

**A COVID – 19 testing and prevention support program for homeless and congregate living services in Toronto, Canada: assessing the feasibility of a hospital-based community-partnering Community Response Team**

**Running head:** COVID-19 Community Response Team

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## Abstract

Background: COVID-19 outbreaks in shelters are a major concern. Women's College Hospital in Toronto, Ontario developed and tested the feasibility of the COVID-19 Community Response Team (CRT), which worked in partnership with shelters, congregate living settings, and supporting organizations (SCLSASOs) to respond to and prevent COVID-19.

Methods: CRT carried out SARS-CoV-2 mobile testing and supported SCLSASOs with outbreak management and prevention through infection prevention and control (IP&C) training and implementation support. To demonstrate feasibility, we detail the work conducted with the first 32 SCLSASOs from April 20, 2020 until August 15, 2020 using descriptive statistics.

Results: CRT supported 32 sites/teams; 30 completed an intake needs assessment; 24 completed mobile testing; and 15 received IP&C support. Mobile testing efforts resulted in 1,566 nasopharyngeal swabs and of those, 64 tested positive and three SCLSASOs had confirmed outbreaks. The median time from referral to needs assessment was four days [IQR=1-13] and then to the testing day was 9 days [IQR=1-49]. The median time from referral to IP&C staff training was 14 days [IQR=4-79] and 100% reported being pleased/very pleased with the training. During the follow-up period, the three facilities in outbreak overcame their outbreaks, three CRT-supported SCLSASOs had subsequent single cases, but no site had subsequent nor secondary outbreaks.

Interpretation: A hospital-led collaborative, flexible, and comprehensive model to support SCLSASOs to manage and prevent COVID-19 outbreaks, is feasible. Collaborative supports of this type between hospitals and the community housing sector may serve as models for ongoing system integration work beyond the pandemic.

**Keywords:** COVID-19, congregate living, mobile testing, community partnership

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## INTRODUCTION

On March 11, 2020, the World Health Organization classified COVID-19 as a pandemic (1).

Within a week, the province of Ontario – home to 15 million people – declared a state of emergency (2). Ontario started seeing reduced doubling rates of infections within a month.

However, alarming trends were noted in the spread of COVID-19 among high-risk vulnerable communities where physical distancing was not possible, such as homeless and refugee shelters.. Shelters have been overcrowded for years in Toronto with a 98% occupancy rate and about 7,000 people sleeping there every night (3-6). Shelter residents have increased susceptibility to SARS-CoV-2 due to crowded congregate living and sleeping arrangements, the sharing of personal objects, limited hygiene supplies, and the closure of public washrooms (3,4). Further, shelter residents often have concurrent mental health conditions and/or substance use disorders and underlying health conditions that put them at greater risk of poor adherence to public health directives and/or health outcomes with SARS-CoV-2 infection (3,7).

In April 2020, COVID-19 surged among Toronto’s homeless with at least 135 cases over 10 days, the majority of which came from one refugee shelter (8). In response, under guidance and support from Senior Leadership, Women’s College Hospital (WCH) rapidly launched the COVID-19 Community Response Team (CRT) on April 20, 2020. This partnership with shelters, congregate living settings, and supporting organizations (SCLSASOs) was intended to prevent and respond to COVID-19 outbreaks, through a comprehensive partnership model rather than the “test and isolate” approach deployed in the general population. The CRT goals were to: 1) assist in identifying, managing and preventing COVID-19 outbreaks; 2) strengthen capacity in both knowledge and resources related to COVID-19; and 3) provide real-time infection prevention and control (IP&C) guidance. The aim of our study was to develop and test the feasibility of the

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3 CRT in preventing and responding to COVID-19 and associated outbreaks in SCLSASOs. The  
4 aims of this paper are to: 1) describe the development of CRT, as a novel model of care, and 2)  
5 describe the adoption and feasibility of and satisfaction with the program based on the first 32  
6 SCLSASOs sites/teams between April and August 15, 2020. In addition to these 32 sites, CRT  
7 collaborated with six Indigenous agencies under the guidance of Centre for Wise Practices in  
8 Indigenous Health (CWP-IH) and a self-determined evaluation project of those collaborations is  
9 underway.  
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## 19 **METHODS**

