SUPPORTING PARTNERSHIPS BETWEEN HEALTH AND HOMELESSNESS

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How to cite this document:
Canham, S. L., Bosma, H., Mauboules, C., Custodio, K., Good, C., Lupick, D., Seetharaman, K., & Humphries, J. (2019). *Supporting Partnerships between Health and Homelessness*. Vancouver, BC: Simon Fraser University, Gerontology Research Centre.

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FUNDERS AND PARTNERS

Canada

metrovancouver
SERVICES AND SOLUTIONS FOR A LIVABLE REGION

HSABC
Homelessness Services Association of BC

Providence HEALTH CARE

SFU GERONTOLOGY RESEARCH CENTRE

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Acknowledgements

This project, Supporting Partnerships between Health and Homelessness, is funded in part by the Government of Canada's Homelessness Partnering Strategy. The opinions and interpretations in this publication are those of the authors and do not necessarily reflect those of the Government of Canada. All errors and omissions are the sole responsibility of the lead authors.

We acknowledge with gratitude that the research for this report was conducted on the unceded territories of the Coast Salish people, including the territories of the Musqueam, Squamish, and Tsleil-Waututh Nations, on which we are privileged to live, work, and play.

We would like to thank the following organizations for their commitment to this project by providing both input and direction on the development of the research and final report:

Homelessness Services Association of BC
Providence Health Care
Simon Fraser University's Gerontology Research Centre
RainCity Housing and Support Society
Lookout Housing and Health Society
Community Builders Society
Catholic Charities Shelter Services, Archdiocese of Vancouver
Vancouver Coastal Health
Fraser Health Authority
BC Housing

In addition, we would like to acknowledge the invaluable insight and knowledge of Nicholas Wennington and Dorothy Kestle who served on the project steering committee.

For valuable contributions to the initiation of this project, we thank Rebecca Barnes. We also thank Shelley Davidson for her involvement in this project and recognize the time and contributions of workshop participants and volunteers, including Emily Lonsdale, Eireann O'Dea, Chester Sun, Emme Lee, Camille Lefrancois, and Brett Diamond. We would also like to thank Kevin Wagner for illustrative contributions.

Finally, we are grateful for the time, interest, and insights given by each participant, and for allowing us to hear their stories.

This is an interactive report: All underlined links in blue will navigate you to the glossary, related appendices, or URL.
All dark blue text links to Chapter 6, Recommendations.

Preface
Executive Summary

Homelessness is increasing across Canada, including Metro Vancouver (Zlotnick, Zerger, & Wolfe, 2013). Homelessness is directly associated with negative health effects, and the health needs of persons experiencing homelessness are often complex and challenging to address (Frankish, Hwang, & Quantz, 2005; Hwang, 2001). Poor health outcomes among persons with lived experience of homelessness (PWLEs) are a result of multiple factors, including limited access to healthy lifestyle options (Homeless Link, 2014); barriers to accessing healthcare, delays in seeking care, treatment non-adherence (Hwang, 2001); and the adverse health effects of homelessness itself, such as exposure to the elements, the spread of infectious diseases within crowded shelters, and injury, trauma, and violence affiliated with shelter and street life (Khandor & Mason, 2007).

PWLEs' limited access to primary care services and difficulties navigating the healthcare system have resulted in increased emergency department admissions and longer hospital stays (Khandor & Mason, 2007; Hwang et al., 2011; Wadhera, Choi, Shen, Yeh & Joynt Maddox, 2019). The appropriate and timely discharge of patients experiencing homelessness from hospital to shelter/housing is further challenged by systemic issues, such as insufficient communication between shelter/housing and healthcare sectors, unavailability of wrap-around supports, and the lack of safe discharge locations that support recovery and after-care. Discharging PWLEs from hospital settings to unsupportive shelter/housing locations can lead to significant costs to the healthcare system, and can negatively impact the health and quality of life of PWLEs.

With the goal of enhancing knowledge about the best ways to support PWLEs in their transition from hospital to shelter/housing, the Homelessness Services Association British Columbia (HSABC) partnered with Providence Health Care (PHC) and Simon Fraser University's Gerontology Research Centre (GRC) on this project, entitled "Supporting Partnerships between Health and Homelessness."

A steering committee, inclusive of PWLEs and healthcare and shelter/housing providers, guided this research and provided critical feedback. The project consisted of three phases:

1. **Scoping Review**: A scoping review of existing literature was conducted to identify the health supports needed for PWLEs who are transitioning from hospital to shelter/housing. The findings from the scoping review were validated through a community consultation.
2. **Interviews:** Forty in-depth interviews were conducted with healthcare and shelter/housing providers and PWLEs to further assess the needs of people experiencing homelessness who are transitioning from the hospital to shelter/housing. This was followed by a second community consultation to expand knowledge about possible solutions for supporting hospital-to-housing transitions.
3. **Case Study**: Twenty in-depth interviews were conducted with healthcare and shelter/housing providers and PWLEs as part of a case study examination of two existing shelter and transitional housing programs in Vancouver, BC: St Paul's Hospital's Rooms at the Metson and the Vancouver Coastal Health (VCH) Shelter Project. This was followed by a third community consultation in which healthcare and shelter/housing providers, as well as PWLEs, discussed recommendations from all previous research phases on how to improve the health and psychosocial supports for PWLEs transitioning from hospital to shelter/housing.

The following chapters offer a detailed look into the multifactorial health and psychosocial needs of PWLEs, the barriers to care, and challenges in delivering care, while identifying both existing and potential solutions and recommendations for achieving these solutions. The data has been divided into five broad chapters following a collaborative data review process that included all members of the multidisciplinary research team. A detailed summary of the methods can be found in Appendix A, along with a glossary of terms (Appendix B), and a review of literature on the costs-benefits of housing and health interventions in reducing homelessness (Appendix C) that can be referred to when implementing the recommendations.

HEALTH AND SOCIAL NEEDS ASSESSMENT

The scoping review revealed the following key areas of support needed for PWLEs transitioning from hospital settings:

1. A respectful and understanding approach to care is needed to combat stigma experienced by PWLEs in healthcare settings.
2. Housing assessments should be conducted at hospital admission for the purposes of developing appropriate discharge plans.
3. Effective communication and coordination between healthcare and shelter/housing providers is needed to assist PWLEs in navigating the hospital-to-shelter/housing transition.
4. Both short- and long-term supports for after-care should be made available to PWLEs.
5. There is a need for complex medical care and medication management at shelters. Medical respite programs would offer an opportunity to meet this need.
6. Practical supports to meet PWLEs' basic needs (e.g., food, clothing, and transportation) should be provided to improve the discharge experience.

Interviews revealed that PWLEs who are discharged from the hospital require multi-level support for a broad range of health and psychosocial needs. The identified needs were categorized into seven categories:

1. Support needs for activities of daily living (ADLs), including bathing, toileting, dressing, transferring, and feeding oneself.
2. Support needs for instrumental activities of daily living (IADLs), including taking prescribed medications, food preparation, maintaining a clean home, mobilizing, and managing finances.
3. Follow-up and post-discharge care needs, including, but not limited to, case management, access to community healthcare providers, home care, bed rest, and wound care.
4. Needs for shelter/housing that is accessible, appropriate, and affordable.
5. Needs related to supporting specific physical and mental health conditions in shelters.

6. System-level needs related to system navigation and limited or overburdened services.
7. Communication and information needs related to health and available supports.

In response to the needs identified above, both existing and desired solutions to improving hospital-to-shelter/housing transitions for PWLEs were identified. Four overarching categories of solutions included:

1. The persons and roles involved in the process of hospital discharge, such as general practitioners, case managers or case management teams, and cross-sector outreach workers.
2. Collaborative cross-sector relationships between healthcare and shelter/housing providers.
3. Locations where patients can be optimally supported upon discharge, including shelters, interim/step-down care shelters (e.g., medical respite or priority shelter beds), supportive housing, and social housing, all of which should be universally accessible.
4. Physical tools, objects, policies, and initiatives that could be implemented, including discharge policies and practices, transportation options, professional education and training, and providers' approach to care.

CASE STUDY OF EXISTING HOSPITAL-TO-SHELTER PROGRAMS

Two existing hospital-to-shelter programs were examined to identify successes and challenges of each program. St. Paul's Rooms at the Metson is a project developed in partnership between St. Pauls' Hospital (SPH) and Community Builders Group (CBG) to offer stable transitional housing through six SPH-designated rooms at the Metson for patients who are ready for discharge but lack a secure location to go to after leaving the hospital. The program offers a range of medication services and funds a SPH social worker who works with the program participant at SPH and then follows them after discharge to the Metson to continue working on housing and supports.

The VCH Shelter Project is a pilot program developed in partnership between VCH, RainCity Housing and Support Society, Lookout Housing and

Health Society, and BC Housing that supports the discharge of persons experiencing homelessness from an acute hospital setting to 10 designated beds in two shelters in Vancouver, BC. The project aims to address the challenges to delivering follow-up care for patients experiencing homelessness who are difficult to track following discharge, while simultaneously addressing the challenges faced by shelter providers to offer clinical supports in non-medical settings. An additional goal of this program is to move program participants from shelter beds to transitional housing that supports increasing independence.

Strengths of both programs included:

1. Stabilization and recovery of program participants following discharge;
2. Respect for program participants' privacy and freedom;
3. Strong relationships between program participants and providers;
4. Support provided to program participants in finding transitional housing; and
5. Positive working relationships between cross-sectoral stakeholders.

RECOMMENDATIONS

The recommendations presented in this document are intended to serve as a framework for the further development and implementation of policies and programs for safe hospital discharges of PWLEs. A one-size-fits-all approach is not realistic nor appropriate, yet our recommendations provide a starting point for developing more effective discharge planning across different settings for a broad range of PWLEs in order to provide safer discharges, reduce hospital readmission, and improve health and housing outcomes for persons experiencing homelessness. The recommendations are organized into the following five categories:

1. Planning, developing, and implementing education and training to providers to reduce stigma.
2. Promotion of intersectoral communication and collaborations to improve working relationships and information sharing across healthcare and shelter/housing sectors.
3. Standardization of procedures surrounding hospital admissions, housing assessment, and discharge planning.
4. Ensuring that PWLEs have access to integrated case management and other community supports upon discharge.
5. Provision of a range of discharge locations that match the needs of diverse PWLEs.

KEY MESSAGES

1. Persons experiencing homelessness have unique healthcare and housing needs
Persons experiencing homelessness have a disproportionate amount of acute and chronic illness when compared to the general population, and encounter systemic barriers that may preclude them from seeking care and maintaining treatment adherence. Such complex health needs may act as a barrier to securing stable and sufficient shelter/housing, which can lead to a 'revolving door' of hospital admissions.

2. Enhanced training and education for providers is needed to reduce stigma
Healthcare and shelter/housing providers should receive training and education to implement trauma-informed and recovery-oriented harm reduction approaches to meet the health and social needs of persons experiencing homelessness. Destigmatization initiatives regarding mental illness, substance use, and homelessness within all healthcare and shelter/housing professions can improve the experience of hospital admission and discharge for persons experiencing homelessness.

3. Fostering intersectoral relationships is integral to the provision of care
Healthcare and shelter/housing providers should be provided opportunities to build trust and develop working relationships; and become aware of the best practices, challenges, and capacities within each sector via intersectoral visits and knowledge dissemination forums.

4. Coordination and communication between sectors leads to positive and effective hospital discharge
Transitions from hospital to shelter/housing should be guided by systematic and consistent procedures of discharge and referral. Healthcare providers should conduct in-hospital assessments of individuals' housing needs and communicate this information, along with relevant health information, to community health providers at the time of discharge. Memoranda of understanding should be developed to formally establish clear parameters for each sector to follow in implementing these standards of practice.

5. Respect for autonomy of persons experiencing homelessness is vital
Necessary information about diagnoses, medications, and after-care should be clearly communicated by healthcare providers to patients at the time of discharge so that they are empowered to make informed healthcare decisions and adhere to their after-care plan. Shelter/housing providers should begin relationship building with patients during their hospital stay, well ahead of discharge, to better understand their needs and preferences and make necessary arrangements to ensure a smooth discharge.

6. There is a need for more appropriate discharge locations and housing
A range of appropriate shelter/housing locations should be made available for persons who do not have suitable options at the time of discharge, including medical respite facilities that provide embedded medical and psychosocial supports, priority shelter beds that bring in healthcare supports, and supportive housing. Existing and proposed shelter/housing sites should have adaptable and universal design to support a wide range of needs. Additionally, there is a need for increased affordable housing stock.

Chapter 1
Project Overview

BACKGROUND

In 2016, the Homelessness Services Association of BC (HSABC; formerly the Greater Vancouver Shelter Strategy) completed a report, Health Supports for Shelters Serving Seniors (Greater Vancouver Shelter Strategy, 2015), which explored the health needs of seniors (aged 50+) and the challenges shelter providers face when trying to meet their needs. The findings showed that shelter providers often struggle to serve vulnerable seniors who have been discharged from hospital. In the report, the authors also recognized that shelter providers experience similar issues in serving the general population, and so the current study builds on this research and examines the needs of individuals experiencing homelessness of all ages.

Homelessness is increasing across Canada, as well as in Metro Vancouver, which is a federation of 22 municipalities, one electoral area, and one treaty First Nation (Zlotnick, Zerger, & Wolfe, 2013). It is estimated that at least 235,000 Canadians experience homelessness each year, and 35,000 Canadians are experiencing homelessness on any given night (Gaetz et al., 2016). In Metro Vancouver, the 2017 homeless count estimated 3,605 persons were experiencing homelessness (including persons both on the street and in shelters), an increase of 30% since 2014 (BC Non-Profit Housing Association (BCNPHA) & M. Thomson Consulting, 2017).

Homelessness has direct negative effects on health, and the health needs of individuals experiencing homelessness are especially complex and challenging to address (Frankish, Hwang, & Quantz, 2005; Hwang, 2001). Compared to the general population, persons experiencing homelessness have a disproportionate burden of acute and chronic illnesses. In Metro Vancouver, 82% of participants of the 2017 homeless count reported at least one health condition, including addiction, mental illness, physical disability, or medical illness (BC Non-Profit Housing Association & M. Thomson Consulting, 2017). Furthermore, individuals who are experiencing

homelessness also suffer higher rates of mortality than populations that are housed (Hibbs et al., 1994; Morrison, 2009). In fact, both males (Hwang, 2000) and females (Cheung & Hwang, 2004) who are experiencing homelessness in Toronto have been found to be at an increased risk of dying prematurely, with similar findings reported in British Columbia (Condon & McDermid, 2014).

Poor health outcomes among individuals experiencing homelessness are a result of multiple factors, including limited access to healthy lifestyle options (Homeless Link, 2014); barriers to accessing healthcare, delays in seeking care, treatment non-adherence (Hwang, 2001); and the adverse health effects of homelessness itself, such as exposure to the elements, the spread of infectious diseases within crowded shelters, and injury, trauma, and violence affiliated with shelter and street life (Khandor & Mason, 2007).

Barriers accessing primary healthcare: Increased hospital admissions

Despite considerably worse health than the general population, a significant proportion of individuals experiencing homelessness do not access healthcare services or have a stable, comprehensive source of primary healthcare (Khandor & Mason, 2007). A survey of 268 adults experiencing homelessness in Toronto found that 10% had not received any healthcare in the past year, 29% did not have a stable healthcare provider, and respondents who sought medical attention tended to access healthcare across a variety of settings to meet their needs, citing two or more providers as their usual source of care (Khandor & Mason, 2007).

As a result of limited access to, and use of, primary healthcare, the main point of entry into the healthcare system for adults experiencing homelessness is often hospitals and emergency departments (EDs) (Hwang et al., 2011; Saab, Nisenbaum, Dhalla, & Hwang, 2016). Khandor and Mason (2007) reported that hospital EDs were the most frequently used source of healthcare for persons experiencing homelessness in Toronto, with 5% reporting hospital EDs as their only usual source of healthcare. In the 2017 Metro Vancouver Homeless Count (BC Non-Profit Housing Association (BCNPHA) & M. Thomson Consulting, 2017), health services were among the most commonly accessed services: half of the respondents had used an emergency room in the past year; 40% had used the hospital for non-emergencies; 39% had been in an ambulance; and, 39% had used a health clinic. In all cases, the sheltered population used such health services more than the unsheltered.

Indeed, acute care and psychiatric hospital admission rates among people experiencing homelessness are higher than the general population and hospital stays are longer compared to other low-income adult patients (Wadhera, Choi, Shen, Yeh, & Joynt Maddox, 2019). Similarly, Vancouver Coastal Health (2012) found that residents of Vancouver's Downtown Eastside accounted for a large proportion of both ED visits and acute bed stays. This pattern of utilization of acute care settings by patients experiencing homelessness for their primary care is associated with high costs (Hwang et al., 2011).

Challenges to recovery following discharge

In addition to ineffective and expensive patterns of healthcare usage, the appropriate and timely discharge of patients experiencing homelessness from hospital to shelter is difficult. Patients experiencing homelessness are often deemed medically stable and discharged from hospital, yet remain too ill to reside in shelters or on the street (Health Care for the Homeless Clinicians' Network, 2007). Indeed, research conducted by the Homeless Link and St Mungo's (2012) in the UK found that more than 70% of patients experiencing homelessness were discharged from hospital back to the street without their housing or underlying health problems being adequately addressed. Premature hospital discharge, whereby patients are discharged from the hospital before they are clinically ready and without a safe home or sufficient support for basic after-care, prevents full recovery and increases health risks (Fader & Phillips, 2012; Health Care for the Homeless Clinicians' Network, 2007). Even when a patient is able to secure a shelter bed following discharge, these locations are suboptimal since there is no guarantee that 24-hour rest can be obtained or that shelter staff are able to assist with healthcare

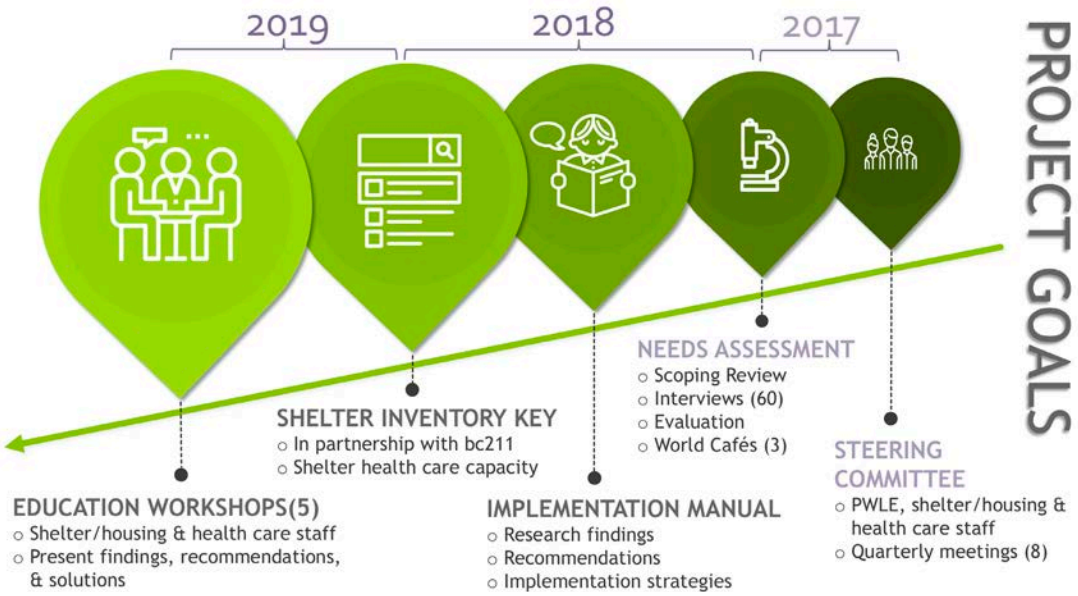


Figure 1.1 Project Goals

needs (Biederman, Gamble, Manson, & Taylor, 2014; Hauff & Secor-Turner, 2014; Kertesz et al., 2009). This situation can result in a cycle from poor health, to hospital admission and discharge, and then readmission—referred to as 'revolving door' admissions (Homeless Link & Homeless Link and St Mungo's, 2012). When persons experiencing homelessness are discharged from hospital settings to settings where they are unsupported and unable to convalesce and/or access follow-up care, costs to both the healthcare system and to individuals' health and quality of life are significant.

THE PRESENT STUDY

To improve the continuity of care and health outcomes for persons who are homeless and who are being discharged from hospital, a more complete understanding of the types of health supports required for this transition is needed. Yet, research on the specific health supports and services required during transitions from hospital to shelter or alternate housing has been scarce. Thus, this project, "Supporting Partnerships between Health and Homelessness," was initiated to enhance knowledge about the best ways to support persons with lived experience of homelessness (PWLEs) in their transition from hospital to shelter/housing (See Figure 1.1).

The project objectives included:

1. Understanding the supports and mechanisms necessary to support successful transitions from hospitals to shelters/housing
2. Increasing the possibility of greater future partnership between the health and homelessness sectors
3. Developing recommendations to improve referral processes between hospitals and shelters/housing
4. Articulating the costs of hospital stays by homeless individuals who continue to remain in hospital because adequate healthcare is unavailable to them in the community
5. Reviewing existing services to assist stakeholders to make the case for additional implementation of initiatives that support transitions from hospital to shelter/housing
6. Expanding the bc211 directory to assist hospitals in identifying which shelters have capacity to support individuals exiting hospital
7. Presenting recommendations and research findings to healthcare and homelessness service providers, as well as key decision makers, through education workshops

In order to accomplish these objectives, the Homelessness Services Association British Columbia (HSABC) partnered with Providence Health Care (PHC) and Simon Fraser University's

BOX 1.1 TERMS DEFINED FOR THE PURPOSES OF THIS STUDY

Healthcare participants: Research participants who were recruited based on their involvement in a hospital setting and having knowledge of PWLEs' discharge experience.

PWLE(s) (person(s) with lived experience): Inclusive of any person(s) who are currently experiencing homelessness or has previously experienced homelessness.

Shelter/housing participants: Research participants who were recruited based on their involvement working in the shelter/housing sector, including shelters and housing staff of not-for-profit agencies.

Gerontology Research Centre (GRC) to undertake a two-year research study using principles of community-based participatory research (See Appendix A for fully detailed Methods). In addition to the project team, a steering committee, made up of healthcare and shelter/housing providers and persons with lived experience (PWLEs) of homelessness, was established to guide the project actions. The steering committee was consulted quarterly, over the duration of the project to confirm that project materials and actions were aligned with meeting the objectives of the study.

The project occurred in multiple phases:

1. Initiated in January 2017, this project began by conducting a scoping review of the existing literature to identify the types of health supports needed for PWLEs transitioning from hospital settings to shelter/housing. Following the completion of the scoping review, our first community consultation with shelter/housing and healthcare providers was held October 25, 2017 to validate findings from the review of the needs and challenges previously reported in the literature and to identify gaps in the literature. Participant feedback has been incorporated into our findings. (See Chapter 2 for detailed Findings.)
2. Following the scoping review, in-depth interviews were conducted between October 2017 and January 2018 with 10 shelter/housing providers, 10 healthcare providers, and 20 PWLEs to assess the needs and gaps in addressing health, mental health and addictions issues for people experiencing homelessness who are transitioning from hospital to shelter/housing. Following analysis of these data, we held a a second community consultation on September 25, 2018 to get feedback from healthcare and shelter/housing providers, as well as PWLE members of our steering committee, on possible solutions for supporting PWLEs being discharged from the hospital. (See Chapters 3 and 4 for detailed Findings.)
3. From June 2018 to December 2018, in-depth interviews were conducted with 10 shelter/housing and healthcare providers and 10 PWLEs affiliated with two existing housing transition programs: SPH's Rooms at the Metson and the VCH Shelter Project. (See Chapter 5 for detailed Findings.)
4. Finally, we held a third community consultation on January 29, 2019, in which healthcare and shelter/housing providers, as well as PWLE members of our steering committee, discussed recommendations that had emerged from all previous research phases on how to improve the health and psychosocial supports for PWLEs being discharged from the hospital (See Chapter 6 for detailed Recommendations.)

While the solutions presented in this report are regionally focused and evidence-based, they might help inform and encourage any and all frontline staff and key decision makers in the healthcare and shelter/housing sectors to improve health supports that enhance transitions to shelters and housing. Alongside this final report, we have included a review of literature on the costs-benefits of housing and health interventions in reducing homelessness (See Appendix C).

KNOWLEDGE MOBILIZATION

In addition to presenting initial findings from this research at 3 community consultation workshops, the project team has been engaged in a number of knowledge mobilization activities over the course of this project.

Presentations:

- Custodio, K. (2018, May). *Health and Housing Research Project: Scoping Review*. Presentation for Department of Psychiatry Grand Rounds.
- Canham, S. L. (2018, June). *Homelessness in later life: Metro Vancouver*. Invited presentation for the Regional Stakeholders Dialogue on Seniors Homelessness.
- Davidson, S., Canham, S. L., Custodio, K., Mauboules, C., Good, C., Wister, A., & Bosma, H. (2018, October). *Health needs of older homeless persons who are transitioning from hospital to shelter/housing*. Paper for the 47th Scientific and Educational Meeting of the Canadian Association on Gerontology, Vancouver, BC.
- Canham, S. L., Davidson, S., Custodio, K., Mauboules, C., Good, C., Wister, A., & Bosma, H. (2018, November). *Health needs of older homeless persons who are transitioning from hospital to shelter/housing*. Paper for the 2018 Annual Meeting of the Gerontological Society of America, Boston, MA.
- Custodio, K., Mauboules, C., Small, S. (2018, November). *Supporting Partnerships between Health and Homelessness*. Panel presentation for the BC Not-for-Profit Housing Association Conference.
- Canham, S. L., Custodio, K., & Good, C. (2018, December). *Health and psychosocial needs of persons who are experiencing homelessness upon hospital discharge*. Presentation to the BC Healthy Built Environment Alliance at the BC Centre for Disease Control.

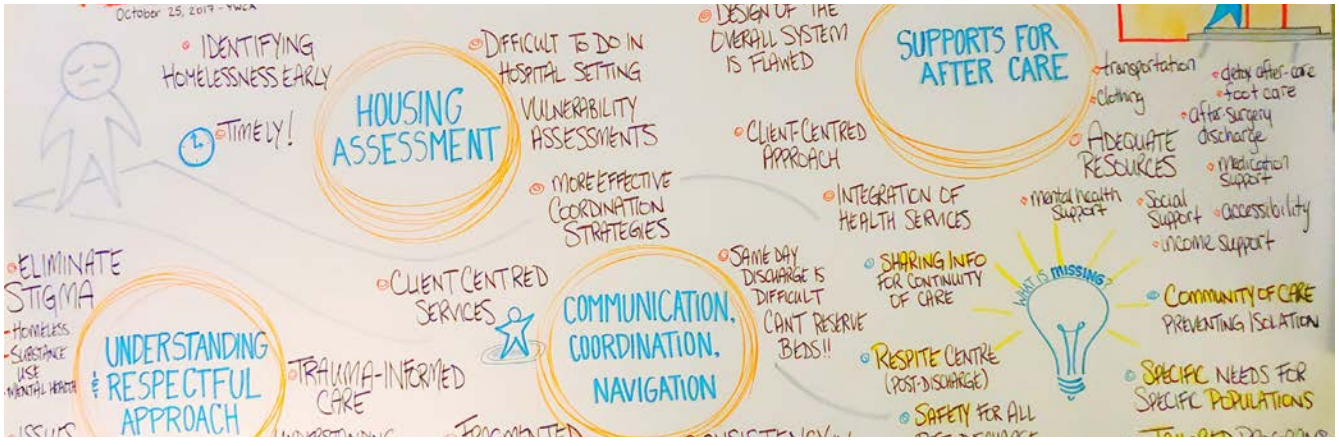
Publications:

- Canham, S. L., Davidson, S., Custodio, K., Mauboules, C., Good, C., Wister, A., & Bosma, H. (2018). Health supports needed for homeless persons transitioning from hospital to shelter/housing: A scoping review. *Health & Social Care in the Community*. https://doi.org/10.1111/hsc.12599
- Canham, S., & Davidson, S. (2017). Scoping review identifies the health supports needed for homeless persons transitioning from hospital to shelter or housing. *Seniors' Housing Update, 36*(2), 6. Available: http://www.sfu.ca/content/dam/sfu/grc/GRC_NEWS/grc_dec_2017.pdf

Additional research funding:

- *Determining the Feasibility of a Medical Respite Intervention Study for Older Homeless Patients in Vancouver, BC*. Funder: BC Support Unit Pathway to Patient-Oriented Research (P2P) Award, Michael Smith Foundation for Health Research. Research lead: A. Wister; Patient co-lead: C. Danielsen; Trainee: S. Canham. Community Partners: Providence Health Care; Catholic Charities Shelter Services.

In addition, future plans include engagement with key decision makers through an additional set of presentations so we can further share our findings and identify opportunities for implementation.



Chapter 2
Scoping Review

The first phase of this research project undertook a scoping review. This scoping review used a methodology based on Arksey and O'Malley's (2005) work, which outlines a five-step process for scoping reviews: 1) identifying the research question; 2) identifying relevant studies; 3) study selection; 4) charting the data; and 5) collating, summarizing, and reporting the results (See Figure 2.1) (See Appendix A for detailed Methods). In addition, a sixth 'consultation' step, organized as a knowledge café, followed our initial organization of primary themes from the literature. In order to identify studies relevant to our research question, "What are the types of health supports needed for homeless patients who are transitioning from the hospital?" we search 15 databases and 2 websites for 10 years of publications between January 2007 and July 2017. In addition, the bibliographies of the selected relevant publications were reviewed to uncover additional publications. After reviewing the full text of 322 publications, 13 sources were identified for inclusion in the scoping review. Two researchers independently conducted thematic analysis of the selected sources, resulting in six themes.

These six themes were then presented and discussed during this project's first community consultation, which engaged health and housing service providers working directly with persons who are experiencing homelessness. The purpose of this community consultation was two-fold: (1) to validate findings from a scoping review that identified the types of health supports needed for persons experiencing homelessness who are discharged from the hospital; and (2) to uncover gaps in the existing literature by drawing on the experience and expertise of healthcare and shelter/housing providers working directly with the homeless population. Ultimately, we sought a deeper understanding of the health supports required by homeless persons to successfully transition from hospital to shelter/housing in Metro Vancouver.

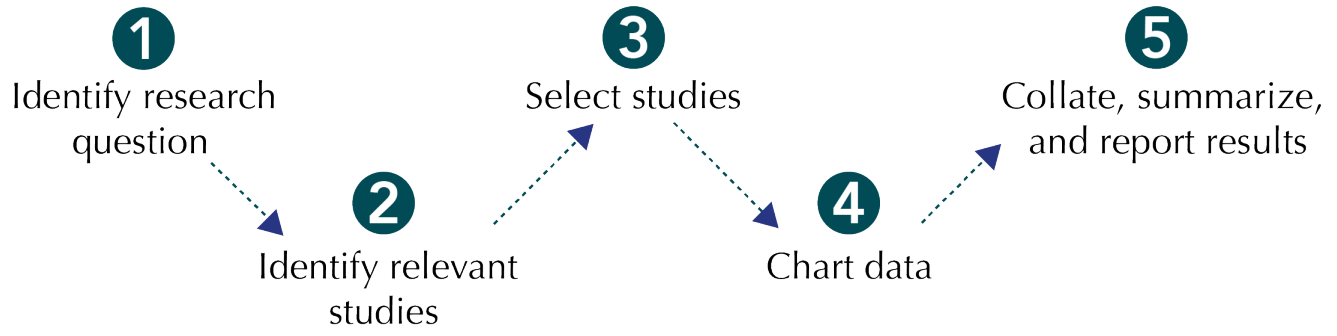


Figure 2.1 Review Framework

SCOPING REVIEW FINDINGS

Six themes related to the types of health supports needed for persons experiencing homelessness who are being discharged from the hospital emerged from the existing literature (See Figure 2.2), including the need for: a respectful and understanding approach to care, housing assessments, communication/coordination/navigation, supports for after-care, complex medical care and medication management, and basic needs and transportation. These needs can be conceptualized as pre-discharge and post-discharge needs, although at all time points along the continuum of care, homeless patients should be treated in a respectful and understanding manner (Theme 1). Upon hospital entry, the housing status of patients should be identified (Theme 2) and communication, coordination, and navigation of patients' post-discharge needs should begin (Theme 3). Once patients have been discharged, supports for after-care are crucial (Theme 4), including complex medical care and medication management (Theme 5), as well as basic needs and transportation (Theme 6). In addition to these themes, participants of the first community consultation highlighted the need for: trauma- and client/patient-centered care; available, appropriate housing for after-care respite; and housing to be viewed as a human right rather than a privilege.

1. RESPECTFUL AND UNDERSTANDING APPROACH TO CARE

The literature described the stigma felt by persons with lived experience (PWLEs), the challenges a sense of discrimination posed for care, and PWLEs' distrust of providers and of the healthcare system as a result of past negative experiences (Raven et al., 2010). Greysen et al. (2013) reported that PWLEs are hesitant to disclose their homeless status to hospital staff due to concerns that this disclosure would result in inferior treatment. In other reports, PWLEs felt that the lack of priority and poor treatment they received, including inappropriate discharge, was because of hospital staff's discriminatory and negative attitudes toward PWLEs' conditions and circumstances (Healthwatch England, 2015; Homeless Link & Homeless Link and St Mungo's, 2012). Feelings of discrimination have been reported to lead some patients to self-discharge prior to treatment completion and to feel discouraged from engaging with health service providers generally (Healthwatch England, 2015). As a participant of the community consultation stated, "I'm sorry to say as a nurse, there are a lot of nurses that don't see homeless people on the

BOX 2.1 TERMS DEFINED FOR THE PURPOSES OF THIS STUDY

Pre-discharge: Time period when a PWEL is in a private or public hospital, including psychiatric hospitals or substance use treatment centres, prior to discharge.

Post-discharge: Time period after discharge from a private or public hospital, including psychiatric hospitals, or substance use treatment centre.

same level as them. There is a lot of stigma and discrimination in healthcare."

Because of the poor treatment received in healthcare settings, the literature identified a need for healthcare providers to receive training to better understand the experience of homelessness and homeless populations in hospitals, including improved treatment of, and respect for, the needs of people experiencing homelessness (Bear, 2007; Homeless Link & Homeless Link and St Mungo's, 2012; Stallworth, 2007; Queen's Nursing Institute, n.d.). Furthermore, shelter staff have reported a need for improved cultural competence and understanding of trauma-informed care among healthcare providers (Hauff & Secor-Turner, 2014). A similar sentiment was expressed during our community consultation:

> Stigma is definitely there. I'm sure most of them [hospital staff] are pretty compassionate people most of the time. But then things happen where they end up reacting in a way that they shouldn't be reacting. That's where the trauma-informed care comes in.

Trauma-informed care is a framework that orients the delivery of care in various settings to persons who have been traumatized, including persons experiencing homelessness. Not only is the experience of being homeless traumatizing, but the pathway to homelessness is often fraught with trauma (e.g., childhood abuse, discrimination, historical racism). With the goal of reducing symptoms of trauma while facilitating recovery, the use of a trauma-informed care delivery focuses on individuals' strengths (Hopper, Bassuk & Olivet, 2010). Providing focused education and training on person-centered and trauma-informed approaches has been identified as necessary to enhance health and housing providers' knowledge and skills (Aubry et al., 2014); doing so can improve the respect for, and understanding of, homeless patients' lived experience.

Research with persons with lived experience of homelessness or mental health conditions have described the importance for providers to understand their experiences of homelessness as well as offer a welcoming, friendly, and respectful approach to service engagement and care continuity (Lamanna et al., 2017). The

Figure 2.2 Summary of Themes

"I'm sorry to say as a nurse, there are a lot of nurses that don't see homeless people on the same level as them. There is a lot of stigma and discrimination in healthcare."

importance of respect for the lived experience and cultural backgrounds of different patients has also been highlighted in research that considers strengths-based approaches, including patient-centered (Cloninger et al., 2014; Henwood, Shinn, Tsemberis, & Padgett, 2013) and trauma-informed (Hopper et al., 2010) care.

Patient- or client-centered care offers a complementary approach to service provision for homeless patients that involves individual choice based on unique needs and challenges (Pauly, Reist, Schactman, & Belle-Isle, 2011). Indeed, Housing First programs embrace the philosophy of providing person-centered care that is driven by the needs and goals of clients and builds on clients' strengths (Gaetz, Scott, & Gulliver, 2013). These frameworks offer models by which providers should approach the care and treatment of homeless patients in the hospital and throughout their transitions to other settings. An important caveat to this recommendation, as highlighted through the community consultation, is that in environments such as Metro Vancouver, where after-care supports and affordable housing are a struggle to obtain, discussions of approaches to care become more challenging. The primary need for care provision is having appropriate housing and after-care support available. Without adequate after-care resources, trauma-informed care is no more than a buzzword. That is, there need to be sufficient resources available to offer PWLEs before providers can offer care that is respectful.

2. HOUSING ASSESSMENTS

Previous research found that 56% of homeless patients reported that their housing status was not assessed while in hospital (Greysen et al., 2013), and only 22% said staff discussed long-term housing as part of their discharge plan (Greysen, Allen, Lucas, Wang, & Rosenthal, 2012). However, several literature sources reported that patients and providers believe there is a need to assess the housing situation of patients while in the hospital (Greysen et al., 2012; Homeless Link & Homeless Link and St Mungo's, 2012), as early awareness of housing status is associated with better quality discharge for persons experiencing homelessness (Greysen et al., 2013). In-hospital housing status assessments have been suggested as a possible avenue for improvement of the transition of PWLEs from hospital to shelter/housing (Greysen et al., 2012). Some of the literature suggested that the housing situation of patients should be questioned upon hospital admission to best prepare for discharge (Homeless Link & Homeless Link and St Mungo's, 2012).

Participants in our community consultation confirmed and elaborated upon this theme, suggesting that housing assessments be done at both intake and discharge because a patient's status may change while in hospital.

> Somebody may check the box of being housed at the point of intake but then it's not monitored. And housing shifts depending on how long they're in hospital or what happens with their condition. Housing assessment needs to be done at admission and ongoing as well.

This was suggested as particularly relevant for older adult patients who pay rent month-to-month by check who may be housed at intake, but evicted while in hospital if rent goes unpaid.

