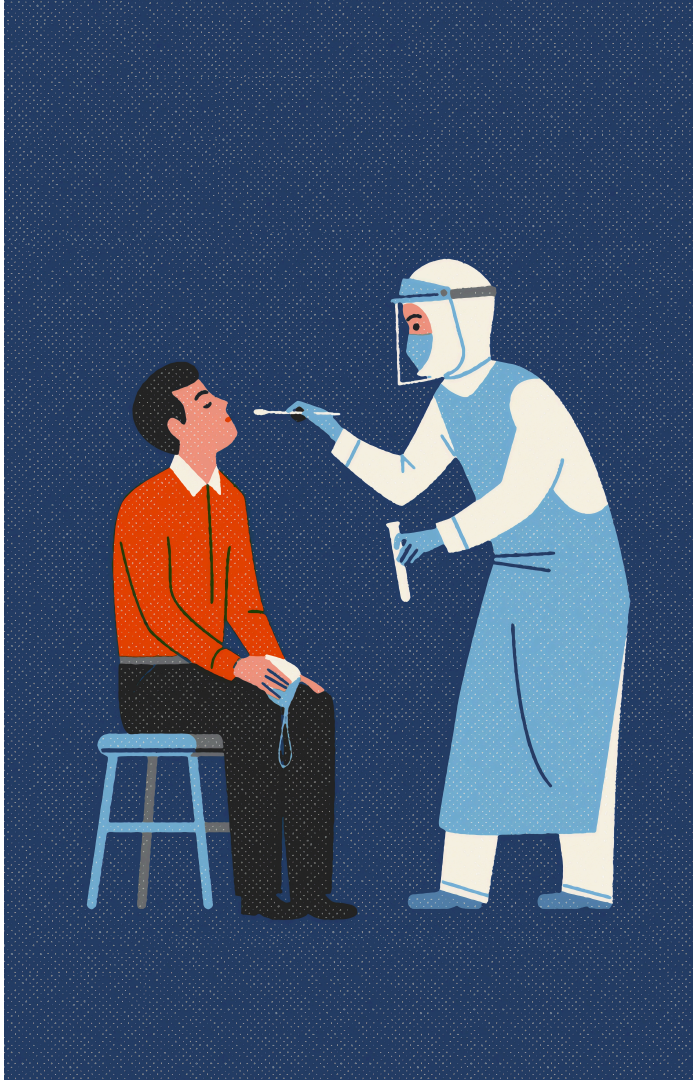
HEALTH COMMONS SOLUTIONS LAB

COMMUNITY-DRIVEN TESTING STRATEGIES FOR COVID-19

Informing an integrated approach for the hardest hit communities



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This document was developed by Health Commons based on input from community members and advisors.

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Note to the reader:
The quotes you see throughout this presentation were gathered by Health Commons directly from residents and community agencies in North Etobicoke - one of the communities with the highest rate of COVID-19 cases. We acknowledge the contribution of those who participated in this process, including the residents of North Etobicoke who shared their stories with us, Albion Neighbourhood Services, Delta Family Resource Centre, Etobicoke Services for Seniors, Humber College, Rexdale Community Health Centre, Rexdale Community Hub, Rexdale Legal Clinic, Rexdale Women's Centre, Somali Women's & Children Support Network, and Youth Without Shelter.

Cover image created by Russell Tate. Submitted for United Nations Global Call Out To Creatives - Help stop the spread of COVID-19.
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EXECUTIVE SUMMARY

COVID-19 is concentrated in **racially diverse and low-income communities** – in Toronto, 83% identify as racialized and 51% live in low-income households

- Health Commons has been working with partners in Toronto and Central Region communities hardest hit by COVID-19 to **better understand the role of local response strategies as part of the recovery effort**

While the province has been successful in achieving a high volume of daily testing and public health messaging, **findings suggest their impact has not been consistent and may not be reaching the communities that need them most**

- Poor access to hospital-based testing sites, coupled with public health messaging that does not reflect their experience, has led to lower rates of testing for COVID-19 in these communities

- Targeted messaging that is more reflective of people's experiences in these communities would address mistrust and stigma

Without strategies that directly respond to the needs and experiences of these communities, recovery plans will be insufficient to manage the spread of the virus in potential future waves

EXECUTIVE SUMMARY

Interviews with over 100 residents and community organizations offer insights about what's driving the high rates of transmission in 'hotspot' communities and how healthcare partners can help

