COVID-19 Isolation and Recovery Sites Evaluation

A MARCO Report

December 17, 2021

MAP Centre for Urban Health Solutions
UNITY HEALTH TORONTO
UNIVERSITY OF TORONTO

About the MARCO Study

The MARCO project is evaluating how local efforts responding to the COVID-19 pandemic serve people experiencing marginalization, and how these interventions can be improved. Changes in society to control the pandemic have affected everyone, but they place a particularly heavy burden on people who are marginalized.

About this Report

This is a MARCO Evaluation report. This report highlights the key findings from the evaluation of the COVID-19 Isolation and Recovery Site. The views contained in this report do not necessarily express the views of any MARCO community partner, funding agencies, MAP, St. Michael's Hospital, Unity Health Toronto, the University of Toronto, or any other organization with which MARCO authors or project team members may be affiliated.

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Land Acknowledgement

We acknowledge the sacred land on which MAP and Unity Health Toronto operate. It has been a site of human activity for 15,000 years. This land is the territory of the Huron-Wendat and Petun First Nations, the Seneca, and most recently, the Mississaugas of the Credit First Nation. The territory was the subject of the Dish With One Spoon Wampum Belt Covenant, an agreement between the Iroquois Confederacy and Confederacy of the Ojibwe and allied nations to peaceably share and care for the resources around the Great Lakes. Today, the meeting place of Toronto is still the home of many Indigenous people from across Turtle Island and we are grateful to have the opportunity to work in the community, on this territory. We are also mindful of broken covenants and the need to strive to make right with all our relations.

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What was evaluated?

The Government of Ontario declared a state of emergency in March 2020, requiring people to isolate from others if they tested positive for COVID-19 or were in close contact with someone that tested positive for COVID-19. The City of Toronto, in partnership with several organizations, opened COVID-19 Isolation and Recovery Sites (CIRS) in response to the need for supported isolation spaces for people experiencing homelessness. CIRS provided an isolation space for people experiencing homelessness who had tested positive for COVID-19, were waiting for their COVID -19 test results, or had close contacts with someone who tested positive.

Over the course of the pandemic, three CIRS were opened in Toronto; one in Scarborough located in the east, one centrally located Downtown, and one in Etobicoke, located in the north west of the city. Each CIRS had a distinct structure and character, but all CIRS provided clients with a private room for 24 hours to 14 days as well as supports and services delivered by staff from several partner organizations that included peer workers, harm reduction workers, nurses, physicians, and shelter staff.

As a team of academic researchers and community partners, we conducted an evaluation to answer questions: How did the CIRS model develop? What are the defining characteristics of the CIRS in terms of structures, services and decision making? Who was involved and what were their roles? How did the model influence staff and client experiences? We focused on two models, which we characterized as a "medical model" and a "community model." Within the CIRS, the medical model emphasizes the effects of the COVID-19 virus on physical health as well as health concerns related to issues such as substance use while the "community model" considers health and wellbeing within the context of socioeconomic factors such as poverty and systemic racism. We conducted qualitative interviews with 43 individuals from the following 5 groups: 1) Nurses and Physicians, 2) Peers and Harm Reduction workers, 3) Executive Leads, 4) Operational leads and 5) Funders and Decision Makers. Through hypothesis coding and thematic analysis, we identified key themes and recommendations for moving forward.

What were the key findings?

Relationships between CIRS partner organizations shifted from being somewhat hierarchical to becoming more collaborative by establishing trust, creating space for open communication between partners, and vocalizing and recognizing power imbalances over time. The CIRS represented a confluence of clinical and community perspectives as the partner organizations brought their own values and ways of working to the executive table. There was consensus from participants around the complexity of decision making for the CIRS, particularly when there was a lot of uncertainty about the dynamics of the pandemic. Leadership structures changed over time to address power differentials. Important considerations at the CIRS included having the flexibility to adapt to frequent changes to pandemic policies and procedures. Consequently, participants shared how communication across and between teams was essential for CIRS to function optimally but the volume of communication was sometimes

overwhelming. When communication worked well, the CIRS created a space where information was shared across teams and views from all workers could be incorporated into decision making.

The CIRS prioritized client independence and dignity. Staff at the sites provided clients with non-judgmental, compassionate care and holistic supports, in addition to basic health and shelter support. Peer and harm reduction workers built relationships with clients by providing emotional supports and wellness checks, which facilitated client comfort during an often challenging time in isolation.

The CIRS were a unique and new service model. Participants noted that the CIRS offer a model for thinking about the kinds of supports that would allow people experiencing homelessness who have complex needs to live in shelter sites. Key to this model are clinical case management, harm reduction services, strong peer support, and adequate and consistent funding.

There was a strong consensus among our study participants that the CIRS were a highly successful and critical component of the pandemic response that have important lessons for the post-pandemic period. The CIRS can serve as a case study for greater integration of services for people experiencing homelessness. A successfully integrated model will need to address power imbalances and hierarchies through formal agreements and processes as well as establishing collaborative cultures. Also, future models must ensure that peers workers have strong workplace protections and adequate representation in decision making. The CIRS offer an important opportunity to rethink shelter settings. Such change will require a strong vision, sufficient funding, political will, and accountability amongst all stakeholders.

What are the recommendations moving forward?

Partnerships need to be inclusive and transparent, with clearly defined roles. Decision making structures need to be collaborative, innovative, and flexible. Addressing power imbalances requires written agreements, attention to how partners control budgets, and processes that encourage ongoing reflection and correction through open communication.

The complex needs of people experiencing marginalization are best met by moving away from siloed, biomedical approaches towards integrated models that are client-centred. Careful selection of all staff members is critical for developing relationships between workers who interact directly with clients in which information is shared openly and effectively.

Projects in which teams work together in integrated models of care for people experiencing marginalization should pay close attention to who gets to be a leader and how to share leadership. Important aspects of leadership include collaborative decision making, effective and open communication, and opportunities for workers to voice concerns. Leaders need to make sure that their decisions have real benefits for clients and for people working directly with clients. Leadership accountability structures should be established early in the implementation of integrated care models. Decision making should be nimble and responsive.

Peer workers or people with lived experience should be involved in providing care for people experiencing marginalization in a wide range of health and social care settings and this involvement is likely to have significant and direct benefits for clients. Peer workers' expertise should be recognized and valued by people in leadership positions. Representatives of peer workers should be included at all levels of decision making, including the most senior. Peer workers positions should have stable funding and workplaces should support peer workers to do their work effectively.

The CIRS underscore the importance of having strong emergency preparedness plans in place for people experiencing homelessness and other aspects of marginalization. Future emergency plans

for sheltering people who are experiencing homelessness should consider both public health needs (such as infection prevention and control procedures and availability of personal protective equipment) as well as clients' needs (such as a space for cigarette smoking and supports for people who use drugs).

Funding for integrated service models should be determined by considering the objectives of the models and the resources required to meet these objectives. Funding for workers who interact directly with clients should be prioritized. Funding should also be flexible, recognizing that clients' needs and client volumes and corresponding service delivery models will necessarily evolve over time.

Community groups, health groups, and governments should come together to develop and evaluate new models for shelter and housing support based on lessons from the CIRS. The models should incorporate a full set of coordinated services for clients, include mechanisms for reporting regularly on their outcomes, and have established accountability for all partners. Governments should make sure these new models are adequately funded to meet their objectives.

Introduction

In March 2020, the government of Ontario declared a state of emergency due to the COVID-19 pandemic, which included a directive for people to isolate from others if they tested positive for COVID-19 or were in close contact with someone that tested positive to COVID-19. This requirement for isolation posed distinct challenges for people experiencing homelessness, especially people who were staying in congregate settings such as shelters. The City of Toronto, in partnership with several organizations opened COVID-19 Isolation and Recovery Sites (CIRS) in the spring of 2020, in response to the need for supported isolation spaces for people experiencing homelessness. CIRS provided an isolation space for people experiencing homelessness who were affected by COVID-19. Many shelters in Toronto experienced outbreaks during the pandemic, including shelters that serve specific populations, such as newcomers and refugees to Canada.[1,2]

Over the course of the pandemic, three CIRS were opened in Toronto – one each in Scarborough, Downtown, and Etobicoke (Figure 1). In total, 197 unique clients were admitted to the Downtown site, with a median number of clients each day of 25 (Interquartile range [IQR] 20 to 42). The total number of unique admissions to Scarborough was 225; the median number of clients each day was 20 (IQR 10 to 32). From April 7, 2020 to December 12, 2021, the Etobicoke site admitted 1167 patients with confirmed COVID-19 infection and 1164 for isolation; the median number of clients each day was 41 (IQR 13 to 87)(personal communication, Inner City Health Associates). Each CIRS had a distinct structure and character. For example, the Scarborough CIRS was a shelter/motel operated by the City of Toronto, and had fewer supports and

The MARCO Programs

MARCO was started in the early days of the COVID-19 pandemic by academic investigators, community investigators, and partner organizations working directly with people experiencing marginalization. Community investigators included people with lived experiences of marginalization, staff or leaders of community agencies, and people from advocacy organizations. We hosted a publicly available online survey to identify programs for evaluation. We considered a broad range of programs, interventions, and policies; these were not restricted to programs from MARCO partner organizations. A sub-committee of community and academic investigators selected programs based on: the potential for the research findings to have an impact on people experiencing marginalization; the need for the evaluation, the current well-being of the population being served by the program; and the feasibility of completing the evaluation within the available time and resources.

The MARCO programs are:

- COVID-19 Isolation and Recovery Sites for people experiencing homelessness
- Substance Use Services at a COVID-19 Isolation and Recovery Site
- Evaluation of Outreach Supports for People Experiencing Homelessness in Toronto Encampments During COVID-19
- Toronto Developmental Service Alliance's Sector Pandemic Planning Initiative
- Adapting the Violence Against Women Systems Response to the COVID-19 Pandemic

services than at other CIRS. The Etobicoke and Downtown sites operated as formal UHN Hospital Facilities, which was permitted under the Emergency Management and Civil Protections Act during the Declaration of Emergency, until July 2021, at which time the sites came under the operation of the City of Toronto (the Etobicoke site still operates as a CIRS, although with a modified structure, while the Downtown site operates as a shelter).

