

Denver Joint Task Force Recommendations:

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

Fall/Winter 2020-2021

December 21, 2020

By Kaylanne Chandler, RN, BSN, Ed Farrell, MD, and Sarah Stella, MD, on behalf of the Denver Joint Task Force.

Background:

Persons experiencing homelessness (PEH) 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. Limiting the spread of COVID-19 among PEH is critical to the health of our entire community.

According to data from the Denver Department of Public Health and the Environment (DDPHE) and Denver Public Health (DPH), 818 unhoused persons in Denver have contracted COVID-19, representing 2% of all COVID-19 cases in Denver. At least 230 of these individuals (representing 28% of COVID-19 cases in PEH) have been hospitalized, compared with 10% of cases in the general population. There have been at least 16 deaths among PEH who were positive for COVID-19. In 9 of these cases, COVID-19 was the cause of death.

In March 2020, recognizing the vulnerability of PEH to COVID-19, and the need for a swift, coordinated strategic response to mitigate the impact of COVID-19 on Denver's unhoused community while preserving vital hospital capacity, we assembled the Denver Joint Task Force (DJTF), which includes stakeholders from the following organizations:

- Colorado Coalition for the Homeless (CCH)
- Denver Department of Public Health and Environment (DDPHE)
- Denver Health Hospital and DPH (DH)
- Denver Human Services (DHS)
- Denver Department of Housing Stability (HOST)
- Denver Homeless Leadership Council (HLC)
- Metro Denver Homeless Initiative (MDHI)

The DJTF collaborates to plan resources, and update strategy in accordance with epidemiologic data and evolving CDC best practices, and to advocate for the needs of PEH in order to optimize health outcomes and promote equity in the response to COVID-19.

Link to Initial Strategic Plan: <https://www.coloradocoalition.org/sites/default/files/2020-09/Denver%20Joint%20Task%20Force%20Recommendations%20-%20FINAL.pdf>

Link to Live Updates Document:

https://www.coloradocoalition.org/sites/default/files/2020-10/Denver%20Joint%20Task%20Force%20Report%2010-7-20_final.pdf

Current Problem statement:

Now nine months into the pandemic we have learned more about the SARS-CoV-2 virus which causes COVID-19. Mortality rates from COVID-19 have decreased since last spring, and access to testing has increased.⁸ Importantly, current research also suggests that asymptomatic transmission accounts for nearly half of COVID-19 infections.⁷ This makes physical distancing and mask adherence crucial in reducing transmission and curbing outbreaks in congregate settings.

Previously, in the spring we had positivity rates of 10-25% based on the shelter surveillance data and needed 238 rooms at one time in 3 Activated Respite hotels during our peak surge in early May. However, in the current fall season, influenza and the common cold and other respiratory illnesses (which were previously seen very infrequently) are being seen very frequently, while COVID-19, for now, is relatively infrequent in the majority of surveilled shelters. This is in sharp contrast to the high rates seen elsewhere in the community. While we anticipate that cases among PEH will rise as people move indoors during cold weather, the surge among PEH may not be as dramatic as what Denver previously experienced.

The CDC recently expanded testing criteria to include testing people with a lower index of suspicion, including those with: “fever or chills, cough, shortness of breath or difficulty breathing, fatigue, muscle or body aches, headache, new loss of taste or smell, sore throat, congestion or runny nose, nausea or vomiting, diarrhea”⁵ The CDC has also expanded its definition for “close contact”, meaning that more people should quarantine to prevent the spread of COVID-19. Additionally, people who have been “close contacts” need to quarantine, even if they test negative

In response to updated CDC guidelines and improved access to testing in shelters and encampments, efforts to control the rate of spread in PEH and congregate settings must be layered, improved and expanded as we approach the winter season

Estimated Population at risk:

In 2019, the Colorado Coalition for the Homeless (**CCH**) served a total of 13,226 PEH-- 3,298 sheltered people, 2,190 people in transitional housing, 964 people doubling up and 2,680 unsheltered people.

Appendix I shows estimated numbers of PEH with estimated prevalence rates by shelter location stratified by risk.

Appendix II shows the estimated proportion of clients in Protective Action at risk for severe disease based on age and chronic conditions. These numbers are likely to underestimate the true extent of the problem.

Denver Joint Task Force Strategic Recommendations for Fall/Winter 2020-2021:

Strategy 1: In conjunction with DDPHE, reinforce and support the congregate shelter system.

