COVID-19 Isolation and Recovery Sites in Toronto

May 2020

Synthesis of Learnings from Community And Client Engagement

HEALTH COMMONS SOLUTIONS LAB

& DR. GILLIAN KOLLA

Acknowledgments

Consultation Advisors

This project was guided by input from an advisory group including Andrew Bond (Inner City Health Associates), Angela Robertson (Parkdale Queen West Community Health Centre), and Andrew Boozary (University Health Network). Members of the advisory contributed to the development of the consultation structure, and provided project oversight and direction.

Consultation Key Informants

This project was possible due to all of people who generously shared their thoughts, experiences and time with the project team. This includes the substantial contribution of clients who were staying at the recovery site, the staff members at the Etobicoke and Scarborough sites, the operational and executive leadership table members, and the community partners and front-line workers who participated in the consultations. Their contribution is gratefully acknowledged.

Project Team

Gillian Kolla, and the Health Commons Solutions Lab team (Sophia Ikura, Kandace Ryckman, Sonia Gaudry, Alexandra Piatkowski, Heidi Hay, and Hannah Carriere) led the facilitation of the consultation groups with community partners, staff and clients, and prepared the final report.

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Executive Summary

In March 2020, a group of Toronto healthcare and City partners (Inner City Health Associates, Parkdale Queen West Community Health Centre, The Neighbourhood Group, University Health Network and Shelter Support and Housing Administration at the City of Toronto) were moving ahead rapidly to set up recovery sites for people experiencing homelessness who had also been diagnosed with COVID-19. The undertaking was complex, facing many unknowns about how the pandemic would progress, and bringing together multiple teams with no established pathways for working together.

An extensive community engagement process was mobilized by the agencies leading this undertaking, involving interviews and consultation sessions with community partners and frontline workers who have experience providing care and support to people experiencing homelessness. The community engagement process summarized in these pages allowed community partners to weigh in on the options for recovery site models, and advise on ways to provide respectful and dignified care for the individuals needing care.

Following from the community engagement process, the consultation was expanded to gather the input of clients themselves about their experience with testing and referral to the recovery site, their stay onsite, and the discharge process. Frontline staff at the sites were also consulted in an effort to identify opportunities for improvement and inform future sites still in the planning phases. In total we spoke with over 100 people through interviews and multiple meetings with community, hospital and city partners, as well as with staff and managers at the sites.

WHAT WAS ACCOMPLISHED?

Rolling back plans for a large-scale congregate recovery site

The first phase of engagement focused on 1:1 interviews and leadership meetings to surface concerns about the planned 400-bed site and create a forum for honest dialogue about risks, complexities, and potential challenges of such a model. The result was a decision to abandon plans for the open-concept congregate site in favour of a hotel-based strategy where medical, community and harm reduction support, and peer supports would be provided onsite.

Surfacing issues essential for site operations

Community agencies and advocates shared their expertise on principles and policy questions related to how the sites would operate, including issues like the need for harm reduction services and providing a safer supply of drugs and alcohol onsite, clients leaving the site, and meeting the needs of distinct populations – from refugees and newcomers, to women and families experiencing domestic violence, to people living rough and who are unsheltered.

Hearing from clients about their needs

Through a series of 1:1 interviews with clients at the Etobicoke recovery site, a map of the client journey was developed to illustrate the experience from their initial COVID test to their eventual discharge from the site. This provided valuable input on what would make it easier to remain in place at the site and highlighted important gaps in the process at the system level.

Supporting rapid implementation of new multi-disciplinary teams

Much of the success of current sites has been due to a strong, highly committed team. We engaged directly with staff working at the sites to understand their experience and provide feedback to leadership of current and future sites on opportunities for improvement.

Informing a New Service Model

The pandemic has required an unprecedented response from public health, shelter and healthcare partners to help meet the needs of people experiencing homelessness. There is no roadmap, and the process has required all involved to continuously test, refocus and shift their approach.

The emerging service model is unique – not quite a hospital and not quite a shelter. Different organizations are responsible for discrete parts of the service, often moving in parallel based on their own scope of knowledge, model of care, and resources (medical, nursing, community and harm reduction, and peer teams). This introduces particular challenges in ensuring that effective and transparent communication can occur rapidly in an ever-changing environment between partner agencies. While the multidisciplinary care teams continue to evolve, care must be taken to ensure that the expertise of all team members is equally valued, and to guard against the dominance of an overly medicalized model of care delivery that prioritizes medical expertise and decision making over social care needs.

While clients overwhelmingly reported having a positive experience during their stay onsite, there are gaps in the referral and discharge processes. The referral and discharge processes are continuously being updated and need to be refined to adapt to changing demands of the system as the pandemic unfolds.

The recovery sites have done an impressive amount of work to set up a compassionate service model in a short amount of time, but there remain gaps and opportunities for improvement in the overall process. This is a snapshot of what we heard:

LEARNINGS FROM CLIENTS

The Stress of Transitions

The biggest areas of anxiety and confusion for clients were at referral and discharge. The overall experience before arriving at the site feels chaotic and stressful.

Positive Experiences During Their Stay

There is a culture of 'yes' among frontline staff at the site that is helping people get what they need to isolate and remain onsite. Clients had overwhelmingly positive feedback about their experience onsite at the recovery site, and noted that community and harm reduction staff and peer workers providing exceptional support.

Communication Gaps

Poor communication – particularly at the moment of referral and around their destination post-discharge – has led to fear and anxiety among clients. Simple communication tools for clients being referred to the site, and involving them directly in discharge planning are necessary.

LEARNINGS FOR THE SITES

Medical Model Needs to Give Way to a More Balanced Approach

The majority of work onsite is social care, and is led by the community and harm reduction staff and the peer team. The medical model doesn't fit the current profile of clients – resources, leadership roles and decision-making must catch up.

Multidisciplinary Care Team

There are many benefits of teams with different domains of expertise. The team onsite is iterating and problem solving; success is largely due to experienced and highly committed staff. Attention must be paid to ensuring that the expertise of all teams and team members is equally valued, and are fully integrated into decision-making processes.

Clarity of Roles And Decision-Making

Lack of clarity among executive decision makers and senior leadership about roles has led to perception of a top-down approach. Decision-making should defer to community expertise onsite on non-clinical issues. Staff members with the most knowledge of clients (usually the community and harm reduction or peer teams) should be centrally involved in decision-making processes.

Physician Touchpoints for Clients

A greater physician presence for regular planned (onsite) touchpoints with clients for medical needs should be prioritized - for example upon admission and discharge, in addition to during escalation of COVID-related or medical issues. Physician involvement in day-to-day decision-making related to non-medical needs should be de-prioritized and left to the expertise of community and peer teams.

LEARNINGS FROM THE SYSTEM

Concerns about Access Persist

The various players and their respective roles are not well understood. Shelters, hospital-based COVID assessment centres, and emergency departments are wasting valuable time navigating what is perceived to be a complex, often restrictive referral process.

Poor Coordination of Large Scale Testing

Multiple players and decentralized decision-making is creating confusion. There were many calls for bolder action to centralize and organize coordination of testing and decision making about referrals – from shelters and from hospitals to recovery sites. Additionally, the standardization of a basket of supports across the sector that all clients will receive regardless of where they are recovering is necessary (i.e. some shelters have enough positive cases to warrant remaining in place).

Inequities Across Sites

Given how the opening of isolation and recovery sites has been evolving quickly to meet the changing needs of the pandemic, resources are not equally distributed across the all sites. As a result, different care models with different levels of resources for staffing have emerged. At the Scarborough site in particular there has been a lack of adequate on-site physician services and no resources for community and harm reduction services, which places additional strain on the providers at the site (nursing, peers, and City staff). There is a need to harmonize the care models and provide funding and support for roles like harm reduction and community and harm reduction workers at all sites. Work to create equitable resources and supports for clients (e.g. TVs, phones, internet access, addiction medicine, more onsite support, etc.) is necessary as the physical sites may vary in the basic amenities available to provide a comfortable experience.

Continuity of Care at Discharge

Planning for discharge should start early in a client's stay and ensure continuity of services (medications, safer supply, OAT, MAP, etc.), while proactively engaging community partners. Clients should be given ample warning (at least 48 hours) of their discharge from the site and be actively involved in discussions about their next destination.

Leaving The Site is a Housing Transition, Not a Hospital Discharge

Clients emphasized that securing long-term, affordable housing and their next destination post-discharge were the issues they cared about most, often mentioning it more frequently than health-related issues.

CONCLUSION

The recovery sites have shown what is possible with dedicated, appropriate funding and a committed multidisciplinary team of partners including harm reduction and peer support workers. These sites set a new standard for the level of care and support we should expect in caring for people experiencing homelessness. We look forward to seeing how the service model continues to iterate to best support clients as the pandemic evolves. We hope that the learnings from this community consultation can inform a new path forward in caring for vulnerable members of our community long after the pandemic has ended.

Contents

Background

In March 2020, the progression of the COVID-19 pandemic in the City of Toronto led to the need to establish spaces for isolation for people experiencing homelessness and/or who were unsheltered and/or living in the shelter system and who may have been either exposed to COVID-19, or had been diagnosed as COVID-positive. To meet the need for isolation spaces, a group of community agencies came together with the City of Toronto to begin offering isolation and recovery sites for people in these populations who either tested positive for COVID-19 or "people under investigation" (PUI) who were awaiting test results. The first site – intended as an isolation site while people awaited their COVID-19 test results - was opened in a Scarborough hotel in March 2020, through a partnership between Inner City Health Associates (ICHA), the Inner City Family Health Team (ICFHT) and the City of Toronto's Shelter, Support and Housing Administration (SSHA). This was followed by the opening of a second hotel site in Etobicoke on April 9th, 2020, through a partnership between ICHA, University Health Network (UHN), Parkdale Queen West Community Health Centre (PQWCHC) and SSHA. This second hotel was originally intended as an isolation site for "people under investigation", however it quickly transitioned into an isolation and recovery site for people who had been diagnosed with COVID-19 due to the identification of several outbreaks within the shelter system.

In mid-April 2020, there was concern that more spaces for isolation of people experiencing homelessness and who had been diagnosed with COVID-19 would be necessary, and planning was underway to open a 400-bed open concept space that could function as a recovery space for people needing COVID-19-related isolation. This led to Health Commons and Dr. Gillian Kolla being initially asked by the team of partners running the Etobicoke site to conduct a community consultation process, to ensure that concerns and expertise from the community could be mobilized in the planning of this open-concept isolation space. During this process, when it became clear that both staff members at existing sites and community partners had grave concerns about the operation of a large open-concept space. Feedback from the community led to a change of direction, and prioritization of the hotels as the setting for future isolation and recovery sites. Following this change, Health Commons and Dr. Kolla were asked to synthesize the learnings from these consultations into a document that could be useful in informing the opening of potential future isolation and recovery sites, and that could provide feedback for current sites.

This document contains two sections. The first section synthesizes the client experience at the Etobicoke site. Here, clients were asked questions about their journey through the testing and referral process, during their stay, and during the discharge process, as they prepare to leave and transfer out of the site. Based on the client experience, we share feedback to inform site operations.