The CIRS were not the only model considered. Early in the pandemic, a large, open, congregate respite site for people experiencing homelessness was proposed, with funding from the provincial Ministry of Health. These plans were shelved following consultations with community members, experts in design, and a medical relief organization, which suggested that the site did not provide dignified care, privacy, recreational areas, social areas, and outdoor access and would require extensive retrofitting to address these concerns.[3] However, the costs for these changes as well as building upgrades (such as lighting) were considered too expensive. The partner organizations proceeded to open the CIRS sites, which aligned with the City of Toronto's strategy of using hotels, albeit with the same funding for staff that was initially allocated for the congregate site.

Clients were eligible to stay at a CIRS if they had tested positive for COVID-19, were waiting for their COVID-19 test results, or had close contacts with someone who tested positive. The CIRS provided clients with a private room for 24 hours to 14 days as well as supports and services throughout their stay. The CIRS offered integrated health and social services delivered by staff from several partner organizations. Staff at the CIRS included peer workers, harm reduction workers, nurses, physicians, and shelter staff. Workers were grouped into teams by their roles and each team had an assigned leader. Services at the CIRS included a range of harm reduction services. The Etobicoke and Downtown CIRS included an onsite overdose prevention site (a room where people could use substances, primarily by injection, under the supervision of trained staff).

A Community-Based Study

MARCO included community-based investigators, many with lived experience, as full partners. The MARCO Community Committee has representatives from 11 community agencies, representing a broad spectrum of organizations. MARCO's steering committee includes both academic and community-based investigators. Each program evaluation team included at least 1 community investigator and hired people with lived experience as peer researchers. Across MARCO, researchers with lived experiences of marginalization were involved in all aspects of the study, from recruitment and interviewing participants to data coding and interpretation.

Peer workers provided emotional supports to clients through regular check-ins, delivered snacks and cigarettes, and accompanied clients on outdoor breaks. Most peer workers were people with lived experience of homelessness, substance use, or mental health issues. Some peer workers had lived experience of living as a refugee. Peers had more frequent contact with CIRS clients than other workers. Harm reduction workers participated in client intake and discharge, worked at the overdose prevention room at the site, and were available to witness drug use in clients' rooms.

The funding mechanisms were different at each CIRS. At Scarborough, the City of Toronto provided funds to run the site when it first opened. Soon after, the City of Toronto, Inner City Health Associates (ICHA), the Neighbourhood Group Community Services (TNG) and the Inner City Family Health Team (ICFHT) reached a funding agreement to fund physician time, nursing and peer support at the site. At the Etobicoke and Downtown sites, funding flowed from Ontario Health to the University Health Network (UHN) to the partner organizations. ICHA had oversight for the budget for doctors and nurses and released funds to The Neighbourhood Group, who had budgetary oversight for peers. Parkdale Queen

West Community Health Centre received funding separately from the Ministry of Health and had budgetary oversight for harm reduction workers. The City of Toronto provided funding for shelter support, housekeeping, building costs, and security.

The Etobicoke and Downtown sites operated as formal UHN Hospital Facilities, which was permitted under the Emergency Management and Civil Protections Act during the Declaration of Emergency, until July 2021. After July 2021, the two sites shifted to being under the operation of the City of Toronto as SSHA shelter sites rather than UHN hospital facilities. Currently, the Etobicoke site still operates as a CIRS, although with a modified structure, while the Downtown site operates as a shelter.

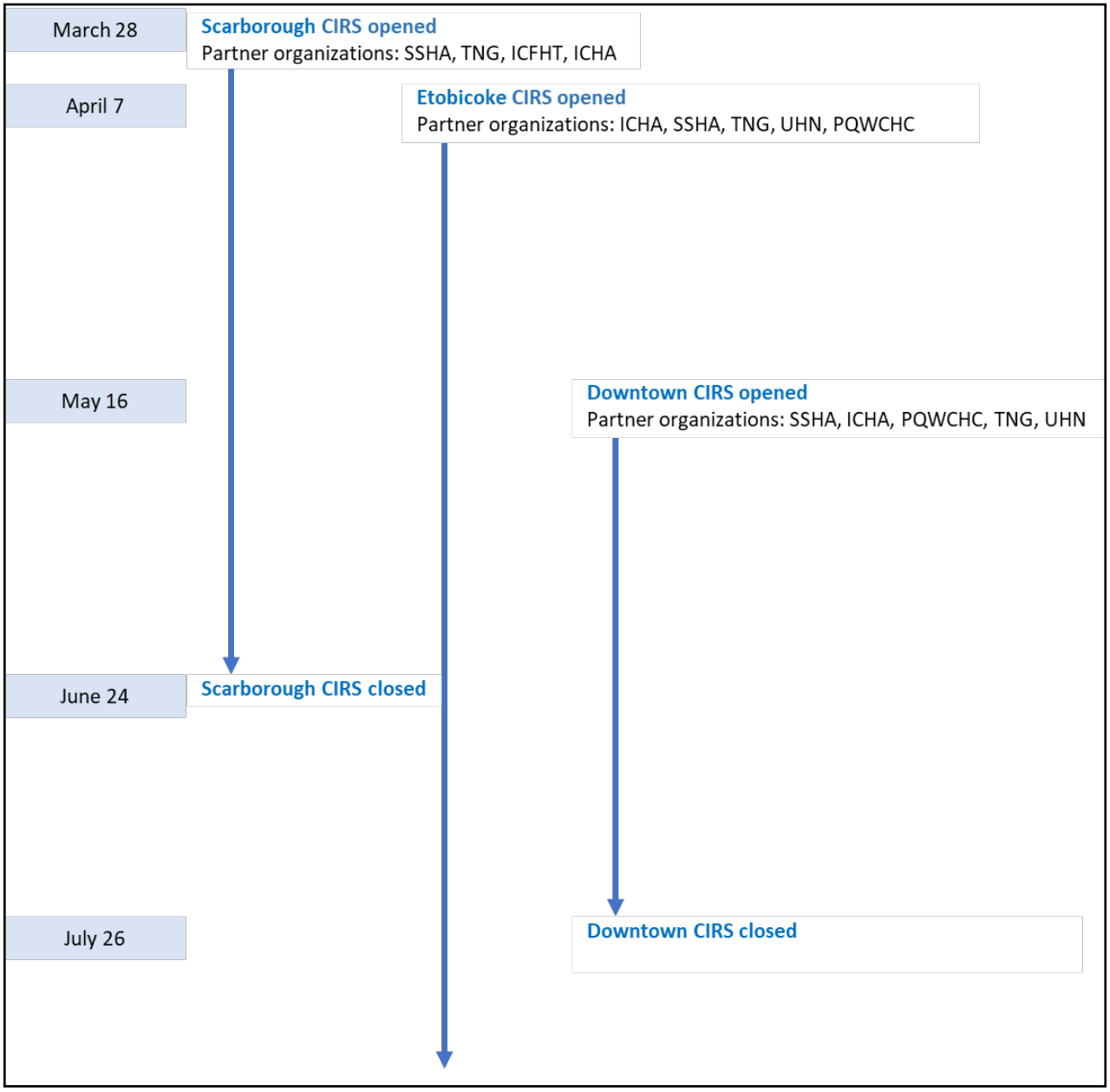

Figure 1 Timeline of COVID-19 Isolation and Recovery Sites in Toronto

All dates are in 2020. The Etobicoke CIRS remains open as of December 2021.
SSHA: City of Toronto Social Services and Housing Administration. TNG: The Neighbourhood Group Community Services. ICFHT: Inner City Family Health Team. UHN: University Health Network. PQWCHC: Parkdale Queen West Community Health Centre

Logic model

We built a logic model for the CIRS to guide our evaluation. Logic models are visual diagrams of a program or intervention that depict the theory of change.[4] A theory of change describes what makes the program work. We facilitated two focus groups to build the logic model. Attendees included workers from the CIRS (operational leads, nurses, physicians or executive leads who worked in at least one of the CIRS), academic and community investigators, and members of the MARCO Community Committee. The first focus group had 11 attendees and the second focus group had 6 attendees.

The logic model guided our evaluation to focus on the models of care within the COVID-19 Isolation and Recovery Sites (Figure 2). We focused on two models, which we characterized as a "medical model" and a "community model." The "medical model" is an approach to care that focuses on disease and physical issues. Within the CIRS, the medical model emphasizes the effects of the COVID -19 virus on physical health as well as health concerns related to issues such as substance use; in general, these issues are conceptualized using clinical approaches, such as addressing substance use through addiction medicine, and focused on individualized care. The "community model" or social service model is an approach to care that considers health and wellbeing within the context of socioeconomic factors such as poverty and systemic racism. Substance use, for example, is not seen as an addiction but as a social issue. Note that our definition of model refers to the approach to caring for clients and the underlying ideas about how to address health and social issues. This definition is distinct from the organizational structure or considerations of which agency had ultimate authority for operating a site or oversight for a site's budget.

Medical and community models not only have differing approaches to care, they also have distinct approaches to organizational structure and decision making. Although both have embedded hierarchies, the community model may be more flexible with more opportunities for dialogue and relationship building between the senior leadership and staff working directly with clients.

Our evaluation

This evaluation explored how the models of care at the CIRS influenced the structure of the programs and services and the decision-making at the site. Our report includes experiences at the sites from the date each was opened until they closed or until the first half of 2021. Specifically, we were interested in answering questions about: How did the CIRS model develop? What are the defining characteristics of the CIRS in terms of structures, services and decision making? Who was involved and what were their roles? How did the model influence staff and client experiences?