### 20 **Design and setting**

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22 WCH is the only ambulatory academic hospital in Canada. Located in Toronto, the organization  
23 is governed by the values of equity, people, collaboration, quality, and courage. In March 2020,  
24 the hospital set up one of Toronto's 14 COVID-19 Assessment Centres for evaluating and testing  
25 community members for SARS-CoV-2.  
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### 33 **Program development**

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35 In April 2020, existing partnerships with Toronto shelters for refugees and the homeless  
36 prompted the expansion of the Mobile COVID-19 Assessment Team (MCAT) from testing in  
37 long-term care facilities to include clients and staff in SCLSASOs. The deployment of MCAT to  
38 sites was done in collaboration with Toronto Public Health (TPH) and later with the regional  
39 health authority, Ontario Health (OH). In anticipation of the need for expanded IP&C training for  
40 the partnering SCLSASOs, WCH established the IP&C Community Support Squad (CSS).  
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## Program processes and procedures

Figure 1 outlines the workflow of CRT.

### *Referrals and needs assessments*

Initial referrals were from partner shelters with outbreaks. Referrals quickly expanded to come from TPH, OH or CWP-IH. Following shelter referral, CRT conducted a needs assessment virtually or in person. Shelters with *a priori* confirmed COVID-19 cases had needs assessments prioritized and conducted within 3 days of referral to CRT. The needs assessment was used to determine whether testing or IP&C support, and therefore, MCAT or CSS, services were most urgent/appropriate. In June 2020, MCAT also began surveillance testing within assigned shelters under the direction of OH and/or TPH. Prior to providing services, a WCH-developed Letter of Agreement was signed by SCLSASOs.

### *Mobile testing*

When assigned to MCAT, a five step process was employed: 1) a pre-test needs assessment and in-person site-visit to prepare for the day of testing (which could be combined); 2) the test day; 3) the immediate 24-hour post-test day when results returned; 4) the 1-2 day post-test day case management period if any tests returned positive where cases and close contacts were isolated; and 5) a 2-week follow up period of daily check-ins and screen for new symptoms warranting repeat testing.

### *IP&C training and implementation support*

SCLSASOs that did not fulfill the requirement for MCAT deployment or had already completed the MCAT process were offered CSS support. This process started with an intake regarding the facility details, their IP&C practices, and their needs. From this, a tailored package of support was offered including: 1) virtual and/or in-person staff training on COVID-19 and IP&C; 2)

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3 virtual or in-person training on COVID-19 and IP&C for clients/residents; 3) sharing of IP&C  
4 and case management tools and posters; and 4) ongoing communication and support via email  
5 and phone. CSS' training was based on IP&C guidance published by TPH, Public Health  
6 Ontario, and the Ontario Ministry of Health and Long-term Care. These materials were distilled  
7 into six IP&C principles: 1) screening [passive and active], 2) hand hygiene, 3) personal  
8 protective equipment, 4) physical distancing, 5) respiratory etiquette, and 6) cleaning and  
9 disinfecting (training material available upon request). To accommodate the influx of  
10 surveillance sites in June 2020, CSS developed a weekly webinar for community engagement  
11 and support in lieu of tailored support.  
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### 23 *Indigenous leadership and partnerships*

24 To ensure the prioritization of Indigenous peoples, CWP-IH (led by Dr. Lisa Richardson and Ms.  
25 Selena Mills) offered the third pillar of CRT. The CWP-IH aims at supporting the reclamation of  
26 Indigenous Knowledge and Governance. As seen in Figure 1, CWP-IH conducted or was present  
27 at all the initial needs assessments with Indigenous sites. They took part in MCAT's activities at  
28 all the Indigenous shelters. The CWP-IH worked to strategically ensure that Indigenous referrals  
29 and requests were continually met in a timely and culturally safe manner. Historically tenuous  
30 relationships were tended and nurtured and cultural safety training was completed by all CRT  
31 staff.  
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### 44 **Statistical analysis**

45 Descriptive analyses were conducted of data collected from the participating SCLSASOs. This  
46 included information from the needs assessments such as type of shelter, number of beds before  
47 and after COVID-19 restrictions, and number of staff, as well as number of nasopharyngeal  
48 swabs performed and their results. For CSS, information on the services chosen and if training  
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3 was chosen, the number of attendees was recorded. Facilities were called by an objective team  
4 member (CM), who was not part of the testing or training to ask questions about satisfaction.  
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6 Facilities names are not reported and data are presented in aggregate for confidentiality.  
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### 9 10 **Ethical approval**