This proposal outlines a proposed model for community-based COVID-19 response, including an integrated approach to testing that could be piloted in hotspot communities

Core elements of the model were designed with the community. This locally coordinated and comprehensive approach would:

- Address **accessibility** through flexible, responsive and local testing options
- Enable **coordinated outreach/education** and
- Activate a network of providers to offer **wrap around care** for those who test positive

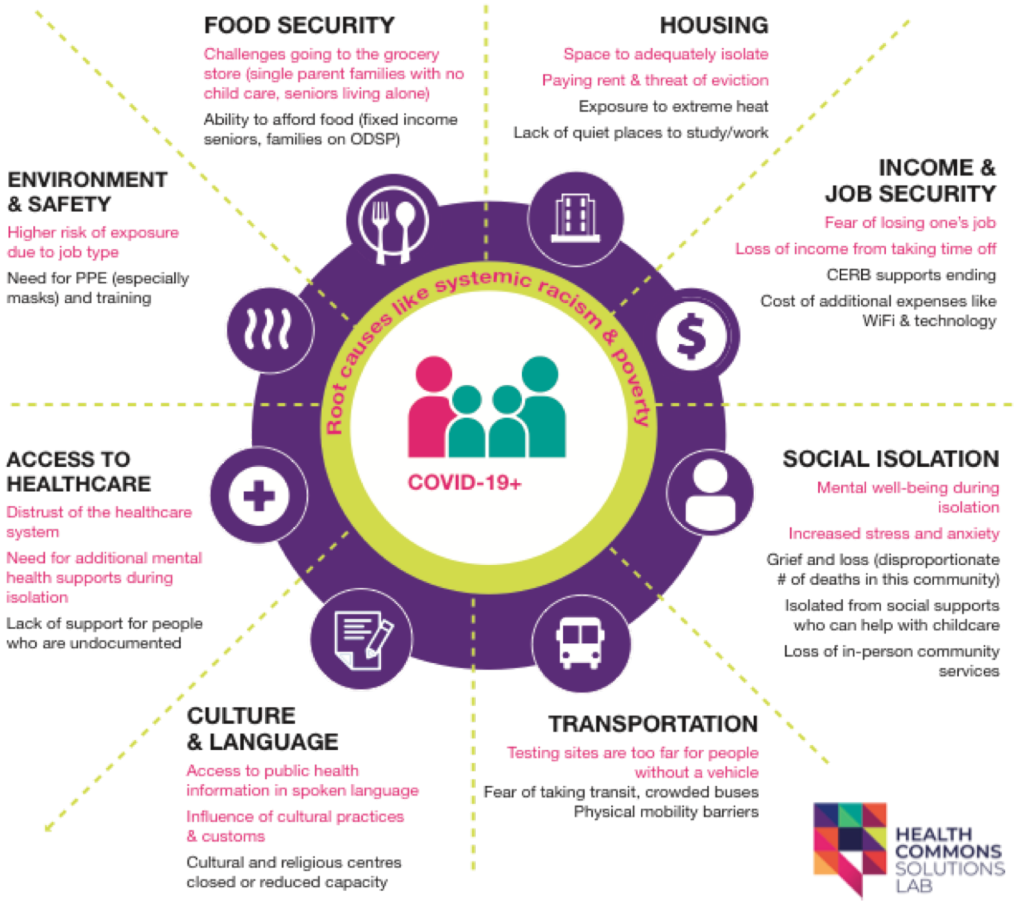
Key success factors include:

- **Shifting resources and authority to community partner(s) to lead a local testing/outreach team** and to direct local activities related outreach
- **A targeted investment** that would be used to leverage local resources and relationships already in place to significantly bolster the Wave 2 response

