforms. Even when provided a device and service for that device, people may lack a safe place to store, charge, or use the device. Providing things such as tablets, data plans, and solar chargers is a start, however this isn't within many of these organizations budgets, who operate largely off of small government grants/budgets or donations. It also doesn't address the safety or confidentially issues. With telehealth, there is less of a reason for these organizations to maintain a physical space in the fast-developing and expensive areas in urban areas. Without a physical space for houseless individuals to go, they may be forced to have visits with their service providers in more open areas. This could have an impact on the type of engagement service providers see from their clients. Not only could engagement be negatively impacted, but there is the ethical issue of protecting a client's sensitive information, and when you can't control the environment, it is extremely difficult to maintain that secure and confidential space. Remote options are also vulnerable to malicious actors in the digital world. "Zoom bombing" was a practice of getting a zoom room code, entering it without permission, and disrupting the meeting (DCC, 2020). While providers take steps to prevent this type

of action now, it's impossible to say where all vulnerabilities in telehealth security have been fixed. There's also the question of where people can engage with these services.

The organizations themselves faced difficulties during the transition through navigating shifting policies and logistic challenges. These organizations heavily invested in securing physical spaces and equipment to conduct outreach and with the pandemic, they were largely forced to operate outside of their normal basis. They themselves had to purchase licenses for telehealth, work from home equipment for staff as well as training for conducting care via telehealth, all while maintaining their current spaces and equipment in their physical office spaces(HHS, 2021).

There was also the concern of telehealth's efficacy in this population and for the types of services rendered. The literature on this topic specific to houseless individuals is extremely limited. It's worth noting there may be limited literature because telehealth wasn't as large of a factor before the pandemic. One such article comparing the efficacy of telehealth versus in-person treatments in a non-inferiority trial found telehealth was not inferior to in-person clinics for rehabilitation efforts surrounding strokes (Cramer, 2019). Another non inferiority trial comparing the delivery of Cognitive Behavioral Therapy in telehealth and in-person settings found telehealth was not inferior to in-person therapy when treating for insomnia (Gehrman, 2021). Both of which provide promising evidence that telehealth could be similar in efficacy to its in-person counterpart for both physical and mental health services. Research in this manner is growing, however, the studies often did not include barriers specific to those in our community experiencing houselessness.

## Relevant Policies for Telehealth

Guidance and policies were quickly passed to make switching to telehealth at least feasible for many of these organizations. The policies and guidance issued during the pandemic were many as specific issues and regulations had to be addressed or suspended. This report will touch on the two that, from discussions with stakeholders, appeared to be the most relevant.

### *Policy addressing HIPPA*

During Covid-19, the Office for Civil Rights and the Department of Health and Human Services, were given more discretion in their enforcement of HIPPA (HHS, 2021). The policy stated that the enforcement of HIPPA's confidentiality clause regarding telehealth platforms would be relaxed under "Good Faith" efforts to maintain confidentiality while utilizing non-HIPPA compliant platforms. For the organizations delivering services during Covid-19, this meant they were able to utilize non-public facing forms of video communication such as Zoom or Apple FaceTime without facing penalties for noncompliance with parts of HIPPA. Public facing platforms such as Facebook Live or Twitch are still not to be used. This was the first step that allowed the stakeholders to start delivering services via telehealth. Not all platforms are the same and some stake holders were able to primarily use upgraded packages to increase security and other appreciated the flexibility to use services such as Apple's FaceTime as some clients were more familiar with it.

The second most influential policy appeared to be policies surrounding billing. As Covid-19 is billed as a public health emergency, reimbursements for services were

expanded and allowed and in some cases required insurances to cover telehealth services. There were also changes made to the eligibility requirements for reimbursements such as a relaxation of policies surrounding patient location, provider location, and the types of services covered(HHS, 2021). This change made it fiscally possible for organizations to deliver services over the pandemic. As well as allowed them the flexibility to offer a variety of services via telehealth in situations where it made sense for them to do so.