Moreover, as Greysen et al. (2013) suggest, there is a need to train hospital staff to conduct housing assessments with homeless patients using a patient-centered approach. Hospital staff should emphasize their concern for patients' well-being and safety when assessing housing status by asking: "Do you have a place to stay where you feel safe?" as opposed to direct questions about their homeless status (Greysen et al., 2013). Inquiring whether someone has a safe place to go recognizes an individual's agency and can build on their strengths for planning and problem-solving. This is important as the ability to assess housing need requires that homeless patients not fear discrimination because of their situation (Homeless Link & Homeless Link and St Mungo's, 2012).

3. COMMUNICATION/COORDINATION/ NAVIGATION

Greysen et al. (2012) report findings from interviews with homeless patients who describe a lack of discharge coordination between hospital and shelter settings, which is reiterated in other research (Healthwatch England, 2015), which suggests a lack of coordination between hospitals and housing services. Similarly, both patients and shelter and hospital staff reported either not being notified when or where homeless patients would be discharged or being notified late, which caused the discharge to feel rushed and created uncertainty about where after-care would be received (Albanese, Hurcombe, & Mathie, 2016; Healthwatch England, 2015; Homeless Link & Homeless Link and St Mungo's, 2012). The lack of coordination creates anxiety (Albanese et al., 2016), affects recovery (Healthwatch England, 2015), and leads to delayed care-seeking (Greysen et al., 2012) among homeless patients and can place patients in unsafe situations (Healthwatch England, 2015). At the same time, a lack of client information leads to frustration among outreach and shelter staff who are then unable to best support clients (Albanese et al., 2016; Homeless Link & Homeless Link and St Mungo's, 2012). Moreover, shelter and health staff have reported that navigating the healthcare system is a barrier for persons experiencing homelessness (Hauff & Secor-Turner, 2014). Homeless patients often require service providers to assist them in navigating the healthcare system, which can be overwhelming, as well as coordinate and advocate for needed services, which are fundamental to clients' progress (Healthwatch England, 2015; Lamanna et al., 2017).

This theme was supported through the community consultation, as participants reported on the "silos" that often exist between health and shelter/housing services because of confidentiality restrictions on sharing personal patient information. One participant stated,

> A lot of information is not being shared. There is no two-way street for the information sharing. To streamline services, it takes someone in the healthcare system who is willing to stretch that boundary for continuity of care. That is where you have improved outcomes.

Shelter staff participants also shared stories of homeless patients who were discharged from hospital and arrived unexpectedly at their shelter. While Metro Vancouver's lack of affordable housing was reported to result in homeless patients being often discharged into shelters, these locations were recognized as an emergency response that provide connections to resources and supports, but not a housing solution for homeless patients.

Research with shelter staff indicates that comprehensive communication—that is reliable, complete, and timely—between hospital and shelter staff can reduce inappropriate discharges that otherwise results in inadequate provision of care in a shelter setting (Bear, 2007; Stallworth, 2007). The distinct service systems of healthcare and homelessness services need to improve coordination to best support the transitions of homeless patients from hospital. For instance, hospital-to-housing projects in which nursing and housing workers are available and able to coordinate the transition of homeless patients from hospital have been reported to be particularly effective PWLEs' transition (Albanese et al., 2016). A collaborative, integrated network of service providers is particularly important in larger Canadian cities because of the challenges of coordinating a multitude of different agencies involved in supporting clients (Mcghie, Barken, & Grenier, 2013). To achieve this, coordination between the healthcare and homelessness service sectors is paramount. As Cloninger et al., (2014) state, "Public health planning requires intersectoral coordination of planning and service delivery because of the reciprocal influences that various sectors have on one another (p. 24)." Patients would benefit from increased collaboration between healthcare and shelter/housing service providers during this transition because the identified health needs may potentially be met by either sector depending on what the need is and where the patient is within the transition. Hospital and shelter/housing service providers should increasingly mandate shared accountability for the transition of persons who are experiencing homelessness from hospital to increase the likelihood that patient's needs are identified and supported during this challenging time. One avenue through which providers can begin partnership building is through

the development of a release of information form so providers can more seamlessly communicate with one another about the health needs of the homeless persons in their care. In addition, cross-sector training for hospital and shelter/housing staff was highlighted during the community consultation, as participants suggested that shelter providers and health staff have different ideas about discharge criteria for those experiencing homelessness. Opportunities are needed to increase understandings of the scope and ability of shelter providers to meet the healthcare needs of homeless patients who are discharged to shelter environments.

4. SUPPORTS FOR AFTER-CARE

Housing is a well-established social determinant of health (Mikkonen & Raphael, 2010). Therefore, discussions of appropriate healthcare delivery need to involve considerations of discharge, but also how to ensure that individuals get connected to housing and other necessary supports. Findings from the scoping review highlight the importance of after-care supports to stop the revolving door of hospital readmissions for homeless patients transitioning from hospital (Homeless Link & Homeless Link and St Mungo's, 2012). The literature describes various challenges reported by both patients and staff as a result of a lack of comprehensive services and supports after discharge (Hauff & Secor-Turner, 2014; Healthwatch England, 2015), including lack of access to specialty health services such as those needed for traumatic brain injury and mental health (Lamanna et al., 2017), lack of affordable or appropriate accommodation or step-down care (Hauff & Secor-Turner, 2014; Queen's Nursing Institute, n.d.), and lack of rehabilitation beds (Homeless Link & Homeless Link and St Mungo's, 2012). The full breadth of after-care needs ranges from sub-acute medical care and medication management to support for transportation, clothing, and dietary needs.

Community consultation participants identified a lack of available services, including detox, addiction treatment, home care, adequate social and supportive housing, and further suggested that the current service system is generally not responsive to homeless patients' needs. One participant stated, "We have implemented a system and then have tried to fit people into it. This is backwards. We should have built a system around the needs of the people." This is similarly reflected in the literature wherein homeless persons have reported a lack of support at discharge for the full breadth of their after-care needs, including mental health, substance use, housing, and financial issues; instead, oftentimes only their immediate physical health needs are considered (Healthwatch

England, 2015; Homeless Link & Homeless Link and St Mungo's, 2012).

The literature suggested that after-care can be scarce for certain patients, particularly those who have intensive, complex, and ongoing needs, such as medically ill patients who use substances who are hard to accommodate in the community or who are not registered with a general practitioner (Healthwatch England, 2015; Lamanna et al., 2017; Raven et al., 2010). Addressing the lack of medical care, social support, and unstable housing experienced by homeless patients is often not possible during relatively brief hospital admissions (Raven et al., 2010). Community consultation participants also reported that limited staffing resources and funding silos were barriers to accessing after-care support.

A related need identified in the literature was for immediate and long-term after-care supports for homeless patients transitioning from hospital. Community consultation participants cited comprehensive services, such as those that offer short-term treatment and then longer-term follow-up care, as having been successful in Metro Vancouver, but only available in one municipality. Similar programs were reportedly needed in other communities so that there is a more equitable distribution of resources across the region. Indeed, in order for staff to assist with coordination and navigation of after-care services, sufficient supports and resources need to be available. Multi-service agencies that offer integrated case management and both primary and mental healthcare are perceived as a solution to the lack of comprehensive services following discharge (Lamanna et al., 2017). With intensive monitoring and support, individuals who have multiple co-occurring disabilities and challenges have been found to be able to maintain their housing (Drury, 2008).

According to Lamanna et al. (2017), service providers and patients both reported that continuity of care could be improved through individualized and low-barrier services, including long-term services, that are scheduled promptly following discharge, and which can show "rapid results" to help homeless patients sustain their motivation to stay engaged in help-seeking. Planning for patients' individualized and long-term service needs requires staff to be engaged early on, regularly, and to be knowledgeable and welcoming (Lamanna et al., 2017).

5.COMPLEX MEDICAL CARE AND MEDICATION MANAGEMENT

At the core of homeless patients' needs when transitioning from hospital is the ongoing treatment and management of health issues. Homeless patients have reported being in poor health when they leave the hospital (Homeless Link & Homeless Link and St Mungo's, 2012). In research with shelter staff, inappropriate discharges occur when patients are transferred from a hospital to a shelter regardless of the shelter's ability to support patient after-care (Bear, 2007; Stallworth, 2007). For example, shelter staff reported that homeless clients with complex medical and medication instructions, or no instructions at all, have been discharged to shelters (Bear, 2007; Healthwatch England, 2015; Homeless Link & Homeless Link and St Mungo's, 2012; Stallworth, 2007). Shelters are typically ill equipped to provide care for discharged patients due to a lack of medical and shelter staff, clean space, supplies, and resources (Hauff & Secor-Turner, 2014; Stallworth, 2007).

These findings were supported by community consultation participants who emphasized that shelter providers are often short-staffed, working at capacity, and unable to provide medical care or assistance with activities of daily living to clients because these activities are outside their scope of practice. A community consultation participant stated, "I understand hospitals want to discharge people because they are not there to house people. They are there to provide medical services. But at the same time, we don't have the resources to take care of these people." Shelter staff have also previously reported that patients' medications are often lost, stolen, or unaffordable (Hauff & Secor-Turner, 2014) and that it is stressful for shelter staff and harmful to patients when patients are without the medications they need to manage their physical and mental health; unmanaged mental health problems can be especially disruptive to shelter environments (Stallworth, 2007).

BOX 2.2 MEDICAL RESPITE

Medical respite is post-acute medical care for homeless persons who are too ill or frail to recover from a physical illness or injury on the streets, but who are not ill enough to be in a hospital (Doran et al., 2013; National Healthcare for the Homeless Council, 2011). Some example programs in Canada include:

Sherbourne Health Acute Respite Care Program
Sherbourne's Acute Respite Care (ARC) program is a short-term health care unit located in Toronto that provides a supportive environment for persons experiencing homelessness to stabilize and recover from acute medical conditions, illness, injury, or surgery. The program provides 24/7 care by an interdisciplinary team of physicians, registered nurses, community health workers, and case workers.
https://sherbourne.on.ca/acute-respite-care/

Special Care Unit for Men and Women
Ottawa Inner City Health has two facilities with 30 (men) and 16 (women) beds respectively to cater to persons experiencing homelessness requiring treatment, care, and housing support. A team of nurses, doctors, case managers, and peer managers provide support for mental health and substance use issues, as well as find appropriate housing.
http://www.ottawainnercityhealth.ca/programs/

The Infirmary at Seaton House
The Rotary Club of Toronto Infirmary at the Seaton House shelter for men experiencing homelessness in Downtown Toronto provides healthcare services for individuals with acute and chronic conditions. The Infirmary also serves as a training site for medical students, nurses, and social workers to gain expertise and competency in treating persons experiencing homelessness
https://rotarytoronto.com/sitepage/past-projects/the-infirmary-at-seaton-house/

Participants in our community consultation agreed that shelter staff are unable to provide patients with specific medical needs and the amount of attention required for complete after-care. Community consultation participants further noted that shelter environments can be overwhelming for many people, as there are issues of theft and safety, as well as stress related to contending with behaviors related to other clients' mental health or substance use issues. For example, participants described instances of homeless patients being discharged but unable to obtain their prescription medications due to a lack of identification, and as a result engaging in illicit drug use to cope with their health issues.

Shelter staff have suggested that nursing, foot care, hygiene, and medication administration support would enable them to better serve their clients (Greater Vancouver Shelter Strategy, 2015; Hauff & Secor-Turner, 2014). Similarly, older adult clients have recommended that nurses visit shelters on a weekly basis to assist with medication management and to provide education on seniors' health issues_ (Greater Vancouver Shelter Strategy, 2015).

With the goal of providing safe locations for individuals to continue medical recovery, medical respite (alternately called intermediate or convalescent care) has been found to improve health and reduce healthcare utilization and costs for general populations of people experiencing homelessness (Doran et al., 2013). Though research on the impact of respite care has found mixed results regarding the mortality risk of respite patients vs. comparison groups (Meschede, 2010; Sadowski & Buchanan, 2009; van Laere, de Wit, & Klazinga, 2009), medical respite patients have been found to experience improvements in quality

of life, medication stabilization, access to health and community care, insurance, income, and housing, as well as reductions in substance use following treatment (Bauer, Moughamian, Viloria, & Schneidermann, 2012; Podymow, Turnbull, Tadic, & Muckle, 2006; Sadowski & Buchanan, 2009; Zerger, 2006). In addition, medical respite programs (See Box 2.2) have demonstrated reduced future hospital admissions, inpatient days, and hospital readmissions among homeless patients, resulting in significant healthcare system cost savings (Basu, Kee, Buchanan, & Sadowski, 2012; Buchanan, Doblin, Sai, & Garcia, 2006).

6. BASIC NEEDS AND TRANSPORTATION FOLLOWING HOSPITAL DISCHARGE

The scoping review identified that upon hospital discharge homeless patients may lack basic needs such as clothing, food, money, and safe and appropriate housing (Drury, 2008; Healthwatch England, 2015; Homeless Link & Homeless Link and St Mungo's, 2012). In addition, the lack of transportation at hospital discharge can be a challenge because it requires a person to walk to their destination at a time when they are often disoriented and vulnerable to experiencing relapse of underlying conditions (Healthwatch England, 2015; Homeless Link & Homeless Link and St Mungo's, 2012). In other instances, available transportation is considered unsafe, particularly after dark (Greysen et al., 2012), and especially so for homeless patients who have been discharged from the hospital with various health issues. The unavailability of transportation at discharge is considered a barrier to appropriate after-care (Hauff & Secor-Turner, 2014), including when discharging from detox and going to after-care (Raven, Doran, Kostrowski, Gillespie, & Elbel, 2011). One community consultation participant stated,

> One guy showed up in the pouring rain in a wheelchair with shorts on and one little change of a dressing that he could give himself, which he is obviously not capable of doing. So there's a lack of basic needs at discharge sometimes as well as safe transportation.

Participants of the community consultation emphasized that a lack of these essentials often impedes complete recovery and, instead, contributes to poor health outcomes and hospital readmission. Service providers also expressed concern that the provision of essentials, such as hygiene items, does not typically fall within the funding structure of shelters, so they are unable to support these client needs. In addition, participants reported that there are specific dietary needs for some individuals experiencing homelessness that cannot be accommodated in shelters.

Practical supports (e.g., safe transportation, healthy food, suitable clothing, appropriate housing) to meet these basic needs could improve the discharge experience and health outcomes for homeless patients, as well as reduce hospital or emergency readmission. Community consultation participants stressed the need for affordable housing with necessary supports in order to be able to meet the unique after-care needs of homeless patients being discharged from hospital. Viewing "housing as a human right" was highlighted by community consultation participants as an imperative whereby housing must be seen as a right, rather than a privilege; society has a responsibility to not allow individuals with medical conditions with no means of housing to be out on the street.

Developing a shared accountability and responsibility model that responds to health needs of this population should include a discussion regarding the costs associated with after-care supports. This conversation should be informed by what services will be offered, who will provide these service, and where they will take place. Future research should explore how to sufficiently finance the range of after-care supports needed by persons who are experiencing homelessness.

Chapter 3
Health and Psychosocial Support Needs and Challenges Upon Hospital Discharge for Persons who are Experiencing Homelessness

During the second phase of this research study, semi-structured interviews were conducted with 40 study participants from October 2017 to January 2018, both in person (n=24) and over the phone (n=16) (See Appendix A for detailed Methods). Participants included ten shelter/housing providers, ten healthcare providers, and twenty PWLEs (See Table 3 in Appendix A). The purpose of these interviews was to assess the needs and gaps in supporting health for people experiencing homelessness transitioning from hospital to shelter and housing. All interviews were audio recorded and transcribed verbatim; and data were analyzed using five phases of thematic analysis (Braun and Clarke, 2006). Findings from these interviews have been organized into two chapters; here, we describe the health and psychosocial support needs and challenges upon hospital discharge for persons who are experiencing homelessness.

INTERVIEW FINDINGS

Participants described PWLEs who are being discharged from the hospital as needing multi-level support, including a range of health and psychosocial supports. These needs have been categorized as: 1) support needs for activities of daily living (ADLs); 2) support needs for instrumental activities of daily living (IADLs); 3) follow-up and post-discharge care needs; 4) needs for shelter/housing that is accessible, appropriate, and affordable; 5) needs related to supporting specific physical and mental health conditions in shelters; 6) system-level needs; and 7) communication and information needs (See Figure 3.1). For each of these categories, we have identified potential challenges and barriers to meeting these needs, which require consideration.

1. SUPPORT NEEDS FOR ACTIVITIES OF DAILY LIVING

ADLs, which are basic activities that are considered necessary for independent living, include bathing, dressing, toileting, mobility and transferring, and feeding oneself (Katz, Ford, Moskowitz, Jackson, & Jaffe, 1963; World Health Organization (WHO), 2004). There was a reported need to support

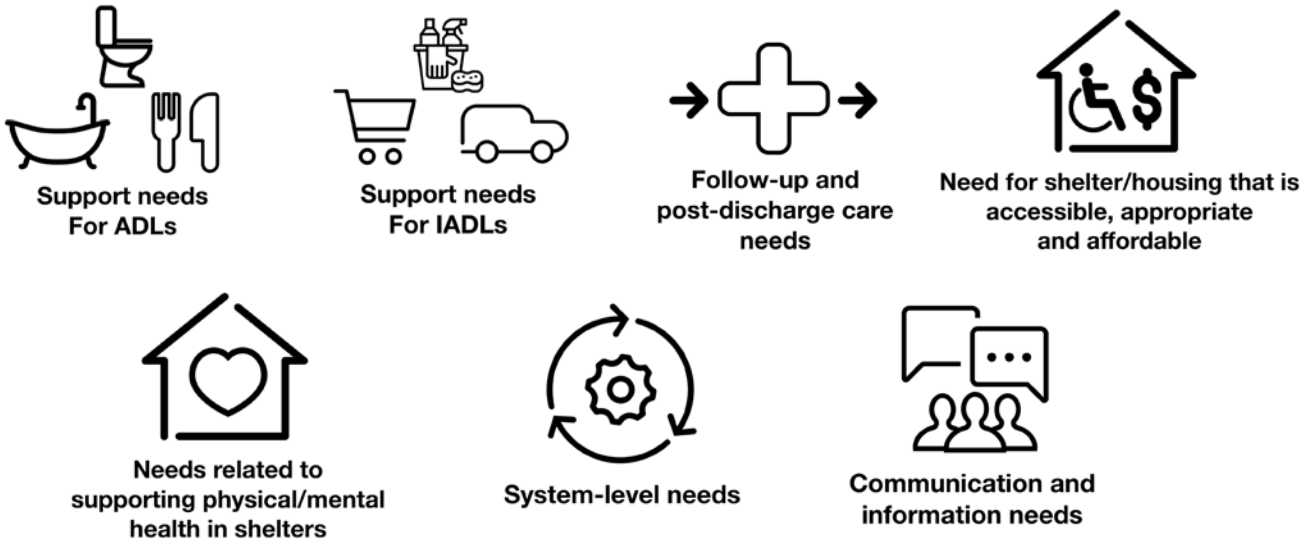


Figure 3.1 Interview Findings

PWLEs' performance of ADLs, particularly PWLEs who were experiencing debilitating chronic illnesses, cognitive impairment, and mental health or substance use issues; older adults whose declining health limits their ability to engage in self-care; and PWLEs who have not learned certain life skills:

> A lot of people [PWLEs] don't have skills around the activities of daily living. A lot of the people in the Downtown Eastside, or that come here, have not been brought up in that environment. Some do, but for the most part, certainly men don't have a lot of skills around how to function to keep themselves fed, cleaned, and their four walls in good shape. So, they really do need support around that. (Shelter/housing participant)

Participants reported that the inability to perform ADLs has important health and safety implications for PWLEs. For instance, one healthcare participant described the risks faced by PWLEs who require assistance with ADLs but transition into unsupported shelter/housing following discharge:

> If there is any assistance needed with personal hygiene or cleanliness or some clients have never had the opportunity or the ability to learn basic life skills, such as throwing out food before it gets rotten or doing things that could potentially cause a fire, those sorts of things. Or poor hygiene that could cause or exacerbate existing health conditions… Oftentimes, some of our clients would be discharged into housing that's unsafe for them…in terms of the person's ability to care and attend to their own needs. (Healthcare participant)

Participants reported that shelter staff are often unable to assist PWLEs who cannot independently perform ADLs and, therefore, a shelter is not the best place for them. For "people who can't do their own ADLs—so personal care, bathing, grooming, dressing, eating, things like that, a shelter is never going to be appropriate for them. (Healthcare participant)" For instance, one shelter/housing participant shared an example of a PWLE who was too weak to perform ADLs because they were on dialysis.

"People who can't do their own ADLs—so personal care, bathing, grooming, dressing, eating, things like that, a shelter is never going to be appropriate for them."

> We can't help people who are not able to live independently; people that can't make their own meals, can't get themselves to the grocery store. People on dialysis are very difficult to help, if they're very weak, just because they're just not able [to do things for themselves]. They're just really weak and they don't get the supports they need.

In situations where the level of care required by PWLEs is too high, such as the need for assistance with transferring from a bed to the washroom, most shelters are not equipped to support PWLEs, even when outside supports are available to come into a shelter.

> There are certain things that home health can do and can come out to a shelter to do. However, sometimes those care needs are way too high and if people can't transfer, then that's an issue…it's hard if they can't do those personal care needs and they require an overhead lift or they require mobility equipment. (Healthcare participant)

1.1 Bathing and Personal Hygiene

Participants identified several personal hygiene needs of PWLEs, including access to home and community care, clean, female-specific showering facilities, private washrooms for showering and personal grooming, and access to inexpensive personal care products, such as soap, shampoo and conditioner, and make-up. For PWLEs who are experiencing incontinence or have other conditions that affect toileting, incontinence pads are needed as well as home and community care to assist with toileting.

Participants reported that bathing and maintaining personal hygiene is a challenge in a shelter environment. First, shelter staff are often not trained to assist with PWLEs' healthcare needs and these tasks fall outside of their job responsibilities. As a result, shelter staff are limited in their ability to assist PWLEs who require help with bathing. Second, shelters seldom have the shower facilities or equipment to assist PWLEs who are unable to bathe alone. As a result of resource and space limitations, shelters often restrict shower and bathroom use, which impedes PWLEs' ability to complete their daily personal hygiene routines, particularly seniors or persons with ADL limitations.

PWLE participants indicated that being unable to complete their personal hygiene routine made them feel disgusting and had implications for their confidence and self-efficacy. As one PWLE participant described, "I didn't shower today, I feel gross, I need to go shower. When you're nice and clean, you can do things better." The lack of personal hygiene products and limited time available for showering and personal grooming was particularly challenging for females who reported not being able to do their hair, shave their legs, apply make-up, or do their nails. As another PWLE participant reported, "To take a shower and do your hair in seven minutes is not a possibility. If I wanted to shave my legs or if I wanted to do my hair, they don't have time in the shelter."

1.1a Oral hygiene needs and challenges

Participants identified several needs related to oral hygiene, including toothbrushes, toothpaste, and mouthwash; dental specialists, including oral surgeons; and proper nutrition and vitamins, including specially prepared meals. For instance, problems with dentition complicate eating and require that meals options are available for those who cannot effectively chew. Without this, PWLEs are at further risk of malnutrition and other comorbidities related to poor oral hygiene.

Participants reported that maintaining good oral hygiene and addressing dental needs is challenging for PWLEs given a lack of access to the tools and

Figure 3.2 Needs of PWLEs upon Discharge

products necessary for proper daily dental care, as well as a lack of follow-through with major dental work, such as oral surgery. For one PWLE participant, whose jaw was disfigured due to clenching during seizures, the lack of access to a qualified dentist prevented timely treatment and led to ongoing headaches and chronic pain. Despite urgently requiring dental work, another PWLE participant was unwilling to have dental surgery while living in a shelter out of concern for post-operative infection. This participant stated, "I need my teeth done really badly, but I won't have that kind of surgery done here. That's a sure death sentence as far as I'm concerned." Shelter/housing participants identified other oral hygiene challenges faced by PWLEs, including inadequate nutrition and substance use (e.g., crystal methamphetamine use). One shelter/housing participant summarized, "We see some of the most complex dental needs in this population. They're not getting the proper vitamins and we see crystal meth and other smoked drugs are really tough on the teeth."

1.2 Mobility and Medical Equipment

Mobility limitations were reported to occur across a continuum, from individuals who can walk, but slowly (i.e., with the assistance of a cane or walker and might not get to the bathroom in time), to PWLEs who temporarily require the assistance of crutches, to PWLEs who have had amputations, use a wheelchair, and cannot transfer unassisted into a bed. Identified needs of PWLEs who have mobility challenges included: accessible shelter/housing for people who use wheelchairs or walkers; shelter/housing locations that have overhead lifts to enable safe transfers; the ability for unsheltered PWLEs to be assessed for power mobility devices; personal mobility devices (e.g., crutches, canes, walkers, wheelchairs); and incontinence underwear (See Figure 3.2). Other medical equipment and safety supports needed for PWLEs to live well and appropriately in shelter/housing following hospital discharge included oxygen tanks, inhalers, and raised toilet seats, and in-unit accessibility features such as safety bars, non-slip rugs, smoke alarms, heat alarms, and buzzers to call someone in an emergency.

While there was some variation in access to medical equipment, some PWLE participants reported being able to access these supports. One PWLE participant reported that getting "support through the medical system [with] prescriptions and other individual needs that are specific to me have…for the most part, been fairly accessible: medication, getting the wheelchair, a walker; different add-ons that I need to make my life more comfortable." Another PWLE, who described problems breathing, reported having four inhalers and an oxygen tank at home. A shelter/housing participant reported that some hospital social workers are "excellent at making sure that everything's in place" for PWLEs upon discharge, ensuring that PWLEs have the necessary safety equipment before they leave the hospital.

Transitioning PWLEs into shelter/housing that is not equipped with safety measures, including safety

bars or non-slip rugs, was a reported challenge. There is a need for more efficient and timely access to equipment. While there are some agencies that provide some safety equipment, PWLEs often require assistance in getting these items or provider participants are unsure where to access medical equipment on loan. One shelter/housing participant stated, "[There] seems to be a huge barrier getting it there in a timely manner, or even being eligible for it." Another agreed:

> They [hospital staff] will send a referral in to get a loan of a walker, but I have to call every morning to see if they have it. In one case it took me two weeks. It was really bad, so this person didn't have a walker for two weeks. And, I thought it was pretty unsafe. (Shelter/housing participant)

Shelter/housing participants acknowledged the limited capacity of shelters to support PWLEs with mobility limitations. For instance, as one shelter/housing participant stated, "If mobility is an issue then they can't be here; the level of mobility has to be that they can at least walk, whether with a walker or cane." The lack of training in safely lifting or transferring PWLEs deterred shelter providers assisting persons with mobility challenges.

In instances when shelters are unable to accommodate a PWLE, an ambulance will be called to take the PWLE to the hospital.

> There was a fellow that didn't have a lot of mental health issues, didn't have a lot of addiction issues but he is obese and has chronic cellulitis in his legs, [he] mobilized using a manual wheelchair and became quite sick while he was at the shelter and was no longer able to transfer safely. So, they had to return him to hospital because they were not able to assist him to transfer. (Shelter/housing participant)

2. SUPPORT NEEDS FOR INSTRUMENTAL ACTIVITIES OF DAILY LIVING

Related to ADLs, IADLs are tasks that allow an individual to live independently in the community, such as food preparation and grocery shopping, taking prescribed medications, maintaining a clean home, mobility within a community, and managing finances (Lawton & Brody, 1969; WHO, 2004). Participants reported that PWLEs need significant IADL support to live in the community.

2.1 Food and Nutrition

Participants agreed that food securing and proper nutrition is an important aspect of PWLEs' health and that PWLEs often have low nutritional status and require nutritional support. As one healthcare participant noted, "Food security is a huge aspect [of health]. There isn't a whole lot of food security for clients who are low-income, so those would be some major health issues or barriers to health." Food-related support was described by shelter/housing participants to be an unmet need, though integral to the recovery of PWLEs who are being discharged from the hospital and need to proper nutrition in order to recover.

Some PWLE participants who reported receiving nutritional support upon hospital discharge described this as enhancing their discharge experience and contributing to a sense of feeling cared for. One PWLE participant shared, "They tried to make sure that I had food. That was a nice thing. Instead of just sending me home not knowing whether I had anything." Moreover, PWLE participants expressed gratitude for having regular access to food; one stated, "Food has probably been the least [challenging issue]. There's always food here. There should be more food, but there's always food. (PWLE participant)"

In contrast, other PWLE participants reported that providers do not understand or sympathize with the challenges experienced with accessing food to meet their dietary needs and preferences:

> I just got out of the hospital; I can't really make it [to the food bank]. It's tough on me, it's tough on my body, it's tough… They'll help you with your IDs or they'll help you with other things that you need, but when it comes to finances for food, it's a big issue. (PWLE participant)

Food needs were reported by one healthcare participant to be particularly challenging for PWLEs who have dietary restrictions or special food-related needs: "Any sort of special dietary requirements would make [being healthy] really difficult." Similarly, while some PWLE participants were

BOX 3.1 MEALS ON WHEELS

Meals on Wheels and a number of other meal programs exist that provide hot meals to people in need. These are volunteer-led and operated by local not-for-profit organizations in different areas within Metro Vancouver.
http://home-to-home.ca/meal-and-grocery-programs/
https://www.carebc.ca/meals-on-wheels.html
http://www.seniorsservicessociety.ca/smow.htm

able to access food upon hospital discharge, they identified the challenge of accessing *healthy* food.

> You know $20 doesn't get you a lot. Maybe it gets you a couple boxes of KD [*Kraft Dinner*], and I remember the social worker at the time on the phone telling me that, 'You know what, go to Dollarama.' I'm like, well I'll go to Dollarama, but am I supposed to live on noodles and macaroni and maybe chocolate bars? Because I don't really eat junk, right? I like to be healthy. (PWLE participant)

> One of my things there [*at a single room occupancy hotel (SRO)*] is not being able to access food sometimes—healthy food. The people I know, some people get food brought and then it's really healthy food and stuff, and I don't know how to access those things. (PWLE participant)

Though volunteer-based mobile meal services were identified, including Meals on Wheels (See Box 3.1), these were considered inadequate in meeting the needs of many PWLEs because of restricted hours of operation and limited service capacity: "The Meals on Wheels are sometimes closed and they just can't take anybody else, and that's quite an issue. (Shelter/housing participant)"

2.2 Prescription Medication Management

Participants reported that PWLEs require a diverse range of medications to manage both acute and chronic physical and mental health, as well as substance use issues. PWLE participants reported needing 1) medications to treat chronic pain, epilepsy, heart conditions, diabetes, and respiratory ailments; 2) opiate replacement therapy; 3) anti-retroviral medication for human immunodeficiency virus (HIV); and 4) antibiotics for infections (e.g., methicillin-resistant staphylococcus aureaus (MRSA), cellulitis, and kidney or bladder infections). Moreover, some medications need to be refrigerated, taken at specific times, or witnessed, so PWLEs "really need medical support around medications (Shelter/housing participant)," and particularly in shelters. Specifically, PWLEs reported needing assistance with arranging for prescriptions to be filled and paid for upon hospital discharge.

Participants described a number of challenges related to the ability of PWLEs to take their medications as prescribed. One shelter/housing participant emphasized, "A lot of PWLEs mismanage their own medication." The logistical challenges of medication management included coordinating with pharmacies for the administration or distribution of medications (i.e., filling and picking up prescriptions); storing or accessing medications (i.e., some prescriptions require refrigeration or need to be witnessed); high costs of prescription medications; and medication noncompliance.

2.2a Arranging for medication pick-up upon hospital discharge

Having to arrange for medication pick-up upon hospital discharge was reported as challenging for PWLEs, many who feel unwell. One PWLE participant stated, "You've got to get back to the shelter, you're not feeling well, and you've got to get medications dropped off and picked up. It would have been nice to have the medications—if they need to be taken, especially if they need to be taken right away—have them already filled." In other cases, PWLEs might be given a prescription, but not know where to get it filled.

Healthcare participants described some instances of coordinating with PWLEs' preferred pharmacies for the delivery or pick-up of prescriptions

BOX 3.2 INCOME ASSISTANCE

Income Assistance
The BC Employment and Assistance Program provides income supplements for persons who meet the criteria established by the Ministry of Social Development and Poverty Reduction.
https://www2.gov.bc.ca/gov/content/family-social-supports/income-assistance/apply-for-assistance

The Canada Pension Plan
The Canada Pension Plan (CPP) provides financial support to contributors throughout Canada (except Québec, which has the Québec Pension Plan) and their families in the event of retirement, disability, or death.
https://www.canada.ca/en/services/benefits/publicpensions/cpp.html

The Canada Pension Plan Disability Pension
The Canada Pension Plan (CPP) provides disability pension and post-retirement disability benefit to contributors who are disabled and unable to work regularly due to a disability. A monthly benefit is made available to dependents (under the age 25 years) of recipients of CPP disability benefit. Only individuals with the person with disability (PWD) designation can access the disability pension. Individuals who are age 18 years and older with a certified mental or physical impairment are regarded as persons with disabilities (PWDs) by the Government of BC.
https://www.canada.ca/en/services/benefits/publicpensions/cpp/cpp-disability-benefit.html
https://www2.gov.bc.ca/gov/content/governments/policies-for-government/bcea-policy-and-procedure-manual/pwd-designation-and-application/designation-application

Old Age Security
The Old Age Security (OAS) pension is a monthly payment made available to Canadians aged 65 and older. The amount of the pension is calculated based on the number of years the individual has lived in Canada after the age of 18. In addition to the OAS pension, persons may also receive: (i) Guaranteed Income Supplement (GIS), if they have a low income; (ii) Allowance, if they are 60 to 64 years old and their spouse or common-law partner receives OAS pension and GIS; or (iii) Allowance for the Survivor, if they are 60 to 64 years old and widowed.
https://www.canada.ca/en/services/benefits/publicpensions/cpp/old-age-security.html

Guaranteed Income Supplement
The Guaranteed Income Supplement (GIS) is a monthly non-taxable payment available to recipients of the OAS pension. It is calculated based on individuals' marital status and their previous year's income.
https://www.canada.ca/en/services/benefits/publicpensions/cpp/old-age-security/guaranteed-income-supplement.html

following their discharge, which was reported to increase the likelihood PWLEs will adhere to after-care treatment, and to align with a patient-centered approach to care. As one healthcare participant explained,

> Unless the patient already has a pharmacy, then we would call them up and ask if they can deliver. If they can't, do we need to send them a taxi voucher to the pharmacy first to pick up their meds [medications] and then to the shelter?

2.2b Medications need to be refrigerated, witnessed, or taken at specific times

Participants also reported that the type and scheduling of a medication could challenge a PWLE's ability to effectively manage medications,

particularly those that need to be refrigerated, witnessed, or taken at specific times of the day. A healthcare participant reported:

> There's some medications that we want to make sure people swallow and they don't just cheek it and save it and sell it or things like that. So, that's why it's witnessed. Another example would be if people have overdose risks or if we're worried they're selling the medication. We only give them small amounts at a time… It's really hard to take medication that needs to be witnessed or taken at a certain time of the day if you don't have a stable base to be going back to or know where you're coming from.

2.2c High costs of prescription medications

Participants described the prohibitive costs of certain medications, which was especially challenging for PWLEs who do not have medical insurance *(known in British Columbia as the Medical Services Plan, or MSP)* or Income Assistance (See Box 3.2). One PWLE participant described having to unexpectedly find funds when their insurance coverage for their diabetes medication was changed:

> My medication just recently is not covered through my insurance coverage. So, coming up with funding for insulin, which I feel I shouldn't have to pay for because I never have had to before in my life…I asked for the previous insulin I was on, which would be covered, but then they said they can't prescribe it to me because they're afraid of rejection issues … So, I had to get the insulin that costs the money, and I had no money.

Another PWLE participant described the frustration in being unable to afford the medication that was prescribed:

> They told me all the things that I could do, but really there's not a whole lot you can do when you're homeless and you're broke. They were trying to help me, but a lot of things they were suggesting—like, 'Oh you can get these medicines'—I can't afford. I'm not covered; so there's nothing I can do, stop offering it.

2.2d Medication non-adherence

One healthcare participant summarized a final challenge to medication management: "Some people are not compliant or they just don't follow-up on their medication post-discharge." Participants described some PWLEs not wanting to take medications on a daily basis or lacking motivation to adhere to medication regimens they believe are unnecessary. A shelter/housing participant noted, "Not everyone wants it [mental health medication], so that's an issue in itself." A PWLE participant confirmed not wanting to take daily medication to manage their mental health because of unwanted side effects:

> If I have an infection I will take that [medication]. If I have some other reason I need to take some kind of medication, I will take it. If I have to do it because my head isn't listening to me, I don't do it. I don't want to take daily medication. I've never been one for taking pills to begin with, so it's like I don't want to take a pill every day to make my head work…I didn't like taking it because one of them was a sleeping pill and I had to work, and I didn't want to be drowsy when I went to work.

2.3 Maintaining a Clean Home

Assistance with housekeeping was a reported need for PWLEs following hospital discharge, particularly for older adults who become less independent as health worsens. Maintaining clean accommodations was reported to be a criterion for staying housed, while poor housekeeping put PWLEs at-risk of eviction.

> I had one client who needed dialysis three times a week, and has no money, and broke her wrist and…she got bedbugs. So, I did everything in terms of the bed bugs. I…did her laundry, because there is no one that will do that, and a lot of seniors are not capable of that. They're just not capable… People get evicted because of this… (Shelter/housing participant)

Participants reported that budgetary constraints to home and community care programs increases the risk of PWLEs being evicted for failing to maintain a clean home. PWLEs who live alone or are disabled were considered to be particularly vulnerable:

> What we've noticed is because over the years there's been cutbacks to the home support program, long-term care, this whole tie-in to personal care, that people don't have the cleaning they need that helps them keep their

> housing. This lady is incapable actually of cleaning up, she's disabled in many ways, and so things fall by the wayside. (Shelter/housing participant)

2.3a Clothing availability and laundry

Access to clean and appropriate clothing was considered an important need for PWLEs who were being discharged from the hospital as personal hygiene and exposure to the elements impact health outcomes. Specifically, participants reported that PWLEs need inexpensive clothing that is appropriate for different seasons, including rain and snow gear, boots, and warm jackets. When asked what supports would be good to have upon hospital discharge, one PWLE participant stated:

> Clothing, because the seasons are always changing, and you always need extra clothes, or you always need different kind of clothes, like summer clothes. And it's hard because you only get one clothing allowance a year and they're really picky about when you get to get some and it's like, 'Well do I get it in summertime or do I get it in the wintertime?' If I get it in the wintertime I can't even buy a jacket because the jackets are too expensive; boots are too expensive—well boots are only $50 at [store], I like their boots.