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12 Approval from the WCH's research ethics board chair was obtained through the Assessment  
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14 Process for Quality Improvement Projects program as the project was deemed to be a program  
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16 development and evaluation project.  
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## 19 **RESULTS**

### 20 21 **Study population**

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23 From April 20 to August 15, 2020, the CRT engaged 32 SCLSASOs teams, in addition to six  
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25 Indigenous SCLSASOs teams in collaboration with CWP-IH. Of the 32 teams included in the  
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27 current analysis, 24 were first assigned to MCAT, seven to CSS, and one site was supported by  
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29 MCAT and CSS from the outset. The median time from referral to CRT to the initial needs  
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31 assessment was four days [n = 19, IQR=1-13]; from needs assessment to the testing day was 9  
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33 days [n = 25, IQR=1-49]; and from referral to CSS intake was four days [n=15, IQR=1-33] and  
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35 to CSS staff training was 14 days from referral [n=11, IQR=4-79].  
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40 Site characteristics are presented in Table 1. At 28 sites that had mobile testing  
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42 conducted, 1,566 nasopharyngeal swabs (1,189 among clients and 377 among staff) were carried  
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44 out and of those, 64 tested positive and three sites were classified as outbreaks (i.e., two or more  
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46 positive cases) (9) as a result of testing (Table 1). One site had a pre-existing outbreak that  
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48 initiated the testing process. The median number of swabs performed per testing day was 38  
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50 [n=28, range=7-153]; 33 (range=6 -135) among clients and 11 (range=0-41) among staff. The  
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52 positivity rate was low except for a few sites (Table 1&2). Table 2 provides the details of each  
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3 facility. During the follow-up period, all facilities overcame their outbreaks, and three facilities  
4 did have subsequent single positive cases, which resulted in repeat testing by MCAT or another  
5 mobile testing team. Additionally, one site (F19) had testing repeated by MCAT due to the high  
6 positivity rate at the initial testing.  
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12 CSS carried out 15 in-depth intakes and supported all 15 SCLSASOs teams in IP&C  
13 training. Table 1 provides information on the services facilities requested and which services  
14 were ultimately provided by CSS. In total, CSS conducted virtual staff training sessions for 11  
15 SCLSASOs, four in-person training sessions, including walk-throughs, one virtual client  
16 education session, and sent documents to 14 SCLSASOs. When asked, of the facilities that  
17 responded, 100% of facilities changed at least two IP&C practices after the CSS training and  
18 80% changed >2.  
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28 Table 3 summarizes the satisfaction of the facilities with the CRT's service. All (n=24;  
29 100%) were pleased or very pleased with MCAT's services and 100% (n=15) were pleased or  
30 very pleased with CSS' services. All (n=24; 100%) agreed or strongly agreed that MCAT met  
31 their needs and 100% (n=15) agreed or strongly agreed that CSS met their needs. All (n=24;  
32 100%) agreed or strongly agreed that they would recommend MCAT's services and 100%  
33 (n=15) agreed or strongly agreed that they would recommend CSS' services.  
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## 42 INTERPRETATION

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44 Between April and August 2020, CRT engaged with 32 SCLSASOs across Toronto and an  
45 additional six Indigenous-specific sites, ranging from shelters to drop-in service providers.  
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48 Through this hospital-community partnership, onsite mobile testing resulted in 1,566  
49 nasopharyngeal swabs and of those, 64 tested positive. Comprehensive IP&C training and  
50 support followed testing events as part of the community-responsive wrap-around service. The  
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3 efficacy of this model in supporting SCLSASOs' prevention needs during Wave 1 of the  
4 COVID-19 pandemic was demonstrated by the high level of satisfaction and uptake of CRT  
5 recommendations. The use of virtual and in-person strategies was deemed ideal early in the  
6 pandemic, but such innovations required ongoing appraisal to identify strengths and challenges.  
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8 The current results demonstrate the feasibility of our hospital-community partnering COVID-19  
9 response.

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12 The containment of COVID-19 spread through optimized IP&C, including early  
13 detection of outbreaks, has presented unique challenges in congregate living. And while the  
14 urgent need to address these challenges was identified early last year, the current re-emergence  
15 of COVID-19 cases in SCLSASOs suggests ongoing innovation and long-term support are  
16 essential. The CRT project efficiently completed mobile testing to SCLSASOs. The high number  
17 of tests completed are the result of the testing occurring onsite in shelters. Other jurisdictions,  
18 such as South Korea, were early to identify the need for mobile testing models (10). Mobile, or  
19 onsite mass testing, was also successfully implemented in workplaces and other types of  
20 congregate living facilities, such as treatment facilities and long-term care homes, with high  
21 uptake and efficacy in mitigating outbreaks (11–13). CRT learnings suggest that there is  
22 immeasurable value in preparatory engagement activities with the sites to create a testing model  
23 and establish support delivery that was responsive to each site.