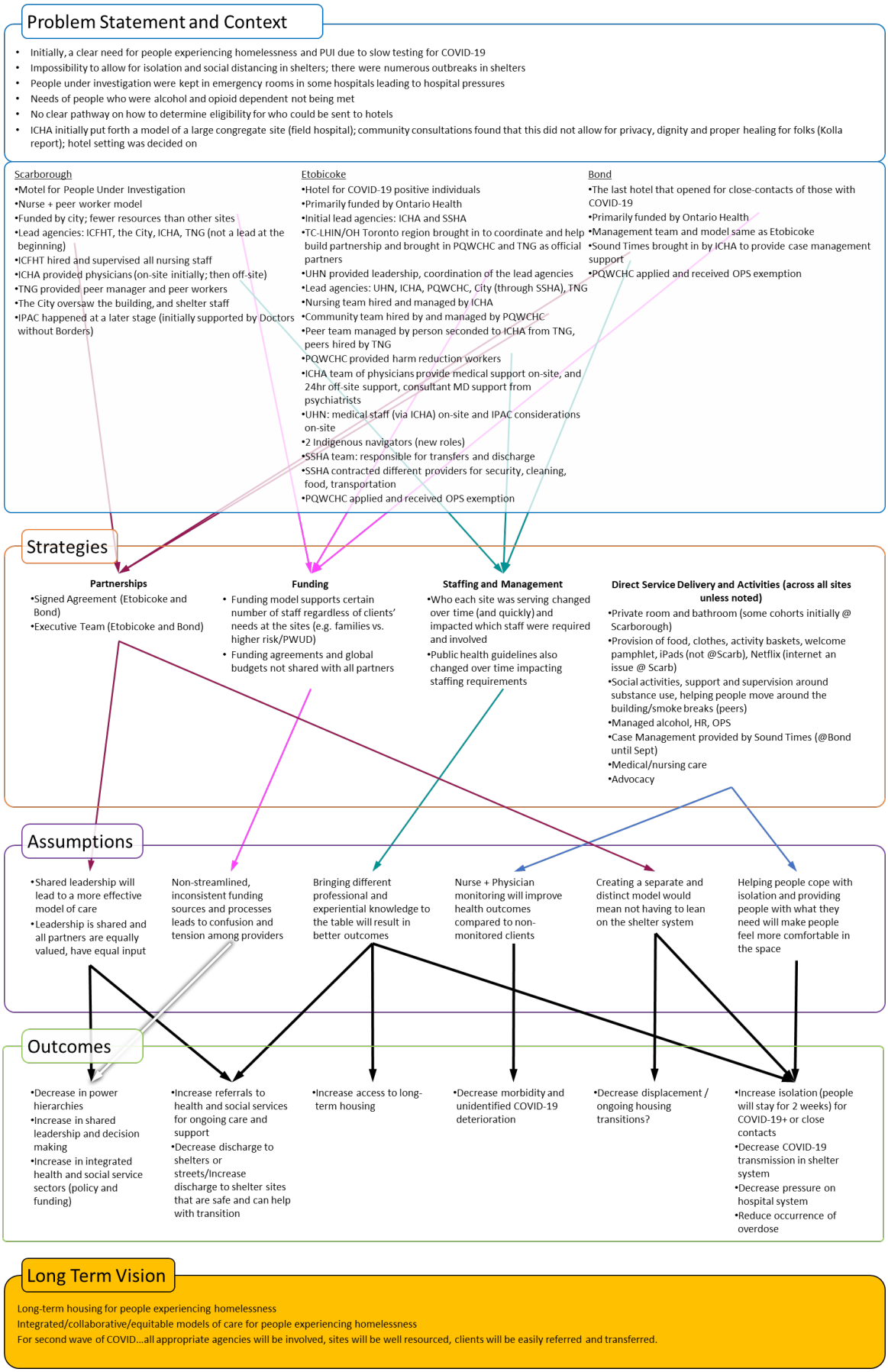

Figure 2. Logic Model of the COVID-19 Isolation and Recovery Sites

ICFHT: Inner City Family Health Team. ICHA: Inner City Health Associates. TNG: The Neighbourhood Group. SSHA: Shelter Support and Housing Administration. PQCWHC: Parkdale-Queen West Community Health Centre. UHN: University Health Network. OPS: Overdose Prevention Site. Open arrow indicates negative influence.

Methods

We used qualitative research methods to evaluate the CIRS, focusing on decision making and the structure of the models. Using selective sampling, we recruited individuals from the following 5 groups: 1) Nurses and Physicians, 2) Peers and Harm Reduction workers, 3) Executive Leads, 4) Operational leads and 5) Funders and Decision Makers. For this analysis, we grouped peer and harm reduction workers together into a single category and we defined operational lead as including team leads, managers, and site leads and executive lead as including members of the executive leadership team. Finally, while several nurses and physicians had multiple roles (for example, as both an executive lead and as a clinician), we categorized them by their clinical role in this report. We conducted 43 qualitative interviews between January and June 2021. Recorded interviews were transcribed and uploaded into Dedoose, a web-based application for mixed methods analysis.[5]

We used hypothesis coding for the interview transcripts. Hypothesis coding is the application of a predetermined set of codes to qualitative data to assess a researcher-generated theory about what will be found in the data.[6-8] Building on the key strategies and assumptions articulated in our logic model, we developed a set of predetermined, theory-driven codes to establish a first draft of the codebook. The codebook was then finalized through an iterative process of coding, refinement of existing codes, and the addition of emergent, data-driven codes.[9]

We developed 24 unique codes organized under three categories: 1) Model Building or Conceptualization, 2) Site Functioning or Operation and 3) Site Outcomes. Six different members of the CIRS evaluation team participated in coding. Each of the 43 transcripts were coded by at least 2 members of the evaluation team. Throughout our results, we refer to study participants as "participants" and to CIRS residents as "clients."

When all interviews were coded, we conducted a thematic analysis, focusing on salient concepts both within and across codes and identified which hypotheses were supported in our data, which were challenged, and why.[10,11] Our team met regularly to discuss and interpret the identified themes. We present findings from 8 key themes in this report. Ongoing, additional analyses will be presented in forthcoming reports and publications.

Results

Theme 1: Relationships between organizations and partners

Relationships between CIRS partner organizations shifted over time as the CIRS models were developed and implemented. Existing relationships were strengthened and new relationships were formed, all within the context of an urgent and unstable pandemic environment. Participants reflected on their experiences and the innovative nature of the partnerships that formed during the process of building the CIRS models. Here one nurse shared their experience:

> "Well, first of all, it's been a real privilege to be part of the whole partnership, and I think that's the first thing to comment on is that it truly is a partnership. It's even more unique than I've ever been involved with … I mean, that's incredibly rich as a group of organizations and providers. And, you know, I think it's all come together and blended exceptionally well." [Nurse]

CIRS partner organizations formalized their working relationship through a Memorandum of Understanding (MOU) when setting up the Downtown and Etobicoke sites. The MOU established a formal executive table for decision making. CIRS executive leads described how the creation and implementation of the MOU was facilitated by a shared recognition of diverse expertise.

> "And I will say the only reason *[the MOU]* worked was because of the partnerships and the trust that we gained very, very quickly. I did not know, in fact, I knew one of the agencies very superficially. We did not have relationships with these teams at all. And it was phenomenal how quickly people brought that trust to the table and were able to lean on each other and to deliver for each other. It was one of the most … dynamic and yet strongest force team building exercises I've ever sat. And that was that was quite remarkable to me. We commented on it in the moment. But in hindsight now, as I look back, it really was quite remarkable." [Executive Lead]

> "Dynamics in relationship with our partners, working on the construction of the MOU, where people would feel that this is something that they, you know, wanted to be a part of and that partners felt respected and that different expertise was being brought to the table." [Executive Lead]

When pre-existing relationships between partner organizations did not exist, they needed to work on building trust and maintaining that trust throughout a rapidly changing and stressful environment.

> "What I saw was a real need for leaders to really have to have people's trust. And that that it was it was really kind of a unique situation where you … had to establish and earn that trust quickly in a situation where, you know, you couldn't have counted on people saying, oh, I know you, from like we've worked together for many years. We have an ongoing relationship. It kind of required that trust building." [Executive Lead]

At Scarborough, the partnership did not have a formal structure, nor were there as many partners involved or resources available:

> "I mean, I would say that probably the biggest distinction was between the Scarborough site and the other two sites. So, the Scarborough site really didn't have a lot of partners. It did have people working who came from different organizations.

But they were kind of all working under one umbrella." [Executive Lead]

A hierarchy existed among the CIRS organizational partners, in which some partners had more power than others. From the perspective of most of the CIRS executive leads, these dynamics changed over time to become more collaborative with shared accountability. Important ways that partners became more collaborative included building trust, creating space for open communication between partners, and vocalizing and recognizing power imbalances. This resulted in changes to structure so that partners had full oversight of their teams and transparency through shared budgets. Here several executive leads describe their observations:

"We really built like a very close relationships over this because it was very collective. So, to the question of like power differentials, I mean, I think we just called each other out all the time. Like, if there were issues, you just pick up the phone call and be like, hey, I don't like what this person from your team is insinuating." [Executive Lead]

"We had some issues that came up that we really tried to talk about at that executive table. And but because we were separate organizations, we didn't always come to a conclusion. But I think it was really valuable that we brought up these issues and we tried to talk about them and tried to talk them through." [Executive Lead]

"But I would like to say that the executive table felt like there was a lot of respect on that table and there was listening. I didn't feel like there were often decisions that I felt that we heard each other, but nobody was going to budge. And that was just the way it was, because our site had started kind of a bit independently. So, you know, I you know, so it felt like there was collaborative people on that table." [Executive Lead]

Theme 2: Underlying Values and Vision

The partner organizations brought their own values and ways of working to the executive table. CIRS partners represented different institutional bodies, professional disciplines and individual self-locations and worldviews. This contributed to a confluence of both clinical and community perspectives. As one operational lead articulated, "You've got like the extreme hospital model. That's a very biomedical model. Then you have a very advocacy-based community model and those historically and completely philosophically are opposing views."

One physician described how this process affected their role:

"And what was interesting is that at some point it was very clinical focused, for example, surrounding evidence that was coming out with about COVID-19. But it did evolve into recognizing that, you know, a lot of physicians haven't had training necessarily related to some psychosocial aspects of care. And we didn't receive quite a bit of training also in relation to caring for individuals who use substances and kind of withdrawal approaches." [Physician]

As one executive lead shared, it was an intersection of new and different approaches at both institutional and personal levels:

"I think we all kind of have to intersect and interact with the cultures of the institutions we work in. So, I think there was some confluence of things happening with different organizations who historically have not worked together, coming together in different executive leads and having different personalities and so forth." [Executive Lead]

One executive lead shared how concerns about the proposed open congregate "field hospital" site were raised:

"We were hearing lots of concerns from our staff and community partners about the field hospital model not being an ideal model for a

"I think what we've done with the recovery site is something that everybody who has participated in, regardless of what their relationship is to that site, should be extremely proud of that work."

recovery site for this community of clients, and that the community had not been the community of providers and staff and clients had not been fully engaged in lifting up such a model." [Executive Lead]

Study participants described the CIRS model in different ways. While some felt it represented a medical model with similarities to a hospital setting, there was consensus that the medical model shifted over time. Others named it a nursing model or a shelter support model or a customer service model, speaking to the ways the model met clients' needs. Some referred to the CIRS as a community model, centred around advocacy and approaches that recognize the impact of traumas that people have experienced in their lives.

