

# Exploring the Impact of COVID-19 on Social Services for Vulnerable Populations in Los Angeles

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Lessons Learned from Community Providers

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RAND SOCIAL AND ECONOMIC WELL-BEING

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## Preface

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The coronavirus disease 2019 (COVID-19) pandemic has significantly disrupted the social safety net programs on which the most vulnerable Americans depend, including those both experiencing or at risk for homelessness and involved with the criminal justice system. In this report, we aim to understand the ways that social services providers serving these populations in Los Angeles County, California, have responded to COVID-19, and to compile lessons learned and innovative strategies. An understanding of the ways that providers have responded to COVID-19 has the potential to inform planning for future phases of the pandemic, both in Los Angeles and in other areas.

### Justice Policy Program

RAND Social and Economic Well-Being is a division of the RAND Corporation that seeks to actively improve the health and social and economic well-being of populations and communities throughout the world. This research was conducted in the Justice Policy Program within RAND Social and Economic Well-Being. The program focuses on such topics as access to justice, policing, corrections, drug policy, and court system reform, as well as other policy concerns pertaining to public safety and criminal and civil justice. For more information, email [justicepolicy@rand.org](mailto:justicepolicy@rand.org).

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# Contents

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Preface .....	iii
Figures .....	v
Tables .....	vi
Summary.....	vii
Acknowledgments .....	viii
Abbreviations .....	ix
1. Background.....	1
2. Method.....	2
3. Results .....	4
Types and Sources of Information Informing COVID-19 Response.....	4
Changes to Service Delivery .....	4
Facilitators and Barriers to COVID-19 Response.....	6
Strategies for Monitoring Response.....	10
Equity Concerns .....	11
4. Discussion.....	13
Summary of Lessons Learned .....	13
Recommendations .....	14
Conclusion.....	18
References .....	19

# Figures

---

Figure 3.1. CFIR Framework Elements Used in This Analysis ..... 7  
Figure 3.2. Equity Concerns and Vulnerable Populations ..... 12

## Tables

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Table 4.1. Summary of Facilitators, Barriers, and Proposed Solutions .....	17
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## Summary

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Given its scale and speed, the coronavirus disease 2019 (COVID-19) pandemic has gravely disrupted social safety net programs on which the most-vulnerable Americans depend. This includes services supporting individuals who meet both of the following criteria:

- currently experiencing or at risk for homelessness
- involved with the criminal justice system.

We conducted semistructured interviews with representatives from several social services organizations in Los Angeles County serving these populations to (1) assess how service providers are responding to COVID-19 in Los Angeles County, and (2) compile lessons learned and innovative strategies for dealing with the pandemic for broader dissemination. We found that organizations relied on information from a variety of sources when developing their pandemic response plans, including national and international health-related organizations, state and local public health agencies, and internal expertise. Most providers have shifted to providing virtual services, including video- and telephone-based care. Community-based work has continued, when essential, with additional safety protocols (e.g., use of personal protective equipment, staggered shifts). Some facilitators (i.e., facilitating factors) of continued services included available technology, additional funding, proactive organizational leadership, dedicated staff, and organizational flexibility.

There have also been significant barriers faced by these organizations, including a lack of technology access among clients, reductions in revenue and workforce, difficulties having clients maintain shelter-in-place procedures, and additional stressors on staff. Organizations described ways in which COVID-19 has the potential to disproportionately affect individuals both experiencing or at risk for homelessness and involved with the criminal justice system, as they might have less access to services, more adverse economic and behavioral health outcomes, greater barriers to quality information, and an increased exposure risk. When creating plans to guide provider response to future phases of the pandemic, providers could consider ways to increase client access technology, measure and address inequities, and leverage increased policy flexibility to speed access to services. Supporting staff well-being and health is also critical.

## Acknowledgments

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## Abbreviations

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CFIR	Consolidated Framework for Implementation Research
COVID-19	coronavirus disease 2019
IHME	Institute for Health Metrics and Evaluation (University of Washington)
PPE	personal protective equipment



# 1. Background

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Given its scale and speed, the coronavirus disease 2019 (COVID-19) pandemic has gravely disrupted social safety net programs on which the most-vulnerable Americans depend. Much of the initial response has focused on ensuring adequate medical services to address testing and acute infections and related containment strategies around avoiding in-person contact. However, other social services systems—such as criminal justice, mental health care, substance use treatment, and housing—cannot function as designed without frequent in-person contact. Programs for individuals with multiple chronic medical conditions, social services needs, or both, generally rely on intensive, community-based service models that might not be possible during the COVID-19 pandemic, or that need to be modified to prevent risk to both workers and clients. Although minimizing the spread of COVID-19 infections within these vulnerable populations is critical, service providers must also find innovative ways to provide ongoing support under conditions that will certainly strain their limited resources; otherwise, they risk damaging the health of workers and contributing to profound declines in health and social functioning among the most-vulnerable community members.