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26 The CRT approach offers some generalizable lessons is the wrap-around and ongoing  
27 IP&C support that was made available to SCLSASOs. Other Toronto hospitals offered IP&C  
28 training sessions to sites where mobile testing was conducted; however, they were limited to  
29 single sessions. With over 80% of teams changing more than two IP&C practices after the  
30 training, it is evident that CSS offered support that was previously absent in the municipal and  
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3 provincial SCLSASOs system. The tailoring of this support was furthered by the collaborative  
4 relationship between CSS and MCAT, through which colleagues were briefed regarding  
5 relationships and their practices in advance of referral to one another.  
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10 Due to the rapid roll out of CRT, frequent adaption was needed. A developmental  
11 approach was used to ensure that the program could pivot to meet the evolving needs of the  
12 pandemic. CRT's ability to maintain a nimble approach to adaptation was facilitated by  
13 expectations that needs would rapidly shift and leaders were selected with this in mind. This is  
14 consistent with an "adaptive leadership" style, which was employed by other WCH's COVID-19  
15 innovations such as CovidCare@Home (14). Notably, the CRT team adeptly responded to these  
16 changes without affecting service quality.  
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26 As the COVID-19 pandemic continues into 2021, future research continuing to explore  
27 the ongoing needs of SCLSASOs will be needed. SCLSASOs continue to face challenges in  
28 supporting clients who have various comorbidities and mental health needs, and often resist to  
29 COVID-19-related policies, such as mask wearing (3,15). With the influx of service users living  
30 in harsher settings, such as within encampments, and the overall implications of reduced bed  
31 capacities, the needs will continue to change and SCLSASOs will require support. Given  
32 changes to WCH's COVID-19 responsibilities, we are unable to comment on the long-term  
33 sustainability and adaptations of CRT as in September 2020, CRT was transitioned to a  
34 partnering community health centre.  
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46 This study has several limitations. Owing to the rapid implementation of CRT, several  
47 pieces of data were not captured. For example, referral dates and number of participants in  
48 trainings were not always recorded. The median intervals reported between referral and CRT  
49 needs assessment, and testing may not fully reflect the nuanced way referrals were triaged when  
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3 urgent. Additional nuances related to the interactions between the various CRT pillars and the  
4 detailed partnering relationships with SCLSASOs were not feasible within this publication.  
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6 Understanding these interactions would be valuable in establishing a similar program and in  
7 explicating why certain activities, such as testing and delivery of IP&C support, were delayed.  
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9 The current description does not include the perspectives of our Indigenous partners.  
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11 Nonetheless, the integration of the Indigenous lens and Indigenous cultural safety training and  
12 considerations from the outset, led by CWP-IH, were essential for CRT's success. Another  
13 strength of CRT was community partnerships, which emerged through listening to the  
14 SCLSASOs needs, tailoring the program to those needs, and most of all through meaningful  
15 relationship-building.  
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## 26 **CONCLUSION**

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28 While COVID-19 continues to impact SCLSASOs, it appears that supportive partnering  
29 prevention programs to mitigate outbreaks and their impacts are beneficial. SCLSASOs are  
30 historically an under-resourced, even under-valued at times, yet integral fibre in the fabric of  
31 society in Canada. They play an important service that contribute the Canadian values of equity,  
32 care, and social responsibility. Without adequate support that was responsive to the unique  
33 needs of SCLSASOs, this vital aspect of our social safety net was in peril in March 2020. The  
34 success of CRT in bolstering the leadership within SCLSASOs is a critical example of how  
35 hospital-community partnerships are possible and essential to handling public health issues such  
36 as the containment of COVID-19 among societies most vulnerable.  
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**Table I.** Description of the first 32 shelters, congregate living settings, and supporting organizations supported by the COVID-19 Community Response Team