1. Provide shelters and PEH with timely, relevant information on measures to reduce transmission and keep themselves safe

- Create and disseminate educational materials based on updated CDC, CDPHE, and DDPHE guidelines, including information on how to space shelter beds, best practices for cleaning and sanitization, guidance on PPE use³
- Ensure proper training for shelter staff and street outreach workers on masking, distancing and other measures to decrease transmission
- Additional shelter-specific training, technical assistance and support from DDPHE for implementation of best practices, particularly for shelters in which outbreaks are identified.

2. Reduce Overcrowding and improve ventilation in Congregate Shelters to decrease transmission

- Universal masking of PEH and staff and appropriate physical distancing measures in existing shelters, and appropriate staffing to ensure adherence with these measures
- Create overflow shelters to aid in de-densifying existing shelters
- If congregate settings must have spaces where multiple people sleep, bunkbeds, or rooms with more than 10 beds, follow the DDPHE's guidance on bed positioning (See Appendix III).
- Assess ventilation systems to improve airflow in shelters
- Where possible, transition to a 24/7 model to facilitate greater stability of the population served to better manage potential exposures and facilitate contact tracing in the event of an outbreak.

3. Provide enhanced clinical support via a Centralized Medical Patient Assistance Line

- Provide real-time clinical support for shelter staff to triage symptomatic or COVID-positive individuals from congregate settings into the appropriate care setting

Strategy 2. In partnership with shelter leaders, continuously improve the processes for symptom screening, triage, and testing for PEH and staff in congregate settings, based on latest CDC recommendations and resource availability

1. In partnership with local and State public health agencies, continue routine surveillance testing in congregate shelters and encampments

- Given high rates of asymptomatic transmission, routine surveillance testing of PEH and staff in congregate shelters is crucial to control outbreaks, and plan resources. It also allows for identification of shelters with high prevalence who may need additional support, and low prevalence who may have best practices to share.
- Routine surveillance testing is recommended every 4-6 weeks as resources allow. Consider size, turnover, connectedness with other facilities, crowding levels, congregate vs. individual rooms in shelters, and vulnerability index in the prioritization of testing resources when capacity or supplies are limited¹⁰
- Outbreak surveillance testing frequency is different than general surveillance testing. An outbreak is defined as having two or more positive cases in a congregate setting where transmission within the facility is likely. If there is an outbreak, public health surveillance testing will ideally occur every seven days until there are zero COVID-19 cases for 14 consecutive days.

2. Continuously improve Triage and Prioritization Processes and Algorithms for people with non-specific but potential COVID-symptoms based on CDC recommendations, testing and resource availability to improve health outcomes

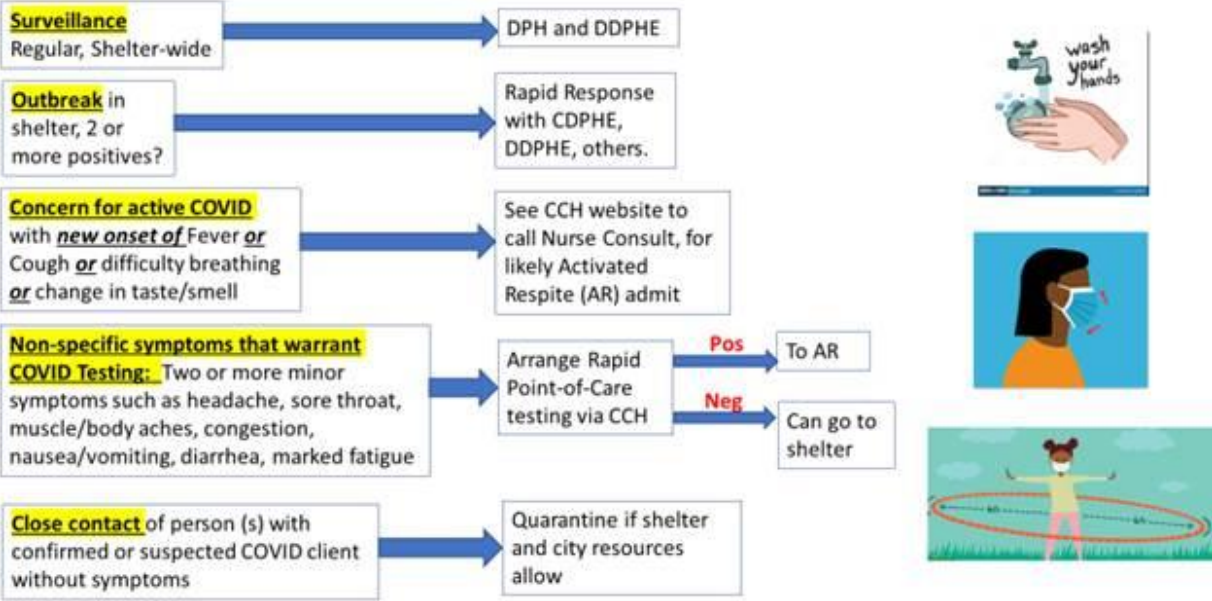
- CDC recommends the use of POC Antigen testing for symptomatic individuals in at-risk populations including PEH¹⁰ With the availability of rapid testing, clinician leaders will develop an enhanced screening and triage algorithm based on symptoms, history, rapid antigen and PCR testing, and shelter outbreak data to determine an index of suspicion to guide placement while awaiting PCR testing.
- Triage and testing improvements are necessary to best utilize limited resources and to differentiate common cold and other illnesses from COVID. Consider size, turnover, connectedness with other facilities, crowding levels, congregate vs. individual rooms in shelters, and vulnerability index in the prioritization of testing resources when capacity or supplies are limited¹⁰
- It is likely necessary, when prevalence of PCR-confirmed COVID-19 in some shelters is low, to have a separate designated area for people with