"I think I get like I didn't really know what I was walking into. I think what we've done with the recovery site is something that everybody who has participated in, regardless of what their relationship is to that site, should be extremely proud of that work. Because I think it exemplifies a customer service model that I think that is what we should be working towards now in all of our projects is this multi partnership approach and one that is built on collaboration, not one that is built on you know, you come in for this couple of meetings, but then … great, we'll make the decision and we'll carry on. But one where this the collaboration is entrenched in … every mechanism and every process that we do." [Operational Lead]

"Are we a shelter? Are we a hospital? I mean hospitals discharge people to the to the street, which is completely unacceptable with no real plan all the time. So in a way, we're actually like - somehow, somehow, just by saying that we will not do that, it's a bit of like an activist perspective, even though that it's not rocket science and it's not you're not actually giving people housing, but at least saying that a smooth discharge is the goal and that we do as much as possible." [Physician]

Theme 3: Global Funding

The funding structures at the CIRS were complex, with funds flowing to multiple organizations, sometimes through several intermediaries. Some funding was not new funding, but rather re-allocated from programs that had stopped due to the pandemic.

Global funding decisions were made quickly, given the emergency nature of the pandemic:

"In regards to the COVID response, the approach we took at the city was to keep the receipts and expect a check later. To give you a sense, I mean, the 2020 COVID response dealing with shelter and homelessness had about a two hundred million dollar price tag … just the emergency response related to shelters and homelessness. And that's everything from the expansion of new facilities, whether that's hotels or other, for physical distancing to isolation and recovery sites. There was, in total the city, I think it was around 200 million dollars in excess funding, our excess dollars that were spent in 2020, I believe the budget in 2021 at one point was estimated at … a quarter of a billion. The approach we took at the city on this file, but it was the same as all of our files were spend the money now, keep the receipts on the assumption that that we would be reimbursed later. It's not money we had. We just spent it because it was necessary." [Funder / Decision Maker]

Participants had divergent views about whether the global budget for the CIRS was sufficient; these perspectives frequently differed by the organization which the participant represented. Some participants thought that the total amount of funds was appropriate, that allocation decisions were flexible, and that funds were appropriately distributed across the three CIRS based on their size and staffing complement. Other participants thought that the amount of funding at the sites was not enough and, in particular, felt that peer and harm reduction work were underfunded. Participants noted that because the clinical budget initially also covered peers, hiring more of the latter groups meant less funding for nurses. In contrast, the funding for harm reduction workers was separate from the clinical budget. Staff who worked for the City of Toronto noted that funding was straightforward, stating that "whatever we needed, we got."

The Scarborough CIRS had less funding and fewer resources than the Downtown and Etobicoke CIRS. One operational lead who worked at the Scarborough CIRS described the funding differences among the sites:

> "I know the funding for *[Etobicoke]* and *[Downtown]* is quite complicated. There's a lot of other funding sources or whatever, but I feel like Scarborough could have been funded better. I wasn't involved in much of the budget stuff, so I don't really have the details of that. But again, knowing kind of the little that I know and seeing how the other sites operated and how much more support they had, generally, I feel like that could have been very beneficial to Scarborough." [Operational Lead]

There was no open call for funding, which participants attributed to the need to make decisions quickly during the pandemic. Participants noted that when the sites were first created, there was confusion around what funding was to be used for and who would have control. The funding process was also fragmented, as individual partners developed their budgets independently. Partners did not see budgets for other agencies until the second year of operation. This led to confusion on the ground.

> "We did have challenges around funding and who was funded to do what…there was a lack of clarity from the funders around who was responsible for covering what pieces of the funding. And so that confusion coming from the funders led to some confusion on the ground about what was required. And so that took some time to even identify that was a problem that each team had a different understanding of what each team was actually funded to be able to cover and do and what were the parameters of that. And so having more clarity for all the partners from the very beginning and having a mutually transparent budget would have been incredibly helpful to allow everybody to make sure that there were long gaps or misunderstandings across teams." [Executive Lead]

Some partner organizations felt left out of some funding decisions and did not understand how funding decisions were made. Over time, there was more transparency. One executive lead described the budget conversations:

> "We weren't allowed to see what other partners were receiving or how they were spending their money. And that's, of course, still an issue that we're talking about today … only, I think in January of this year finally *[we]* had a full budget of what everybody was spending and doing for the first time. And that was nine months in. We had never seen the budgets for all of the partners" [Executive Lead]

For staff working directly with clients, funding decisions were often based on staff to client ratios. Participants felt that there were both times when there were too few staff and times when there were too many staff for the number of clients, which often reflected the challenges of operating sites during a pandemic, with large variations in the number of clients due to rates of testing, number of people diagnosed, and availability of resources for recovery and isolation throughout the city, which often reflected the challenges of operating

sites during a pandemic, with large variations in the number of clients related to rates of testing, number of people diagnosed, and availability of resources for recovery and isolation throughout the city.

Theme 4: Leadership

The leadership structures differed between CIRS and changed over time

Participants noted that the leadership structure was complex, given the large number of partners involved in decision making:

> "There were so many stakeholders involved … it was sometimes difficult to know who was in charge, I guess. And arguably there wasn't sort of one because there wasn't really like a structure where it was very clear. We had a leadership table or an executive table, which, again, was run as ... a coordinated table with the leads of all of the different organizations. So I guess the barrier to me would be the inherent complexity in having many stakeholders come together and no one identified lead." [Physician]

Views about leadership and decision-making structure varied by site, by date, and by the role of the participant. At the Scarborough CIRS, the leadership structure was relatively horizontal and described as being not "overly bureaucratic," which supported quick and responsive decision making. The executive leads and staff who were involved with the Scarborough site shared how there both advantages and disadvantages to the distinctive context at the Scarborough site.

> "I think things *[at Scarborough]* were probably a little bit more chaotic because there weren't very well resourced with many teams. But at the same time, it felt like decisions could be made very, very quickly because there was a nimbleness and an adaptability and was kind of just a sense that if it was the right thing to do, they could find a way to make it happen." [Executive Lead]

> "Yeah, so Scarborough site, there was no real hierarchy, I think in my time there was just kind of a mish mash, you know, like whoever like whoever's there in that room, kind of like in the heat of the moment, just collaborates, has a discussion and then it just like move on and try it out. And if it doesn't work, come back to the drawing board." [Operational Lead]

The perceived lack of leadership structure at the Scarborough site was also seen as a vulnerability that weakened the ability of leaders at the site to participate in decision making, as reflected in the decision to close the Scarborough site. Several participants noted that this decision was particularly challenging, and one nurse described how they "felt abandoned" when it was announced.

At Etobicoke, the leadership structure evolved over time, from one that was more hierarchical at the beginning, with physician voices trumping other voices, to one that was more open and collaborative. This change happened over several months.

> "So I think that, you know, for different teams that weren't used to working in partnership with others, there was an assumed decision making power at which point that created an enormous amount of tension. And so we had to wrestle it out for a good long time until we actually came to a place where the operations leaders meeting that we have every week became a place of negotiation instead of instruction around the decision making forward … And I think that, too, just in terms of project maturity, I think you need to practice something that you do for a while before there's an organic experience around decision making." [Operational Lead]

The partners worked to replicate the beneficial aspects of the leadership structure established at the Etobicoke site, at the Downtown site.

> "The intent when *[Downtown]* opened was to really make … a concerted effort to make decisions in a different way, in a much more

collaborative fashion. And I think that all of the teams on the ground were committed to that. And that was different." [Operational Lead]

Power differentials and decision-making structures

Participants described "a lot of chaos in terms of the decision-making structures," particularly early in implementation of the CIRS, which reflected the high degree of uncertainty about many aspects of COVID-19, including infection control at the start of the pandemic and the many organizations involved in planning.

"I guess my biggest challenge as a leader in this project is that I didn't feel like I was aware of all everything that was going on around the planning of these projects. There were people who were kind of above me in the hierarchy making decisions that directly impacted my ability to actually develop this project, that I had no idea what was going on … I often felt like I had questions that I could not get answered because the people at those tables were kind of caught up in other levels of conversation in the context of the chaos of the pandemic." [Physician]

The involvement of numerous partners was both valued and seen as a challenge around decision making. Participants liked that each partner had domain over a different aspect of the site functioning and that there was "not one boss."

Power differentials were experienced at an executive level (between partners), at an administrative level (between operational leads), and among client-level workers (within and across teams). Physicians, hospital leadership, and physician-led organizations were initially perceived to have more decision making power than other partners. However, decision making moved towards a more collaborative approach over time.

"Clinical status … has a lot of weight in society. And I think people are used to their power and their privilege, and it's hard for them to relinquish it or appreciate that others have expertise that's more grounded in … experience or community work and that sort of thing. So those were the big contested battlegrounds around addressing power differentials." [Operational Lead]

"The hierarchy was one where at the beginning, decision-making seemed to reside almost exclusively in the clinical leadership. And given that, most of the care that was happening was care that was being led by what we call the social care elements and not the clinical care, but the social care in that it was harm reduction supports, it was case management, life support, it was crisis management support, it was peer support work. That was the largest component of the care that was being delivered at that site. Then there was conversations that surfaced in the partnership that we needed to reflect on shifting the hierarchy of heavy clinical leadership exclusively to one where there was a more collaborative involvement of the community, partners in the leadership and an operational leadership, decision making and processing." [Executive Lead]

"So I think that, you know, there's a big difference in how community rooted agencies comes to decision making versus institutional agencies like hospitals or like have your clinical settings, and there were significant power imbalances…It's like we have people who are on peer teams that are doing an enormous amount of client facing work, really carrying the load of client support, making probably close to the least amount of money. Whereas when we have, like MDs making a ton of money who aren't onsite, that don't have a lot of contact. And so, like, if there's a client conflict and the peer brings forward this this whole landscape of what's going on, and then like because the MD off site is unfamiliar with the particular scenario, and then they choose to take a different approach around resolving a client issue, that that power differential, it's like, well, the peer holds this enormous amount of knowledge and suggestion around resolution and then the MD goes in a different direction." [Operational Lead]

Physicians' relative power also decreased because they were not as consistently present as nurses, which allowed and empowered nurses to advocate

"It's really not until … we're actually working together and serving the client that you understand the breadth and depth and scope of each of the roles"

for a greater role in decision making.