<b>Facility or service characteristic</b>	
<b>Characteristic of facility</b>	
<b>Type of facility, n (%) (select all that apply)</b>	
Shelter	26 (81.3%)
Rooming house	1 (3.15%)
Drop-in centre	1 (3.1%)
Other*	9 (28.1 %)
<b>Facility speciality, n (%) (select all that apply)</b>	
Women	8 (2.5%)
Refugee	4 (12.5%)
Low barrier**	3 (9.4%)
Other***	19 (59.4%)
None reported	2 (6.3%)
<b>Resident and staff numbers and capacity</b>	
Resident capacity prior to COVID-19, median (range)	70 (0-300)
Resident capacity since COVID-19, median (range)	36 (0-300)
Current number of residents, median n & % (range)	36 [100%] (0-300)
Number of staff prior to COVID-19, median (range)	25 (0-129)
Number of staff since COVID-19, median (range)	24.5 (1-200)
<b>Room occupancy type for residents, n (%)</b>	
Shared rooms****	16 (50%)
Single rooms	12 (37.5%)
<b>IP&amp;C measures in place, n (%)</b>	
Facilities had IP&C policies prior to COVID-19	20 (62.5%)
Facilities changed IP&C policies since COVID-19	25 (78.1%)
Facilities had adequate hand sanitizer, soap, tissues, lined garbage cans, and no touch garbage cans at the time of needs assessment	25 (78.1%)

Facilities had adequate supplies of PPE at the time of needs assessment	20 (62.5%)
<b>Team that provided services, n (%)</b>	
MCAT only	17 (53%)
CSS only	4 (1.3%)
MCAT followed by CSS	7 (21.8%)
CSS followed by MCAT	4 (1.3%)
<b>Mobile testing information provided by MCAT</b>	
Facilities that underwent mobile testing, n (%)	28 (87.5%)
<b>Number of swabs conducted</b>	
Number of total swabs conducted on clients/residents per site, median (range)	33 (6-135)
Number of swabs conducted on staff per site, median (range)	11 (0-41)
Number of sites with positive resident swabs, n (%)	9 (28.1%)
Number of residents with positive swabs at those positive sites, median (range)	1 (1-26)
Number of sites with positive staff swabs, n (%)	2 (6.3%)
Number of staff with positive swabs at those positive sites, median (range)	1.5 (1-2)
<b>IP&amp;C support information provided by CSS</b>	
Number of facilities that declined IP&C support	1
<b>CSS services facility interested in, n (%)</b>	
Staff education on COVID-19 & IP&C principles	12 (80%)
Resident education on COVID-19 & prevention principles	4 (27%)
CSS curated documents and resources	9 (60%)
Answering questions on IP&C and COVID-19 via email and/or phone	8 (53%)
Links to other resources	3 (20%)
Others^	6 (40%)

<b>CSS services provided, n (%)</b>	
Staff education training presentation	13 (87%)
Resident education presentation	1 (7%)
Median number of attendees at training and/or education sessions (range)	9.5 (2 – 36)
For staff	7 (N/A)
For residents	7 (N/A)
CSS curated documents and resources (including googledrive resources)	14 (93%)
Presentation	9 (60%)
Other^^	5 (33%)
<b>Change in IP&amp;C practice based on the training and/or interaction with the CSS, n (%)</b>	
0 change	0
1 change	0
2 changes	2
> 2 changes	12
Unknown	1

IP&C, infection prevention and control; MCAT, Mobile COVID-19 Assessment Team; CSS, Community Support Squad.

\***Type of facility, specify other responses included:** respite, supportive housing, mixed model housing, recovery centre for homeless and underhoused individuals, support service teams (i.e. mobile outreach), and satellite for physical distancing

\*\***Facility specialty, low barrier** facilities work to remove as many ‘exclusion criteria’ to entry as possible and seek to support the needs and realities of any individual seeking shelter

\*\*\* **Facility specialty, specify other responses included:** pet friendly, human reduction, violence against women, co-ed, men only, long-term stay, high needs individuals, and intake.

\*\*\*\* **Room occupancy type for residents** responses were based on all occupancy types within the facility.