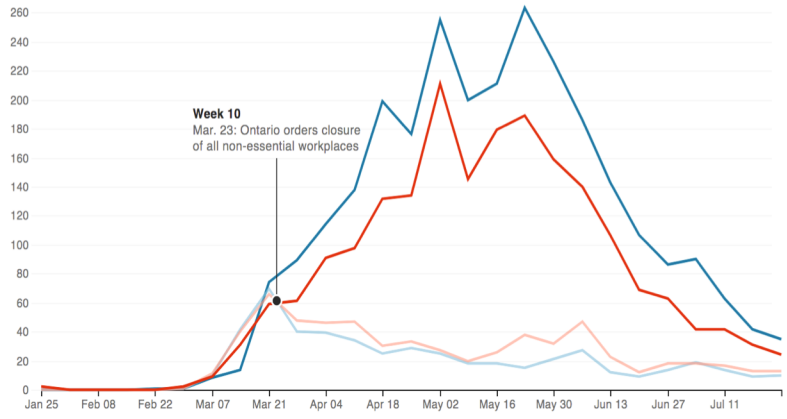
AS THE PROVINCE ESTABLISHES ITS TESTING STRATEGY, A CONSORTIUM OF HEALTH AND COMMUNITY PARTNERS ARE PROPOSING TO PILOT THIS LOCAL APPROACH TO OUTREACH/TESTING AND COORDINATION

The pandemic has exposed the structural forces that marginalize residents in many communities

Provincial and City-wide public health strategies did not adequately account for the impact of social determinants in the first six months of the pandemic



The impact of this inequality and systemic racism cannot be understated…the cost to these communities has been enormous



Toronto Star, August 2020

"Lockdown protected Toronto's richest, whitest neighbourhoods, but not the poorest and most racialized ones."

"In Toronto's 20 whitest, richest neighbourhoods …the widespread closures had an immediate and sustained effect. Almost instantly, their curve flattened.

But for the 20 poorest, most racialized neighbourhoods — with the highest percentages of visible minority residents and people in low-income households — **lockdown made little or no difference. Cases kept rising and didn't begin to trend downwards for two months**."

What we heard directly from community members and organizations

Core public health messaging didn't reflect many people's experiences

People were trying to make sense of policies that are not designed for them – e.g. 'work from home', 'stay off public transit', etc.

The strategies that worked for the majority of communities did not work in the hardest hit communities.

"Isolation is challenging for immigrants who live in poor neighbourhoods. I think if people had to go to hotel spaces for 2 weeks at a time they would go."

"I have a friend who had it [COVID-19] earlier, no one has followed up with her or anything like that…awful. She lives with husband and kids. There should have been supports in place for when people test positive – what's the next step? She tried to call and get a test, still couldn't get a test."

Generic public health messages can lead to confusion and misinformation when they don't match people's realities

"The drive-through testing is not accessible for people in this neighbourhood (who don't have cars). More importantly – (we) had a senior who took a cab...ended up with a significant bill."

"If you are a single mom and you test positive what will be there to make sure that your family will be taken care of (while you self-isolate)?"

"Not every community has access to the same outdoor/green spaces (to physically distance)."

Resulting in mistrust, misinformation and stigma in many communities

"If I test positive, how will I pay my rent, how will I feed my family. No good can come from it. There is no one coming to help me."

"One person in the factory was positive. There were 500 of us workers there… Why did they wait 5 weeks?"

"They go into hiding. They don't want anyone to know that they are sick."

"It's been 40 days since we got better and still not one is coming to see us. The funeral is done, and no one is coming."

"I have to ask myself, why did they do 65,000 tests in Brampton and now they are just thinking about coming here? What is behind that? What is that about?"

Local agencies are fully mobilized around COVID-19 response, even while their doors are still closed

Communities are generating their own solutions, addressing gaps and creating a conduit to reach 'communities within communities'

Donation drives and volunteers

"We have discovered that connectivity is a major issue in the community. Have partnered to provide people smart phone, laptop…unfortunately the need is huge."

"We had churches come forward offering volunteers, had to be nimble in terms of virtual policies."

"As a management team we're out there too on Fridays making deliveries."

Virtual meeting places

"Recovery for us is how do we work differently because we will no longer have 26 people in the room… We need to be more educated in what tools and programs we deliver remotely."

One-on-one outreach to those who need it most

"We've called every single one of our clients. WE know clients that are vulnerable. Quick check-ins and we found at first they didn't need much help, as time went on the calls got longer and more serious. Doing case management. Been critical for them."

