Addressing COVID 19 Among Vulnerable Populations

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To welcome all of you to the fifth in a series of faculty lectures that have been sponsored by the Wright State Faculty Senate during this state home order as part of our shelter in place series. I'm Laura Luehrmann professor of political science and president of the Faculty Senate.

And I'm really happy to invite you to today's discussion and I think you're really going to enjoy it and we're going to learn quite a bit. What I will do.

I'm going to briefly introduce our two speakers and then turn it over to them. As Craig has been reminding those of you as you've been arriving, this is a webinar format so you are muted and you are unable to be seen by any of the panelists or any of the other attendees. But we can see your questions and your comments in the chat room.

If you just hover your mouse over toward the bottom part of your screen, you'll see a little conversation icon. If you click on that, you're a, we hope you will submit questions and both of our panelists today have agreed to accept questions and look at questions throughout the presentation today to help make this as interactive as possible.

So our first panelist is Dr. Sydney Silverstein and she is an anthropology anthropologist by training. She received Ph.D. and anthropology from Emory University in 2018,
after completing a dissertation on the social changes wrought by the emergence of a new cocaine production enclave in the lowland Amazonian Peru,

including an increase of illicit drug consumption.

She joined the center for interventions treatment and addictions research in the Department of population in public health sciences in 2018 and is the ethnographer on two NIH NIDA funded projects the study and treatment in the Dayton area. She is published in journals such as the Journal of Latin American Caribbean anthropology, visual anthropology review, the International Journal of drug policy and drug and alcohol dependence. In addition to her more traditional academic, she also makes the ethnographic and documentary films, and works as a volunteer with harm reduction Ohio in the Columbus sanctuary collective.
Our second panelist is Dr. Timothy Crawford. Timothy Crawford is a chronic disease epidemiologist and bio statistician.

He is an assistant professor in the Department of Population and Public Health Sciences and Family Medicine in the School of Medicine at the Boonshoft School of Medicine at Wright State.

He has been with the University since 2017. Timothy received his BS in Microbiology from the University of Tennessee and his Masters and Public Health and PhD.

in Bio Statistics and Epidemiology from the University of Kentucky. His research focuses on using existing data to examine factors associated with multiple chronic conditions among people living with HIV.

So, those are our two panelists today they will be joined by some of their colleagues from the Department of Population and Public Health Sciences in our discussion today. So, Sidney, I'm going to turn it over to you. All right.

Okay, so our presentation is called Addressing COVID-19 among Vulnerable Populations. Is my audio okay? There's a bit of an echo at first. Okay. Okay.

So Timothy Crawford and I will be presenting, but we also want to acknowledge collaboration from our fellow MPH program faculty, including Naila Khalil, Jo Ann Ford,

Nicolle Kinzeler, Christina Redko who helped with some of the brainstorming and editing and collaborative work on this. So we are all at home right now in the midst of a global pandemic.
And the graphic that you see out the screen is a screenshot from the Johns Hopkins dashboard that's tracking all the COVID cases across the world, and what's evident from this

So, it's a pandemic, it's affecting populations, and every continent maybe not Antarctica, but everywhere else and it's really affected people diverse as the prime minister or Johnson to the lady that my step mother walks or dog with every week.

So, it's really spread throughout the globe and is affecting everyone either directly or indirectly. However, there are a few key elements in this global pandemic that are not equal.

So, what we're going to focus on today as public health scholars, how we as public health scholars really try to understand how what elements of this pandemic are unequal and how we can kind of brainstorm and think about tailoring responses to global pandemic, such as COVID to meet the needs of diverse populations,
so that's we're gonna talk about today.

We're gonna give a few short case studies and then wrap up with some ideas about how public health is uniquely positioned to think about innovative ways that we can address this pandemic and future pandemic as they affect different populations and really unique ways.

So I'm going to turn it over to Timothy. Hello everybody. Thanks for being here. Thanks Sydney. So,

one of the things that we have, we've done to try to reduce the risk of transmission has been, you know, staying at home sheltering in place and also social distancing.

I like to call it physical distancing because, you know, we're trying to be physically distant apart.

Technically, socially, not socially distanced always. Right now we're being social through WebEx and listening to this, but not everybody has the privilege and ability to actually shelter in place or stay at home

and be physically distant. Some people are in jobs where they couldn't work from home, or they have jobs where they cannot afford to actually not work.

And so there are these disparities with these individuals that we see here throughout the US is. In addition there has been more research coming out, showing that populations like people with chronic conditions, people experiencing precarious housing.

Also, African Americans were likely or disproportionately diagnosed and have more severe outcomes.
So basically, the bottom line here is, we know that no one is really invincible from this virus.

If you look at the data that the Department of health has, basically cases go from people who are less than one years of age up to people who are 106. So, pretty much anybody and everybody is susceptible.

However, there are more groups that are more vulnerable to this virus and can experience more severe outcomes, like hospitalization, and even death due to this virus.

So, in our department, we have a lot of great faculty in our department that conduct a lot of information and research with a number of vulnerable groups that we have here, including people with communication differences, language differences, people with mobility impairments.
We also have faculty working with people who are homeless or marginally housed, people who are currently incarcerated and newly released. We also deal with people with chronic conditions, whether that's physical also, whether that's mental health problems and substance use disorder.