Over the past several years, the RAND Corporation has been involved in a number of collaborations with organizations in and around Los Angeles that provide services to people who meet both of the following two criteria:

- currently experiencing or at risk of homelessness
- involved with the criminal justice system.

We built on those ongoing relationships to (1) assess how service providers are responding to COVID-19 in Los Angeles County, and (2) compile lessons learned and innovative strategies for broader dissemination.

## 2. Method

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We conducted semistructured interviews with representatives from a variety of social services organizations serving people who both are currently experiencing or at risk of homelessness and involved with the criminal justice system. We focused on organizations that had a relationship with RAND through a previous or current evaluation project, which enabled us to begin the study rapidly. Our initial discussions with providers revealed that these organizations were rapidly adapting to their new circumstances, and we opted for a qualitative, interview-based approach to this study to minimize burden on organizations while gaining detail about their decisionmaking process and pandemic response. This study was approved by the RAND Institutional Review Board.

We developed a semistructured interview guide that covered the following topics:

- sources of information guiding organizations' pandemic response plans
- changes made in response to COVID-19 regarding services, communication, policies, procedures, or some combination thereof
- barriers to and facilitators (i.e., facilitating factors) of implementing COVID-19–related changes
- strategies for monitoring COVID-19 response
- disproportionate impacts of COVID-19 on certain subgroups.

We emailed interview invitations to representatives from 32 agencies, which included Los Angeles City and County offices, behavioral health providers, intensive case management providers, interim and permanent supportive housing providers, vocational service providers, legal service providers, and funders of these services. We began with existing contacts at each organization; in some cases, they referred us to colleagues or invited additional team members to join the interviews. In total, we conducted 25 interviews between April 20 and May 22, 2020, representing 22 agencies (69 percent of agencies contacted).

To analyze data, we used Rapid Qualitative Analysis (Hamilton and Finley, 2019; Taylor et al., 2018). We first developed a template to reflect key topics of interest using our interview guide as a foundation. After each interview, the team member completing the interview summarized key findings within each theme. Each week, the project team met to discuss findings from interviews discussed over the previous week, which enabled us to extract key findings and identify ways in which organizational responses evolved over the five-week data-collection period.

As we reviewed and discussed the analysis template, we identified major organizing themes within each topic of interest and more-detailed subthemes. We also selected illustrative quotes. This process was guided by both deductive and inductive approaches. For example, we used the Consolidated Framework for Implementation Research (CFIR) (Damschroder et al., 2009) to

deductively organize our findings related to facilitators and barriers, but those subthemes (i.e., individual barriers and facilitators) were inductively identified from the data in the analysis template.

## 3. Results

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### Types and Sources of Information Informing COVID-19 Response

When asked about the information that has informed their pandemic response, organizations described both types and sources of information on which they relied. Organizations described the importance of guidelines for preventing infections, including handwashing and cleaning, physical distancing, types and uses of personal protective equipment (PPE), and ways to monitor symptoms. Some organizations also relied on information about local rates of COVID-19 infection. Sources of information about preventing infection included national and international health-related organizations (e.g., the Centers for Disease Control and Prevention, the World Health Organization), state and local public health agencies, the University of Washington’s Institute for Health Metrics and Evaluation (IHME)’s COVID-19 infection projections (IHME, 2020), personal connections with infectious disease experts, and local media coverage.

Guidance on operational changes for services was also important, including how to prioritize among services and service recipients, how to provide virtual care,<sup>1</sup> ways to adapt transportation or congregate care arrangements, and changes to funding and reimbursement. Information came from a mix of federal agencies, such as Centers for Medicare and Medicaid Services, the Substance Abuse and Mental Health Services Authority, the Internal Revenue Service, and the Social Security Administration. Local county agencies were other important sources of information for these changes, including the Los Angeles County Departments of Health Services, Public Health, and Mental Health, and the Los Angeles Homeless Services Authority. A small number of organizations described relying on professional organizations as a source of guidance and peer-to-peer consultation.

In turn, many organizations distilled this information to develop specific guidance for their staff. This was often accomplished by organizational leadership or a task force developed to guide the pandemic response. Some organizations supplemented information from outside sources with “bottom-up” suggestions from staff using their experiences with clients.

### Changes to Service Delivery

#### *Common Changes to Service Delivery*

We learned of several common changes to service delivery that were nearly universal across types of programs and providers.

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<sup>1</sup> Note that we use the term *virtual care* to encompass a variety of methods that providers use to remotely connect with clients, including video, audio, and other forms of messaging (e.g., email).

Many services and operations switched to virtual modes, including video- and telephone-based communication methods. This included service delivery with clients (e.g., therapy and case-management sessions, document signing), staff meetings, and supervision. Many staff were working from home. Certain community-based outreach services and office-based services have continued when essential, but have been scaled back as much as possible.

Organizations noted that when staff are in the office or in the field, they are taking extra precautions, such as using PPE, including masks, screens, and seat covers; engaging in physical distancing; implementing screening protocols for COVID-19; and staggering shifts. Some organizations were not requiring staff to participate in field-based activities, instead relying on staff who volunteer that they feel comfortable doing so. There has also been an increased frequency of cleaning protocols for high-risk areas (e.g., common spaces, vehicles).

