RACHEL DEERR: Hello, I am Rachel Deerr, host of today's program, COVID-19: Keeping Up with a Moving Target. This is the May 8 update of DKBmed Radio's coronavirus educational series. Thank you for joining us.

As a reminder, we are providing TWICE-weekly, 15-minute webcasts and podcasts featuring the latest news, treatment updates, and clinical considerations as well as answering your questions about COVID-19. These will be available on Wednesday evenings and Friday mornings. Sign up at COVID19.DKBmed.com to be sure you get the latest updates.

Today's program is accredited for ANCC and *AMA PRA Category 1* credits.

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Today's learning objectives are:

- **Describe the specific challenges faced by the homeless population during the COVID pandemic**
- **Describe a strategy to address a challenge faced by the homeless population**

Today we welcome Karin Huster, who earned a BS degree in Nursing from the University of Washington in 2005 and an MPH degree from the UW's Department of Global Health in 2013.

On her most recent assignment in 2020, Karin worked as a field coordinator responding to the coronavirus (COVID-19) pandemic in Hong Kong, where the team developed infection prevention control, health promotion, and mental health activities packages targeting the most vulnerable populations. She now volunteers as one of the coordinators on the homeless response for COVID-19 with Seattle King County Public Health.

Dr. Paul Auwaerter, clinical director of the Division of Infectious Diseases at the Johns Hopkins School of Medicine, will be interviewing her today. Karin, Dr. Auwaerter, we're happy to have the chance to speak to you today.

DR. AUWAERTER: Thank you, Rachel. Karin, you're speaking from the West Coast; I'm on the East Coast, and I've been in Baltimore for over 30 years. We have a significant issue with people who are without homes and intermittently dependent on a number of services, and I know that is probably a similar situation in Seattle. Since you're at the vanguard of COVID-19 in Seattle, how has your city shaped its responses for dealing with this population to give them the kind of access and help they need?

KARIN HUSTER: Thank you for the question. Seattle, as many people know, is one of the top cities for homelessness in the United States, with a population of about 12,000 people living without homes, so it very quickly became a big concern for everybody here, from the mayor on down, as to how we would go about responding to the needs and risks of a population that doesn't have a roof over their heads and what those risks represent for us. We were pretty aggressive in putting a team together to focus on what the needs of that population would be.

As you know, people living in homelessness live in a variety of ways. Some live in shelters, which are congregated settings with a lot of people together, a situation that is conducive to spread of all kinds of diseases. Some people live in tents under bridges. All these ways that people experience living in homelessness come with different risks. That has been one of the challenges for us: how best to respond to these groups of people with different needs.

DR. AUWAERTER: I'm sure you've had to work with a number of different groups, both in government and within your own institutions. A good friend of mine has a son who is a chef for one of the shelters, and I've been hearing first-hand about the difficulties. How have you approached a way to help people who are helping the homeless in these settings to mitigate risks, and then also among people who are homeless themselves? Because as you've said, transmission could be greater than in the general population for certain diseases.

KARIN HUSTER: It's been interesting, because it's one of the things we were concerned about for that population, who are typically quite vulnerable. We've done a lot of testing in that group and found that the percentage of people who test positive is below that of the general population. I mean, we just have a better denominator for them than for the general population. We think about 6% of the homeless population are being infected, versus 10-11% of the general population in Seattle.

Seattle has about 250 shelters or so, some bigger than others. We've seen outbreaks in 45 of them, for a total of 220 cases. Of those, we've had about 33 hospitalizations and eight total deaths. These are certain numbers to give you an idea of how that population has been hit. For us, the challenge, or the goal, has not only been to mitigate the risk of spread, but also to try to prevent spread in these populations.

A big effort on the prevention side has been to develop what we call "fast teams." These teams focus on going from shelter to shelter providing infection prevention and control training, such as how to distance sleeping mats 6 feet apart, recommend that people sleep head to toe, make sure there are enough hand-washing stations, train staff to do symptom screening and temperature checks, although we're noticing a lot of people are asymptomatic. We also recommend wearing masks for the staff and residents in those places. These are some of the main prevention efforts we take.

We've also deintensified shelters. In some shelters maybe 200 people would sleep there in one night, so we proactively deintensified them by moving half of those folks to other shelters. The difficulty with that approach is, you're spreading people apart and putting them in places that might not have been designed to be shelters in the first place. Those facilities might miss or lack some other basic components of shelters like showers, for example. It's a double-edged sword: you want to make sure you move people and spread them out a little more, but you want to do it in a safe way.