However, roles and processes are often poorly defined, and approaches vary in different parts of the city

Emerging models have not yet been tested in response to escalating COVID-19 cases (e.g. outbreaks) or changing environments (e.g. back to school)

The structure, leadership, and roles of community partnerships have evolved in response to local needs - partners are playing very different roles in the City's two most well-established community initiatives

> *In East Toronto, there is a primary care and hospital-led initiative that incorporates outreach, testing, and community supports - initiated to improve access to COVID-19 testing in east end communities.*
>
> *In North Etobicoke, it is a community-driven response (via Cluster Table), tackling a range of issues from food security to pop up testing.*

Some of the city's most vulnerable communities lie outside the Toronto healthcare boundaries, adding to the complexity of ensuring a timely response as the pandemic evolves

> *North Etobicoke and the neighbouring communities participate regularly in Peel Region planning meetings and depend on Peel hospital assessment centres.*

While there is a commitment to ongoing monitoring and outbreak response, community-level roles and structures have not yet been defined

> *Emergency management models offer a possible approach (e.g. escalation protocols, command centre structures, etc.) but current tables may not be well suited to play those roles.*

SUMMARY - *new strategies needed to address real and perceived barriers to participating in testing and self-isolation*

What we heard from residents and partner organizations:

I) Overcoming barriers to participation in testing and public health measures

- **Public health messages don't speak to people's experience** – people who work in informal or precarious jobs, take public transit, live in multi-generational households
- **Mainstream communications channels may not be effective** - language barriers; higher newcomer populations; experience of public institutions has led to mistrust

II) Lack of accessible testing options in communities where COVID-19 rates are highest is a significant barrier to early identification

- **People may avoid or delay** getting tested

III) Higher burden of COVID-19

- **Burden of illness...and of public health measures** – higher financial impact, risks to family members, stigma; growing impact on food security, housing security, job security
- **Poorly-resourced and poorly coordinated supports for those who test positive** – local agencies are filling the gaps

What is needed:

Local approaches to education and outreach

+

Access to testing when and where people need it

+

Supports for those who test positive to self-isolate

Where COVID-19 risks are highest,
communities need locally-driven solutions

Prevention efforts need to go beyond 'one-size-fits-all'

More nimble and responsive local strategies, supported by better integration across local, provincial and municipal partners

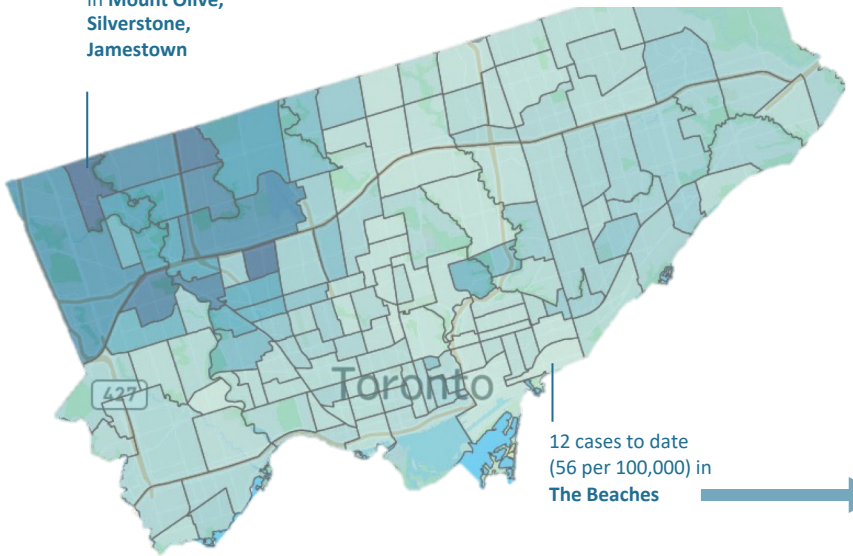
TAILORED AND TARGETED TACTICS

For a handful of communities, many factors are making it harder to stay safe.

Communities have mobilized to fill the gap, but they lack access to COVID-19 funding and don't have the authority to direct testing or other strategies