We also learned of ways in which programs and organizations have adjusted the focus of their services. Organizations have emphasized getting individuals into housing and supporting maintenance of housing. There has been a shift to providing food and other needs (e.g., cleaning supplies) to clients. Organizations have also been leveraging their relationships with clients to provide social support and deliver health education about COVID-19. Generally, organizations are prioritizing the most vulnerable clients they serve (e.g., those in independent housing with limited supports) and many have focused on existing clients, rather than enrolling new clients.

Other reported changes are more setting- or service-specific. Notably, there have been ongoing efforts to minimize the number of people in jails and correctional settings, where the risk of community spread is high. This led to an increased need to provide housing because more individuals who are experiencing or at risk for homelessness have been diverted from the county jail system.

There have been efforts to screen for COVID-19 symptoms in staff and clients, especially when clients are in group living settings (e.g., interim housing) or staff are doing outreach work. This includes using questionnaires about symptoms, temperature checks, and observations, which take place before in-person contacts between staff and clients. Symptom-monitoring procedures seemed to evolve over the study period, with organizations moving from simple symptom screening to formal testing protocols as testing has become more available in Los Angeles.

Clients enrolled in programs that provide housing have been asked to shelter in place. In these congregate housing settings, services led by outside organizations (e.g., contracted providers) have been reduced, with some services being streamlined or absorbed by existing staff. Group services have also been reduced or suspended. The goal has been to both limit contact with outside people and groups of people gathering.

Given the impact of COVID-19 on the economy and certain occupational sectors, vocational service providers have also had to adapt services. For example, distance learning was being used to provide some vocational training as a replacement for transitional jobs. In addition, substance use treatment providers have been increasing their use of harm reduction approaches (e.g.,

prescribing alcohol or marijuana edibles) to help reduce overdoses from more-serious substances, reduce withdrawal problems, and help clients to shelter in place.

### *Innovative Changes to Service Delivery*

As described in the previous section, organizational leadership often took on the role of compiling information from various sources and distilling that information into specific plans for their organization. However, a small number of interviewees, especially from the larger organizations, talked about quickly mobilizing a crisis-management team who would meet regularly (e.g., weekly) and disseminate guidance. In some cases, these teams included infectious disease experts, who were seen as particularly valuable to guiding the organizational response. For those serving clients in congregate settings, we learned that the organizations quickly assigned staff and clients to specified groups to minimize the risk of infection spread. Some organizations that moved to fully remote services ensured that signs with instructions about how to engage with providers were clearly posted for any drop-in clients.

As described previously, many organizations worked to ensure that their clients had access to needed supplies and services. One organization developed an especially innovative way to do this by setting up a “store” at the housing site to ensure that clients did not have to leave the site. As the interviewee said, “We brought the store to them.”

We learned about friendly competitions that some providers organized to engage their staff and clients. For example, clients in some congregate housing settings had the opportunity to engage in competitions designed to build awareness around pandemic risks. Specifically, each house developed a presentation about COVID-19, with a prize to the winning house. An interviewee from a case management organization described competitions among staff members to see who had the highest percentage of their meetings via virtual connection.

Finally, some organizations have begun to address barriers to technology access among their clients. For example, one agency described distributing solar chargers so that individuals without stable housing still had access to their mobile devices and could stay in touch with outreach teams and caseworkers.

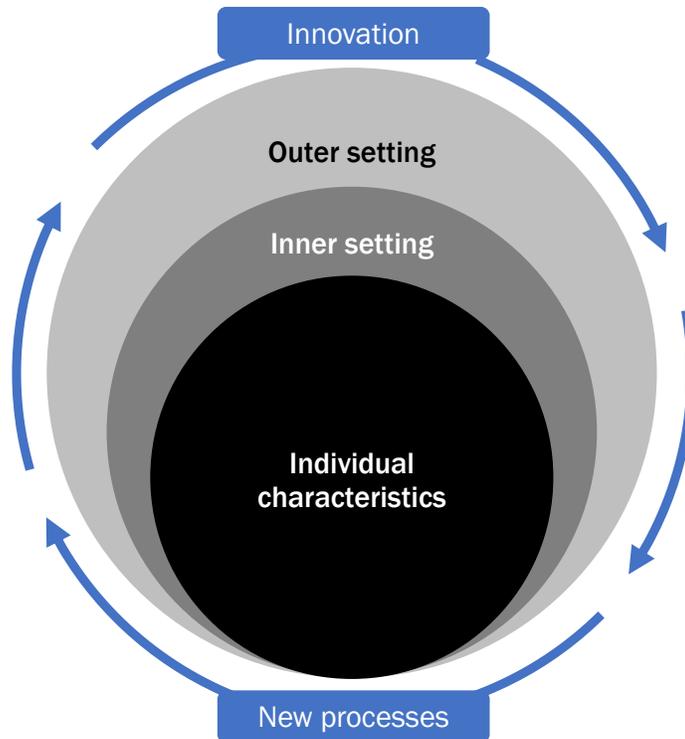
## Facilitators and Barriers to COVID-19 Response

To organize our findings about facilitators and barriers to organizations’ COVID-19 responses, we used the CFIR (Damschroder et al., 2009), which identifies the following five domains shown to affect practice implementation:

- *innovation*, or characteristics of the new practices that are being implemented
- *outer setting* factors that are external to the organization implementing the practice
- *inner setting* characteristics of the organization itself
- characteristics of the *individuals* who are executing the practices
- and the *process* that is undertaken to make the changes happen (see Figure 3.1).