Ongoing use of shared rooms depended on the specific facility (i.e. dormitory style shelters continued to use shared rooms while shelters with the ability to convert to single rooms had done so to optimize physical distancing)

^ **CSS services facility interested in, specify other responses included:** IP&C audit, tailored training sessions, external documents and resources, and training videos for staff

^^ **CSS services provided, specify other responses included:** medical education, videos, signage, IP&C audits

**Table II.** Detailed information for each shelter, congregate living setting, and supporting organization supported by the COVID-19 Community Response Team

ID	Type	Specialty Characteristic	Capacity prior to COVID-19	Current Capacity	MCAT (y vs. n)	Total COVID-19 swabs by MCAT	No. of positive swabs	CSS services provided (y v. n)	Staff training (y vs. n) Virtual (V), In-person (I), Both (B)	CSS staff training (y vs. n)	CSS materials sent (y vs. n)
F1	Shelter	N/A	32	25	Y	44	1	Y	Y B	N	Y
F2	Shelter	Women; Low barrier; Other (Pet-friendly; harm reduction)	55	45	Y	25 & 45	0 & 0	Y	Y V	N	Y
F3	Other (Supportive Housing)	Low Barrier	88	88	Y	62	0	Y	N	N	Y
F4	Shelter; Other (Respite)	Women	30	20	Y	14 & 15	0 & 0	Y	Y V	N	Y
F5	Shelter; Other (Mixed Housing)	Women	140+	72	Y	37	0	Y	Y V	N	Y
F6	Shelter	Other (Violence against women)	24	15	Y	21	0	Y	Y V	N	Y
F7	Shelter	Other (Violence against women)	9 rooms	6 rooms	N	-*	-	Y	Y V	Y	Y
F8	Other (Supportive Housing/Mixed Housing)	Women	300	300	N	N/A	N/A	Y	Y V	N	Y
F9	Rooming House	Other (High needs individuals)	30	25	Y	30	0	Y	Y I	N	Y
F10	Shelter	Women	103	80	Y	64	15	Y	Y V	N	Y

F11	Shelter	Low Barrier	60	80	Y	80	0	Y	N	N	Y
F13	Other (Drop-In)	N/A	N/A	N/A	N	N/A	N/A	Y	Y B	N/A	N
F14	Shelter	Other (Respite)	50	25	Y	59	1	N	N/A	N/A	N/A
F15	Shelter	Refugee	-	-	Y	101	26	N	N/A	N/A	N/A
F16	Other (Recovery site)	N/A	0	0	Y	39	0	N	N/A	N/A	N/A
F17	Shelter	Other (Intake)	40	31	Y	35	0	Y	Y I	N	Y
F18	Shelter	Other (Men; Long-term stay)	72	36	Y	35	1	Y	Y V	N	Y
F19	Shelter	Other (Co-ed; Couples)	275	150	Y	141 & 67	15 & 0	N	N/A	N/A	N/A
F20	Shelter	Women; Other (Pet-friendly)	122 +10	55	Y	49	0	N	N/A	N/A	N/A
F21	Shelter	Other (Men; Satellite site for physical distancing)	NA	62	Y	38	1	N	N/A	N/A	N/A
F22	Shelter	Refugee; Other (Men; Families)	18	13	Y	21	0	N	N/A	N/A	N/A
F23	Shelter	Other (Men)	105	61	Y	46	0	N	N/A	N/A	N/A
F24	Shelter	Women	7	7	Y	7	0	N	N/A	N/A	N/A
F25	Shelter; Other (Satellite for physical distancing)	Women	70	72	Y	33	0	N	N/A	N/A	N/A
F26	Shelter	Refugee	-	-	Y	153	1	N	N/A	N/A	N/A
F27	Other (Support service team)	Women	N/A	N/A	N	-	-	Y	Y V	N	Y
F28	Shelter	Women	40	26	Y	27	0	N	N/A	N/A	N/A
F29	Shelter	Refugee	74	35-40	Y	50	0	N	N/A	N/A	N/A
F30	Shelter	Other	82	36	Y	36	1	N	N/A	N/A	N/A
F31	Shelter	Other	42	18	Y	23	0	N	N/A	N/A	N/A
F32	Shelter; Other	Other	0	42	Y	44	0	N	N/A	N/A	N/A

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F34	Shelter	Other	100	50	Y	32	1	N	N/A	N/A	N/A
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MCAT, Mobile COVID-19 Assessment Team; CSS, Community Support Squad.

