Denver Joint Task Force Recommendations:

COVID-19 Planning and Response for Persons Experiencing Homelessness in the City and County of Denver

Denver Joint Task Force Recommendations:

COVID-19 Planning and Response for Persons Experiencing Homelessness in the City and County of Denver

May 5, 2020

Problem statement:

Persons experiencing homelessness are exceptionally vulnerable to COVID-19, secondary to age, substantial comorbidities, lack of access to adequate hygiene, and inability to self-isolate or quarantine.[1] This is compounded by crowding in shelters and encampments, and limited available sites for isolation and quarantine.[2] Limiting the spread of COVID-19 among persons experiencing homelessness is critical to the health of our entire community. If COVID-19 spreads rampantly in the homeless population, this will contribute to a rapid and significant spike in use of hospital resources, resulting in a catastrophic decrease in hospital capacity in the Denver metropolitan region. All efforts focused on "flattening the curve" may be for naught if COVID-19 is able to spread rapidly throughout the homeless population. The lessons learned from the Seattle King County COVID-19 response provide a useful roadmap for Denver's planning and response.[2]

Estimates of Homeless Population at risk:

In 2019, the Colorado Coalition for the Homeless **(CCH)** served a total of 13,226 individuals experiencing homelessness. **Figure 1** shows the total number of individuals served by housing status. **Figure 2** shows the estimated number of people experiencing homelessness who may require hospitalization and critical care based on percent infected. **Figure 3** illustrates the proportion of CCH population who is at risk for severe disease based on age and comorbidities. These numbers are likely to underestimate the true extent of the problem.

Figure 1. Total Number of People Experiencing Homelessness Served by the Colorado Coalition for the Homeless in 2019 by Housing Status

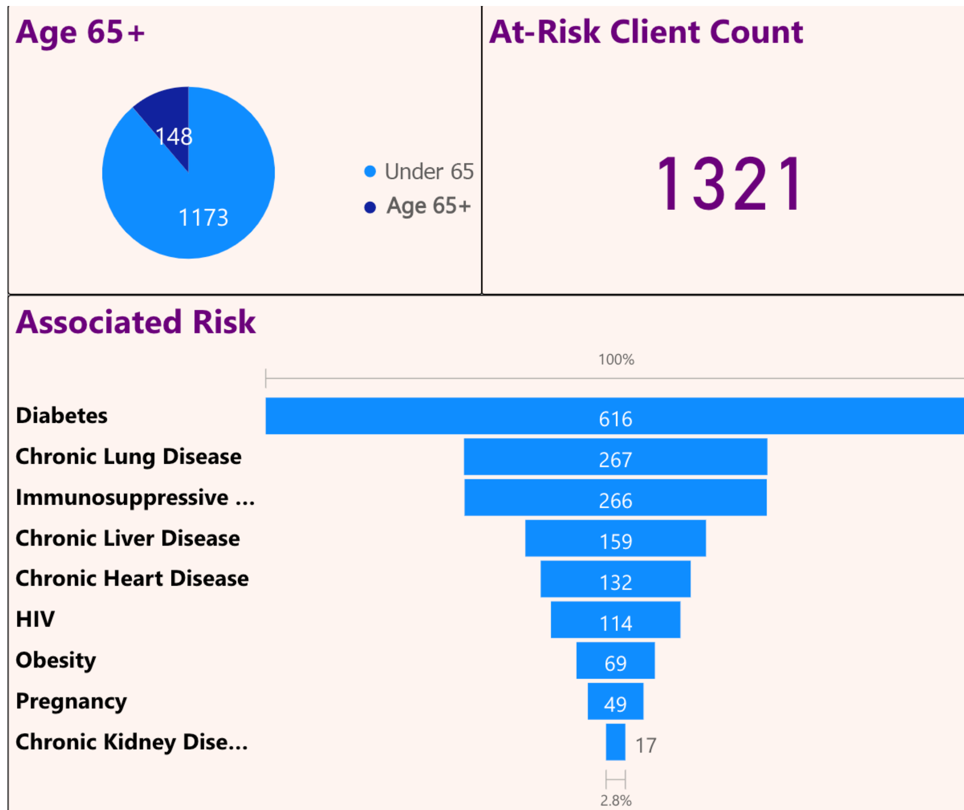
CCH UDS Data	2019
TOTAL Served	13,226
SHELTER	3,298
TRANSITIONAL	2,190
DOUBLING UP	964
STREET	2,680

Note: CCH data is primarily representative of the Denver metropolitan region, although approximately 400 individuals per year are attributed to Fort Lyon.