For a summary of facilitators and barriers, see Table 4.1.

**Figure 3.1. CFIR Framework Elements Used in This Analysis**



### *Innovation*

Regarding innovation, interviewees noted that many clients and staff have liked the option of virtual meetings, which has helped facilitate the transition to remote and virtual services. Organizations that welcome drop-in visits from their clients placed signs on their doors with information about available services and any key guidance that might be needed. Providers also expanded the types of services provided, as described previously (e.g., providing food and other goods, expanding harm reduction approaches).

There were also key barriers to the success of these innovations. Some clients lack the access (e.g., to internet, devices, private space) or technological literacy to participate in virtual services. Some providers also prefer video sessions, especially for their clients with more-serious mental health disorders; however, participation in video sessions is especially difficult for these client populations. Other interviewees highlighted how certain activities have been more challenging, such as applying for government benefits, because key offices are closed and it can be difficult to walk clients through more-complicated forms remotely. As one interviewee stated,

The other group that is at a disadvantage is . . . people without phones, people without access to computers are really having a hard time accessing some of the benefits, some of the relief that is being offered. The stimulus payments. Even

just accessing public assistance, if you don't have a phone or if you don't have a computer, it's really difficult to access CalFresh, General Relief,<sup>2</sup> any of the public assistance benefits because the [Department of Public Social Services] offices are closed.

### *Outer Setting*

Interviewees noted that some funders have been collaborative in shaping their pandemic response, allowing their organizations to repurpose existing funds or providing additional funds for expanded services, such as rent and food assistance. Changes in federal policies (e.g., expanding reimbursement for virtual behavioral health services, allowing for initiation of buprenorphine for treatment of opioid use disorder via virtual health services) were also described as key. One interviewee from an organization providing substance use treatment services highlighted the way that changes in policies have facilitated expanded access to services:

We are scratching the surface of what's needed, but we are building the service so now we can make it broadly available, receive it without having to navigate the Byzantine county health structure and now can start [medication-assisted treatment].

Outer setting barriers were related to the limited availability of resources, especially in early interviews. Some interviewees described challenges following county and federal recommendations for PPE use because of a lack of supplies, and also noted that the shortage of supplies made it difficult to meet all client needs. In addition, many clients—especially those experiencing homelessness—have had little to no access to public Wi-Fi and phone charging options because of the closures of libraries and restaurants. As one interviewee highlighted:

Pre-COVID, our [space was] a place of respite. That was such a loss for [our clients]. Losing the libraries and parks. Safe spaces, those have really diminished.

### *Inner Setting*

Interviewees discussed the importance of proactive leadership both to make sure that their organizations have well-communicated, long-term plans, and to request additional support from funders. Some noted that their organizations already had resources available for remote working, such as laptops and mobile phones, because the nature of their work requires staff to be away from the office (e.g., those conducting outreach in the community). Some interviewees also cited a collaborative process that allowed direct service providers to make suggestions to fill gaps they saw in the field.

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<sup>2</sup> CalFresh is California's state food benefits assistance program; General Relief is a county-funded assistance program for individuals without resources or income.

However, there were common barriers that were related to the inner setting. For example, when COVID-19 affects revenues, it can result in hiring freezes, staff furloughs, or reduced schedules. In congregate housing settings, staff cannot compel clients to shelter in place; however, when clients leave and return, this has the potential to place other residents and staff at risk of infection. This was especially challenging for clients whose behavioral health concerns (e.g., substance use) made it difficult to shelter in place. As one interviewee said,

For our clients who are in interim housing or Board and Cares,<sup>3</sup> we're definitely trying to work on helping to support housing as best we can, because we know our clients are getting pretty antsy . . . With Safer at Home guidelines, it's been very tough on the clients and likewise tough on the housing sites.

Finally, some organizations lacked some of the facilitators described previously (e.g., technological capacity, medical expertise) that, in turn, acted as barriers.

### *Individual Characteristics*

Several characteristics of individual staff were cited as facilitators. Interviewees described staff as highly dedicated to clients, working together to problem-solve and develop solutions. One interviewee highlighted staff members' efforts to support one another:

One of the things that we do is, every day, we hold a hangout Zoom [online videoconference] so people can come in and have interactions just for a half hour . . . So we try to create that once a day for people to voluntarily join and I think that helps keep everyone's mental health and spirits up when we're working in a very difficult time.