> "As a nurse, I felt this before. There are some cultures that are very like certain hospitals or certain places I've worked, that hierarchy was very respected, even between nurses and doctors. But I have to say that this is a place where I have not felt it in … *[a]* negative sense. I felt in the sense of, hey, that's above my pay grade, I'm going to shoot it upstairs because I don't want to deal with it, which is great, which is fine, but I haven't necessarily felt it any other way." [Nurse]

Bringing together various partners to discuss processes and outcomes was seen as important for providing opportunities for learning how things could be done differently. Participants valued the opportunities to reflect together across teams and leadership levels.

> "Clarity comes through working together and you can't put everything on paper. It's really having an outline or a framework and a general understanding. But it's really not until … we're actually working together and serving the client that you understand the breadth and depth and scope of each of the roles. For me in particular, was learning about peers and harm reduction workers." [Executive Lead]

Some physicians talked about the CIRS as a distinct environment from healthcare settings, which are often rigidly hierarchical. In particular, they valued the ability to establish relationships with other team members to address power imbalances, including peer workers and nurses, and to create an environment where multiple perspectives were valued.

> "One of the biggest challenges that also the great things about the site is … it's not a completely sort of flat hierarchy … I think people generally value each other's input fairly, equally and that's a really different model than I experienced working in health care before." [Physician]

Implementing Decisions

Some participants made a distinction between decision making and decision implementation. While the strong focus on collaboration in decision making was valued, there was a concern that the process for implementing decisions was more rigid and did not reflect the same collaboration as the leadership structure.

> "It is very much hierarchical … I'm not sure if you can address anything because the system is so designed that it doesn't allow for the kind of collaboration of feedback along that line. Decisions are made and you're told what the decisions are." [Operational Lead]

Both decision making and decision implementation were also contextual. For example, some processes, such as client transportation, followed a set protocol and required little discretion. Others, such as decisions about safety plans or clients' health, were complex and included multiple levels of decision making and multiple teams, including peer workers, nurses, and operational leads. However, some peer workers felt that the operational leads had disproportionate influence in implementing safety plan decisions.

Several participants talked about how leadership operated at both the executive level, which had overarching responsibility, and at an operations level, where operational leads were responsible for day-to-day management and conflict resolution.

"I think that the steady thing that is sort of my bread and butter that keeps me going is the operational leadership. There's like a high demand for - it feels like there's a lot of - I call it like putting out fires … operational leadership where there's like crisis of the day and there's a need. The managers contact me for direction of how to handle something." [Operational Lead]

"There was way more deliberation at the at the higher level, and they weren't on the on the ground. And a lot of the times there was comments like, I don't know because I'm not on the ground. Like ask the person who's on the ground, like from that higher body. And like I expected it, like in a community agency or even sometimes in a hospital, like, you know, the people make the decisions and they make the most informed decision and then they send it up to someone who just looks it over, make sure is like all the T's are crossed, I's are dotted, like ask a bunch of questions and then they approve it. But that wasn't the case. Like it was way more deliberation. They had to come back down to us to, like, change things. So I think there was a little bit of a lack of trust in some aspects." [Executive Lead]

Operational leads sometimes felt constrained in their ability to make decision quickly because of the processes at the executive level.

Giving All Workers a Voice in Decision Making

Some participants felt that the decision-making structures evolved to allow everyone to have a voice in decision making, including peer workers and harm reduction workers. However, others felt that peers' voice in decision making was limited. For example, peers had fewer representatives amongst the leadership at both executive and operational levels compared with multiple representatives for nurses and physicians.

The reporting structure for peer leadership was unclear during the early implementation of the CIRS when the Peer Manager was seconded by another agency. It was not clear who the peer manager reported to and the peer workers were initially grouped with clinical teams, which decreased opportunities to present their concerns and influence decision making. Peer workers expressed frustration that some managers from other teams had limited experience working with people with lived experience, including as staff. Because peer workers rarely saw executive leads onsite, they didn't always know if their work was perceived as having a positive impact, or if their performance was valued.

Some workers felt they had a limited say in decision making. While they would raise concerns to their managers, the managers acted as an intermediary in taking these to executive leadership. Some participants perceived leaders as being concerned with risks and legal matters; although these were recognized as important considerations, this nevertheless constrained leaders from making decisions about client-level priorities, leading to concerns about a lack of transparency in decision making and a feeling that processes for listening to workers were about "venting" rather than about making changes. Participants described some experiences raising the concerns of front-line workers to the executive leaders:

"We would never hear anything about it. We would never hear anything about it because we didn't have time to, like, wait for responses and stuff when we were so busy doing other things or it just wouldn't come back down to us like a decision would be made and we wouldn't be aware of why it was made. So I think mostly it was kind of … venting .... We would just … expect the directors to bring it up at that higher level. And it would just kind of fall flat, largely because we just don't have time to follow up on things." [Operational Lead]

Some participants were also frustrated that decision making was too slow for client level decisions.

"[Decision making] just took a long time … there was unnecessary, like discussions about like, oh, what's the higher team going to think of this?

> And … we weren't focusing on …how is this going to impact the clients. It was … very administrative and it just slowed things down and it made things really muddy and it upset people." [Operational Lead]

Theme 5: Communication

How People Communicated

Participants used multiple modes of communication, depending on their role, location, and time at the CIRS. Almost all teams communicated in several ways.

- Some meetings were face-to-face, including quick meetings about clients to "touch base" when shifts were changing.
- Peer workers communicated regularly at team check-ins, through notes on a board about what clients needed, and at team debriefing sessions.
- Messages were also exchanged by text, email, and a secure messaging system (initially only for physicians and nurses and later extended to other workers). Email was viewed as sometimes challenging way to communicate given the lack of detail that could be communicated in a message.
- Charting about clients was mentioned relatively infrequently as a way of exchanging information. Only nurses and physicians had access to the electronic medical record.
- Case conferences were implemented at the Downtown CIRS, motivated by an understanding that many clients at the site had a high level of health and social needs and that many were admitted to rule out COVID-19 infection and so would have a shorter stay at the site. Participants valued the case conferences as a means of being efficient with discharge planning and, over time, the conferences were also implemented at Etobicoke.
- Operational leads and executive members often met by videoconferencing, particularly early in the course of the pandemic. Some participants noted that it could be challenging to resolve differences in opinion when meetings were being held over an "impersonal medium" like this.
- Each team also had regularly scheduled meetings and determined how frequently they would meet. Operational leads and managers met on a daily basis. Some teams sent out notes or kept meeting minutes in a binder so that people who missed the meeting could catch up at a later date. Physicians communicated most directly with other physicians and with nurses.

The format of meetings, orientation materials, and the ways in which people communicated became more structured over time. Teams learned how to balance their workload and to calibrate their work to the time available, which helped communication, particularly between people who had never worked together before as well as between people in different roles across teams.

The culture that encouraged communication through many different mechanisms and across the different care teams.

> "I never felt we had a lack of communication. There was the opportunity, we would all, if there were concerns or issues, there were personal conversations. People were very, very comfortable calling each other or texting each other and our group discussions, as I've said, we're very dynamic." [Executive Lead]

The Volume of Communication

Participants noted that there was "a lot of information" that was "sometimes hard to filter through." Some executives and managers noted that there was a very large volume of communication and appointments at the start of CIRS implementation, particularly when roles and responsibilities were being established.

> "The teams huddled multiple times a day to talk about what happened, what did we need to tweak, what do we need to change? What do we need to formalize and change versus what is sort of in the moment and more situational? So

there was definitely, definitely a combination of that." [Executive Lead]

One participant described a "massive array of meeting … that just seemed to never end." Some questioned whether all of the meetings were necessary and others remarked that the volume of communication could be overwhelming. Similarly, operational leads noted that they would spend about half a day or more in meetings. Executive lead meetings occurred less frequently over time and were supplemented by other communication mechanisms, including one-on-one meetings.

"I think what made communication work well is having in the early part of the pandemic, there were weekly huddles weekly meeting of the executive later in the day. And that continues. And it has shifted from weekly to biweekly. So having clear space and a clear mechanism for issues to be brought to, I think, facilitated good communication. I think also there were opportunities in between meetings for executive leaders to reach out to each other if there are needs. And folks some folks took advantage of that." [Executive Lead]

Some people working directly with clients noted that the large volume of communication was necessary to optimize coordinating care with so many teams and organizations.

"It's a very complex system. And I think I didn't anticipate how much time it takes to actually have closed loop communication with all of these different parties." [Physician]

When Communication Worked Well

Participants appreciated that efforts to break down silos across teams and having the "right people" at the CIRS were important for facilitating open communication.

"I can't stress this enough that the right people made communication work well. Right. So they weren't people that were quick to a decision. They were people … that entered into complex situations with questions and not statements. You know, that sort out other folks' opinions that, you know, like really leaned into specific roles and needs. So whether that was like case conferencing, where you would invite, like the harm reduction team, the peer team, the addiction on call team doing case coordination ... So you didn't have, like, one team making these decisions about a particular client care. That communication worked well when we all, like we all came together to decide on a particular pathway for client care." [Operational Lead]

Overall, many participants reported that they felt that the CIRS created a space where information was shared and views could be heard.

"But it's like there's a lot of information. It is really good in that way. Also as a nurse practitioner, right now, I'm getting a lot of support from the doctors. And yeah, and then there is like the handbooks that are being written and updated as we go, as we learn more about COVID and as we gain more information. So they're always being updated and it's open … I could update if I wanted to." [Nurse]

"I think right now there's a lot of transparency. I can speak between the doctors and nursing. There's like a lot of transparency and they're encouraging communication." [Nurse]

"Sometimes it took maybe several, several conversations or things like that, but I think at the end of the day, like despite all the tensions or disagreements that might happen, like, you know, we all had kind of one goal in mind and it was to provide the best support we could to the folks at the site. So I thought concern for the most part, again, it might take several conversations, but we were able to come to a resolution at the end and I felt like I was heard when needed to be." [Operational Lead]

Clinical teams also described communication about clients. A nurse said:

"I have any questions or if I want to run a plan by *[the physicians],* I do. And then I work with the nursing team to get information about

"I think the barriers to effective communication, again, were a lack of clarity and roles at times and historical tensions there, or just sort of a lack of certainty among partners around how we would be dealing with each other"

> what's happening with the patients or what's needs to be done. Or if I need more details about how the person has been presenting and things like that, I'll work with them." [Nurse]

The physical space at the Downtown site facilitated communication because there was one large, open room in which members from all teams worked together.