\* Dash (-) indicates missing data

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**Table III.** Satisfaction of the first 32 shelters, congregate living settings, and supporting organizations with the COVID-19 Community Response Team

<b>Characteristic</b>	<b>Number of facilities, n (%)</b>
<b>MCAT Service Satisfaction</b>	
<b>Organizations' satisfaction with MCAT's service</b>	
Not very pleased	0
Not pleased	0
Neutral	0
Pleased	1
Very pleased	23
<b>MCAT met organizations' needs</b>	
Strongly agree	19
Agree	5
Neutral	0
Disagree	0
Strongly disagree	0
<b>Would recommend MCAT services to other organizations</b>	
Strongly agree	21
Agree	3
Neutral	0
Disagree	0
Strongly disagree	0
<b>CSS Service Satisfaction</b>	
<b>Organizations' satisfaction with CSS service</b>	
Not very pleased	0
Not pleased	0
Neutral	0
Pleased	1
Very pleased	14

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<b>CSS met organizations' needs</b>	
Strongly agree	13
Agree	2
Neutral	0
Disagree	0
Strongly disagree	0
<b>Would recommend CS services to other organizations</b>	
Strongly agree	15
Agree	0
Neutral	0
Disagree	0
Strongly disagree	0

MCAT, Mobile COVID-19 Assessment Team; CSS, Community Support Squad.

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## Figure Legends

### **Figure 1:** COVID-19 Community Response Team (CRT) workflow.

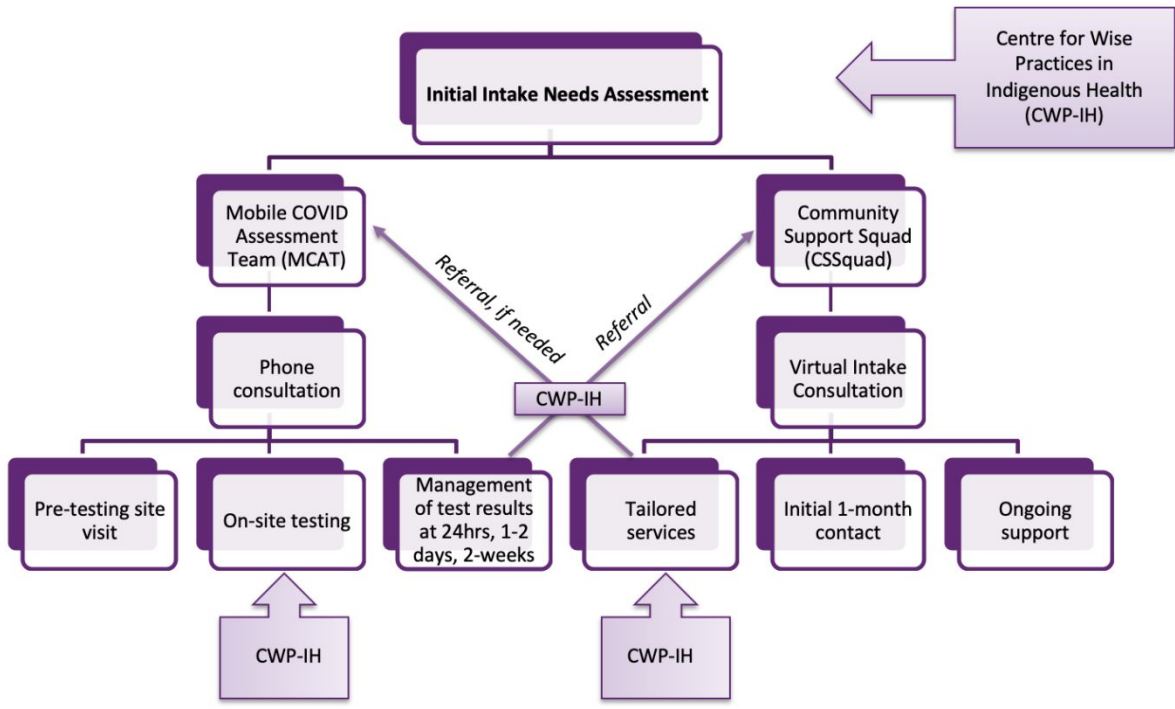
CRT's workflow and its three components: i) the Centre for Wise Practices in Indigenous Health (CWP-IH), ii) the Mobile COVID-19 Assessment Team (MCAT), and iii) the Infection Prevention and Control (IP&C) Community Support Squad (CSS). CRT employed an evolving, iterative process whereby sites were referred back and forth between CRT's three components based on need. Referrals were triaged centrally through a standardized intake needs assessment. Daily communication between MCAT and CSS Project Managers was essential to ensure the effective workflow with monthly communication with CWP-IH leadership.

### **Figure 2:** Site infection prevention and control (IP&C) training requests from the COVID-19 Community Support Squad (CSS).

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Figure 1



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FIGURE 2.