Yet, PWLE participants shared experiences of having been discharged from the hospital with limited clothing, as exemplified by one PWLE participant:

> Maybe even a clean shirt would have been nice… I just walked out and then walked across the street to [anonymous organization], and that was that… I didn't have any stuff… I just had whatever was on my back and a small bag. (PWLE participant)

Equally important to having clothing was the need for regular access to laundering services. Participants noted an increase in the number of seniors accessing shelters who require help with laundry as well as circumstances that hinder PWLEs' ability to maintain an adequate supply of clean clothes, including mobility challenges.

2.4 Transportation

Mobility within one's community is an important IADL and is enabled through appropriate transportation. Participants reported a variety of transportation needs that would enable PWLEs to move around their communities, including: 1) transportation to get to a shelter or other location upon hospital discharge; 2) post-discharge transportation to get to and from necessary follow-up care (i.e., to begin or complete various treatment protocols, or pick-up prescription medications); 3) improved access to the Saferide program or other volunteer transportation services (See Box 3.3); and 4) low-barrier wheelchair accessible transportation.

Participants reported several challenges in accessing transportation, as well as inconsistencies in obtaining safe, convenient, and reliable transportation both to and from the hospital. While some PWLEs reportedly receive rides to the hospital and are given taxi vouchers or bus tickets to shelter/housing or other locations upon discharge, other PWLEs have to find their own means of transportation to the hospital and are discharged without any transportation arrangements. One PWLE participant stated,

BOX 3.3 TRANSPORTATION SERVICES

BC Bus Pass
The BC Bus Pass is offered at a reduced cost to low-income older adults. Persons receiving provincial disability assistance can access a monthly transportation supplement of $52.
https://www2.gov.bc.ca/gov/content/transportation/passenger-travel/buses-taxis-limos/bus-pass/people-with-disabilities

HandyCard
HandyCard provides public transit fare concession for persons with permanent physical, sensory, or cognitive disabilities. Through this service also allow customers' attendants to travel free of charge while accompanying customers on public transit.
https://www.translink.ca/Rider-Guide/Accessible-Transit/HandyCard.aspx

HandyDART
HandyDART is a shared ride service offered by Translink for persons with physical or cognitive disabilities in Metro Vancouver who cannot use public transit without assistance.
https://www.translink.ca/Rider-Guide/Accessible-Transit/HandyDART.aspx

Saferide
The Saferide program is operated by the Vancouver Recovery Club and provides safe transportation within the healthcare system for clients with substance use issues seeking recovery. The program responds to both emergency and non-emergency transportation (e.g., shuttle) requests from partners and collaborating agencies.
http://www.vancouverrecoveryclub.com/?page_id=128

TaxiSaver Program
TaxiSaver coupons are provided to HandyCard customers whose disability prevents them from using public transit without assistance at a reduced rate of $25. Customers can book a taxi themselves by calling participating taxi companies.
http://redbookonline.bc211.ca/service/9492478_9492478/taxisaver_program

> Some places around here, they give you a cab voucher to get up there, but they don't give you a cab voucher to get home. And now you've been at the hospital for six hours, seven hours, it's 3:00 in the morning and there's no more buses and now you've got to walk.

In addition, some PWLEs need to meet eligibility criteria in order to receive transportation services, which was perceived as a barrier; one PWLE participant reported that they were "asked a million questions" by hospital staff before getting a bus ticket. Healthcare participants reported that formal policies regarding provision of transportation upon hospital discharge do not exist, but that bus tickets and taxi vouchers are provided to PWLEs at the "discretion" of the healthcare provider or social worker, based on factors such as PWLE vulnerability, mobility level, and length of hospital stay.

In order to access safe and reliable transportation, participants reported a number of additional challenges, including not having access to a phone, being cognitively impaired, having mobility challenges, and not having a fixed address. Though participants noted that HandyDART *(See Box 3.3)* is available, advance appointments are required and individuals need to have the functional skills and financial means to access this service.

> We can enrol them on HandyDART, but you have to book those appointments weeks in

advance and that can be a barrier to using HandyDART as well because people have to phone that in and they have to have that wherewithal to make that appointment. (Healthcare participant)

Moreover, eligibility requirements, such as having a permanent address, preclude PWLEs from accessing HandyDART.

2.5 Financial Needs and Challenges

Participants agreed that increased income supports are needed for PWLEs and that money management "is a real problem." PWLEs reportedly require assistance with a range of financial matters, from banking and rental payments, to annual income tax submissions and estate planning. In addition, PWLEs need assistance in applying for and navigating the system of income support resources.

2.5a Income assistance

Limited income was reported to be a barrier to PWLEs' ability to access healthcare and obtain good health, particularly for issues that are not covered or are only partially covered by the Medical Services Plan [*MSP*] (See Box 3.4). As one healthcare participant stated, "The number one social determinant of health is income. The more money you have, the better health you have." One PWLE participant reported that their precarious financial status threatens their ability to pay for medical treatments and services; and without the necessary insurance coverage, they would become destitute.

> I'm on Disability [Assistance], so all my meds and stuff like that are covered and the tests—like the radiation—and the all that kind of stuff is also paid for. So, if I lost that, then I would lose everything for sure again.

"I'm on Disability [Assistance], so all my meds and stuff like that are covered and the tests—like the radiation—and the all that kind of stuff is also paid for. So, if I lost that, then I would lose everything for sure again."

PWLE participants also reported needing income support for other basic necessities, such as clothing, food, and household supplies, including bedding, pots and pans, and towels. However, one PWLE participant described the challenge in obtaining such items when their shelter/housing provider automatically withholds their disability income:

> I know at [anonymous hospital] they let you keep your full [disability] check, I'm wondering if all the hospitals can do that, like even here, if we're in treatment…you should be allowed to have all that money because people need things. How else are you supposed to get things, like your shoes or your jacket or anything like that, because you can't get them unless you have your full check, right?

2.5b Money management support

As a result of individual vulnerability to financial abuse, participants described the need to assist PWLEs with a range of financial matters—either firsthand or connecting them to community resources. Participants described some PWLEs who need more financial management assistance than others, including those who are struggling with issues of substance use or reduced cognitive capacity. It was suggested by a shelter/housing participant that these individuals make poor financial decisions that impact their ability to pay for health- and housing-related expenses and would therefore benefit from money management assistance.

> I can tell you another story of a really lovely 40-something year old woman who is working in the [neighbourhood] for a non-profit. She herself is a heroin addict, she is homeless… I

BOX 3.4 MEDICAL SERVICES PLAN

The public health insurance in BC is known as Medical Services Plan (MSP). BC residents pay monthly premiums which contribute to the costs of healthcare in the province. Premium assistance is offered to BC residents who have financial need (adjusted net income less than $42,000) and are unable to afford to pay the regular premium.
https://www2.gov.bc.ca/gov/content/health/health-drug-coverage/msp

> was able to locate her housing… She seemed to be very high functioning, but she just would not follow through with getting her intent to rent and getting moving into the building where I located her housing… After about a week and a half of trying to ascertain what was going on, her outreach team discovered that her last month's rent cheque had actually been given to her personally. And so, she had spent it and so therefore she didn't have rent money available to her and she did not want to disclose that. And so that was what was around the delay and following up on accessing the housing.

Similarly, money management assistance was considered to be important for older adults on restricted income who make independent financial choices, yet lack the full capacity to make responsible decisions. One shelter/housing participant described the 'tough situation' of an older adult who is "on OAS [*Old Age Security*] or CPP [*Canada Pension Plan*] and they're deemed financially capable and make poor decisions and they decide not to pay their rent for whatever reason and subsequently get evicted. However, they are deemed financially capable…"

Despite the need, participants agreed that money management supports are inadequate.

> A lot of the problems also are financial management. The service is only available for people who have an estate or there's one agency that does financial management, and that agency has had a pretty rocky road for the last two years, made many mistakes, and they're the only one available. They don't take anybody on PWD, so people who are on Persons with Disability don't have any help with managing their finances. Some of them have just really, really bad management but also some of them, some of the clients…aren't capable cognitively to, they might be able to live on their own, but they can't organize payments and all that stuff. It's too complicated now for people. So, there's a real gap there. (Shelter/housing participant)

In addition, participants recognized that assistance with taxes is needed because some services cannot be accessed if income taxes have not been filed. Specifically, participants noted that PWLEs whose income tax submissions are outstanding are unable to access medical premiums to meet healthcare needs.

> Another barrier is people doing their taxes. If they don't do their taxes then they don't qualify for services, and MSP premiums, these kinds of things. If they want to get on MSP they have to have done their taxes, but then they can't get their prescription. (Healthcare participant)

Finally, long-term financial planning for end-of-life matters was reportedly an additional need of PWLEs. Since many providers lack financial expertise and the legal authority to make financial decisions on behalf of PWLEs, it was emphasized that PWLEs need professional assistance with wills and estates. As reported by one shelter/housing participant, "They don't have much, but they want to know what's going to happen. We're not allowed to be guarantors or anything like that. We're not experts in that field."

3. FOLLOW-UP AND POST-DISCHARGE CARE NEEDS

Following hospital discharge, PWLEs have a variety of ongoing health and psychosocial support needs, including case management; social networks; transportation to follow-up care; access to general practitioners (GPs), health specialists, and counselling; home and community care; bed rest; wound care and IV therapy; foot care; and pain management. These post-discharge care needs are described along with associated challenges.

3.1 Case Management Needs and Availability

Case management is a collaborative, client-driven, goal-oriented process for providing PWLEs with quality health and support services within a complex health, social, and fiscal environment (National Case Management Network of Canada, 2009). Case management was a commonly cited healthcare need for PWLEs following hospital discharge. As one healthcare participant described, connecting PWLEs to community supports is an important component of follow-up care, particularly for PWLEs who lack an informal social network:

> Connecting them up to outside services, so whether people are also struggling with mental health or substance use, or they just don't

have an advocate, anyone else, any other support in their life making sure that they're being followed, that someone actually is aware of other services that they need, that if there is issues with transportation, of getting to outpatient follow-up resources, that they're actually able to get there. So yeah, really being connected in the community, at least if they don't have their own informal supports and connecting them with more formal supports, so that they are being supported at least one way or another.

Not only was having a case manager reported to be of value in facilitating after-care, case management was considered necessary given barriers to accessing services for PWLEs, including identification (ID) replacement and transportation to appointments.

Well, there's a lot of form filling that they need help with—applications for OAS, help with getting ID if they've lost it, because they're very at-risk, they're very vulnerable, so they get robbed a lot and need to replace their IDs. Like, I've had to go through a whole year before one of my clients could get OAS because of being out of the country for a period of time, so not being, once you're not consistently in Canada… It's a big problem. So, a lot of form filling. They definitely need help with getting groceries and often getting to appointments. Some of them can take the bus but a lot of them can't, so that's a bit of an issue for them. There's HandyDART, so hooking up to that, like these things have to be organized for them. They can't do this on their own. It's too complicated. A lot of it is computer, and you can only go to the library for like an hour. (Shelter/housing participant)

One of the main advantages participants described in being connected to a case manager or team is advocacy work that case managers can do on behalf of PWLEs. One shelter/housing participant felt that because "we have more homeless, fewer shelter beds, and we're in the throes of the worst ever opioid overdose crisis…having a strong advocacy team at the hospital upon discharge" was key to effectively assisting PWLEs transition from the hospital to shelter/housing, particularly given the inflated cost of living in the region.

Case management, however, was reported to be more available to some PWLEs than to others. Specifically, participants noted that PWLEs who have mental health diagnoses or HIV can more

> "People with some of the most complex health needs…don't see complex case planning"

easily access outreach support and community-based teams. Services were reported to be lacking for PWLEs whose primary health concern is related to substance use or other social issues.

Actually, mental health, patients with mental health issues, patients with HIV issues—they're fairly well supported—there's different programs that they can either go into a clinic or there's teams that will go visit them in their homes, do outreach in the community. But it seems like for addictions, especially or for patients that don't have any of those other needs, it's easier for them to fall through the cracks, like there doesn't seem to be a team out there that does addictions follow-up, or for patients that…have other social issues. (Healthcare participant)

One shelter/housing participant reported that "people with some of the most complex health needs…don't see complex case planning" and case management is further challenged by PWLEs who are transient: "We're not going to do wrap-around services with this population that have proven to be intrinsically transient. (Shelter/housing participant)"

3.2 Formal and Informal Social Networks

Participants reported that social support networks fulfilled both practical and emotional needs for PWLEs (i.e., help monitoring health, assistance with ADLs and IADLs, and companionship) and that having a support network was key to successful post-discharge care for PWLEs. One shelter/housing participant stated, "They just need somebody that cares. Not all of them need this, some of them have friends and family, but those that don't are at major risk." Several healthcare participants agreed:

How are we going to make sure that messages get passed onto you? And then how do we ensure that you have the support that you need to actually make it to your next medical

appointment? How are we supposed to arrange follow-up of any kind when someone is homeless? So, then you're looking at alternative measures, like is there family, is there friends, is there someone else that we can contact that you have regular connections with?

One or two of the most challenging issues that they face… it's having follow-up and someone helping them with their IADLs, like helping them get to appointments… There isn't a person in the community who can make sure they go to their follow-up appointments or that they are on top of their meds, they're on top of their chronic diseases, there just is not that comprehensive follow-up for people.

Participants described the association between social support and overall well-being, even when PWLEs' connections are with paid service providers. One PWLE participant shared how important human interaction is for reducing isolation and improving one's mood:

Support, it's just like a human being, even if it's fake—just like a human being that acts like they care. It makes a world of difference and people don't get that. Having that one person, even if I know you're getting paid…you feel not as isolated… Human connection is really important and when you're homeless you don't get that. The human connections that you do have are really shitty and toxic and when you do find a good human connection, it feels really good and that feeling lasts with you, it stays for sure.

Other participants confirmed the importance of having a support network during health crises to prevent a difficult situation from getting worse (i.e., going unnoticed and untreated).

I have always been told that I'm the one that has to get this equipment for them, because if left to the client it wouldn't happen… Some of them are very isolated, they have absolutely nobody, so they can't get somebody to do it for them… With the isolation, nobody sees them going down…unless they have a caring neighbour, they don't get the help unless they seek it out and a lot of them don't even know they need the help. So, the isolation's a big issue. It's a health risk. (Shelter/housing participant)

"With the isolation, nobody sees them going down…unless they have a caring neighbour, they don't get the help unless they seek it out and a lot of them don't even know they need the help. So, the isolation's a big issue. It's a health risk."

The lack of informal supports for PWLEs was reported to impact opportunities to access healthcare as well as safe and stable housing following hospital discharge. And yet, it was reported by one shelter/housing participant that family involvement in the provision of care in a shelter could be positive or negative:

Generally, we allow family to come in and that has mixed results. Sometimes family members come in—like this particular woman we have right now, her daughter who has a lot of

> psychiatric histories is coming in and helping her—but sometimes our past experiences, arguments can break out, disagreements can break out, and then they're involved in family issues, right?

Another PWLE participant shared the experience of having a family that was unwilling to help: "I tried to find another place to live, it was tough. I couldn't find, nobody knew. I had five family [members], they wouldn't help me, so it was tough."

3.2a Social network needs and challenges for individuals who use substances

Individuals with substance use issues were identified as a particular group in need of community-based support, both prior to entering detox treatment and upon treatment completion. One healthcare participant described the negative consequences of inadequate community support for PWLEs who want treatment:

> Even something as simple as they want to get support with treatment—[the] detox waitlist is really long, so now they have to wait in the community for it, but they don't have a phone or it's just easier to go back to what they know than to the unknown of trying to get sober. Even once they get clean there isn't really any—I wonder if there's any support out there for them; or are they out there having to create their own support network, to find housing or to stabilize?

In addition, PWLE participants described how substance affected their social support networks. One PWLE participant used drugs to cope with the loss of family members:

> I've been too busy being homeless, and using drugs, and forgetting everything, forgetting everybody. I just haven't tried…I just gave up on everything after my mom passed away and my son was killed. I just gave up on everybody. I gave up on my family, my relationship, myself.

Another PWLE participant decided to end relationships with former friends who continued using substances:

> I had to leave all my friends behind and everything and say goodbye to them, was very difficult. My boyfriend and everything, I had to say goodbye and he's with another girl now… but I have to live a new life where I'm clean and sober and he's still using so it's not good…

3.3 Transportation for Follow-Up Care

Lack of access to transportation upon hospital discharge was reported to be both frustrating and stressful for PWLEs. One PWLE participant, who was experiencing medication side effects (i.e., dizziness) at the time of a recent discharge, reported having been fearful of being hit by a car or bus while crossing the road to get to the bus stop and was "pissed off" that he was not offered a ride to the shelter. Safety concerns around taking the bus home after hospital discharge were echoed by other PWLE participants, some who reported being afraid of having a seizure or collapsing while on the bus.

In addition, participants reported that being unable to access transportation has implications for post-discharge treatment completion and recovery. Though there are multiple reasons why PWLEs might need ongoing transportation support, examples highlighted by participants included for ongoing IV therapy at the hospital, medication pick-up at a pharmacy, or physiotherapy.

> Transportation is a challenge. Say, someone is to come back every day for IV antibiotics. That's great, but they can't always get there, and transportation is a huge issue. We have one fellow here who's in an electric wheelchair and has to go back every day for IV antibiotics. Well, he couldn't go on a bus, needed a taxi, actually some of the support workers got their church to get a bit of money for him because there was no taxi vouchers available and he's someone who needed that, and the hospital doesn't have that capacity, or so we were told. So, that's a big gap, as well. (Shelter/housing participant)

In comparison, when post-discharge transportation was arranged, PWLE participants reported being appreciative, particularly in light of the discomforts and fatigue resulting from their illnesses. For some, the only aspect of their hospital discharge that went well was being provided with support for their transportation needs: "I got a bus ticket, and I had adequate transportation…that is one thing. They did make sure I had that. (PWLE participant)"

3.4 Access to a General Practitioner

Participants reported that general practitioners (GPs) are often integral to accessing health and psychosocial services, including home and community care and disability benefits, and act as a conduit for continuity of care within the healthcare system. Thus, participants emphasized that PWLEs need access to a regular primary care physician or a community clinic where they can receive appropriate post-discharge support. Reportedly, PWLEs who are hesitant to engage with the healthcare system or seek care could benefit from support in accessing a GP, as well as encouragement to actively participate with the healthcare system. One shelter/housing participant stated, "We try to encourage people to see their GPs or the medical supports that they do have already."

> "The only thing would be just not having a consistent GP to follow up with. That was probably the only thing that didn't work well was not having a primary care physician. So, you kind of get bounced around and you're going through many different doctors, just there's inconsistencies"

Despite the importance of having a GP for ongoing care, participants described challenges in creating a safe and effective discharge plan for PWLEs because many do not have a regular GP. Moreover, PWLE participants described the challenge in finding a regular doctor, particularly those who were considered high-risk patients. Noted challenges included doctors not accepting new patients and walk-in clinics telling PWLEs to find a regular doctor. As one PWLE participant stated, "[The clinic] can just tell you, 'You have to go see a regular doctor, we can't give you anything for pain.' And so, then I go drink." Another PWLE participant described their ongoing challenge in finding a regular GP.

> I don't have a family doctor and that's the thing that I had issues with—trying to find a family doctor—and there's none taking patients on. I've been struggling with that for the last four years now. I did have a perfect doctor, but now he's not doing his work out here, he moved back home.

Having regular access to the same GP and consistency in care was a further challenge identified by PWLEs.

> The only thing would be just not having a consistent GP to follow up with. That was probably the only thing that didn't work well was not having a primary care physician. So, you kind of get bounced around and you're going through many different doctors, just there's inconsistencies. (PWLE participant)

Finally, accessing a GP was reported to be even more difficult for PWLEs who wanted healthcare providers who are willing to prescribe medication for substance use treatment. As one healthcare participant noted, "They [PWLEs] might need support with addictions support. So, do they have access to a physician that prescribes opioids? Do they have access to a pharmacy that provides opiate replacement therapy?"

3.5 Access to After-Care Specialists

Once discharged from the hospital, accessing physical and mental health specialists for follow-up care was reported to be important for PWLEs' continued health and recovery. PWLE participants reported needing pulmonary specialists, speech pathologists, physiotherapists, occupational therapists, and mental health teams. In order to improve access to physical and mental health specialists, PWLEs need more information about available community-based services and assistance navigating the system. In addition, there is a need for better communication between healthcare and shelter/housing providers so that PWLEs can access specialists.

Despite the need, participants described access challenges to after-care specialists, including long wait times and eligibility criteria requirements. PWLE participants acknowledged that while hospitals can help PWLEs get on waiting lists for medical specialists, there are lengthy wait periods that require patience and perseverance on behalf of the PWLE.

> I do find that hospitals are good at getting you partial access to things. They will get you on

> a waitlist for something, they will try to get you access to a specialist where they can, and they make those things happen. It's just that that requires patience on the part of a patient because things are slow. (PWLE participant)

Meeting eligibility criteria for mental health services was also highlighted as a challenge. Shelter/housing participants described difficulty in helping clients who have mental health issues access community-based mental health services. Specifically, it was reported that a PWLE's inability to effectively communicate, coupled with providers' lack of access to a client's mental health history prevented shelter staff from determining which clients meet criteria for community mental health support. As one shelter/housing participant expressed, "When we're dealing with a client that's not even communicating clearly and we don't even know her name, we have no way of confirming that kind of history [such as the number of annual hospital visits]."

3.5a Wound care, infection, and IV therapy

It was reported that PWLEs requiring follow-up care for wounds, infection, or IV therapy need: outreach nursing care in shelters (e.g., to assist with bandage changes), information on community wound care resources, transportation to and from the hospital or clinic for ongoing IV antibiotic therapy, a clean and safe place to rest so wounds can heal, and assistance filling prescriptions and managing medications. As one shelter/housing participant suggested, follow-up wound care would "minimize the number of calls we make to 9-1-1 to take clients for simple things that could be avoided like dressing changes or bleeding wounds."

Though some healthcare providers deliver follow-up care in some shelters, wound care often requires specialized dressings, and many shelters are neither equipped to manage these issues nor have the training to provide wound care or IV therapy. As one shelter/housing participant reported, "We can do basic first aid, we're all trained in occupational first aid… but, we're not trained to do wound care on a heavier level." PWLEs requiring regular wound dressing changes or IV therapy to treat an infection continue to face challenges in shelters. For instance, improper follow-up or barriers to

accessing after-care support for wound care can result in a full-blown infection that requires IV antibiotics or even amputation. Additionally, crowded or unclean shelters, combined with poor personal hygiene, can cause bacterial infections.

3.5b Foot care

A common health need of PWLEs is adequate foot care, including cleaning and trimming nails. While foot care is a matter of personal hygiene that reflects personal care habits for some PWLEs, others require foot care as part of managing a chronic illness. One PWLE participant reported that shelters are not equipped with personnel or equipment to help with pedicures. Another PWLE participant who had diabetes described the inability of his feet to properly heal because of being on his feet all day:

> My feet are in terrible shape and I don't have enough time off my feet to successfully heal my foot because there's nowhere I can take my shoes off and let my feet go. I'm just always on my feet and it just gets worse.

Shelter/housing participants acknowledged the challenges associated with proper foot care in a shelter. With a lack of resources to offer foot care and the inability of PWLEs to care for themselves, shelter/housing participants described how they encouraged PWLEs to seek appropriate foot care from healthcare professionals. One shelter/housing participant recalled encouraging a PWLE "who had diabetes and [whose] feet were absolutely gross" to visit a doctor to receive foot care. In shelters where foot washing services were occasionally offered to PWLEs, this provided an opportunity to identify underlying foot care needs and make appropriate referrals. As one shelter/housing participant described, "We have student nurses that come in and do foot washing with a teacher that oversees and can identify if there's more health issues with their feet and refer them onward."

3.6 Counselling Services

Counselling was among the most commonly reported after-care support needed for PWLEs. PWLE participants reported experiencing emotional stress ranging from family and relationship stress, to stress associated with the loss of loved ones, which impacted their health. Despite the persistence of stigma associated with accessing mental health supports, participants reported that counselling is needed to help manage mental health issues, such as anxiety and trauma, and life changes, such as the loss of a job or relationship.

> If our community in this area had more resources for counselling—counselling coupled with medications—like dealing with some of the mental disorders that we see down here, it would be very valuable; that would be a great support. And even for people in general who may not be dealing with something like a physical health issue or a mental health issue or a mental illness, but their mental health is not good because they're in this area, because they've lost work, or they're in broken relationships. Counselling is very valuable in those times. (Shelter/housing participant)

There was a reported need for onsite professional counselling services in temporary accommodations as participants regarded professional counsellors as able to provide a service unable to be met through casual social exchanges with friends or other untrained persons. Even shelter staff who receive training in active listening cannot replace the need for professional counselling. As one shelter/housing participant noted, "A lot of organizations train their staff to do their best to be present and actively listen, but it's not the same when you actually get a counsellor." Moreover, in the absence of having a case manager, one healthcare participant emphasized the importance of PWLEs having someone stable, such as a counsellor, to rely on "to access medication or antibiotics, or issues with addiction, counselling, just all-around support. Not everyone has a case manager who they can depend on, so just having a constant person or face that they can work with on their issues."

"If our community in this area had more resources for counselling—counselling coupled with medications—like dealing with some of the mental disorders that we see down here, it would be very valuable; that would be a great support."

Having counsellors available following hospital discharge was described by PWLE participants as one way in which their discharge experience could be improved; having someone to check in on them and be concerned for their safety and well-being was reported to be comforting.

> Counsellors are there to make sure that you're going to be okay where you're going to be situated at, that you're going to be safe, that I'm not going to harm myself or others or that I'm in this proper mind state to be living on my own; that's what they're there for. (PWLE participant)

3.7 Home and Community Care

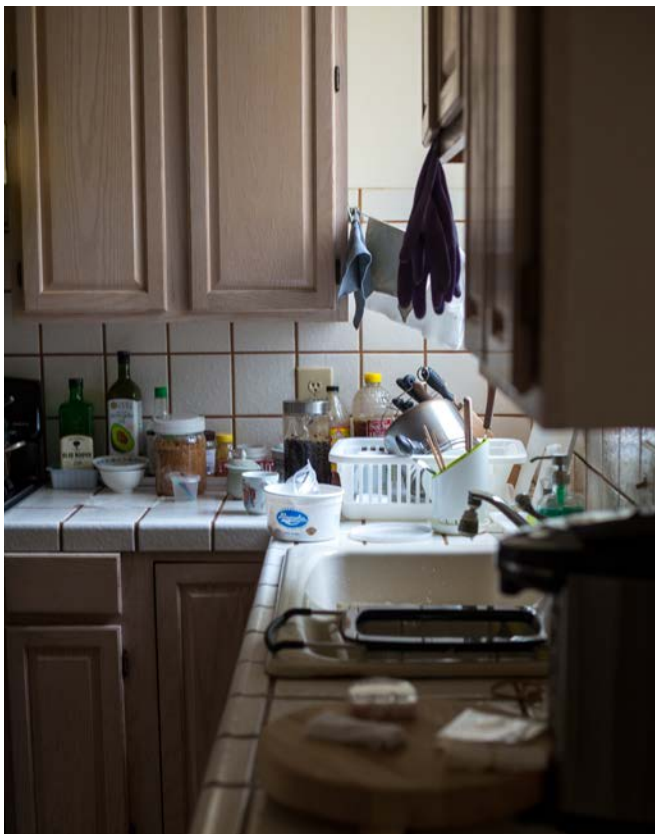
Delivered by regulated healthcare professionals (e.g., nurses), non-regulated workers, volunteers, friends, and family caregivers, "home and community care" services help people to receive care at home, rather than in a hospital or long-term care facility and to live as independently as possible in the community (Government of Canada, 2016). Home and community care, also referred to as home care or home health by participants, includes services such as nursing, personal care (i.e., help with bathing, dressing, and

feeding), physiotherapy and occupational therapy, speech therapy, social work, dietician services, homemaking, and respite services.

Home and community care were reported health needs for PWLEs following hospital discharge. When asked what types of supports were unavailable, but would have been helpful at the time of discharge, PWLE participants described needing assistance managing their medications, cleaning and completing household chores, bathing and grooming, preparing food, and traveling to and from medical appointments and follow-up care. Some PWLEs reported needing help with multiple health-related tasks:

> Someone to take care of me, to be there if I fall, and when I'm in pain, or whatever, I need my medication…There's no transportation... And I couldn't get myself going. I couldn't get up, my bones would ache, and there's no one to help you to get something to drink or eat. (PWLE participant)

Participants agreed that in-home or onsite home and community care are needed for PWLEs who have been recently discharged from the hospital and emphasized that services should be comprehensive, mobile, and specialized.



> You would want to be able to provide that really embedded health element, that 24-hour nursing component here. It's preventative medicine… It's also getting ahead of pneumonia instead of having pneumonia go to the full-on surgery where we're removing fluid from someone's lungs. (Shelter/housing participant)

In addition, home and community care should be aligned with the principles of patient-centered care.

> I think we need better community supports, you know if we had more access. It's kind of like this domino effect; if we had access to housing then we could do home IV (therapy), and we have nurses that could come to your house and do that, that's more patient-centered than someone in hospital for six weeks getting four times a day antibiotics and whatnot. (Healthcare participant)

Participants reported a willingness to facilitate home and community care for PWLEs who have been recently discharged from the hospital, and the success in doing so. One shelter/housing participant noted, "When it works, it works great." Home and community care was also seen as a potential avenue for preventative care.

> There's some people who are coming all the time to emergency, and we wonder, if we just proactively set up someone to go into their house to check in with them, maybe they'd be less inclined to come here [to the hospital]. (Healthcare participant)

However, there were gaps identified in patients who could access home and community care.

> There's not really a middle ground. So, if they're really not doing well and not functioning and not mobilizing well, then we can put in home supports. But, if they have diabetes, they have chronic disease and COPD, but they're independent with mobilizing, then there isn't much for those guys. (Healthcare participant)

3.7a Challenges with home and community care

Providing or arranging for onsite or home and community care was reportedly made difficult because there are long wait times for PWLE

assessment and limited resources. One shelter/housing participant described the one- or two-week waiting period following hospital discharge before home and community care services are set up, during which PWLEs are not receiving necessary care.

> People with physical needs sometimes need more follow-up by the health system. Now, one of the things is when they leave the hospital and even though they're going to be getting what they call home care assistance, that doesn't get set up until a week or two later. That really puts people at-risk sometimes. So, I've had a client who's gone into the hospital, been released back home, but the procedure is, and even though there was a whole planning team talking about what was going to happen for this client, the home health had to come in and do an assessment to see what the needs were. That's their process, so that would take a few days, and then after the assessment then they would assign tasks for the team to provide medication or assistance with a bath, or whatever.

In addition, bringing home care workers into shelters was also acknowledged as a challenge because these locations were not designed to support PWLEs who require healthcare services.

> I appreciate the fact that there's a willingness from home health to try to make it work, but then our concern is, then what? …We don't have care aides; we don't have the facility to keep this equipped. Where do we store all their stuff? So, if they provide a chair or a certain showerhead or whatever, where do we put that when that's not needed? …It would just be too hard to accommodate all that. (Shelter/housing participant)

> Home health are starting to go to the shelters but sometimes they have to think of safety for themselves, so home health may not go in at certain hours of the day, it might be it's only in the afternoon, but these guys need around the clock IV therapy. (Healthcare participant)

3.8 Bed Rest Following Hospital Discharge

Participants reported the need for a safe, clean place for some PWLEs to rest and continue recovery following hospital discharge. One shelter/housing participant stated, "It's that recovery part that is missing, what the person really needs to come back up to health." Adequate respite was regarded to be integral to optimizing recovery, minimizing post-discharge stress, and promoting healing for both acute and chronic healthcare issues.

In some temporary shelters, there are rules that shelter guests need to leave during daytime hours. As a result, PWLEs need to vacate and often have little opportunity for rest and recovery, which can exacerbate poor health conditions. For example, wearing footwear for extended durations and being constantly mobile can prevent foot wounds from fully healing, delay recovery, and increase risk of infection for individuals with diabetes. Other PWLEs who are discharged from the hospital after spending hours in the emergency room waiting for medical care are often fatigued with no safe, clean place to rest.

While shelter/housing participants reported the importance of proper bed rest upon hospital discharge, staffing limitations and restricted hours of operation resulted in the inability to provide around-the-clock bed rest for clients. Even when given post-discharge instructions advising recuperative rest, many temporary shelters do not have the capacity to provide PWLEs with undisturbed bed rest. As one shelter/housing participant stated, "We can't give them bed rest 24/7. We're not equipped for that."

3.9 Pain Management

Pain treatment needs include being able to receive treatment in a low-barrier clinic that is close to where PWLEs are staying or being provided with a sufficient supply of pain medication upon hospital discharge. As reported by one PWLE participant, "An ideal discharge would be making sure that patient has adequate pain control regardless of whether the norm is this or that. Make sure they have what they believe is going to be enough to get them through."

Participants described how chronic and acute pain affects the physical and mental well-being of PWLEs. For one PWLE participant, enduring chronic pain was reported to create an inability to

concentrate or think, leading to unhappiness: "It's when I have pain and when I can't concentrate or think, I get really sad… and then I have migraines because I worry a lot." Another PWLE participant described wanting medication to manage chronic leg pain: "The pain in my legs is so bad that I would really like to have some kind of other medication so that I don't have to suffer the pain all the time."

While PWLE participants reported challenges in getting adequate pain relief because they did not have a regular GP who could administer pain medication or because they are unable to get to a clinic every four or five hours for methadone treatments, healthcare participants also reported that limited income restricted PWLEs from accessing after-care programs that can help manage pain. As one healthcare participant stated, "Where are they supposed to go when they have chronic back pain and they need to be able to access yoga? Well, yoga's a $20 class thing, and they can't afford a gym." Moreover, PWLE participants reported being told, "You need to deal with it [pain] somehow" or to find a regular doctor to acquire medication.

> "When I'm in pain I need pain medication, but I drink vodka for my pain because I can't get to a doctor. Whatever works for pain."

Participants reported that accessing pain medication, particularly in an appropriate and timely manner, could be challenging for some PWLEs. As described by one PWLE participant, "Now with this whole opioid thing going on, it's really tough because what was done in the past, we can't do anymore…they've clamped down on people getting pain medication in the Downtown Eastside." In the absence of an adequate pain management treatment, PWLE participants reported using alternative substances, such as alcohol, to manage their pain. As one PWLE participant shared, "When I'm in pain I need pain medication, but I drink vodka for my pain because I can't get to a doctor. Whatever works for pain."

4. NEEDS FOR ACCESSIBLE, APPROPRIATE, AND AFFORDABLE SHELTER/HOUSING

Participants reported that shelter/housing that is accessible, appropriate, and affordable is a critical need for PWLEs and that housing is fundamental to health. However, there were significant challenges to accessing shelter/housing, including 1) a lack of housing stock and 2) long waitlists for affordable housing.

As a result of the lack of safe and appropriate shelter/housing, participants reported that there is a negative cycle whereby PWLEs who are discharged to shelters or the street, are subsequently readmitted to the hospital. As one healthcare participant described: "That cycle of going from a shelter to hospital, maybe to the street, to a shelter, to hospital, and then it's just this ongoing cycle." This cycle was also described from the lived experience of a PWLE participant:

> Unfortunately, a lot of people when they're discharged from a hospital they have no place to go. They're back on the street again. And the hospitals, unfortunately, if the person is well, they have to release them and they're just basically back on the street again, or to a hotel room—a small, dirty, little hotel room. And then they start the cycle all over again. They're put back in that environment. And this is what I went through, I was put back in that environment of alcoholism again. That's why I was back and forth to [anonymous] hospital.

4.1 Need for More Accessible, Appropriate, and Affordable Housing Stock

The lack of shelter/housing stock was among the core challenges encountered in assisting PWLEs with their hospital discharge.

> In terms of housing and, for example, finding a shelter bed for a client is close to impossible… The lack of adequate, affordable housing just kind of pulls all the other social determinants of health with it. It kind of puts a weight on all the other, and so even though there are other resources and they're very valuable and they're really very impressive and progressive, without that housing piece it all kind of falls apart. (Healthcare participant)

Participants highlighted the need for supportive housing:

> I have a gentleman that really should be in supportive housing, and he's got absolutely nobody. He's very hard to understand, he's at risk of falls, and I don't think he's had proper medical treatment. …I've had him as a client for three years… He transitioned from a shelter to temporary housing, and then I found him permanent housing, and then the housing he was in closed down and then I had to move him again and he's functioning, but he really needs supportive housing, and I can't find it. (Shelter/housing participant)

Finding affordable housing was reported to be a particular challenge for PWLEs who are low-income and only have $375/month from their Income Assistance (See Box 3.3) benefits to spend on housing. There are simply too few safe and acceptable places available to PWLEs for $375/month.

> I feel $375 dollars would not sustain me somewhere comfortable, at all, not even close. I don't think my entire check would be enough for a place to live. Because in some cases I don't feel comfortable going into someone else's life and jumping into a family or a housing unit that I don't know people, or getting a place where you have roommates that's going to cost me my entire check or more. (PWLE participant)

In addition, because of the limited housing stock, finding long-term stable housing was reported to take a significant amount of time:

> Actually, securing housing, that was obviously the tough part. That took…longer than a year. From the time I was discharged to when I actually secured housing was probably, yeah, I think a year is fair. (PWLE participant)

4.2 Long Waitlists for Affordable Housing

The significant waiting lists for subsidized housing or to obtain a rent subsidy presented challenges for PWLEs getting housed and transitioning from the hospital or a shelter to housing.