> "I think because there was an open workplace, so the city was sitting with nurses who were sitting with harm reduction, who were sitting with the peer, leadership, like everyone kind of we're in this big boardroom together. And we had a shared whiteboard." [Physician]

When Communication Did Not Work Well

Participants emphasized some exceptions to the culture of open communication. A notable example was the decision to close the Scarborough site. Several participants described how the decision to close the site was communicated without providing a clear reason for the decision, which left many people feeling confused and upset about how this decision was disseminated. Generally, participants noted that it took a long time for information to get from the executive level to the staff onsite and that feedback on performance was not always communicated clearly to peer and harm reduction workers.

Some participants attributed communication barriers to historic tensions between hospitals, the city and community-based organizations:

> "I think the barriers to effective communication, again, were a lack of clarity and roles at times and historical tensions there, or just sort of a lack of certainty among partners around how we would be dealing with each other given … how different spheres have worked together in the past, I think there was a lack of trust in some cases." [Physician]

At other times, communication barriers were attributed to policies and practices at the CIRS. For examples, nurses reported a lack of access to data related to admission rejections to the CIRS, because this information went directly to physicians. Several workers noted that communication around client discharge was challenging as this often happened quickly or people didn't transmit details effectively, leaving staff only a few hours to address discharge-related needs.

> "There are some challenges because there are times that, you know, sometimes people … forget to communicate information, the bed was given away, person didn't recognize there was service restriction, and so many other nuances that happened, then put you in a place whereby a person couldn't leave … you had to keep them in there for a day or two … the transmission of information was not very clearly articulated." [Operational Lead]

Participants identified other challenges to communication, including having big spaces within which they worked, the need to maintain physical distancing while communicating, having a combination of some workers being onsite and others working virtually, and having different reporting mechanisms for physicians and for workers who reported to the city.

Theme 6: Client-Centred Care

The CIRS prioritized client independence and dignity. Staff at the sites provided clients with non-

judgmental, compassionate care and holistic supports, in addition to basic health and shelter support. Client-centred services and support included:

- Wellness checks for emotional supports
- Access to outdoor space and social-recreation opportunities
- Harm reduction Services:
  - Safer supply – providing opioids or opioid agonist therapy to clients who use opioids
  - Providing cigarettes
  - Managed alcohol - providing alcohol to clients who use alcohol
  - A space where clients could safely take drugs under supervision of trained staff
- Creating safety plans for clients (e.g. arranging more frequent wellness check for clients who are at higher risk of overdose or suicide)
- Linking clients to health, social and financial supports in the community
- One operational lead described the services provided at the sites as "some of the best care items that people experiencing homelessness have ever had. … Anything that they wanted we were able to get."

Peer and harm reduction workers were very involved in providing emotional supports and wellness checks at the sites. Peer workers and harm reduction workers built relationships with clients through these regular check-ins, which facilitated client comfort during an often challenging time in isolation. space. One harm reduction worker described the emotional supports they provided:

> "Because sometimes it's like you're offering counselling too. So I would say if it's changing, it just depends on because if you knock our client doing wellness check and they start talking to you sometimes they will start crying. I mean the most you can do is give a listening ear so you can encourage them. Just just be there. Because in this time, it's really hard for everyone, even for the workers … So we just be there for each other in ways that we can. This is the most common ways to just listen to something, listen to their concerns, listen to what they have to say." [Harm Reduction Worker]

Participants noted that clients felt more comfortable sharing information and requesting items from peer and harm reduction workers compared with other staff. One peer worker expressed how clients felt more comfortable asking for harm reduction kits from peers:

> "For peers, it was more on an emotional level, like a more like heart to heart, where some clients really feel as open telling nursing or doctors about, you know, something that they're struggling with. Might it be like they want a kit and they don't feel comfortable letting the doctors or nurses know that, hey, I need a kit for their substance. They'll usually come to peers or harm reduction and just say, hey, can I grab a kit? We'll bring it up. We're more of I guess they feel no judgment, kind of, because majority of them know peer support. You know, we've all been there. We all kind of have to understand we have lived life experience, so they can they feel more inclined to open up to us about what they're going through or like if they need any support, they know that we will probably have an answer as opposed to nursing And doctors might not." [Peer / Harm Reduction Worker]

Clients also came from refugee shelters or shelters for women experiencing violence. One executive lead noted that the sites would benefit from having more peer workers from these communities:

> "So there are families from family shelters and violence against women shelters and refugee shelters, they were more family oriented. So our peers did a great job. But we might have picked our peers differently if we'd realized that the makeup of the of the of the residence would not be the typical profile of a men's shelter or a woman's shelter. So, yes. So there were a large number of racialized communities who stayed at the shelter, mostly who were refugees … There were many families and women and I think women of colour who were

… coming from the violence against women shelters and family shelters … I think we strove to have peers who were racially diverse and to bring different life experiences, but again, they were largely people who had experience with the men's and women's shelter sector, not the not the refugee shelters or necessarily the violence against women shelters." [Executive Lead]

Clients had access to a menu of harm reduction supports at the sites. The harm reduction workers would link interested clients to these supports. Some participants reported that clients thought that the overdose prevention site (OPS) room, where clients could go to take drugs while being supervised, felt too medical. Some clients also were not comfortable using drugs around other people. One harm reduction worker described how staff adapted to be flexible in letting clients use drugs in their own rooms:

"We do have OPS room, we have a TV. You can relax, you can chill. You know, you can do that. But still, it's still there is an oxygen tank there. There's all these medical facility there. And people don't always would feel comfortable there, you know, and if they had their own room and they own TV, they might definitely feel comfortable, more comfortable in their own space. And I think since I've been working there, I've seen that when we are there, we're around them. It does not necessarily mean that they're not comfortable with us, but they're definitely not comfortable using in front of someone else. Right. And that makes sense. And sometimes we used to feel that it's because we don't make them feel comfortable. Doesn't always mean that. It means that they just want to be in their own space, want to use whenever they want. They don't want to wait for someone. So if they want to go to OPS room, they have to call us and we are going to take them. So they not they don't want all that kind of barriers in use. they will be like, you know, I'm going to wake up and use whenever I want to. Right. So we did give them a little leeway and said, OK, if you want to use, can you just let us know at least, so that if we can maybe do regular checks on you so that just to make sure you're safe." [Peer / Harm Reduction Worker]

Some participants were concerned that the facilities at the Scarborough CIRS were inadequate, particularly compared to other sites:

"The rooms at the Scarborough site were just not great at all, like I you know, there were mice and infested roaches everywhere. And the TVs, like the living amenities, like just not not great for someone who is expected to stay in a room. The lighting was horrible. Like just I don't even think across the board that that place is a good place for anyone to live in. There's a ton of renovation I think needs to happen to get that's a good living space and to put people with COVID in there. I don't think it was it was acceptable. Like there were children there that had nowhere to go to play with. So I think the hotel aspect *[at Etobicoke and Downtown]* was good. The suites were incredible. The size was good there. There, you know, we could have probably used some more accessible suites and also, like accessible from like wheelchairs, but also like hearing impaired, visually impaired like devices, like being put into those suites." [Operational Lead]

Theme 7: Innovation and a Changing Environment

The CIRS were a completely new and unique service model. Many of the policies and procedures were created from scratch, which required a lot of creativity and flexibility. For many participants, reflecting back to their early involvement and experiences with the CIRS, there were many lessons about the extent to which the sites evolved and adapted throughout the pandemic.

Site adaptation was very closely linked to the unpredictability of the COVID-19 pandemic in terms of rising and falling numbers of cases. This affected the number of people flowing through sites at different times and heightened the level of health and social complexities that clients were

facing. One executive lead described different phases of the pandemic and how the CIRS responded:

> "There was … this phase where it was kind of like, go, go, go, build, build, build, recruit, recruit, kind of get everything in place, expand. And … that was the first phase. And then the second phase was at peak dealing with, you know, I would say two key issues. It was the … really high level of behavioral and mental health issues that came up for clients. And the issue of addictions and the concern about overdose, those were really kind of - those became the overriding concerns. And then the next phase was as the first wave receded, kind of adapting to how would we how would we scale down our service or scale the size of the operations." [Executive Lead]

The criteria for CIRS clients changed at different time points during the pandemic which meant that processes needed to be adapted and staff had to adjust their roles accordingly. One of the operational leads described this experience of pivoting their role as the designation of the sites for different populations changed:

> "Some of my role was consistent and other times it changed based on whether the client group changed. Remember, we had COVID positive individuals, we had PUI *[people under investigation]* individuals as well as close contact [*with COVID-19]* and both singles and families. And so, under those circumstances, it was a bit of a pivot that we had to make as the circumstances changed." [Operational Lead]

With the opening of the CIRS and, in particular, the Scarborough CIRS during the early and uncertain days of the pandemic, some procedures were not formally in place or did not exist, resulting in a period of troubleshooting alongside the provision of care, which is described by one nurse below:

> "So, there was a lot of constant troubleshooting and problem solving around as we learned more about COVID and as we sort of shifted from taking this kind of client to that kind of client, positive or close contacts or whatever persons under investigation, because in the beginning, I mean, it was taking like weeks for tests to come back. So, there was questions around what to do with people just undergoing investigation and what kind of PPE was needed and what kind of nursing care and management was needed. And so, my typical day was a combination of like administrative work in terms of trying to continually formalize the operation of the site and sort of like troubleshooting and problem solving, different issues that would come up either from a nursing practice side or from sort of an operations side." [Nurse]

The Scarborough site opened quickly in response to an urgent need in the community which meant that even Infection Prevention and Control (IPAC) procedures and policies around Personal Protective Equipment (PPE) were ad hoc at the beginning. At the Downtown site, inclusion of a hospital as a partner facilitated easier access to IPAC protocols and PPE. A nurse shared their perspective on this experience:

> "So I think there was an identified need for like a site to just happen now and then to figure out the sort of systems later, which meant that the other sites *[Downtown and Etobicoke]* had the opportunity to then think more deeply about all the kinds of supports that you would really want to have in a site like this, which they were able to do, which is great, but sort of like being like the jealous sibling or something where you're like, oh, man, they have scrubs onsite. Like they had someone come to do like IPAC. Like we had to beg public health to come and look at our systems that we had developed for PPE and for IPAC, and they didn't come for months. *[We]* just sort of developed a system that made sense based on our collective experience." [Nurse]

Participants shared other instances where procedures and staffing adaptations took place at the CIRS. For example, the intake process initially involved a survey with direct questions about

substance use. Peer and harm reduction workers raised their concerns about the potential stigma and harm associated with this approach resulting in a new intake process that included a menu of harm reduction services for people to indicate what they may want to access at the site rather than direct questions about their current drug use. As the teams expanded at the Downtown and Etobicoke CIRS, staff were able to transfer certain responsibilities to others. One example was how the nurses handed over calculations for managed alcohol to the harm reduction team. Operational leads also shared how their roles could change daily depending on the staffing and client needs, sometimes working on the floor when there was a staff shortage.