From the response side, we have what is called strike teams, which are composed of nurses, sometimes doctors — if there's not a doctor on site, we have definitely a doctor on call — and an environmental health specialist. They go to facilities that have reported at least one case of COVID-19 in their population. We do a thorough site assessment and also a thorough symptom screening of all the residents, and then testing as well. We test everyone, not only people who are symptomatic, but just the residents and all the staff. Everybody who tests positive is moved to isolation and quarantine facilities.

At the same time, we make sure that all the prevention strategies we talked about are implemented, and if the facilities are not capable of implementing them, we try to support them so they can practice the implementation. That's pretty much what we do.

DR. AUWAERTER: It sounds tremendous. There's obviously a lot of messaging there as well as activities. Some people who may be listening have taken care of people without homes who are now in hospital with COVID-19 and are going to be discharged. I think sometimes you have to keep messages as simple as possible, but someone who's had COVID-19 and been hospitalized could be a champion. If they go back to a shelter and talk to others about what's most important. Sometimes they might be a better advocate, because it's not someone telling them what to do. They're telling them their story.

What are one or two things that you think have the greatest impact, if you had someone who was in a particular shelter and was a champion for trying to help prevent COVID-19?

KARIN HUSTER: It's a good point to bring up. I think that's something we're not doing enough of, so we're putting in place a number of interventions like testing and controlling the population, but not doing enough of using the survivors, making them champions, to encourage the population to self-isolate or self-quarantine. If that's something you don't want to happen if there is an outbreak, we should do this.

When I was working on Ebola, we had exactly the same issue and it took us a few years, until the second outbreak in the Democratic Republic of Congo, to realize that we should be using those survivors to become our champions, not of good behavior, but of stewardship of what you should do.

But I think it's the population. Experiencing homelessness has a lot of challenges that make it difficult for them to do some of the things that public health agencies recommend. It's easy for us to self-isolate, but it is much harder for the homeless population to do so. Many have mental health issues that make it more difficult for them to follow recommendations from public health agencies. A lot of them mistrust government or public health systems in general. Some have drug or substance use issues that make it difficult for them to obey self-quarantine or isolation orders if they test positive.

All these things need to be taken into consideration when we approach that population, because they are much more complex than you and I are. You're right that we should make an effort to use those survivors to help us be stewards of what they can do to keep the shelters be good places for people to behave in a way that reduces spread or continued spread of COVID-19. And other diseases, by the way.

DR. AUWAERTER: Of course. Karin, specifically for people who use substances or have mental health problems or other challenges, how have the city and your group dealt with people who refuse to be quarantined or isolated or doing their part for social distancing? Are there certain techniques that you feel have been effective?

KARIN HUSTER: That's probably one of the biggest challenges we're faced with: what do you do with somebody who tests positive and does not want to go to an isolation and quarantine facility? This is where a lot of good negotiation skills matter, because we do have isolation and quarantine areas that take into account the needs of these populations. We set them up recognizing that this is not the time for them to stop their drinking habit or their drug use habit, so we have these systems in place for them to carry them through the isolation time. Hopefully at the end, we can set them up with a structure to

help if they're interested in modifying or kicking that dependency, but that's not the focus of the isolation time. We try to explain that to them, but there are still people who will not want to go. Yes, there are things like orders from a health officer, but taking coercive measures is probably the very last thing that you want to do. Jail is probably a very bad idea, as we all have seen, so that's definitely not the route we'd prefer to go.

In congregate settings, we try to find how the staff that works there sets up an area that can be used for isolation, should they have a client that refuses to go. It doesn't have to be very complicated; it can be just removing a few mats and putting some screens up and having that person stay in that area.

But then the issue is, the staff is not comfortable with having somebody who's tested positive in a congregate shelter, so it's always decided on a case-by-case basis. There is no specific rule, but definitely the one major consideration is how can we work with the with a client to make sure we can accommodate them so that are not a risk for their community and can be taken care of if they become sick, and a place where there is some medical oversight.

DR. AUWAERTER: I wonder, in a number of cities people don't want to go to shelters because the fear of contagion. It's not just paranoia, it's a real fear, for example, people living in the subway stations in New York or other areas of mass transit. That's also probably not sound idea. How do you address people who have that fear at this stage? Is there some reassurance or other maneuvers you can offer?

