Developing a COVID-19 Medical Respite Unit for Adults Experiencing Homelessness: Lessons Learned from an Interdisciplinary Community-Academic Partnership

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Abstract

Individuals experiencing homelessness are at particularly high risk for infection, severe illness, and death from COVID19. Local public health initiatives to address the pandemic should include medical respite services for individuals experiencing homelessness with documented or suspected COVID-19 infection, who are well enough to not be admitted to the hospital. We are a group of public health officials, clinicians, academics, and non-profit leaders who partnered with the City of New Haven, Connecticut to develop a COVID-19 medical respite program for people experiencing homelessness in our community. We seek to describe the key processes and challenges inherent to designing the COVID-19 respite including: the balance between patient autonomy and a public health agenda, how to deliver trauma informed, equitable, patient-centered, high quality care with low resources, and approaches to program evaluation.

Keywords: COVID-19, coronavirus, homelessness, medical respite, housing

Introduction

The spread of COVID-19 across the U.S. is exacerbating the systemic structural inequities that plague our healthcare system and social safety net programs, rendering traditionally marginalized populations especially vulnerable to infection, severe illness, and death. Individuals experiencing homelessness are at particularly high risk for COVID-19[1] as they are more likely to be elderly, have underlying health conditions[2], and live in congregate spaces where following public health guidelines like hand washing, physical distancing and disinfection can be near impossible. Additionally, these populations face systematic exclusion from care, stigma, and discriminatory treatment leading to fear and distrust of the medical system. From both a health justice[3] and public health perspective it is imperative that communities across the United States institute special protections for unhoused individuals during the coronavirus pandemic. Federal agencies[4], local governments[5] and advocacy organizations[6], such as the National Health Care for the Homeless Council[7], have outlined policy recommendations[8] for reducing the spread of COVID-19 amongst the homeless population including providing adequate staffing, supplies and screening for shelters as well as emergency housing to facilitate physical distancing.[9] Expanding medical respite programs for individuals experiencing homelessness with documented or suspected COVID-19 infection, is an additional and critical strategy to safely quarantine patients, who are well enough to not be admitted to the hospital.

We are a group of public health officials, clinicians, academics, and non-profit leaders who partnered with the City of New Haven in Connecticut to develop a COVID-19 medical respite program for people experiencing homelessness in our community. Along the way, we

benefited from the generous contribution of colleagues implementing similar programs across the country. Although our protocols continue to evolve, and solutions will vary by local context, lessons learned during the strategic planning may be applicable to other communities taking on similar endeavors. Therefore, we seek to describe the key processes and challenges inherent to designing a COVID-19 respite unit for individuals experiencing homelessness in a small to medium sized city.

The Devil Is in the Details: The Rapid Design and Implementation of a COVID-19 Respite Facility and Clinical Protocol

Of the city's population of about 130,000 approximately 500 are unhoused.[10] The city and state made tremendous efforts to shelter unhoused individuals in hotels to reduce crowding in existing shelters and facilitate physical distancing.[11] Anticipating the need to provide separate facilities for non-hospitalized homeless individuals with COVID-19, New Haven leadership began planning for a COVID-19 specific medical respite in March 2020.

Assets of New Haven

New Haven is fortunate to have a single hospital system and academic medical center, access to community and hospital-based clinicians with a focus on mental health, SUD, and individuals experiencing homelessness, and a nimble city government. Notably, academics, the local hospital system, state government, and a local non-for-profit homeless service agency have

previously worked together to build and sustain a medical respite program for people experiencing homelessness as well as other public health initiatives.[12]

Gathering the Team

The city engaged diverse stakeholders including local and state government, health care systems, and non-profit organizations. The city also leveraged academic partnerships, convening a working group of health professionals (many of whom authored this piece) with experience providing health care for these populations, to develop clinical protocols. We acknowledge and regret that we did not engage impacted New Haven residents or individuals experiencing homelessness in the development of these protocols. Feedback from patients participating in the respite will inform iterative improvement moving forward.