Figure 2. Estimated number of People Experiencing Homelessness who will require hospital and critical care based on percent infected

CCH Total Population	13,226			
% Infected	# infected	10% Hospitalized	20% Hospitalized	5% critical care
10	1322	132	264	66
20	2545	254	509	127
30	3967	396	793	198
40	5290	529	1058	264
50	6613	661	1322	330
60	7935	793	1587	396
Housed Population	4,000			
% infected	# Infected	10%Hospitalized	20%Hospitalized	5% Critical Care
10	400	40	80	20
20	800	80	160	40
30	1,200	120	240	60
40	1,600	160	320	80
50	2,000	200	400	100
60	2,400	240	480	120
Street Population	2680			
% Infected	# infected	10% Hospitalized	20% Hospitalized	5% critical care
10	268	27	54	13
20	536	53	106	26
30	804	80	160	40
40	1072	107	214	53
50	1340	134	268	67
60	1608	160	320	80
Shelter Population	3298			
% Infected	# infected	10% Hospitalized	20% Hospitalized	5% critical care
10	330	33	66	16
20	660	66	132	132
30	989	99	198	198
40	1319	132	264	264
50	1649	165	330	330
60	1979	198	396	396

Figure 3. Estimated Proportion of CCH Patients at Risk for Severe Disease Based on Age and Chronic Conditions



Strategic Recommendations:

1. **Establish Joint Taskforce to develop a coordinated, strategic response to COVID-19 among persons experiencing homelessness in the City and County of Denver.** At a minimum, stakeholders should include representatives from the following agencies and organizations: Denver Department of Housing Stability **(HOST),** Denver Human Services **(DHS)**, Denver Department of Public Health and Environment **(DDPHE)**, Denver Health and Denver Public Health **(DPH)**, Metro Denver Homeless Initiative **(MDHI)**, the Colorado Coalition for the Homeless **(CCH)** and other homeless service providers. Task force should have clear reporting structure, roles and responsibilities and communication strategy to partners and stakeholders at the city, state and federal levels.

2. **Plan and implement a coordinated strategic response to COVID-19 in persons experiencing homelessness, utilizing lessons learned from Seattle-King County, with the goals of limiting the transmission of COVID-19 in the homeless population, improving health outcomes AND preserving vital hospital capacity.**

Strategy 1: Reinforce and Support the Existing Shelter System

1. **Provide timely, relevant education, training and support for COVID-19 for homeless service providers, and for people experiencing homelessness**
    - Create FAQ documents/“hot sheets”, posters and other educational materials based on CDC and DDPHE documents/tools, including: information on how to space shelter beds, best practices for cleaning and sanitization, guidance on PPE use[3]
    - Provide triage tool to aid non-clinical staff in screening and identifying symptomatic persons and those at risk for severe disease
    - Education and training for shelter staff and street outreach workers
    - Consider bulk ordering of cleaning supplies and PPE with distribution for high traffic shelters, guidance regarding cleaning, and consider sending cleaning crews to shelters to support staff
    - Consider deployment of Field Assistance Support Team (“FAST Team”) to provide additional technical assistance and support in implementation of best practices

2. **Reduce Overcrowding in Congregate Settings**
    - Ensure appropriate physical distancing measures in all existing shelters
    - Create new, auxiliary shelters at the National Western Complex and Coliseum to aid in de-crowding of existing shelters with appropriate staffing to ensure safety and provision of services
        - For those experiencing unsheltered homelessness, utilize outreach teams and deploy support including screening for symptoms and referring to protective action rooms, activated respite or other shelter settings as needed. Provide education around importance of social/physical distancing and hygiene practices to minimize poor outcomes.

3. **Develop a centralized Medical Patient Assistance Line**
    - Provide guidance and support for shelter and homeless service providers AND assistance with triage and transition for symptomatic or COVID-positive individuals from congregate shelters, hospitals and other healthcare facilities to the most appropriate type of care setting.

4. **In partnership with local and State public health agencies, develop a plan for surveillance testing in congregate shelters**
    - Testing of both residents and staff of congregate shelters to understand local transmission, plan resources for isolated COVID-19 positive individuals, and provide tailored support to shelters with high prevalence.

Strategy 2. Create Activated Respite Facilities for Isolation of people experiencing homelessness with confirmed or suspected COVID-19 in shelters and healthcare facilities

- Provide large motels/hotels to be used for cohort isolation and low to moderate acuity medical step down of individuals with confirmed or suspected COVID-19 in shelters or healthcare facilities
- Triage and Prioritization via Medical Patient Assistance Line
- Create an integrated care model at each Activated Respite site, supporting 24/7 tailored, on-site supportive services for persons experiencing homelessness. Services include medical and behavioral support, care management, medication access including medication-assisted treatment (MAT), security, manager and on-site support staff
- Provide daily symptom assessment and clear policy re: transition plan and process to maintain capacity to ensure appropriate discharge.