Both of these policies are temporary emergency measures with no guarantee of their continued existence. The latest renewal of the “Determination That a Public Health Emergency Exists” was on April 12th (HHS, 2022). There is no stated expiration date and this declaration could change at any moment, but they typically require a renewal every 3 months. This makes this report useful as a tool to determine guidance around what continued telehealth could look like, as well as describing the barriers and facilitators of telehealth to better inform how policy could be shaped to improve access to the most beneficial forms of telehealth.

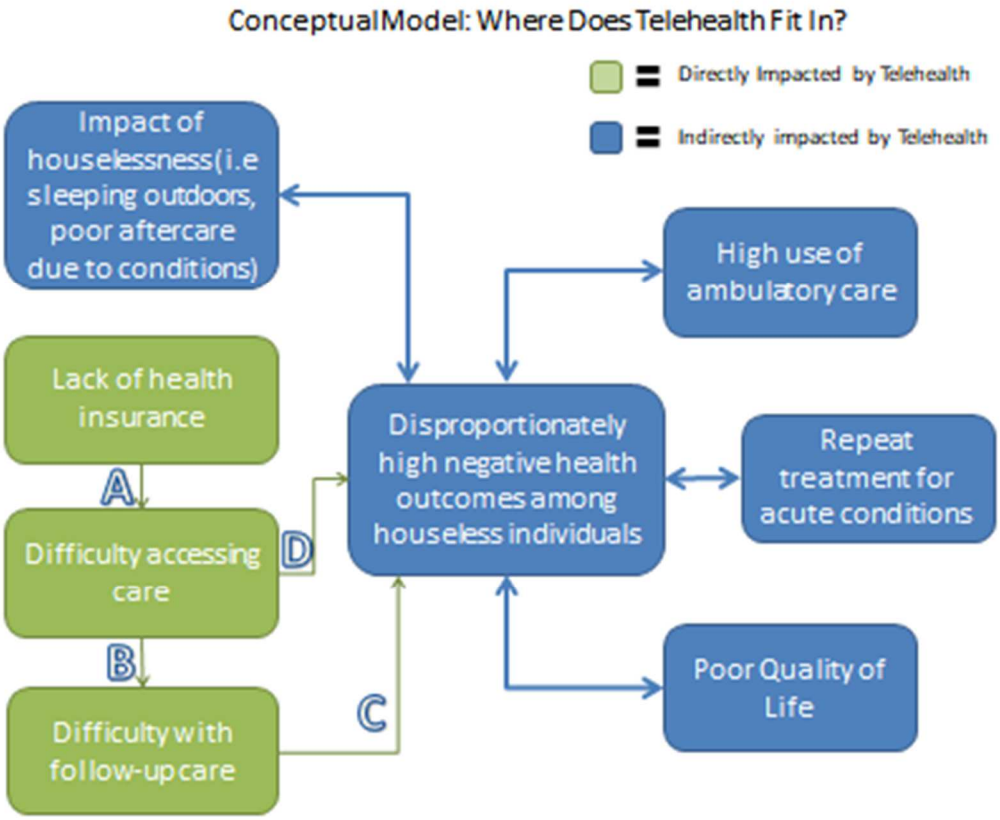


Figure 1

*Summary of concepts*

So where does telehealth fit in? In this report, telehealth is suspected to remove barriers to care. One study found that around 70 percent of the houseless individuals surveyed were not aware if they were eligible or not for Medicaid or Medicare (Freeling, 2015). This low enrollment rate could be indicative that a concerted effort for these organizations to continue assisting houseless individuals in enrolling in Medicare/Medicaid and the continuation of the policy allowing for telehealth reimbursement could remove a barrier to accessing care (Conceptual model, A). The continuation of reduced HIPPA confidentiality enforcement surrounding telehealth could also remove barriers to accessing primary and follow-up care. Another study found that

“Seventy-three percent of the respondents reported at least one unmet health need, including an inability to obtain needed medical or surgical care (32%), prescription medications (36%), mental health care (21%), eyeglasses (41%), and dental care (41%)” (Baggett, 2010). This critical unmet need might be better filled by telehealth options (Conceptual Model, B). Both of these policies together could lead to a decrease both in the unmet needs of houseless individuals, as well as a reduction in the disproportionally high amount of negative health outcomes experienced by this population (Conceptual Model, C and D).