Site adaptations were also made in response to challenges with infrastructure and resources. One example that several staff members shared was around the need for more accessible and inclusive spaces for smoking and the process for accessing the elevators.

> "The elevators went down and it was a decision to how are we going to work as best for clients to smoke like that? Because a lot of our clients were smokers, lot of them, and we had to figure out how to safely use two elevators instead of three…Then we had to change the timing. So instead of clients just calling whenever they felt like it, yeah, we had to inform all the clients that on the hour and a half hour or so and they were concerned that that was the only time and we were doing floor by floor. So this floor on this hour could go for a cigarette, then the next floor could go. And we changed the schedule and it was there was a bit of kickback from the clients. Clients didn't like that. They wanted to go outside for a smoke when they wanted to. But as a team, we stuck to … the process and we made sure people were safe." [Peer / Harm Reduction Worker]

For many participants, particularly the executive leads, ongoing changes and adaptations at the CIRS were opportunities for growth, reflection and strengthened collaboration. However, the unpredictability of constant adaptation also took a toll on people. The instability of the environment was stressful. For example, as client volume went down, several workers felt their job security was in jeopardy and as sites changed, some of the perks of the job went away, like free coffee.

> "I would think the next best thing for us to help and at least keep our jobs. And there are less peers now. The peers got shafted, right? They had more peers coming in, they opened up this new place and it shut down less than a week. So what happens now with our overload appears now program so successful we don't even learn that they're dropping off our hands and now we can facilitate them because the whatever the lockdown is over, we've got seven clients in one room. We have maybe less than 50 after this month. I don't know. And when it's done, what happens to my life, I go back to normality, I go back, what? Like the war is over. I just forget everything I went through. I just forget, you know, my service in the war against COVID. That's it. Like a veteran, we're just going to be oh, you're disposed now. We should get benefits, our basic income." [Peer / Harm Reduction Worker]

Theme 8: Broader Social and Health Systems

Participants noted that CIRS operated within broader social and health systems, including the systems responsible for shelter and housing for people experiencing homelessness and hospital and other health care systems. At times, these existing systems constrained what the CIRS could do for people experiencing homelessness, in particular the inability to provide housing for some clients due to rigid bureaucratic rules. This constraint resulted in CIRS staff sometimes being forced to direct clients to spaces that were not safe or not dignified, including shelter environments with the possibility of exposure to COVID-19.

> "Not having a shelter space or housing that really is a dignified space is the biggest barrier by far. And we because of our limited mandate,

"Not having a shelter space or housing that really is a dignified space is the biggest barrier by far"

we can't hold people forever until a good space comes up." [Physician]

"We were discharging people back to sites where they came from, where they were concerned. They said, look, I got COVID because of that site and we sent them back to that same site literally after hearing them say, I'm terrified to go back to that site, we went and sent them back there. Like, it just doesn't make sense ethically by any means. But we had to send them there because we had nowhere else to go." [Operational Lead]

Participants were also concerned about the inability to continue safer supply opioid prescribing after discharge.

At other times, the CIRS presented alternatives to existing systems. For example, whereas an emergency department or hospital ward may abruptly discharge someone experiencing homelessness to the street, the CIRS would typically aim for a smoother transition to the community.

"Planning for discharges is probably one of the rockiest practices that we have. And what has more so occurred now is upon discharge, having a more integrated approach. So looking at like the case management needs of any particular client, especially higher needs clients who may need referrals to safer supply programs out in the community as they get discharged, because, again, it's kind of that like short term, like clinical lens or it's like once you're discharged, you're not our problem anymore. Versus like … holistic care would be ensuring that people are connected before they're discharged and that it is a problem if somebody gets disconnected from care or support because what happens to them in the community is something that we're responsible for." [Operational Lead]

More generally, the CIRS need to be understood in the context of social determinants of health and the ongoing displacement of people experiencing homelessness. The COVID-19 pandemic has exacerbated displacement and instability for people who were already experiencing marginalization, including for people who were experiencing homelessness or precarious housing, poverty and racism. There is an ongoing need to address these issues at a structural level.

"You have to take into consideration the whole... You're looking at … income. You're looking at persons facing barriers based upon the race, the gender, the economic status. … We live in an environment where *[there is]* oppression." [Operational Lead]

The CIRS offer important lessons for how services for people experiencing homelessness might integrate the work of partners across sectors and organizations. Participants envisioned an approach that "actually start*[s]* to function like a system." Within the Ontario context, this approach might be particularly salient for the roll out of Ontario Health Teams.

"I hope to God we don't all go back to our corners after this is said and done, I think we've seen more - I've seen more integration across our sector throughout COVID. This is a great example, but I've seen it in many areas. I've seen us actually start to function like a system. That brings me great hope. I hope we can see

"I think blending those models like the medical and social kind of world … it worked really well. It was quite beautiful to see."

our funding models continue to support that. I hope we can see the Ontario health teams leveraged to be able to support that." [Executive Lead]

Many participants reported that they were enthusiastic about the partnerships that had been formed during the implementation of the CIRS and hoped for these to continue. Some organizations have already implemented programs inspired by what they have learned from CIRS, such as greater integration of peer workers in hospital emergency departments and expanding health care teams for people experiencing homelessness to be more interdisciplinary.

"I hope that, like in the future, particularly thinking about as we build up the harm reduction services … and as we try to have more social and peer engagement … ideally, I think if we can learn from the site … the importance of doing that in a in a way that is more collaborative and less hierarchical, that would be a really big benefit." [Physician]

"We started to like improve people's wellbeing through … social aspects. And I think blending those models like the medical and social kind of world … it worked really well. It was quite beautiful to see. And I think … the opportunity for peer workers as well to be involved in medical environments would be really great. Like peers could play a really great role in emergency departments and detox centers, for example. And so I think that was very helpful." [Operational Lead]

"On the harm reduction side, we're rolling out more supervised consumption space within the shelter environment and partnering very closely with the harm reduction community in order to operate those services. We're bringing more clinical supports into our program that that offer a whole range of primary and allied health care to people who experience homelessness. So I think there's been great learning and things are already changing the landscape of what the broader homelessness service system looks like." [Executive Lead]

Several participants noted that integration of services and coordination of care across partner agencies was particularly important at the time of client discharge from the CIRS. The CIRS provided several examples of how people working in silos with respect to their roles and responsibilities were detrimental to effective and coordinated discharge planning. Thus, the CIRS underscore the importance of effective and collaborative case management for people experiencing homelessness.

The CIRS emphasized the limitations of the approach typically used to deliver health care in shelter settings, which relies heavily on doctor site visits. Participants expressed concerns that these visits do not provide adequate follow-up or comprehensively address clients' needs. An alternative to a physician-exclusive model would include nurses, case managers, peer support worker, social workers, and harm reduction workers who together would provide harm reduction support, opioid agonist therapy, managed alcohol programs, primary health care, and mental health supports in a single space. Participants articulated a vision of inter-professional, interdisciplinary and collaborative health care for people experiencing homelessness

beyond the pandemic. This approach would both help clients and generate new ideas about how to work together for better outcomes.

> "The medical infrastructure is a totally colonial driven experience. And so it doesn't consider the integration of needs of racialized communities, Indigenous communities, … queer and trans communities. *[It]* historically has rejected the needs of those groups. And so this just replicates itself without planning. And so I think we absolutely, before doing anything, need planning and consultation with all groups of people to then design and implement a new system and a new structure that's accommodating to … a variety of people's specific needs." [Operational Lead]

Participants noted that the CIRS underscored that the shelter, housing, and health care systems were unprepared for an emergency at the scale of the pandemic. As one participant noted, "pandemic preparedness planning at an intergovernmental level was not in a position to adequately protect those who were unhoused or under housed." Another lesson of the CIRS is the need to center the needs of people who are marginalized in planning for public health and other large scale emergencies. Such planning should also consider the needs of people who work in such systems. One participant speculated that, without the CIRS, shelter and housing staff – who are mostly low-income workers and often from racialized communities – would have resigned in large numbers because of concerns about unsafe working conditions.

Several participants noted that the CIRS offer a model for thinking about the kinds of supports that would allow people experiencing homelessness with complex needs to live in residential sites. Others expressed this as a vision of what supportive housing would look like with the "most robust model possible." Key to this model are clinical case management, harm reduction services, strong peer support, and adequate and consistent funding. Participants contrasted this model with historical and ongoing supportive housing models, which were seen to be lacking key necessary elements for success and that have not been funded at levels to allow them to address all the needs of clients. As one participant noted, housing models can do a "huge amount more … to support people." Another participant noted that the CIRS lessons should prompt decision makers to consider how shelter and housing support can provide people experiencing homelessness with pathways out of homelessness, rather than just being a place to stay.

> "While we provide*[d]* isolation for COVID through this model, we've also learned what kinds of support allow people to be maintained in residential sites with high complex needs supportively and what supportive housing might look like if it actually had the most robust model possible. And so I think there were some real learnings beyond COVID isolation toward supportive housing about what kinds of support need to come together and how they can do that in a way that is mutually respectful, supportive and most impactful for clients. And so I certainly hope and intend to continue working with our partners to take this model as we continue to work in a post COVID world towards one where we are going to continue to advocate to have folks housed and housed in a way that is supportive enough that they can maintain and sustain their housing." [Executive Lead]

Many participants identified having adequate funding as a key barrier to implementing changes towards a new model for people experiencing homelessness.