TWO EXAMPLES, TWO VERY DIFFERENT NEEDS

439 cases to date (1,332 per 100,000) in **Mount Olive, Silverstone, Jamestown**



12 cases to date (56 per 100,000) in **The Beaches**

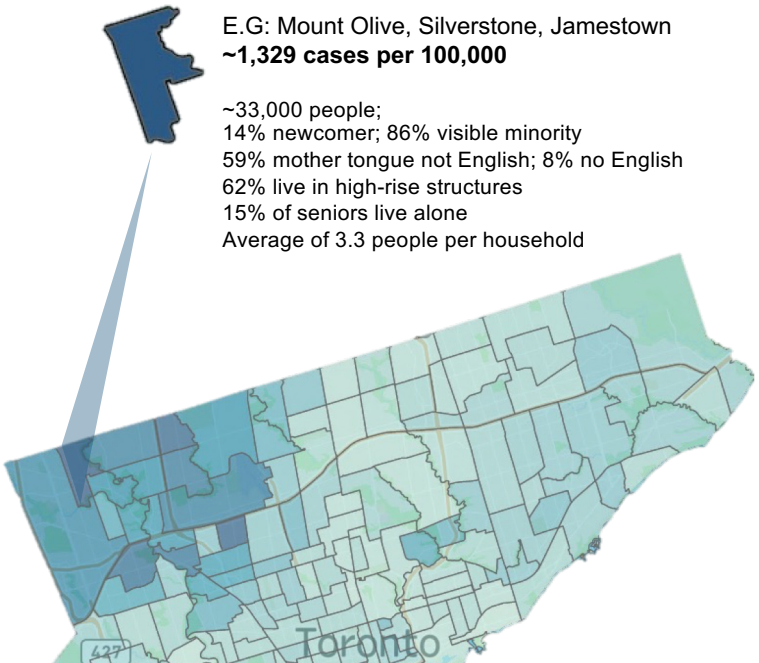
PROVINCIAL & CITY-WIDE TACTICS

For most communities, mainstream channels are working.

However, roles and processes among partners are still largely informal and dependent on prior relationships.

Community networks can be the backbone, but they need the resources and authority to direct efforts

Targeted resources where they are needed most…



…and mobilizing local assets and relationships for greatest impact

- **Activating local partners** with established trust, using peer supports and mobilizing 'ambassadors'
- **Assisting public health to adapt messages** and sharing through existing communication channels
- **Community-based case management to coordinate services** for those in need or pivot programs/ services
- **Hosting and/or coordinating** targeted testing
- Early warning system to **identify and respond to potential outbreaks**

Formalized roles and integration between public health, municipal, health and social services will be essential in Wave 2 to encourage appropriate participation in testing and to respond to localized outbreaks and limiting spread