## Methods

### *Process*

Coding was completed via DEDOOSE and assisted by a fellow graduate student. The first transcript obtained by the primary investigator was used to find the initial inter-rater reliability kappa of the main themes of about 73 percent. The codebook was adjusted to include notes and more comprehensive “example quotes” surrounding sub-themes with the lowest inter-rater reliability to describe the construct the investigator was seeking. A second pass through the transcript led to an interrater reliability kappa of around 88 percent, which was deemed acceptable by the investigator as it was a strong score (McHugh, 2012).

### *Outcome*

This project was deemed to be “minimal risk” and was thus exempt from further review by the Institutional Review Board at the University of Washington. Participants were informed about how their interviews would be used, how the recordings would be

stored, and about their choice to decide to participate or not participate but no formal consent was obtained.

A qualitative approach was used to ascertain the barriers and facilitators to receiving telehealth services given to houseless individuals and to deepen the understanding of the impacts policy surrounding telehealth may have on these organizations, as well as the houseless individuals they serve. Data was collected through semi-structured interviews with staff and leaders at organizations that assist houseless people connect with various services. A total of 5 interviews were conducted via Zoom with staff and providers in the state of Washington. Along this qualitative portion, data from Human and Health Services (HHS) and Washington State's Department of Health (DOH) was pulled to better describe the impact of the findings of the qualitative portion.

**Sample**

To be eligible, respondents must have worked with houseless individuals or an organization assisting houseless individuals who received telehealth care in the state of Washington, either as a direct service provider, supervisor, or administrator with direct reports providing services. These organizations are based in Washington State and primarily work in the greater Seattle Area. They provide services or connection to services that involve outreach, housing support, preventative services, as well as mental and physical health services to people experiencing any degree of housing insecurity. Through the pandemic, they continued to offer these services in a mostly remote capacity. Some services required in-person interaction such as methadone

treatments or physical exams; however these were done in a more limited capacity. A total of five organizations were interviewed, with one person providing an interview per organization. As the sample size was small, to maintain confidentiality, this report will not be stating the names of the organizations involved.

In this sample, the organizations involved were a mix of government and non-profit organizations operating within the Greater Seattle Area. They offered a wide array of services specific to unhoused people, with a significant portion of those services directly relating to either physical or mental health. The individuals themselves were comprised of administrators and supervisors, case managers, and behavioral health counselors.

**Recruitment**

Snowball sampling was used to gather a sample of five participants for these interviews. The first respondents were recommended by a research mentor working in the area of youth housing instability and from there, respondents were asked to share the names and if available, contact information of people or organizations doing similar work that have similar experience but perhaps they might have a view different from theirs. Due to initial low recruitment, cold-calling was added and two participants were gathered through this mean. Participant's experiences were largely limited to urban areas on the west side of the state. Once participants were identified, they were emailed a brief description of the project and asked to speak on the phone to determine eligibility and answer any questions they might have before scheduling the interview. Of all organizations contacted and asked to participate, none declined. Attempts were made

to contact other organizations who did not respond in a timely manner to participate in these interviews.

**Data collection**

A single interview guide was developed for all participants (Appendix A). The questionnaire was developed in with the intent to gather as much information about the research question in hand as possible within a 30 minute time limit. The interview guide was developed under the plan that an inductive analysis was going to be performed, so it aimed to gather insight to pre-determined themes. The guide was created using DeJonckheere, 2018 as a reference point for the structure. Themes were initially created in an attempt to answer the research questions at hand, as well as gain further insights into the findings of previous literature surrounding telehealth implementation. After the initial interview, the interview guide was re-shaped and the themes previously identified were refined to better understand the research questions as hand.

