



Island Health response teams mitigate impacts of COVID-19 in underhoused populations

When the COVID-19 pandemic began, we knew that robust and targeted efforts would be necessary to ensure that underserved populations on Vancouver Island received adequate support. The burden on populations who are underhoused was unique because of structural inequities and barriers to service access. By developing a dedicated multidisciplinary team, we were able to mitigate the spread of COVID-19 in communities of people who are underhoused while also building trusting relationships that will be maintained into pandemic recovery and beyond.

In response to the pandemic, we pulled together a specialized response team within Island Health whose mission was to mitigate the spread and burden of COVID-19 among our underhoused population. Our response focused on persons who were precariously housed, which includes persons experiencing homelessness, unstable temporary housing or unsafe housing. This community often faces challenges related to transiency, mental health and substance use disorders, low income, limited access

to supports and technology, structural vulnerability and stigma. Our primary goal was to lower the barriers that folks faced in accessing protective resources and health services in the new COVID-19 context, such as COVID-19 testing, isolation support, and vaccinations, while supporting everyday functioning complicated by the virus. We wanted to ensure that contact tracing could occur, and that folks could recognize when they needed to seek care and how to seek that care.

This Equity in Action story is distilled from an interview with Dr. Sandra Allison (Medical Health Officer) and Megan Klammer (Director of Special Projects) at the Vancouver Island Health Authority (Island Health). The interview took place in December 2021, and its details should be considered within the context of that time period.

Coordinated Team Structure to support community management of COVID-19 outbreaks

We set up a new “core-local” response structure with two distinct teams to respond to outbreaks. The “core” team acted as a regional hub of expert knowledge, offering guidance and support to the “local” outreach teams. The core team included two medical health officers, a communicable disease nurse specialist, an environmental health officer, an epidemiologist, analysts, a project director and a Communicable Disease Manager. This team also had access to internal researchers and ethicists.

The local outreach teams were structured as multidisciplinary community dyads (teams of two), who were deployed into communities in response to outbreaks or a cluster of cases. The local teams supported communities through outbreak management, calling on the core team if they needed additional support. This structure was advantageous for many reasons. The local teams were recognizable and accessible as point people in the community; agencies such as shelters knew who to call if they needed health personnel to help manage a situation. Beyond this, because the local teams and core teams worked closely together, even connecting daily during periods of intense case management, the core team had a regional record of all outbreak activity.

Our team repeated some key mottos during this initiative that reflected our mission. One was *Support not Enforce* – to signal that we worked in partnership with people to do their best and were not enforcing anything. Another was *Fear to Pride* – reflecting our mission to help community members and community partners feel like “we know what we’re doing, we know how to mitigate risks, we’ve got this.”

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Building partnerships within Island Health and across the system to better reach community members

Our response involved many key departments within the health authority, including primary care, mental health and substance use, and public health partners. To increase the success of the outreach teams, public health staff who had not gone out into the field before (i.e., staff who didn’t have relationships with community members) were buddied with other staff members who had existing relationships and could bridge the gap. Mental Health and Substance Use staff gained immunization competencies they hadn’t had before. Primary care staff were available for virtual consults with our field staff, and some were in outreach practice. Within our own in-house Island Health teams, we suddenly had people working together and learning about one another’s jobs in a new way – and we have seen that continue.

We also partnered with local community organizations and local peer workers to ensure that we were arriving in the community with what we call “friendly faces” from the client perspective. We would identify people who represented these friendly faces and who were known in the community, and then bring that person up to speed on our mandate, goals, and recommendations. We would work side-by-side with these folks to get our messages out to the communities and to hear what the community challenges were. We needed to work together to minimize the spread of COVID-19 and to help support people who were impacted.

When we saw “clustering activity”, a high volume of cases in certain areas, we invited a suite of community partners to daily virtual meetings to plan responses. We had municipal leaders, shelter operators, supportive housing managers, BC Housing decision makers, physicians, Indigenous organizations and local band members invited and coming together to talk about how, as a community, we could mitigate and prevent harms. Each partner brought a different lens – and we were able to work collaboratively and creatively to generate community responses that looked different each time and drew on the strengths of all partners involved.

For a few of communities, we also held larger “health and housing COVID weekly meetings” where people could ask questions. We tried to convey to folks who were attempting to manage challenges that we’re in this together, we’ll answer your questions, we’ll troubleshoot this together”. We had a lot of positive feedback about how our team was so accessible, able to answer questions in real time, and able to recruit others to help with problem solving. One community member reported that these meetings helped keep them grounded, knowing they were up to date and had a whole bunch of support on the call. We were also able to collate some of these questions and answers and share them with other communities to leverage learnings.

Adapting service delivery models to reduce barriers

In addition to collaboration across Island Health, organizational endorsement to use a different approach with this population, and to draw on outreach and inreach, was key. Outreach practice involves staff actively reaching out to people at known areas of congregation, whereas an inreach approach involves partnering with an established setting to set up regular services, such as immunizations. For folks who were able to attend mass immunization clinics, we used a password to try and reduce barriers: no appointment required, no standing in line, you just use the password at the front door, we take you to the side door and someone comes out to administer your vaccine. We recognized that not everybody has capacity to wait or go into a large group setting where they may be treated in a way that doesn’t help their relationship with health care. For folks who couldn’t attend the mass clinic, even with the password, we relied on the outreach or inreach teams and friendly faces described

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earlier to administer vaccines in all sorts of locations in the community. This occurred for testing and wellness checks as well. With the help of our partners, and people we had relationships with across the community, we were able to identify high-risk areas and employ targeted approaches.