The second section contains a synthesis of what we heard from partners, both those working as staff members or in organizational leadership positions at the Scarborough and Etobicoke sites, and those working at agencies in the community who were not directly involved in running the sites. The information is organized into five sections: setting up isolation and recovery sites, operating a site, accepting & receiving clients at the sites, and supporting clients at the site. Within each theme, we highlight relevant feedback to the site(s) and for the broader health and social system.

For the purposes of this report, we will use the term "site" to refer to the two sites in operation at the time of writing (in Scarborough and Etobicoke), which broadly encompasses sites for "persons under investigation" or for isolating close contacts, and isolation and recovery sites for people who test positive for COVID-19.

Consultation process

For this consultation process, we spoke to executive leadership, onsite managers, clinical and non-clinical front-line service providers including physicians, nursing staff, harm reduction and community service workers, and peer workers. This included those directly involved in the current site operations, as well as those providing services in partner agencies in the community. While Indigenous leaders and Indigenous community members participated in several of these sessions, a parallel Indigenous-led process has been convened to create a culturally relevant pathway for Indigenous people as part of the COVID-19 response. Finally, a consultation was conducted with clients at the Etobicoke site who had been diagnosed with COVID-19 and were in isolation for 14 days, to assess their experience receiving services and care at the site.

Consultation Touchpoints

- 20 community leaders in a 90-minute consultation session regarding planning for the launch of a second recovery site
- 45+ community partners, leadership, staff working at the current sites for a 2-hour discussion regarding key operational questions
- 50 person consultation with front line workers on the Weekly COVID-19 Front Line Harm Reduction Call - followed by an online survey
- Interviews and conversations with 21 community partners, leadership, shelter directors, hospital assessment team leads, and staff working at current sites
- Four visits to the Etobicoke Site to meet with 9 staff members
- Interviews with 9 clients currently staying at the Etobicoke site

Insights from Client Engagement Process

INTRODUCTION

Following a request by site leadership, 9 interviews were conducted with clients of the Etobicoke site during the week of May 4-8th. There were 40 people staying at the Etobicoke site at the time, so these interviews represent 22.5% of clients onsite at the time. The interviews were conducted by external project consultants using video-chatting software, and clients were informed that the interviewers were not staff members of the site nor would they suffer any repercussions on their care if they chose to participate or not in an interview. Clients were provided with an honorarium for participating. We interviewed 5 men and 4 women. Two of the clients were isolating onsite with their children (in one case, the parent had been diagnosed as COVID-positive while the child had not, and in the other the child had been diagnosed with COVID while the parent had not), while an additional client had been isolating separately from their child as their child required medical treatment.

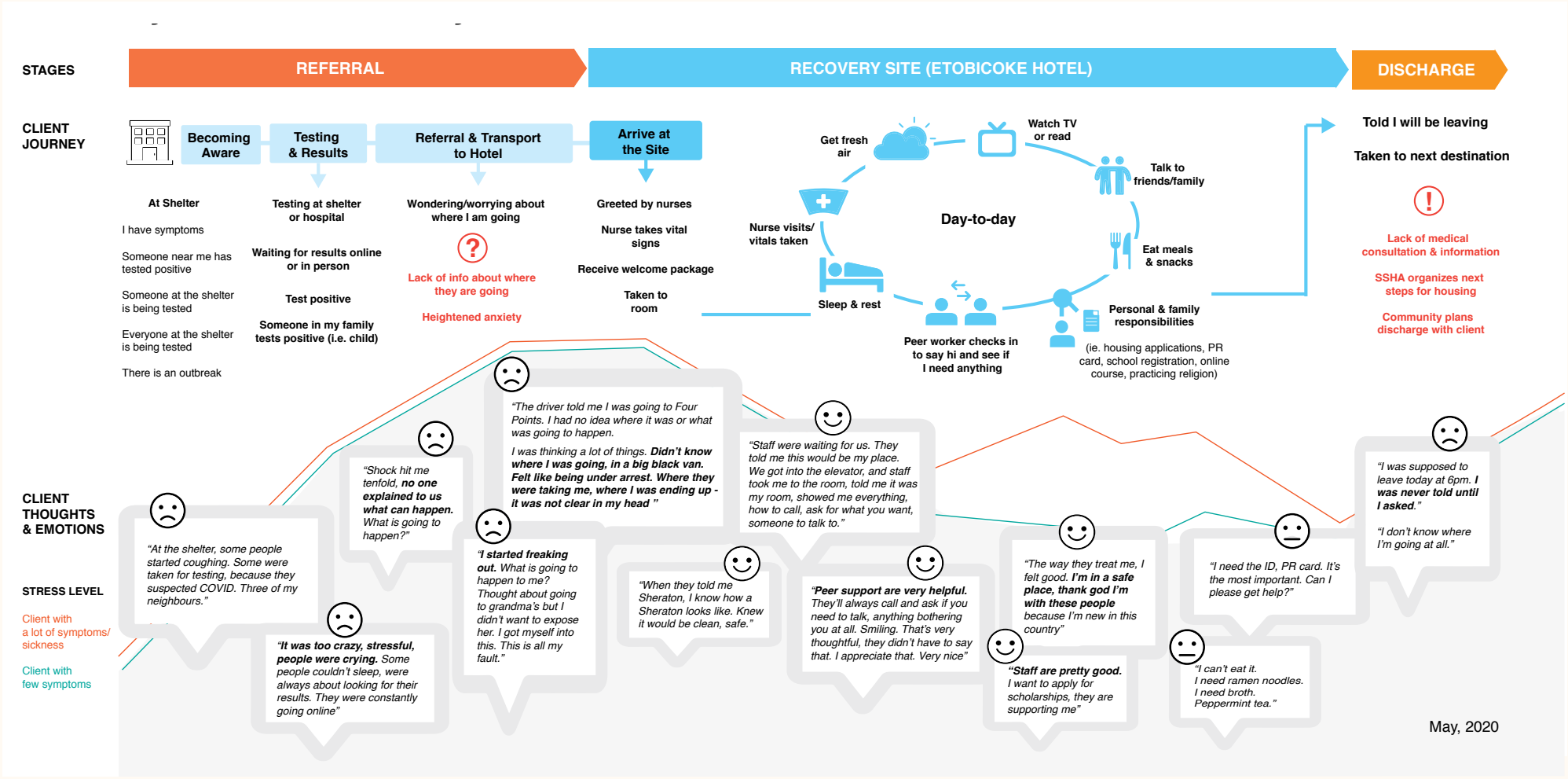
Clients represented varied ethnic and cultural backgrounds, ages, lengths of time living in Canada, and had been staying in a variety of different types of shelters prior to coming to the Etobicoke site (e.g. shelters for newcomers and refugees; men's shelters; family shelters, shelters for women and children experiencing domestic violence). Two clients were part of the onsite managed alcohol program.

During the interviews, clients were asked questions about their journey through the testing process and referral to the site, their time onsite, and their thoughts on their discharge from the site. To mirror these themes, the learnings from the client engagement interviews are organized into three main sections:

- Before arrival at the site: Testing and referral
- Staying at the site
- End of Stay

A snapshot of the client journey can be found on the next page, followed by an overview of key themes surfaced within the interviews.

RECOVERY SITE CLIENT JOURNEY



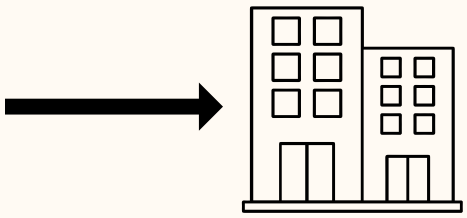
KEY THEMES FROM CLIENT INTERVIEWS

There are several key themes that were cross-cutting in the client interviews. First, clients were extremely appreciative of their stay at the Etobicoke site – they were extremely appreciative of the conditions at the hotel, including being grateful for being able to convalesce in private rooms, with private bathrooms. They also highlighted the attentiveness of staff – particularly peer workers – and frequently spoke of the efforts made by peer and community workers to help meet their needs during their stay.

The second major theme was that across the client interviews, the major concerns expressed by clients were not health-related – where they would be going next after their stay at the hotel and how they might secure permanent housing were the biggest concerns expressed by clients, with many expressing a desire not to return to the shelters where they had previously stayed due to negative conditions there. In the client interviews, homelessness, having to stay in the shelter system and the lack of stable housing remained the largest concern of clients, and their most frequently cited challenge, despite facing a potentially critical illness. That clients highlighted social needs as larger concerns than medical ones may be related to the fact that most clients interviewed were experiencing sub-acute COVID-related symptoms. Additionally, when medical needs did come up, they were often not directly COVID-related (i.e. concerns related to postponed cancer treatment, previous medical issues that remained unresolved, medical exam as a newcomer to Canada, etc.). However, the two clients interviewed who experienced more severe COVID-19 symptoms expressed how their health status has been challenging and stressful, with one client who experienced more severe symptoms expressing concern that they were not ready to leave the site due to continuing health issues.

Finally, it is important to note that despite overall positive experiences staying at the Etobicoke site, the experience of both the referral and discharge process was fraught with anxiety for clients, primarily due to lack of information. In the case of the referral process, an almost total lack of information about the site itself, where it was located, which services would be available onsite, and what type of accommodations awaited them led to an extremely stressful period during referral and transport. During the discharge process, a lack of information about where clients would be transitioning to and being given very short notice that they were about to be discharged were cited as major concerns among clients. Additionally, the lack of a medical touchpoint with a physician at discharge to answer any remaining COVID-19 or health-related questions emerged as a concern.

BEFORE ARRIVAL AT THE SITE: TESTING AND REFERRAL



TESTING

When describing their experiences becoming aware of the need to be tested for COVID-19 and their experience of getting tested, clients had very little positive feedback to report. This portion of the client journey is uniformly described as being stressful and chaotic. This stress was described as stemming from the uncertainty following the realization that someone (or multiple people) within the shelter they were staying at had developed COVID-19 symptoms, fear because they had developed symptoms themselves, and a difficulty navigating the testing process and the quickly changing rules on testing eligibility.

What we heard from clients about the positive aspects of the experience:

- There was a lack of positive feedback about the testing process

What we heard from clients about the negative aspects of the experience:

- Navigating the testing process is hard – clients described being unsure of how to access or navigate the assessment centres. Some clients sought to access testing at the shelter they were staying, and could not do so, leading them to seek out testing on their own at local assessment centres.
- Selective testing in shelters (where only certain people within a shelter that has a confirmed COVID-19 case are tested) was reported as being very problematic, as clients did not understand testing criteria, and why some were prioritized for testing and others refused.
- Clients expressed how stressful it was to have to remain in a shelter setting knowing that people staying there had tested positive for COVID-19:

  "It was too crazy, stressful, people crying. Some couldn't sleep, always about looking for result, constantly going online (to check for COVID-19 test results)."