Interviews were typically around thirty minutes and participants were once again told about the project and how the interview would go. Stakeholders were informed about how they would be asked to participate in a thirty minute interview asking questions surrounding their work in providing telehealth care to those of us experiencing houselessness. Participants were informed about how their responses would be used as a part of this report, that de-identified quotes may be presented in this report, and how analysis would include this report's author and another graduate student going through the transcripts to code for themes. They were informed they may leave at any time for any reason. Interviews were held via Zoom all participants interviewed made it

through the entire questionnaire with some slight differences in follow-up questions to better expand upon their specific knowledge and answers. Fourteen questions were asked (Appendix A) alongside several follow-up questions seeking to gain more information or clarification around the original question. All interviews were held in English. The questions were open-ended and follow-up questions were asked as more information or more detail was needed. The questions asked participants to think about their experience and 1) What made it easier/harder for them to engage in telehealth and in-person healthcare with their clients, 2) what concerns they had surrounding telehealth, 3) what support they had or need to continue telehealth, 4) how engagement with their clients changed, and 5) what policies, rules, or guidance change they knew of that made this possible. Interviews were transcribed using the Zoom auto-transcribe feature and then corrected by the investigator using the audio recordings.

**Analysis**

Transcripts were analyzed with a thematic analysis with an inductive approach. This included the investigator firstly creating a codebook based on the research question at hand as well as previous literature and then familiarizing oneself with the data (Fereday, 2006). The codes were applied to all transcripts. The codebook (Appendix B), included codes of facilitators and barriers to telehealth, facilitators and barriers to in-person services, organizational needs, concern, engagement, and policy. Secondary codes were included to better answer the research questions with some more specificity.

The themes were identified as being similar to the primary codes, with the only changes being that the code “concern” was changed to “confidentiality” as it was the only concern spoken about at length by every stakeholder. This was expected as the inductive approach meant the questions were shaped to provide information to the pre-determined themes

## Results

### *Facilitators Telehealth*

Telehealth held several advantages for these organizations in their ability to offer and maintain their pre-established services. Stakeholders mentioned it was easier for them to hold drop in clinic hours, meet with more clients, as well as some clients preferring to meet remotely.

*“…there's still a lot of focus on these sort of middle class norm of like well we'll schedule an appointment a week or two in advance it's going to be exactly this time and if you don't show up then you missed your appointment the more that but we can accommodate the needs of individuals who are either in crisis or do not have the capacity to sort of maintain a schedule and can receive services on a drop in basis on a less on a less rigidly scheduled basis the more that that will be able to help them and I think that yeah I think that one of the things I was excited about was that perhaps telehealth will allow allow that to be an option…”*

Telehealth enabled service providers, especially those providing services to houseless individuals, to be more available for their clients. This added flexibility allowed some stakeholders to offer more drop-in style sessions for clients experiencing crisis. Stakeholders spoke about the ways in which client’s attendance went up as they no longer had to struggle to find or access transportation. Stakeholders also spoke about how they or their employees could work remote and had to spend less time traveling either to offices or clients.

*Barriers to telehealth*

Stakeholders described the barriers for telehealth as largely logistical. Clients did not always have stable internet or a device capable of holding meetings over internet connections. One stake holder mentioned how schools offered some youth a laptop or tablet for schoolwork that could also be used for telehealth visits. Some organizations offered laptops or tablets that could be used in their shelters, however, they were few in number. Organizations also had to struggle at the start of the pandemic to build the infrastructure needed to engage with telehealth in what was considered 'good faith' efforts to be compliant with HIPPA. This included trainings on the part of service providers and the establishment of a Virtual Private Network (VPN) to secure telehealth communications over the internet. Lastly, some clients didn't respond well to remote options.

*"But they were not… not comfortable doing zoom, So there were a couple of people that I lost track of, at least for a little while"*

It was common for stake holders to discuss the difficulty engaging with some clients over remote options, especially at the beginning. Issues stemming from unstable internet connection, difficulty engaging with services where one are unable to get a proper grasp of someone's body language or a general dislike of remote services, there was a myriad of reasons someone might have difficulty engaging with telehealth.

It's also important to consider the new variable environment has in a telehealth setting. Service providers working with a client via telehealth no longer were able to control the environment that a person is in.

*"People using in the middle of their appointment I mean I saw that you have one little turn away, and there's a cloud of smoke, and i'm like I can see behind you. We had one*

*therapist famously whose kid what started like rolling a joint that's a I think I think that separation again like that mental separation of this is a place I'm going to work on myself versus I'm still here in my own environment so."*

While receiving services, one client was using and another preparing to use. This raises interesting questions regarding what new directions therapy may head. Therapists are now able to interact with their clients in their environment and thusly may have a more accurate picture of their clients for treatment purposes. Of course there is also the possibility that telehealth removes a protective factor in care, removing someone from a negative environment for treatment. With these factors in mind, there is a clear need for more research to be done on this topic.

