COVID-19 Response Framework for People Experiencing Homelessness

The below guidance was developed by a number of public health professionals, primary care physicians, psychiatrists, addictions medicine specialists, Municipal shelter and housing leadership, community health, social support, housing and addictions agencies, provides practical information and guidance to reduce the impact of the COVID-19 pandemic on the homeless population.

Due to the unique circumstances of serving people experiencing homelessness or at risk of homelessness, service providers should connect with their respective provincial or territorial public health authorities to ensure that any measures taken to effectively service this extremely vulnerable population are in line with the service standard levels required by the province or territory, while continuing to meet the needs of this group, per this guiding document.

It is important to note that none of the key pillars of the Response Framework identified below will be possible without the adequate procurement of personal protective equipment (PPE) for shelter and health care workers. In addition to accessing the physical space required for these operations, procurement of PPE is one of the foundational elements. Support from nurses and physicians will also be critical to be able to deploy the enhanced health supports described below.

The key pillars of the Response Framework include:

1. Testing:

- **All people experiencing homelessness with a new or increasing cough, shortness of breath or fever, with OR WITHOUT travel history, should be sent to an assessment centre (or ER) for COVID-19 testing. If sending to an ER, ensure there is a protocol in place to notify the ER in advance that a potential COVID-19 infected patient is on route.**

Note: The testing protocol was developed and approved by a whole-of-city large urban healthcare system and explicitly varies from Public Health Unit general guidance to address the following:

- people experiencing homelessness are at heightened risk of susceptibility to coronavirus and morbidity and mortality from COVID-19;
- people experiencing homelessness will quickly propagate outbreaks when infected if not controlled very carefully; and,
- many newcomers and refugees access large urban centre shelters and the colocation and congregated living results in most people being exposed to a recent traveler given that none can effectively self-isolate.

The testing protocol adds an additional layer of surveillance that can identify early community transmission in the homeless population, which is critical to helping to time the deployment of additional resources as required.

2. Sentinel Surveillance:

- In addition to the above testing, explicit ‘sentinel surveillance’ testing in the homeless shelters **should be carried out by trained health care staff with appropriate precautions**, which is critical to identify early community spread and to reassure clients of shelter safety.

3.Health System/Shelter System Co-Ordination:

- **Health care system staff who work with people experiencing homelessness need to be embedded in all of the formal COVID-19 planning tables including at the municipal, regional, and provincial and territorial levels.**

Note: It is necessary to establish a robust communication system between both health care workers in the homelessness services sector and the rest of the health care system, as well as between Municipal Public Health Unit (PHU) and Shelter/Housing Administration leadership. This requires 1-2 contact and coordination points daily.

4.Covid-19 Risk Stratification:

- **Risk stratification tools need to be developed urgently and be accompanied by systems to rapidly assess the entire shelter population based on the levels of risk of having an adverse outcome from COVID-19 (Low, Intermediate, High).**
  - All individuals categorized as high-risk need to be prioritized for enhanced social distancing to public health directed standards within the existing shelter system, as well as staff cohorting to protect them from contracting COVID-19. It can be anticipated that this will make up 10-20% of the shelter population, depending on local demography, health services and affordable housing access and rates of low-income status.
  - Individuals categorized as intermediate risk will require some social distance supports, as available, with no staff cohorting necessary.
  - Individuals categorized as low risk will often have to remain in the general shelter population unless alternatives are able to be identified to support social distancing. Wherever possible, all people should have social distancing provided to public health specifications. If there is absolutely no safe space to do so the above may, on balance, be the safest option.

Note: Risk stratification will help with clinical care should patients test positive for COVID-19 to indicate those requiring closer observation and assessment over the highest risk of an adverse outcome.

Social distancing as described by risk may require some additional shelter spaces (recreation facilities, community centres, hotels, modular units all may be used for this purpose).

Resources: The Public Health Agency of Canada has developed guidance for public health officials on case and contact management. It includes a table that stratifies contacts based on exposure risk, as well as consideration for co-living setting.

5.Isolation Shelters for Persons Under Investigation:

- **Specific shelters for the isolation of Persons Under Investigation (PUIs) need to be developed that meet the highest standard of 'self-isolation', including a private room and private bathroom with safe social space.**

Note: Isolation shelters will require on-site shelter workers, nursing support 16-24 hrs/day (nursing team such as RPN RN or NP), day-time case management and peer worker support, addiction medicine telemedicine services, and 24/7 on-call primary care physicians to coordinate all care, including support to triage with the wider healthcare system and manage all patient care.

Importantly, the use of the isolation shelters REQUIRES COVID-19 TESTING TO HAVE BEEN COMPLETED PRIOR TO ADMISSION. With testing, clients can be cleared to return to the wider system in 24-48 hrs; without testing, clients require 14 days of observation, which would, under most circumstances, immediately overwhelm the capacity of the shelter, as they are unable to be circulated out.

Public Health Unit involvement is essential as they have a dedicated staff who should track all admissions to the facility and inform the MD of test results immediately upon availability to ensure flow management of the patients.

Transportation needs to be reliable, safe, well-coordinated, and dedicated to the facility to ensure timely access and flow management. Flow is essential as most models will be leveraging very limited number of rooms or facilities and they need to operate extremely efficiently in order to prevent backlog that leads to an inability to receive patients having been tested. Such patients would be expected to be returned, without proper isolation, to the wider shelter system, which would be unsafe and undermine the purpose of developing an isolation facility.

Referrals will need to be accepted and processed on the same schedule as testing facilities in the area, requiring 12-24 hours of operation depending on local health system service schedules. Shorter hours lead to patients accumulating in hospitals and testing centres unnecessarily and to the detriment of all.

Resources:

- Resource: Public Health Agency of Canada guidance on case and contact management
- Resource: Public Health Agency of Canada guidance on vulnerable populations and COVID-19
- Resource: Public Health Agency of Canada guidance on isolating in the home or co-living setting
- Resource: Public Health Agency of Canada guidance on educating staff on protection from potential COVID-19 cases

6.Cohorting COVID-19+ Cases for Community-Based Shelter Care:

- **Shelters specifically for COVID-19+ patients are required as part of a city-wide cohort strategy to separate out the uninfected from the infected and PUIs. These will not require social distancing or private rooms, and thus could be large cohort facilities with congregate living.**

Note: Shelters for people with COVID-19+ confirmed cases are not a replacement for the mainstream health care. All people with COVID-19 who are actively unwell and needing admission to hospital will be transferred to the hospital system.

These shelters will require enhanced nursing supports, case management, peer workers, addictions medicine service access and have on-site primary care and 24/7 on-call primary care physicians as back-up.