low index of suspicion for COVID, yet who need testing and isolation while awaiting results.

3. Provide timely, relevant education, training and clinical support shelters to implement optimized screening process

- CCH Medical Patient Assistance Line will be available for remote nurse triage support as needed 7 days a week, 8am-8pm.

COVID Strategy for People staying in Congregate settings.



Strategy 3. Maintain Activated Respite (AR) Facilities for Isolation of PEH with confirmed or suspected COVID-19 from congregate settings and healthcare facilities

- Provide an integrated care model at each AR site, including tailored, on-site supportive services for appropriate PEH with COVID-19 who require isolation, monitoring and medical support. Services include medical and behavioral support, care management, medication access including medication-assisted treatment (MAT), security, and on-site support staff
- Provide regular symptom assessment and clear policies regarding transition plans, processes to maintain capacity, and to ensure appropriate discharge
- Ideally motels or hotels with external facing doors are used to isolate individuals with confirmed or suspected COVID-19 illness.
- Important for front-end and back-end hospital decompression during hospital surge
- Use of AR facilities for people with cold-like and other non-specific symptoms, who do not have COVID would possibly increase spread of COVID-19 and is not recommended. Use of AR for this purpose may also be impossible due to staffing challenges, and would limit access for patients with confirmed COVID

Strategy 4: Create Cohesive, Unified Strategies with Communication Plans for PEH who meet CDC criteria for “Close Contacts”

- Quarantine is a critical public health strategy to minimize spread and preserve hospital and Activated Respite capacity.
- Per CDC guidelines, people who are “close contacts” are instructed to quarantine for 14 days after their last contact, or 10 days if there is no testing and the person is asymptomatic, or 7 days if they have a negative diagnostic test and do not have any symptoms.⁹
- If there is an outbreak in any congregate shelter, complete contact tracing for the facility and quarantine all close contacts separate from non-close contacts for 14 days. Ideally, all close contacts would have individual rooms and bathrooms.
- If there is an outbreak in any congregate shelter, send any positive or symptomatic individuals to AR, and repeat surveillance testing weekly.

Strategy 5. Leveraging support from the City and State, maintain Protective Action (PA) Facilities for PEH who are NOT COVID-19 positive but who are vulnerable in a congregate setting

- Provide motel/hotels to be used for temporary housing PEH from congregate settings who are at high risk for severe disease based on vulnerability factors defined by CDC.
- Provide updated referral guidelines for healthcare facilities and homeless service providers based on resource availability pathway, and triage referrals through central Medical Patient Assistance Line
- Provide tailored on-site services including medical and behavioral support, case management, and transition planning through nonprofit partners

Strategy 6. Utilize equity, accessibility, and trauma-informed approaches to serve people experiencing homelessness throughout deployment of all sheltering strategies and provision of services