- An additional source of stress was being unable to successfully socially distance themselves from others within shelter settings, resulting in some clients being required to undergo multiple unpleasant tests in a short time frame.
- Testing itself may be painful and traumatic:

  "They put an enormous q-tip up my nose, I think up into my brain. Twisted it once or twice...3 days later, they did another test, it went up even farther. Feels like they were trying to turn it from negative to positive. It went up into my brain cavity, turning it 10-12 times. I could feel my brain coming out. Why so violent?"

- Conversations around results were also a frequent source of stress, and there was a wide variety of experience around results disclosure. Some clients learned their results in hospital assessment centres, and had the opportunity to speak with medical staff about the implications. Others received results online or on a piece of paper, without the benefit of a medical professional to explain their test results:

  "I was wondering why aren't they giving me my results? They told me they were taking me to another place. After, then, someone came with documents and results. They didn't explain results to me, it was just written on paper."

Feedback for the system

- There continues to be major information gaps regarding testing for COVID.
- The changing testing criteria has led to confusion and a lack of clarity for people residing in shelters when a fellow resident tests positive. There is a need to reduce uncertainty and institute uniform testing guidelines and procedures in shelter settings following a positive test result.
- There is a need to support people before, during and after the testing process, particularly around the discomfort associated with testing/ swabbing.
- There is a need for clear, easy to understand information regarding the testing strategy (who, what, when, where, why, why not), and demystify testing wait times and why repetition of testing is sometimes necessary.

REFERRAL AND TRANSPORT TO THE SITE

Clients described much anxiety about the process of being referred to the Etobicoke site following a positive COVID-19 test result, primarily stemming from a lack of information regarding the site, including where it was located, what services were offered there, and how long they would be expected to stay onsite. Clients who received even limited information about the site (for example, from workers at their current shelter) or reassurances from them about the site described lower anxiety levels.

What we heard from clients about the positive aspects of the experience:

- Concerns about going to a 'corona place' were mitigated for clients who received information about the hotel. Some clients received information from staff at their previous shelter that the hotel would be a safe place for family members who are COVID positive and negative (as some parents were referred to the site after their children tested positive, while they were still negative).
- For those who were in shelters where staff took the time to listen to people's concerns about going to an unknown hotel, it was valuable to have the opportunity to express those concerns and talk them through.
- The name of the hotel (Sheraton) - and its google-friendliness for those who were provided with more information - can be a positive association for those familiar with the brand as a clean, safe and comfortable place.

  "When they told me Sheraton, I know how a Sheraton looks like. Knew it would be clean, safe."

- Even with little information, some clients (particularly those who had been staying in shelters for newcomers) trusted that the hotel would be good enough - it is also notable that they were pleased with the hotel once they saw it.

What we heard from clients about the negative aspects of the experience:

- The majority of clients did not receive information about where they were going after testing positive for COVID:

  "They never told me where I was going, just to another place. I said "am I going back to where I was?" They said no, you are just going to another place."

- Clients expressed that it was scary to be going somewhere where one has no connections.

  "I started freaking out. What is going to happen to me? Thought about going to grandma's but I didn't want to expose her."

- This lack of information led to high levels of anxiety for clients:

  "The driver told me I was going to a hotel. I had no idea where it was or what was going to happen."

- A total lack of information about the destination made the referral and transport process much more unpleasant and stressful than necessary:

  "I was thinking a lot of things. Didn't know where I was going, in a big black van. Felt like being under arrest. Where they were taking me, where I was ending up - it was not clear in my head."

  "I stared out the window, not even paying attention. I was just the driver and me. 10 seat van, I was the only one in there"

- Parents with children faced a potential 28 day stay at the site (if, for example, the parent was positive and the child was negative, or vice versa, they would need to stay for the 14 day COVID-19 period, and an additional 14-day isolation period to ensure the uninfected person was not infectious). Committing to a 14- or 28-day stay with little information about the hotel felt overwhelming for clients who had little information about the site, or the services they would have access to onsite.

  "The social worker told me need to sign on paper that you might stay up to 28 days. I said no, that's too much...I wasn't happy. I was little bit scared of where I'm going. Then I came here and saw place and said, it's okay."

Feedback regarding site operations:

- Whenever possible, keep family members together for the isolation period:

  "I wanted my daughter with me, know that she was doing okay. Every day I talk to her she says she's ready to come, I tell her she has to stay [in the hospital]. She's 16, so she says okay I'll stay."

- Ensure people at to the site have the means to keep in touch with those not going with them - and that they know that this is possible and supported before arrival.

- Ensure that clients who received their COVID-19 diagnosis online or without the benefit of an interaction with a medical provider have access to and receive information from a medical provider onsite who can answer any question about their diagnosis that they might have.

Feedback for the system:

- Distribute clear and understandable information about COVID-19 to clients who test positive (or when a loved one – such as a child - tests positive). Ensure that clients who receive this diagnosis have access to medical providers who can answer questions about what it means to be given this diagnosis.

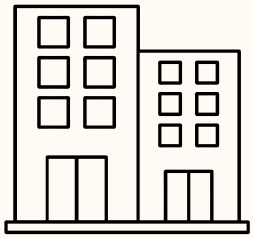
- Distribute clear and understandable information about the site, the purpose of self-isolation at the hotel, and what to expect during one's stay to clients being referred to the site.

  "Even a pamphlet would have put my mind at ease"

- Include information about how everyone housed at the site will be housed in private rooms (with private bathrooms). Due to communal sleeping arrangements in many shelters and respites, people may assume they will be sharing accommodations with unknown people. This may be a deterrent to testing and referral.

  "My daughter was excited to get away from [shelter]. She has own room now, is excited for that. The nurses check on her. Peer support, she knows number off by heart, she calls all the time."

STAYING AT THE SITE



OVERALL EXPERIENCE

Based on the interviews conducted with clients, they described having a generally very positive experience at the site. One client described it as "vacation". Several described how the site – due to its location in a nice hotel – was a better setting than what they were expecting. This is particularly the case for clients coming from congregate settings or who expected to be sharing a room. However, it's important to note that there was variation in the client experience, and that some of this variation seemed to be tied to the severity of the medical symptoms that clients were experiencing. While people with few or no symptoms seemed appreciative of the hotel setting as a 'break', one client who was experiencing more severe symptoms stated that "this is not a holiday".

What we heard from clients about their overall experience of the site:

- Clients appreciated the privacy of having their own rooms, the cleanliness, and expressed being comfortable at the site:

  "It's like you're home. You get your own room, your TV… it's very comfortable."

  "I was like wow, I'm on vacation, it's so nice."

  "Staff is good, food is good, place is good."

- Clients spoke positively about the site, especially in contrast to the other settings they have stayed in within the shelter system:

  "It's not going to be so bad after all, I'm gonna enjoy it. My daughter says she can't believe we're gonna have to go back to the house (former shelter). Can't we just stay here?"

- Clients say they have felt safe at the site:

  "I was little bit scared of where I'm going. Then I came here and saw place and said, it's okay."

- The severity of COVID-19 symptoms that someone has may affect their experience. One client who described having experienced more severe COVID-19 symptoms stated:

  "This is not a holiday. Something is really wrong with me that I'm here. Because no doctor spoke to us…I was just told I was going to hotel, like a hiatus. This is not a hiatus. I'm thinking more realistic, this is not a holiday."

POSITIVE ASPECTS OF THE EXPERIENCE

Arrival to the site

Clients felt welcomed when they arrived at the site – they mentioned appreciating how they were greeted, that they received basic information about the site, and they appreciated the welcome package that was provided to them. They also mentioned appreciating the walkthrough of the room by the peers as they were shown to their rooms.

"I was greeted by amazing staff. You guys are doing a great job. I felt at home."

Physical Space

Clients appreciate having their own room and bathroom. They also noted the cleanliness and comfort of their rooms, and expressed appreciation for the quality of the housekeeping, clean sheets, taking the garbage, having access to a TV, fridge, and microwave.

"You have your own TV, connected to everything. Can't get bored, watch whatever you want. Place is clean, everything is good. Take your garbage."

"It's like you're home. Get your own room, your TV...it's very comfortable."

Basic Needs

Clients may have arrived onsite without having a chance to return to their regular shelter to gather personal belongings (e.g. they were transported directly to the site after testing at a hospital-based assessment centre). The Etobicoke site has made available clothing and pyjama donations, hygiene and personal care items, and has sought out baby and child related necessities for parents who are isolating onsite with their children. Clients were very grateful for these necessities being provided onsite.

"They have a little area to look for clothing for you. This was a major plus."

"Earlier today, I got a call, asking if I was okay, if I needed anything. I was telling staff I was low on clothes, they brought me clothes. They are very nice here, doing a good job."

Clients with children staying with them at the site expressed appreciation for the entertainment items that have provided for their children (i.e. art supplies, books, games). They also highlighted the importance for school-aged children to have access to internet and devices to be able to do schoolwork:

"They got my daughter toys, colours, paper to draw. They are very good, very friendly."

Harm reduction/Managed Alcohol program/ Safer Supply

In order to facilitate isolation of people who use drugs and/or alcohol, there have been attempts to ensure access to harm reduction equipment and programming, including the development of a managed alcohol program (MAP) for those isolating on site, and guidelines for the prescribing of Safer Supply to facilitate isolation at the site. While we were unable to speak to a client receiving Safer Supply, we spoke to 2 clients receiving MAP who were grateful for the program, and who stated it assisted them to isolate at the site:

"Before I drank my own thing. At the hotel, I get 3 or 4 beers, after 4 hours, 1 more beer. They give it to me. It's making it easier."

Entertainment/Passing Time

Clients are spending their days differently, and were very appreciative of the attentiveness of staff regarding ensuring that they had access to Netflix, iPads, books and other ways to pass their time. This may include relaxing with TV, watching movies on Netflix, news, going outside when able to, talking to friends and family, doing exercises, in religious observation, sleeping/resting, and taking online classes. Clients appreciate the entertainment options available and the availability of free Wi-Fi access at the site to assist with the ability to continue online courses and to apply for online benefits and social assistance programs. Clients also appreciated the ability to make requests to go outside for fresh air and for smoke breaks.

"I'm taking online classes. I want to get into computer science, I'm studying for a programming exam. It's an online IT certification"

"I smoke cigarettes, I call on the phone to ask, and they take me down to smoke. I'm comfortable, it's very nice here."

Food: As will be seen below, the food quality was an area that many clients felt could use some improvement, and was the source of the majority of client feedback. However, some clients were satisfied with the quality of food and felt that it was an improvement over the food in the shelters where they were staying before the site. Clients were also very appreciative of having access to snacks available in addition to meals. They also liked that snacks are available all the time rather than just at set times.

"I like it, good food, good service, sandwich, everything is so nice."

"Staff is good, food is good, place is good."

People were very appreciative that there were a variety of options to meet dietary needs (e.g. vegetarian, Halal, gluten-free), and that accommodations were available for Ramadan.

"The food here is good. They asked me if any dietary concerns. I eat gluten free, so they bring me gluten free food. They take precautions, it's a very good thing. No complaints here."

Religious Needs

Clients who are Muslim appreciated having access to the Quran and the accommodations made for Ramadan.