*Barriers to In-Person services*

In tandem with telehealth services, several of these organizations continued to offer services in-person, albeit often in a very different capacity. When it comes to traditional services, the barriers tended to be around transportation and scheduling. Stakeholders described the difficulty their clients had getting to services as they largely did not have access to a reliable ride. Some organizations offered help in getting transportation, whether that was them arranging a ride or setting up the route needed to take on public transport, to get to services. Another issue was the scheduling of these services.

*"there's a lot of there's still a lot of focus on these sort of middle class norm of like well we'll schedule an appointment a week or two in advance it's going to be exactly this time and if you don't show up then you missed your appointment the more that but we can accommodate the needs of individuals who are either in crisis or do not have the capacity to sort of maintain a schedule and can receive services on a drop in basis on a less on a less rigidly scheduled basis the more that that will be able to help them"*

Stakeholders often spoke to the difficulty they had in providing services in-person that met the needs of their clients. The idea of offering more drop-in services came up frequently, but with the limited space and staff, that wasn't always possible. One stakeholder mentioned that they could sometimes offer space for session but once they ran out of rooms, it became a group session. This lack of space has potential implications for the efficacy of services received in such cases.

*Organizational needs*

This report aims to explore how policy impacts telehealth access and while issues around funding were spoken about; they fall outside of the scope of this report. Things within the scope as reported by stakeholders included a lack of guidance as well as well as barriers surrounding technology. Stakeholders often lacked guidance in the specific details of telehealth.

*'probably probably guidance right like on on sort of like exactly what's needed from from a from a for example for like a mental health meeting what like what a good sort of like setting for that would be'*

When it came to delivering care via telehealth, guidance around setting and format were generally lacking. This left much of these decisions up to the organizations to figure out within the defined parameters of policy. Specifically, stakeholders had questions around best practices for re-creating their traditionally in-person warm and welcoming spaces in a remote format.

*Confidentiality*

Stakeholder's expressed concerns relating too many of the barriers discussed earlier. In addition to those factors that acted as barriers, stakeholders were concerned about confidentiality.

> *"If they're crashing with friends or kind of moving around is, you know, doing a therapy appointment when you've got 3 little cousins in the living room right .Cause you're couch surfing so then you know it's really really hard to get some kind of meaningful therapy."*

Organizations did not control the physical spaces in which clients received services. With many places closed, this further exacerbated the issue. Specific to people experiencing houselessness, if they were at a shelter, they may not have had the ability to access a private space. Some clients were at a friend's house and not always able to or in some cases, interested in finding a private space. Stakeholders would express this concern with clients, but as the organizations primary concern was getting them services and private spaces weren't always an option, this potential lack in confidentiality was passed over.

*Engagement*

Engagement changed with the immediate shift to telehealth, both for the stakeholders and clients. As mentioned earlier, some clients had a difficult time with the transition and were lost to follow-up, at least for some temporarily. Some stakeholders mentioned how attendance went up and the organizations ability to have a more drop-in style clinic went up. Other stake holders mentioned how for some youth, telehealth didn't work for them.

*“not being able to sort of enter into a space and adjust so that space also sort of creates this sort of psychological barrier it it doesn't feel as real or as substantial to them perhaps”*

This idea of telehealth not working or “real” persisted through several of the interviews. The main idea, in terms with engagement, came down to the individual. For some people, there were unique opportunities within telehealth such as game-therapy for some youth. Other individuals had a hard time or did not like telehealth for very valid reasons. This idea may best be summed up by one of the stakeholders who said:

*“I think the reality is that there's some youth for whom it's a lot better than some some youth for whom it's a lot worse finding a way to combine the benefits of you would receive better engagement in person can do that for people who receive better engagement to get to help can can do that and I think that that would be a pathway to improving quality of service that the entirety of our clients”*

*Policy*

Largely, stakeholders couldn’t point to any specific policy or new guidance other than broad strokes about what was and was not allowed. They were, however, able to discern how policy changes impacted their ability to use telehealth and by what means they could now use telehealth. Broadly, before COVID, telehealth was used in an extremely limited capacity in these organizations, almost exclusively for mental health services. During COVID, these service providers were able to engage with clients in ways that worked for them and more importantly, with platforms they were already using.