> Usually the first step [in working with PWLEs to find housing] is a shelter and then, because for [long-term] housing it just takes quite a long time. Sometimes even the [SRO] hotels, which are not really suitable for anyone, but it's usually the only place they can get in first, even some of them have waitlists and you know they're often full so they're often told, 'Well you'll have to wait 'till the end of the month to see if someone doesn't pay their rent.' or that kind of thing. Even with housing there's a wait, subsidized housing is years, but yeah, we usually have to start from the beginning at the shelters. (Shelter/housing participant)

> "That's a barrier for us to get into a lot of shelters; so, then all the hospitals are all kind of competing for these narrow amount of beds. And a few of them will allow home supports in, only a few."

4.3 Importance of Autonomy and Choice of Where to Live

Participants suggested that many PWLEs, particularly those who are working on their recovery and trying to not use drugs and alcohol, would prefer living in neighbourhoods where they are not tempted to use or reengage with friends who are active substance users. Two PWLE participants confirmed this:

> A lot of the homeless people, when they [are discharged from] the hospital they're sent back to that environment again which is not good. Basically, it's back to the Downtown Eastside. And I think this is where they're going to be putting me from [my current treatment location] right back down to the Downtown Eastside so I'm going to have to monitor the alcohol intake because I do not want to be starting drinking again.

> I don't want to live on the Downtown Eastside anymore. I tried that before and it's just too convenient to use drugs and it's too convenient to bring people over and party and just spend your money right away and I'm sick of doing that, right.

Healthcare participants agreed that there are shelter/housing locations where PWLEs do not want to go because they feel unsafe because of substance use, violence, or theft.

> There's…some shelters that patients are either hesitant or unwilling to go to because they feel that they're not clean, they're not safe physically, they're not safe emotionally, they're not safe in regards to their addiction use; there's so many triggers. Those places are too chaotic, and they're…just not comfortable, right? …Places where…relationships are poor or there's some history between them and staff. Those are places that patients don't want to go. (Healthcare participant)

Because of these concerns, some PWLEs choose to return to the street over going to a shelter upon discharge.

> Some people have been homeless for years and that is what they're more comfortable with, so they feel safer on the street than they do in a shelter—there's a lot of people who do decline shelter… I know a lot of people rather just stay in a 24/7 Tim Horton's or McDonald's because they feel safer there and it's warm there still and there's less risk for them. And then there's also people who would rather stay in a train station—like a SkyTrain station or bus stop—or in a tent down in a ravine, or a tent in a field where they know someone else or where they share, where like a woman is sharing the tent with a guy who she feels safe with. (Healthcare participant)

4.4 Shelters are Not Suitable Locations for Supporting Healthcare

Participants reported that a lack of shelter beds available to support the health needs of PWLEs has a significant impact on discharge planning. For instance, accessing a shelter bed for a patient who needs a bottom bunk and cannot climb stairs is a challenge because the limited supply of shelter beds that could accommodate such a patient are always occupied. Most shelters have environmental barriers, including stairs, non-wheelchair accessible bedrooms and bathrooms, a lack of overhead lifts, and non-flat surfaces. In addition, many shelters do not have private bathrooms, which can challenge PWLEs who need regular access to a bathroom.

With a limited number of shelters that are can support PWLEs' health needs, hospital providers were reportedly in competition with one another to access these beds.

> That's a barrier for us to get into a lot of shelters; so, then all the hospitals are all kind of competing for these narrow amount of beds. And a few of them will allow home supports in, only a few. (Healthcare participant)

5. CHALLENGES IN SUPPORTING PHYSICAL AND MENTAL HEALTH NEEDS IN SHELTERS

Hospitals, shelters, and other housing locations are distinct environments which have different capacities to meet the health needs of PWLEs. It was reported that PWLEs are challenged in transitioning from the hospital, which is a highly supported setting, to a shelter where there are minimal supports and little structure. In the hospital, a medical team monitors PWLEs and their medications are administered on a schedule, meals are provided, and they can remain in bed all day. Thus, it was reported that while PWLEs are in the hospital their functioning might appear to be good, but this is because they are receiving extensive care and support. Once in a shelter, where supports are reduced and PWLEs are required to be more independent, functioning levels are reported to decline, as suggested by one shelter/housing participant:

> The most challenging part is they go from a hospital—somewhere that everything is provided for them—into the shelter… There's minimal support within the shelter setting because of the large number of clients that we do have and the limited services we can provide. So, I feel like that is probably the biggest challenge for us is to just get everybody on the same page and then to understand, yeah, we are a shelter but you may think this person is functioning at a high level at the hospital, but that is not the same case in a shelter setting.

Related, it was reported that shelter staff are not trained medical professionals who can ensure the safety and care needs of many of the PWLEs who have been discharged from the hospital.

> The staff are not medically trained, so they cannot make any judgement or assessment, so 9-1-1 is called often in those situations. If somebody's sick…it's a 9-1-1 call back to [the hospital] and maybe discharged back to the community in the same day, but that sort of

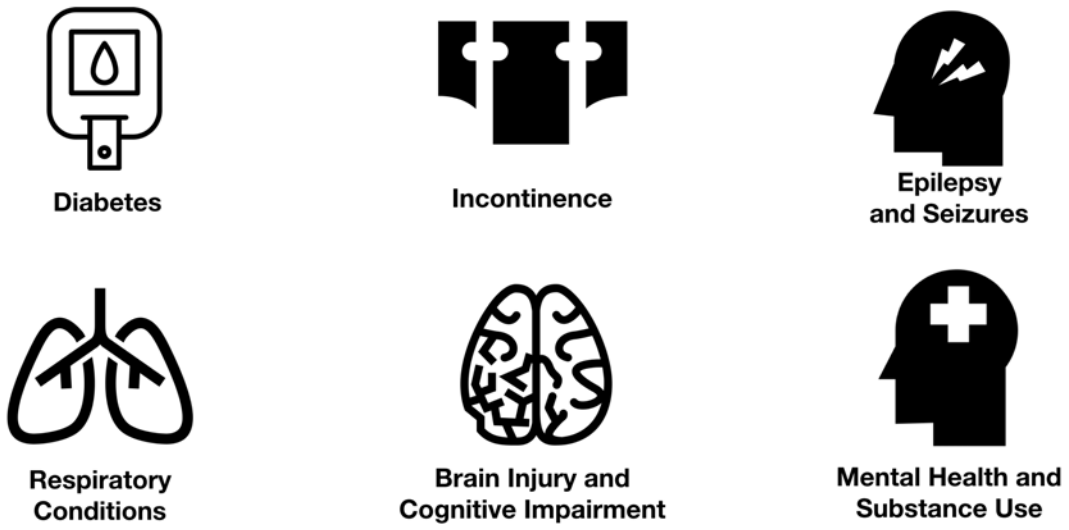


Figure 3.3 Challenges in Supporting Physical and Mental Health Needs in Shelters

thing is not well-managed. (Shelter/housing participant)

When PWLEs are discharged to a shelter that is unable to accommodate their needs, the PWLE will often need to return to the hospital, as described by a shelter/housing participant:

> We would refer them back to the hospital. We will try to work with them and if it's not working out or if there is some risks to the staff or the residents, or if safety is a concern, then we will send them back to the hospital.

Participants identified several specific medical conditions as particularly challenging to manage while staying in a shelter: Diabetes, Incontinence, Epilepsy and Seizures, Respiratory Conditions, Brain Injury and Cognitive Impairment, and Mental Health and Substance Use Issues (See Figure 3.3).

5.1 Challenges of Diabetes

Diabetes was reported to be a health condition that requires a level of disease management that can be difficult for PWLEs who are staying in shelters. For instance, there is limited access to proper nutrition or professional supports with daily activities, such as checking blood sugar levels or managing insulin intake. For PWLEs who have diabetes, the consequences of having irregular meals and a poor diet were reportedly serious. As one PWLE participant stated, "I'm diabetic and not having regular timed meals really fucks with your blood sugar." As a result of having low blood sugar, this participant reported going into hypoglycemic shock and needing to go to the hospital regularly.

"A lot of these clients do need outreach support…I wouldn't say health is not a priority, but I would say that sometimes they're too disorganized and focused on their survival… And, they don't really have the ability to remember appointments."

Primarily, participants identified unmanaged mental health issues and cognitive impairment, inadequate nutrition, and limited foot care as complicating the self-management of diabetes. One healthcare participant explained how impaired cognition affected PWLEs' ability to adhere to their diabetes medication regimen: "People who are cognitively impaired can't take their [mental health] meds, so how are they even remembering to take their [diabetes] medications?" A shelter/housing participant agreed: "One of the things that is a little bit of an issue for some shelters is people who are quite mentally unwell and managing Type 1 Diabetes with sliding scale insulin, because of the dosing levels and accuracy."

To improve diabetes management in shelters, participants identified several needs: refrigeration to store insulin; ongoing support and reminders for proper foot hygiene and follow-up care; healthy, affordable food options; management of both

mental health and diabetes medications; and a safe and quiet place for PWLEs with foot issues to adequately rest and heal.

Participants reported better success in providing care for PWLEs who have diabetes in settings where training and support for diabetic care was available. One shelter/housing participant recounted that having a nurse practitioner onsite, with the appropriate tools to conduct a blood-sugar test, which allowed for the quick assessment of a client who suddenly collapsed; this enabled informed communication with emergency responders regarding the PWLE's vital statistics. Another shelter/housing participant reported feeling more confident in providing care for PWLEs with diabetes after receiving education about diabetes: "Our team's well versed in care for diabetes. We partnered with UBC [*The University of British Columbia*] and they came over with these kits and a PowerPoint to educate our team about diabetes. So, we're super equipped for that."

5.2 Challenges of Incontinence

Having incontinence was also reported to present challenges for PWLEs' ability to find shelter/housing upon hospital discharge, as well as for supporting PWLEs in shelters. Related challenges included PWLEs not having access to a private bathroom; not being able to get to the bathroom in time; having to suddenly void in shared sleeping quarters; and having to leave the shelter during the day and not having access to a bathroom.

> Having a private bathroom is virtually impossible… Oftentimes that meant my client had to void in their room in a shelter situation where you're typically placed in bunk beds with other individuals. That's not conducive to physical or emotional well-being. (Healthcare participant)

It was reported that shelters often turn away PWLEs who have incontinence because shelter staff are limited in their ability to assist with high-level care needs, particularly co-occurring incontinence and mobility issues.

> It's very hard if someone is incontinent or if they're physically not able to do their own care… There's issues like incontinence or issues with mobility that shelters aren't able to accept those higher levels of care (Healthcare participant).

5.3 Challenges of Epilepsy and Seizures

Living with epilepsy and experiencing recurring seizures was also reported to limit PWLEs' ability to stay in a shelter. Although shelter/housing participants acknowledged that individuals with epilepsy deserve equal access to shelter beds, the added risk of sheltering persons who have seizures was reported to create reluctance in providing a shelter bed to individuals with a history of epilepsy. Furthermore, in the absence of training and information on epilepsy, a seizure may appear to be a drug overdose. One PWLE participant described being unnecessarily taken to the hospital when his epileptic seizures were mistaken as a drug overdose: "When I had seizures, they [the paramedics] thought I was OD'ing on drugs, and I don't do drugs… They Narcan [*Naloxone*] you, even when you're having a seizure, because they think you're OD'ing." Medication management for PWLEs living with epilepsy and experiencing recurring seizures was also reported to be a challenge. While the frequency and intensity of seizures can be managed with consistent, appropriate medications, medication changes or improper management was reported to worsen epilepsy.

To be safer staying in a shelter and prevent unnecessary calls to emergency responders, PWLE participants reported the need to communicate with shelter staff about their healthcare needs:

> I explained to them that because of the head injury and my seizure history that I could have a seizure and if I do then don't worry. 'I've had lots of banal seizures, I'll be fine. Don't freak out.' So, I think communication in general is really important. (PWLE participant)

5.4 Challenges of Respiratory Conditions

Participants reported that PWLEs suffer from a number of respiratory conditions, including chronic obstructive pulmonary disorder (COPD), lung cancer, and pneumonia, and require different treatments, including pulmonary therapy or radiation. Respiratory conditions were reported to be particularly incapacitating and complex for PWLEs to manage.

> I have another guy with COPD, can barely walk like a few meters because of his lung capacity, and he also is a bit impaired, so he can't go home on oxygen because he smokes with the oxygen tanks and has had a few fires and it just creates risk for everybody else. (Healthcare participant)

Finding appropriate shelter/housing for PWLEs with respiratory conditions was reported to be challenging. Limited respiratory capacity often requires PWLEs with lung conditions to have a bed on the first floor or accessible by elevator, limiting the shelter/housing options.

> I had an apartment upstairs and it was getting hard for me to breathe when I was going up the stairs. Like packing groceries or anything like that I couldn't do it. And so he moved me downstairs to the ground floor and it was much better. (PWLE participant)

PWLEs with respiratory conditions reported needing extensive follow-up care, though the lack of coordination between services providers often prevented post-discharge treatment. Moreover, once discharged from the hospital, participants stressed that PWLEs who have issues with their lungs require lengthy bed rest and a high level of support to fully recover, which is challenging in some shelters. A shelter/housing participant stated, "People that come out [of the hospital] that have had pneumonia and they're really not well—how to support that? …We'd often advocate for more bed rest for them."

While it was reported that nurses periodically deliver preventative healthcare services in shelters, such as administering pneumonia vaccines, it was also noted that in the absence of 24-hour nursing services, the healthcare for PWLEs with existing respiratory conditions is delayed until the condition becomes severe. One shelter/housing participant explained:

> You would want to be able to provide that really embedded health element, that 24-hour nursing component… It's getting ahead of pneumonia instead of having pneumonia go to the full-on surgery where we're removing fluid from someone's lungs.

5.5 Brain Injury and Cognitive Impairment Challenges

Impaired cognitive function, whether temporary (i.e., post-concussion syndrome) or permanent (i.e., dementia, stroke), and a lack of insight into one's health condition was reported to impact PWLEs' ability to attend to their healthcare needs in a shelter in a safe and appropriate manner. The capacity of PWLEs to effectively manage their overall health, access food, and manage medications was reportedly impacted by their insight into their condition. One healthcare participant stated, "When their cognition's not good, their insight is also a concern." Another healthcare participant questioned whether PWLEs with impaired cognition "are able to find food… and remember to take medications." A third healthcare participant noted that PWLEs may neglect personal hygiene or cleanliness because they may "never have had the opportunity or the ability to learn basic life skills or hygiene that could cause or exacerbate existing health conditions."

> "There's been a growing number of people with cognitive issues who also have substance use issues, but there's nothing for them. They have to be sober enough to fit this one program or to stay housed they have to be sober… But, these guys don't fit in the treatment box either because they're so cognitively impaired that they aren't even eligible for a treatment program."

PWLEs recovering from acute head trauma reportedly require extended bed rest, which is not always possible in a shelter. Moreover, participants described specific challenges of PWLEs with cognitive impairment. For instance, one PWLE participant who suffered a stroke described not being able to comb her own hair, while another who was recovering from a concussion reported having difficulty remembering things. Healthcare participants suggested that PWLEs with brain injuries require home and community care and outreach support in a shelter to manage ongoing healthcare needs.

> A lot of these clients do need outreach support…I wouldn't say health is not a priority, but I would say that sometimes they're too disorganized and focused on their survival… And, they don't really have the ability to remember appointments. (Healthcare participant)

However, persons with traumatic brain injuries were described as especially vulnerable, but challenging to engage following hospital discharge due to limited access to follow-up services:

> A difficult one is traumatic brain injuries. We have it all the time where they do not reach eligibility for acquired brain injury services, however their cognition has been impaired enough that it's not safe to be sending them to a shelter and having that expectation for people to be able to participate in their own care. However, they haven't checked all those boxes where they are now eligible for this follow-up. So yes, I'd say acquired brain injuries are very hard to place for discharge. (Healthcare participant)

Older adults with cognitive impairment and comorbid substance use issues were also described as vulnerable in shelters. As one shelter/housing participant recalled, "I had a senior woman earlier this year, in her 60s, who does meth and the young drug dealers were threatening her life because she owed them money, because she couldn't remember if she paid them or not." Participants noted a gap in services for PWLEs with comorbid cognitive impairment and substance use disorder because access to some programs and housing is contingent upon PWLEs being sober, while getting treatment is contingent upon a PWLE being cognitively intact:

> There's been a growing number of people with cognitive issues who also have substance use issues, but there's nothing for them. They have to be sober enough to fit this one program or to stay housed they have to be sober… But, these guys don't fit in the treatment box either because they're so cognitively impaired that they aren't even eligible for a treatment program. (Healthcare participant)

5.6 Mental Health and Substance Use Challenges

Participants identified mental health and substance use issues as among the most challenging health needs to support in a shelter environment, including 1) individuals with severe mental illness or who are experiencing psychosis, 2) individuals who are not ready or willing to address substance use issues, and 3) individuals with concurrent mental health and substance use or physical health illness. A shelter/housing participant stated, "Complex mental health married to a stimulant drug consumption is one of the more uniquely challenging things you could deal with."
A shelter/housing participant reported that some individuals with mental health issues are challenging to help and that "mental health

requires a lot of follow-up and working closely with a team." Acute situations, such as a suicide attempt, a newly diagnosed mental illness, or a change to a psychiatric medication regimen, were reported to negatively impact PWLEs' ability to live unsupported in a shelter.

> When we get psychiatric patients or people we suspect are psychiatric, the communication is very confusing. Often, they just sort of tell us what we want to hear. Or sometimes it's just high levels of paranoia and confusion. They forget where they are, they don't know, or they think people in their lives are still around and that kind of thing. (Shelter/housing participant)

Participants also reported that PWLEs with unmanaged mental health and substance use issues have difficulty remaining in a shelter if they are unable to follow shelter rules or pose a risk to the safety of other shelter guests. As one shelter/housing participant reported, "[PWLEs with uncontrolled mental health issues] jeopardize the capacity to properly shelter other people…who have the right to be in an environment that doesn't have someone screaming, yelling, potentially naked." Inappropriate behaviour or violence often resulted in PWLEs being evicted to the street:

> And they are actually discharged from the shelter to the street. They're told to leave now. And if they have an explosion it doesn't matter who you are or what you are, you're not coming back, and so with their goods and chattels they're out on the street. And we've seen that frequently. Because they can't put other people's lives in jeopardy, so they have to kick them out whether it's winter or summer, we see that a lot. They'll try and get them somewhere else, but for the most part if they've been violent in any way they're gone. (Shelter/housing participant)

Furthermore, it was acknowledged by one healthcare participant that PWLEs with substance use issues require "detox beds or addiction treatment when needed, not the next day or the next week, or 10-days from now." "Housing, detox beds, adequate addiction treatment programs, availability of spots in those addiction treatment programs, and more addiction treatment resources," were reported needs by another healthcare participant. However, there is limited access to these resources and long waitlists.

> [Mental health] teams are kind of hard to get… and in order to get one it's usually very black and white. It's usually like, 'Oh well, you have to have schizophrenia.' Or something like that. If someone has chronic or severe depression, they're probably not going to get a team. There's lots of exceptions where they won't be able to qualify for a team. (Shelter/housing participant)

> Addictions is a big challenge… There's a lot of waitlists and I think for that population it's hard for them to be on a waitlist and manage that, so if you want to get into a treatment program, the shortest one is three weeks and then you have to call in every week, so even that's a barrier. (Healthcare participant)

Limited or inadequate mental health and substance use resources have serious consequences for PWLEs living in a shelter who often end up back on the street or sent back to hospital. A shelter/housing participant shared,

> That happens all the time where someone's mental health needs are going unmet. One of our clients most recently was in a manic episode, was picked up, went to hospital, 48 hours in forensics, sedated, balanced, released. We'll do this again in a week's time.

An additional consequence of limited access to treatment programs upon hospital discharge is that PWLEs return to environments that trigger their substance use.

> The typical process is: they'll be discharged from hospital and then they have to call every day for about two weeks and see if there's still a [treatment] bed available for them. However, oftentimes we miss that opportunity and because we're putting people back into the same situation where they are triggered to use substances to cope, we've just missed a really crucial time in their life where they could have made a change. (Healthcare participant)

Participants reported that some harm reduction programs or services to help manage withdrawal were difficult for PWLEs to access given limited hours of operation. For instance, rapid access

addiction clinics (RAACs) (See Box 3.5) have restrictions:

> We have a rapid access clinic that is open 9:00 to 4:00, Monday to Friday. What do I do when somebody comes in on a Saturday morning and they're in crazy withdrawal and need to start methadone and the clinic is closed? Even these "rapid access clinics" are not rapid. They're appointment-based. Okay, sure, tell a homeless person to leave and come back the next day. That's very realistic for a person with a raging heroin addiction. (Healthcare participant)

Participants reported that PWLEs who are experiencing mental health or substance use issues require providers to have improved cross-sector communication and coordination, such as case conferencing from all supports involved. To improve cross-sector collaboration, confidentiality restrictions need consideration so information can be shared.

> I know it gets into confidentiality, but maybe a bit more communication between people that run residential housing, so that they can help support whatever the mental health plan is, because often they don't know, and we don't know. We see the medications, but we don't really know what the plan is. (Shelter/housing participant)

6. SYSTEM-LEVEL NEEDS AND CHALLENGES

Participants identified a number of system-level needs—and associated challenges—that could affect PWLEs' discharge experience. These include the ability of PWLEs to navigate the system of health and social supports and the challenges that result from limited and overburdened resources and organizations having distinct mandates, resources, and eligibility criteria.

6.1 System Navigation

Participants reported that an important component to assisting PWLEs with accessing the wide range of health and psychosocial services is system navigation, including help securing or replacing housing, identification (ID), income support, and health coverage. A PWLE participant described the experience of trying to apply for services without adequate support: "You get sent in circles, and then they give up and send you to somebody else, and they give up and then nothing happens."

BOX 3.5 RAPID ACCESS ADDICTION CLINIC

Rapid Access Addiction Clinic (RAAC) at St. Paul's Hospital is a short-term outpatient addiction clinic that serves individuals with substance use issues by offering access to physicians, nurses, and social workers. The clinic's care philosophy is trauma-informed and client-centred. Services offered include assessment, management, prevention, treatment, and stabilization for substance use issues.
http://www.providencehealthcare.org/rapid-access-addiction-clinic-raac

While hospital-based social workers reported trying to assist PWLEs in filling out forms for housing and supports needed post-discharge, the processes was described as complex and time-consuming, limiting the support that can be offered during a hospital stay.

> I help them, but when I did it yesterday I'm like, 'This is an hour-and-half process, I don't have the time to do that…' It used to be 20 minutes… There's not a lot of people who will spend or have the time to orientate someone through that process. (Healthcare participant)

Moreover, lack of access to a computer and an email address or a phone with available minutes creates additional barriers to navigating online applications.

> I helped someone fill out an Income Assistance application yesterday, and it was so cumbersome… They wanted you to upload a recent picture of yourself. Some people don't even know how to use a computer or have an email address, and they make you have an email address. It took over an hour with me and this other guy who's very capable… (Healthcare participant)
>
> These forms and working through government ministries, it's all very timely, very processed and

it's really hard. A lot of people don't necessarily have cell phones or a fixed address that's being sent to them or to be able to follow-up with someone at a later time. So many services are not able to reach the populations that they are pretty much trying to target. (Healthcare participant)

6.1a Applying for transitional or longer-term housing

As summarized by one healthcare participant, PWLEs need assistance applying for appropriate "housing that's specific to their needs in the community." In addition, participants emphasized the need to support PWLEs in following-up with pending housing applications.

It seems like everybody fills out their BC Housing application, maybe from hospital, but is unable to follow-up with. You have to contact them every few weeks to make sure your account's still active. So not everyone's able to follow-up with that. So, they'll fill out the application and then it'll kind of go nowhere, and they don't even know if their application is still active. (Healthcare participant)

6.1b Replacing identification cards

PWLEs also require assistance replacing lost or stolen identification (ID) cards. Without ID, timely access to needed supports and services, including to social assistance, housing, and provincial medical coverage, is reportedly a common problem for PWLEs.

A lot of the time, unfortunately, by the time low barrier clients get to shelter their ID has been stolen many, many times. Whether it is stolen or lost or misplaced, sometimes people go for years without having ID… Quite often I know people would put the original somewhere and then just carry around a photocopy but that is a problem when you're homeless because then you have no place to store things. And there isn't really any easy place to have a repository for these items if you're homeless. (Shelter/housing participant)

6.1c Applying for income assistance and Canada Pension Plan

Participants described the benefit of social Income Assistance (i.e., welfare) and Canadian Pension Plan (i.e., pension) programs in providing PWLEs additional income to finance housing costs. However, there was a reported need to support PWLEs in the application process to access these benefits.

Finances are always an issue, and even applying on persons with a disability. A lot of times people will be eligible for it; however, they don't have a family doctor and they can't find anyone to help assist with these forms or navigating the system. (Healthcare participant)

One shelter/housing participant described their frustration in not having help in filling out the paperwork required for PWLEs to access benefits to which they are entitled:

The Income Assistance Office will tell people they absolutely have to apply to Canada Pension Plan…that's not a difficult application. But if they're applying for Canada Pension Plan Disability (CPPD), it's a totally different ballgame. And for a time, the Disability Alliance was not doing those applications, and [the] Income Assistance Office doesn't help and there is nobody to help. So, I had to learn how to do those to help my clients. There was nowhere to go [for help], and yet they're requiring it. It was just so frustrating [laughs]. I think if they require it, they should help them with it.

6.1d Applying for health coverage

PWLEs who want to apply for persons with disability (PWD) assistance first have to apply for basic social assistance. It was reported that PWLEs often need assistance to fill out Disability Assistance forms and that keeping track of multiple applications can be confusing and time consuming. PWLEs also require assistance applying for medication coverage to ensure access to needed medications.

The only thing that's been a consistent follow-up would be my inhaler refills, because I don't know what I'd do without those… I'm just really lucky they [the health center] have offered to pay it for the last few times… But this last one I actually bought myself, but it's expensive… I go through two a week and they're like $25 each… I used to [have coverage] because I went on a one-time check from Welfare and they put me on a plan. And for a while there, I was covered

and then it just stopped… I don't know who to talk to. Someone brought me to that Welfare office, but I haven't been back there since. (PWLE participant)

6.2 Limited and Overburdened Resources

In addition to the lack of appropriate housing and post-discharge resources, participants reported that the existing resources have limited hours of operation, vary from one region to the next, and are overburdened. One healthcare participant stated:

I would say they're not adequate. I would say the services, there are, there is a number of services available, but they're overburdened, and inadequately funded… resources do exist, but they are very overburdened, so you know you get, there's a lot of turnover in staff…

6.2a Limited hours of operation

Participants reported that it is difficult to access resources outside "normal working hours" (i.e., 9-to-5) and stressed the need for services for PWLEs to be offered during evening hours. For instance, healthcare participants described the challenge in accessing income support services for PWLEs on the weekend or after 4:00pm.

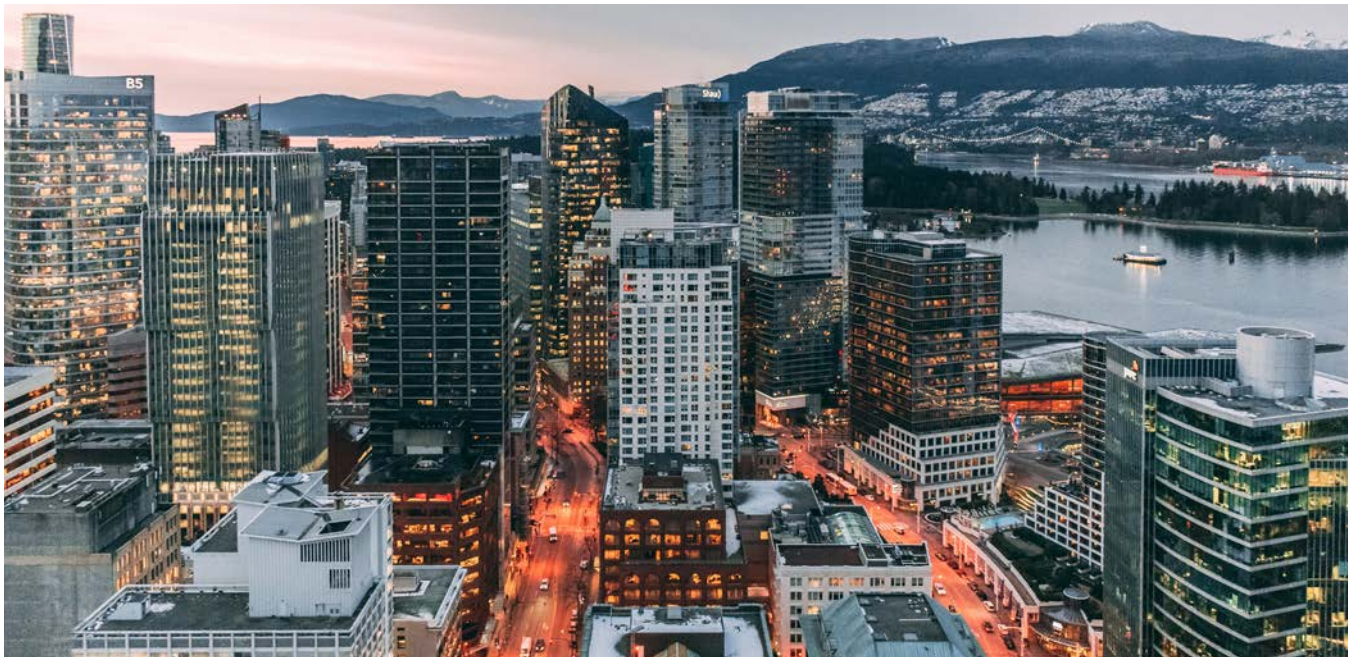
In a 12-hour shift, you're probably getting five to eight referrals for housing or homelessness… which comes with needing assistance with accessing some income… However, there's really only one or two agencies out there that can help with that and if it's on a weekend they're typically not open; if it's after 4:00 they're typically not open. And so yes, trying to help people access persons with disability or applications or income assistance, we need almost like a walk-in social worker services so that when someone comes in with all of these issues, people can actually help other people access these services because they're quite complicated even when you understand the system and work in the system. (Healthcare participant)

Healthcare participants identified the importance of accessing services after-hours in order to develop appropriate and timely discharge plans.

I would include that in a good discharge plan—if I could actually call the mental health team and there was somebody to talk to on a Sunday afternoon, or I could call the wound-care nurse, but I can't because no one else is working, they're all business hours. So, that would be another component, because [the emergency department] is kind of a unique beast in the hospital. (Healthcare participant)

6.2b Regional variations in service availability

Participants reported significant regional variability in the availability of post-discharge, after-care



resources, which challenged the transition of PWLEs from hospital to shelter/housing. Highlighting the need in for services in every community for all residents, one PWLE participant summarized how one municipality is home to the majority of the resources in Metro Vancouver:

> I just kind of migrated from Surrey to Vancouver at that point because the supports and options they have down here, I mean their bank account is considerably larger, so they can offer more in that sense because they have to deal with more people. If you're going to Surrey, Coquitlam, these towns are very limited in what they can do.

PWLEs moving from one municipality to another are challenged when eligibility criteria require residence in specific catchment areas. For instance, PWLEs who are attached to a mental health team in one municipality need their file to be transferred to the municipality where they move in order to have continuity of care. This becomes challenging for PWLEs who access a shelter outside of their identified municipality. A shelter/housing participant described this challenge:

> I'm thinking of a particular woman—she was in and out of hospital, schizophrenic. Most of the mental health housing is in Vancouver, Burnaby area, but because we were in New West she wasn't allowed to access any of that housing. We were basically told that we would have to put her on the street in Vancouver if she wanted to access mental health housing in that region. So, the sense I got, and I'm not an expert at it, is that the mental health services are very municipality-based and the conflict for us as a shelter is we take people from all over.

Other shelter/housing participants described challenges in getting PWLEs reassigned to different community clinics, even within the same municipality. This can introduce a significant barrier to care, particularly for PWLEs with complex care needs, such as mobility issues or chronic pain.

> They'll come here from the hospital, but if they have been catchmented [*sic*] before to one of the community health clinics they may not be able to go to [another clinic]. So, if at some point, for example, they've lived near [anonymous] Health Clinic [before], they're basically told, 'Well you have to go [back] there for medical care.' And it can be really hard to get that changed even if they are homeless, it can be quite hard. (Shelter/housing participant)

"I'm thinking of a particular woman—she was in and out of hospital, schizophrenic. Most of the mental health housing is in Vancouver, Burnaby area, but because we were in New West she wasn't allowed to access any of that housing. We were basically told that we would have to put her on the street in Vancouver if she wanted to access mental health housing in that region."

6.3 Organizational Mandates and Client Base

An added challenge in the discharge planning of PWLEs from the hospital to shelter/housing was the different mandates, resources, and eligibility criteria of different organizations and providers. Participants reported that some PWLEs are "bounced around" from one organization to another as they try to access care, particularly when a PWLE does not fit into a defined category, so that no single organization takes full responsibility for their care.

> Sometimes all the hoops and circles that we go in trying to advocate for clients when they're really complex… One part of the organization thinks that mental health should be responsible, the other thinks home health should be responsible, and then someone else thinks [housing provider] should be responsible, and then someone else thinks that brain injury supported housing should be responsible. So, sometimes we go in circles that way. (Healthcare participant)

7. COMMUNICATION AND INFORMATION SHARING

A final reported need of PWLEs was appropriate communication and information sharing between healthcare providers and both PWLEs and service providers who are supporting PWLEs. For instance, in order for PWLEs to transition from the hospital to shelter/housing that can meet their after-care needs, a hospital-based provider and a community-based housing provider (e.g., a shelter intake worker) need

to communicate. One shelter/housing participant stated, "It's that lack of communication that everybody's pressured for time and that causes an issue." Another stated:

> We'd like to have the conversation with the social worker or the charge nurse, or whoever's discharging to find [out] what is the situation and if we can accommodate them… We'll do our best to accommodate because we want to keep that partnership, but there have been times where there's no conversation and someone just shows up at our door in a taxi, and sometimes we can't keep them, sometimes we just basically say no and tell them to turn around and take them back.

Communication between the hospital discharge physician and the PWLE's community-based physician was acknowledged as needed for post-discharge care continuity.

> If a person in the community has a physician it behooves the discharging physician to contact the community physician because we see people coming out on medications that they really shouldn't be discharged on and that has caused problems. (Shelter/housing participant)

One consequence of inadequate communication between hospital and shelter/housing providers was the lack of care continuity experienced by PWLEs as they transition from one location to another. Several PWLE participants reported that one of the most challenging issues was the absence of a coordinated and informed continuum of care following their discharge.

> It doesn't seem like there ever is any connection between doctor, hospital, patient, and then staff at a shelter or any other institution sort of thing. It's like there's no continuum of care there, it's just like three little islands of care that sometimes have to communicate maybe once, but there's never a continuum it seems. (PWLE participant)

On the other hand, "going the extra mile" to improve care continuity was described by one healthcare participant as helpful in transitioning PWLEs from the hospital into shelter.

> Just going the extra mile to make sure the shelter is prepared for that person and just ensuring that they're going to get their scripts [prescriptions]… making sure that there's follow-up around that. Are they able to take it? Are they aware? Just ensuring that those other pieces are done, the patient has education around it—how are they coming to their follow-up appointments? Are they able to do that? If not, if we're like, if that's unrealistic, what is realistic?

BOX 3.6 CONSENT FORMS

Consent forms allow healthcare providers to ensure that persons experiencing homelessness being discharged from hospital into shelter are providing their informed consent to the release of information between providers (e.g., Fraser Health Hospital-to-Shelter form used by healthcare providers to provide shelter staff with important information about patients' support needs, including information pertaining to follow-up appointments, prescribed medications, patients' diagnosis, mobility disabilities, bladder control, and connection to community supports). (See Appendix D)

7.1 Consent to Release Information Form and Information Sharing

Shelter/housing participants reported that when they are informed of PWLEs' post-discharge needs, there are fewer challenges. In comparison, when a consent to release information form (See Fraser Health hospital-to-shelter form, Appendix D) is not in place, shelter/housing providers are unable to access health information or discharge plans that could inform how they can best support PWLEs. Having this information would, in the opinion of shelter/housing participants, improve the support they can provide to PWLEs:

> I need a bit of medical information about clients. Even if they've signed a release, sometimes they're hesitant to give me all that information… It does provide some difficulties because I'm not really aware of what the person's dealing with. (Shelter/housing participant)

Oftentimes, there is a delicate balance with the information healthcare providers need to share with shelter/housing providers and that which

"It doesn't seem like there ever is any connection between doctor, hospital, patient, and then staff at a shelter or any other institution sort of thing. It's like there's no continuum of care there, it's just like three little islands of care that sometimes have to communicate maybe once, but there's never a continuum it seems."

would violate a PWLE's privacy. However, limited communication to shelter/housing about PWLEs' mental health was reported to be a particular challenge.

> More information [would be helpful] I think. I appreciate that they have confidentiality and they can't share a lot, but it would be nice to have, particularly around psychiatrics, to know that there's suicide ideation. But I also understand the hospitals can't release information. (Shelter/housing participant)

Moreover, although hospitals were reported to be "getting better in terms of acknowledging people's non-traditional family members as significant players in their lives," by one healthcare participant, other participants noted that confidentiality issues restrict the level of knowledge that non-traditional support persons, such as outreach workers, can have on PWLEs, which limits their ability to provide needed health support.

> Basically, they don't have family. They're homeless. We are their family. We are their supports. We are their outreach workers. So, sometimes if we need to follow-up or work with somebody it's
>
> like, 'Well you're not family.' Okay, but, 'They're homeless, we're the outreach workers.' How do we get the hospital staff to understand who are the outreach teams, who are the ones that are working with so-and-so and have those releases ready and in place so that the client can, in the moment, in the hospital, sign off and say, 'Yes, these are the people that support me; I give you permission if they call or if they come by that you can give them information.' (Shelter/housing participant)

7.2 Inclusion of PWLEs in Healthcare and Discharge Planning

Participants considered the communication of health information to PWLEs to be integral to self-determination and their ability to make informed healthcare decisions. Care that was not explained led one PWLE participant to feel that "the doctors and nurses are just dismissing me. (Healthcare participant)" Being given insufficient information about diagnoses, medical care, or discharge planning was reported to be stressful and anxiety-provoking for PWLEs; an already stressful situation is made worse when healthcare providers neglect to explain medical processes, procedures, and documentation to PWLEs. Moreover, inadequate communication was reported to be particularly traumatizing for PWLEs in the hospital for a head injury or a mental health crisis and, as a result, were confused and unable to fully comprehend their situation. One PWLE participant recounts, "It didn't seem like anyone really took the time to just be with me and explain to me what was going on, and that it was going to be okay, and it was a really scary experience."