- Utilize Equity Framework in decision-making
- Assess for accessibility needs within activated respite, protective action, and auxiliary shelter facilities
- Provide training for city staff and volunteers supporting sheltering sites

References:

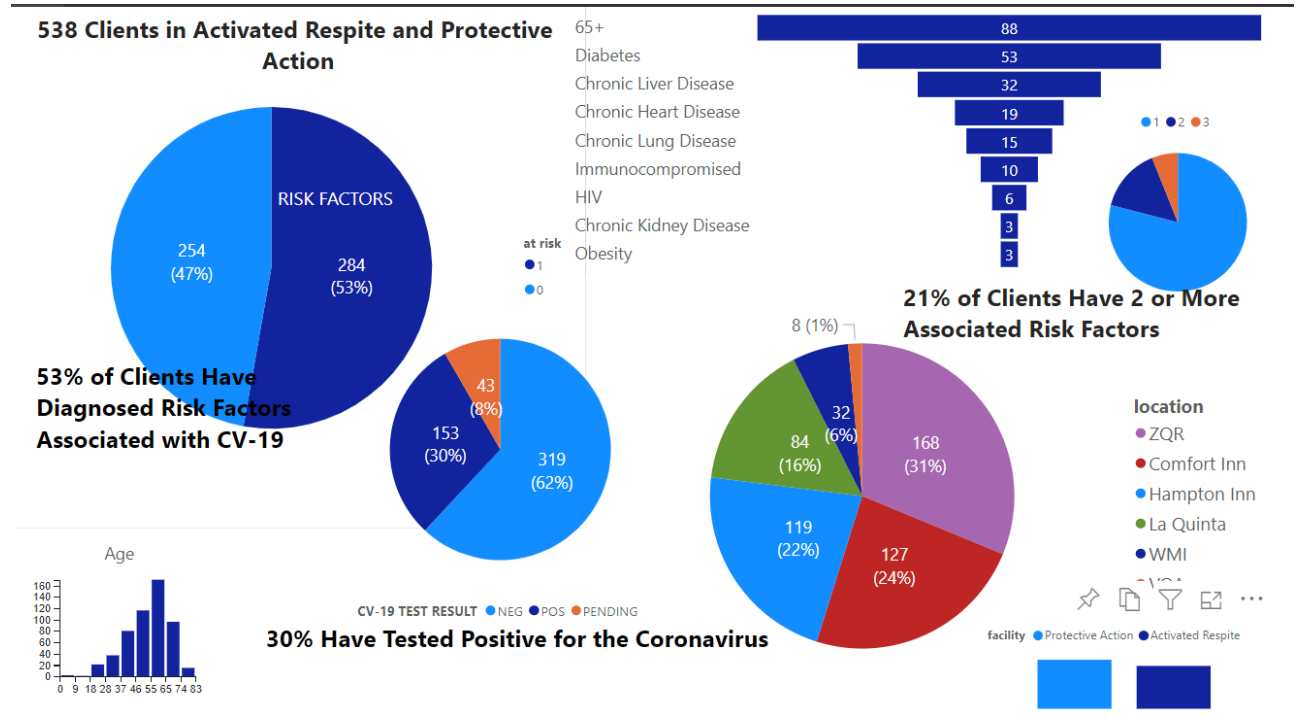
1. CDC Interim Guidance for Responding to Coronavirus Disease 2019 (COVID-19) among People Experiencing Unsheltered Homelessness. March 22, 2020. Accessed at: <https://www.cdc.gov/coronavirus/2019-ncov/community/homeless-shelters/unsheltered-homelessness.html>
2. United States Interagency Council on 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>
5. CDC: Symptoms of Coronavirus. Published May 13, 2020. Accessed at: <https://www.cdc.gov/coronavirus/2019-ncov/symptoms-testing/symptoms.html>.
6. CDC: Summary of Changes, Glossary of Key Terms. Published October 21, 2020. Accessed at: <https://www.cdc.gov/coronavirus/2019-ncov/php/contact-tracing/contact-tracing-plan/appendix.html>
7. Oran DP, Institute SRT, Topol EJ, Jeanne Marrazzo RMC and . Prevalence of Asymptomatic SARS-CoV-2 Infection. *Annals of Internal Medicine*. <https://www.acpjournals.org/doi/abs/10.7326/M20-3012>. Published September 21, 2020. Accessed November 4, 2020.
8. Two Studies Show Drop In COVID-19 Death Rates, Web MD. Published October 22, 2020. <https://www.webmd.com/lung/news/20201021/two-studies-show-drop-in-covid-19-death-rates>
9. CDC: Options to Reduce Quarantine for Contacts of Persons with SARS-CoV-2 Infection Using Symptom Monitoring and Diagnostic Testing. Published December 2, 2020. Accessed at: <https://www.cdc.gov/coronavirus/2019-ncov/more/scientific-brief-options-to-reduce-quarantine.html>
10. CDC: Interim Considerations for Health Departments for SARS-CoV2 Testing in Homeless Shelters and Encampments. Published October 19, 2020. Accessed at: <https://www.cdc.gov/coronavirus/2019-ncov/community/homeless-shelters/testing.html>.