*“you know a lot of times our agency was doing a lot of, if not necessarily Telehealth, a lot of remote case management names we would call client on Facebook Messenger we would engage with them via text via email whatever else we always try to accommodate [clients] in whatever way we can”*

Stakeholders described the ability for them to be able to engage with their clients in this manner as extremely helpful and some of the barriers associated with using something like Teams or Zoom was the difficulty in getting that up and running when something like FaceTime was already known to their clients.

**Discussion**

Increasing access to healthcare is a critical piece of improving the health outcomes for individuals experiencing homelessness. This is especially true with a population that is defined as a “hard to reach population” (Bonevski, 2014), the ability for these organizations to offer a more flexible service to houseless individuals is crucial. The potential implication of this added flexibility being an increase in services provided via telehealth. The primary way houseless individual’s access care pre-Covid was through ambulatory care (Kushel, 2001). This flexibility could lead to a reduction in ambulatory usage in some cases; however more research would need to be done. There is also the need to increase access to care, especially follow-up care. As stated earlier, seventy-three percent of houseless individuals experience at least one unmet need (Baggett, 2010). This means that the addition of telehealth services, serving in tandem with in-person services, could remove significant barriers to care and lead to a decrease in negative health outcomes.

For telehealth to be applied more broadly, equity must be at the forefront of that decision. Everyone should be able to benefit from telehealth, directly and indirectly. One current evidence based practice handbook, Telehealth for the treatment of Serious Mental illness and Substance Use Disorders cites that Americans above 65 and older

are more likely to have chronic disease and less likely to have access to a smartphone or internet access, as well as people experiencing poverty and people of color (SAMHSA, 2021). It's important that decisions around policy, while good in intention, don't create further barriers to care for our most vulnerable populations. This is especially true in the findings of this report, as any recommendation could impact the lives of Washington's houseless population.

There could be a limited impact that the continuing of Medicare/Medicaid reimbursement policies may have on easing barriers for organizations working with houseless individuals. One study found that around 70 percent of the houseless individuals they surveyed were not aware if they were eligible or not (Fryling, 2015). This would mean that the extension of this policy on its own would not be enough, but there must also be continued efforts by these organizations to assist houseless individuals with enrollment into Medicare/Medicaid. Ultimately, this means that the main policy to focus maintaining would be the policy surrounding HIPPA confidentially enforcement to allow for telehealth to continue.

*Recommendations*

After these interviews, the best course of action appears to be three-fold. Firstly, this report suggests encouraging a mix of telehealth and in-person services for organizations that work with houseless individuals. Telehealth appears to remove barriers for some and add barriers for others, so it's important to consider both sides. This appears to be reasonable as many organizations are beginning the process of implementing this mixed approach to care. Next, there should be further research on the

efficacy of types of services to ensure no harm is being done by offering these services in tandem with traditional in-person services. There appears to be very little research on the efficacy of telehealth when working with houseless clients, specific to chronic conditions that are common is the houseless population. Lastly, HIPPA policy surrounding telehealth should maintain the reduction in enforcement of its confidentiality clause while efficacy is researched and proper guidance is created. This guidance will need to include ways in which we can protect people's confidentially in telehealth as much as possible through good faith efforts. One participant summed up the recommendations nicely, saying:

> *"I think what's really important to understand is that we've had this capability for a while, and it took a pandemic to get it mobilized and on a large scale. And that that tells me that sometimes, you know, like we're not of as in a I just as a general like profession. You know, like we kind of have our ideas about the way things work just like anybody Right? But I think that at least my organization seems to have adapted really well. So I'm really I'm really happy about that and I mean, I think it only took a month or so, for between lockdown being sent home and like getting online. So that was it was impressive. It was an impressive undertaking, cause we're a pretty large organization covering, like all of Northwest Washington, a a big deal is a big job. Yeah. I just think that now that we know we have the capability to do something that big and to do something that expansive and kind of paradigm shifting hopefully, we can continue to move along those lines and offer you know hybrid sessions, or, you know, tele health where needed or something like that."*

We have had the capability to utilize telehealth and now we have the capability to study it for efficacy. In order to do that, the policies both allowing telehealth to take place much more broadly in a telehealth capacity must stay in place, as well as the policy allowing for the funding of such a measure to be finically viable for these organizations. To ensure equity, we must look beyond these policies and we must also look to see what else can be done to address barriers specific to people experiencing houselessness.