EDUCATION & OUTREACH

+

TESTING WHERE PEOPLE NEED IT

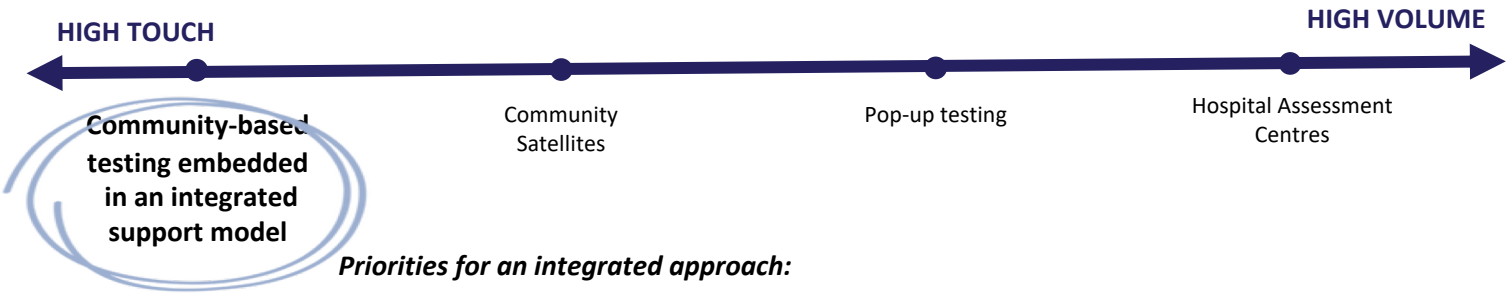
+

WRAP-AROUND CARE IN THE COMMUNITY

Informing **community-based testing** strategies – an integrated approach

For some communities, a high touch model can have a bigger impact, at lower cost

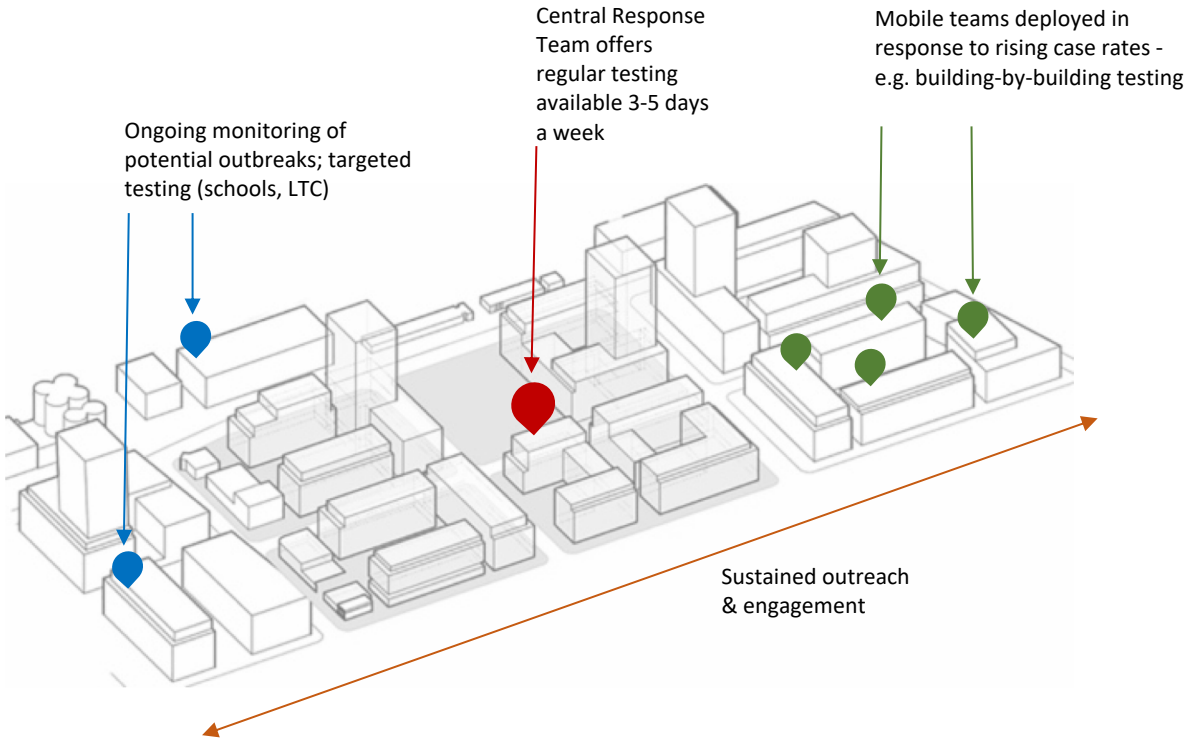
Local input highlights the need for a more holistic approach to testing, health and social care in communities where COVID-19 risks are higher



Priorities for an integrated approach:

- ***Accessible, familiar testing locations*** *– so that people don't delay or avoid getting tested*
- ***Timely access and follow up*** *– to minimize chance of local spread*
- ***Outreach and education shared through familiar channels*** *- adapting as the pandemic evolves*
- ***Support if I test positive*** *– services to minimize the burden and help people self-isolate*
- ***Local outbreak response*** *– mobilizing partnerships to minimize spread (e.g. TCH, schools, employers)*

What would a community-based model look like?



Key roles and functions in an integrated community-based model

LEAD ORGANIZATION

- **Operational lead, coordinating activities and recruiting resources**
- Primary contact for external partners in ongoing planning and coordination
- 'One number to call' for those needing information or support

***May be primary lead or part of a joint leadership/ governance table**

CENTRAL RESPONSE TEAM

- **Multidisciplinary team empowered to direct the community response to outbreaks or escalating cases**
- Includes clinical, support and outreach functions
- Dedicated resources to a core team that can deploy additional resources as needed
- Team can be deployed in multiple settings - i.e. building by building, to school, etc.

CASE MANAGEMENT

- **Dedicated resource(s) to coordinate access to services** for those who test positive or need to self-isolate

CONTRIBUTING PARTNERS

Community Organizations

- **Contributing support services as needed**
- Community service partners linked to provide wrap around support to those who need it

Health Care Partner

- PPE, IPAC, Group Code for Physician billing, Testing Kits
- **Surge capacity for staffing when large scale outbreaks occur**

Public Health

- Public education campaigns
- Data monitoring; early identifications
- Communications and translation support
- Outreach staff for surge capacity

EXAMPLE

Getting out ahead of rising COVID-19 cases that are localized in a high-rise community

Community testing location notices rising number of visits from a particular high-rise building in the neighbourhood.

Concerns are flagged to the **Central Response Team,** which mobilizes additional outreach resources. Local partners confirm an increase in requests for information and support.