Prior experience with phone- or video-based services was also described as an asset. Some organizations were able to leverage relevant expertise of staff, such as medical training.

Regarding barriers, interviewees noted that staff are under increased stress. They described how staff are working to provide quality services to clients while balancing the impact of the pandemic on their own health and well-being. Some interviewees described the importance of additional professional supports (e.g., increased supervision frequency) and personal supports (e.g., stress coping resources). Other interviewees described scheduling constraints experienced by staff (e.g., because of increased caregiver responsibilities).

### *New Processes*

Finally, several new processes supported the changes in services. Information-sharing and cross-collaboration were deemed important facilitators. Some organizations received access to PPE and other supplies through the lead agency at the county level when those supplies were difficult to access. Organizations worked to reorganize operations and staff duties to maintain

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<sup>3</sup> A Board and Care home is a type of assisted-living facility, available as an option for some individuals served through certain county programs.

revenue and staff jobs, and one organization reported that it was able to provide hazard pay to its staff.

However, the processes guiding organizations' COVID-19 responses have had their own challenges. Interviewees reported that their organizations have mainly been reactionary, rather than being guided by existing crisis plans for supplies, staff, and policies. They also described how the responses within the city and county governments were not always well coordinated, especially early on, which came with an increased administrative burden for organizations as they attempted to reconcile conflicting guidance. One interviewee highlighted the burden of additional reporting requirements being put in place by government agencies:

I think there's just a lack of sensitivity around just how much we already have on our plates . . . A lot of times, these kinds of things are created, the framework is created without input by the organizations [that provide services] of what would actually be useful . . . It's just stacks of paperwork, basically.

We learned that there has been a decrease in high-quality communication and collaboration among some providers, including on such important issues as client COVID-19 status. Finally, although clients have the potential to access certain COVID-related benefits (e.g., unemployment benefits), there have been long waits to be in touch with relevant agencies and certain offices have been closed, causing delays in services.

## Strategies for Monitoring Response

We asked interviewees how their organizations have been monitoring their COVID-19 response. Many informants were not aware of new data being tracked, but a small number of interviewees provided examples of efforts to monitor the response in the following domains:

- **Services:** Some organizations are tracking changes in the services being provided or requested. This has included the number of virtual appointments, COVID-related service requests, and additional documentation of supports offered to clients.
- **Client status and symptoms:** This includes tracking client responses and needs over time, including mental health needs, medical issues, substance use risk, behavioral issues, COVID-19 symptom checks, and financial needs.
- **Staff status and symptoms:** This includes tracking staff responses and needs over time, with a focus on COVID-19 symptom checks.
- **Financial impact:** This includes assessing changes in the financial status of the organization, such as daily revenue, COVID-related expenses, and donations.
- **Human resources:** This includes examining changes in staff duties and work patterns, such as proportion of staff working from home, number of staff furloughed or laid off, and which staff have had contact with each other and with client sites.
- **Supplies:** This includes monitoring levels and use of supplies over time, such as PPE, cleaning supplies, and food.

## Equity Concerns

As one of our final questions, we asked organizations to reflect on any disparities they have observed in how COVID-19 affects the subpopulations that they serve—whether they noted differences in groups’ social needs or organizations’ ability to address those needs, differences in the effectiveness of their responses across groups, or even discriminatory reactions to COVID-19 against certain groups.

We heard a wide variety of responses, highlighting ways that specific equity concerns cut across a number of vulnerable populations. In Figure 3.2, we highlight the populations and equity concerns that were discussed. Populations that were identified as being especially adversely affected by COVID-19 included the primary populations served by many of these organizations (e.g., justice-involved individuals, people experiencing homelessness, individuals with serious mental illness, individuals with substance use disorders) along with various other dimensions, including racial or ethnic background.

Across these populations, five specific equity concerns were described most often. First, interviewees described how certain groups might have more challenges *accessing services*. This included older adults, who may have more challenges with technology access and literacy, as well as non-English speakers and undocumented immigrants, who may experience more barriers to accessing benefits. Second, interviewees raised concerns about COVID-19 having a disproportionate *economic impact* on certain subgroups, such as those recently involved with the criminal justice system who already experience obstacles to obtaining employment. Third, interviewees discussed the potential for a greater adverse effect of COVID-19 on the *behavioral health* of certain groups. For example, they noted that justice-involved clients could be especially triggered by shelter-in-place orders. Difficulties accessing services could also lead to an exacerbation of existing mental health and substance use disorders. Fourth, interviewees cited barriers to *determining what is accurate information* about COVID-19. For example, one interviewee noted that in certain homeless encampments, there were perceptions that the virus is not real or would not be likely to affect the residents. Another reported that Black and Latinx clients in low-income areas were especially in need of psychoeducation and guidance as to sources of reliable information about the virus. Finally, interviewees indicated that certain groups may be at a greater *risk for exposure* to COVID-19. This included individuals with substance use disorders and sex workers who were reported to be breaking shelter-in-place orders. This had the dual potential of placing them in riskier situations in the community, and of infecting others in their congregate settings.