*Limitations*

This report lacked the ability to examine the efficacy of telehealth for houseless individuals. While there is evidence of telehealth being effective in certain settings for certain health issues, there isn't enough in this author's opinion to make a reasonable claim about its efficacy with this population. This report also only engaged with organizations that largely worked in an urban environment, so there could be implication for rural environments that would not be represented by this piece. Lastly, this report only included the organizations that deliver care and not the individuals who receive it. This leaves out an important perspective on the barriers and facilitators for receiving such care and omits the voices of those most impacted by policy changes.

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**Appendix A: Interview Guide**

Introduction:

Hi, my name's Elliott and I appreciate you meeting with me today. A couple of things before we get started. First, as mentioned before, this interview will be recorded and transcribed. Video and audio recordings will be saved to my computer and transcribed by me. I am the only one who has regular access to this computer and it is password protected. The transcribed interview won't include any identifying information like your name or organization. The recordings will be kept until analysis is complete and finalized which is expected to happen sometime in May. I will be the only one who sees the recordings but I will not be the only one who sees the transcripts.

This interview is part of my thesis work, I'm conducting research looking into the impact covid has had on your organization and organizations like yours, ability to provide services via remote options to houseless folks. This could be through means like zoom, teams, the phone, etc. This thesis will attempt to describe what going remote meant for organizations that assist houseless folks actually looked like, and ultimately describe the pros and cons of telehealth services for houseless folks going forward. Thing like what do organizations have, what do they need, what could policy look like, etc. The project is expected to hold about 6 of these interviews and the conversations form these interviews will be used as the data for the thesis. What this means is that I and another graduate student will go through these transcripts to identify and analyze themes before I write a report on any findings. All potentially identifying parts of our conversation today, such as names or addresses, will be redacted by me. Pieces of our conversation today may be shared in the thesis but your name and organization won't be attached, thusly you are speaking for yourself and not the organization. Only de-identified quotes will be shared in the thesis.

At any point in the interview today if you have questions or want to stop for any reason please let me know right away. You do not have to answer any question you do not want to, for any reason. All of that said, do you have any questions before we get started?

1. What organization do you work for and what is your role in it?

2. How has telehealth been adapted by your organization or the service providers you work with?

3. What makes it hard for houseless people to access these telehealth services?

4. What makes it easier than traditional in-person services?

5. What makes it easy for people to access these telehealth services?

6. What makes it harder than traditional in-person services?

7. Concerns with telehealth services specific to unhoused folks?
    a. Confidentiality?
    b. Safety?
    c. Space?
8. Broadly, how has engagement changed?
    a. More willing to share in calls? Less?
    b. Schedule more?
    c. Attendance up?

9. How did your practices change?
        a. Can you offer more or less services?
        b. Meet more or less clients?
        c. Cover a smaller or larger area?
        d. Provide resources (spaces for staff/clients, phones, etc.)

10. When these changes were made, what rules/policies/guidelines helped you implement them?

11. Does your organization have the capacity/desire to continue to offer these services in the long run?

12. What is the strain you have experienced?

13. Is that something you want?

14. When it comes to telehealth being access by unhoused individuals, what is something important that you think I should know?