So, our faculty in our department works with a lot of different vulnerable populations, trying to understand is that can help them with their situations.

And so many of these groups can struggle to observe these physical distancing recommendations that we have set. And so, for example, people experiencing homelessness, they must rely on shelters and friends, or people with disabilities some of whom may be relying on home health care workers, having to deal with the, with that idea. And that also the fear of contracting the, the virus and so struggling with that among these populations is very,

It's very difficult during this time.

So as an epidemiologists I want to provide some numbers for you all because I like numbers, but as as looking at people living with chronic conditions, as a vulnerable population, they experienced a lot of things.

So, they experienced the potential impact of exposure as well experiencing more severe outcomes, like death or hospitalization. So there's been a lot of reports that have been coming out and there's probably more coming out by the minute.

But a lot of them are showing that people with chronic conditions are more likely to be hospitalized compared to their counterparts.
And so the studies are showing that basically those who are hospitalized are dying and more likely to have conditions like diabetes, hypertension, COPD, and so these studies are looking at those characteristics. What we do know, and at the CDC has shown that basically, sixty percent of the US population actually has at least one condition and forty percent of them have two or more conditions.

So that's just to show you how the populations at risk for these severe outcomes due to COVID. A recent article that just came out from the data I'm showing you here in this slide, looked at people hospitalized and the number of hospitals in New York, and they wanted to see the characteristics of those individuals and so 5,700 people, 88 percent of those that were hospitalized to COVID-19 actually had two or more chronic conditions.

And when they looked at those chronic conditions over half had hypertension followed by obesity in diabetes.
and then roughly around twelve percent had coronary artery disease.

81
00:10:23,934 --> 00:10:28,254
So just looking at those different types of conditions.

82
00:10:28,884 --> 00:10:42,414
And so then there's another study that came out in the morbidity mortality, weekly report that looked at, not only the conditions that these individuals had, but also wanting to look at some outcomes.

83
00:10:42,480 --> 00:10:53,260
So, for example, of those who were hospitalized, what percent actually had a chronic condition? Of those who were hospitalized and had to go to the I. C.U.?

84
00:10:53,420 --> 00:11:00,080
What percentage had a chronic condition? And so of the 7,000 individuals they had information on,

85
00:11:00,120 --> 00:11:04,960
they found that 78 percent of those that were hospitalized and had to go to the I.C.U.

86
00:11:05,000 --> 00:11:16,680
were actually had one or more chronic condition and 71 percent of those hospitalized that didn't have to go to the I.C.U. had a chronic condition and these conditions that they found were commonly diabetes,

87
00:11:17,004 --> 00:11:19,465
chronic lung disease, and cardiovascular disease.

88
00:11:19,500 --> 00:11:33,980
So, these studies are basically suggesting that chronic conditions, people with chronic conditions are a much higher risk really severe diseases compared to those without any conditions.

89
00:11:34,140 --> 00:11:48,475
And so unfortunately, one of the things I've been interested in looking at is how is COVID-19 actually indirectly impacting people with chronic conditions, not necessarily looking only at those who have been diagnosed
but those who have not been diagnosed with COVID-19, or haven't even been exposed and how it indirectly impacts them. For example, the fear of going out and managing their chronic conditions.

So going out and getting their medications. Here, you know, making sure that they are being able to physically distance from other people. And so trying to model from previous outbreaks,

there was a study in 2009 that came out to look at what happened during SARS outbreak in 2003 and post SARS. and what they found was, there was a drop in hospitalizations due to chronic conditions during SARS, which makes sense.

No one wanted to go out in fear of infecting the virus, but then after post SARS, they found a huge spike in hospitalizations from people with hypertension and diabetes.

And what they suggested was during that time during the outbreak and trying to contain it a lot of people were not managing their chronic condition properly due to possibly fear of stepping out to their medications and things like that.

And so that's what we don't want to happen during this time that we have people living with chronic conditions being able to manage their conditions and not have a spike hospitalizations post COVID-19.

And of course, there's also other other, vulnerable groups. And so, for example, people who are experiencing homelessness.

So one of the things with people who are homeless are living in shelters, they're typically more likely to be older. They're also more likely to have underlying chronic conditions.
So that means they're at a more increased risk of having more severe outcomes due to COVID-19. And so we just wanted to show this brief table here, looking at a recent MMWR article that looked at four cities, and they looked at, they tested staffers and residents from homeless shelters just to see what proportion of those individuals actually tested positive for COVID-19.

And essentially what they found was are approximately 25 of the residents had a positive COVID-19 test and then also 11 percent of the staff had a positive COVID-19 test.

So, it kinda shows you how COVID-19 can move through, different vulnerable populations. For example, homeless individuals living in shelters as well as the staff that are working at those shelters. But fortunately, public health can intervene in a number of ways here. So we have public health scholars throughout that can work on understanding the ways that COVID can spread.
throughout populations or creating policies and interventions that we can address this pandemic.

00:14:41,815 --> 00:14:50,215
So like Sydney said earlier we want to focus on what public health scholars are doing and their awareness on these specific groups and vulnerable groups,

00:14:50,514 --> 00:14:56,605
and thinking about how we can customize interventions and solutions to meet the needs of these,

00:14:57,294 --> 00:14:58,434
these populations.