While some PWLE participants reported that they were excluded from their hospital discharge planning, healthcare participants described making efforts, where possible, to ensure PWLEs were included in conversations and comfortable with the discharge plan. Inclusion in discharge planning, however, was reported to be dependent upon a PWLE's willingness to actively engage and participate with healthcare providers.

In addition, healthcare participants noted that a lack of resources, including shelter availability, precluded discharge plans from always being self-directed. In many cases, healthcare providers made decisions based on shelter/housing and treatment availability without input from PWLEs. As one healthcare participant explained, "Every step of the way they're involved…they direct where

"It didn't seem like anyone really took the time to just be with me and explain to me what was going on, and that it was going to be okay, and it was a really scary experience."

they want to go. Sometimes [though]…it's really based on availability…so I'd say they're informed of the process, they're not necessarily making the decisions." Another healthcare participant agreed:

> There's some days where I'm calling through the list and the first shelter that picks up the phone and says, 'We'll take your patient,' that's where the patient's going to be advised to go. If we had a choice of six beds, of course you'd pick the one that's most superb or that had the most services, but on any given day you might have only one shelter that's willing to take them, then that's just where they're going.

7.3 Information Needs for PWLEs Upon Hospital Discharge

At the time of discharge, participants reported that PWLEs need information on a wide range of resources—from income assistance and shelter/housing options to meal provision, medication plans, and follow-up care. However, PWLE participants explained having been given limited information. One PWLE participant shared that "supports were basically, 'Here's the [shelter] list.' That's basically what the supports kind of worked out to be." Another PWLE participant stated:

> The social worker came and talked to me, but she didn't really give me a whole lot. She just told me that I could go to the welfare office and this and that. It was tough… I had to figure out how to get to [one region] from [another region]. I had to get bus fare and I'd rather eat than take the bus, right.

Instead of being given information upon discharge, PWLEs described getting information through service agencies or word of mouth.

> [Anonymous outreach program], they helped once I was able to connect with them. They expedited things a lot quicker… Talking to someone, 'You might want to try this person, or try this number, I've heard good things about them.' Just more information that I was given… but not in the hospital though. (PWLE participant)

Shelter/housing participants also suggested that PWLEs need additional assistance to understand their medication plan upon discharge, while PLWE participants described not being adequately

informed about medication side effects, proper dosage, and expected course of recovery. One PWLE participant shared, "They didn't tell me that your medication's going to make your urine funny colors and a funny smell. Now I'm freaking out even more. Nobody told me those things that I would need to know."

Finally, some PWLE participants reported not even knowing what information would be helpful upon hospital discharge. One PWLE participant stated, "I don't know because I don't know what there is or what I need." Another PWLE participant confirmed lacking knowledge about resources.

> A lot of people don't know there's that 2-1-1 number, I never knew that. I had no idea about that. And then like the [24-hour drop-in centre], I didn't know anything about this, come and eat food.

7.3a Information needed on shelter/housing options upon hospital discharge

From the perspective of healthcare participants, significant time is needed to help PWLEs find housing, which is beyond the scope of practice for many hospital social workers who might not be fully aware of the available resources. The challenge is ensuring that patients are referred to housing workers early on in their hospital stay.

> We're not housing workers, we're social workers who also help people with their housing. But we don't know all the ins and outs of BC Housing or what alternative housing is available, so we spend a large part of our time trying to get our clients housed properly, get our clients transitioned to better housing that's more appropriate for whatever their medical needs are or anything else that they might need to have addressed. (Healthcare participant)

PWLE participants who did not know where they would go upon discharge were specifically interested in receiving information about shelter/housing, including which places would be safe.

> Some ideas of safe places to go. There's [anonymous shelter], which is a terrible place to be for someone my age. If I didn't know about [anonymous youth shelter], and I highly doubt I would have been told, I could have ended up somewhere else, which wouldn't have been good. I could have relapsed because a lot of other shelters aren't drug-free. (PWLE participant)

"We're not housing workers, we're social workers who also help people with their housing."

Other PWLE participants described the challenge in getting assistance with finding housing upon discharge.

> I just haven't been able to find anybody to help me get a place. I don't know where to look, I don't know who to ask. I don't know. Because it's so expensive out there nowadays, and there's certain places I don't want to live, like on the Downtown Eastside. I don't want to live here no more. It's bad. I want to get away from all the drugs; I want to have a new life. (PWLE participant)

For PWLEs who are new to the region, one PWLE participant suggested that PWLEs be given a map and sufficient directions to help them get to their accommodation more easily upon discharge: "Maybe a map where I'm going… I'd never been to the [anonymous region] area… A map of where I am, how to get back out of there."

BOX 3.7 BC211 SHELTER LIST

The bc211 Shelter List details the availability of shelter beds and mats in Metro Vancouver, Fraser Valley Regional Districts, and Greater Victoria. The staff of the Shelter and Street Help Line program contact shelters in these regions twice a day and publish the Shelter List. Information regarding the availability of shelter beds and services in the Lower Mainland and Victoria can be obtained by dialing or texting 2-1-1.
http://www.bc211.ca/help-lines/
http://shelters.bc211.ca/bc211shelters

7.3b bc211 shelter list

It was reported that when PWLEs are discharged from hospital without secure housing, they are regularly given the bc211 shelter list (See Box 3.7), a detailed list of available shelter beds in British Columbia that is updated and published 2-3 times daily.

> That would always be part of the discharge planning process, where all options would be provided to them, contact numbers to outreach as well, shelter lists, 2-1-1, for example, different recovery houses list. We would even explore whether or not they are ready to consider detox. You know, to open up more opportunities and a lot of the time, last resort, when they're not open to it, it's, 'Okay, well here's the shelter list and some contact numbers and you can figure out your own transition plan.' (Healthcare participant)

Though the shelter list was made available to PWLEs, participants stressed that more assistance with identifying appropriate interim housing was needed and that providing a shelter list to PWLEs was not an adequate discharge plan or a solution to finding shelter/housing:

> Just giving a piece of paper and saying this is your best chance to at least get some interim housing or at a shelter… The availability of

housing obviously is tough, it's Vancouver. But it didn't seem like there was any end at all, it just seemed very, blank and meh. 'Well we don't have a home for you so you're going to be homeless.' (PWLE participant)

It's typically not a very good discharge plan at all. Okay, this person's homeless, okay we speak to them, see where they stayed last night, they may have stayed at a shelter the previous night or in a recovery home and then provide them a list of shelters that they can call and see if there's any beds available or call 2-1-1. We all know it's not a very good system. (Healthcare participant)

8. ADDITIONAL BARRIERS TO CARE

Participants described a wide range of barriers to accessing care for PWLEs, which have been categorized here into three overarching themes: 1) the lack of a stable place from which to engage with and access healthcare; 2) stigma and discrimination; and 3) attitudes and beliefs of PWLEs. These categories are not mutually exclusive, but interrelate in various ways, and contain several sub-themes.

8.1 Lack of a Stable Place from Which to Engage with and Access Healthcare

A fundamental barrier for PWLEs' ability to engage with, and access, healthcare was their lack of a stable base from which to navigate the health and social service sectors (e.g., the inability to stay in a shelter for more than 30 days).

Other barriers for homeless people and clients in particular, I'd say, would be not having a stable place to stay at and sometimes having to move every 30-days—typically most shelter stays are 30-days or even having to move more often than that. (Healthcare participant)

Life without stability was reported to be "chaotic" and challenging and to negatively influence PWLEs' ability to be located by service providers, safely store personal belongings and medications, and challenge PWLEs' ability to maintain a schedule.

8.1a PWLEs can be difficult to locate

Though outreach services were highlighted as an important solution to better serve PWLEs, a significant barrier to engaging in outreach work with persons without stable housing was the difficulty in locating people.

Homeless people are impossible to find. We don't know where they hang out. They may change their hangout spots. You can't set up wound care to come in three times a day or medication management if we don't know where we're going to be able to find the person. (Healthcare participant)

The difficulty in locating people was cited as negatively affecting care following hospital discharge, whether it be medication management, wound care, IV therapy, or communicating test results.

If you're homeless it becomes really hard for any type of discharge planning to be comprehensive because if you're homeless the chances of you having a way to be contacted is much less, if you need medical follow-up it's really hard because we have no idea where to reach you, and there's no stability for people who are homeless, especially if you're staying in shelters, or you're staying out on the street. (Healthcare participant)

What are the barriers to accessing care for a homeless person? There's no address for follow-up, so the amount of times a doctor comes to me and says, 'Can you call this person back because their cultures have come back negative or positive;' or whatever and I can't find them is difficult, so you're not accessing care in that respect. (Healthcare participant)

Similarly, a shelter/housing participant described the challenge in finding a PWLE with whom they were working on connecting to housing.

I've got outreach teams scouring everywhere to locate him and it is almost impossible to find people when they're living in homeless camps or living under the bridges or hiding in [anonymous] park; and that is true for healthcare and all sorts of things.

As detailed in the Solutions section, one healthcare participant stated that stable supportive housing is needed for PWLEs: "You just need to get the person in good supportive housing before you can really

"If they're concentrating on just maintaining, finding a dry place to sleep and their next meal, sometimes healthcare priorities are not as high as those."

connect them properly with care…where their teams can find them, where the home support can find them."

8.1b Without a stable place, PWLEs have difficulty keeping a schedule

Keeping to a schedule or remembering follow-up appointments for after-care services was reported as a barrier for some PWLEs' ongoing care and engagement with healthcare services.

> It is difficult for them to access community supports if they don't know where they're staying one day to the next—so if they don't have a routine, if they don't have a roof over their head, if they don't have an address or a contact number, how do people find them? How do they keep track of appointments in their life? If they're concentrating on just maintaining, finding a dry place to sleep and their next meal, sometimes healthcare priorities are not as high as those. (Healthcare participant)

> It's hard to be on a schedule when you're homeless; it's hard if you don't feel clean to go in and access resources. If you don't know that your stuff is going to be safe, you don't want to go into an organization where you can't take your things with you. (Healthcare participant)

Other healthcare participants confirmed that the challenges of remembering follow-up appointments are even more pronounced when PWLEs without a stable home also have cognitive impairment.

> I don't want to say everybody, because some people do, but if they have a bit of an impairment, maybe they've been drinking for years and they have some sort of cognitive impairment, then it's hard for them to make appointments, it's hard for them to follow-up with things. (Healthcare participant)

Being able to keep appointments was also affected by other factors as well, as explained by one PWLE participant:

> Actually, it was when I forgot the date because they set it really far in the future and my phone went missing so…I just didn't know exactly at that point, I kind of lost track because it was so far [away], and I was distracted.

8.2 Stigma and Discrimination

A second category of factors that acted as barriers to care for PWLEs were attitudes and opinions held by providers, both within healthcare and shelter/housing sectors, as well as the broader cultural stigma and discriminatory beliefs around homelessness, substance misuse, and mental health.

> There's a real problem with discrimination at the hospitals. They will release somebody to the street if they have any history of being in a shelter system or if they have an appearance of some sort and they will keep other people for months. It's basically classism. And I'm not kidding about this. (Shelter/housing provider)

PWLE participants reported experiencing stigma and being judged by providers based on their appearance. One PWLE participant reflected on this:

> They judge you… They look at you, they don't realize that you can't shower every day, or you can't make it to the bathroom. They don't realize that you…can't go get clean clothes everyday.

Healthcare and shelter/housing participants also reported experiencing resistance when seeking services on behalf of PWLEs. For instance, healthcare participants reported being met with resistance when calling providers looking for a discharge location for their patients. They reported that their patients were often rejected based on negative assumptions about the patients.

"They judge you… They look at you, they don't realize that you can't shower every day, or you can't make it to the bathroom. They don't realize that you… can't go get clean clothes everyday."

> Transition houses—it's brutal, it is the worst. I have to say that is probably the hardest relationships. And not that it's with me personally, but with [hospital] because you have women, unfortunately 90% of women fleeing domestic violence are in abusive situations, are women who are vulnerable, which are women with addiction issues and homelessness or precariously housed, or mental health issues and they're in the [specific neighborhood]. And when they decide that they want to transition out, transition houses want the white docile female with two children that's mentally stable and that is leaving a middle-class man, they want that client…so a relationship with transition houses is abysmal because they just don't want our clients. (Healthcare participants)

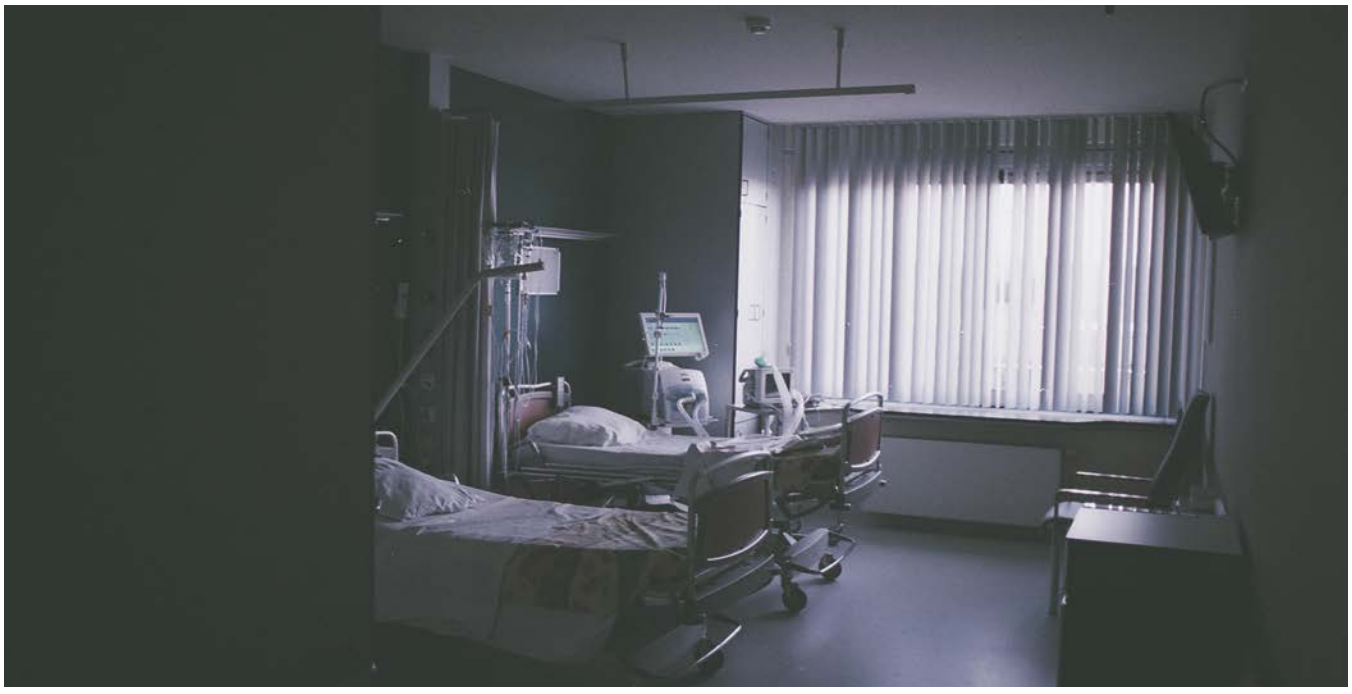
8.2a Lack of meeting PWLEs "where they are at" and patient-centered care

Participants reported that providers often fail to meet PWLEs "where they are at." The philosophy of meeting people where they are aligns with the goal of providing client- or patient-centered care and services. However, participants stated that the needs of the healthcare system are more often prioritized over those of PWLEs.

> In every other portion of the medical population that we serve, we shape the modality of medicine to the needs of the client. With this population, we never shape the modality of the service of medicine to the needs of the patient… Their needs…aren't met because we ask them to meet us instead of us meet them. And it's a notable failing of our health systems… (Shelter/housing participant)

Even healthcare providers suggested that the lack of meeting client where they are is especially evident in hospitals:

> We're not patient-centered. We say we are, but we're not. You have to do everything on our timeline, according to what our doctors' orders are, and our nurses, and you can't go out and smoke, and it's difficult …if you're an addict how are you supposed to use regularly? So, now we've put you in an environment that's very, very structured. Often there's institutional trauma—somebody was in a residential school or somebody has had a negative experience in a psychiatric ward, then we're just going to put them back in a medical ward and it feels the same. …I certainly know it's much higher amongst the transgender populations that don't want to come to hospital because people will use the wrong name, and the wrong gender pronouns and that's really traumatizing for them. So, there's a myriad of reasons why people don't want to come or don't want to be in hospital. Staff often treat patients not great—especially



patients that are homeless or are struggling with addiction issues or might be working in the sex trade. (Healthcare participant)

8.2b Healthcare provider attitudes and treatment of PWLEs within healthcare settings

The attitudes of healthcare providers and treatment of PWLEs in healthcare settings were described as barriers to care for PWLEs. For instance, PWLE participants reported that healthcare providers often discredit their knowledge about their health situation.

> I was trying to talk to them, I was giving them all the information they needed, they weren't listening to me, they were claiming I was somebody I wasn't, it was hard to fathom. And I was having a low blood sugar; my brain was shutting down… They claimed I wasn't diabetic in emergency when I'm there in a hyperglycemic shock. (PWLE participant)

According to participants, the negative treatment of PWLEs was made worse when the patient was thought to be an active substance user.

> A lot of the nurses are very ignorant and rude and very arrogant and very judgmental; I find that especially if they know you do drugs, as soon as they find out you do drugs that's it. It's like you're, like nothing, like you're a piece of garbage and that's where it's got to… (PWLE participant)

One PWLE participant who required pain medication to treat symptoms of pain felt especially judged and reported being treated rudely and unkind as providers assumed dependence to pain medication.

> They're being so judgmental—when I say I'm having pain and I need pain medicine, they don't want to give you pain medicine and they feel that you just want to be high or something. That's how I see them as now, since I've been homeless, okay? That's how they see me, as a drug addict.

Feeling that healthcare providers were inconsiderate and uncaring was a direct barrier to care for many PWLE participants who suggested that because of the poor treatment they received, they were hesitant to remain engaged with care.

"It's scary because you just don't think, you trust your doctors to look at you as a human being. [*Crying*] And when they stop doing that it sucks. Because there's not many other people that do look at us like human beings, right?"

Moreover, being treated poorly was reported to have a negative impact on PWLE participants' sense of self-worth, further influencing their health outcomes.

> I felt that it was kind of a hostile environment for me…I had an overdose…I know they get sick of people overdosing, but I mean it's not like we set out to piss off ERs [emergency rooms] when we're out there and this kind of stuff happens… It just makes you feel like less of a person…a hospital is supposed to be a place of total safety and I should be able to feel as though I am going to be okay here because if I don't have that feeling, if I feel scared, or fearful, or apprehensive, or angry, or whatever, that's not going to help my healing process, and I'm not going to have good health returns. …I trust my doctors and I trust the healthcare system to take care of me, but when I start seeing things like the lack of care and you start seeing that you're looked at differently—and I mean I deal with enough shame and guilt and I deal with enough self-loathing—that the last thing I need is somebody that I trust in my medical life to also look at me the same way I look at myself. That's hard to deal with. It's scary because you just don't think, you trust your doctors to look at you as a human being. [*Crying*] And when they stop doing that it sucks. Because there's not many other people that do look at us like human beings, right? (PWLE participant)

8.2c Landlord attitudes

Among the more challenging experiences of discrimination that participants reported were during interactions with landlords of market rental housing. In order for PWLEs to transition from hospital to housing where they can receive home care, they often need access to rental units. However, participants reported resistance among landlords to rent to PWLEs with a history of homelessness, substance use disorders, mental

health, or disability. One shelter/housing participant described the challenge in finding housing for PWLEs with mobility limitations: "Landlords won't take people, often won't take people if it's not on the first floor because of the safety issue. So, it's very hard to house people." Similarly, a PWLE participant described her challenge in finding a rental location: "I looked for a whole year for housing and nobody would rent to me because I was a lone girl and probably because I was Aboriginal, and nobody wanted me to live there alone or anything."

This resistance was thought to be particularly challenging in Metro Vancouver, which has a severely competitive rental market. Participants described a need for advocates to engage landlords to be more accepting of PWLEs and to understand that PWLEs can be supported in their rental housing.

> Mobility, age, health, a lot of landlords are picky and choosy, they'll be like 'Oh, how is this person going to help themselves,' or 'Are you sure there is going to be supports? I don't think they can manage.' Even clients that are in walkers that can walk down a couple of stairs they're not very confident that they can be housed. So just to have somebody there to advocate on their behalf a little bit more would definitely be beneficial. (Shelter/housing participant)

8.3 Past Experiences, Beliefs, and Behaviors of PWLEs

A final category of barriers to care included past experiences, personal beliefs, and challenging behaviours of PWLEs that limited their desire or ability to engage with healthcare.

8.3a Experiences of poor treatment limits PWLEs' engagement with healthcare

Based on personal histories of having been treated poorly within the healthcare system, PWLEs were reluctant to disclose certain information or displayed aggressive and challenging behaviours. One PWLE participant reported leaving the hospital with untreated pain when their healthcare providers were disrespectful:

> If the nurses or doctors are ignorant I walk out. If I find they're very rude and ignorant I tend to just say 'fuck it' and walk out and suffer with it or go get high and numb the pain.

"If the nurses or doctors are ignorant I walk out. If I find they're very rude and ignorant I tend to just say 'fuck it' and walk out and suffer with it or go get high and numb the pain."

Because of the negative or dismissive treatment experienced in healthcare settings, there is a hesitance among PWLEs to engage with healthcare.

> There have been times where I have felt like so suicidal…but I couldn't even bother to go to the hospital because I knew that they wouldn't do anything… There have been times where I know I needed to go get help and I just didn't go and it's not because I don't want the help, it's because I knew deep down they weren't going to give it to me, that they just wouldn't care… (PWLE participant)

Past trauma with healthcare professionals was also cited as a reason that PWLEs might not want to engage in the healthcare system.

> A big issue is also negative past experiences with healthcare professionals. I believe that's especially evident or more frequently experienced with a lot of First Nations communities. There's a very troubled history of the kind of past policies when it comes to healthcare and also the institutionalized racism towards indigenous peoples and healthcare was also a big part of that. So, yeah, I would say also past traumas, for both First Nations and non-Aboriginal clients, past traumas and past negative experiences. (Healthcare participant)

8.3b Symptoms of mental health and substance use disorders

Symptoms of mental health and substance use disorders were reported to present unique barriers and limiting PWLEs' engagement with healthcare. For instance, mental health and substance use disorders can impact the willingness of some PWLEs to engage in care.

> I think the other part of that is the client's own willingness to engage in healthcare as well. Which is problematic because some people

> choose not to take medication, they choose to decline their wound care and miss their wound care. It may be a mental health reason, it may be because they are, got a high level of addiction and they need to engage in behaviours that will facilitate their addictions. (Shelter/housing participant)

The intersectionality of mental health and substance use was seen as putting PWLEs further at-risk of being lost to follow-up because the pattern of intermittent engagement, disengagement, and then reengagement with healthcare and social services compromised continuity of care. For instance, it was reported by a healthcare participant that PWLEs might leave the hospital against medical advice on "check day"—the day when social assistance checks are issued—to go use substances, which they cannot use in the hospital. In addition, the barriers faced as a result of symptoms of mental health and substance use disorders are worsened by the long wait times for mental health and additions treatment.

8.3c Aggressive or challenging behaviours

A final reported barrier to care was aggressive or challenging behaviours displayed by PWLEs, which can prove difficult for healthcare and shelter/housing providers to manage. Participants described how some PWLEs can be too aggressive or challenging, which excludes them from certain services. Particularly challenging behaviours were reported to include fire starting, violence towards other people, and psychotic episodes that put others at risk for harm.

Participants involved in housing searches with PWLEs with a history of aggressive behaviours reported the importance of appropriately matching PWLEs' needs with the capacity of the shelter/housing. Referring PWLEs who have behavioural issues to locations where they may not do well compromises the relationships between providers.

> It's delicate because you want to make sure all your patients are housed, but also because you have relationships with these organizations, you don't want to send a person who's going to trash the place or like crap on the floor or do all kinds of behavioural things or be violent because then it can negatively impact your relationship and the next time you ask that shelter or that housing place for a favour or to accept your patient they may be less inclined. (Healthcare participant)

Moreover, without proper matching, it was suggested that PWLEs with aggressive behaviours would lose their shelter/housing.

Chapter 4
Solutions to Improve Hospital Discharge for Persons Experiencing Homelessness

During the second phase of this research study, semi-structured interviews were conducted with 40 study participants from October 2017 to January 2018, both in person (n=24) and over the phone (n=16) (See Appendix A for detailed Methods). Participants included ten shelter/housing providers, ten healthcare providers, and twenty PWLEs (See Table 3 in Appendix A). The purpose of these interviews was to assess the needs and gaps in supporting health for people experiencing homelessness transitioning from hospital to shelter and housing. All interviews were audio recorded and transcribed verbatim; and data were analyzed using five phases of thematic analysis (Braun and Clarke, 2006). Findings from these interviews have been organized into two chapters; here, we describe solutions for supporting PWLEs who are being discharged from the hospital. Following the development of an initial set of Solutions, we engaged in a second round of community consultation to get the feedback of healthcare and shelter/housing providers, as well as PWLEs, on possible solutions for supporting PWLEs being discharged from the hospital.

INTERVIEW FINDINGS

Data analyses revealed four overarching types of solutions offered by participants as ways in which to improve the current systems of hospital discharge for persons who are experiencing homelessness: 1) People; 2) Cross-Sector Relationships; 3) Places; and 4) Things. *People* encompasses those persons and roles that should be – or could be – involved throughout the discharge process. *Cross-Sector Relationships* involve the development and maintenance of collaboration between shelter/housing and healthcare providers. *Places* are locations in which participants reported that patients could be optimally supported. *Things* are everything else, from physical tools and objects that would be helpful during these processes, to policies and initiatives that could be implemented in support of PWLEs.

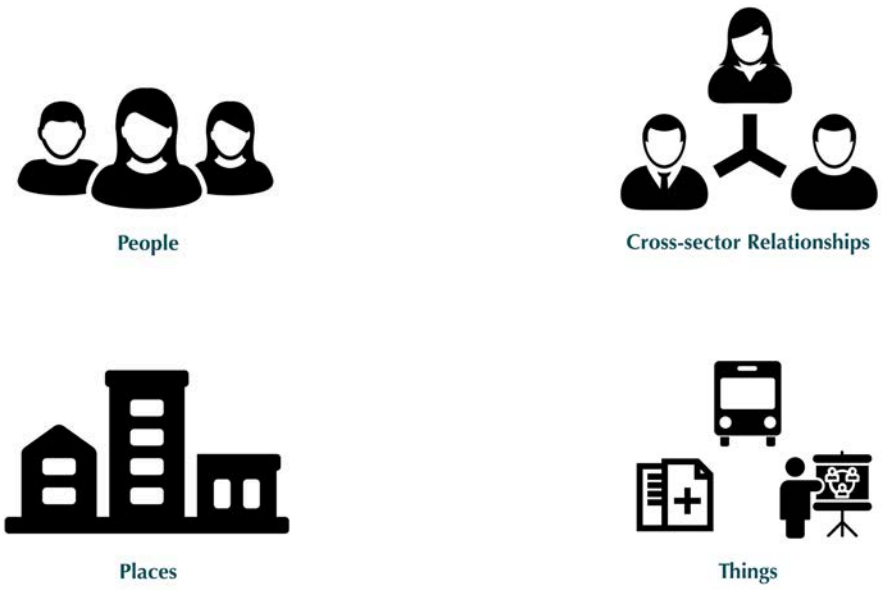


Figure 4.1 Case Study Findings

1. PEOPLE

Participants reported a variety of persons who could be helpful and improve the care of persons who are experiencing homelessness as they are discharged from the hospital to a location in the community, whether it be to a shelter, transitional or other housing, or to the street.

1.1 General Practitioners

General practitioners (GPs) were reported to have an important role in the community for improving hospital discharges for PWLEs by ensuring the connection of PWLEs to follow-up care and services. Following their discharge, one PWLE participant reported being "able to follow-up with a doctor for probably about six weeks [after discharge]" and that this doctor "was able to open a few more doors," which was helpful. In addition, the value in having the hospital physician contact the PWLE's community physician upon discharge was noted as one way to support the continuity of care and also ensure an appropriate review of medication regimens that might have been altered during a hospital stay.

1.2 Case Managers and Case Management Teams

An often-cited solution was the need for more case management, which could take multiple forms—from case managers in the hospital (e.g., social workers) to case managers in shelters or elsewhere in the community. In addition, identifying what a PWLE with physical or mental health needs so they can effectively transition to shelter or housing, a shelter/housing participant suggested "having a worker assigned to them in the community and regular support, regular follow-up, regular communication, who knows? Maybe a peer support worker could work in some situations."

Participants described hospital discharge as a particularly vulnerable time for PWLEs. Therefore, having a case manager to assist PWLEs during such transitions was suggested as one potential solution for individuals who are experiencing unstable housing, who have little informal support, and who have debilitating healthcare issues. One PWLE participant shared a post-discharge experience that could have been improved with immediate follow-up care management:

> I know when you go home with a baby, they send a health nurse to come see you, right? They make sure that everything is going smoothly, to see if there is any more resources they can help you with. Maybe something like that [could be provided for medical needs]. I know, okay, I broke my arm, you don't need to come see me and make sure my arm is still okay. But, you know what? Cellulitis is a big thing. Like, I could barely move my arm. This thing is five times its size, I feel like I'm going to die. You need to give me a phone call, 'You know, it should be draining by now. You notice any concern with drainage?' Just kind of touch base, so that way we're still on the same page.

1.2a Social workers in the hospital

Participants reported that when PWLEs in the hospital are connected with social workers, their experience is improved. As one PWLE described, their discharge from one hospital went well because of the support and treatment they received:

> Oh yeah…every time they've had a social worker with guidelines, and helping me, supports and if I need it…If I needed prescriptions, insulin, or whatever, making sure I had food when I left. But those other hospitals basically flush you through and you're just another number… [But in this hospital] they talked to you like you're a human and actually being listened to…offering more than one option, I guess. Which is good because if you're left with just one option, you're kind of cornered.

One PWLE participant, who did not have a positive experience of feeling supported in the hospital, reported that having "one-on-one time" with social work services would be of value:

> I think if we were to establish more personal contact I'd be a lot more comfortable explaining my situation, you get a certain level of trust and it would be more acknowledged… As opposed to just being in the system, which is tough because so many are in the system.

Other participants agreed that one-on-one, individualized attention to patients would be an important step towards the prevention of readmission.

> When you're close to getting discharged, having that person step in and working with you to do what's best; I would think that the last thing that the healthcare team wants is to see people coming back repeatedly. Like, regulars at the psych ward—I mean that's a problem, right? (PWLE participant)

A healthcare participant offered the idea of developing "walk-in social worker services," so that when PWLEs come to the hospital and need assistance with disability or income support applications, they can be assisted in accessing these services and navigating the complicated social support systems. This participant described what this role would entail:

> Almost like a case manager, of recognizing, like actually understanding this person and knowing what their needs are, and ensuring that they don't fall through the cracks and ensuring that, okay, you know what, this case manager is going to connect them with some housing and actually working through the various facets of making a more stable life for them…it's just so challenging and difficult to understand on your own…

"This case manager is going to connect them with some housing and actually working through the various facets of making a more stable life for them... it's just so challenging and difficult to understand on your own."

Other PWLEs agreed with the suggestion for increased connection to social workers both in the hospital as well as following discharge. Specifically, participants expressed a desire to be linked with social workers who could assist with the hospital discharge and then work with the PWLE once they were out of the hospital and back in the community. Some PWLEs reported not receiving case management in the hospital and leaving the hospital without determining their follow-up plans:

> Maybe they could have made sure that I left with a worker of some sort…cause I just kind of walked out… So, it would have been nice if someone had walked out with me and been like, 'So, this is what our plan is. Will you come back in a week and check-up?' …Making sure that I have somewhere safe to go, that I've got someone that's got my back, someone that I can call. They didn't seem to care that I didn't have anybody. …It would have been nice if they'd taken the time to care about if I was going to be okay just for like the first day, cause like after that it's obviously on me, but that first day when you're out of a hospital you're still kind of like taking those baby steps back. (PWLE participant)

Participants agreed that having someone who could support PWLEs in accessing post-discharge care, ensuring that they had follow-up appointments and were able to get to these appointments—or having

someone accompany them to their follow-up appointments, would be of value.

1.2b Post-discharge case managers and support workers

Once PWLEs have been discharged and transitioned into a shelter or other temporary housing, different types of support workers were reported to be helpful in supporting PWLEs. Workers were cited as assisting PWLEs in picking up medications, caring for their pets, and talking through health issues. As a healthcare participant suggested, other ways a case manager would be useful for PWLEs include helping with:

> The day-to-day needs, getting them connected to…whatever it would be: follow-up here and there, daily connections, engagement. That's what I found most helpful with some of our folks here who are connected to, let's say, mental health case managers because I know it works quite well. And this is coming firsthand from their mouths, that they need that person who knows the process, who knows how to guide them in the right direction, who knows the system to make sure that they're on that right path. So, it can be something such as getting them to an appointment, like a health appointment, to getting them connected to work on housing stuff…anything like that, daily check-ins.

Similarly, other participants reported that PWLEs need someone to check in on them to monitor their health and to ensure follow-up care is completed. Shelter/housing participants described PWLEs whose declining health situation was improved through persistent intervention.

> CT scans are missed, and nobody phones to say the person's not showing because nobody knows. I'm just thinking of a fellow here, he's long-term HIV and other illnesses, but he was diagnosed with lung cancer. He's someone who will never get to an appointment… We took him to all his radiation treatment and his follow-up. Without that there is no freaking way he would ever, ever have gone or had any treatment. …He would not have got treated for his lung cancer, and he's been successfully treated. (Shelter/housing participant)

While case management was recognized as intensive work, it was also seen as being able to lead to healthcare savings:

> [The accompaniment of PWLEs to follow-up care] is labor intensive and that's really, let's be honest, that's what's needed. Sorry if it's time consuming, but it is actually saving the healthcare system money at the other end. You know, wasted appointments, and then the person ends up much sicker in hospital. That type of thing. So, money needs to be spent on those basic things. (Shelter/housing participant)

Participants agreed that more involvement with PWLEs and developing a deeper understanding of their individual physical and mental health needs is valued and leads to better outcomes. This holistic type of service provision was referred to as wrap-around care.

> I would like to see them go into clean, safe, temporary accommodation, one that probably has some measure of wrap-around support services, whether it's nursing care, onsite addictions support, onsite counselling… A place

that takes pets and is fully accommodating of all their health, mental health, emotional, and social needs in some way. (Healthcare participant)

1.2c Case management teams

Wrap-around case management following hospital discharge may be particularly important for PWLEs who are managing complex health needs and concurrent mental health and substance use issues. For example, regular medication management provided by a case manager was reported to help stabilize a PWLEs' mental health and to help prevent emergency situations.

> I need to have a complex case plan to understand how we can support this person… Further embedded client team wrap-around services for those populations. We see these individuals, the mentally ill, concurrent poly-substance user, really stabilize well when they're able to get a regular psychotic medication… a script that's actually functional for their needs and then when that is found, which obviously we all know takes time, if there's somebody who's there to support the consumption of it. I can't force you to take your pills. That's not something that is any way in my power to do, nor should it be. So, how are we going to build teams, wrap-around service around people so their continued health is improved, they have case management and so that we were having monitoring, so that the only time that we're doing medicine is not in a state of full emergency. (Shelter/housing participant)

As one shelter/housing participant summarized, "People who have serious mental health issues should have ongoing supports in some way to connect them to community." Indeed, participants agreed that this population experiences "more success (Healthcare participant)" from having "multi-level support (Healthcare participant)," "someone who checks in on them frequently (Shelter/housing participant)," and a worker who can "follow this person through the system and can navigate the systems and can jump over those barriers that we [shelter staff] just simply don't have time to do. (Shelter/housing participant)" Moreover, it was reported that "people with mental illness need the mental health team on demand. They need them there, not having to go somewhere. And a more flexible, component to it. (Shelter/housing participant)" A healthcare participant echoed the benefit of a community mental health team that can "follow-up with all their [individuals with mental health] post-discharge needs, like medication."

Successful wrap-around care is often provided by inter-professional case management teams. These teams can include general and nursing practitioners, psychiatrists, social workers and peer support workers. Participants reported several examples of case management teams in practice in Metro Vancouver, including Assertive Community Treatment (ACT) teams, the Community Transition Team (CTT), and Intensive Case Management (ICM) teams (See Box 4.1). Because of the intensive care that these programs provide, the number of clients that each team followed was reported to be quite low.

> Because they're intensive case management, their numbers are really low; they probably have 40 people on the team. But, their outcomes are really good because each case manager has twelve people…and they can intensively manage those twelve. (Healthcare participant)

Having a case management team was reported to successfully enable PWLEs to remain engaged with healthcare following hospital discharge, which led to better physical and mental health outcomes.

