Learning Together Virtual Series Webinar Recap

COVID-Alert Risk Evaluation (CARE) program

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About Learning Together

The COVID-19 pandemic has increased the urgency to share learning across care settings, in real time. The need to move quickly to improve support for underserved people, and the people who care for them, is especially critical as existing gaps in health and care widen. To help facilitate cross sector learning, Healthcare Excellence Canada launched Learning Together: Delivering in Uncertain Times, together with partners the Canadian Centre on Substance Use and Addiction and the BC Patient Safety and Quality Council. It is part of the LTC Expanded program, however everyone interested is warmly welcomed to participate and help co-create the series. This webinar was the first of the learning series.

importance dans la protection des personnes extrêmement vulnérables, la disponibilité des mesures de soutien à l'encadrement et les pertes de revenus causées par la maladie.

Pour veiller au bien-être des employés de première ligne et à la qualité de leur travail, il faut se pencher sur les menaces et les solutions possibles.

About the CARE program

Population Health Services, part of Inner City Health Associates, launched in spring 2020 and developed the COVID-Alert Risk Evaluation (CARE) program as an emergency response to the COVID-19 crisis in Toronto, Ontario shelters. CARE is designed to respond to the complexities and vulnerabilities of people experiencing homelessness and the fact that each shelter is unique. The transdisciplinary team currently serves 144 shelter programs and nearly 5,000 clients in the Greater Toronto Area.

The three main components of the CARE program are:

- **COVID-19 prevention and mitigation** – involving risk stratification, site consultation, outbreak support and targeted testing.
- **Health promotion** – involving customized services, health ambassadors and health promotion resources.
- **Immunization planning** – involving pre-immunization planning, on-site health promotion and a post-immunization huddle.

COVID-19 prevention and mitigation

Using the CARE risk assessment tool, the Population Health Services team work closely with shelter staff to identify the clients' COVID-19 risk profiles and support needs. Following on-site discussions of the shelter's specific IPAC (infection prevention and control) and immunization needs, the team and shelter staff co-create support systems and solutions for these. Outbreak support includes creating pre-outbreak and post-testing plans.

Some shelter clients can be very vaccine hesitant. So they need to work together and understand the challenges the shelters are experiencing on-site and what clients say, and identify the most high-risk individuals using the risk stratification data. The Population Health Services nurses use saliva kit tests and their established relationships with shelters to help the testing to be as low-barrier as possible.

Health promotion

CARE provides resourceful and accessible health promotion and information materials related to COVID-19. The team meet one-on-one with identified high-risk clients to discuss any concerns they might have. Health ambassadors, either people living within the shelter system or staff, are selected by shelter staff to spearhead the development, dissemination, and utilization of the CARE health promotion resources.

Immunization planning

Immunization planning involves addressing specific vaccination hurdles for shelters and shelter clients. The team draw on the pre-gathered data and uses a client-centred perspective for on-site health promotion. The post-immunization huddle (meeting) provides learning points about vaccine uptake, challenges experienced by staff and clients, and how concerns can be addressed for the next round.

Working with people with vulnerabilities

Fundamental to the CARE approach is co-creation and using a client-centred perspective, key elements of which are:

- **Language** – being mindful of the language used in the health promotion materials and taking a site-specific approach, as sometimes what's used for the general public doesn't always work for shelter clients.
- **Community engagement** – making the most of valuable assets - the shelter clients and staff, who really understand the needs of their community. They can help implement solutions; such as using health ambassadors to improve vaccination uptake.
- **Empowerment** – increasing community engagement supports community empowerment, as seen through the CARE program work with shelter partners on saliva testing, which shelter staff have fully engaged with to ensure their clients are safe.

Long-term goals

Population Health Services aims to further develop CARE to be used beyond COVID-19 as a community-based health promotion model focused on empowering people within the shelter community to co-create models of information sharing and knowledge translation that fit their unique needs. This model sees the health ambassadors as an embedded part of the shelter system.

Two long-term goals for the CARE program are:

- **Enhancing immunization** – expanding the CARE model would support immunization uptake of any sort of preventable disease.
- **Ending homelessness** – this involves a thorough understanding of the people who need the most support and what that support involves, to help improve their situation and lead them to thrive. CARE's risk stratification work collects useful data to support the co-creation of solutions for this end goal, as people experiencing homelessness are not usually studied.

Questions and answers

Q: How you ensure co-creation and not imposing of solutions, whether that be on the shelter clients or staff? What checks and balances do you put in place as a team along the journey to ensure this?

A: One of the most important things that we consider is having representation - a diverse group of people involved. For the health ambassador program we're developing at the moment, we don't have a set plan, we don't know what it's going to look like until we have all the ambassadors and different partners, so we can have a conversation. This is because we only have our lens of perception and it's really important to have a diverse perspective before we go ahead and co-create any sort of programming. That has been a really important part of ensuring co-creation is happening versus imposing solutions.

Q: Are there any challenges in trying to do that kind of co-creation work?

A: Yes. Because we're working with our partners, they have to identify who the best people are and bring them together. We ensure that they are paid and compensated for their services. The onboarding and the beginning process are some of the challenges, then once we have that we're able to move forward pretty quickly in terms of having a truly co-created model of service.