00:14:58,465 --> 00:15:03,715
And so after that, I'm going to turn it back over to Sydney. Thanks, Tim.

00:15:04,884 --> 00:15:05,215
So,

00:15:05,215 --> 00:15:08,575
yeah,

00:15:08,575 --> 00:15:22,855
we're gonna be a little bit of cheerleaders for public health right now,

00:15:23,125 --> 00:15:37,524
and we're going to backtrack a little bit to a Pre-COVID era and we're gonna look at some of the ways that local public health scholars in the Dayton area approached an emergent epidemic and try to think of innovative ways to respond.

00:15:37,644 --> 00:15:41,845
But we also understand that it affects different people in different ways. Right?
And particularly vulnerable populations are gonna be more at risk to experiencing severe symptoms, or potentially exposing themselves to the virus or, you know, perhaps most, interestingly, the indirect effects.

Like, how are COVID related restrictions changing the way that people manage their every day care of things, like chronic conditions?

I'm gonna backtrack to about three and a half years ago when the Dayton area found itself in the midst of another epidemic, which was the Opioid overdose epidemic, which we can say we're still in the thick of, although the numbers have gone down a tiny bit. But if we think back a few years, there all of a sudden started to be a ton of Opioid overdoses or people who were found dead who are surprisingly,
you know,
not even originally identified as drug users.

And so why did opiates present a particularly challenging problem to community in public health workers? Well, people who use often may try to hide their drug use

and so people may not even be necessarily identified as people who use Opiods because of the shame and stigma secrecy surrounding drug use and surrounding, asking for help.

And as we all know from kind of the current narratives of the ongoing Opioid overdose crisis, a lot of people who transition to heroin use may not have started off as even people who are experimenting with drugs

but perhaps people who were mis-prescribed pain killers, or people who are experimenting, didn't realize that

pills like Oxycodone and Percocet were even Opioids themselves. So there's a lot of secrecy and stigma and so it was initially really hard to address the opioid overdose problem because a lot of people who are using these drugs we're using them in secret.

We're trying to hide out of fear out of shame out of stigma.

A lot of people were using drugs and out of the way places, such as abandoned houses, so overdoses were happening, but they were not happening in places where people could seek help.

Sometimes people were using drugs

just in the company of other we use drugs,
and the same people might have been afraid to call 9/11 due to fear of arrest or legal consequences,

or having their families find out that they use drugs and so opioid overdose problem was a serious issue,

and it was also particularly challenging to find interventions to meet the needs of that particular population because so many of them were using drugs in secret, were felt shamed or stigmatized by their drug use.

So you take all these factors of shame, secrecy, stigma, fear, legal consequences and in the particularly in the Dayton area, you mix that with an adulteration of the local drugs supply with lethal non,
pharmaceutical fentanyl on fentanyl analogs that came to replace heroin.

00:18:40,345 --> 00:18:53,125
So, Dayton, as many of you may know is one of the epicenters of fentanyl. My center has done numerous studies about the presence of fentanyl and fentanyl analogues, the drug supply, and we are really kind of ground zero of fentanyl in the United States.

00:18:53,394 --> 00:19:03,025
And so you mix all the secrecy, shame, stigma around drug use and add it to a bunch of highly potent opioids that have kind of come to replace heroin in the drug supply

00:19:03,625 --> 00:19:16,825
and you get a graph that looks like this. This is the overdose rate in Montgomery County. So you see the spike in 2017. In 2017 Montgomery County had the highest per capita overdose rate in the state of Ohio.

00:19:17,220 --> 00:19:31,704
And in that same year, Ohio was second in the nation, only after West Virginia and overdose rates. So we can safely say in twenty seventeen that Dayton was really the epicenter of the opioid overdose epidemic. So we really see this emergent public health crisis.

00:19:32,184 --> 00:19:46,525
So, just to kind of flip gears a little bit, what are some of the ways that kind of public health scholars, public health workers in the community try to address this problem? You have a population that's really difficult to reach, they may be using drugs and secret,

00:19:46,525 --> 00:19:54,894
they may be stigmatized. So one of the most important and I think you know, biggest impact interventions to this crisis was

00:19:55,769 --> 00:20:04,855
community Narcan distribution. So, this was a local public health response to an emergent crisis. So really the overdose rates really started spiking.

00:20:04,855 --> 00:20:17,634
There was tremendous effort by different community organizations to get Narcan into the hands of people who use drugs and into the hands
of people who live, or have social relationships or kin with people who use drugs.

159
00:20:18,025 --> 00:20:22,105
And so Narcan, which is a medication that can reverse overdoses,

160
00:20:22,795 --> 00:20:34,255
it has no potential help harm, so you can train anyone from adolescences, children, senior citizens, people who own grocery stores or barbershops,

161
00:20:34,255 --> 00:20:48,984
it's a very simple mechanism for reversing an overdose. The that is pictured here on the slide is just a nasal spray, and it's really a life saving medication that can be administered by people in the community.

162
00:20:49,855 --> 00:20:58,585
They can reverse fatal overdoses, which was very important in an era of fentanyl. What was most was, it could be given directly to the people who are using drugs.