SUGGESTIONS FOR IMPROVEMENTS

Arrival to the site

One client felt that the process of arriving on site felt somewhat chaotic, and that it involved a lot of waiting, with many staff involved. They also felt that they didn't have a full explanation of what was happening and would have appreciated more information on the arrival process. This was potentially a result of this client arriving onsite with several other people at the same time and the need for many people to be admitted to the site at once.

"When I arrived, there was also a mother with son who had a fever, so they took him out first. The process of us arriving and coming in a little chaotic. Hot zone, cold zone. When we came out, it was a hot zone until inside hotel. Nobody was really explaining it. Then they called me, brought me out, I was coming into foyer, the nurses were hanging out onsite, checking us all out."

Physical Space

While clients overwhelming had positive feedback about the physical space, clients who were experiencing more severe COVID-19 symptoms expressed that needing to vacate their rooms for housekeeping was challenging for them. One client also had to move rooms multiple times and found this frustrating. Finally, attention should be paid to ensuring that clients needing rooms that are physically accessible are accommodated, as one client was having difficulty using the bathtub due to a lack of grab bars to aid with accessibility.

Food

The meals that are being provided to clients was one area where several concerns were voiced by clients. The two major concerns that were voiced were:

- Lack of access to food that is appealing when sick. Clients complained about the food quality, small portion size, but also that the food was not appealing to people who were ill and having difficulty eating:

  "I don't know who is doing cooking, apparently, it's outsourced. They need to do a reality check. The food is like ugghhhh."

  "Everything here is pretty much okay, except for food thing."

  "I wish they were providing more for breakfast time. Most people are wasting it because they don't like it. It could be better. A lot of people have been complaining. It's just the same thing all time."

- There was a particular concern about a lack of child friendly options for food for the children onsite

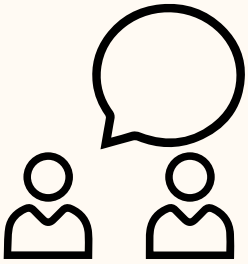
  "Food…my concern is daughter. Even in (previous shelter) we were having difficulties with her eating. She is a picky eater. Yesterday I ordered food from outside. Dinner was pasta and she doesn't eat pasta. I had snacks with me, but she has to eat. So in the evening I ordered nuggets and French fries for her."

- There were several suggestions that were made by clients regarding improving the food.

These included:

- Availability of immune boosting options, as well as food options that reflect the fact that many onsite are experiencing cold and flu-like symptom (e.g. soup, fruit juices or Gatorade, lemon, ginger, a wide varieties of tea)
- More food options for children.
- More options for breakfast, including cereal for children.
- There was also a request by one client to view halal certifications for food, and some clients requested having access to dates (a traditional way to break the fast during Ramadan).

RELATIONSHIP TO STAFF



The multidisciplinary team onsite is comprised of several different types of staff members that interact with client on a daily basis, including nurses, harm reduction and community support workers, and peer workers. Overall, the client experience with staff onsite has been very positive, particularly their interactions with peer workers and with harm reduction and community support workers. This emphasizes the benefits of having staff with different areas of expertise, knowledge and perspectives within the site team.

What we heard from clients about the positive aspects of the experience:

- All clients had positive feedback regarding the staff members that they had interacted with, including comments about their attitudes in making them feel welcome, answering questions, helping them cope with isolation, and their ability to de-escalate situations. This was particularly the case regarding the checks that peer workers conduct by phone with clients several times a day.

"When someone calls, you can explain how you're feeling, they want to make sure you're feeling okay. Makes you feel not lonely."

"I've had nurses come in and say it's okay when I'm freaking out. Got me forward to next day."

"Thank you people for the care you are giving people coming here…I have only good words for you people. Taking care of us. Thank you for that. Just keep doing what you're doing. I'm a satisfied guy. Nothing bad, nothing extraordinary happened to me. These people took care of me."

"Nurses have been extremely good. Very professional, talk to me in professional manner. No complaints at all."

"I'm in room by myself but I'm not lonely. People always call and ask if you need anything. They assist you a lot. The service is really good."

- Most clients appreciated the check-ins, and the fact that staff were very willing to help them with anything they needed:

  "So far everything is okay, everything is good. People are very helpful, whatever I want, I ask for. Something I need, they deliver it to me quickly. They are really concerned about my health and my daughter. Everything is okay. I'm really happy."

  "They are also making me comfortable, making sure I'm alright, making sure I'm happy, if I need anything, if I want to go outside. They will call me on the phone and ask if okay, if I want to go outside."

  "They're constantly phoning me and asking me how I am, looking after well-being. They're concerned, they're doing their job as best as they can do it. I'm quite content with what's going on. I think it's great, I really do. They're making the space the best they can under circumstances."

- Staff – particularly peer workers who respond to requests for cigarette breaks, walks outside or snacks - have been able to meet clients' needs when they request something. Clients appreciated the speed with which their requests are being met.

  "Anytime I need something, I just phone downstairs. They take me downstairs, take me up. No problem at all. Nice people, not rude to me, they've been great, outstanding as far as I'm concerned."

  "I got it in 10 minutes, yes"

  "I told them I smoked, and they called me an hour later and asked if I wanted to go. The phone rang right when I wanted a cigarette."

- Staff have also been crucial in connecting clients with workers offsite, helping with housing, supporting them in applying for scholarships, and have been paying special attention to the needs of children:

  "I was talking with staff about housing, right now I'm in a shelter. I'm not going back. I asked, could they help me with housing for me and my daughter? They are trying to do a good job. I think my social worker talked to somebody downstairs. I don't want to go back to the shelter."

  "They care. One of them yesterday, she brought a backpack for daughter. Mostly the nurses check her in morning. One of them asked if my daughter was here, she saw that her mask was a little loose and was falling down. And then gave her another mask to put on that's easier. She also got my daughter some stuff."

- Clients specifically comment on the quality of support provided by the peer workers:

  "If it wasn't for peer support I don't think I would have lasted this long"

  "Peer support are very helpful. They'll always call and ask if you need to talk, anything bothering you at all. Smiling. That's very thoughtful, didn't have to say that. I appreciate that. Very nice."

What we heard from clients about the negative aspects of the experience:

- Some clients voiced having mixed feelings about their interactions with nurses.

  "The nurses are 50/50. Some of them are very standoffish, like I had the plague. Really hardcore. They would come to my door, they would stand at the door, like we're going to do blood pressure at door. Why does everyone need to see me? Looking at nurses like how do you want me to stand? I can't stand."

  "Some show more care than others."

  "They're just doing job, want to get it over with, come out. I'm not sure how many nurses are working. They have to check other people. Maybe they are getting overwhelmed, they have to get it over with, and have a break."

- It is notable that only one client mentioned their interaction with physicians on site. This client expressed having to request to meet a physician several times, and felt that they had to wait too long to meet with the physician and that when they did, the visit was too short.

  "The doctor didn't come into picture until days later. I don't know where the doctor was, but they only visited me later."

Feedback regarding site operations:

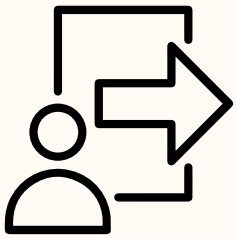
- Some clients were not aware of the range of services and supports available on site, including peer support and the ability to make requests for things they needed. Promoting more awareness of these services may be helpful, but it may be especially helpful for it to occur a few days after people have arrived, once they have had a chance to settle in.

  "I don't know everything they have to offer. They didn't sit me down to tell me. I don't know if they have services on the outside where people come in."

- While feedback on regarding the harm reduction and community support workers was overwhelmingly positive, feedback regarding some interactions with medical team members were brusque. It is possible that some nursing and physician staff do not have as much experience working with populations experiencing homelessness and could benefit from additional training in this area.

- Interactions with physicians were not frequently mentioned; however, when this was mentioned, clients expressed wanting to be able to meet with a doctor more quickly, or having COVID-related health questions they would like answered as they neared the end of their stay. It may be worthwhile to work to that clients have access to appropriate medical touchpoints during their stay.

WANTING TO LEAVE THE SITE EARLY



Due to the importance of ensuring that clients are able to complete their period of isolation at the site, in the interviews we explored whether clients had any difficulty with wanting to stay onsite. Among clients we spoke to, there had not been a strong desire to leave the site, and none had attempted to leave. Care should be taken in interpreting these finds, as we did not necessarily speak with people with the most complex mental health needs or patterns of substance use, which may influence their experience at the site.

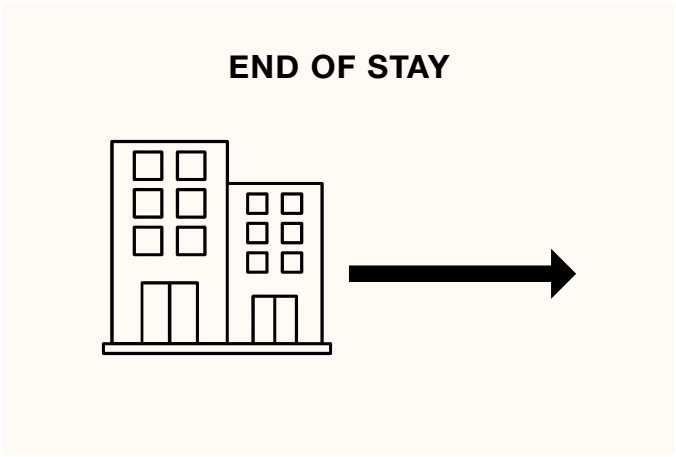
"Not even close. No desire to leave whatsoever. I understand why we are here, I'm here for duration. This won't have any impact on me."

Although clients have things they would like to do off site i.e. take a walk, deal with commitments, they understood the need to stay on site:

"I like walking, I like talking to people. I like interaction, I'm a social being but I understand why I'm here. They're trying to contain spread. That's okay, I won't complain about it."

In fact, it often seemed like the opposite was true – clients sometimes expressed that since the conditions at the site were so much better than at the shelters they were at before, that they would prefer to stay onsite even at the end of their stay.

"This is a better place to be, I can see how someone wouldn't want to leave. If I get a place like this (afterwards), I'll be fine."



The process of discharge and transferring out of the site emerged as an area of anxiety for clients we interviewed. Much of this anxiety was related to uncertainty regarding where they would be going next after their stay at the hotel. However, clients that were interviewed also frequently expressed concern about how they might secure permanent housing. Additionally, many clients expressed a strong desire not to return to the shelters where they had previously stayed, some due to negative conditions there, and some because of ongoing COVID-19 outbreaks.

What we heard from clients about the positive aspects of the experience:

- Several clients stated that they hoped that the next place/hotel that they were discharged to "is like this" – a reference to the positive conditions at the site.
- Two clients expressed a desire to work or volunteer at the site after their discharge, which speaks to the positive experience they have had at the site.

  "I would like to volunteer. This shelter has been helping me. I would like to give back."

  "I was asking if they would take me on staff after this. The job is so sociable, and making me so comfortable. Do you think they would offer me job after this? They said all you have to do is ask."