Q: How has your team balanced the pressure between co-creation and the crisis in front of you. The pressure to act which can sometimes lead us in the wrong direction and things like paternalistic approaches/ What have you found works to make sure that immediate needs are being met but that you really are engaging in those co-creation engagement practices?

A: Our team tries to put our services out there to the sites and then give them some space to think about if they want to take up some of the services. Then usually we'll go on-site, have a frank conversation about their needs, with an open-minded approach, and do a needs assessment. Sometimes you may see a different need, but you really have to work together with the site to first understand where they're coming from and then maybe bring up some of your own ideas. Ultimately, it's up to the site to take any recommendations we make, and we're there to support them the whole time. It's a new space and we're inventing the plane as we're flying it, so that's always what we tell the sites too. That kind of approach has been really helpful and we've had partners come back and ask for other services when they're ready.

Q: Are there some key areas that you're noticing that are causing vaccine hesitancy? How are you addressing them?

A: There are definitely some trends that we've started to notice. One of the biggest challenges is mistrust of the medical profession because of the experiences clients have had when they've encountered healthcare. So we work together with the site to see how can we address this, and it really is an individualized approach.

Another big challenge is mental health; we use a trauma-informed approach in this case. And again, using the health ambassadors is key, because my perspective is so different to that of a peer they really trust to give good information or a community worker who knows the client really well. So it's not us saying, "Hey, listen to us, this is what we think about the vaccine", but having people the clients know really well ask questions and then taking the really non-pushy, non-judgmental approach of, "Please ask questions if you're interested. We understand if you decide not to do it."

Q: Can you give more information on what you mean by saliva tests?

A: We order the saliva kits from Public Health Ontario, which anyone can do. Any shelter can order their own rather than having, a hospital come on-site and do the testing. So we have a number of saliva kits and all of our partner sites can access them. When a mass testing happens but the positive numbers are not very high, we can come on-site and do saliva kit testing with the high-risk clients and any other clients that might have missed the mass testing.

Saliva is very easy sample to collect because you just spit in a little cup. Once the sample is collected, you put it in a biohazard bag and send it to Public Health Ontario for processing, then you get the results. So that's another component to empower the sites to make sure that anyone who needs to be tested can be, especially for clients who might not be at the shelter during the day when the mass testings tend to happen.

As the pandemic progresses there's a lot of burnout in terms of the NP (Nasopharyngeal) swabs and sometimes a lot of resistance. When there's a large outbreak or even a smaller outbreak on-site and they're trying to understand the magnitude of it, just like with vaccines there can be a lot of hesitancy around mass testing, so sometimes having a more individualized approach like the saliva test makes it more likely that the client will do it. So that's what we've been offering recently as well.

Q: Can saliva tests detect for variants, and is it asymptomatic testing or symptomatic testing that you're doing?

A: Ideally, it's asymptomatic testing. The hope would be that if they were symptomatic, because shelters do screen their clients every day, that they would be sent to a COVID Assessment Centre (CAC) right away. But sometimes they are asymptomatic, so you can test either way. It's not as sensitive as the NP swab but it's another option and it does detect the variants.

Q: Do you have recommendations for innovative ways to continue to provide services and support to clients during an outbreak, based on what has worked for the sites you are working with?

A: This is a struggle, because most sites have shut down their programs where clients have to congregate or meet; a lot of things have been moved to virtual. Sometimes we recommend if you really have to meet with a caseworker or you do have to meet to continue a service, meet outdoors, make sure you both have a mask on and follow all other safety guidelines. I think educating shelter staff about what the parameters are and how you can best meet so you can still provide those services goes a long way. I recommend reaching out to the service providers to make sure that they can provide services as safely as possible and if they can be moved to virtual, they know how they can do that so they're still effective. I know a lot of sites have done wonders with setting up rooms where they can virtually connect clients and their case workers or whoever may be providing support to them, and they're happy to take appointments and set those kinds of things up.

Q: Do you have any recommendations for using nasal swabs when saliva tests are not available?

A: Yes, that's pretty much the alternative if there's no saliva test available, then the nasal swab is what clients get offered.

Q: For those who are vaccine hesitant, how do you make sure that there's not a duplication of efforts in speaking with them multiple times? How do you support those who are hesitant?

A: Touching base with a shelter manager is helpful because it's likely that they've already had these conversations, so when they're asking for additional support it's to address any of those questions or concerns. If someone's resistant or is going to get upset they're being approached

multiple times, we would let them be and let them to come around to it if they're willing. Let people know that your door's always open if they ever have questions or concerns. The sites know their clients really well and they've had multiple conversations with them before our team even steps in, so we always touch base with them first.

Q: Are you having to deal with vaccine hesitancy among shelter staff? How are you dealing with that?

A: Yes, anecdotally most sites I've been hearing about have a 50 percent uptake among staff, and the way we're dealing with it is, it's again each person's decision. We're providing shelter providers with resources and sometimes doing webinars at staff meetings. I think the uptake has been pretty good for the most part but there is definitely resistance among shelter staff as well, and I think the shelter managers and the shelter system are really trying to give them the resources and the space to make their own decision and keep that door open if they ever do want the vaccine.

Webinar recording

You can access this webinar recording on YouTube here.