163
00:20:58,585 --> 00:21:09,295
So, even despite the stigma and the fear and the fear of legal consequences, Narcan was getting out into the actual hands of people using drugs or the people that we're spending time with people who are using drugs.

164
00:21:09,569 --> 00:21:23,545
So, Narcan was being distributed by (audio loss) and behavioral health, through the life enrichment center. You could do Narcan trainings. It was a different sort of community resource hub. And so, and there's even pharmacies also have it

165
00:21:23,545 --> 00:21:25,194
If you get a prescription for it.

166
00:21:25,795 --> 00:21:35,365
So, Narcan is really an example of an innovative public health response to an emergent crisis that took into consideration the particular needs of the hidden and stigmatized population of drug users.
So here's just a little bit of data from a steady conducted by my own center of taken from a group of 357 individuals with opioid use disorder that reported to me a number of an average twelve people that they knew who had died of opioid overdoses. And so this is data taken from a few years back. And I would say that if it was updated to 2020 the graph would be even higher.

But you see a large percent of this group had carried Narcan and had used Narcan to help someone.

So this is a quote from a qualitative interview that I conducted with someone with opioid use disorder, who was actually fourteen months into her recovery and she had told me the story of, you know, once fentanyl came on the scene, she overdosed and she with Narcan and really prompted her to seek help and to begin taking medication and going to counseling and getting off Opioids. And so she was an opioid user for fourteen years, and when I interviewed her, she was almost a year and a half into her recovery. This was over a year ago and she still has not she has not gone back to using opioids and so she really credits Narcan in the hands of one of her friends who's also an opioid user with saving her life. So, you know, this is really kind of a life changing life, saving drug, and an innovative solution to a public health crisis.

So now we think about what Opioid overdoses mean and then and we have this novel risk environment. You know 2020 Dayton is still in the midst of opioid overdose crisis. The numbers have gone down since 2017 but there's still record high numbers.
And so, how is COVID changing, how are these two emergent epidemics intersecting and, and kinda playing off one another and having direct and indirect impacts on the people who are affected by both of them.

So,

interestingly,

thanks to my colleagues at the public health Dayton and Montgomery County,

I learned there was a spike in overdoses immediately after the implementation of stay at home orders,

and the closures of businesses such as restaurants and schools and libraries.

And so in January of 2020, I believe there was twenty fatal overdoses, in February. There was twenty four and then in March, there was thirty seven, which is a really big spike, and that spike really started in mid March

once we started having closures of businesses and right before the stay at home orders. So we see this really, you know, kind of alarming spike in overdoses that we might guess is linked directly to these changes brought by COVID.

Do you think about why COVID (audio loss) might prompt overdoses? We can think about the stress of an emergent pandemic prompting people to use drugs.
People were losing jobs, that could also cause stress. It could be a different sort of triggers and or people even being afraid again, to call them when one and seek help because they were afraid of exposure.

Again, to try to think about some of the positive ways that public health recognize that these two epidemics are intersecting and have a unique set of needs,

I'm going to talk a little bit about some of the local responses to the ongoing overdoses and the spike in overdose is caused by COVID.

So, Narcan, as I mentioned before, has been this really fantastic community, based response to an overdose crisis.

But what happens if people are not leaving the house,

don't want to go to a pharmacy to pick up Narcan because,

as Timothy mentioned,

they may be afraid of

you know,

even picking up a regular medication,

because they're afraid of contamination. And so Montgomery County,
Ohio have been doing lots of so you can write or you can call in and request that,

197
00:25:35,664 --> 00:25:41,244
you know,
say that you're a person who uses drugs or you're in contact with the person who uses Opioids and you need Narcan

198
00:25:41,244 --> 00:25:51,265
and they will actually mail it to you for free to your house. There's also ways to do online Narcan trainings to learn how to use. Can you can do in our Ken training over the phone.

199
00:25:51,775 --> 00:26:05,335
So, narcan, which was this important kind of life saving intervention to the overdose crisis they've innovative workers and public health have thought of ways to work around social distancing shelter in place is still and to the hands of people who need it.

200
00:26:07,555 --> 00:26:10,555
We also have telehealth and virtual counseling services.

201
00:26:10,825 --> 00:26:22,585
So, a big worry among people who who use drugs who are currently in recovery from substance use disorders is, you know, a lot of people are really dependent on counseling, on self, help meetings, such as AA, NA.

202
00:26:23,214 --> 00:26:27,894
So what happens when we have shelter in place? What happens when we have physical distancing orders?

203
00:26:28,404 --> 00:26:33,505
So, there's been a new emphasis on telehealth and virtual counseling sessions and again,

204
00:26:33,505 --> 00:26:34,914
this is very preliminary data,

205
00:26:34,914 --> 00:26:37,134
but from anecdotal reports from public health Dayton
and Montgomery County,

there is reports that for the one on one counseling attendance has actually been a bit better than it was for in person counseling,

so this is kind of an exciting innovation and it's a way that people have figured out a workaround.

However, it's not without problems because not everyone who uses drugs has access to the Internet, access to cellphones. So, again, it's creating some uneven results or uneven access, but it is at least some kind of innovation.