Appendix I: Estimated number of People Experiencing Homelessness with estimated prevalence by shelter location

Shelter Name	Description	Size	2% Prevalence	5% Prevalence	10% Prevalence	20 % Prevalence	Turnover
Saint Francis Center	Day Shelter	500	10	25	50	100	High
Coliseum + Overflow - Temporary/DRM	24/7 Shelter - Men	350	7	17.5	35	70	Low
Haven of Hope/Father Woodys	Day Shelter	300	6	15	30	60	High
Center	Day Shelter	300	6	15	30	60	High
48th Avenue	24/7 Shelter - Men	271	5.42	13.55	27.1	54.2	High
Crossroads/Salvation Army	24/7 Shelter - Men	250	5	12.5	25	50	High
Holly Street/DRM-Tested at LSCC	Night Shelter - Men	200	4	10	20	40	High
Zuni Properties/PA Site	24/7 Shelter - Men, Families	174	3.48	8.7	17.4	34.8	Low
Hampton Inn/PA Site	24/7 Shelter - Women/Trans	151	3.02	7.55	15.1	30.2	Low
The Gathering Place	Day Shelter - Women/Trans	150	3	7.5	15	30	High
A-Loft/PA Site	24/7 Shelter	140	2.8	7	14	28	Low
Comfort Inn/PA Site	24/7 Shelter - Men	138	2.76	6.9	13.8	27.6	Low
Family Motel/VOA	24/7 Family Shelter	120	2.4	6	12	24	Medium
Family Promise/VOA	24/7 Family Shelter	110	2.2	5.5	11	22	Low
Western Motor Inn/PA Site	24/7 Shelter - Men	107	2.14	5.35	10.7	21.4	Low
Urban Peak Drop In	Day Shelter - Youth	100	2	5	10	20	High
New Genesis	24/7 Transitional Housing Program - Men	100	2	5	10	20	High
Smith Road/Catholic Charities	Night Shelter - Women and Trans	82	1.64	4.1	8.2	16.4	Low
Beacon Transitional Housing	24/7 Transitional Housing	82	1.64	4.1	8.2	16.4	Very Low
Rodeway Inn/Gathering Place	24/7 Shelter - Women/Trans	82	1.64	4.1	8.2	16.4	Low
The Crossing/DRM	24/7 Transitional Housing Program - Men	75	1.5	3.75	7.5	15	Low
Ramada Inn	24/7 Shelter - Women/Trans	60	1.2	3	6	12	Low
Lambuth Family Center/Salvation Army	24/7 Family Shelter	50	1	2.5	5	10	Low
Samaritan House - Programs	24/7 Shelter Program - Family, Women, Vets	49	0.98	2.45	4.9	9.8	Low
Delores Project	24/7 Shelter - Women/Trans	40	0.8	2	4	8	Low
Elati - Temporary/Bayaud	24/7 Shelter - Women/Trans	40	0.8	2	4	8	Medium
Harbor Light/Salvation Army	24/7 Transitional Housing Program - Men	40	0.8	2	4	8	Low
Urban Peak Shelter	Night Shelter - Youth	30	0.6	1.5	3	6	High
Irving Street/VOA	24/7 Transitional Housing Program - Women	25	0.5	1.25	2.5	5	Very Low
Samaritan House - Holy Rosary Overflow/Catholic Charities	Night Shelter - Women and Trans	24	0.48	1.2	2.4	4.8	High
Colorado Village Collaborative-Beloved	24/7 Transitional Housing Program	19	0.38	0.95	1.9	3.8	Very Low
Sinton's Sanctuary/VOA	24/7 Shelter - Older Women 50-64	18	0.36	0.9	1.8	3.6	Low
Colorado Village Collaborative-Women's		14	0.28	0.7	1.4	2.8	