> When you look at patients that are attached to the intensive case management teams, which are the ones that will do that intensive work, they have much higher success rates at attending appointments and getting primary care and dealing with antibiotics and getting a lot of stuff done, and so their baseline health goes up. So, that support in the community is really important. (Healthcare participant)

> The continuity of care [after discharge] with the community team linkages. For example, the fellow that is going from the [emergency shelter] into housing. He's hooked up with an ACT team [for mental health] and the ACT team will liaise both with the hospital social worker, with the shelter, and with the prospective housing provider to ensure continuity of care. (Shelter/housing participant)

BOX 4.1 COMMUNITY TEAM-BASED OUTREACH SERVICES

Assertive Community Treatment
Assertive Community Treatment (ACT) is a mental health service for persons living with complex mental health and substance use issues and functional impairments. Multi-disciplinary ACT teams consist of a team coordinator, psychiatrist, staff from core mental health disciplines (e.g., registered nurse, social worker, occupational therapist, substance use specialist, and vocational specialist), peer support specialist, and administrative staff.
https://www.act-bc.com/

Assertive Outreach Team
The Assertive Outreach Team (AOT) consists of psychiatrists, nurses, clinical supervisors, and police officers from Vancouver Coastal Health and Vancouver Police Department providing short-term transitional support to clients with substance use and/or mental health issues, as they transition from hospital or jail to the community. AOTs aim to reduce violence and self-harm among clients, as well as their involvement with the criminal justice system.
https://vancouver.ca/police/organization/investigation/investigative-support-services/youth-services/mental-health.html

Community Transition Team
Community Transition Teams (CTT) assist clients who have mental health issues to transition from the hospital to the community. Services include housing searches and placement, rapid crisis response, connecting clients to community mental health teams, mental health monitoring, and medication monitoring.
https://find.healthlinkbc.ca/ResourceView2.aspx?org=53965&agencynum=17676293

Intensive Case Management
Intensive Case Management (ICM) teams serve individuals with substance use and mental health issues by addressing their health, social, and housing needs. Teams include clinicians, nurse practitioners, addiction physicians, psychiatrists, and housing outreach workers. Services include housing support, access to medical care, substance use counselling, life skills support, grocery shopping, connecting persons to community resources and income assistance services, money management, and medication assistance.
https://www.fraserhealth.ca/Service-Directory/Services/mental-health-and-substance-use/substance-use/intensive-case-management-teams#.XHnZTtGIZp8

Overdose Outreach Team
Overdose Outreach Team (OOT) is a team of outreach and social workers appointed to connect individuals with opioid use disorders to (i) addictions care and support; (ii) other health and social services; and (iii) general harm reduction and overdose prevention education.
http://www.vch.ca/Locations-Services/result?res_id=1422

The ability of a PWLE to "be attached to a care team" was acknowledged as beneficial for both PWLEs and for healthcare providers in coordinating patient care. Expansion of case management teams to be available to other patient groups was suggested:

> I think that even though we can't resolve the housing situation, at least they've got the ACT team for folks with certain mental health concerns that meet that criteria [sic]. …I feel like we would benefit from something like the ACT team, but for everybody else [too]. Somebody that can do ongoing case management with these guys outside the hospital, to keep them on their path, get connected with certain things, because these guys are super transient… (Healthcare participant)

1.3 Cross-Sector Outreach Workers

Participants reported on the potential benefits of having cross-sector workers available in settings where they might not traditionally be found. For example, having shelter staff go into hospitals to meet with PWLEs, or having healthcare providers go into shelters or onto the street to provide care. Having a housing liaison worker based in the hospital was another suggested solution.

1.3a Healthcare outreach in the community

Participants suggested that healthcare providers be mobile and accessible to PWLEs outside of traditional healthcare settings. One shelter/housing participant reported on the success and efficiency of a physician who works on the streets two days per week and is able to "access people that are not making it into the clinic, or they're too sick [to go to a clinic], or they don't have any follow-up." Another participant agreed that having a nurse practitioner or a licensed practical nurse onsite at a shelter offers a solution to many of the unmet healthcare needs of PWLEs.

> More follow-up through medical professionals, whether it be somebody in the mental health field or even just a nurse practitioner coming in and checking in and seeing what is needed and what is not. Just to make sure that what they are taking is working the way it is supposed to work. …Maybe we could hire our own nurse practitioner to be onsite. That would be a good idea, somebody that is well rounded and well versed in both fields, whether it be [a] psychiatric or medical component, it would be good to have somebody onsite who would know what to do in the situation or where to refer somebody to, what kind of care they need. (Shelter/housing participant)

"It would be good to have somebody onsite who would know what to do in the situation or where to refer somebody to, what kind of care they need."

Participants reported that some shelters have hosted a nurse's outreach clinic in the past, which was considered successful, yet a lack of funding for such outreach had forced the program to close. As one participant from the second community consultation described, "[Health outreach in the clinic] saved a lot of people's lives…especially wound care. And now we don't have that and it's like: more hospital visits." Participants emphasized that funding to hire healthcare staff to work in shelters is needed.

> [We need] the funding to have actual staff that are trained for [the work]. The ability to have funding where we can hire care aides and have a care aide per shift, pull in that as some part of their responsibility so they're actually trained to dispense medication, they're trained to check these things. (Shelter/housing participant)

A healthcare participant noted that some hospital staff are able to arrange for nurses and home health workers to serve PWLEs in shelters and that by doing so they "may have resolved some of the [care] challenges." This participant explained:

> Personal care, to me, doesn't seem like that big of a challenge because we've been able to work [something out]—personal care meaning bathing. There's been some partnerships developed with home health and the shelters where they would go in to provide that support, so I feel like that hasn't been too much of a barrier anymore.

1.3b Shelter providers going into the hospital

Participants agreed that a PWLEs' transition to the shelter following a hospital stay is eased when outreach workers can go into the hospital after they receive a referral from a hospital social worker. It

was suggested that shelter outreach workers who can make in-hospital assessments of PWLEs prior to discharge are able to prevent PWLEs from being sent back to the hospital because their health needs exceed the resources of the shelter. This was reported to happen in cases where PWLEs are discharged from the hospital and sent to a shelter without being independent or well enough.

> [Outreach workers do the assessment] face-to-face [in the hospital], they go over everything that is written in this form and instead of asking the social worker, 'Are you able to do this?' Or what the function level is, they will ask the client. At times, we have been told the client can move from wheelchair to bed themselves, and we've asked them to demonstrate, and it was quite evident that that wasn't the case. We were able to avoid sending that person back. (Shelter/housing participant)

Having shelter staff come into the hospital was also reported to enable the beginning of an effective engagement process with PWLEs:

> I think having outreach come to the hospitals, the shelter staff to come to the hospitals to connect with them has helped. And that way shelter staff start to get to know some of these guys a little bit more, which…starts that engagement process so that when they get discharged to the shelters these outreach workers can continue on that journey of that continuity with them. (Healthcare participant)

BOX 4.2 COLLABORATIVE CARE SOCIAL WORKER

The collaborative care social worker is a specialized social work role within Fraser Health Authority aimed to provide additional collaborative support for patients who frequently use the Surrey Memorial Hospital (SMH) emergency department. This social worker collaborates with healthcare and community-based service providers to create care plans that are available within the hospital.

> "We don't really have time to form those relationships, and help someone along the continuum, we just have time to discharge them and find them a bed, but then there's so much more needed when you're sending someone out."

An example of this presented during the second community consultation is the "collaborative care social worker" (See Box 4.2) in Fraser Health who has connections to shelter providers. For Fraser Health staff, this relationship has been successful in facilitating communication with shelters.

1.3c In-hospital specialized shelter/housing liaisons

Participants also suggested that housing outreach workers be embedded within healthcare settings. While this was reported to be something that was being done in the mental health unit of one hospital, it was suggested that having a housing liaison in other hospital units would be ideal.

> I'd also like to see more funding placed towards housing outreach workers whose sole job is to help people find housing; a couple of housing teams, within the [health authority]. (Healthcare participant)

> I know social workers do their best and we try to do our best to collaborate. I can see someone like a liaison person who would be able to move between and be active in the community, but also in the hospitals… Someone that works with the social worker, but they have the ability to actually leave the hospital and maybe walk with people a little farther. (Shelter/housing participant)

One healthcare participant suggested that a BC Housing employee serve in this housing liaison role: "The hospital should have BC Housing workers attached." Others reported that housing workers could be employees of the health authority (i.e., a hospital-employed social worker). A successful example of having a designated person, described during the second community consultation, is a housing consultant that links Fraser Health with the shelter/housing community.

Having a hospital-based housing liaison worker was reported to be one way to help hospital providers stay updated "around what's happening in the community, with shelters, with housing [generally] (Healthcare participant)." This housing liaison could "build a lot of rapport" (Healthcare participant) with shelters so that when there is a PWLE in the hospital who needs a shelter bed following discharge, the liaison is able to connect with the shelter providers who might have an appropriate bed.

> They liaise with shelters, someone who has a relationship with people at shelters and in community and have stronger ties, like to the community, but based in the hospital, because we don't really have time to form those relationships, and help someone along the continuum, we just have time to discharge them and find them a bed, but then there's so much more needed when you're sending someone out. (Healthcare participant)

One healthcare participant further outlined what a hospital-based housing liaison could provide:

> My wish list would be we need a shelter person whose job it is just to coordinate people going to shelters, and this would be the ideal…and that person is like the liaison between the shelters and [the hospital]…this person actually is the link between shelters and frontline and care coordination, or that transition to home health, or whatever the case may be. But right now, it's just us making phone calls and them making phone calls and them sending people back because they don't meet their criteria or they're too heavy care, and us being stuck with them and being angry.

2. CROSS-SECTOR COMMUNICATION AND RELATIONSHIP BUILDING

In order to foster the development of collaboration across shelter/housing and healthcare sectors, participants suggested ways to 1) increase coordination and communication; 2) improve cross-sector education and knowledge sharing; and 3) build cross-sector relationships. As one healthcare participant stated, "It's all about relationship building, and communication, those are very key." A shelter/housing participant made a similar statement: "The more that we're interacting with each other and communicating with each other and knowing each other it's just part of the relationship in supporting, together." Having senior leaders support partnership development was reported to be particularly effective in relationship building.

BOX 4.3 FRASER HEALTH HOSPITAL-TO-SHELTER FORM

The Healthcare to Shelter Communication form is used by healthcare providers in Fraser Health to provide shelter staff with important information about patients' support needs during their shelter stays. The form contains information pertaining to follow-up appointments, prescribed medications, patients' diagnosis, mobility disabilities, bladder control, and connection to community supports. (See Appendix D)

2.1 Cross-Sector Coordination and Communication

Participants suggested that shelter/housing and healthcare providers need increased coordination to improve discharge experiences for PWLEs, as good discharges are enabled by knowing the "right" people—those who could work with various PWLEs to ensure continuity of care. At the core of developing and maintaining successful collaborations across sectors is having "a shared sense of…wanting to work together to help someone succeed (Healthcare participant)."

Cross-sector communication was reported to be an intervention effective in assisting PWLEs discharged from the hospital in finding shelter/housing. One shelter/housing participant stated, "The more communication there is between service provider and social worker…I would say the success rate just goes way higher. It makes a lot of sense when more than one person is working with this individual." Healthcare participants agreed on the importance of open communication with shelter/housing providers:

> Just that constant communication, open communication, trying to work in having that, having them know what kind of care needs our patients from hospital may need so that we can

work collaboratively together…definitely lots of open communication. (Healthcare participant)

2.1a Communication between providers for PWLE discharge

The need for basic communication between healthcare providers and shelter providers was identified as a way to facilitate smooth transitions:

> It's picking up the phone and connecting with whoever is on the other end that they know they're going to be discharged to; and it doesn't take a lot of time. To me, that would be the easiest. Communication is one thing, but another one that comes to mind also is… hospital staff sharing [how they have supported the PWLE in hospital] with these shelters, if that's where they end up going… Just to let them know what interventions have been tried… [and what else is needed] (Healthcare participant)

Moreover, PWLE transitions from hospital to shelters are made easier when there is "pre-planning" (Shelter/housing participant) and when shelter providers are given sufficient advance notice: "making sure that you put in the referral as soon as possible. That's very helpful. It's very helpful for us to know as soon as you know when they will be discharged. (Shelter/housing participant)"

Some participants reported that a hospital-to-shelter form (See Appendix D) is used in some shelters to assess PWLE information to determine whether the PWLE who is being discharged is appropriate for a shelter.

> We ask if they need a para-med to follow them to the shelter and if they need help in maintaining the cleanliness of their room; if they can get in and out of their wheelchairs if they are in a wheelchair; if somebody is coming to do bathing support; if there is any addiction issues; and what their mental health status is; if they're on a medication regiment if it's daily dispense or if they're okay to maintain their medication on their own; if they're working with any other like [health authority] identities to keep that in mind with us so we can work closely with them as well. (Shelter/housing participant)

One healthcare participant reported that even in the absence of a patient engaging with the healthcare provider to develop a discharge plan, it is important to inform shelter providers if they believe a PWLE may end up in their shelter. Keeping this line of communication open between healthcare and shelter/housing providers was reported to be appreciated and a way to build trust:

> We've done it in the past where we've had some folks who…were not engaging in transition plans. No matter what options you gave them, they were dismissive, they didn't want to play a part in their housing search…these guys just are not working with the social workers here, so they have to be discharged. So, from that sense, giving a heads up to the shelters to let them know, 'Hey this is what we've done. It's not that we haven't tried but these guys might end up at your shelter, so just a FYI.' That seems to have helped a lot and I know because I end up getting emails to say, 'Thanks for the heads up.' And from there I think that builds trust and it helps with our partnership. (Healthcare participant)

In light of the challenges present by confidentiality regulations, both healthcare and shelter/housing participants suggested that release of information forms could improve service to PWLEs. One

BOX 4.4 DESIGNATED HOSPITAL-TO-SHELTER BEDS

St. Paul's Rooms at the Metson
St. Paul's Rooms at the Metson is a short-term transitional housing program for persons experiencing homelessness who are discharged from inpatient mental health units at St. Paul's Hospital in Vancouver, BC. Program clients are assisted with the development of a comprehensive care plan, long-term housing plan, and treatment for mental health and addictions.
http://mh.providencehealthcare.org/room-for-recovery

VCH Shelter Project
Vancouver Coastal Health provides medical support to persons experiencing homelessness who are discharged from a Vancouver hospital. The project includes 10 priority access shelter beds in the Triage (RainCity Housing Society) and Yukon (Lookout Housing & Health Society) shelters in Downtown Vancouver. As part of this program, BC Housing and the shelter organizations that operate these shelters partner together to develop a housing plan for clients.

healthcare participant described the use of a simple form in which PWLEs give permission for providers to share information with others (See Appendix D):

> Different people have different interpretations of what information we can share, but it's not been a problem. There's a one-page form that we fill out for referring people to the priority shelter beds. And, it kind of highlights the main issues and the people that clients are connected to or the services clients are connected to.

The second community consultation revealed that some PWLEs may be reluctant to sign release of information forms due to past negative experiences, which may be especially true for those in vulnerable positions (e.g., those who have a warrant out for their arrest). As a solution, it was suggested that information sessions with PWLEs be held at shelters and hospitals by social workers to explain the purpose and benefit of providers sharing information and providing reassurance that information is not shared with police. In particular, PWLEs were reported to be more likely to provide consent to providers with whom they are working and trust that they would make sure that things were taken care of properly.

2.1b Partnership agreements between healthcare and shelter/housing
Some participants reported on formal partnership agreements and memorandums of understanding (MOUs) between healthcare and shelter/housing providers to promote information-sharing and cross-sector collaboration. One example included the agreement to dedicate specific beds to patients who were being discharged from hospitals (See Box 4.4):

> With the support of our regional practice leader, [we] developed a healthcare-to-shelter group and we've all started to get together to talk about some of our challenges and really figure out a way to support the marginalized, in partnership, versus against one another—a collaboration… And then through that we've also worked on developing a model where the two main shelters that we have…would save the hospital five beds each—mainly for [health authority] clients—and the whole purpose around that was really to minimize the length of stay from the hospitals because we couldn't discharge these people to a super low-barrier shelter because of their health issues so the shelters would save us five beds and we would transition our homeless folks who are ready for discharge into these shelter beds. So that's built up a good partnership. (Healthcare participant)

Even with the partnership and MOU between hospitals and shelter/housing providers, however, there are waiting lists for priority beds, as one shelter/housing participant described: "We usually

have three or four people on our waitlist waiting to get in."

Participants described other formalized partnership agreements between healthcare and shelter/housing providers, including the use of specific referral forms, though this practice was not consistently reported across the region.

> We do have a form, it's called a hospital-to-shelter form, that we use before they [patients] are discharged from the hospital into our care… We have a memorandum of understanding with them [the hospital]. It just outlines how many people we can priority refer and the expectations of that referral… There definitely is more collaboration, we have phone conversations every two weeks and we try to refer people to supports but sometimes it is just not enough. (Shelter/housing participant)

MOUs were identified in the second community consultation as helpful in allowing providers in different sectors to communicate more openly about PWLEs since these agreements got around confidentiality issues. Additionally, the agreement could be modified and updated over time as needed. It was also suggested that partnership goals in MOUs should be targeted, action-based, time-limited, and have clear objectives.

2.1c Knowing which shelters can support PWLEs' healthcare needs

Participants suggested that understanding which health needs can be supported in different shelter settings would help facilitate discharges. One healthcare participant stated, "Having a clear idea of the strengths or capacity of each shelter, even however limited they are, might be helpful in sort of matching [patients to the best setting]…" At present, when healthcare providers are looking for a shelter bed for one of their patients, they are hopeful that any bed is available, regardless of whether it is the best fit for the PWLE's health needs.

> I think [shelter providers] feel like we dump on them a lot, we'll send people who might still be acute or not able to do the stairs…and fair enough it probably happens a lot because we have our own pressures and we just worry about that. So, if we had that communication being like, 'These are the patients we can take; we can't take someone in a wheelchair who's not able.' … Just knowing these things about the shelters, just knowing the nuances, so maybe sitting down and meeting with them. I know everybody's so busy to be meeting with everyone, but even once a year or what not; if we just had them or we go there to kind of understand their capacity and then they can kind of have a bit of compassion for us when we call or we just know what they're able to support and not. (Healthcare participant)

BOX 4.5 POST-DISCHARGE HOUSING SOLUTIONS

Social Housing

Social or non-market housing is typically subsidized by government and targeted to low-income renters who can live independently. Rents are based on 30% of household income.
https://www.bchousing.org/glossary#S

Supportive Housing

Supportive housing is social housing with additional supports that are provided both on and off site to meet the needs of tenants with mental health and substance use issues. Rents are deeply subsidized – typically to the shelter level of income or social assistance.
https://www.bchousing.org/housing-assistance/housing-with-support

Housing First

An approach that aims to end chronic homelessness by providing immediate access to permanent housing and working with program participants to promote ongoing recovery and wellbeing. Core principles of Housing First include immediate access to housing with no housing readiness requirements; consumer choice and self-determination; individualized, client-driven, and recovery-oriented supports; separation of housing and services; harm reduction; and community integration.
http://housingfirsttoolkit.ca

> Social workers working in hospitals, as well as other healthcare providers who are involved in discharge planning, would need to be aware of what the situation is in shelters… in terms of what the shelters look like, what is the kind of support that the shelters provide, what populations the shelters serve, as well as what are the healthcare needs that the shelters can accommodate versus the kinds of needs that they cannot. I find that that's sometimes missing. I believe more so because a lot of healthcare professionals may not realize what the conditions at some of the shelters are in… having a list of shelters and a brief description of the program would also be useful. (Healthcare participant)

Healthcare participants described a potential solution as a centralized shelter/housing system that could track availability and appropriateness for different PWLEs. While there are a variety of post-discharge housing solutions available, connecting PWLEs to the right solution for their needs is a challenge that could be streamlined through a centralized database.

> The shelter system that we need is one that is run by central administration with some sort of provincial housing standards, with essential intake. (Healthcare participant)

> I'm trying to think of all the different areas. There's BC Housing regular stream, there's BC Housing Supported Housing, there's Mental Health Housing, there's Housing First (See Box 4.5), there's all kinds of other non-profits providing housing, so if there was some sort of centralized process where you could figure out what stream to put people through that would be a good start. …it would still be our responsibility to connect them to the right stream, so we could provide that assessment. It would help if it was standardized; if they used the same tools. (Healthcare participant)

Participants also reported that there would be value in better understanding the experiences of working in the other sector: "I think it'd be interesting to know what the shelter's concerns are, what their issues are with some of our discharges; and for them to know our struggle with finding a place for our patient discharges. (Healthcare participant)" It was suggested that all providers receive education on what other sectors are able to provide and who the key contacts are in different organization.

> I guess, just better education, better training, and better preparation for social workers working in hospital; oftentimes I get a sense that some of them simply don't know what some of these shelters are like. (Healthcare participant)

Participants of the second community consultation suggested that education and information sharing be facilitated through regularly hosted information events.

Another participant at the second community consultation provided suggested that a weekly call of which they were apart worked well as a tool for information sharing:

> We share the information with the shelter providers about the clients, about what we're working on, what the plan is, how we're moving the plan along. And the shelter providers who are seeing the folks every day share the information with us about how they're doing, how their needs may be changing… so that has been really, really positive… that could be built on too.

This lack of understanding of what shelters can provide to residents is especially exemplified in the use of the term 'medically stable.'

> Some of the phone calls from shelters are from their perspective—for lack of a better term—[are] 'dumps from the hospital.' Or from their perspective, these guys [patients] are clearly not medically stable, 'Why are you guys discharging them?' And they would send them back to the emergency department. So, we've learned over time that even the definition of medically stable is very different, healthcare versus community… Having that communications and providing the education on the difference between what medically stable looks like between hospital and community, I think has maybe clarified things a little bit more. (Healthcare participant)

2.1d Cross-sector visits to shelter and hospital

Participants reported that spending time in shelter settings would offer an opportunity for healthcare

providers to empathize with and better understand shelter/housing providers' perspectives, and vice versa. Doing so could enable cross-sector education on the scope of services offered by specific shelters.

> I feel like almost at times that social workers will be like, 'Yeah, they're fine, send them off.' But they don't know what it's like to be in the shelter; they don't know what the shelter setting is like. So, the assumption is there that 'Oh, they're doing great in the hospital, maybe they're doing great there.' So, it would be nice for them to come and experience what goes on in the shelter when the resident is there. What they are capable of doing and what we expect them to do. (Shelter/housing participant)

> I think if they all got to know each other. It's interesting, you're referring to places, to people, you hear these people on the phone, you've never met them you've never seen the work that they do. Sometimes it's just about educating yourself and going out and seeing the resource and physically understanding the situation, the placement, the community. (Shelter/housing participant)

Several healthcare participants who had visited shelters agreed that visits helped them to understand the challenges that shelter providers encounter when a PWLE who they are unable to appropriately support comes to shelter.

> Tours with the shelters…clarified a lot of the assumptions of hospitals and shelters, especially with what shelters can and cannot provide. When I first checked out some of these shelters it made me really see that, 'Okay some of these folks are probably not the best to be discharged at [this] shelter because they don't have A, B, C, and D [intake criteria].' It really provides a better understanding, which in turn impacts on how we deliver our services to our clientele. (Healthcare participant)

"I think going there physically is always a really good idea if you can get out at some point to see the setting, and I think some social workers make the effort to do that and it's a good thing…it's a good thing for the organization to offer opportunities to do that."

While participants acknowledged that there may be challenges in getting hospital staff out to shelter settings, it would be useful in the long run:

> I understand there are time constraints and I guess some departments are chronically short-staffed, so I understand that it does sound a bit ambitious, but it would be really useful. (Healthcare participant)

> I think going there physically is always a really good idea if you can get out at some point to see the setting, and I think some social workers make the effort to do that and it's a good thing… it's a good thing for the organization to offer opportunities to do that. (Healthcare participant)

Participants also suggested that cross-sector visits could help build relationships between staff members in hospitals and shelters.

> It'd be helpful to just see with my own eyes what, like spend that day and build those relationships because I think the more we understand how the other end goes, the frustrations we have, the more we can work collaboratively. So, yeah, relationship building I'd say is very important. (Healthcare participant)

2.2 Having a Primary Point of Contact

Healthcare and shelter/housing participants stressed the importance of developing relationships and that getting PWLEs successfully discharged and supported in a shelter setting is made easier by knowing the right person to contact in the right location. One healthcare participant stated:

> Finding a shelter bed for a client is close to impossible. Really, the only way I manage to find shelter beds for housing were through programs where I had a partnership with the site or if I know someone working there who would do it as a favor and would do it because we have that relationship and we know each other. But other than that, it's just making numerous phone calls and being told over and over again that all the shelter beds are full.

Healthcare providers reported the value in having a specific shelter/housing provider who they can contact when a PWLE is being discharged. This was considered particularly important due to frequent staff turnover and the challenge of knowing who was in charge.

> Part of my job is also to build relationships with these guys so…at least the shelter staff know that there is a point person that they can connect with in the hospital. That, I feel, seems to help them a lot. Even though I may not be the person to have the answers…at least for them they know, 'Okay. there's a point person I can connect with who can guide me in the right direction.' (Healthcare participant)

> She [housing provider] comes to our social work meetings, she has a face. That piece is actually really helpful and important when you have a face for someone and you kind of know who to go through because everyone is so faceless in the shelters and you don't know who you're going to be talking with. (Healthcare participant)

Shelter/housing providers also reported on the value in having a specific healthcare provider who they can contact when a need arises with a PWLE.

"Face-to-face communication" with providers in other sectors was preferred over simply interacting with "voices at the end of a phone." Having been involved in the field for longer periods of time improved healthcare providers' ability to develop and maintain connections with providers in different sectors so they could advocate on behalf of PWLEs.

> The relationships I have, over the years are I've gotten to know different service providers, I've gotten to know different programs, and I'm able to call different service providers and different community partners, consult with them, and/or advocate with them for a client. (Healthcare participant)

> People who have been in the game for a while definitely maybe have a bit better of a grasp, like what is actually going on and who to talk to to get things moving. …I could say, 'Oh hey, I know your name and I know I can actually tell you a bit about why this person may need a bed over someone else.' (Healthcare participant)

Related, participants of the second community consultation agreed that having one person to go to was a key element of successful cross-sector partnerships. As one participant summarized, "At the end of the day, it really boils down to knowing who it is that you call. Knowing who your point person is for a client… just something very simple like that."

2.2a Maintaining cross-sector relationships through appropriate referrals

Participants reported on the importance of appropriate referral and the hesitancy of referring PWLEs to situations in which they would not do well (e.g., PWLEs whose care needs are too complex for a shelter setting or whose behaviors were challenging). As one healthcare participant stated, "If we didn't listen to them and we just kept discharging these guys there without extra support…I think that it could potentially lead to a break down in our partnerships."

At the crux of maintaining good cross-sector relationships is the ability to candidly communicate what a PWLE's needs might be and give advance notice when a PWLE might be challenging to accommodate.

> I learned pretty quickly in doing this job that you don't want to ever be sending them [shelter/housing providers] inappropriate referrals because that'll damage your relationship with someone later. You've got to be really up front about what someone's care needs are and make sure that it's the best referral possible. It might not be a perfect referral, but if you know it's the best option possible and you can articulate that, that helps. (Healthcare participant)

Making appropriate referrals to shelter/housing providers was also highlighted as important in matching a PWLE to their housing location, as noted by a shelter/housing participant:

> …they have to trust you because it's your judgment on who you're referring to them. I'm never sending someone to a place that they're not a fit for. I'm not going to send someone who's actively using [substances] to an abstinence-based location. That just doesn't make sense.

3. PLACES

Many of the solutions offered by participants indicated the critical importance of providing safe, supportive, affordable, and appropriate shelter/housing to PWLEs upon hospital discharge. It was emphasized that there cannot not be a one-size-fits-all solution. Rather, participants noted that in addition to providing more shelter/housing options for PWLEs, a continuum of shelter/housing is needed to best meet the diverse needs of PWLEs.

> This is not ground breaking: housing stock and sheltering stock. So that the people who are stabilizing in shelter can move on to some form of housing, so you actually have a housing continuum and individuals who are at that lower performance threshold have a place where they can stay. (Shelter/housing participant)

More housing was also reported to be one way in which to better reach out to PWLEs and to provide them with the healthcare they need:

> More housing… if we had more housing we could get more people indoors and might be able to avoid future hospitalizations… they have a roof over their head. They're warm, they're dry, they maybe have a place to store their food, their medications, they have ongoing contact. A place where healthcare providers can actually outreach and find them… (Shelter/housing participant)

3.1 Accessible Shelter/Housing

Across the shelter/housing continuum, participants indicated that all locations should be accessible and designed to accommodate the mobility limitations of PWLEs. This includes shelters being equipped with elevators and having bottom bunk beds available. As one shelter/housing participant reported, there is not "a single [floor] seam in this entire shelter" so that PWLEs with mobility limitations or who use mobility devices and are challenged to get over ridges or edges in certain flooring designs can be accommodated. Other shelter/housing participants similarly reported that by having accessible features in the shelter, they are able to better support the health needs of PWLEs who require a wheelchair, scooter, or walker.

> We're one of the few shelters that is semi-wheelchair accessible. Like we have an elevator, we're on a flat floor. All our doors are wheelchair accessible. (Shelter/housing participant)

3.2 Shelters

Participants offered various ideas for how shelter settings can better meet the health needs of PWLEs who were being discharged from the hospital.

One suggested solution was to have private rooms (as opposed to dormitory style rooms) in shelters for those PWLEs who need to continue recovery following discharge. PWLEs were reported to have better health outcomes when they are in private rooms.

> Maybe shelters having less dorm rooms and more private rooms would be good. I know that people with more medical complications and things like that do better in a private room and people with mental health issues and issues with paranoia and stuff they do better in private rooms. (Shelter/housing participant)

Emphasis was placed on both the need to address the increasing number of seniors who are particularly vulnerable in communal shelter settings, as well as the need for low-barrier shelter options to support those with mental health and substance use problems.

> With the senior's population, we've seen a growth in that where a lot of these guys they don't fit in the shelters, but they can't get into independent living because they don't have enough money, they can't get into assisted living because they're alcoholics, and a lot of the seniors' homes here they don't support folks who've got alcohol issues, or brain injuries and dementia, coupled with substance use, there's no supports for these guys. So, what happens is the only 'option' available is really a shelter, even though it's not really an option. So, I feel like there needs to be more creativity… to support these folks that don't fit in any box. (Healthcare participant)

> I think the conversation with political will is it's easier to create sheltering for a family—families and women exiting abusing relationships. And I'm by no means suggesting we shouldn't be opening more of those, we should be. But, we, at the same time, are going to need to really create no-barrier shelters that accept and understand that there are poly-substance users out there that need a place to be sheltered regardless of their consumption practice. (Shelter/housing participant)

"With the senior's population, we've seen a growth in that where a lot of these guys they don't fit in the shelters, but they can't get into independent living because they don't have enough money, they can't get into assisted living because they're alcoholics, and a lot of the seniors' homes here they don't support [these] folks..."

Additionally, participants of the second community consultation noted that shelters should be considered part of a continuum of care within the healthcare model. As one participant summarized, "Sheltering is healthcare, not housing… the very first need before water and food, is shelter… Once we understand it as a health concern [it becomes necessary] to bring embedded health services into that environment."

3.2a Daytime shelters

Another recommendation for providing care for PWLEs recently discharged from the hospital was to have all shelters accessible 24 hours/day and 7 days/week. While many shelters are open 24/7, suitable daytime resting areas for PWLEs with health conditions should be ensured in more shelters. This was a solution offered by PWLE participants who reported that when they do not feel well, they want to have somewhere safe and dry to rest. PWLEs staying at temporary winter shelters or other shelters that are not open 24/7 would benefit from a daytime shelter where there are activities and PWLEs are not required to leave during the day.

> When I had the cellulitis and I had the dog and everything and they let me bring the dog with me, the shelter I was staying at, we could only come there at 7:00 at night, and we had to leave at 9:00 in the morning. So, of course, at the same time as I had to go do all my IV treatment, I can't go back to the shelter when I'm done. I've got to wait until 7:00 at night. And that was another thing, especially when you're not feeling well, you're in pain, and it's like now you don't really have anywhere to go. …Now you're just tired because you just spent half the day at the hospital and now you've got to go sit in the breezeway at the shelter because you can't actually get into the shelter for another

five hours. That was the one thing I found that was really challenging. I'm not one to want to sit outside with a blanket over me; when I'm sick, I want to be in my bed. (PWLE participant)

3.2b Shelter beds for couples

One participant acknowledged the important informal support that partners can offer one another. Accommodating couples in shelter settings was suggested as a solution to providing PWLEs with an additional source of caregiving when they leave the hospital.

One of the other things that would be interesting is having some couple shelter beds available, [couple] shelter spaces, because there are couples that are homeless. One partner's in the hospital and then the other partner is the primary, but then when they come out of hospital the partner isn't able to care give because they can't be together in a shelter. Quite often they can't even get housed together in low barrier housing, it's a challenge to house couples. (Shelter/housing participant)

3.3 Interim/Step-Down Care Shelters

In light of the need for sub-acute locations where PWLEs can continue to rest and recover following hospital discharge, several solutions were put forth for interim and step-down care shelter/housing.

3.3a Medical Respite

Participants reported that having a dedicated shelter (a single location) or multiple shelter beds (across many sites; i.e., "scatter site") where PWLEs could go directly from the hospital would offer an invaluable solution. This model of care was referred to as "medical respite" or "step-down care" and discussed in light of the fact that such a model is available in other regions, including Toronto (See Box 2.2). For persons experiencing homelessness who are too ill to recover on the streets, but who are not ill enough to be in a hospital, medical respite provides short-term acute and post-acute medical care, as well as other supportive services, which enable recovery in a safe setting (National Health Care for the Homeless Council, 2011). These are envisioned as locations where PWLEs can go following discharge "to get stronger and be supported with nutrition and a safe place to heal (Shelter/housing participant)" and to get "stable on their meds. (Shelter/housing participant)" As one healthcare participant stated, "Ideally it would be wonderful to almost have our own shelter from the hospital and almost having their second stage housing."

It would be great to have a shelter for hospital discharges because you are sometimes discharging people who have just regained some strength or just came over this acute issue to just go back into their same situation and that's when a cycle [of readmission] can be seen because without shelter and some sort of security, that's not going to be beneficial for their health, especially if they were just in hospital for it. (Healthcare participant)

I've worked in group homes for the mentally challenged where staff there do all the personal care, do all the cooking; you get trained in lifting, moving people. I don't understand why that's not done in the homeless community. We don't have a facility that responds to medical needs. It's really needed. It's really, really needed. And if this core group of group homes can do it, I don't see why it's not done in our field. (Shelter/housing participant)

Other participants who agreed with the medical respite solution suggested that PWLEs often need respite support for more than 30 days, which exceeds the maximum 30-day limit that is typical in most shelters. Thus, it was suggested that medical respite stays in shelters be available for at least two to three months. Several PWLE participants concurred that medical respite programs would be beneficial for PWLEs following discharge.

For what I see, when people come out of the hospital and go to the shelter they got to be ready to go to the shelter, not half better. You know what I mean? They should have a shelter for people that are sick and have wheelchairs and crutches or whatever, they should all be in one shelter and then they can get the help they need. (PWLE participant)

3.3b Priority shelter beds

In addition to establishing a medical respite program, healthcare participants suggested that having priority to a "few beds at a few different shelters" would be good. Some participants were

familiar with a few shelters in Metro Vancouver that have reserved beds for PWLEs with complex healthcare needs (See Box 4.4).

> One thing is if the shelters, either as totality as a group or even individually, if they were to start from the place of recognizing by saying, 'We prioritize patients coming from hospital.'—That would be a great place to start… That's something that, not just the hospital, but the hospital and the Health Authority, and the Ministry of Health have to say, 'Which shelters in Vancouver are going to take hospital patients as a priority?' Okay, those are the ones we'll focus on. (Healthcare participant)

Designated shelter beds were thought to be one solution that would allow PWLEs who are being discharged from the hospital to have a place to continue recovery without having to stand in line to get a bed.

> A secured spot, maybe, to go to—versus waiting in line. If there was some sort of reservation that we can access, like certain beds or…knowing that there's like 10 beds a day specifically for hospital discharges that maybe are free until like 5 o'clock and then after that it could be opened up to the public. I'm just trying to think of a place where they can rest and not go out into the cold or the rain. (Healthcare participant)

Participants suggested that purpose-built, dedicated shelter beds are needed to support the wide range of PWLEs' needs. Building new shelters targeted to meet the needs of PWLEs who have been recently discharged from hospital would provide an opportunity for PWLEs to heal.

> Creating—through funding—better facilities to accommodate them [PWLEs] when they do come, when they do have to be discharged to a shelter, so there's better staff that are equipped to support them or just cleaner or more segregated environments that they can go to where they're safer while they heal. (Shelter/housing participant)

3.4 Supportive Housing

Supportive housing is a subsidized housing alternative with both on-site and off-site supports, which is intended to ensure that the health needs of PWLEs are met and housing stability is maintained (Metro Vancouver Regional Housing, 2012). Participants emphasized that more supportive housing locations would enable PWLEs with complex health needs, including substance use and mental health issues, to receive needed support. Supportive housing was regarded as one model of assisting people who are unable to live independently, but who are excluded from assisted living because they have addictions issues or concurrent disorders.

> As people age, and it's not even all the old, 40 to 60…the chronic disease starts to mount and their illnesses start to mount and they can't really manage independent living, but they're not helpless in many other ways, but there is a need for more supported housing, where food is included and housekeeping…and more staff on around the clock, so the person can function better because that's a lack that we don't see that here. I mean, assisted living, fine, but then all your money's taken and most people, if you've got an addiction issue, that's not working for you. (Shelter/housing participant)

> "Housing is a right, you have a right to housing. And we talk about it like a privilege."

To address this gap, participants proposed that PWLEs have access to low-barrier supportive housing. Following a harm reduction philosophy, low-barrier housing is generally defined as housing where there are a reduced number of expectations regarding substance use for people to live there (BC Partners for Mental Health and Addictions Information, 2007). For instance, individuals may not be expected to abstain from alcohol or drug use.

