CORRESPONDENCE

COVID-19 NOTES

To rapidly communicate short reports of innovative responses to Covid-19 around the world, along with a range of current thinking on policy and strategy relevant to the pandemic, the Journal *has initiated the Covid-19 Notes series.*

An Isolation Hotel for People Experiencing Homelessness

One April morning during the height of the pandemic in Rhode Island, 43-year-old Mr. H. picked up the phone in his hotel room and dialed our primary care clinic. "You wouldn't believe how awesome they're treating me here," he said. "This is actually great."

Two days earlier, after testing positive for Covid-19, Mr. H. had been transported from the hospital to the Department of Health's newly established isolation facility, a hybrid boarding home–military base in a former midbudget hotel in Warwick. Mr. H. had been incarcerated for more than half his adult life, but he seemed content inside the hotel, where residents were confined to their rooms. Mr. H. had always found the constraints of hospitalization challenging, frequently leaving against medical advice. It was his contention that the isolation imposed by hospitalization and the hospital's rules, including prohibition of smoking, made the hospital resemble a prison.

Humvees surrounded the isolation hotel, with state police at the entrance and volunteer emergency medical technicians (EMTs) checking temperatures of staff members and asking them screening questions. The smell of sanitizing solution was everywhere. High-top bar tables were now workstations; conference rooms stored clothing and snacks for residents; and the ballroom was now the National Guard's headquarters, complete with large screens for surveillance video. Residents' rooms were on the upper floors, where meals, medications, and care packages were delivered by National Guard members clad in personal protective equipment.

During the day, the hotel bustled with staff — a registered nurse, case managers, National Guard members, and peer specialists. After hours, the staff became just two volunteer EMTs, who "admitted" people from shelters, emergency departments, and inpatient units, but without any accompanying medical information.

"There's just one thing missing," Mr. H. told us. "I don't have my Suboxone." He was not alone; the hotel staff had no consistent system for addressing medical issues, including opioid use disorder. It was clear that although the social-service framework was robust, near misses related to gaps in medical care were happening too frequently. Responding to feedback from onsite staff, we mobilized a group of attending physicians, trainees, and medical students who volunteered their time to evaluate people who were being referred to the hotel and assess their medical needs over the phone. These interviews led to several people being redirected to more appropriate care settings, including hospitals, psychiatric units, and nursing homes.

The admissions became the easy part. At several points during the ensuing days, we worried that Mr. H. would try to leave, as he had so often left the hospital. After a week of enjoying the hotel bed, bubble baths, and TV, he started to feel the weight of his solitude. He asked, "Is there any chance to get out of here at all? I need a cigarette so bad right now." He hadn't had any Covid-19 symptoms, and the nicotine-replacement products were not enough. His history of congregate living — whether in prison or in a shelter — was also compounding his experience of isolation.

Knowing the risks associated with ending his isolation early, we tried to tailor our support. We arranged for regular video check-ins with his community health worker, a telemedicine visit with his primary care provider, and, perhaps most important to Mr. H., some cigarettes. We did not make the decision to have cigarettes delivered — nor the decision to provide alcohol to people

with alcohol dependence — lightly. Mr. H., along with all the other residents, remained at the hotel voluntarily until meeting the health department's criteria for safe discharge.

As the number of Covid-19 cases in Rhode Island has declined, so has the number of people in need of isolation; the facility was closed at the end of June. During its 3 months in operation, 179 people were admitted for isolation, staying an average of 10 days; only 8 people required transfer to a hospital. The most frequent discharge destination was a shelter, but 18 people went to substance-use programs. Mr. H., like many others, was discharged back to the street. He quickly found home in a tent encampment in a park north of Providence.

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Identifying details have been changed to protect the patient's privacy.

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