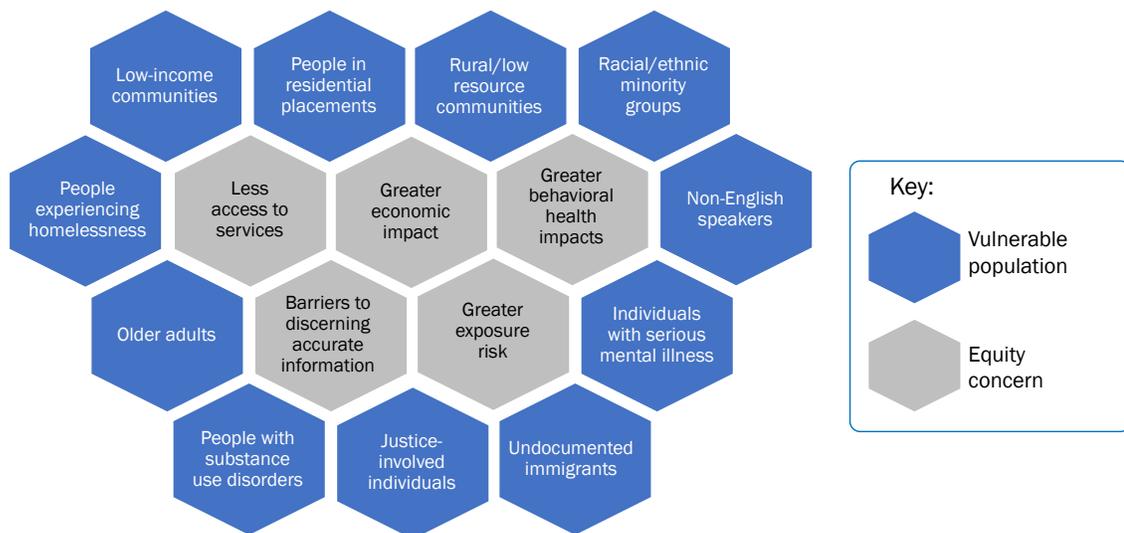
Many interviewees noted that their clients are often members of multiple at-risk groups, leading to compounded risk. For example, justice-involved individuals are already disproportionately from racial or ethnic minority groups and experience barriers to employment and housing. One interviewee also highlighted that many of the staff members of community-

based organizations also have their own histories of justice-system involvement, homelessness, or behavioral health issues:

[These are] all people of color who already survived all of [these] things. Most of them are in recovery, some of them have a homelessness story, many of them have an incarceration story. A lot of them are raising families on their own or have other dependents. And they are in camps every day trying to protect people . . . They're also, I imagine, all close to [living] paycheck to paycheck.

Finally, it is important to note that when asked this question, many interviewees reported that all their clients are disadvantaged in many ways, which makes it challenging for them to parse disparities between the many disadvantaged groups they serve. In these cases, they often underscored the vulnerability of all their clients.

**Figure 3.2. Equity Concerns and Vulnerable Populations**



## 4. Discussion

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Our study explored the experiences of social services providers working with vulnerable populations in Los Angeles County—specifically, those both experiencing or at risk for homelessness and involved with the criminal justice system—during the early stages of the COVID-19 pandemic. Our goal was to understand the ways in which organizations have adapted their services and ultimately identify early lessons learned and innovative solutions developed by these organizations.

### Summary of Lessons Learned

Many providers quickly pivoted to providing virtual care (using telephone and video) to help maintain continuity of services. In some cases, the use of technology enhanced the care previously provided because clients and staff no longer had to coordinate for an in-person visit. However, not all staff or clients have the same level of comfort or familiarity using technology to facilitate care and not all services are as amenable to being provided virtually (e.g., helping a client complete a lengthy benefits application). Moreover, ongoing funding and regulatory support might be needed to continue providing virtual services. That said, it is also worth considering ways to continue capitalizing on the benefits of virtual care, even as agencies reopen for in-person services, because this might be a pathway for improving access to services for certain populations (e.g., those living in more-distant areas of Los Angeles County).

Organizations providing services in congregate settings have had additional challenges. They have worked to limit exposures in the congregate settings through a number of methods, including reducing staff contact with clients. Clients have also been encouraged to shelter in place, including through the use of expanded harm-reduction approaches, though service providers are limited in their capacity to enforce shelter-in-place recommendations.

It is clear that resources and information from external sources have been critical in shaping organizations' pandemic responses. This includes guidance for limiting infections, access to PPE, additional funding or increased flexibility in use of existing funds, and policy changes. Organizational staff have also played a key role, demonstrating flexibility, a willingness to adapt quickly, and dedication to their clients. However, the initial phases of the pandemic response have not been without challenges. Decreases in revenue have led to staff furloughs or reduced schedules, and there have been shortages in supplies and equipment. This also raises concerns about the sustainability of current efforts, especially when service adaptations have been more costly (e.g., because of the need to invest in technology or additional supplies).