KARIN HUSTER: One of the things we try to do with the staff is give them good training so when they do encounter those types of residents who don't want to come in, they can provide information: "We've done testing of all the residents in this facility, this is what we've found so far, we have these measures in place, so you can you can rest assured that your risk of getting COVID-19 will be reduced. The mats are 6 feet apart, there are hand-washing stations, everybody's wearing a mask, the food is also served either by staff and not self-serve, or meals are put together in containers so there is no touching of cutlery, and so on. These are some measures you can provide somebody who might want to come in the shelter but is scared of going.

Soon it will be summer, the weather will be warmer, and people will probably prefer to be outside. One thing to be said about homelessness: the fact that they live so much in isolation, in a way, might be a bit of a protective factor. Somebody who's sleeping in a tent under the under a bridge might be somewhat more protected than somebody who's sleeping with 150 other folks in a shelter. It's hard to convince them, in any case, that this is not the case, that they should be in this congregate setting.

DR AUWAERTER: Some hospitals, to address concerns among patients and health care workers, have pivoted to universal screening. I wonder, has there been any discussion, especially in homeless shelters, where once-weekly swabs or something of that nature would lend significant reassurance?

Obviously, there are costs and other things, but rather than just syndromic assessments, looking for people who are ill and then helping them with care, is that something that's been discussed at all in King County?

KARIN HUSTER: Our strategy in the homeless shelters has been blanket testing. We don't do syndromic testing; we've been testing everywhere we go. We've tested everyone, every resident and every staff member. That's something we've put in place since the beginning.

DR. AUWAERTER: How frequently are you doing that?

KARIN HUSTER: That has been the learning curve. If we do blanket testing in a facility and you have no cases, then it's easy; you stop. You might go back in three weeks or so, nothing specific.

If you do have a setting or an outbreak — we define for now an outbreak as two or more cases within two weeks — we've been blanket-retesting everyone at one week. So long as there are new cases, we continue testing. But that's an unsustainable strategy. Right now we are in the brainstorming phase of what this looks like in the long term, especially as we're moving more and more people. We've been pushing shelters to use motels and hotels that have been leased by the county, also by the agencies that have shelters to push these congregant shelters into individual rooms in hotels and motels. We'll have more opportunities to do testing, and I think the urgency hopefully will be somewhat reduced because these congregated settings will no longer be so common.

DR. AUWAERTER: So, Karin, the pandemic is clearly a once-in-a-lifetime, we hope, or once-in-a-century circumstance, but you have worked in a lot of challenging situations overseas and with populations that have their own challenges. When you come in and parachute into these kinds of situations, there's a lot of uncertainty, a lot that's not known, a lot of learning on the fly. What kind of things from your background would help us here in the United States where we prefer a very ordered approach? We think we can control everything, and this is clearly showing us that we cannot.

KARIN HUSTER: I think definitely one thing I've learned is that good coordination for response is essential. You need to have that in place if you want to have an efficient response. We also need to remember that vulnerable populations are always going to be the most vulnerable in any kind of situation. It doesn't matter if it's Ebola, measles, or COVID-19; it's affecting all of us, but it's affecting vulnerable populations even more. We need to make sure that whatever response we have takes into account their needs, and make sure we focus there. Otherwise, the price will be paid most dearly in those populations.

Another important thing we've learned — at least what I have learned working on outbreaks — is that we tend to be hyperfocused on whatever emergency we're dealing with. Right now, COVID-19 is about the only thing people talk about and think about, and that comes at the expense of all the other diseases we forget about. If you talk about resource-constrained countries, thousands and thousands of people are dying of malaria, of childbirth; and in the United States, all these other chronic diseases.

People with strokes are scared of coming into the hospital, and we need to make sure that this is not happening. We don't want more collateral disease death than we can avoid. We have enough already with COVID-19. It's important for all health care providers, and for the public at large, to remember that COVID-19 is not the only thing we need to think of. We must not forget all of the other illnesses that people have. We need to make sure that people feel safe coming to the hospital to be treated, and that's one of the big messages it's important for people to remember.

RACHEL DEERR: Thank you again, Karin and Dr. Auwaerter, for joining us today.

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Don't forget to access our resource center on covid19.dkbmed.com. You'll find a range of information including the latest COVID-19 data and statistics, medical society guidelines, and resources in Spanish.

Any questions for our faculty can be submitted by sending them to qa@dkbmed.com.

Again, thanks for joining us and thank you for your dedication to your patients with COVID-19.