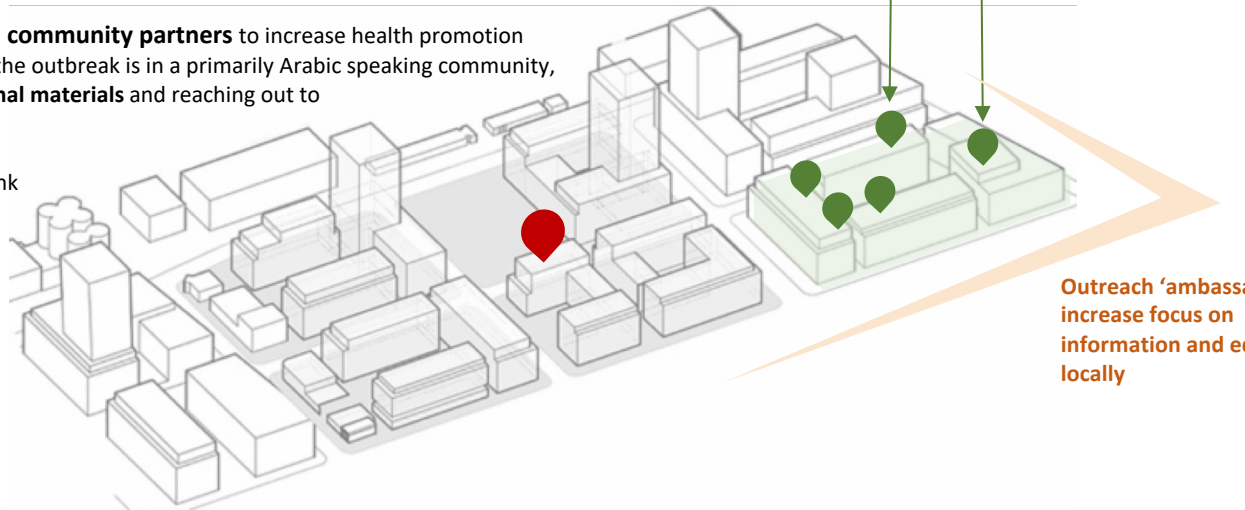
The Response Team determines that door-to-door testing is the highest impact, lowest cost option and deploys a testing team.

Outreach team works with **local community partners** to increase health promotion efforts. Partners recognize that the outbreak is in a primarily Arabic speaking community, **translating additional educational materials** and reaching out to local faith leaders.

Case manager is available to link people to needed supports.

The issue is escalated by the **Lead Organization** to Public Health and Ontario Health.

New translated outreach materials are shared with neighbouring communities.



Enabling effective outbreak response - *creating a community-based operational response committee structure*

LOCAL OPERATIONS COMMITTEE

LOCAL COORDINATION

- **Clear escalation processes** – defined roles and protocols to mobilize additional resources if case rates rise
- **Regular touch points with partners** – two way sharing with City and Ontario Health partners, ongoing planning as the pandemic evolves, coordinating adjacent communities

LOCAL OUTREACH/TESTING TEAM

- **Multiple testing modalities** – Local team staffed to execute a range of testing modalities e.g. regular testing sites, mobile testing, targeted surveillance (e.g. schools, Long-Term Care)
- **Outbreak response** – testing, follow up, monitoring in case of outbreak
- **Outreach capacity** – ability for sustained messaging about testing