As organizations have worked to adapt their services, they have been aware that their clients often have multiple vulnerabilities that increase the risk that their clients will be adversely

affected in some way by COVID-19. This includes risk of infection but also risk for downstream consequences, such as economic impacts and behavioral health concerns.

## Recommendations

Though certain services are beginning to reopen in Los Angeles County, it is clear that COVID-19 will continue to influence the way services are provided—especially to vulnerable populations—for the foreseeable future. The changes to service and innovations described in the previous section demonstrate organizations’ commitment to continuing to serve their clients, despite the many obstacles presented by COVID-19. However, interviewees also expressed a desire for more proactive approaches. Drawing on the identified barriers and challenges and efforts instituted elsewhere, we offer the following recommendations (for a summary, see Table 4.1):

1. **Continue providing psychoeducation to clients regarding COVID-19.** Interviewees described how certain clients have misperceptions about the virus, and others have difficulty discerning which sources of information are accurate. As the pandemic progresses, shifting government guidance and discrepancies between federal, state, and local communications can make it difficult for clients to identify what sources of guidance apply to them. Some provider organizations described existing efforts to provide psychoeducation about the virus and safety procedures, and these organizations are well-positioned to continue to serve as a source of reliable and accurate information for clients.
2. **Increase client access to technology.** Los Angeles could replicate recent partnerships between cities and technology providers (e.g., the New York City Mayor’s Fund and T-Mobile) to provide tablets to vulnerable populations. In fact, the Los Angeles Regional Initiative for Social Enterprise (LA:RISE) recently published the *LA:RISE Nonprofit Technology Resources Guide* (2020), which includes valuable information about corporate entities giving product donations and grants, technology funding and grant opportunities, and technology assistance resources. In addition, some cities in Los Angeles County, such as Santa Monica and Pasadena, offer free public Wi-Fi (Melvoin, 2020) and it is also available in certain areas of the City of Los Angeles. That said, expanding and sustaining Wi-Fi access would support consistent contact with clients. Finally, researchers have highlighted the importance of having outreach workers carry supplies, such as chargers and portable hotspots, to support access to services (Torous et al., 2020).
3. **Help clients become more comfortable with technology-enabled care.** Beyond access to necessary technology, client familiarity and comfort is also important for virtual services. Curricula have been developed to help individuals with serious mental illness learn to navigate digital health options, such as the Digital Opportunities for Outcomes in Recovery Services training (Hoffman et al., 2020). Providers might find such programs useful for many client groups that could require extra support to use technology (e.g., older individuals, those recently released from long periods of incarceration).
4. **Focus on equity issues because the pandemic is creating disproportionate impacts that will likely widen over time.** There are concrete steps that county agencies,

community-based organizations, and communities can take to address this concern. Such steps can include engaging individuals with lived experience in pandemic response planning and ensuring collaborative planning among the many systems serving these individuals (National Alliance to End Homelessness et al., 2020). It can also include the use of equity-based decisionmaking protocols. There are existing equity toolkits and decision tools (e.g., those geared toward addressing racial or ethnic disparities, such as that published by the Government Alliance on Race and Equity [Nelson and Brooks, 2016]), and some organizations have developed or cataloged new protocols that are specific to COVID-19 (see Racial Equity Tools, undated, and the protocol from the Center for Community Investment in Urquilla, 2020).

5. **Continue to enforce safety protocols, including the use of COVID-19 testing.**

Although most providers are using symptom-based screening, it is important to remember that these screenings cannot detect asymptomatic carriers. Also, many of the individuals being served by these organizations need to be particularly cautious because of preexisting vulnerabilities, such as age and comorbid conditions. Both staff and clients need to maintain vigilance to prevent spread of the disease, and it is more important than ever to maintain social distancing and PPE use because of the contagious aspect of the disease. As access to testing has increased, there is room for greater attention to COVID-19 testing among high-risk populations and the staff that work with them. Services that require regular in-person contact should be prioritized for frequent, easy-to-access testing protocols.

6. **Leverage increased policy flexibility to speed access to services.** Both county agencies and providers might have opportunities to capitalize on this type of flexibility. For example, in another county that we are working with, emergency measures have streamlined access to supportive housing. This includes waiving the housing inspection process with a landlord affidavit stating that a property is housing-ready, which helps to speed up the move-in process and get clients more rapidly into housing. This county has also waived the requirement that a participant receiving a federal subsidized housing voucher is required to provide multiple types of identification; instead, the participant is able to sign a document indicating that they will provide identification within a 60-day window, given that many offices where identification provision takes place have been closed.

7. **Support staff well-being and health.** As previously described, COVID-19 has placed great burdens on staff of provider organizations, increasing their potential support needs. Support for staff might include making sure that organizations are aware of resources that are available to providers on the front lines (e.g., many health systems have compiled lists of mobile applications, websites, and articles; see, for example, the University of Wisconsin Department of Psychiatry, undated). This could also be demonstrated by ensuring that staff have meaningful time off (e.g., by developing rotating schedules) and providing opportunities for staff to support each other through consultation, especially when people are working remotely and do not have the same chance to regularly connect with one another. These strategies have been previously developed to help providers working with vulnerable populations, or who are exposed to trauma (e.g., Harrison and Westwood, 2009).