A Strategic Plan

In consultation with experts in infection control and the Boston Health Care for the Homeless Program respite team[13], we developed an "ideal" and "realistic" plan. From an infection control standpoint, it would be ideal to provide four separate emergency shelters for individuals experiencing homelessness who are (1) COVID-19 positive, (2) COVID-19 testing pending, symptomatic, (3) COVID-19 testing pending, asymptomatic, and (4) no testing pending or known exposures, asymptomatic. From a feasibility standpoint this would be challenging. As of April 2020, we have a single respite unit for COVID-19 positive individuals. We worked with our local health system to prioritize individuals experiencing homelessness for rapid testing to

reduce the number of symptomatic or exposed individuals with unknown infection status. We continue to advocate for universal over symptom triggered testing for shelter-based individuals. A study from Boston demonstrates high rates of asymptomatic infection and the potential for rapid transmission within a shelter.[14]

An Appropriate Site

Traditional shelters are not equipped to provide respite services nor appropriate infection control. New Haven's pre-existing medical respite program[15] does not have capacity to accommodate individuals with COVID-19. Our team explored the pros and cons of a respite facility with congregate living quarters vs. private rooms, balancing patient comfort and autonomy, feasibility, and the ease of monitoring with limited staff and PPE. The City's final choice for location, a local high school, was based on pre-existing disaster shelter planning, proximity to acute healthcare services, capacity (projected need determined by size of local homeless population and nightly shelter use), accommodations (such as bathroom facilities) and ability to provide adequate infection control. Notably the school board and the local community expressed concern about infection risk. Local residents also vocalized fear that their community was preferentially used as a "depository to address yet another risky health concern of the City that other neighborhoods would not tolerate."[16] In response city leadership explained the urgent need to move forward with these plans and a promise to protect the surrounding community with 24-hour police presence.

Clinical Protocols

A clinician working group developed clinical protocols[17] to account for referrals, admissions, everyday management, and safe discharge of respite patients. We built on the experiences of our city's pre-existing non-COVID-19 respite and colleagues across the country, including those in Boston[13], Seattle,[18] and New York City.[19] Our detailed protocols do not account for all the complex processes required every day on the ground. Operational concerns, such as handing deliveries and communication between "contaminated" and "decontaminated" zones, could not be properly addressed until on-site.

Nothing Is Ever Simple: Logistical, Philosophical and Ethical Challenges

A number of complex challenges arose in designing the respite program. Below we share the questions we considered and our thought processes.

Balancing Patient Autonomy and a Public Health Agenda

The City of New Haven invested money, time and effort towards the COVID-19 respite facility as a public health measure, with a goal of protecting the health of individuals experiencing homeless and the greater New Haven community. The question arose as to whether or not this facility would be a voluntary or enforced quarantine in the setting of a public health crisis. Our group felt that participation in the respite facility must be voluntary, prioritizing safe access to health care and basic human rights. In New Haven there is no enforced quarantine for COVID-19 positive individuals residing in private homes. Therefore, enforcing a quarantine on individuals

experiencing homeless would be discriminatory treatment and essentially criminalize poverty. To optimize participation in the respite program we focused on patient education, comfort and safety. Modeled after our partners in Boston[13], we counsel our patients upon admission on the importance of voluntary isolation as they recover from COVID-19. We provide entertainment to prevent boredom, food, personal items, as well as services to address comorbid mental health conditions and SUD. If a patient desires to leave the respite prior to meeting discharge criteria, staff will explore the patient's perspective, attempt to address concerns, and as a last resort, counsel individuals on how to protect themselves and others in the community.

Serving the Unique Needs of the Population

Individuals experiencing homelessness have significantly higher rates of mental illness and SUD than the general population.[20] Medical respites are a unique opportunity to link patients to care.[21] One of our primary prerogatives was to prepare our medical respite to accommodate individuals with mental illness and SUD. We grounded our policies in the principles of harm reduction[22] and trauma informed care[23] and developed a mental health team and referral process. Our work force primarily includes health service corps volunteers presumably with minimal experience in de-escalation and management of mental illness compared to typical staff at shelters and respite units. Therefore, we developed training in relationship building, trauma informed care and behavioral de-escalation for the volunteers' orientation session. Additionally, we recommended including an onsite behavioral health specialist to ensure our staff was adequately supported in maintaining a safe environment. This individual will screen individuals on admission, triage

referrals to an on-call psychiatrist via telehealth, de-escalate behavioral concerns and manage acute behavioral emergencies. Additionally, a police officer, stationed outside the facility, is available to assist should a behavioral health or other situation threaten the safety of patients or staff.

