



March 16, 2020

Re: COVID-19 Response Framework for People Experiencing Homelessness

People experiencing homelessness will face a disproportionate burden of morbidity and mortality during the Covid-19 pandemic. Most public health advice regarding social distancing, self-isolation, quarantine, and even respiratory and hand hygiene are not possible to be deployed for > 30,000 people living in homeless shelters, 24-hr drop ins and day-shelters across the country every day.

The following guidance document was developed by public health professionals, primary care physicians, psychiatrists, addictions medicine specialists, Municipal shelter and housing leadership, community health, social support, housing and addictions agencies working together in partnership. The recommended guidance below supersedes that being used for the general public; it provides a realistic and practical opportunity to blunt the impact of the Covid-19 pandemic on the homeless population.

The key pillars of a successful practice 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.
- This testing protocol was developed and approved by a whole-of-city large urban healthcare system.
- This testing protocol, which explicitly varies from Public Health Unit general guidance, was developed to address the following: people experiencing homelessness are at heightened risk of susceptibility to coronavirus and morbidity and mortality from Covid-19; they will quickly propagate outbreaks when infected if not controlled very carefully; 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.
- This testing protocol adds an additional layer of 'sentinel 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. This is critical to identify early community spread and to reassure clients of shelter safety when one can consistently note negative test results.

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 levels and Provincial levels.
- 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 urgently developed 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 those 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 Covid-19 acquisition. 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.
- Those categorized as intermediate risk will require some social distance supports, as able, and no staff cohorting.
- Those 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.
- Risk stratification will help with clinical care should patients become 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).

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.
- Isolation shelters should be staffed by shelter workers and a nursing team (RPN, RN or NP) with 24/7 MD on-call support to triage with the wider healthcare system and manage all patient care.
- Importantly, the use of the isolation centres **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.
- These shelters will require on-site shelter workers, nursing support 16-24 hrs/day, day-time case management and peer worker support, addiction medicine telemedicine services, and 24/7 on-call primary care physicians to coordinate all care.
- 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 back-log 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..

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 congregative living.
- Shelters for people with Covid-19+ confirmed cases are not a replacement for the mainstream health care. All people with Covid 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 MD back-up,

It is important to starkly note than none of the above will be possible without the adequate procurement of PPE for shelter and health care workers. In addition to accessing the physical space for these operations, it is one of the foundational elements of any strategy that might avoid an otherwise predictable and avoidable tragedy. Depending on the Municipality, many will need support for nurses and physicians to be able to deploy the enhanced health supports described above.