8. **Develop disease outbreak response plans to increase future preparedness.** These plans should address procedures and operations to mitigate spread; how to build a

sufficient stockpile of cleaning supplies, food, PPE, and technology; and leadership structures for rapid response (e.g., forming a task force). This type of response plan can ensure that organizations at all levels—funders, lead agencies, and providers—have a coordinated, proactive response to future waves of COVID-19 and similar events.

Together, these recommendations could serve as a roadmap for county and city agencies, community-based organizations, and funders as we enter the next phases of the pandemic.

**Table 4.1. Summary of Facilitators, Barriers, and Proposed Solutions**

<b>CFIR Domain</b>	<b>Facilitator (F) or Barrier (B)</b>	<b>Example</b>	<b>Solutions or Recommendations</b>
<b>Innovation</b>	Organization, staff, and client flexibility (F)	Staff and clients adapted to provision of virtual services	<ul style="list-style-type: none"> <li>• Continue providing virtual care</li> </ul>
	Access to virtual services (B)	Lack of mobile smartphone or tablet, internet access, level of technological skill	<ul style="list-style-type: none"> <li>• Provide free Wi-Fi and smartphones or tablets</li> <li>• Offer technology training</li> </ul>
<b>Outer setting</b>	Collaborative and flexible funding (F)	Funds repurposed and expanded to expand services, such as rent and food assistance	<ul style="list-style-type: none"> <li>• Continue to provide flexible funding to best meet needs of affected populations</li> </ul>
	Federal policy changes to virtual behavioral health and medication initiation for substance use disorders (F)	Policies expanded reimbursement for virtual therapy, or gave an allowance to start medication for substance use without in-person visit	<ul style="list-style-type: none"> <li>• Continue allowances for virtual therapy and medication induction</li> </ul>
	Access to PPE (B)	Initially, a shortage of supplies made it difficult to follow Centers for Disease Control and Prevention guidance	<ul style="list-style-type: none"> <li>• Provide support for organizations to engage in disaster response planning</li> </ul>
	Access to benefits (B)	Some offices closed or reduced access	<ul style="list-style-type: none"> <li>• Advocate that identification and other benefits offices be considered essential services</li> <li>• Temporarily waive inspection and identification requirements</li> </ul>
<b>Inner setting</b>	Proactive leadership (F)	Organizations engaged in long-term planning, established task forces, or consulted infectious disease experts to inform organization policies	<ul style="list-style-type: none"> <li>• Provide support for organizations to engage in disaster response planning</li> </ul>
	Remote work equipment (F)	All staff had laptops, mobile phones, and other equipment to work remotely	<ul style="list-style-type: none"> <li>• Ensure staff have equipment to work remotely</li> </ul>
	Engaging vulnerable populations (B)	Both staff and clients represent vulnerable groups that might be disproportionately affected	<ul style="list-style-type: none"> <li>• Engage individuals with lived experience in response planning</li> <li>• Use equity-based decisionmaking protocols</li> </ul>
<b>Individual characteristics</b>	Dedicated staff (F)	Staff problem-solved and developed solutions to best meet their needs	<ul style="list-style-type: none"> <li>• Provide staff support to engage in organizational planning</li> </ul>
	Burden on staff (B)	Staff experienced greater stress while providing care for clients and protecting their own well-being	<ul style="list-style-type: none"> <li>• Provide additional professional supports (e.g., supervision) and personal supports (e.g., coping resources)</li> <li>• Consider hazard pay</li> </ul>
<b>Process</b>	Cross-collaboration (F/B)	Initially, there was some reactionary responses but agencies improved information- and resource-sharing over time	<ul style="list-style-type: none"> <li>• Provide venues for the multiple agencies serving populations to communicate and engage with one another</li> </ul>
	Safety protocol enforcement (B)	Use of symptom-based screening is not adequate	<ul style="list-style-type: none"> <li>• Maintain vigilance to prevent disease spread</li> <li>• Institute COVID-19 testing protocols</li> </ul>

## Conclusion

This report describes the early experiences of organizations in Los Angeles County that serve individuals both at risk for or currently experiencing homelessness and involved with the criminal justice system during the COVID-19 pandemic. Findings demonstrate the ways in which providers quickly adapted to ensure continuity of care for their clients, to the extent possible, though there have certainly been obstacles along the way.

There are certain limitations to this work. We focused on organizations with which we have existing relationships; this enabled us to quickly initiate this work and conduct interviews, but it might limit the generalizability of the findings. In addition, the state of the pandemic and associated government response has continued to evolve rapidly since data collection ended. However, understanding early successes and limitations might help to guide the ongoing response of similar organizations, both in Los Angeles County and beyond, and provide an opportunity to reflect on next steps that could help these organizations continue to provide high-quality services into the next phases of the pandemic.

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