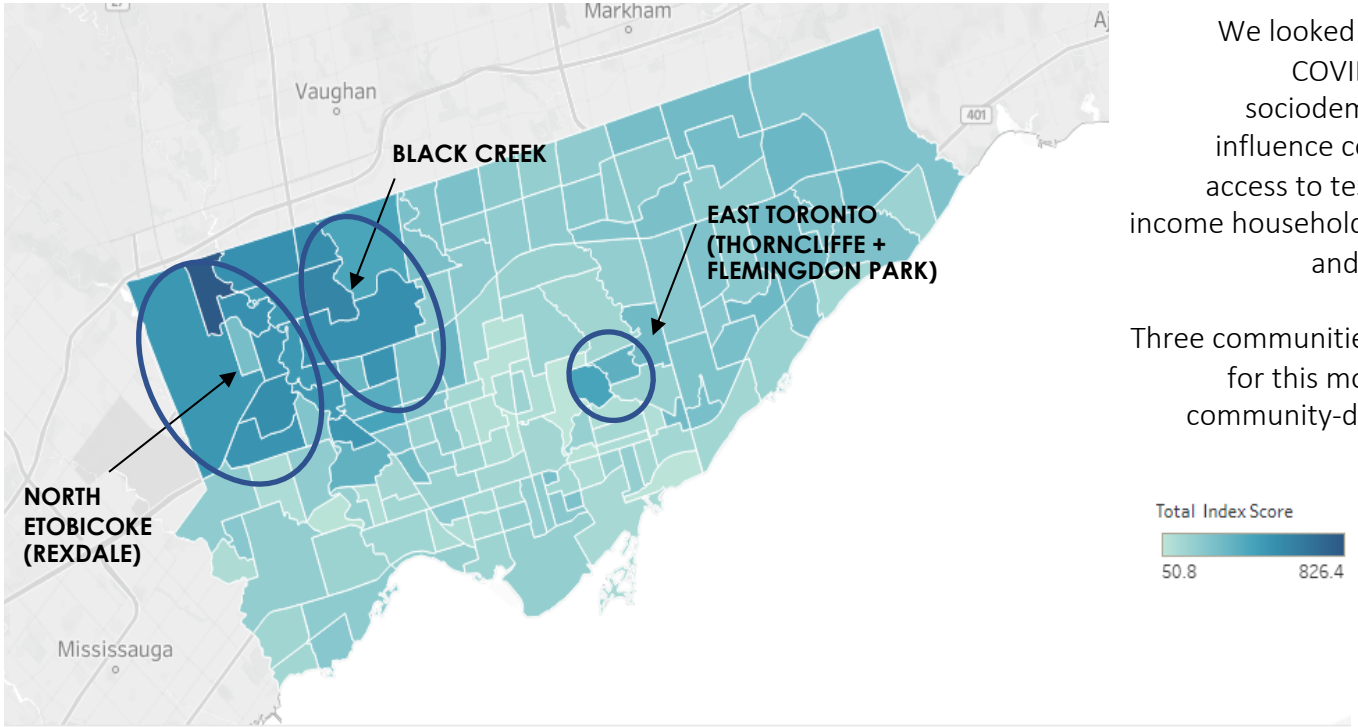
MOBILIZING PARTNERS

- **Integrating wrap-around support for those who test positive or need to self-isolate** – clear processes to connect residents to local and city-wide services (case-management resources)
- **Coordinating local relationships** – touchpoints with local institutions at risk of outbreaks (e.g. schools, Long-Term Care)

Scale up, scale down as needed– ability to meet changing demands on the system as rates of COVID-19 change

Targeted strategies in communities at highest risk

Public Health data points to 3 priority areas



We looked at data on the rate of COVID-19 and a number of sociodemographic factors that influence community spread and access to testing (e.g. rate of low-income households, recent immigrants, and racialized residents).

Three communities emerged as priority for this more resource intensive community-driven testing strategy.

Data provided by Toronto Public Health. Includes all confirmed and probable cases from May 29, 2020 to August 27, 2020 except long-term care and retirement home outbreaks. Sociodemographic data provided from the 2016 Census. To generate the composite index (risk) score, each variable was assigned equal weight.

Current response in these communities

- All 3 communities are fully mobilized in COVID-19 response - sharing lessons learned and collaborating on the proposed model
- Structure, leadership, and roles have evolved in response to local needs - partners are playing very different roles
  - East Toronto – primary care and hospital-led initiative that incorporates outreach, testing, and community supports – hospital is providing backbone support for testing
  - North Etobicoke/Black Creek – CHC led as part of the local Cluster Table; Ontario Health Central Region is providing backbone support for testing
- Local cluster tables launched in partnership with United Way and the City of Toronto providing support to coordinate services; piloting case management in North Etobicoke with United Way funding

Resourcing community-based teams – *targeted investment needed to address current gaps*

Community clinic (3 days/week, fixed site)
Registered Nurse
Nurse Practitioner (or MD OHIP funded)
Admin support

Community testing (to be deployed as needed)
Registered Nurse
Admin support
Case manager

Outreach team
Peer workers

These roles are presently unfunded and would require an estimated $250k from Sep to March 31st

In-kind contributions
Community Health Centre - administration of the Emergency Operations Centre function
United Way – support outreach activity across UW funded orgs
Hospital/Ontario Health - PPE, IPAC, IT, lab capacity, testing kits, staff training, physician billing group code
Public Health - contact tracing, communications including translation, outreach support, data surviellance
Community partners - translation support, outreach support, non-clinical services for COVID positive people