> There might be some mental health, there might be [early] onset dementia because they've been chronically homeless and smoking drugs for years. But they're never going to quit, so unless they quit, then they can't be accepted into the low-income assisted living programs… but then all of their other health, everything overall is declining, right? They're becoming more incontinent, their memory is losing, they're getting weaker. If we weren't here cooking for

BOX 4.6 RENTAL SUBSIDIES

Shelter Aid for Elderly Renters
Shelter Aid for Elderly Renters (SAFER) is a BC Housing program that provides monthly rent subsidies for BC residents aged 60 and older who have low to moderate incomes and are renting.
https://www.bchousing.org/housing-assistance/rental-assistance-financial-aid-for-home-modifications/shelter-aid-for-elderly-renters

Homeless Outreach Program
Homeless Outreach Program (HOP) is a BC Housing program that funds outreach and support programs for persons experiencing homelessness, either living on the street, in shelter, or temporary housing, by linking them to outreach workers who provide assistance with referrals to shelters and/or healthcare providers, applying for identification, income assistance, housing search and move-in, and obtaining rent supplements.
https://www.bchousing.org/housing-assistance/homelessness-services/homeless-outreach-program

Homeless Prevention Program
Homeless Prevention Program (HPP) is a BC Housing program that provides persons experiencing homelessness with portable rent supplements and supports to access rental housing in the private housing market.
https://www.bchousing.org/housing-assistance/homelessness-services/homeless-prevention-program

them, I won't even know if they would be eating. So, having that same thing as a senior's home that just sees to all those needs, their basic needs, helping them bathe or reminding them to bathe, or helping them get their clothes done and keeping their room clean, but then there's a community still, so there's still that connection of people they know, and they feel safe and it's secure and there's staff there to talk to, and no one's going to take advantage of them. And if they fall there's someone to pick them up, and who's trained to pick them up. (Shelter/housing participant)

The Housing First model was identified as an example of a successful low-barrier model that should be duplicated further. "Housing First, that's been around for a number of years now and that's a great program…it has a great structure for having patients housed sooner rather than later in terms of stabilizing healthcare or stabilizing mental health and addictions. (Healthcare participant)" Under this model, PWLEs are provided housing and supported with the services and resources necessary for their lived experience. Housing First is based on a harm reduction model that views housing as a right that serves a fundamental need – regardless of where a person is at (Tsemberis, Gulcur, & Nakae, 2004). One shelter/housing participant agreed:

> Housing is a right, you have a right to housing. And we talk about it like a privilege. Like, you have performed well enough, within our normative modalities of thinking about what doing well looks like by my definition, not by your definition, now you've been deemed worthy of housing. So, the carrot for a long time was housing to get off drugs, clean, whatever that looks like. Yet we know from the At Home/Chez Soi study the outcomes are drastically improved and consumption notably diminished if you have housing. And we're still not taking best practice and applying it. (Shelter/housing participant)

While supportive housing was considered a successful solution, participants of the second community consultation reported limited availability.

3.5 Social Housing and Housing Subsidies

Social housing is subsidized housing for people who can live independently (Metro Vancouver Regional Housing, 2012). Participants suggested that increased social housing, either in the form of dedicated subsidized buildings, or through the provision of portable housing subsidies, should be available for PWLEs who can live independently in the community:

> They need to build more social housing for people… I'm on my ninth month here [in a temporary housing location] and they're still looking for a place for me to live and it's very

> difficult because there's no places to live… There needs to be more social housing for the people because we have thousands of people who are homeless that need a place to live. And I hope that this interview helps the government realize that—they need to get on top of it. (PWLE participant)

Moreover, having social housing options that are integrated throughout market housing was identified as a way to provide individuals an opportunity to "start over".

> For people who are trying to avoid…specific people or gangs or all kinds of things; I think if we lump everyone in a Downtown core it's really hard to get well. So, when people are spread around into other market housing areas… it also kind of gives people opportunities to sort of start over. (Healthcare participant)

While it was acknowledged that there are subsidies for market housing (See Box 4.6), it was suggested that these are hard to access and inadequate for the cost of market housing in Vancouver.

4.THINGS

The final category of solutions offered by participants includes the "things" that could improve the experience of hospital discharge for PWLEs and support PWLEs in community. Things included physical objects, as well as ideas or policies.

4.1 Discharge Policies and Practices

Participants described various formal and informal policies and practices that currently exist related to hospital discharge for PWLEs, while others noted what would be helpful. One healthcare participant reported that the only current protocol in place regarding homeless patients was to make a referral to the hospital social worker, while another healthcare participant reported that the only policy was to ensure a safe discharge, though what this means is not formalized. Participants agreed that when developing individualized care and discharge plans, a PWLE's housing situation and community follow-up care needs should be considered.

4.1a In-hospital assessments of PWLEs' needs

Healthcare participants confirmed the importance of conducting a psychosocial assessment in the hospital to understand a PWLE's support system and to "really understand their bigger picture," including the range and type of supports they do or do not have. Knowing a PWLE's housing status and after-care needs was considered to be particularly useful upon hospital admission, as it was believed to improve and expedite discharge planning.

> What we were doing with home health is ensuring that when your clients are admitted [to the hospital], you start the discharge planning process with the care team in the hospital

> from that point on, not a day before they get discharged. (Healthcare participant)

A participant of the second community consultation agreed, "It's definitely more important to do things on point-of-entry as opposed to point-of-discharge because sometimes, by the time of discharge, people are very eager to leave."

Moreover, interview participants reported that it is beneficial when hospital social workers "make sure that appropriate housing referrals are done to the supported housing registry, to Housing First, to assisted living…it's better to have all of the assessments done while the client's in hospital. (Shelter/housing participant)" and that "all attempts have been made to help them [PWLEs] try and find housing or connect them with a housing resource. (Healthcare participant)" Conducting appropriate assessments and connecting PWLEs to community housing and resources while they are stable in the hospital was reported to be one way in which healthcare providers could facilitate PWLEs' receipt of community support.

One healthcare participant described the success in keeping certain PWLEs in the hospital long enough for them to stabilize, get sober, and have a more meaningful assessment of their needs, though this requires a collaborative approach and approval of an admitting physician or a psychiatrist.

> I don't know if it would be a protocol, but one thing I found really helpful also was sometimes I find these guys are discharged too prematurely and you can't really engage with them, especially with folks who are, let's say, intoxicated or under the influence of something. And what we've found really helpful over time was to actually keep them in the hospital over a period of time, so they can sober up to truly have a meaningful engagement… And a lot of the time it's either to keep them over night until they sobered to have a conversation or to ask a doctor to actually seek admission to keep them for two weeks plus so that they can actually sober up to assess or rule out any underlying mental health or anything like that. That would be more of a process because we would have to have the buy-in of the emergency doctor and then you would need a psychiatrist to be on board, so it's more of a collaborative approach.

4.1b Process for delaying discharges when appropriate

Healthcare participants reported that delaying a discharge because the patient lacked access to housing is "a very common occurrence." based on the recognition that housing is an important social determinant of health. Participants described instances in which they had worked to delay, or knew that there was a desire to delay, the discharge of patients who would not have a safe, stable, or appropriate location to go to following discharge. For instance, one healthcare participant stated, "I think social workers would like to delay discharges more often than not when people don't have secure housing." The decision to delay discharges was described as being based on clinical assessment of a fundamental healthcare need.

> I'm certainly working with our inpatient team around, what is the demand for the beds from the emergency department or from other units and weighing it against the importance of trying to ensure patient safety and health and support after discharged; and what can be feasible in terms of delaying a discharge. If a patient is vulnerable, then we have to assess them as sort of a vulnerable patient in the community and if there's a one- or two-day wait for what could be a reasonable safe plan, then we're often willing to do that. And if a patient isn't as vulnerable as other patients and there's no beds on the horizon in terms of confirmed shelter beds and waiting one or two or three days isn't going to change that dynamic, then especially if there's a huge demand on bed usage from the ER, then the team's less likely to be inclined to delay a discharge. (Healthcare participant)

Other healthcare participants agreed that it is often a matter of advocating to the clinical team for certain patients to remain in the hospital, which was considered easier to do for some patients than for others. PWLEs who healthcare participants reported most often advocating a delayed discharge for included: cases when no appropriate shelter bed is available or the discharge would be unsafe (e.g., bad weather), for newly homeless persons, patients who have mobility and cognitive challenges, or

patients who have health needs that will not be met in the community.

> It's a team decision, but for those people who've been severely frail or unable to mobilize then that way has been pretty good to state my case to keep people in hospital… If people are staying longer in hospital there's really time to build a plan and a lot of people are being discharged to facilities or to assisted living or to some supported housing. (Healthcare participant)

4.2 Transportation

Discussions of solutions to the transportation issues and challenges for PWLEs included support both transportation upon discharge, as well as after discharge to access follow-up care. In addition, a variety of transportation solutions were described—some of which were considered more reliable and safer than others.

One obvious solution to the challenges PWLEs face when being discharged from the hospital was the facilitation of appropriate transportation assistance.

> Facilitating transportation [is important]. You're asking somebody who's in a diminished state of health who has co-morbidities—if you achieve shelter for that individual, put them in a cab and get them there. That alone goes a long way in that success, right? (Shelter/housing participant)

Participants described a variety of transportation methods that were arranged by hospital staff for PWLEs to use upon discharge from the hospital. In some cases, PWLEs were provided a bus ticket and were pointed in the direction of a bus stop; in other cases, a taxi was arranged to transport a PWLE to their destination; and in other cases, formal transportation services, including the hospital transport, HandyDART, or Saferide (See Box 3.3) were arranged to transport PWLEs to their destination. The type of transportation arranged often depended on the person's needs and abilities. For instance, "If people are a bit more vulnerable and precarious, then we book them in the hospital transport to go home. (Healthcare participant)"

Not unlike reports that transportation upon hospital discharge can improve successful outcomes, it was also suggested that transportation to follow-up care in either the hospital or an outpatient setting would allow PWLEs to remain engaged with healthcare providers, receive ongoing treatment, and increase the likelihood of treatment completion. Ongoing transportation support was reported to be particularly beneficial: for ongoing IV therapy at the hospital, to pick-up medications at a pharmacy, or for post-discharge physiotherapy. One solution suggested that the Ministry of Social Development and Poverty Reduction provide bus tickets to PWLEs.

> Say you want to go to physiotherapy—that's $2.75 each way. So you figure that out every day for 5 days. HandyDart you can get that, but you got to know what time you're going to be there—that's a challenge. And you got to pay for that too. I think welfare should just give you a bus ticket when you need it. As soon as you go on welfare, they should give you one… That's why I couldn't go to all of my physiotherapy; I didn't go to any physiotherapy ever. I just couldn't do it… I just can't afford it.' (PWLE participant)

4.3 Approach to Care

As a general principal, participants described several solutions related to changing the fundamental approach to caring for PWLEs. This included solutions for 1) non-stigmatizing treatment; 2) meeting PWLEs where they are in their life; 3) communicating appropriately with PWLEs; 4) taking a harm reduction approach; and 5) taking a more holistic view of PWLEs' health and social context.

4.3a Non-stigmatizing treatment of PWLEs

PWLEs reported that if they felt heard and believed by providers, this would improve the degree to which PWLEs are willing to engage with healthcare. In addition, participants reported that a non-judgmental and respectful approach to care and treatment of PWLEs would be a way to

> "Having humane engagement that's de-stigmatized, having de-escalating non-violent, de-escalation techniques and training, and having a humane engagement—conversation with people goes a long way in keeping people safe on a regular basis."

approach PWLEs who may have had past negative experiences with the healthcare system and may be wary of re-engaging with the healthcare and shelter/housing systems.

> Having humane engagement that's de-stigmatized, having de-escalating non-violent, de-escalation techniques and training, and having a humane engagement—conversation with people goes a long way in keeping people safe on a regular basis. (Shelter/housing participant)

Some participants suggested that changing people's views on homelessness and substance use, and eliminating the associated stigma among healthcare providers, would improve the experience of hospital care and discharge.

> I don't know insofar as just the scope of this study what can be done or what can be the biggest change. I think maybe it's just starting to affect how people view homelessness within the medical system and view the individuals with addiction [who are] homeless, and trying not to get into a place where there become these extra barriers of burnout and apathy and stigma…if we can even just fight that much of the problem then I think that'd be a win right there. (PWLE participant)

In addition, it was acknowledged that hospital discharge would be a more positive experience for PWLEs if the treatment of all persons involved was improved—not only should PWLEs be treated with more respect, but so too should healthcare and shelter/housing providers.

> On the healthcare professional's side, I'd like to see them look at us a bit more as lost causes and not have that look of, 'Oh shit, here we go again,' every time they see us. I know there's people that have been to the hospital 40 times for overdoses and, I mean, I can't even imagine how frustrating that is for a professional, but many of us, we are trying to get better at our own pace and in our own way and just to keep that faith and really just show us the same level of care and attention as you would anybody else. I think you'd be very surprised to see how people's healthcare returns, starts actually coming back positively just from that. And from our side, the patients need to do a better job of asking for what they need, not being rude about it, showing people the respect that they deserve, and also making sure that we're taking care of our end of the bargain…being open and honest and forthcoming. And the shelters need to do a better job of bridging that gap between their clients and the healthcare professionals because a lot of time it gets left to the staff at a shelter to communicate back to a hospital or a clinic or whatever to find out whatever information they need to, or if there are any instructions, so just having everybody on board and communicating would be a big step, and also just treating each other with that same mutual respect is also a big deal. There's really no reason for any disrespect in any human interaction in this process. (PWLE participant)

4.3b Meeting PWLEs "where they are at"

Participants suggested that care provision needs to be self-directed to promote a sense of autonomy and improve the likelihood of treatment adherence and overall well-being. Indeed, PWLE participants acknowledged that their motivation and attitude were part of the solution to improving their discharge experiences. As one PWLE participant reported, the one thing that worked well with her discharge experience was herself and her resilient attitude: "When I was knocked down, I got back up and I was stronger." Another PWLE participant had a similar report of what worked well with her discharge experience:

> What worked well is my ability to figure out what I was doing; because if I didn't know, if I didn't have that ability, I probably would have sat there [at the hospital] a lot longer. I wanted to be discharged, I did not want to be up there for that long.

Participants reported that flexible and accommodating care, which aligns with the philosophy of meeting PWLEs where they are in their life, would be one way to overcome some of the barriers to care for PWLEs. Moreover, rather than assuming what the needs of a PWLE are or making decisions on their behalf, it was reported that PWLEs should be engaged in decision making efforts to feel invested in their care and discharge

plan. A common phrase used in discussions of engaging with PWLEs is "meeting folks where they're at." To do so, it is valuable to understand which services PWLEs are willing to engage with.

> Working with the patients we know what resources they've used, what their housing history is, and really understanding from them… what they're willing to do, what places they're willing to go to, what places they want to stay away from, and their level of participation in that, and trying to get a hand on that early so I know, 'Okay, this patient's going to be here [in the hospital] for three weeks so I have three weeks to find a place that they'll actually go to.' Sort of prioritizing your planning that way. (Healthcare participant)

One healthcare participant agreed with the solution to have more flexible care delivery, offered at times more suited to drop-in care, whereby PWLEs can access care when they are able to.

> There's a lack of urgent care centres that can deal with…the person who's not able to make appointments for the methadone doctor or to go and see the infectious disease physician because they're not organized enough. They need somewhere that's open, 18-hours a day, or 24-hours a day that isn't the emergency room.

PWLE participants who reported satisfaction when their personal needs were accommodated support this sentiment. In one instance, a PWLE's dog was allowed to be with them while they received care.

> And they actually allowed me to bring my dog with me. I don't have a little dog. I have a full-grown pit bull…they allowed me to bring her in while I did my IV treatment. She sat right beside me in the corner… They had no problem with me bringing her in there, so that was nice. They were accommodating to that.

4.3c Appropriate and engaging communication between PWLEs and providers

In order to actively participate in healthcare, participants reported that PWLEs need clear and understandable information about their health and discharge plan. Hospital discharges could be better facilitated by fully informing PWLEs about their health, ensuring they understand the information and feel comfortable with what is happening—whether it's related to treatments available to them in the hospital or post-discharge, or other available resources to help address their social determinants of health.

> The discharge also includes…making sure that they feel comfortable with the discharge, making sure that there's the follow-up and having that conversation with them, and kind of providing that education about what's out there for resources for them as well. (Healthcare participant)

In addition, participants emphasized the value in PWLEs being informed about where they would be going upon discharge, what time they would be discharged and how they would be getting to their post-discharge location.

> One hundred percent, I want to know where they are going to be putting me. I want to know that… They could have given me the specific time I would be moving, or where I was moving to, and more information about the place that they were going to send me. All I knew was that I would be moving, but I did not know where. (PWLE participant)

> Better communication…doctors having a better idea of what prescriptions and what medications and what proper follow-up is needed so that that's properly communicated and there's minimal stress for the client. The client knows that they're being discharged into a supportive environment with all of their questions answered and the people supporting them having that information so that their care is not a stressful situation. (Shelter/housing participant)

PWLE participants reported that their discharge experience could be improved if they understand what their recovery will entail. For instance, PWLE participants wanted to know more about the side

"They could have given me the specific time I would be moving, or where I was moving to, and more information about the place that they were going to send me. All I knew was that I would be moving, but I did not know where."

effects of certain medications, how long they could expect to be taking a medication, or how long it would be until they could expect to start feeling better.

> And a little bit more information about the medication, making sure they know when I'm supposed to take it and maybe letting me know; they didn't tell me too much. I never had a kidney infection or bladder infection, I didn't know if once I get medication in a week should I be getting my strength back? …I thought, 'Okay now I'm on medications, the medication's done now…I should be getting my strength back.' It took me…over a month to get most of my strength back. (PWLE participant)

Some participants suggested that hard copies of medical notes be provided to PWLEs so that they could review their information in more depth once they were out of the hospital and better able to reflect on their condition.

> Maybe some sort of little portfolio thing could have been [given]…a letter could have been given to me from the hospital, taken with me to go with me as far as saying, 'Mr. [last name] was at the hospital. He sustained an injury. He's going to be okay.' If there were any concerns that the staff at the hospital had—doctor, nurse, social worker, etc.—put them on paper so that they can be communicated elsewhere down the line. Sometimes people like myself or other individuals, who have some sort of anxiety, mental illness, or are still just recovering from an injury, they're not going to be so good at communicating what professionals have suggested. (PWLE participants)

Finally, for individuals with a mental health issue or cognitive impairment, in particular, it may be necessary to take extra time to convey health-related information, in plain language, to minimize fear and ensure that healthcare participation is a positive experience.

> I guess just making sure that we know what to expect…when they discharge you with a baby, usually they tell you this is what you would

> expect is going to happen to you. Sometimes they don't tell you this is what's going to happen to you when you get better from this. Like, 'You know what? In a month you're going to be all cleared up, but you're still going to feel just like this.' [*laughs*] Okay, so I know two months, I'll worry about it in two months. (PWLE participants)

The value of having healthcare providers explain information to PWLEs is reflected in the experience reported by one PWLE participant:

> They explained everything to me, what was going on and what they thought was going on and I had diarrhea really bad, and that's the way colitis starts. And they wanted to keep me long enough to make sure that that was being handled but they couldn't get the results back right away, so they had to let me go because they needed the bed obviously, but they took very good care of me.

4.3d Harm reduction approach

Participants suggested that policies around discharge could take a harm reduction approach:

> I think [an appropriate discharge policy for homeless patients] would center more around harm reduction. I'm not going to solve the housing policy at anywhere past 3:00 [a.m.] on a Friday night. If I have somebody that comes in at 2:00 in the morning, it's unrealistic for them to sit in my hospital for 24-hours, or 48-hours, or three days until they get a shelter; so, it would be more around harm reduction: 'Do you have the right clothes? Do you have a take-home Naloxone kit? Do you have a bus ticket? Do you know where to go for resources?' (Healthcare participant)

4.3e Applying a holistic lens

Participants suggested that it is important to consider all aspects of an individual's social context when addressing care needs. By doing so, there is a greater likelihood that the cycle of readmissions-discharge-readmission can be broken and long-term health outcomes can be improved.

> There's some doctors who I know that when they refer to social work, they will take our word; they highly value the importance of looking at the full social history and situation. However, others are pretty black and white…they don't recognize that sometimes it's not helpful to keep putting the Band-Aid on top of the wound when we're returning [a PWLE to] somewhere that still has unsafe conditions, a place that's just going to keep having them become infected or becoming quite ill and keep coming back instead of actually taking a more holistic approach and understanding their lifestyle, what their life situation looks like, what their environment is going to look like returning, who their supports are—then we can actually start helping on a more long-term case. (Healthcare participant)

4.4 Professional Education and Training on Engagement with PWLEs

A final solution suggested for healthcare providers is further education and training on how to engage with PWLEs who have histories of mental health, addiction, and trauma. Participants agreed that this education would be an important step towards humanizing healthcare.

> I think we need more training for staff. There is a total lack of understanding about the history of colonization, about why people are struggling with addiction, about how that impacts social determinants of health. (Healthcare participant)

In particular, it was suggested that educating healthcare providers (e.g., doctors and nurses) about the influence that social determinants of health have on health outcomes would improve continuity of care throughout the healthcare system. This aligns with the earlier recommendation to consider larger social determinants of well-being.

> It would be better for the doctors and the nurses to be aware of this [the social determinants of health]. There's no social worker that's not aware that housing is an important component of a discharge plan, but it would be a good thing for the entire organization to look at in terms of housing as a key social determinant of health. (Healthcare participant)

Chapter 5
Case Study of Existing Hospital-to-Shelter Programs

The third phase of this study involved in-depth interviews with 8 shelter/housing and healthcare providers and 10 persons with lived experience (PWLEs) affiliated with two existing hospital-to-shelter transition programs that operate in Metro Vancouver: the St. Paul's Rooms at the Metson and the Vancouver Coastal Health (VCH) Shelter Project (at the Triage and Yukon shelters) (See Appendix A for detailed Methods). We interviewed organizational staff and healthcare providers ['provider participants'], as well as PWLEs who are current or former program participants affiliated with each of the three sites to understand the experiences of delivering and receiving services. Data were thematically analyzed.

1. PROJECT DESCRIPTIONS

1.1. St. Paul's Rooms at the Metson

In 2015, mental health care providers based at St. Paul's Hospital (SPH) brought the idea for the SPH-designated rooms for SPH's mental health patients forward to the Executive Director of Community Builders Group (CBG). The project was conceived as a strategy to meet the needs of the growing number of patients at SPH who were ready for discharge, but lacked a secure location to go to after leaving the hospital. The close proximity of the Metson to SPH and the availability of rooms on the main floor of the Metson made it a good site for the short-term transitional housing project.

To initiate the project, CBG signed a five-year lease with the owners of the Metson, repurposed it to serve as transitional housing, and took over management of the property. To start, SPH signed a one-year agreement with CBG to lease the six SPH-designated rooms. Since then, this agreement has been annually renewed and is expected to continue for the five-year lease period between CBG and the Metson owners. Initiating this pilot program of SPH-designated rooms also required approval from Vancouver Coastal Health (VCH), which oversees service delivery to persons experiencing homelessness through the Access and Assessment Centre (AAC) (See Box 5.2).

BOX 5.1 PROGRAM PARTNERS

Community Builders Group Society
Community Builders Group (CBG) is a charitable organization that operates 12 privately owned supportive housing sites for 800 PWLEs in DTES.
https://communitybuilders.ca/housing-sites/

RainCity Housing Society
RainCity Housing is a non-profit society that operates shelters and provides specialized housing and supports for people experiencing mental health conditions and substance use challenges. Housing programs are operated from a low-barrier, Housing First perspective and include emergency housing, transitional housing, women's housing, long term housing.
http://www.raincityhousing.org/what-we-do/

Lookout Housing and Health Society
Lookout Housing and Health Society is a non-profit society that operates 42 facilities, which include shelters, supportive housing, independent housing, health services, and resource centres, in 14 municipalities across Metro Vancouver, the Fraser Valley, and Vancouver Island.
https://lookoutsociety.ca/what-we-do/housing/

CBG manages all 100 rooms in the four-storey Metson and SPH supports individuals who are staying in six designated rooms. The SPH-designated rooms are located on the ground floor of the Metson, where the CBG staff office is also located. Typically, the SPH-designated rooms operate at full capacity, with few periods when some are vacant. The SPH-designated rooms are single room with ensuite washrooms. They come furnished with essentials, such as linens and towels; additional furnishings are provided to program participants as-needed and as-available from donations.

Above the SPH-designated rooms, the remaining units in the Metson provide longer-term, low-barrier housing for individuals with a history of homelessness or precarious housing. CBG also operates a Temporary Winter Shelter (from November to April) in the former restaurant space of the Metson Hotel.

1.1a. Program features of the St. Paul's Rooms at the Metson

Based on criteria set by SPH staff, patients who are assessed as physically and mentally stable are discharged from an inpatient mental health unit to one of the six SPH rooms at the Metson. With rental costs of the SPH-designated rooms covered by SPH, program participants are offered stable transitional housing until more permanent housing or residential treatment is available.

Services offered to program participants staying in the Metson SPH-designated rooms include:

1. A range of medication services, depending on the program participant's need: some require no assistance to acquire and self-administer medications, while others need support to obtain medications from the pharmacy and/or need outreach services to oversee medication administration.
2. A SPH social worker who works with the program participant at SPH and then follows them after discharge to the Metson to continue working on housing and supports.

BOX 5.2 ACCESS AND ASSESSMENT CENTRE

VCH Access and Assessment Centre (AAC) provides 24-hour support, stabilization, and crisis management to Vancouver residents aged 17 and older who have mental health and/or substance use issues. Clients self-refer by walking in to the AAC or via phone, or are referred by others. AAC clinical staff provides clients with screening, assessment, and treatment recommendations.
http://www.vch.ca/Documents/AAC-VCH-Brochure.pdf

Connection to community supports is an important feature of the program, including substance use supports and services. One program participant reported getting connected to a range of physical and mental health supports while at the Metson, including a general practitioner who prescribes methadone, trauma counselling, and a health clinic. Another program participant reported being particularly satisfied with their experience of working with a psychiatrist at a nearby mental health clinic during their stay at the Metson. Nursing support is also offered on an as-needed basis, particularly in the event of medical issues or emergencies. Finally, the Metson-designated social worker and building staff support program participants to keep their medical appointments for follow-up care.

Participants also reported how the social worker assisted them to connect (or reconnect) to community-based support teams, such as the Assertive Community Treatment Team (ACT), Assertive Outreach Team (AOT) (See Box 4.1), and Seek and Treat for Optimal Prevention of HIV/AIDS (STOP), as well as to community mental health organizations such as the Motivation, Power, and Achievement (MPA) Society (See Box 5.3). Representatives from the community-based support teams visit program participants while they are staying in the SPH-designated rooms daily, if needed.

In addition, there is a common kitchen on the third floor of the Metson where dinners are prepared by a cook daily for all Metson tenants. There is also a daily "tenant-run" breakfast program funded through tenants' rent and supplemented with food donations.

> A tenant in the morning will come to the office, get a big coffee urn, put coffee on and then come back out later and they'll put out bread, and peanut butter, and margarine, and some fruit and then it's out for an hour or two. People can come down at their leisure and have some breakfast, chat with their neighbours, [and] start the day off with some food.

Finally, Metson staff were reported to conduct monthly room checks, monitor maintenance issues, and provide additional assistance as needed, such as a regular wellness check if a program participant has not been seen for a few days.

This project has evolved and changed in various ways since its initiation. For instance, when it was originally organized, the goal was to accommodate twelve patients in double occupancy rooms. However, program leaders recognized that this model was unsustainable as it required more staff support and case management than was available. As a result, the program was scaled back to accommodate one person per room. A provider participant described how programmatic and operational challenges have been resolved through teamwork and communication.

> There's been various roles that have had to be looked at and changed…we had some issues with people smoking and healthcare providers going in and not feeling comfortable, so there have been a few practical operational issues that we've addressed, but those have really just been managed by the communication between both organizations having similar goals of being able

BOX 5.3 COMMUNITY-BASED SUPPORT TEAMS

Seek and Treat for Optimal Prevention of HIV/AIDS

"STOP" or "Seek and Treat for Optimal Prevention of HIV/AIDS" is a province-wide project aimed at improving the quality of care for people living with HIV in B.C. It involves linking individuals to health care services, including prevention, testing and diagnosis, treatment, while supporting their continuum of care.
http://stophivaids.ca

Motivation, Power, and Achievement Society

Motivation, Power and Achievement (MPA) Society is a non-profit organization founded by people facing mental health problems to support the recovery of other people with mental health challenges through social, vocational, recreation, advocacy and housing programs.
http://www.mpa-society.org

to maintain housing for people coming out of St. Paul's in a transitional way.

1.1b. Funding structure of St. Paul's Rooms at the Metson

The Metson Hotel is a privately-owned hotel that is leased to CBG with funding support from the City of Vancouver. The operating costs of the SPH-designated rooms are jointly funded by SPH and CBG. The Mental Health Program at SPH covers the rental costs for tenants in the SPH-designated rooms and a SPH-Metson social worker, while CBG is responsible for the costs of staffing the Metson, which includes 24/7 front desk support for all the Metson Rooms.

1.1c. Referral and Transition into the Metson

Only patients from mental health inpatient units at SPH are eligible for transfer to the SPH-designated rooms. While in SPH, the unit social workers, in consultation with the SPH Metson social worker, assess whether patients meet the criteria for intake to ensure they are a good fit for the program. One provider participant described the mutual trust that has developed between SPH social workers, who screen patients, and Metson staff who manage the intake into the Metson.

> [The mental health social worker at SPH] screens those people and I just trust her judgement because it's worked well…And if I wasn't sure I would just go meet the client and talk to them and try to get a feel for them… [and] do that sort of risk-factor screening with the inpatient social workers. On the plus side, usually with the inpatients we know them quite well. They've usually been in for at least a week and we have a good sense of their history.

This participant also outlined additional criteria for assessing fit for the SPH-designated rooms:

1. Program participants must be able to manage their activities of daily living (ADLs) and instrumental activities of daily living (IADLs);
2. Program participants cannot be at high-risk for aggression, substance use, or suicide; and
3. Program participants require a 30-day housing plan, that is a plan to be rehoused in a subsequent residential situation within 30 days of entry to the Metson (e.g., supported mental health housing or residential addiction treatment).

It was noted that while having a 30-day housing plan is a criterion in principle, there is some flexibility because it is more realistic for program participants to find housing within 60 days following transition into the Metson. Without this flexibility, patients' hospital stays would be prolonged awaiting a concrete housing plan.

1.2. VCH Shelter Project: Priority Shelter Beds

The VCH Shelter Project is a pilot program in Vancouver, BC that supports the discharge of persons experiencing homelessness from an acute hospital setting to 10 designated beds in two shelters (five are located at the Triage Shelter, which is operated by RainCity Housing Society, and five are located at the Yukon Shelter, which is operated by Lookout Housing and Health Society) (See Box 5.1). The focus is to streamline shelter access for PWLEs coming from acute care amidst pressure from the Ministry of Health to reduce patients' length of stay in hospital. The project aims to address the challenges to delivering follow-up care for patients experiencing homelessness who are difficult to track following discharge, while simultaneously addressing the challenges faced by shelter providers to offer clinical supports in non-medical settings. Dedicating a portion of shelter beds to complex patients with no fixed address at time of discharge was seen as an opportunity for hospital and community care providers to facilitate PWLE care continuity, while the shelters benefitted from having healthcare expertise onsite to address the health needs of clients.

To initiate the Shelter Project an agreement was reached between VCH, RainCity Housing Society, Lookout Housing and Health Society, and BC Housing with intent to help program participants create successful linkages to community health services following hospital discharge. Such organizational collaborations need to have transparency, as well as accountability among senior administrators, as explained by one provider participant:

> It's pretty important to have rules and expectations well documented—what the shelter's going to do; what the health authority's

> going to do; who are the different players; what are the key contact points; how did the referral happen…what's the procedure if there's problems on the line… You can do it very pragmatically at the start in terms of role definition, risk mitigation, safety, performance quality, what the goals are and who's going to do it… It's nice to have a comprehensive document that, basically, you can lean on in times of strife or times of uncertainty…it's not all-encompassing as it could be, so it gets re-drafted and we update them organically, as required, if we face any challenges and difficulties. (Provider participant)

An additional goal of this program is to move program participants from shelter beds to transitional housing that supports increasing independence. This is a collaborative process that involves weekly consultation meetings via conference calls with representation from a VCH Housing First case manager, the VCH Mental Health housing team, shelter staff, and BC Housing. For each program participant, VCH, BC Housing, RainCity Housing Society, and Lookout Housing and Health Society partner on developing a housing plan.

1.2a. Program features of the VCH Shelter Project

Based on a harm reduction framework, program participants can access a bed 24-hours a day and receive comprehensive support through case management and staff supervision. Program participants are offered the same basic services provided to all the shelter clients, but receive additional support to meet their more complex needs. For example, a program participant, who had mobility difficulties, reported that the [anonymous] shelter staff played an important role in acquiring the appropriate mobility equipment needed to meet their mobility requirements. Support also includes medication management and administration, three meals a day plus snacks, access to laundry machines and clothing donations, harm reduction supplies, assistance securing and moving into transitional housing with appropriate supports, and linkages to community health services. In addition, VCH supports the healthcare needs of program participants whose healthcare plan is managed by a designated community health clinic or specific team (e.g., Assertive Community Treatment (ACT), Downtown Community Health Centre (DCHC), or VCH's DTES Connections Clinic) (See Box 5.4). Outreach nurses were also reported to serve some of the program participants in a nurse's room onsite at the shelters.

If program participants are not connected to a community health provider, it was reported that referrals are made to an appropriate clinic (e.g., Heatley or DCHC (See Box 5.4)). One program participant reported not being connected to a community health centre prior to being in the Shelter Project, but was referred to a mental health outreach team during their hospital stay, which then got them connected to a community health centre upon transition to the [anonymous] shelter. Similarly, another program participant reported being connected to a community health centre prior to transitioning into the [anonymous] shelter and continuing to be served by this health centre during their stay in the shelter.

Partnerships were identified as integral to well-organized case management and positive health outcomes for program participants. For instance, a partnership with the STOP team (Seek and Treat for Optimal Prevention of HIV/AIDS) was highlighted. This is an outreach service for shelter clients that supports health, social, and advocacy needs. Other partners included pharmacies that enable medication administration onsite and non-profit organizations that offer psychiatric outreach and counselling.

BOX 5.4 COMMUNITY HEALTH CENTRES

Downtown Community Health Centre
Downtown Community Health Centre (DCHC) offers primary health care services to PWLEs in the Downtown Eastside (DTES) who may not be connected to a physician and other necessary health care services.
http://www.vch.ca/Locations-Services/result?res_id=707

Downtown Eastside Connections
Downtown Eastside (DTES) Connections is a low-barrier clinic that is open seven days a week and provides addiction services to clients without an addiction doctor.
http://dtes.vch.ca/dtes-connections/

Heatley Community Health Centre
The Heatley Community Health Centre is an integrated health centre providing primary, care, mental health, substance use, addictions, and harm-reduction services to clients in the DTES.
http://www.vch.ca/Locations-Services/result?res_id=1418

Pender Community Health Centre
Pender Community Health Centre (CHC) provides healthcare and support services to individuals with acute, chronic, palliative, and rehabilitative care needs, as well as those seeking opiate replacement therapy. Integrated Care Teams at the Pender CHC consist of nurses, social workers, counsellors, peer specialists, community liaison workers, family physicians, nurse practitioners, psychiatrists, occupational therapists, and dieticians, who provide on-site and outreach services.
http://www.vch.ca/Locations-Services/result?res_id=1340

1.2b. Funding structure of the VCH Shelter Project
VCH funds some of the community healthcare supports (e.g., mental health or nursing) that come into the shelters to serve program participants as well as the VCH Housing First case manager. BC Housing funds the shelter operations and the staff to support program participants to find housing.

1.2c. Referral and Transition into the VCH Shelter Project
Referral and intake into a VCH priority shelter bed were reported to be jointly managed by hospital social workers, a VCH Housing First case manager, a manager at the Triage shelter, and a case planning team at the Yukon shelter. During the time of this study, the beds in the Shelter Project referral process transitioned from being managed by the Housing First case manager to the Community Transition Team. It has since reverted back to its original process. It was noted that having a single point-person is more efficient for making referrals to the priority shelter beds than a team, which involved multiple persons and added complexity. A provider participant suggested that building relationships with patients, assessing their needs, and determining their suitability for referral to the VCH Shelter Project is improved when hospital social workers do this crucial groundwork and coordinate with a single point-person.

Though the priority shelter beds have the same eligibility criteria (experiencing homelessness, compromised health issues and/or un/treated mental health and substance use issues), the Yukon and Triage shelters have different levels of capacity to manage program participants. One provider participant described how the intake strategy for the priority shelter beds is based on a combination of factors, including the complexity of the patient's health needs and the shelter's capacity to meet those needs (i.e., shelter staff, services, and environment). Maintaining a balanced composition of clients who have various health needs, without too many having complex health needs at one time, allowed the shelter staff to adequately serve clients without spreading staff too thin. Having straightforward discussions of whether the shelter can meet clients' needs was reported to ensure that clients are the right fit for the shelter.

> I do feel the pressures to take who they're sending me, but I reserve the right to hold my agency values at heart and my project mandate at heart and to defend that and keep stuff available for the folks that fit who we're here to support… (Provider participant)

"When I went to the Metson, I was able to understand that I have it better than a lot of people who are downtown…it was an eye-opener for me because living in downtown, I had seen how difficult life can actually be…"

2. SUCCESSES AND STRENGTHS OF THE METSON AND VCH SHELTER PROJECT

2.1. Successes and Strengths of the Metson Project

Participants described a number of successes of St. Paul's Rooms at the Metson:

a. Program participants achieve stability following hospital discharge;
b. Program participants have privacy and freedom;
c. Program participants have opportunities for social interaction;
d. Program participants build relationships with providers;
e. Program participants get support finding transitional housing; and
f. Relationships were established between cross-sectoral stakeholders.

2.1a. Program participants achieve stability following hospital discharge

The experience of staying in one of the SPH-designated rooms empowered program participants to manage their activities of daily living (ADLs) and instrumental activities of daily living (IADLs) independently, while being able to reach out for support if needed. This contributed to their stabilization and facilitated their move into transitional housing. A provider participant explained how program participants achieve a reasonable level of independence.

> By the time [the program participants are] ready to leave our program they are generally able to manage their own medication…receiving treatment for their mental health and…[are] in a much more independent stage where they are able to manage their medication and their health with some prompts or…assistance.

The ability to stabilize in a supported setting was also highlighted by program participants, including one who described their experience of staying in the SPH-designated rooms as 'eye-opening' amidst the alternative of being homeless.

> When I went to the Metson, I was able to understand that I have it better than a lot of people who are downtown…it was an eye-opener for me because living in downtown, I had seen how difficult life can actually be… And I had a bed there, so I wasn't sleeping on the floor…it was about as good as it could be for being what it is…a run-down hotel that they tried to convert to help people that are homeless. I think that it's a very reasonable place compared to being on the street dying out in plain view where people don't want to help you.

This participant reported achieving mental health stability and no hospital readmission since moving from the SPH-designated rooms to transitional housing. Another program participant reported that because of the assistance received from SPH hospital social workers in preparing their resume, they were able to secure job references and eventual employment following stabilization at the Metson.