And then also, I want to just recognize the work that public health Dayton and Montgomery County has been doing further outreach services. Once people experience a non fatal overdose.

So they are still visiting people writing letters to people who experienced a non fatal overdose and encouraging them to seek help. There used to be a team that would visit people after and overdose at their homes, but clearly in the sort of COVID era distancing request that's not as possible, but those phone calls are still happening, letters are being mailed. And so there's still is an effort on behalf of public health to reach out to the people who are really vulnerable and may even be at risk of going back to using drugs

Due to some of the stressors and cues related to COVID, related restrictions, job loss, etc.

Okay, so this is just a screenshot of project Don, which is one of the places that we could go and Dayton and to get to learn how to use Narcan to get a free Narcan kit.
Now, you can go on their website, you can watch a video about how to use Narcan, and you can request that a kit email to your house, or you can pick up the kit. So, this is kind of an exciting way that public health has dealt with the intersection of opiate overdose and COVID. And then just kind of branching out a little bit, this is an app.

This organization called the Brave co-op that's based in Vancouver, but has won some grants in Ohio to develop innovative tech based solutions to the opioid crisis. They had developed an app that was basically it's called BeSafe.

And what it is, is for people who use drugs who are afraid of overdosing, but are using drugs alone.

You can actually log on the app and a peer support will stay with them until they're finished to ensure that they don't overdose and are by themselves. And so this app was in development, but Brave kinda sped it up as soon as COVID hit because of, you know, social distancing, many people who use drugs may be using drugs alone more than they were in the past and if you're using drugs alone, even if you have Narcan, there may be no one to revive you.

And so, what this app does is it kind of gives people opportunity to call and have someone, you know, virtually on the other end of the phone just to make sure that you are able to that you complete your what you're doing, your drug use and are able to kind of respond at the end. And if you don't respond, then they kind of alert the authorities and call 9-1-1.

So, again, this app is also can be somewhat uneven. It has to be someone who has a cellphone, who has apps and I think that, of course,
there would always be the suspicion that people really want to call into an app and admit that they're using opioids.

But Brave Co-op has gone to great lengths to make people feel safe and to ensure the security and privacy of the people who use the app and brave is run by people who are in recovery themselves from drugs and they kind of the specific needs.

And so, again, this is just another interesting example of public health and tech kind of coming together and thinking of innovative ways, not only to address overdose crisis but what overdose means in the context of a global pandemic like COVID.

So that was my kind of case study about opiate overdoses Dayton, and it's intersection with COVID and then I'm going to turn it back to Timothy to kind of wrap up.

Great so so, basically a conclusion, like, we talked about some vulnerable, vulnerable population. So we know that everybody is vulnerable to COVID-19,

but there are some groups like people living with chronic conditions, people who are homeless and other groups that are more susceptible to not only exposure, but more severe outcomes.

But today,

the case study focused on people with Opioid use disorders,

but take away from what Sidney was saying is that there are these interventions,
physical distancing or sheltering in place that may not be interpreted by by all and they may not be applied with the same ease,

and so just thinking about not just someone being exposed to COVID-19,

but how COVID-19 can indirectly impact these vulnerable populations?

Like,

for example,

people being afraid to call 9-1-1, to go to the emergency room due to a fear of exposure or going to get their medication because of a fear of exposure and how that can have a indirect impact on their management of their chronic conditions,

or other things, and

so really what we wanted to kind of have you take away,

is that as public health scholars we are working to really identify these specific risk environments that are occupied by these populations and hopefully tailor these interventions to meet their needs.

So, going to them and seeing what they need as opposed to us developing things and saying, here, this is what you, you really need when it's not for them.
So actually working with them, having their input on what are ways to help them through these tough situations.

And so there's a lot of good things are going on with public health, especially during this time. So, yeah so, you know, just thinking about that, we wanted to bring that up to you all and and do that. So.

Yeah, and just sentiment again, we, you know, we're here to kind of also introduce to the community a little bit of the work that we do as public health scholars. We collect epidemiological data on the spread of illness who it's impacting.

And then, we also kind of try to use that knowledge and our experience with these different groups understanding "Okay, how do we take these numbers and how do we make these kind of models of the spread of diseases and and mortality rates and hospitalization rates?"

And then,

how do we think everyday realities and every day lived experience of people with different kind of needs are different,

you know,

different kind of context of their life,

whether they're living with a chronic condition,

like hypertension or a substance use disorder or if there's someone who's living with a physical disability,
you know, how do we think about making interventions, make sense for them and have them not be an afterthought. So,
yeah, just to conclude on that note,
you know, we are still trying this is new for all of us.
we are still trying this is new for all of us.

So, these are just kinda findings,
but I think as a department,
and as a program are really committed to trying to think of how we can make the kind of nationwide interventions towards COVID with stopping the spread and trying to think of a better future to meet the needs of people who are a little bit less considered from the mainstream.

Oh, good. So, we have a question about COVID in the homeless shelters and so It asks "Have the services in shelters been responding and changing their operations during the stay at home?"
So,

I know from the MMWR study as well as just reading up on the CDC they have made guidelines on making sure that those shelters are doing things they need to do to prevent further spreads.