Meaningfully supporting people by honoring where they are at

In the earlier stages of our pandemic response, we had an elaborate process for supporting individuals in isolation. We became very attuned to meeting people’s needs, for example ensuring they could access Netflix, iPads, game consoles, cannabis, alcohol – you name it. At times, our efforts were met with scrutiny related to how far we should go. We tried to ensure there was an understanding among partners about what was medically necessary and that compliance with isolation was highly correlated with folks having their needs met. We acknowledged that for folks who were housed, authorities were not dabbling in or controlling all aspects of their lives, nor would this be a sustainable model in the long run, or for the general population. Our global knowledge of the virus was still very new, and isolation was a successful strategy when people had resources to isolate.

The harm reduction approach was critical in this practice. We had to meet the population where they were at and really try to understand what they were willing and able to tolerate, what their health thresholds were, what their health literacy was, and what misinformation they had been exposed to in order to support them and provide a trusted voice. This was a key learning in our work; it was important to go back to baseline for everybody and make sure we sought to fully understand our community members at risk, within their setting, context, and existing contacts and resources, as best we could. From there, as advocates, we could explore what the right thing to do was. We are grateful that we had the latitude to go as far as we did in this initiative and, in the future, we will likely conduct after-action reviews to understand how we might do this more effectively –

with clear guidance from provincial partners around roles for all service providers. The overlap between health and social circumstances blurs even more during community wide communicable disease outbreaks.

Overcoming stigma and mistrust experienced by people who are underhoused

Stigma and a paternalistic attitude towards populations that are marginalized and underserved were significant barriers that we had to mitigate. We knew that some staff were operating from a place of fear. For example, going into a shelter, some of our staff would put on their gown, gloves and mask in the parking lot, before entering the building even though it was a multiroom hotel. Community perceptions of risk were disproportionate and stigmatized, and these behaviours could perpetuate cycles of fear. It was hard to get ahead of that sometimes and say, let's calm it down, let's review our PPE principals, and let's address the bias in our own risk perceptions and the impact it has on the client and community.

To support a population who is underhoused, we also had to address huge mistrust of the government and health care providers. People may have experienced stigma, racism or trauma in both past and recent interactions. Every interaction people have with the health care system and with other public services affects how trust is built, and that influences whether people can or want to adhere to public health recommendations. We had to acknowledge that there are very good reasons why there is skepticism and mistrust of recommendations, even if there is capacity to follow them. When we do *for* instead of do *with*, it can be traumatizing, so we had to reflect on historical practices and their impacts on people.

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To bridge this gap, we tried to determine who is connected to, and has trust with, this population that could go into the community, talk with folks, and continue building that trust. These individuals were peers, community champions, health care workers, physicians or outreach workers – it varied in every community, and it varied by individuals within sub-communities. This variation reminded us of the importance of flexible responses that can be tailored to each situation.

Envisioning a future where all communities are adequately resourced

This work highlighted the interconnectedness of systems. Many people were looking to health systems to solve everything related to COVID, and we responded that this can and should be approached at the community level, so we're going to pull together as a community. There were some communities that had things up and running within days, whereas other communities experienced exhaustion and low resources. A big takeaway from this project was that structural inequities create disparities in capacity and resources across communities. When a crisis like the COVID-19 pandemic hits, communities have differing abilities to respond. As we saw in this work, providing communities with flexible support and resources can help them come together to respond to crises in the way that they need. Moving forward, we hope to see the health system direct resources towards building community-level capacity and resilience so that communities are better equipped to respond to priority health needs in the future.

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LESSONS LEARNED:

- 1** Creating a core-local response structure that included multiple departments, disciplines and outreach teams enabled Island Health to provide flexible, tailored support to community partners to meet community needs.
- 2** Partnering with peer outreach workers, community members and organizations that have trusting relationships with people who are underhoused helped new staff to build relationships with this population. By building on these relationships, staff were able to provide services that were more accessible, appropriate and accepted (for example, offering vaccinations in the community.)
- 3** Collaboration among agencies across levels and sectors allows for comprehensive responses that leverage the skills, experience, and strengths of various players.
- 4** Communities need adequate resources and support so that they are well-positioned to address self-determined priorities. Community resiliency should be considered in equitable distribution of public health resources.

BACKGROUND

Island Health (formally known as the Vancouver Island Health Authority) provides health care and support services to more than 860,000 people on Vancouver Island, the islands in the Salish Sea and the Johnstone Strait, and mainland communities north of Powell River.

KEYWORDS

COVID-19, Access to health services, Community engagement, Intersectoral action, Housing, Substance use, Structural determinants, Stigma and discrimination

To learn more about the initiative described in this story, contact the National Collaborating Centre for Determinants of Health at nccdh@stfx.ca.

Do you have an idea for an Equity in Action story? If you have heard of other health equity-promoting COVID-19 pandemic response initiatives in Canada that we should share, please let us know.