What we heard from clients about the negative aspects of the experience:

- Anxiety about short and long term housing were major themes in client interviews, and were the major concern voiced by clients. Concerns about housing were even more pronounced than medical concerns in client interviews. Some are concerned about going back to where they were before coming to the hotel (given the conditions at shelters and at the hotels for families in the shelter system).

  "My daughter says she can't believe we're gonna have to go back to the house (former shelter). Can't we just stay here?"

- Clients generally don't know a lot of detail about what will happen after they leave. Clients early in their time onsite had only a vague idea of when they might be leaving, and where they would go after.

"I don't know what's happening to me. Monday will be 2 weeks."

"Girls that were here, they went to Scarborough. Sounds like everyone is going there when they leave here."

- Clients who were getting close to the end of their stay still expressed receiving a lack of information about where they might be going post-discharge. The discharge process can happen fast - we spoke to one client who was leaving shortly after our interview and had only recently been told this. He was also unclear about what it would look like to leave (who was providing transport, etc.).

  "I was supposed to leave today at 6/6:30. They never told me until asked. They're supposed to tell me so I can prepare things. They said they would come to me when I'm leaving."

  "I'm going to hotel in Brampton. No, I don't know anything else."

- There is concern about health status after leaving the site. Clients have questions like: do I need to get tested again? Is there a risk of contracting COVID-19 again? Is there continuing risk for children to get infected with COVID?

  "I don't want to go back to (previous shelter). I called a friend who's living there, more people are getting diagnosed with virus. I need to go somewhere else, my child can get infections easily."

Feedback regarding site operations:

- There is an opportunity to provide better information about when clients will be leaving, where they will be leaving to, and to allow more time to prepare psychologically and physically. All clients interviewed expressed that regular updates on potential discharge date and housing options throughout the stay would be helpful.
- More information should be provided to clients about what the next stop in their journey will be (where they are going, type of lodging (hotel, shelter), city where shelter will be, services available onsite at next location).
- Providing a medical touchpoint prior to discharge, so that clients have an opportunity to meet with a doctor and clarify any remaining COVID-related questions or health concerns would be helpful.
- There may be an opportunity for earlier communication between medical team and SSHA team (ie. at 48 hours pre-discharge), so that clear information on discharge destination is transmitted to clients during their final 2 days at the site and to allow for continuity of care post-discharge to be arranged (for medications and prescriptions renewals, to connect with community medical and social service providers, etc.).
- A simple hand-out explaining health after COVID-19 and answering some key questions that clients (and the staff at their next place of lodging) may have around COVID-19 risks would be helpful.

Feedback for the system

- There is a need to ensure continuity of interventions started at hotel following discharge - including MAP and transfer of other prescriptions to prescribers in community, as well as psycho-social interventions (e.g. ID replacement).
- There is a need to ensure that clients are placed in a shelter or housing situation that meets their needs (i.e. people who use drugs are not placed in a shelter or hotel that does not permit drug use).

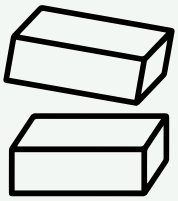
Insights from community partners and staff members working at the site

INTRODUCTION

We feel it is important to provide context around the opening of the two sites in Toronto to provide some nuance to the feedback given in this section. Much of the operational structure of both existing sites (Scarborough and Etobicoke) has evolved under the considerable strain of attempting to adapt quickly to the changing nature of the emergency response to COVID-19. For the Etobicoke site, this meant shifting quickly from a 'person under investigation' (PUI) site to a recovery site – with the early goal of decanting largely asymptomatic COVID positive patients from hospitals. It was also clear during the consultations that immense and intense amounts of work has gone into creating, operationalizing and running 24/7 sites to house vulnerable people, some with very complex medical and social needs, in a very short period of time. This occurred against a backdrop of an ever-changing and evolving COVID-19 response at the municipal and provincial levels, including changing testing requirements, difficulties in the initial days in getting prompt test results, and uncertainty over the clinical course and illness severity that might be expected among people diagnosed with COVID-19.

Conversations with both organizational and community partners revealed an active attempt by all parties to evolve and re-iterate on the isolation and recovery site model being developed to address an ever-changing context. Partners expressed a desire to engage in opportunities to continue to improve processes. The success of these evolving models has been very dependent on the goodwill and dedication of the team members, and these insights contained in this synthesis should not be interpreted as a critique of their efforts. Instead, we attempt to highlight some reflections and advice as the sites continue to adapt to the continually changing context that characterizes the rapidly evolving global pandemic response. We also note that due to the changing and quickly evolving nature of pandemic response efforts, some of the feedback outlined here may have already been actioned (or be in the process of being addressed) by the sites themselves or by health and social system partners.

SETTING UP COVID-19 ISOLATION AND RECOVERY SITES



THE NEED FOR APPROPRIATE SPACES

What we heard:

- When we began this community engagement process, the initial plan was to open a 400-bed open-concept space to temporarily house people experiencing homelessness who tested positive for COVID-19.
- Through previous experiences of how open-concept spaces have been used as respite centres, community partners felt very strongly that these types of spaces were not appropriate for clients recovering from COVID-19. Partners expressed ethical concern around the warehousing of people experiencing homelessness.
- Partners were concerned about creating harmony and safe spaces with so many people from multiple different types of shelters (including newcomer and refugee shelters, men's shelters, women's shelter, shelters for women and children in situations of domestic violence) in one space.
- Several concerns were voiced around large open-concept spaces including security for clients and staff, lack of privacy and high-levels of noise, and lack of comfortable spaces for clients to sleep, relax, and do activities during the day.
- Community partners also expressed concerns around inequities if clients with certain needs were housed at hotels and others in less dignified open-concept spaces.

Feedback regarding site operations:

- People experiencing homelessness are not a homogenous group. Isolation and recovery sites need to be responsive and flexible enough to meet a variety of needs.
- Sites need to ensure they are welcoming and that the physical spaces make it possible to prioritize dignity, safety, privacy and recovery of clients.

Feedback for the system:

- Community partners who provide services to clients experiencing homelessness felt very strongly that it was necessary to only use hotels with individual bedrooms and washrooms as COVID-19 isolation and recovery sites. A decision was made by the City shortly thereafter to only use hotels as isolation and recovery sites.
- There is value in convening community partners (those involved in site operations and those providing services to clients in the community) early in the planning process, to highlight ongoing needs and advocate for policies that best address the specific needs of a variety of client populations.

PARTNERSHIPS & GOVERNANCE

What we heard:

- In order to provide high quality care for clients, COVID-19 isolation and recovery site operations will need to rely on multiple contributing organizations, including both existing partnerships and the development of new working relationships.
- In response to a rapidly evolving and complex situation, the current sites have benefited from working together to clearly define roles, responsibilities and resource allocation (external funding and in-kind contributions).
- The process of bringing together an onsite operational leadership team and

structure comprised of staff from multiple organizations with different cultures, norms and communication structures has been challenging at certain points. However, having highly dedicated operational leadership team members onsite who were committed to working together and innovating a new model together emerged as a major factor in the success of the Etobicoke site.

- The multiple leadership tables that have been developed to manage both executive and operational decision making at the Etobicoke site has sometimes led to the perception of a top down approach to decision making, or confusion regarding the appropriate table for different decisions to be made. This may indicate confusion between levels of leadership (executive governance vs. operational decision making) and who should be part of which conversations, as well as how to ensure information flows well in both directions.

Feedback regarding site operations:

- Future sites may benefit from more time to separate out planning from operations, and would benefit from formalizing these partnership and governance aspects in advance of launch.
- With newer relationships, there is a need to quickly establish shared ways of working that build trust and transparency between partners. Communication processes and tools were discussed as a key component of working together effectively (see section on 'Communication').
- Site leadership structures should put multiple disciplines on an equal footing. This is important to recognize and operationalize the unique and varied contributions each partnering organization makes to the sites.
- Having operational site leads onsite together has been a strength of the model so far. It has allowed for dedicated space and time for site leads to engage in joint problem-solving across disciplines in a supportive environment.
- Attention to information sharing processes is a key component of building new teams. This is especially important when new working relationships are being formed and every organization has their own perspective and approach to working with clients. Delineating the flow and path for communications between teams when attempting to address emerging issues is key.
- Operational decision-making should defer to those onsite and recognize community expertise on non-clinical issues.
- There is a need for clarity on which disciplines should weigh in on what types of decisions (e.g. designate who is responsible, accountable, consulted, informed). Clear decision trees - who to go to for what, and how the decisions are made would be helpful.
- While there are important roles for the executive governance team in responding to larger issues (e.g. legal considerations, external communications, etc.), these should be delineated from other aspects of the day-to-day operations that should be led by the operations teams who oversee/support staff and have day-to-day accountability for what happens on site.

MODEL OF CARE

What we heard:

- The sites have benefited from staff coming with different areas of expertise, knowledge and perspectives. Not everyone has the same training or background, and that brings richness to a new team.
- Sites are not quite hospitals, and not quite shelters. Those with a clinical mental model see patients within a hospital, but those who work in community organizations or shelters see themselves as providing care within someone's home. This mindset impacts how staff interact with clients and provide their services. For example, even how staff refer to people staying at the site differed across disciplines (i.e. patients vs. clients).

- The lens through which partners view the purpose of the site has implications for how they respond within the space. Community partners felt the site would benefit from adopting more of a whole-person approach that moves beyond a medicalized approach, centres the needs of the client, and views the sites as a (temporary) home for people while they isolate and recover.
- Peer support workers, harm reduction and community service workers and City staff have been invaluable in supporting clients day-to-day and meeting them where they are at.
- While the Etobicoke site has benefited from iterating on their multidisciplinary care model, this has been more challenging at the Scarborough site given lack of resourcing for community and harm reduction workers, and a lack of on-site medical supports. This poses additional strain on partners providing day-to-day services at the site such as the nursing, peers, and City staff.
- In particular, the role of harm reduction and community service workers on site was seen as a key component in the care model. The absence of this role at the Scarborough site was felt by staff at that site.
- Peer workers perform crucial work and have a high number of touchpoints with clients during the day (e.g. for snacks, provision of support, cigarette breaks, and taking people for breaks outside).
- Onsite managers for the care teams (nursing, harm reduction and community support, peer workers) play an essential role in providing support for staff working in high stress environments. Their presence onsite is crucial to ensuring the smooth running in a rapidly changing setting.
- There is a need for medical providers onsite during specified periods to address minor medical concerns as they arise and reduce the need to transfer people to hospital for medical issues that could be dealt with onsite.

Feedback regarding site operations:

- There is a need for a common multidisciplinary team approach at each site, including nursing, harm reduction and community support workers, peer workers and onsite physicians.
- Future sites would benefit from more explicit communication and commitment up front about what the model of care will be and what the balance of clinical versus social/community emphasis will be. This should then inform related governance, resourcing, on site decision-making, and accountabilities.
- The high demand from clients for the services provided by peer workers is often not reflected in the staffing ratios.
- There is a strong need to ensure adequate resourcing for onsite teams (particularly the harm reduction and community support team and the peer workers team) to ensure they can adequately respond to the social needs of clients. Sites may also benefit from more formal case management resources and/or social workers depending on the volume and needs of clients onsite.
- Access to on-site specialized supports (psychiatry, substance use), as well as long term follow up with specialists post-discharge from the site is necessary. This is particularly an issue for any medications or treatments (e.g. safer supply) started onsite.