***Recent Denver shelter prevalence rates range from 2-10%. This is consistent with national reports for PEH.^{2,7}

Appendix II: Estimated Proportion of Clients in Protective Action at Risk for Severe Disease Based on Age and Chronic Conditions



Appendix III: CDC Definitions⁶

1. **Close Contact** = “Someone who was within 6 feet of an infected person for a cumulative total of 15 minutes or more over a 24-hour period starting from 2 days before illness onset (or, for asymptomatic patients, 2 days prior to test specimen collection) until the time the patient is isolated”⁶
2. **Isolation** = “The separation of a person or group of people *known or reasonably believed to be infected* with a communicable disease and potentially infectious from those who are not infected to prevent spread of the communicable disease. Isolation for public health purposes may be voluntary or compelled by federal, state, or local public health order”⁶
3. **Quarantine** = “The separation of a person or group of people *reasonably believed to have been exposed* to a communicable disease but not yet symptomatic from others who have not been so exposed to prevent the possible spread of the communicable disease. Quarantine may be voluntary or compelled by federal, state, or local public health order”⁶

Appendix III:

SOCIAL DISTANCING AND BED POSITION FOR RESIDENTIAL AND CONGREGATE SETTINGS

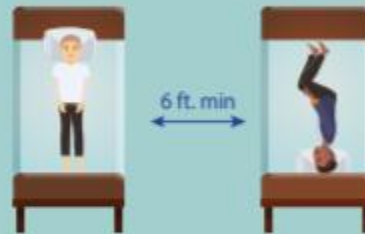
Social Distancing

involves establishing ways to increase physical distance between individuals in settings where people commonly come into close contact with one another. Due to close proximity of staff and residents, residential and congregate settings can be vulnerable to the spread of COVID-19.

To ensure the safety of patients in residential and congregate settings and reduce the spread of COVID-19 transmission, below are instructions for bed positioning on all open sides of bed.

For single beds positioned next to each other (side-to-side):

- At least 6 feet apart AND patient's laying position is head to toe



For beds positioned across from one another (end-to-end)

- Feet of beds are at least 6 feet apart AND patient's laying position is toe to toe.



For bunkbeds that are positioned next to each other or across from one another:

- Position beds at least 6 feet apart.
- Ensure the patient's laying position is head to toe on each separate bunk bed, so positioning allows for the least transmission risk as possible. This includes laying position that is head to toe with adjacent bunks.



Placement When Positioning Beds 6 feet or more is NOT Possible:

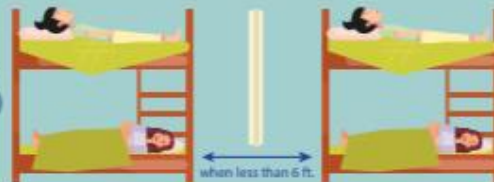
For single beds:

- Position beds at least 3 feet apart.
- Consider placing partitions (e.g., nailing string from wall-to-wall and hanging sheets or blanket, using dressers or cardboard boxes as a barrier, etc) between beds.
- Ensure patient's laying position is head to toe.



For bunkbeds:

- Position beds at least 3 feet apart.
- Consider placing partitions (e.g., nailing string from wall-to-wall and hanging sheets or blanket, using dressers or cardboard boxes as a barrier, etc) between beds.
- Ensure the patient's laying position is head to toe on **each separate bunk bed**, including positioned head to toe on adjacent bunks.



For rooms with more than 10 beds:

- Include partitions to separate beds to the fullest extent possible.



IMPORTANT!

If patient has been diagnosed with or shows symptoms of COVID-19 (e.g., fever, cough, shortness of breath), follow specific guidance available on DPH coronavirus website to appropriately isolate individuals and prevent intermingling with non-symptomatic individuals. This includes having clear signs indicating when people are entering and leaving isolation areas, requiring that symptomatic individuals wear surgical masks when leaving isolation areas, having separate bathrooms and meal areas, maximally separating or partitioning sleeping and common areas, and taking appropriate cleaning and disinfecting precautions.