A Harm Reduction Approach to Substance Use Disorder (SUD)

Implementing evidence based-harm reduction practices can be challenging in a shelter setting,[24] due to liability concerns and local, regional and national politics. Our team unanimously agreed that SUD should not preclude access to crucial respite services[25] and that adopting a harm reduction framework was critical. We included key policies in our protocols such as quick-initiated buprenorphine[26], onsite referral to a peer recovery specialist and mental health clinician, and Naloxone training for staff. However, we anticipate many challenges will arise when considering the respite's limited resources and how to ensure the safety, health and wellness of all patients and staff. Can we successfully support those with active SUD and those in recovery simultaneously in a congregate setting? How will we avoid precipitating withdrawal when asking patients to shelter in place? How do we support patient autonomy and a harm reduction approach while balancing liability concerns? We continue to explore these complex issues in our first stage of implementation. In our first week in operation, we were able to collaborate with local treatment programs to facilitate daily methadone delivery to the respite facility.

COVID-19 Respite: A medical facility or specialized shelter?

While there are national standards[27] for respite care, the level of medical care and monitoring provided by respite facilities varies.[28] We found it challenging to determine the appropriate level of clinical monitoring for our respite facility while balancing patient safety, autonomy and staffing constraints. Individuals referred to our medical respite meet criteria for self-quarantine at home - a setting in which there is no additional medical monitoring. However, COVID-19 infection is associated with rapid and often unexpected clinical decompensation.[29] We worried that individuals with comorbid mental health conditions may, for various structural and individual reasons, be unable to alert staff if they were to experience worsening symptoms. We considered protocols with a range of intensity from every 4-hour vital signs checks to once daily symptom checks. We settled somewhere in the middle and will take advantage of the congregate nature of our respite facility which allows passive observation of patients throughout the day.

Fear of Unintended Consequences

We remain concerned about the unintended consequences and potential negative impact of the program on our patients. Some individuals choose to reside on the street because they do not feel comfortable or safe in congregate living settings. Although the program is voluntary, we hope patients remain in quarantine by choice, encouraged by a comfortable and acceptable environment, not because they feel coerced to do so. Presently, the unit has adopted a collaborative approach to security that aims to balance the comfort and safety of patients, staff, law enforcement and the surrounding community. However, we worry about the paradoxical

effect of police presence and its potential to undermine the safety of our patients. We hope that police presence does not unnecessarily escalate behavioral concerns given the evidence that mental illness can increase one's risk for a fatal law enforcement encounter.[30] Additionally, we worry about the message police presence sends, perpetuating stereotypes that individuals experiencing homelessness and poverty, especially those suffering from mental illness and SUD, are inherently dangerous.

Refining the Process and Anticipating Future Needs

The City of New Haven's COVID-19 medical respite recently opened its doors to its first patient. The program's protocols have already adapted and will continue to change iteratively to meet the demands of the physical space, our patients and staff, and the evolving realities of the pandemic. While this public health crisis is uncharted territory it will not be short lived. Therefore, learning from our successes and failures is imperative for the present as well as our short and long-term futures.

The CDC framework[31] for effective public health program evaluation is broadly applicable; however, the scale, theory[32] and approach must be unique to individual circumstances and context. Given urgent need and resource limitations, evaluating a COVID-19 respite program should likely utilize a rapid cycle evaluation[33] in which data are analyzed as collected to inform iterative change and additional data collection. This approach can still include both quantitative and qualitative data to capture key outcomes and processes. How to measure success across the respite program continues to be an active discussion. Do we measure infection rate in

the homeless population? The number of individuals referred to our facility? What about our patients' perspective - do individuals feel safe and value the program? Is the program acceptable and feasible to all stakeholders involved? Are we balancing the goals of autonomy and public health? Equally important will be the evaluation of unintended consequences.

Conclusion

In the time of COVID-19, local public health initiatives must include the rapid development of medical respite programs for individuals experiencing homelessness with suspected or confirmed COVID-19 infection. Program success relies on engaging diverse stakeholders, addressing the unique needs of homeless populations, and prioritizing safety, autonomy and dignity. We hope the recommendations and challenges presented here, as well as references to additional programs and advocacy organizations across the country, help facilitate improved protections and care for those experiencing homelessness during the current pandemic and future public health crises. Our detailed protocols can be accessed in full through the National Health Care for the Homeless Council website.[17]

Notably, the intervention we describe is simply a band-aid for our broken social infrastructure. COVID-19 has emphasized that our country's housing crisis is also a public health crisis.[34] As cities across the country manage to house previously unhoused individuals, we recognize that safe housing for all is feasible when there is political will. We sincerely hope for lasting change in the wake of this crisis.

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