For example,

making sure that there can be physical distancing within those shelters, making sure that things are clean and sanitize so that surfaces are not contaminated.

Making sure that people are tested,

not just people that they suspect are exposed, but making sure everyone the residence, and the staff are tested to prevent any further spread.

And I believe, I'm not sure Dayton, but I know in Columbus, there is a shelter that specifically for people who have tested positive.

So, you know, I think there's also people who have asymptomatic that can be spreaders or there's people who suffering from flu symptoms but don't require hospitalization. And so there are also with the shelters,
I think they're trying to do as extensive testing as possible, just to make sure that there is a space for those people. So, you know, once people are already living with COVID, but if they don't require medical attention that people are isolated because one of the things we've learned

275
00:35:14,070 --> 00:35:28,525
you know, since this whole first thing came out, is that people who are asymptomatic can also spread. And so in a shelter, if you think about how important testing is in one asymptomatic person and that whole cluster of people living together. You know, not only.

276
00:35:28,525 --> 00:35:41,394
The people who were using the shelter for shelter, but the people who are working, they're providing food. It's very, very dangerous. So they are also creating special shelters for people who have tested positive for COVID but who don't need specifically medical attention.

277
00:35:43,045 --> 00:35:52,405
We're getting some great questions in the chat room right now. One of the questions "What about low level of vitamin D. Could this be on its own a risk factor for COVID?"

278
00:35:58,284 --> 00:36:12,114
I will defer I have, no idea. I don't want to sound like I know the answer to that question. I will say, kind of we talked about earlier that there's all this stuff coming out,

279
00:36:12,114 --> 00:36:14,304
like, by the minute. I will say

280
00:36:15,114 --> 00:36:21,264
I did see a headline in PubMed that talked about vitamin D could be a potential can help prevent the spread of COVID-19,

281
00:36:22,164 --> 00:36:28,105
but I didn't read the article.

282
00:36:28,105 --> 00:36:29,485
So, I'm not well versed on that. So, I'm not sure that's interesting.
Yeah, that was a very interesting question. Definitely changing environment. I've got a policy question here.

"Have you seen any willingness by states or localities make policies that they may have otherwise been reluctant to embrace prior to the pandemic?"

The questions the asker is sending the (audio loss) like safe injection sites. Yes, I think that's a fantastic idea. Yes, although safe consumption sites

I think it's gonna be a little bit of a ways away. Okay. So, one of the biggest issues has been the prescribing guidelines for good therapies for good use disorder.

Like buprenorphine and methadone. So, methadone usually requires that people who are on methadone maintenance, make daily visits to a clinic to get their daily dose of methadone and with buprenorphine there's a little bit more flexibility.

But people are still kind of required to show up periodically to get a prescription and so

one of our recent one of the most recent papers we published at Sitar is about why people are using buprenorphine that they bought off the streets to self treat opioid use disorder even when they're on even when they have the kind of health insurance that would get them that same medication

for free and so one of our key findings was that people often resent the requirements of outpatient treatment centers to go to three three hour group therapy sessions a week to get a medication.
A lot of people argue that it's really impossible for them to hold down a job or to fulfill care obligations when they have this heavy burden from a treatment center.

and if really, the medication is the evidence based approach to treating opioid use disorder while counseling is recommended that degree of heavy outpatient counseling, there's no sort of evidence to show that that kind of large counseling requirement has any benefit.

And so,

It's, it's been very challenging for people to accept that, in a lot of times people would, rather buy those medications off the street,

but now,

SAMHSA in light of COVID era has changed around a lot of the prescribing guidelines and people are able to get more take home doses of methadone, are allowed to do telehealth appointments to get a buprenorphine prescription.

And so,

a lot of harm reduction advocates
have been trying to push,

push, push for people to have less onerous requirements to get these life saving medications and they flipped it pretty quickly to where people sort of

more radical pro harm reduction policies are actually being implemented

because people simply don't have the ability to attend those counseling sessions. So that's pretty exciting.

I know there is some fear about,

you know, things like take home methadone because people can overdose from methadone buprenorphine not so much but it has been also a requirement in some of the methadone clinics that if you're getting take home doses of methadone,

you get Narcan along with it just in case and. so,

yes,

I mean,

I don't know safe consumption,

safe injection sites.
It's such a polemical thing, and, you know, Philadelphia has pushed it through, but I really don't know what the chances are about that in the United States. I think you can make an argument for it.

I don't know if people are ready for it, but I do think that there have been some kind of very massive harm reduction based policies that are moving forward because of COVID era restrictions. And so it is a tiny bit of a ray of hope. I think.

For those of us that kind of come from the harm reduction approach to substance use disorders. Thanks for the question, it's fantastic.

And a lot of talk about prisons, could you talk a little bit about the vulnerable population and prisons we've been hearing about outbreaks and how again different localities are responding to the crisis in prisons in very different ways.

Yeah, I mean, there's been a push to let non violent first time offenders out, you know, again, this is all speaking anecdotally, but at Sitar, we're continuing to do search.

So, phone follow up interviews with participants who are already consented into our studies and so,

there have been people who have mentioned that they were in a sort of halfway program,

and they left early because because of COVID they would they just trying to kind of create space,
but I think the person situation is very alarming,
because it really brings to light.