Feedback for the system:

- Different care models with different levels of resources for staffing have emerged at the different sites. There is a need to harmonize the care models and provide funding and support for roles like harm reduction and community service workers at all sites.
- Properly resourcing peer workers and supports for them should be a priority across the system.
- The multidisciplinary care provided at the site is a good opportunity for cross-sector learning that can translate positively after the pandemic.

- The success of the multidisciplinary team requires sufficient resources to support and sustain the model of care.

RECRUITING STAFF

What we heard:

- Several partners felt that the success of the sites was largely due to the presence of a strong, highly committed staff and onsite managers working above and beyond to innovate new care models during this pandemic.
- Staff in management roles acknowledged that this was not a job for everyone and careful recruitment of staff was a key component of site success. Many partnering organizations are asking for voluntary redeployment of staff to the isolation and recovery sites, which means staff want to be there and are motivated to provide high quality care.

Feedback regarding site operations:

- When considering hiring and 'fit' for staff, consideration must be given to whether they have experience working with the client populations onsite and are able to cope with a rapidly changing environment.
- It was felt that rather than needing people with a particular background or skill set, there was a need for high caliber people with a variety of backgrounds with strong compassion in working with people experiencing homelessness.
- Future sites may benefit from sharing of resources related to recruitment of staff across disciplines (e.g. job descriptions, self-assessment for prospective staff on what skills they have and what they need training / refreshers on).

MEDICALIZATION OF CLIENTS

What we heard:

- Both clients and staff felt that people staying at the sites were primarily there because of a social issue (homelessness), not a medical issue (COVID-19 infection).
- Given most clients have sub-acute medical issues (i.e. clients are frequently asymptomatic or mildly symptomatic), there is an opportunity to strike a better balance of perspectives between the medical and non-medical needs of clients.
- Staff members felt that there was a clear hierarchy of staff and with peers and harm reduction and community service workers at the bottom, and physicians at the top. This hierarchy heavily influences which partners have decision-making authority.
- There can be a tendency for the medical point of view to dominate decision-making and trump the non-clinical perspectives of other team members, as a result of the inherent power differentials between the types of roles on site. A lack of meaningful self-reflection by those in positions of power on site further reinforces this dynamic.
- The choice to default to the medical model in a setting that does not require medicalization to this degree can be disruptive to the multidisciplinary team dynamics. Some staff and peer workers feel that this led to an erasure of staff/peer voices and impacted trust within teams.
- This is particularly an issue when staff members from other disciplines spend more time onsite than physicians, giving them a more nuanced view and understanding of what will work best from the client perspective.

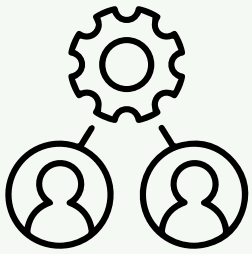
Feedback regarding site operations:

- Prioritize the integration of harm reduction, community and peer support teams to support clients when a medicalized understanding or solution is not necessary.
- For future sites, embracing a community-led or community-co-led model of care (from governance to site leadership structures) would help to address and prevent the unnecessary over-medicalization of the care model.
- Consultation with different disciplines is not sufficient and should not be considered an adequate replacement to shared decision-making.
- Onsite decision making should remain with those as close to clients as possible, with the staff member who know them best taking a lead role. Strong attempts to recognize and integrate community expertise on non-clinical issues should be made.
- Physician roles and expectations should be clarified – e.g. the need for physician input regarding an escalation of COVID-19-related or medical issues vs. day-to-day decision-making regarding clients should be clarified.

Feedback for the system

- The power dynamics that results in the over-medicalization of clients at the sites is not unique to these spaces; it is part of a broader societal structure that prioritizes medicalized understandings of social problems and dismisses the impacts of the broader social determinants of health within people's lives. An attentiveness to models of care that are community-based, that centre the client and client autonomy in decision-making processes, and that are attentive to the broader power dynamics inherent in multidisciplinary teams would be productive.

SITE OPERATIONS



PEER WORKERS

What we heard:

- Peer support workers play a vital role in ensuring the site's commitment to client-centered care.
- Peers go above and beyond for clients to make them feel supported. Clients are very appreciative of their work at the sites.
- Peers bring a lot to the table. Peers contributions are unique in that they offer flexibility on the type of tasks they take on, but also can engage with clients in all sorts of non-medical, social interactions. This can include social and emotional support, support navigating resources, advocating on behalf of clients, and getting clients what they need to meet their needs while in isolation and help keep them comfortable.
- Peers need unique support but they also bring unique experience that needs to be recognized as expertise.
- Peers acknowledged and were grateful for the strong support they were receiving from their manager. They appreciated having a manager onsite at the Etobicoke site to assist in troubleshooting and in providing support for them.
- Peers are assumed by some other disciplines on site to struggle more with things like IPAC, but not everyone felt this was a true or fair assumption.

- Peer workers appreciated the supports available to them (e.g. meals, weekly conference call, access to counseling, healthcare spending account, training, excellent support provided by management and coworkers).
- The lack of scrub service was a particular issue for peer workers, as they may lack the ability to easily wash their clothing (due to precarious housing or a lack of onsite laundry where they live). Additionally, the cost that frequent washing of work clothing entailed may be a significant issue.

Feedback regarding site operations:

- Clients overwhelmingly recognized the role of peer support workers in making their stay at the site positive. There is a need to ensure that the important contribution that peers make to the site is seen, recognized, and valued by all members of the care team.
- Peer support workers may be experiencing many of the same social and economic challenges that clients at the site are facing. They may be worried about precarious housing, future employment or other issues in ways that other members of the care team are not.
- Variable schedules, last minute schedule changes and shift cancellations are difficult to negotiate for peer workers. Consistent schedules and payment for last minute shift cancellations should be considered if possible.
- Access to scrub service and meals on site are important supports for peer staff.
- Health spending accounts are very helpful to support both medical needs and needs emerging as a result of new employment (e.g. clothes, glasses, etc.).
- Access to technology (e.g. smart phones, wifi, computers, etc.) may not be available to all peers. Any work-related technology needs should be accommodated by the sites.
- Transportation to and from the site is a challenge. Upon request, the site has been offering TTC tokens for peers but tokens are often not accepted everywhere. Metro pass or cash (to load on presto cards) would be preferable.

Feedback for the system

- There is a need to sustain employment for peer workers post-pandemic. Peer workers expressed interest in continuing in similar roles in hospitals, housing and/or harm reduction services. There is a strong need to transition peer roles from precarious, short-term contract position to permanent, long-term employment with good pay and benefits.
- For some peers, their social assistance or disability payments may be impacted as a result of wages earned during this time, which only further underscores the need for continuous employment.
- Organizations that have less experience in employing and supporting peer workers can benefit from the deep experience present in many community agencies (including several partners) regarding the ways in which peer workers can be integrated as key collaborators in the provision of services and care.
- While community agencies have been leaders in integrating peers and peer roles into their models of care for decades, there is a need for education for health system partners about the importance of peer roles. This is relevant both for COVID-19 isolation and recovery sites but also as part of a broader conversation about people with lived/living experience as key collaborators in caring for clients throughout the healthcare system.

COMMUNICATION

What we heard:

- Communication is of utmost importance in a quickly changing environment. When everyone is busy and there is a lot of uncertainty, making time to fully communicate plans both within and across teams is very important.

- Teams may have their own record keeping system that is mandated by the organization they work for. The lack of shared work tools and information systems (OSCAR, SMIS, google docs, etc.) is a barrier to inter-team communication. The context and consequence of not having sharing communication tools is important to note.
- There are a number of external communication gaps (particular as related to referral to the site and discharge from the site) that result in anxiety and confusion for clients as they arrive and leave the site. While these communication gaps may fall outside the purview of site operations, any work to increase information sharing with community providers, hospital-based COVID-19 assessment centres, shelters, and clients during the testing process would improve the overall experience of clients as they are referred to the site. The same is true about the need for information sharing with clients regarding their eventual discharge, including where they may be staying post-discharge, so clients know what to expect.

Feedback regarding site operations:

- A shared view of clients (e.g. history, needs, staff interactions, etc.) would be beneficial to increase quality of service from client perspective, increase accountability of partners, and better support coordination of resources across teams. It was not immediately clear whether a whole new client record should be created or if organizations should pursue opening their existing records to each other.
- There is a need for clarity on which partner(s) is responsible for external communications and how communication channels between partners, between levels of staff, and to broader external partners should function.

Feedback for the system:

- There is an immediate need for more fulsome communication around testing, referrals, what staying at the sites is like on a day-to-day basis, and the discharge process for both community service providers (particularly shelters and organizations providing front-line services to people experiencing homelessness) and potential clients themselves.
- There continues to be a need for clear and transparent communication regarding sites and their operations to community partners not involved in direct site operations. Information on site openings, capacity and services should also be provided on a regular basis.

SUPPORTING STAFF

What we heard:

- The extraordinary dedication of the team on the ground has been consistently highlighted as a major factor in the success of sites. Staff supports, and the recognition of their work, will be essential if these successes are to be maintained.
- The sites are high stress environments and attention to strategies that may lessen the risk of burnout for staff is necessary, especially since the COVID-19 pandemic is unlikely to be a short-term event.
- At the Etobicoke site, hotel rooms are available for staff who are working at the site if they wish to make use of them.
- There are inequities between supports provided to each discipline that are not conducive to a positive multidisciplinary team dynamic. For instance, until early May there was no scrub service available for all staff at the Etobicoke site.
- Training for staff was a key theme for partners working at the site. Every discipline has something new to work with (e.g. donning/doffing for non-clinical staff, how to work with peers, etc.). Comprehensive orientation is important for all roles.

Feedback regarding site operations:

- The provision of meals onsite for staff and funding for transportation to and from the site can be a huge support for staff members and can relieve a significant burden on staff engaged in crucial front line work in a high stress environment.
- There is a need to maintain availability of hotel rooms for staff to ensure that workers who are concerned about the need to isolate from their families are supported.

Feedback for the system:

- The COVID-19 pandemic – and ensuring a sustainable response to its impacts among vulnerable people experiencing homelessness - requires financial supports that are not frequently made available to organizations working with this population. Ensuring that adequate resources are available to fully support workers onsite – and particularly peer workers who may be impacted by precarity themselves – is necessary.

INFECTION PREVENTION AND CONTROL (IPAC)

What we heard:

- Staff members discussed the importance of IPAC in planning all elements of the service because it influences so much about how the site can run.
- Having a single point of contact who can be the authority on IPAC requirements and guidelines has been immensely helpful for staff at the Etobicoke site.
- Training around IPAC and PPE is critical to keeping staff and clients safe.