Strategy 3. Create separate Protective Action Facilities for the cohorting of people experiencing homelessness who are NOT COVID-19 positive but who are vulnerable within a congregate shelter setting

- Provide large motel/hotels to be used for cohort identified within emergency shelters or who are living unsheltered as needing "Protective Action" in non-congregate setting, leveraging support from the State as needed
- Establish clear criteria for protective action rooms based on vulnerability factors for COVID-19
- Triage through Medical Patient Assistance Line
- Provide on-site services including medical and behavioral support, case management, and transition planning through nonprofit partners

Strategy 4. In partnership with the State, plan Alternative Care services for symptomatic or COVID-19 positive people experiencing homelessness who do NOT require hospitalization but who require additional monitoring and support

- An emergency surge strategy is NOT an alternative to hospitalization
- Plan for large congregate facility designed to provide supervised care for large number of symptomatic or COVID-19 positive adults experiencing homelessness
- **Establish "Front- and Back-end Hospital Diversion"** model similar to Seattle-King County[4]
    - "Front-end": diverting people from going to hospital if they don't need to

- “Back-end”: leaving hospital because they no longer need that level of care but do not have a home to which they can return, and who cannot be safely quarantined in motel room based on need for assistance with activities of daily living, or acuity needs

Figure 4. Alternative Care Site (“Assessment and Recovery Center”) in Seattle/King County

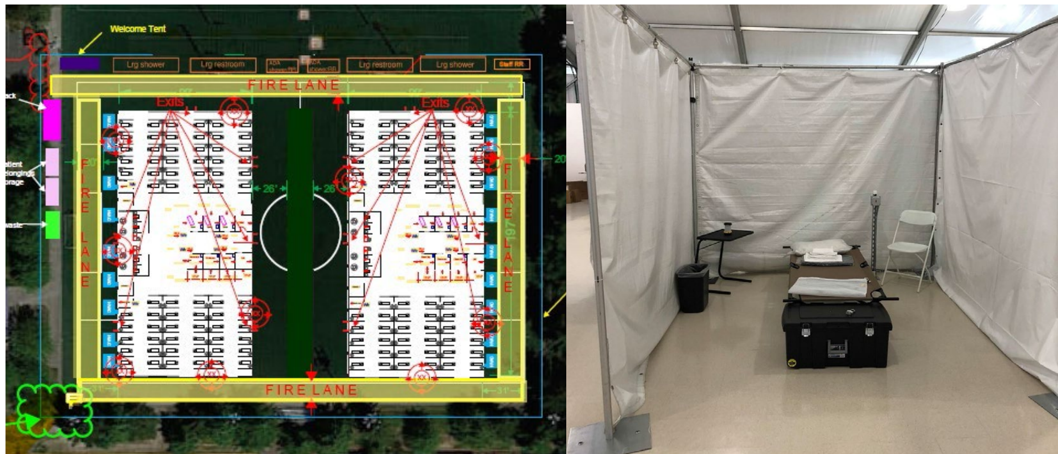


Figure 5. Examples of Services Provided in Assessment and Recovery Center Model

Medical care

- Vital signs
- COVID-19-specific symptom monitoring and medical management for 1-14 days of isolation/quarantine
- Chronic medical conditions – On Site
- Acute medical conditions – Off Site

Behavioral health care

- Mental health
  - Mental health specialist and/or mental health professionals on duty 24/7 if possible
  - Psychiatrist consultation (via telepsychiatry) for psychiatric med management
- Substance use disorder
  - Coordinate with addiction medicine specialists and regulations for treatment of:
    - Opioid use disorder: Buprenorphine, methadone, naltrexone, naloxone
    - Alcohol withdrawal: CIWA protocol and benzodiazepines for delirium tremens
    - Other withdrawal medications and supportive care

Discharge planning

Assistance with transportation, shelter placement, and other disposition considerations

Strategy 5. Consider equity, accessibility, and trauma-informed approaches to serve people experiencing homelessness throughout deployment of sheltering strategies including protective action rooms, activated respite rooms, auxiliary shelter, and rehousing strategies.

- Utilize Equity Framework in making decisions
- Assess for accessibility needs within activated respite, protective action, and auxiliary shelter facilities
- Partner with EOC to review each property for accessibility and pursue modifications and/or partnerships as needed to address issues
- Provide training for city staff and volunteers who are supporting sheltering sites

References:

1. CDC Interim Guidance for Responding to Coronavirus Disease 2019 (COVID-19) among People Experiencing Unsheltered Homelessness. March 22, 2020. Accessed at: https://www.cdc.gov/coronavirus/2019-ncov/community/homeless-shelters/unsheltered-homelessness.html
2. United States Interagency Council on Homelessness. Webinar: COVID-19 Planning and Response—Isolation and quarantine: Lessons learned from King County. March 24, 2020. Accessed at: https://www.usich.gov/resources/uploads/asset_library/Webinar_COVID_19_Seattle_King_County_Slides_03242020.pdf
3. CDC: Resources to support people experiencing homelessness. April 13, 2020. Accessed at: https://www.cdc.gov/coronavirus/2019-ncov/community/homeless-shelters/index.html
4. United States Interagency Council on Homelessness. Webinar: COVID-19 Planning and Response—Isolation and quarantine: Lessons learned from King County. COVID-19 Planning and Response: Assessment and Recovery Centers: Lessons Learned from Seattle & King County. April 13, 2020. Accessed at: https://www.usich.gov/tools-for-action/webinar-implementing-assessment-and-recovery-centers-and-providing-transportation-to-isolation-and-quarantine-facilities-lessons-from-seattle-king-county