Some of the reality is the mass incarceration and, you know, you were just unprepared. I mean, you know, the prison systems have become these kind of hotspot outbreak epicenter, because once it's in there, there's really nothing you can do.

So, maybe, you know, it'll be I know that at least in California, they've been able to kind of push forward and release people for non violent offenses.

I don't know a ton about the data on Ohio, but, you know, I hope it's gonna move some of the conversations forward to why do we need to keep so many non violent offenders in prison? But we're still a long way and the prisons are still, I mean, it's just gotta be terrifying.

So I think that's a great Super key, vulnerable population that's really being impacted by this. And it's very hard to advocate for because

we at the public college, we just don't really have so much access so there's so many other barriers in the way.

One of the questions is asking you to respond to some of the data that you presented earlier. The spike in evidences,

which was an increase of thirteen is greater than the number of COVID deaths in Montgomery County. (audio unclear)
What are your thoughts on what the impact on drug users might have been, overdose is or other factors had no social distancing measures been put in place.

00:42:25,405 --> 00:42:26,905
It's a fantastic question.

00:42:29,934 --> 00:42:31,014
You know, and I think,

00:42:35,635 --> 00:42:50,485
I think the public of Montgomery County county kind of wants to know, wants to hear about what the experience of those social distancing measures were like for people who use drugs because we can only kind of do the guesswork. From from my experience again,

00:42:50,485 --> 00:42:54,324
just anecdotally continuing to follow up with some of my participants who do

00:42:54,355 --> 00:42:58,434
who are people who use opioids (audio loss) imagine that,

00:42:58,465 --> 00:43:05,275
you know, normally even relapse after someone has stopped using drugs is caused by a stressor,

00:43:05,304 --> 00:43:08,425
a queue or the presence of an accident themselves.

00:43:08,425 --> 00:43:23,125
And, you know, what greater stressor than thinking, you know, people are laid off from jobs, especially, you know, a lot of the people in the Dayton area who use drugs, who work work in food service, or work, you know, in in these.

00:43:24,119 --> 00:43:35,755
They may not be vital workers and so, you know, you, you have no income. A lot of people maybe earned money by pan handling or by scrapping all of those kind of things all of a sudden become impossible.
So that the kind of dismay in the fear, I think, you know, may prompt people to use drugs a bit more. At the same time there's something really interesting that I've been reflecting on and that, you know, people who use opiates in the Dayton area are confronting epidemic everyday. You know, they're confronting the risk of overdose. They're confronting hepatitis C and HIV exposure.

So, you know, I wonder, in some ways, if this was not as much as a shock for them, because they're already living in this kind of vulnerable gray space, and kind of confronting potential fatalities and illness everyday.

So, I think it's a great question. I don't wanna pretend to know the answer to it, but, you know, hopefully we will be able to do some research on it in the near future. And, you know, if no social distancing measures have been put in place would that same spike of happened? I don't really know.

I mean,

I think there's enough kind of collective trauma,

just from turning on the news that it may have prompted people who had,

maybe ceased using opiodes to start using again even without social distancing,

just kind of seeing the collective trauma of what's going on in the world and the kind of changes that are happening,
But again,

it's all kinda speculation and I really hope I will have the opportunity in the near future to,

to understand for people who continue to use opioids what those changes were like for them.

Thank you. Are there community that have strategies to assist vulnerable populations that should be considered models for mid sized metro areas like Dayton? If of course,

perhaps we had received,

or we will be able to receive additional resources,

who are the models right now, do you believe about who are adopting methods to assist very vulnerable relations during this pandemic?

Do you mean during the pandemic?

I think I think it's John. Vulnerable populations. Let's see.

Yes, you do mean during the pandemic. Okay.

I don't know. Timothy, do you know, during pandemic strategies to assist populations? So, this actually a good question.
And that's something I've been trying to find the past weeks just to see, like, what are some models out there that are helping these populations and it's for me, it's been hard to find. But that could be just horrible at finding you without there.

But I know there's been a lot of volunteering to help these populations, especially like people with chronic conditions, and the older adults who cannot leave their homes in fear of exposure, and putting them at higher risk.

So, there's things like, for example, there are pharmacies that are now offering delivery for their medication.

So they don't actually have to step out of their, their home. There are organizations that had been volunteering for help with these individuals. But, I'm not sure if any models out there yet.

You know, I think that there probably will be some in the next, probably tomorrow as we say this, there's there'll be a paper out on on, you know, a good model. But unfortunately, I don't know of any models out there yet that could be implemented in here.

I mean, one thing I was usually sort of at the front lines, is the VA.

You know, they have kind of,

they pull out resources and they tend to be,
you know, pretty innovative and really their kind of health services are pretty top notch and so,

again,

this is not necessarily COVID era,

although I know they have implement certain changes like telehealth but the V.A.

has been at the forefront of these different hub and spoke programs that look at how you address the health needs of rural populations

if there's no nearby specialists and so this one VA

the program with the University of New Mexico was kind of looking at hepatitis C care and taking specialists in Albuquerque who were mentoring

local nurses,

nurse practitioners,

even some CNA's in rural areas of New Mexico and how to administer certain elements of a hepatitis C treatment regime and so it was kind of this hub and spoke model of the specialists,
which are concentrated in the cities working within supporting less,

maybe less qualified,

but,

you know,

definitely willing enable health workers,

or even outreach workers in rural areas and so I think models like that are probably going to be,

you know,

what we have to think about,

like.