Feedback regarding site operations:

- All staff (from medical/nursing to harm reduction, community support and peer workers) deserve access to the same level of PPE and infection control standards. Scrub service should include all staff members by default.
- Staff working in the site may have differences in individual risk perception. Additionally, personal risk may become more normalized over time so reminders and refreshers for staff will be important as sites continue.
- If staff will be working at multiple sites, there is a need to ensure that there is consistency between sites, particularly in terms of IPAC policies and supplies to avoid confusion.

STANDARDIZATION OF POLICIES:

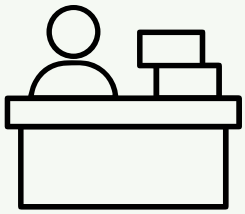
What we heard:

- Partners agreed they would have benefited from more written guidance for clients, staff, and management on how the site will be run, what they can expect, and who they can contact with concerns.
- While guidance and protocols are very helpful, many staff referred to the importance of the ‘can do’ spirit of all team members as the most effective way to respond to issues as they arise, and the need for flexibility to address complex situations.

Feedback regarding site operations:

- Not everything can be written down but having more information up-front would be helpful for the next site.

ACCEPTING & WELCOMING CLIENTS AT THE SITES



COHORTING CLIENTS

What we heard:

- Anticipating the opening of subsequent isolation and recovery sites for people experiencing homelessness, there were differing opinions regarding creating cohorts of clients by population-specific needs at the site level.
- There was concern that cohorting different populations at different sites might introduce difficulties in system level management given the dynamic nature of shelter outbreaks.
- Cohorting within the site (eg. by floor) has been working well at the Etobicoke site and is very helpful for ensuring that the needs of different client groups are able to be met (e.g. women with children on the same floor, people receiving the managed alcohol program on the same floor).

Feedback for the sites:

- Cohorting within the hotel sites (by floor) might be more feasible and provide more flexibility. Current sites could provide guidance to future sites on the best way to coordinate cohorting by floor so that clients are not moved from room to room as surges in intake occur.

Feedback for the system:

- All sites need to be prepared to offer a wide range of services to a wide range of populations, depending on where outbreaks occur in the community. Sites need to have access to resources and partnerships with community providers/experts to ensure clients can be adequately supported to remain in place throughout isolation.

REFERRALS

What we heard:

- What was once a referral process designed around hospital and assessment centre transfers has quickly pivoted to meet the needs of shelters that are doing onsite testing and may be experiencing larger scale outbreaks.
- All partners were very conscious of minimizing the total number of transitions to ensure that clients experience the least disruption possible. Transitioning clients from a ‘person under investigation’ or close contact site to a COVID-positive recovery site requires significant upheaval for clients.
- Some staff involved in site operations felt the centralized referral pathway is working well for providing a medical assessment for clients prior to their arrival onsite. They felt that the pathway was coordinated , systematic, and allowed for referring physicians to provide medical care guidance and information in advance of a client’s arrival – rather than trying to fill in these information gaps later.
- Other partners and staff working at the sites felt that having a physician as the gatekeeper for referrals, especially one who typically does not know the patient and/or has not done an in-person assessment, felt arbitrary and subjective. There were concerns that potential clients are being turned away from the site unnecessarily, and that all people experiencing homelessness who did not need hospital admission and were COVID positive should be accepted at the site.

- Some partners felt that the eligibility may be overly centered on medical criteria and was unnecessarily screening out people who were over age 65 or who were alcohol or opioid dependent, and who may otherwise be candidates for the Etobicoke Site. It was suggested that a transparent process for evaluating criteria for site admission might keep more people out of hospital.

Feedback regarding site operations:

- There is a need to reduce the number of points of intersection within the referral pathway as some clients experienced multiple transfers and have received unclear information.
- There is a need for transparency in the referral process to ensure that potential clients who may have higher levels of need or vulnerability are not being unnecessarily disqualified from referral to the Etobicoke site. There may be a role for multidisciplinary input and ensuring that partners on site with expertise in working with vulnerable populations are engaged to ensure they can adequately support a potential referral.
- A multidisciplinary committee including representation from onsite partner agencies could be formed to review all past referrals to the site and to make policy recommendations going forward as it relates to referrals.
- The liaison nurse who processes referrals could be positioned at the site and more embedded in day-to-day operations. This would allow the referral process and criteria to be more closely aligned to the realities of the site and would allow for more multidisciplinary input in decision-making about referrals.

Feedback for the system:

- Health and social system partners should consider if the referral pathway to the site should be more of an opt-out policy whereby people who test positive and do not have adequate or appropriate housing are assessed by the clinician doing the testing/assessment. If the person's condition does not warrant admission to hospital, they would, by default, be transferred to one of the sites.
- Information on the Etobicoke site (including its location, the accommodations and food offered to clients, the service offered onsite, and the typical length of stay) should be provided to all clients at the point of referral to ensure they have information on where they are being transferred and alleviated the anxiety involved in a high stress moment.

COMMUNICATION WITH COMMUNITY PARTNERS

What we heard:

- Referrals happen at the interface of a medical assessment by ICHA and a SSHA intake – and it's not clear that community partners or shelter providers know how to trigger the beginning of a medical intake with ICHA following a positive test. Clients and providers would benefit from more information being made available to them at the point of testing regarding the isolation and recovery sites and their operations.
- Providers, especially those who work in shelters or other congregate living settings, also need access to this information as they are often at the interface of the client and the system. If providers in the community are equipped with correct and timely information, they can support clients throughout the process (from testing to discharge).
- There have been communication gaps regarding the process of admission to the site following a positive COVID test, and services offered once onsite. Clients in initial interviews expressed receiving no information about where they were being taken during the referral process, leading to fear and distress during this process. This may be leading to clients experiencing fear of living at the site (which is compounded by the understandable fear they feel following a COVID-positive diagnosis).
- Providers and clients would benefit from sharing more information about what amenities

and supports are available at the sites, for example: that clients will be lodged in their own rooms, with private bathrooms, Wi-Fi, and harm reduction, community support and peer support available onsite. Communicating this information to clients earlier in the referral pathway may ease anxieties.

Feedback regarding site operations:

- For clients who may arrive at the site with little to no information, it is important to let them know about the full suite of amenities and services available to them once they have settled into the site. Intake staff and peer workers are already playing an important role in this at current sites.

Feedback for system:

- SSHA has released some information to shelter operators on the isolation and recovery sites, but the dissemination of that information may need to be further amplified to reach everyone who needs it. This will become more prominent as more outreach testing happens in shelters experiencing an outbreak.
- Provide as much information to clients as possible to demystify and explain what is happening to them at all points in the testing and referral process is necessary (i.e. during testing, at assessment centre or emergency departments, following positive test results and during referral to a site).
- If possible, more advanced notice on shelters planning onsite testing and sharing of that information with a broader network of community and to site staff would be helpful.

INTAKE

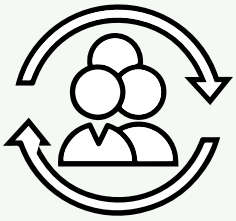
What we heard:

- The current referral pathway ensures that there is physician to physician connection made in the transfer of clients. Shelter-to-shelter connection is also helpful in understanding what the client might need to stay in place for 14 days.
- Communication between onsite SSHA or community support staff and clients on arrival is helpful to better understand where a client is coming from (drop-in, shelter, respite, sleeping rough, etc.). This provides a frame of reference for what service expectations will be for that client (what they are used to and what supports they may need onsite).

Feedback for sites:

- There is a need for a multidisciplinary approach to intake that allows each discipline to gather the information needed to fully support clients.
- Onsite partners need to work together during the intake process so that clients are not overwhelmed by staff immediately upon arrival and to ensure that all clients get access to the information they need regarding their stay.

SUPPORTING CLIENTS AT THE SITES



MEETING CLIENT'S NEEDS

What we heard:

- Staff members working at the site highlighted the importance of taking the time to understand the unique needs of clients at the sites. Because clients were coming from several different types of shelters (including newcomer and refugee shelters, men's shelters, women's shelter, shelters for women and children in situations of domestic violence), there was a very wide variation in potential needs.

- Due to the different pathways of clients to the site, some were arriving at sites from hospital with no extra clothing, toiletries or hygiene items. Some parents were not able to bring enough diapers, formula or toys for their children.
- Due to the need for clients with COVID-19 to maintain isolation on site, staff members have been empowered to make purchases to meet clients' basic needs and ensure their ability to remain onsite more liberally than is usually the case within shelter settings.
- Community partners who were not directly involved in the day-to-day operations at the site were often concerned with ensuring that population-specific needs were met at the site. This concern likely stemmed from a lack of information regarding site operations and the provisions staff were making for clients onsite.

Feedback regarding site operations:

- The approach to designing an inclusive site is both about being ready (planning) for patterns/ known needs - but once a site shifts into operations mode, it also just about meeting each person where they are at.
- For conversations with a higher potential to stigmatize clients (e.g. substance use, mental health issues) it may be necessary to create multiple avenues for clients to express their needs (and create space for them to change their minds!). Having team members with strong harm reduction backgrounds and the availability of peer workers is key to this.
- One partner at the site described that there could sometimes be a tripping over each out where multiple staff from different teams reach out to clients (unknowingly) in rapid succession. It might be possible for clients to have input into how they would like to be contacted, and after they have been at the site for a while, which provider they are most comfortable with doing that reach out.

POWER OF YES

What we heard:

- Due to the recognition of the unique situation involved in asking clients to isolate for 14 days, the Etobicoke site has been able to create 'culture of yes' that allows staff to proactively engage with clients about their needs, and provides resources and material supports to allow staff to be able to meet those needs.
- This was a consistent theme among staff members providing services at the site. They spoke about how rewarding it felt to work in an environment where saying "yes" to a client request was the default response, as they often work in resource-constrained settings where there are many more no's than yes's.

Feedback regarding site operations:

- Future sites should continue to provide resources that allows and empowers staff to say yes to client needs (e.g. budget for purchases, allowing staff to run errands for clients during their shifts).

Feedback for the system:

- Shelters and organizations providing services for people experiencing homelessness have become accustomed to working under severe resource constraints that can render the provision of even basic necessities for clients difficult.
- There is a need to properly resource shelters and organizations providing services to people experiencing homelessness to allow them to provide services that maintain people's dignity. This would also prevent service providers from continuously feeling like they are gatekeepers to much-needed resources.

SUPPORTING INDIGENOUS CLIENTS

What we heard:

- An Indigenous-led process has been convened to create a culturally relevant pathway for Indigenous people as part of the COVID-19 response.

Feedback regarding site operations:

As part of a discussion on population-specific needs at a community partner engagement session, necessary supports for Indigenous clients were shared by Indigenous leadership and community members, including:

- Having Indigenous staff members on site should be prioritized, and having access to elders by phone may be helpful for Indigenous clients.
- Ensuring that workers understand the western-Traditional Medicine balance and hold respect and care for Indigenous community members who wish to use their medicines should be prioritized (i.e. no eurocentrism/cultural imperialism/superiority complex).
- People who speak Anishinaabemowin, Kanienkeha, Cree, and Inuktitut should be available to provide language support for clients who may need to access it.
- Sites should explore the possibility of having traditional medicines onsite for clients who may benefit from them, as well as Indigenous-specific coping supports for isolation
- Ensuring that Indigenous clients are supported in maintaining access to community members (including friends and family members) should be prioritized.