> "It does come with a need for real funding, both for the support and for the housing and in general. While there is a now a national housing strategy that will fund a substantial amount of the house, the supportive housing models historically have not included robust clinical case management and harm reduction and peer support. They tend to be lightly supportive for the most part outside of the developed disability sector. And what we've learned is that

you can do a huge amount more than that to support people." [Executive Lead]

Participants noted that the funding for CIRS was not planned; the municipal government simply spent what it needed to spend to implement the CIRS, which amount to $200 to $250 million in excess of what had been allocated. While it was politically expedient to obtain this funding during a public health emergency, it is very unclear where future funding to support long-term solutions would come from. Public responsibilities for funding are also a concern, since health care is a provincial mandate but housing and shelters are a municipal mandate. As such, it is unclear which level of government would assume responsibility for funding a new model. Some participants also noted that CIRS offer opportunities for cost savings, such as shifting safer supply opioid prescribing from physicians to nurse practitioners. As such, a cost-effectiveness analysis may be helpful for demonstrating that the new models represent good value for money.

Besides funding, participants identified several other barriers. Moving a costly new model forward, even if it is cost-effective, will require political leadership, but it is not clear which elected officials will be willing to advocate for this approach. The model will require collaboration across organizations and disciplines and a commitment to a mixed staffing model, which may be challenging. In particular, there is a need to avoid the implementation of a medicalized model and to address issues of power and ownership. This must include the priorities of racialized, Indigenous, queer, and trans communities – and avoid operating within an "institutional, oppressive and … white supremacist lens without even knowing it." Some participants expressed concerns that implementing a system in which providers compete for funds to implement new models will result in powerful winners keeping most resources with no system-level change. Finally, there is a need to ensure that any changes incorporate an accountability structure.

"So you can't just take the dollars and then not be accountable. That's the other piece. And sometimes, and I think we need to set very clear expectations. Accountabilities need to align with funding. And we need to ensure that people are delivering." [Executive Lead]

Despite the shared vision that the CIRS inspired, many participants were skeptical that actual change could happen beyond the pandemic, given the enormity of the obstacles to implementation.

Discussion

The CIRS were an essential component of the response to the COVID-19 pandemic in Toronto for people experiencing homelessness. Had the CIRS not been established, it is likely that Toronto would have experienced more large-scale outbreaks of COVID-19 in shelters for people experiencing homelessness. Furthermore, in the absence of the CIRS, people experiencing homelessness who were confirmed to have been infected with the COVID-19 virus or who were being investigated for COVID-19 would likely have been admitted to hospitals or would have stayed for extended periods in emergency departments, stretching capacity at key times in the pandemic. Much of the planning and implementation for the CIRS recognized this need within the context of a public health emergency. The early implementation of CIRS was characterized by uncertainty, rapidly changing plans, very long work hours, and long meetings but also by strong enthusiasm for the work that was being done, commitments for partner organizations to collaborate in innovative ways, and generous public funding. There was a strong consensus among our study participants that the CIRS were a highly successful and critically important component of the pandemic response that have important lessons for the post-pandemic period.

The models of care at the CIRS evolved rapidly. Both the medical model (focus on disease and physical issues) and the community model (considering physical issues alongside social and structural issues) co-existed, to some extent, at all times within the CIRS (the most medicalized model, of a "field hospital", was never implemented). At the executive level, the different models were characterized by decision making, control over budgets, and relationships between partners. Each of these characteristics evolved over time to be more collaborative and inclusive of all partner organizations, representing a shift away from a highly medicalized model towards a more community-oriented model. These shifts occurred both because of formal mechanisms – including an interim program evaluation, establishing a memorandum of agreement, inviting an additional community-based partner organization to the executive table, and greater budget transparency – and informally, as the representatives for partner organizations learned from and listened to each other.

The models of care were also reflected in how teams were structured, the roles assigned to workers who interacted directly with clients at the CIRS, and the services offered to clients. While the team structure had the potential to entrench hierarchies and power imbalances and to be overly managerial, it also served to protect the roles for teams with less power – such as peer and harm reduction workers – by ensuring that the services delivered by each team could be feasibly implemented and were valued. Participants from all teams emphasized the essential role of peer and harm reduction workers in providing client care – care that included obtaining important medical histories that physicians and nurses sometimes did not obtain. While the CIRS undoubtedly attracted clinicians who were interested in working to break down hierarchies, we also heard that these models were both possible and valued. The physical structure of the team space at the Downtown CIRS – a large single room in which all teams worked together and shared communication – is an apt metaphor for the kind of working relationships that many participants, across all teams, aspired to create.

While the CIRS were successful in integrating many aspects of community care within their structure and services, they were constrained in their ability to continue this model of care for clients after they were discharged. We heard from several participants about the frustrations behind discharging clients back into congregate settings where the risk of ill health was high, the persistent lack of permanent housing, and the challenges in continuing innovative harm reduction interventions, including prescribing of safer supply opioids. Participants strongly emphasized the need for reform of the larger systems of care – shelter, housing, and health, in particular – that limit the ability of any single setting, such as a CIRS, to have a meaningful impact on clients' trajectories of health and housing.

Many participants noted that the CIRS can serve as a case study for greater integration of services across partner organizations for people experiencing homelessness. Integration has been championed by health systems across the world as a means of improving both efficiency and patient or client experiences and is at the centre of current health care restructuring reforms in Ontario as part of Ontario Health Teams. Our evaluation suggests that being deliberate about the model of care that will be implemented is essential for successful integration. This deliberation requires careful attention to power imbalances and hierarchies and is critical for allowing all partner organizations to participate fully in decision making. These hierarchies include social stature (such as for physicians), control of budgets, and structures for participation in decision making. Addressing such power imbalances requires both formal agreements and processes as well as establishing collaborative cultures.

A successfully integrated model will also require careful thought about how to support peer workers. While peer workers provided critically important services at the CIRS and this work was largely valued, we also heard that peer workers were concerned about the large ratio of workers to managers, which limited their ability to have a voice in operational issues. Furthermore, some of the non-peer staff were perceived to have little or no experience working with people with lived experience as colleagues in client care. We also heard that working conditions at the CIRS could change rapidly for workers and that there was some uncertainty around sustainability of their roles. Several organizations were enthusiastic about hiring peer workers in the future (such as in hospital emergency departments). Because peer worker positions are both novel and lower paid, employers will need to ensure that peers workers have strong workplace protections, adequate representation in decision making, and structures to ensure accountability of employers.

While we conducted a large number of interviews from a variety of perspectives, it is important to recognize that the environment at the CIRS was dynamic and differed across the sites. Accordingly, many participants' experiences may have been specific to a certain time and place. Nevertheless, we are confident that the range of experiences across our clients allows us to put together these "snapshots" into a global, comprehensive, picture of the CIRS.

While the CIRS experiences are specific to Toronto, many of the most important lessons and recommendations are generalizable to other cities, including the importance of incorporating community models of care. Indeed, such models might be easier to implement in smaller cities where the number of partner organizations is smaller and relationships may be stronger.

There was a strong consensus among participants that the lessons from the CIRS offer an important opportunity to rethink shelter settings. Such change will require a strong vision of what the alternative might look like (where the CIRS experience can be strongly informative) as well as sufficient funding, political will, and accountability amongst all stakeholders. The alternative, however, is to return to a system widely recognized to be siloed, inefficient, and not working well for clients. As one executive lead said, "we run the risk of just going back to our own sandboxes and that would be tragic."

Recommendations

1. Partnerships are key to integration of health and social services for people experiencing homelessness. For these partnerships to be effective, they need to be inclusive and transparent, with clearly defined roles for each partner. Partnerships should also recognize that for all parties to have an equal voice, decision making structures need to be collaborative, innovative, and flexible. Because societal hierarchies may often be reflected in such relationships, addressing the related power imbalances requires written agreements, attention to how partners control budgets, and processes that encourage ongoing reflection and correction through open communication.

2. The complex needs of people experiencing marginalization are best met by moving away from siloed, biomedical approaches towards integrated models that are client-centred. The CIRS represent a novel and successful model that strove to address needs related to the health of clients, isolation during the pandemic, and social issues such as housing insecurity. Moving away from conceptualizing client needs as belonging solely within the health domain will facilitate innovation and involvement of a more diverse care team that serves clients more holistically than a narrower and more clinical approach. Careful selection of all staff members – including clinical and community workers – is critical for developing relationships between workers who interact directly with clients in which information is shared openly and effectively.

3. Projects in which teams work together in integrated models of care for people experiencing marginalization should pay close attention to who gets to be a leader and how to share leadership. Important aspects of leadership include collaborative decision making, effective and open communication, and opportunities for workers to voice concerns. Leaders need to make sure that their decisions have real benefits for clients and for people working directly with clients. Leadership accountability structures should be established early in the implementation of integrated care models. Decision making should be nimble and responsive. Structures which require multiple levels of approval, such as from both managers and executives, should be avoided.

4. Peer workers or people with lived experience should be involved in providing care for people experiencing marginalization in a wide range of health and social care settings and this involvement is likely to have significant and direct benefits for clients. Peer workers' expertise should be recognized and valued by people in leadership positions. Representatives of peer workers should be included at all levels of decision making, including the most senior. Peer workers positions should have stable funding and workplaces should support peer workers to do their work effectively.

5. The CIRS underscore the importance of having strong emergency preparedness plans in place for people experiencing homelessness and other aspects of marginalization. While the CIRS were able to innovate and adapt rapidly, this adaptation also reflected a lack of adequate planning and allocated resources. Future emergency plans for sheltering people who are experiencing homelessness should consider both public health needs (such as infection prevention and control procedures and availability of personal

protective equipment) as well as clients' needs (such as a space for cigarette smoking and supports for people who use drugs).

6. Funding for integrated service models should be determined by considering the objectives of the models and the resources required to meet these objectives. Funding for workers who interact directly with clients should be prioritized. Funding should also be flexible, recognizing that clients' needs and client volumes and corresponding service delivery models will necessarily evolve over time. Analyses of the return on investment from services delivered in the CIRS can help to inform future resource allocation decisions related services for people experiencing marginalization.

7. Community groups, health groups, and governments should come together to develop and evaluate new models for shelter and housing support based on lessons from the CIRS. The models should incorporate a full set of coordinated services for clients, include mechanisms for reporting regularly on their outcomes, and have established accountability for all partners. Governments should make sure these new models are adequately funded to meet their objectives. These models are most likely to be successful if they have strong champions inside and outside of government, backed by a broad array of organizations committed to social justice.

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