Dayton has vulnerable populations, but then we also have rural populations in Ohio or people who are living with different disabilities and can't and don't even have the option of of making out, or navigating certain technologies.

So, I think it's really thinking about how we can make connections between the specialists, and the places where those kind of resources are thinner.
So, again, I don't know if models during COVID, but I would say that the VA's probably a good place to, to look because they tend to be ahead of the curve on this kind of thing.

Do you have a question? Yeah.

Second Wave, right. Especially I was gonna ask you to make the connection to some of the research from the prior epidemic that you had shared just we see spikes. And then we see lines.

Do you expect to see greater challenges among many of the vulnerable populations that you've talked about today and that you study as things start to relax a little bit and we go back to some sense of this new normal or might it be different because,

like you said earlier,

or some of these populations are living in such high risk categories already.

How do you perceive the impact to be different? If at all.

I mean, one thing that I always think of is the people. (audio echo)

The people who are trying to make positive changes in their life and try to taper off, or maybe cease using Opioids completely what recovery is going to look like for them. Because one of the huge things is, if you're a person who uses opiates, and that is the kind of social world you live in,

and that is your economic reality, one of the biggest challenges, how do you transition back into kind of the formal sector? How do you build relationships
with people who are not drug users? How do you kind of build a recovery community?

And what I worry about is what's gonna happen to those resources?

You know,

what it's gonna be the motivation for someone in terms of trying to build a new life for themselves away from drugs when there's no jobs within the economy crashing what kind of purpose there in terms of in economic future?

So that's one thing I worry about,

not even necessarily the direct physical health consequences,

but,

the kind of emotional health,

and the hope that you need to really sustain recovery from substance use disorders.

Be it alcohol opioids whatever is you need to have some kind of hope or some kind of vision of a life for yourself that's beyond drugs and in a kind of climate where the economy's crashing,
they're sort of all over unemployment, fear, you know, all these changes in our society, I worry about what is gonna be that hope that people will left onto.

And again,

I mean,

part of it is that because of shelter in place,

and because this is affecting everyone there is a way in which communities maybe strengthen family bonds maybe strengthen people may be kind of,

forced to spend and confront some of these issues with their family and maybe if they can't hide from them,

it'll force them to confront and create some sort of positive,

clear some moving forward.

But, again, when I think about the second wave or the long term trajectory, I think not only of things like, you know, overdose or contract in covet. But what is our sense of what is the kind of hope that you build recovery towards?

Because I think some of the work that's being done treatment programs or substance use disorders is things like vocational training, you know, and becoming a peer support counselor and just trying to think of what life is like. And so that's one thing that I immediately worry about.
Is just kind of that overall sense of,

you know, pessimism,

even in terms of, like yeah,

you know,

if there's no jobs sort of people going to kind of turn to? And,

Montgomery County has had really pretty low COVID rates of mortality and also,

even it seems like infection,

but again,

I mean,

they're not really some places,

or there's some kind of still guess on why some are hit harder than others.
But, I mean, there is a way in which Montgomery County and the Dayton area does have so many pockets of vulnerable populations.

So many people were experiencing homelessness, so many people who are living with substance use disorders that maybe it hasn't hit yet, but it's still could be.

It could hit hard here, just because of the kind of proximity and the reliance on on kind of social spaces and sociology that people were experiencing homelessness or substance use disorders may rely on. So, I don't know that we're out of the clear even for that yet, or maybe, you know, we'll kinda be spared, but I think that the two problems put together are gonna be somewhat troubling.

Thank you. Do we have any other questions from our audience? Our invisible audience?

I think Sidney the Timothy have done a fantastic job, wanting to add for the tremendous insights that can be gained through public health and the work of our public health professionals also really highlighting the interdisciplinary nature and the need to look at crisis from so many different angles. I think that's been extremely helpful.

If there aren't any questions that are submitted, we're seeing a number of comments on how interesting this was and expressing significant appreciation for you and your colleagues in population and public health sciences are doing.
We really appreciate everything you've shared and helping us understand the insights from your fields better.

And also please do feel free to reach out to anyone in their department with questions as a follow up.

We really appreciate your time today and I think we'll wrap up today by reminding everybody that our series of shelter in place lectures will continue next week.

As you know we've been alternating on Thursdays and Fridays. Next Friday we will have one of our faculty members from the college of nursing and health, Dr. Sherry Farra, who is going to be presenting on crisis standards of care and COVID-19.

So because it's Friday afternoon next week we will be convening at three o'clock.

We hope many of you can join us again next week for another extremely insightful presentation by our superb faculty at Wright State University.

Before we end today, if everybody could join me in a round of applause for Dr. Silverstein and Dr. Crawford and of course their colleagues in population and public health sciences who helped them put together a very important and extremely interesting presentation.
So thank you for joining us, everybody take care and we hope to see you next week. Thank you.

00:55:35,920 --> 00:55:43,220
Thank you everyone for, for letting us talk for awhile and for sharing the research that we do. Thanks guys.