**Appendix B: Codebook**

| Primary | Secondary | Example | Notes |
|---|---|---|---|
| **Barriers – Telehealth** | **Logistics** | **‘**specific to telehealth access to Internet access to technology for some of our youth the lack of having in person communication**’** | |
| | **Therapeutic Implications** | **‘**08 But a lot of times I had had sessions with youth who are walking around the program, and I would be like, hey?**’** | |
| | **Acceptance** | **‘**not being able to need someone physical cues not being able to sort of enter into a space and adjust so that space also sort of creates this sort of psychological barrier it doesn't feel as real or as substantial to them perhaps**’** | |
| **Barriers – In Person** | | **‘**helping to make that space available I think there are broadly in the field of medical health there's a lot of there's still a lot of focus on these sort of middle class norm of like well we'll schedule an appointment a week or two in advance it's going to be exactly this time and if you don't show up then you missed your appointment**’**<br><br>**‘**moment to access the impersonal services yeah a lack of access to transportation is bigger than and I think so while there are some youth for whom the sort of of lack of physical presence is hard**’** | |
| **Facilitators – Telehealth** | **Logistics** | **‘**so for the provider partnership with places that are able to help facilitate access to telehealth you know**’**<br><br>**‘**they are coming to our facility and needing to use our laptops and our Internet and all that sort of thing the more that there's like a infrastructure for providing young people access to a confidential space and fast reliable Internet**’** | |
| | **Therapeutics** | **‘**And it provided real opening | |

| | | | |
|---|---|---|---|
| | **implications** | therapeutically and i'm i'm very interested in utilizing games tabletop games and video games for therapeutic purposes.**'** | |
| **Facilitators – in person** | | **'**the advantages like having in person space yeah that for a lot of our youth is address the physical just the the being able to read someone's physical cues being able to be in a space and and have an access to to understanding what that person you how that person is based on how they move or how they look or whatever**'** | |
| **Needs** | **Future plans** | **'**I really hope to see telehealth as an option especially for mental health counseling and you know consulting within nurse or getting some quick medical advice in the future**'** | |
| | **Physical needs** | **'** probably probably guidance right like on on sort of like exactly what's needed from from a from a for example for like a mental health meeting what like what a good sort of like setting for that would be uh for us you know space is very limited we have a drop in center we've we have a shelter and we have a housing program for young adults so I mean just the physical space**'** | **Captures the sentiment of what organizations physically need to deliver services, like computers or physical locations.** |
| | **Security** | **'**somehow we certainly implemented policies are self from like using a VPN and like a number of things that that sending confidential documentation via via email**'** | |
| **Concerns** | **Confidentiality** | **'**what if this like what if this meeting isn't perfectly confidential I'm thinking what if my client doesn't get counseling so yeah after 2 the counseling out wasted whatever confidentiality concern might might also exist or super reasonable get it counseling that why we getting all this**'** | |
| | **Organizational capacity** | **'**one of the challenges that we have is that like you know employment is really difficult for us we're nonprofit | |

| | | | |
|---|---|---|---|
| | | that works with folks it's piercing homelessness so while I think about like the quality of service and the range of services in the amount of service that we're able to provide it's kind of hard for me to parse that out because like also it's just hard for us to hire and retain but so but but they haven't been said I do think that telehealth remote remote meeting all that sort of thing it does expand our ability to provide services to expand our abilities our clients access to two services’ | |
| **Engagement** | **Therapeutic engagement** | ‘the lack of having in person communication the sort of like not being able to need someone physical cues not being able to sort of enter into a space and adjust so that space also sort of creates this sort of psychological barrier’ | |
| | **Attendance** | ‘So this removed a lot of those kinds of barriers, and I've heard that to be true in my clinic as well like our no show rate dropped significantly’ | |
| **Policy/Rules** | **Before Covid** | ‘yeah I mean probably what we were hearing is that it wasn't for youth to tend to tell health visit that due to confidentiality concerns’<br><br>‘to my perception a combination of bureaucracy and like legitimate concern for attending to clients confidentiality but’ | **The goal of this is to capture the sentiment of ‘There was a rule before covid but now it’s not’** |
| | **During Covid** | ‘or like the way the information was shared or even just the information was being shared had like an addendum that attended to the account for confidentiality there there it seems as though there were allowances that were made’ | **The goal of this is to capture the sentiment ‘There is something in place that allows us to do X now’** |

**Appendix 3. Recruitment email**

Hello (potential participant),

I got your information from (participant/website) and I was wondering if you would be interested in participating in my research project at the University of Washington. I am conducting work to better understand the impact covid-era policies have had on people experiencing houselessness' ability to access telehealth services. If you have 5 minutes I'd love to find a time to call you and answer any questions you might have and explain the study in more detail. Is there a day that works best for you?

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