ONSITE SERVICES

What we heard:

- Community partners felt that there should be a minimum basket of services that clients should be able to access at any site. This ranged from peer supports, access to harm reduction and community support workers, harm reduction supplies, overdose prevention interventions, medication management, mental health supports, and other community services (e.g. language services, immigration supports, ID replacement, etc.).
- Staff members felt that common spaces including outdoor spaces and spaces that give the ability to socialize safely would be helpful for clients.
- Community partners working outside the site also felt there could also be an opportunity to leverage emerging support systems related to the pandemic including clothing and food donations, care packages, phones, etc. that could reduce people's sense of isolation.
- As part of the community engagement sessions, several organizations offered to support individuals living at the site with services that include: additional peer support, supports for psychiatric survivors/ mental health service users, case management, replacement therapy/ medication management, advocating for immigration and social services supports, training supports, legal supports, youth resources, violence against women outreach resources, supports to access COVID-19 financial benefits, and housing supports.

Feedback regarding site operations:

- Sites should explore opening common areas within the isolation sites that would allow for clients to socialize with each other. This may include outdoor common areas.
- One staff member working at the Etobicoke site (where all clients are COVID positive) suggested that programming would be helpful (e.g. games, movie night, talking with each other, other ways of social connection, etc.).
- Several staff members expressed that the quality of the food could be improved. Most importantly, this would include expanding the

range of foods available to include foods that people like to have when they are sick (soup, juice, tea), more nutritious food, fresh fruit and produce, and child friendly food options.

- As service needs are identified, sites should connect with community partners who provide those services in the community and may be able to provide guidance and/or resources.

SERVICES FOR CLIENTS WHO USE SUBSTANCES

What we heard:

- Ensuring that clients have access to substances (including alcohol and drugs) is an important part of helping them remain in isolation for the duration of their stay.
- Due to histories of discrimination within healthcare settings for drug use, clients who use drugs made be more reticent to disclose drug use to medical team members, and more likely to disclose to harm reduction and community support or peer workers. The need for information sharing and expectations for privacy must be balanced.
- There was consensus across consultations that the availability of harm reduction expertise and services was a necessity to facilitate isolation at the sites. This includes access where necessary to: harm reduction equipment and supplies, safer supply prescribing, naloxone for overdose prevention, low-barrier supervised consumption sites, and access to information and education from harm reduction workers and peers.
- The Etobicoke site is providing cigarettes, managed alcohol and cannabis programs onsite. The ICHA substance use team has arranged for medical supports for clients at the site including access to opioid agonist treatment and safe supply prescribing.
- Staff at the Etobicoke site felt like the availability of a managed alcohol program onsite had been very successful in helping people isolate onsite, and that is was easy to administer and manage. They did not report any issues related to the managed alcohol program.
- While the client population at the Etobicoke Site during the first month of operations has contained few people who inject drugs, this may change in the future and require the exploration of an onsite Overdose Prevention Site.
- The Scarborough site felt they would have benefited from harm reduction supports and had specific requests for guidance on how to best serve people who use stimulants and how to work with clients using and purchasing drugs during their isolation period. Despite not having access to these resources, the Scarborough site was able to implement a managed alcohol and cannabis program.
- Staff, especially those working in the clinical disciplines, have varying amounts of experience working with clients who use substances. Harm reduction workers onsite can be valuable sources of expertise due to their experience in this area.

Feedback regarding site operations:

- Ensuring that people who are dependent on alcohol, opioids or benzodiazepines have easy access to managed alcohol programs, opioid agonist treatment or safer supply programs that provide pharmaceutical opioids or benzodiazepines to facilitate isolation is necessary.
- Given the backdrop of the ongoing North American overdose crisis and the need to help facilitate onsite isolation for clients, the operation of a small, onsite Supervised Consumption Service would be helpful in meeting the needs of people who use substances and in providing quick response in case overdose occurs. Attention should be paid to ensuring that SCS are low-threshold, and could be staffed by harm reduction workers and peers to ensure they remain easily accessible. Alternate overdose prevention strategies (e.g. virtual peer witnessing) should also be explored.

- Providers with less experience working with people using substances could benefit from training or orientation, especially with how to prevent stigmatizing health care encounters with people who use substances.
- Community providers with expertise in harm reduction and support for people who use substances should play a leadership role in onsite decision making regarding how to best support clients using substances. This should include not only consultation based on their expertise, but shared decision making power regarding the care of clients using substances, especially when dealing with situations directly related to substance use.

Feedback for the system:

- In order to ensure continuity of care post-discharge, there is a need to ensure that clients on managed alcohol programs, opioid agonist treatment or safer supply are able to access prescribers following discharge to continue treatment.
- It is important to ensure that explicit communication on the commitment to harm reduction philosophies and access to harm reduction services onsite is happening, to ensure clients who use substances are not discouraged from accessing the sites. Several community partners remain unaware of the supports for harm reduction that are in place onsite.

CLIENTS WHO WANT TO LEAVE THE SITE EARLY

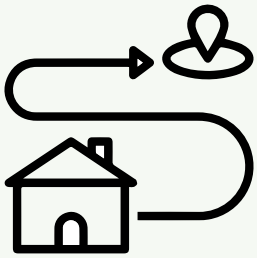
What we heard:

- People staying at the site have the same rights as any other person who tests positive for COVID.
- The importance of remaining at the site is explained in ways that are easy to understand and sensitive to the experiences of many individuals who may be dealing with trauma or have a history of incarceration or mental illness.
- Staff members spoke of going to great lengths to ensure that clients had access to everything they needed to ensure they would be able to remain onsite.
- Even after that support, if clients decide that they wish to leave, partners working at the current sites felt they should prioritize what is needed to ensure the client will be welcomed back safely (e.g. arrange transportation, get contact information, etc.).
- This highlights the important role of the peer workers onsite who check in with each client, arrange extra resources to meet their needs, including amenities, food, laundry, and access to managed alcohol programs, etc.

Feedback regarding site operations:

- Creating a supportive environment that makes it easy for individuals to stay should be prioritized. Current practices and principles in place at the isolation and recovery sites seem to be effective in supporting this.
- Ensuring that frontline staff are empowered to meet client needs is a key tactic in ensuring that clients can remain onsite to complete their isolation periods.
- Ensuring that staff members are skilled in de-escalation, and that staff members with experience working collaboratively with populations of people who use drugs and people who may be experiencing mental health challenges is key.
- Sites should be clear about how issues are escalated and what contingency plans are available to the team.
- Community partners suggested articulating principles for how to address potentially difficulty situations with clients as a way to ensure consistency across teams and across sites. This includes clarifying escalation processes to support staff on the ground (including which staff members should be involved in the decision to escalate a situation), and being up front with clients about what happens if an issue is escalating.

SUPPORTING CLIENTS AT THE END OF THEIR STAY



DISCHARGE

What we heard:

- Where clients will be housed after leaving the site is a very (if not the most) important question for both clients and staff. There is a need for more clarity in communication on where clients are going after their stay.
- Staff members who work with clients at the Etobicoke site described the importance of options for clients (or as much choice as can be created within a system that often has limited availability of housing and shelter options). Some clients want to return to where they were before, others do not.
- One staff member felt that discharge was a difficult process because most people don't want to leave – clients who had already been discharged described to current guests that the experience at other hotels had been negative and completely different.
- Continuity of care after discharge was a common concern expressed by community partners, especially for clients who are connected to managed alcohol programs or safe supply prescribers during their stay at the sites.
- There is sometimes a lack of clarity regarding COVID-related medical questions at the time of discharge (e.g. lack of clarity around need for testing at discharge, questions regarding continued infectiousness and whether re-infection is possible, etc.). This can lead to fear and potential for stigmatizing experiences for clients leaving the site.

Feedback regarding site operations:

- Community support workers should be involved as early as possible in helping to prepare clients as they get ready to leave the site, since the majority of their needs are social.
- There is a need to give clients as much advance notice as possible when they will be leaving and where they will be going. Currently, discharge is triggered by medical staff members, followed by SSHA staff initiating the search for a space post-discharge. Clients are often only informed of the process once a space for them has been located. There may be an opportunity to provide more advance notice on timing of discharge so that clients can be better prepared and provide input into the process.
- Sites should prioritize ensuring the whole health of an individual, rather than absence/presence of COVID-19 status, when indicating a client is ready to be discharged. If adequate supports (especially for prescriptions or connections with necessary community supports or providers) are not in place for the client prior to discharge, their discharge from the site should be paused until onsite staff can ensure care coordination and the continuity of care in the community.
- A medical touchpoint with a physician (preferably in person) should be provided for all clients at discharge who have any COVID-related or health questions remaining.
- The medical team should produce a simple informational handout that explains many common COVID-related questions to clients (whether there is a need for testing at discharge, questions regarding continued infectiousness, and whether re-infection is possible), so they can refer to it post-discharge if they have any questions.

Feedback for the system:

- Increase the level of communication with community providers and shelter operators about the process of discharge. In particular, it is important for everyone to understand what the rationale behind not testing clients at discharge is to dispel myths and address fears surrounding continued infectiousness.
- Continuity of care between care providers onsite and community care providers should be prioritized.
- Ensure that there are suitable housing options upon discharge are available. Steps should be taken to ensure that clients on MAP, safer supply or who use substances are referred to appropriate services that allow for continuity of care.

NEED FOR LONG-TERM, AFFORDABLE HOUSING

What we heard:

- The need for long-term, permanent housing for people experiencing homelessness both during the pandemic and post-pandemic was top of mind for all partners we spoke with. Partners wondered how the COVID site end-of-stay planning intersects with the broader conversation about the need for longer-term housing.
- The systemic challenges involved in trying to find stable housing for clients include a lack of affordable, long-term housing options. This was a longstanding issue prior to the COVID-19 pandemic, but the pandemic has revealed the magnitude of this problem and exposed the health issues that can stem from the lack of affordable housing options throughout the system.

Feedback for the system:

- There is the potential for the stay at the sites to be a unique opportunity to work with clients on case management and long-term housing goals if resources are available for this.
- The majority of clients at the Etobicoke Site have been very happy with their stay at the sites, largely because of the high quality service being provided, the privacy and comfort afforded by a private room and bathroom, and the breadth of supports they have been offered during this time period.
- The Etobicoke site has shown what is possible with dedicated, appropriate funding and a multidisciplinary team of partners including harm reduction and peer support workers. It sets a new standard for the level of care and support we should expect in caring for people experiencing homelessness.
- The level of resourcing and the multi-disciplinary model of care provided at the Etobicoke site is leading to a high level of satisfaction among clients of the site. Resources should be made available throughout the system to allow for the services and level of care provided to be sustained beyond the COVID-19 pandemic.