2.1b. Program participants have privacy and freedom

As summarized by one program participant, having a private room with an ensuite bathroom washroom provided a sense of freedom to come and go as desired:

> I liked the fact that I had my own place. It was important to have my own little area where I could sleep if I needed to or I could leave if I wanted to. So, the option to stay or go was good. It was important.

"I liked the fact that I had my own place. It was important to have my own little area where I could sleep if I needed to or I could leave if I wanted to."

Another program participant reported that having a private room was necessary so they could be alone during a challenging phase of their mental health. This much-needed separation from others helped them regain stability and normalcy.

> I didn't really interact with anybody else…I boxed myself in my room because…my mind was pretty messed up and I was thinking people could hear me thinking and stuff, so I stayed away…even though I was going through all that, [the stay at the Metson] was great. If I didn't have that, I would not be in the place I am right now… [The SPH-designated rooms offered me] safety, seclusion, [and] support… just having somewhere you can go [be] by yourself is a huge thing.

Further, this participant mentioned that the Metson staff were polite and helpful when they needed help, but would leave them alone if they wanted. Another program participant agreed that having the freedom to follow their own routine was preferred over the stringent schedule of the hospital inpatient unit: "[I] didn't have any wake-up time [in the SPH-designated rooms] or go to bedtime like the hospital. [I] had more freedom."

2.1c. Program participants have opportunities for social interaction

On the other hand, some participants appreciated the opportunity for regular social interaction. One program participant reported on the benefits of being surrounded by people at the Metson and how the environment provided them with ample opportunities to socialize. Another program participant similarly described having developed friendships.

> "We all hung out together. Sometimes we made friends. I made friends I still talk to."

> [Program participants in the SPH-designated rooms] still talked to [other Metson tenants] and hung out with them. If we're a smoker in the common area we would see them outside, so in that sense I made many friends there and they're all very nice…I had a good experience there… it was interesting…we all hung out together. Sometimes we made friends. I made friends I still talk to. They still call me…I've gone back to pay a visit.

2.1d. Program participants built relationships with providers

Program participants reported that the Metson staff were friendly and helped clients. One program participant reported that they felt trusted by the Metson staff. Other program participants reported similar feelings of trust and connection. For example, they described that they built trust and close relationships with the Metson-designated SPH social worker through the practice of open communication and transparency with them. These program participants believed that they treated them with compassion, dignity, and respect. One said, "[The SPH social worker] gave me hope because when I explained to [them] that… [I was] not making progress [with the search for

housing]… [they] knew that I was being honest." Another program participant felt safe and secure and not judged by the social worker when they confessed their drug relapses during their stay in the SPH-designated rooms.

> I relapsed twice while I was there. I told [the social worker] when [they] came. [They] said it was alright, but I mean I still feel so bad, right? I'm ashamed. [They were] good. [They] would show up every once in a while, and ask me, "Do you feel safe here? Are you okay?" [They'd] check every week. [They] said [they] used to do that for all the guys [in the SPH-designated rooms].

From the perspective of the provider participants, developing close relationships with clients helped to better understand their needs and more effectively support them. One provider participant considered being proactive, engaged, and building rapport with clients as essential. Despite the higher needs of the program participants in the SPH-designated rooms compared to other tenants in the building, the proximity between the staff office and the SPH-designated rooms, which are both on the first floor, facilitated the development of staff-client relationships.

"[They were] good. [They] would show up every once in a while, and ask me, 'Do you feel safe here? Are you okay?'"

2.1e. Program participants get support finding appropriate housing

The SPH Metson-dedicated social worker plays an integral role in managing the program participant's transition both into the Metson as well as into subsequent housing:

> I think that if it wouldn't have been for [the social worker's] work, I probably wouldn't have gotten very far…[they] seemed to have made an extra effort to help me that's where I got lucky; that [they were] willing to try to find a place like this…I don't know how [they] did it. To me it's like [they] pulled a miracle. (Program participant)

Other program participants also reported how they required significant assistance from the Metson-dedicated social worker to obtain housing. One program participant described how their decompensation following discharge from SPH became a barrier to effectively searching for housing. Without participation in the Metson Project, and the support from the Metson-designated social worker, this participant felt that securing satisfactory housing in a timely manner was less likely: "I might have had housing but…I wouldn't have gotten in as fast as I got it and I think I would have [gone] through some torture before getting anything nice and I don't think it would have been this nice." The SPH Metson-designated social worker also assisted in having donated furniture delivered to their new home by a local charitable organization.

Program participants, who had moved from the Metson into subsequent housing, reported being satisfied with the quality of their current housing, but not always the location of it. One program participant appreciated that [their] home had been newly renovated: "[I like] the fact that they completely renovated this place before I moved… There was somebody that was really thinking, 'We'd like [them] to be happy here.'" However, this participant would prefer not to live in Downtown Vancouver:

"It's been really rewarding to see how well non-profit housing providers and medical professionals can work together."

> Even though I got this place, and it's a very nice place, I don't want to live here [for] very long. I want to move back to where I'm comfortable… What I thought of is maybe exchanging with somebody who's in Port Coquitlam. [If] they wanted to move closer to Downtown Vancouver, they could have this nice place. I don't think too many people who would be asked to exchange would really refuse a place like this.

2.1f. Relationships were established between cross-sectoral stakeholders

A final success of the Metson Project is the cross-sector relationships between healthcare and shelter/

housing staff, which was central to the initiation and evolution of the project. A provider participant reflected on the positive outcomes of intersectoral partnerships for clients.

> It's been really rewarding to see how well non-profit housing providers and medical professionals can work together and…really deliver a service that supports…clients in a partnership that involves different levels—not just health, not just government, not just non-profit, but sort of a blend of those.

Working relationships between Metson staff, the SPH social worker, and community services were also reported to contribute to clients' care plans and clients' connection to community-based mental health services (e.g., Mental Health teams; local pharmacies, etc.). Regular meetings to discuss clients' needs were reported as key to sustaining effective working relationships among community providers toward facilitating a tailored and individualized care response. One provider participant explained that partnerships are fruitful when there is flexibility and focus on caring for the client without bureaucratic issues or barriers: "It's a recognition that the clients need the support and…just providing the support and not being too sticky about roles and how to be more focused on the client."

2.2. Successes and Strengths of the VCH Shelter Project

Participants described a number of successes of the VCH Shelter Project:

a. Program participants achieve stabilization and recovery;
b. Program participants have privacy and freedom;
c. Program participants build relationships with providers;
d. Program participants get support finding transitional housing; and
e. Relationships were established between cross-sectoral stakeholders.

2.2a. Program participants achieve stabilization and recovery

Having 24-hour access to private rooms and round-the-clock support was reported to contribute to program participants' stabilization and recovery. As one provider participant stated, "The fact that we have 24-hour bed rest and three meals a day goes a long way to [ensure] peoples' healing." A program participant described how their persistent nausea and diarrhea required bed rest which was possible in the priority shelter bed: "I'm feeling nauseous and I'm feeling ill, and if I wasn't able to access my bed and lay down and recoup, it would have been a lot more miserable."

One provider participant similarly described the significance of the rest and stabilization that the priority shelter beds offer program participants, which serves as the first step in moving onto transitional housing.

> They'd be in a hospital and then coming into a shelter for a short period of time. The health is significantly better because they've got some medical attention, food, rest, and stabilization. But for most people, it takes longer than that and that's the healing that happens once we get them into permanent housing or transitional housing…there's a remarkable first stage… this person was really, really sick in an acute situation when they arrived at emergency, but they're not in that crisis anymore.

Program participants reported that the food offered at the [anonymous] shelter was one of the strengths of the program due to the importance of good quality meals for health and recovery. One program participant reported being underweight and particularly appreciated how the quality of the food helped them gain weight again. Another program participant credited the food program for aiding their recovery, particularly the quality and portion size of the food.

> I didn't eat much at [the hospital] because there's no taste. It's just bland… [The food at the shelter] is really good…I'd lost so much weight [at the hospital]. I gained 15 pound [after coming to the shelter]…I eat a lot…for breakfast you can have extra. And Saturdays and Sundays you can have [extra] too.

2.2b. Program participants have privacy and freedom

Private rooms were also reported to improve program participants' sense of freedom and privacy. While shelter staff were reported to stop by and

check on clients, there are also personal door access codes that allow program participants to enter and exit their rooms on their own timetable. Moreover, a program participant appreciated that the shelter staff were not "nosy" and did not intrude on participants' privacy. Another program participant reported that shelter staff are supportive and respectful of privacy:

> The freedom and the accessibility to making your own choices in when you want to lay down, when you want to sleep, when you want to rest, when you need to get up and go, [is excellent]. They won't harass you so, in that respect you got a lot of freedom and privacy… That's really above and beyond any experience you can get in any shelter.

2.2c. Program participants build relationships with providers

A program participant reported having a positive relationship with the staff at the [anonymous] shelter. They described them as being warm and friendly and mentioned staying in touch with them even after moving into transitional housing. Program participants who were currently living in the [anonymous] shelter also mentioned that the staff were friendly. One described their relationship as reciprocal and based on mutual cooperation and respect: "[The shelter staff] are so helpful to you as long as you do what you say you're going to do—that means a lot to them here. [So] I don't go out all night long, or do nothing [like that]."

2.2d. Program participants get support finding transitional housing

Having a transitional location where program participants can stay following hospital discharge gave providers additional time to match program participants—even those with multiple barriers—to housing that suited their needs.

> It allowed us to have faith and to hold people longer [in the shelter] to get the right fit. So, as a general sense, my belief is that instead of just squirreling someone into whatever room comes up at whatever SRO, to get someone in a home and a building that they're going to be happy in, have community and their needs met – far outweighs a quick turnover; to take a little longer, to make sure someone gets where they need to be and then we won't see them back for a year or two, or maybe never, hopefully. (Provider participant)

The VCH Shelter Project program also has the flexibility to allow participants to stay in a priority shelter bed until suitable housing becomes available.

> Quite often, the stays at [anonymous] shelter were extended, sometimes for months on end because I knew where the best housing location was for some of the challenging clients and we just had to wait for units to become available. And so, there was just sort of a lot of back and forth about, 'Yes, [the patients are] on the list [and] they're going to get the next bed. We just need to hang on and wait.' And, sure enough, it did move, slowly. And we got some really, really challenging folks housed really well. (Provider participant)

Having the assistance of a housing outreach worker made the search for housing easier for one program participant who stated, "[The search for housing] was much easier for me right

now because I don't have to go nowhere. [The housing outreach worker and shelter staff] do all the work, and that's great." Moreover, the ability to connect program participants to subsidized rents in quality housing contributed to housing satisfaction. A program participant said, "[The rent of the apartment is] only $320 a month… they're beautiful apartments. It's got a balcony that faces the mountains and everything." Another program participant reported receiving a rent supplement for their apartment, a supportive housing unit. Their rental assistance program was designed so that their monthly rent payments were sent directly to the housing provider, which was hugely beneficial for this participant who had memory difficulties and worried about forgetting to pay their rent.

2.2e. Relationships were established between cross-sectoral stakeholders

Provider participants identified partnerships and the importance of communication and trust across sectors as key to the success of the VCH Shelter Project. These partnerships enabled open communication and creative problem solving toward ensuring positive outcomes for program participants. Improved case planning through open dialogue with hospital providers allowed shelter staff to be better informed of program participants' health status so they can plan services appropriately. For example, when program participants have to be temporarily readmitted to the hospital, the shelter can keep their bed reserved for them.

> We can be really transparent and say this person's going to need to come back into the hospital now and then, and it's going to be for short periods of time. And then we know we can reserve that bed for the person knowing that they're going to be gone to the hospital for a few days, that they're going to come right back out and they're going to have a bed available as opposed to us not knowing that, giving the bed away, and then the person coming back to us and we're going "oh crap, now we don't have a place for that person to stay." (Provider participant)

Having the time and opportunity to get to know providers in the other sectors was reported to improve the partnership and communication.

One provider participant described the value in developing relationships with shelter staff who might be new to the project:

> Developing [long-term] relationships with staff [enabled the program to be accepted]… I would go over about once a year and sort of reintroduce the project because they have quite a turnover of staff…I would just drop in [at the shelter] regularly as well…[the program] was received well. Face-to-face [interaction and being] very transparent [and] explaining the logic behind [the program] and listening to the input of the other side is always very good.

In addition, as community health services are brought into shelters to care for program participants, shelter staff gain additional knowledge about health.

> This idea that we've got strengths that complement one another, and the learning from my staff around the clinical opinion and being a little closer to case-management [and] case-planning for folks…I think that having the clinical staff onsite to be able to inform and be able to help broker relationships between shelter staff and their patients, I think it makes for stronger, better opportunities for care.

3. CHALLENGES OF THE METSON AND VCH SHELTER PROJECT

3.1. Shortage of affordable and appropriate housing

Participants affiliated with both the Metson and VCH Shelter Projects identified the shortage of affordable and appropriate housing stock and long housing waitlists as fundamental challenges to moving program participants into more stable housing, particularly in light of the volume of other shelter clients who need housing.

> We've got people in these shelter beds, they've been ill, they've come from hospital, now they're in shelter beds—we have nowhere to send them. It takes months, sometimes, to get them into appropriate housing. It's a lack of physical housing stock that creates the roadblocks in the shelters. (Provider participants)

As a result of the limited housing options, one program participant stated, "It's hard out there

getting a place. It's really hard. Especially when you don't want to live in that area." Moreover, limited options served to disconnect program participants from established health and community supports. For instance, one program participant recalled wanting to live geographically close to their psychiatrist, but because of limited housing options had to move to another location and find new support services.

Participants also described that landlords could be particularly discriminating in who they would rent to and those most in need, hardest to house, and medically and socially complex are often stigmatized.

> [There is] a lack of affordable housing stock and a lack of housing stock landlords that will accept the clients…you see the NIMBY-ism [Not in my Backyard] with the modulars going up in neighbourhoods …people don't realize [that] these buildings [going] up in their neighbourhood are housing the folks that [are] already in [their] neighbourhood…we're just giving them homes. (Provider participant)

"They don't seem to talk to each other, this is what I don't like with doctors. They should talk to one another."

3.2. Other shelter guests' way of life

A second challenge described by participants affiliated with both the Metson and VCH Shelter Projects was the location of the transitional beds in low-barrier settings. For instance, there was some consideration that shelter environments where active drug use can be observed can be a challenge to the recovery of some PWLEs, especially those with a history of using substances. One provider participant said, "I just think there's quite a heavy drug-use scene in the [anonymous shelter] building and I think that for some people it's a hard space to use moderately or stay clean." While several program participants acknowledged the low-barrier environment, they had strategies to manage within it. One program participant avoided interactions with people who were using substances: "There were a lot of drug users in there…It's low-barrier, right? So, there's some pretty rowdy people I stayed away from." Another participant removed themselves when the temptation to use became too strong:

> The temptation was there and it was a detrimental influence, but when I saw that it was a little bit too much to bear, I started staying at my mother's place as much as possible. I just didn't want to be downtown anymore.

3.3. Challenges to food security, hygiene, and cleanliness

Some of the challenges reported by participants were unique to the different projects. For instance, food security, hygiene and cleanliness, pest control, and complex mental health needs were challenges for some program participants. Program participants identified the importance of needing food security, which was challenging because of limited food storage space, a lack of a stove or kitchen sink, or limited low-cost options in the nearby area. Inaccessible, limited, and nonfunctioning laundering facilities were also reported to be a challenge.

3.4. Complex health needs and after-care

Program participants affiliated with the Metson Project reported facing symptoms associated with complex mental health issues, which challenged their ability to stay in the SPH-designated rooms. One program participant was candid about their mental health challenges, citing uncertainty about whether or not they were having auditory hallucinations while at the Metson. Providing mental health follow-up care for patients in the SPH-designated rooms was also acknowledged by provider participants to sometimes be a challenge for Metson staff.

> It's particularly tough when dealing with mental health, to sometimes have the appropriate follow through for someone. If they've stabilized well enough in the hospital, and then they don't consent to follow-up in the community, and then we have them for a while and they start to slide again, they don't slide enough to be certified or recalled, but they are certainly unwell and we struggle with how to support them. So, that after-care sometimes is tricky. (Provider participant)

While home and community support services were provided to clients of the VCH Shelter Project,

the levels of home support were not always adequate. For example, more home support for clients who have difficulty with activities of daily living or require assistance with housekeeping was a reported need. Incontinence was specifically highlighted as an issue for shelter staff, who lacked the resources to support individuals with such personal care. With home-support workers only available to provide care for a limited period of time, clients are unable to access personal care assistance when needed at other times of the day.

3.5 Care (dis)continuity and access to community amenities

Program participants affiliated with the Metson Project reported that when they moved from the SPH-designated rooms to transitional housing, their health and community support networks changed. One program participant noted that their doctor, nurse practitioner, and psychiatrist changed when they left the SPH-designated rooms at the Metson and moved to a different municipality. Though this participant reported success in building trust with a new team of healthcare providers, another program participant who was disconnected from their healthcare providers when they moved across the city expressed dissatisfaction in having to repeat their story and build trust with new healthcare providers.

> Because I moved from the Metson, I'm out of their jurisdiction so they transferred me…so I'll be going over there now—to the new team…I will have a new psychiatrist and…this story starts all over again…rather than the psychiatrist talking with the [new] team. They don't seem to talk to each other, this is what I don't like with doctors. They should talk to one another.

Program participants also had varied experiences of accessing community amenities in the locations where they relocated. While one program participant reported living in a neighbourhood where there was no accessible grocery store, another program participant was satisfied with the convenience of being in downtown Vancouver in close proximity to several grocery stores.

3.6. Staff restructuring and turnover

Unique challenges to the VCH Shelter Project identified by participants included staff turnover, which resulted in incoming staff having to get trained and knowledgeable in their new role, as well as the partners having to come together to rebuild the partnership. One provider participant explained that staffing restructuring impeded intersectoral partnerships because relationships have to develop over time and losing important point-persons disrupts the collaborative process. Having recently experienced the loss of a key point-person, one participant stated, "I think we lost a lot of what we had worked really hard for a long time to achieve. And I think the trust isn't [yet] there

and the knowledge isn't there [for] appropriate placements."

3.7. Limited resources challenge equity

Participant affiliated with the VCH Shelter Project highlighted the inequity in service as the priority shelter beds are filled through referrals from healthcare, while "walk-in" clients that need the additional health supports are unable to directly access the service. A provider participant indicated that having to turn away individuals who walk in off the street takes away from the process of relationship and trust building that is central to the ethos of shelter provision. Another provider participant similarly reported the high demand for the priority beds and the challenge in limiting access to these beds to only one referral source:

> Managing the need is tough…So, there's a lot of need for this type of program and so, for us, just having only a few beds…it continues to be difficult to manage in terms of referrals and having available beds…it's difficult to park five or six beds at any given time for the health authority and it proves to be challenging, particularly when you have people walking up that [have] great need and are health compromised; and will end up in hospital if you don't help them.

A program participant expressed concern about the increasing volume of hospital patients into the shelter and the likely impact of this on other shelter clients: "I'd hate to see a steady influx of hospital patients and have it overflowing, and have a situation where people are being removed just to make room for the hospital patients."

4. RECOMMENDATIONS FOR HOSPITAL-TO-HOUSING TRANSITION PROGRAMS

Based on the case study of these two hospital-to-housing transition programs, several recommendations can be made:

1. Increase housing options across the housing continuum
2. Develop a medical respite program
3. Expand the number of shelters with dedicated transitional beds that are adequately resourced with the necessary health supports
4. Embed intersectoral providers across hospital and shelter settings
5. Have a single point-person in each organization to coordinate transitions
6. Promote intersectoral communication, collaboration, and case management
7. Conduct additional research and evaluation, including cost analyses

4.1. Increase housing options across the housing continuum

In order to help support PWLEs in their transition from the hospital to housing, participants noted the need for a broad range of housing options along the housing continuum. This includes shelters, transitional housing, and social and supportive housing. In addition, it is recommended that PWLEs be given more choice in their housing. One program participant who did not have much say in their housing stated:

> I would say giving [program participants] a choice—options—is what I think is most important…not just say, "You take the first thing that you're given." I understand the urgency behind it because if space becomes available here you kind of have to jump on it… [but] at least give them two choices, not just one.

4.2. Develop a medical respite program

In addition to offering more options across the housing continuum, provider participants also identified a need for a purpose-built medical respite facility that would provide full-time clinical support services to PWLEs following hospital discharge.

> You could have facilities that do nothing but this type of work; that could have a little more of a clinical setting…The shelter setting wasn't made with clinical services embedded…Some of our sites have a nurse's room that have what you would see in a typical kind of walk-in clinic… that's kind of as far as that went. But this could be taken much further… A transitional [medical] respite pilot project that is completely stand-alone.
>
> It would be a shelter model with more embedded staff, like an Licenced Practical Nurse, care aid, possibly a Registered Nurse, depending on the amount of beds there are…

or [having a] personal care aide on staff. It's just to give that additional level of support to people who are still recuperating but do not need the hospital level of care [and] certainly cannot survive on the street.

4.3. Expand the number of shelters with dedicated beds that are adequately resourced with health supports

In addition to the creation of a dedicated medical respite facility, provider participants also suggested dedicating more beds in existing shelters to medical respite to expand upon the successes from St. Paul's Rooms at the Metson and The VCH Shelter Project (e.g., increased cross-sector collaboration and reduced PWLE wait time to access a shelter bed).

> "I definitely see an opportunity for more shelters to have this type of program. I think it's a win-win."

One provider participant reported that the Metson Project deserved more support because it has significant implications for healthcare costs: "More support for this particular model that's going away from long hospital stays [involves] recognizing that the community and non-profits do have a lot to offer and an ability to support people."

Program participants also indicated the need for respite beds in shelter locations outside the DTES, as well as the creation of spaces that are abstinence-based for the stabilization and recovery of people who may not feel supported in a low-barrier environment.

Finally, provider participants suggested that hospitals or health authorities partner with other housing providers to dedicate units for patients on a short-term, transitional basis. One provider participant suggested dedicating an entire property for short-term transitional housing units, while another provider participant emphasized the need for a range of transitional housing options that offer tailored support to patients with different needs.

4.4. Embed intersectoral providers in other settings

Bringing healthcare supports into shelters was another recommendation for addressing PWLEs' medical care needs, including the management of complex health conditions.

> Having a nurse dedicated for this purpose would probably make things a little bit easier…if you had a nurse onsite…all five of those people could be very health challenged, and that would certainly take a lot of the onus off the shelter staff, as well as provide better support to the folks that are coming in from the hospital. And that doesn't have to be anything substantial, but just having the ability for them to pop in and provide a little more direction for folks. (Provider participant)

Having onsite nursing staff was acknowledged to require additional funding: "Fund us. Give us more money. We need more staff, more beds…we're getting through, but we're not making progress and we need to make progress…we need funding for a nurse onsite. (Provider participant)"

Alternatively, other provider participants suggested that shelter staff be embedded into hospitals so they can initiate the process of assessment and referral early on, while simultaneously developing relationships and rapport with PWLEs.

> Connecting with patients within the hospital setting [could] expedite care [and] create relationships…If we had staff embedded at the health authority; take a wing, a block of five or six offices, and have a group of non-profits office-sharing…so that we can do front-end assessments and create relationship and rapport, help navigate the non-clinical care that people need, and then be ready for discharge.

4.5. Have a single point-person in each organization to coordinate transitions

Having a single point-person promoted efficiency in the process of making referrals for patients into the transitional shelters following hospital discharge. Having one point-person enabled working relationships to be developed and enabled trust and understanding between providers in different sectors:

> [The Metson building manager doesn't] come back and say, '…I don't think we want to have that person there.' We have an understanding that…as long as I choose people who seem appropriate and provide the follow-up support

then we don't have that extra step of justifying our referrals. (Provider participant)

4.6. Promote intersectoral collaboration and coordinate case management

Another recommendation was to improve the communication, knowledge sharing, and trust building between healthcare and shelter/housing providers, which will translate into improved health and housing outcomes for PWLEs.

> I feel like there's something about just doing that application and faxing it off where…we're just in our silos, in isolation, not knowing or communicating with other agencies or sites or services. And I think that communication that we're all here to help the exact same folks—to do the same job—and some of us know some things and some of us know other things; and if we can share knowledge and build relationships and trust, I think that the outcomes will serve our folks. (Provider participant)

One recommendation for improving communication, collaboration, and coordinated access to shelter was to have a clear process for PWLE consent to release information. This could be achieved through the implementation of a simple form that healthcare providers can fill out for referring people to the priority shelter beds that highlights the PWLE's main issues and the services they are connected to. While it would allow PWLEs to give permission for providers to share information with others, they should be reassured that information will not be shared with police or others, especially if they have had negative experiences signing release forms in the past. This could result in more seamless communication between providers about the health needs of the PWLEs in their care.

Another suggestion for how to improve intersectoral collaboration was through increasing coordinated case management where cross-sector providers are working together to serve PWLEs, rather than independently.

> I definitely see an opportunity for more shelters to have this type of program. I think it's a win-win. I think a lot of the folks that we see are coming in and out of the hospital as it is, and so it makes better sense to do joint case planning [rather] than to be working independently. (Provider participant)

> We could do more of embedded healthcare, coordinated case management with [other] shelters…if we started case management from day one in a coordinated way like this at those shelters…I would seriously consider what this would look like at other shelters. (Provider participant)

4.7. Conduct additional research and evaluation, including cost analyses

A final recommendation suggested by the project team is to develop more robust monitoring, tracking, and follow-up of program participants. Additional research should be considered that evaluates the long-term health and housing outcomes of program participants who have accessed the priority shelter beds. Doing so would enable enhanced knowledge generation and translation, as well as an improved understanding of the cost savings of intervention programs.

Chapter 6
Recommendations

This chapter outlines a comprehensive set of recommendations based on data collection and analysis from all three phases of the project (scoping review, interviews, and community consultations). These recommendations were presented during a third and final community consultation, when healthcare/shelter/housing participants had the opportunity to provide feedback and to suggest additions. This feedback was then organized and evaluated by the project team before finalizing this list of recommendations. For a detailed table of recommendations with examples of any similar initiatives, see the Recommendations Table. In this table, we identify the desired outcomes of each recommendation and whether this is a short-, medium- or long-term goal. We define a short-term goal as one to two years, a medium-term goal as three to five years, and a long-term goal as five or more years.

These recommendations are intended to serve as a framework for the further development and implementation of policies and programs for safe hospital discharges of persons experiencing homelessness. Our primary research question asked, "How can we strengthen partnerships between the health and shelter/housing sectors in order to improve discharge practices?" It must be stated that shelters are often not appropriate places for people following hospital discharge and shelter providers are usually not trained or able to meet more than the basic health needs of those discharged from the hospital. These recommendations outline policies and practices that can improve communication and collaboration between the sectors to support PWLEs being discharged from the hospital. They also explore alternatives to discharging to shelter.

These recommendations are intended as guidelines for those working with PWLEs in hospitals or shelters/housing. They are based on the recognition that individuals have diverse needs and reflect the understanding that a one-size-fits-all approach is not realistic nor appropriate. There is a need for flexibility according to individual needs and

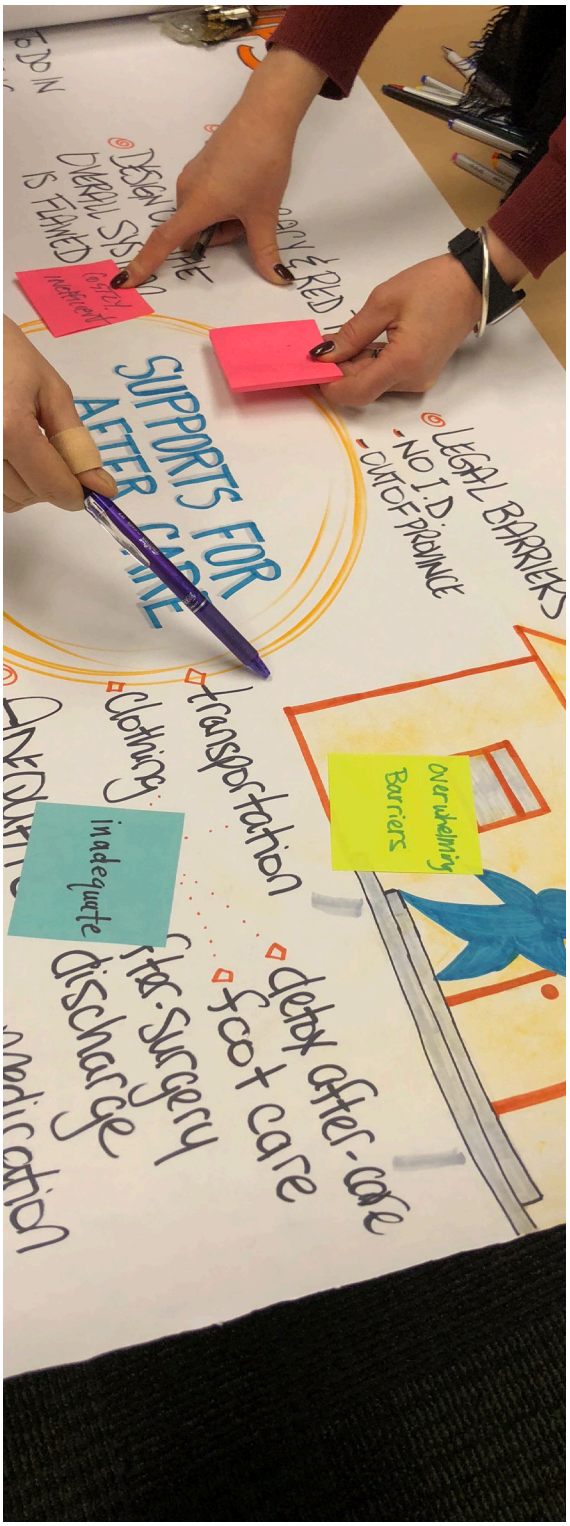
site-specific settings and contexts. Nevertheless, these recommendations provide a starting point for developing more effective discharge planning across different settings for a broad range of PWLEs in order to provide safer discharges, reduce hospital readmission, and improve health and housing outcomes for persons experiencing homelessness.

Implicit in these recommendations are a number of broad overarching assumptions:

1. Funding for additional programs, services, and supports related to the discharge of PWLEs is needed, including the development of medical respite programs, enhanced healthcare outreach in communities, increased and more robust staffing for both healthcare and shelter/housing providers, and enhanced education, training, and research to increase awareness and understanding of the drivers and solutions to homelessness and meeting the needs of those being discharged from hospital.
2. PWLEs must be involved in the implementation of these recommendations at every stage. PWLEs offer invaluable insight into what supports are needed and how best to effectively deliver them.
3. Health, housing, and shelter staff working with PWLEs must maintain a trauma-informed and patient- centered approach to care.
4. De-stigmatization initiatives are needed within all health and housing/shelter professions to increase awareness and understanding of homelessness.

The recommendations have been organized into five categories:

1. Professional Training and Education
2. Intersectoral Communication and Collaboration;
3. Hospital Admission, Assessment, and Discharge Planning
4. Integrated Case Management at Discharge
5. Discharge Locations



1. PROFESSIONAL TRAINING AND EDUCATION

This category of recommendations considers the development and implementation of education and training opportunities for reducing stigma and understanding the causes of homelessness for those working with PWLEs in hospital and shelter/housing. Education and professional training are widely recognized as core to successful admission and discharge planning efforts for patients experiencing homelessness. Education can also be an effective strategy to initiate changes in organizational culture surrounding homelessness.

Opportunities for education and training for those new to the field, and those already working within it, can help reduce stigma toward PWLEs and promote a patient- and client-centered approach.

Recommendation 1.1. Incorporate PWLEs in the development and delivery of training resources.
Incorporate PWLEs into the development and delivery of training to provide the lived experience knowledge that professionals without lived experience cannot learn otherwise.

Recommendation 1.2. Identify core training and education competencies about homelessness and homeless populations.
Provide training to healthcare providers so that they can better understand the experience of homelessness both inside and outside the hospital, to improve treatment of, and respect for, the needs of people experiencing homelessness. Such core competencies could include, but are not limited to: cultural awareness and safety training, trauma-informed practice, harm reduction, and recovery-oriented practice.

Recommendation 1.3. Develop curriculum for Medical, Social Work, and Nursing programs at university and college level.
Provide interdisciplinary training to students in coursework and practicums regarding patient- and client-centred approach to care.

Recommendation 1.4. Create ongoing professional development training opportunities for healthcare and shelter/housing providers.
Develop education and training opportunities for reducing stigma and understanding the causes of homelessness for those working with PWLEs, which is needed to effectively work with patients who have histories of mental health challenges, addiction, and trauma.

2. INTERSECTORAL COMMUNICATION AND COLLABORATION

This category includes recommendations regarding increased communication and collaboration between the health and shelter/housing sectors. In previous literature, communication and collaboration across sectors is generally referred to as "cross-sectoral." We recommend, instead, an "intersectoral" approach, whereby the divisions between the healthcare and shelter/housing are diminished and overlaps between them are forefronted. A more integrated approach to relationship building and information sharing can help break down silos and improve discharge processes.

Maintaining open communication between healthcare and shelter/housing service providers helps build a sense of trust and knowledge sharing—both formally and informally. Thus, the recommendations below are organized into two categories: i) *Informal Relationship Building*; and ii) *Formal Partnerships*.

Intersectoral training and partnerships provide opportunities for service providers across settings to understand the scope and abilities of other sectors. In addition, findings suggest that "face-to-face" contact aides in the development and maintenance of intersectoral relationships. A primary desired outcome of the recommendations in this category is to ensure continuity of care for clients and to reduce the number of discharges to inappropriate settings.

Recommendation 2.1. Develop intersectoral visits/tours to shelters/housing & hospitals, both in person and online/webinar.
Offer opportunities for site visits, interaction, best practices discussions, and information sharing between healthcare and shelter/housing staff.

Recommendation 2.2. Host annual intersectoral dialogue, knowledge translation, and best practices forum at HSABC's annual conference.
Homelessness Services Association of BC (HSABC) to host an annual intersectoral dialogue that provides an opportunity for health and shelter/housing workers to engage in face-to-face communication, share perspectives, and ask questions to improve understanding and build empathy.

Recommendation 2.3. Develop a healthcare to shelter/housing Community of Practice.
HSABC to facilitate education and information sharing through regularly hosted meetings with shelter/housing and healthcare providers.

Recommendation 2.4. Implement a standardized hospital-to-shelter referral form.
Develop standardized policies and procedures for use of a hospital-to-shelter referral form (See Appendix D) that includes a release of information agreement, to assess and identify primary healthcare needs and necessary supports for PWLEs discharged to shelter.

Recommendation 2.5. Utilize MOUs to formalize partnerships.
Develop targeted, action-based, time-limited, formal memoranda of understanding (MOUs) between shelter/housing providers and healthcare providers, with clear objectives, and parameters for information sharing and confidentiality.

Recommendation 2.6. Develop and maintain an electronic contact list of key positions in each hospital and shelter/housing to improve communication and collaboration in discharge planning.
Develop an electronic staff contact list that is regularly updated and identifies key positions, roles, and responsibilities for hospital and shelter staff to support improved discharge planning for PWLEs from the hospital to shelters.

Recommendation 2.7. Explore opportunities for a centralized database for sharing health and housing outcomes between healthcare and shelter/housing providers.
Improve information sharing and health and housing outcomes for PWLEs through a centralized database.

3. HOSPITAL ADMISSION, ASSESSMENT, AND DISCHARGE PLANNING

This category of recommendations involves the discharge process at the hospital, beginning at hospital admission for PWLEs, through assessment and discharge. Our focus is on what is most relevant to the transitioning of PWLEs from hospital to shelter/housing, and is not exhaustive.

Consistent with our overarching recommendations, a non-stigmatizing and trauma-informed approach to managing discharge for PWLEs is recommended to improve the treatment of all individuals involved. Furthermore, we again recommend taking a patient- and client-centered approach to meet PWLEs "where they are at" to best meet their needs. It is from this perspective that we share the following recommendations.

Recommendation 3.1. Conduct a housing assessment in the hospital, both at the time of admission and prior to discharge.
Ensure patients admitted to the hospital undergo a psychosocial assessment that includes a review of a patient's housing status at time of admission and throughout their stay in hospital.

Recommendation 3.2. Engage with shelter/housing providers to begin planning for discharge as early as possible.
Initiate early and frequent communication and planning between hospital and shelter/housing providers can ensure that appropriate supports and services are put in place to accommodate the PWLE being discharged. Note that shelters are typically not an appropriate discharge location (see "Discharge Locations" recommendations below).

Recommendation 3.3. Connect or reconnect PWLEs to primary care and community healthcare providers prior to discharge.
Ensure PWLEs being discharged from hospital are (re)connected with a primary care physician or a community health clinic where they can receive appropriate post-discharge support.

Recommendation 3.4. Forward relevant health records to primary care and community healthcare providers to ensure healthcare information gets communicated.
Ensure efficient and effective communication between hospital and primary care providers by forwarding any relevant records.

Recommendation 3.5. Establish dedicated professional and peer-navigator positions within hospitals to support successful transitions from hospital to shelter/housing.
Create a dedicated social worker position focused primarily on supporting PWLEs with necessary referrals relating to the social determinants of health (housing, income, etc.). It is important that the staff person work with a PWLE at admission to assist them in navigating the complex healthcare and shelter/housing systems. Furthermore, the PWLE should be engaged in the planning process and provided with choices in decisions being made about their post-discharge shelter/housing options.

In addition, create a dedicated peer navigator position in the hospital who can support PWLEs and connect them to services.

Recommendation 3.6. Refine updated bc211 directory to more clearly define available shelter services and supports.
Continue to update the bc211 online directory with information on the types of services and supports available at each shelter, so this can serve as a guide to hospital staff who are seeking shelter options for their patients. Confirm the summary information and associated icons of available services and supports, and regularly update the list to ensure accuracy.

Recommendation 3.7. Provide PWLEs with sufficient information and discharge summary at discharge.
Provide PWLEs sufficient and clear information about their diagnoses, follow-up care, medication regimen, and discharge plans. Share the information in plain language to ensure the PWLE understands medication instructions and the need for any follow-up appointments.

Recommendation 3.8. Apply a harm reduction approach to patient-initiated discharge.
Utilize a harm reduction approach when PWLEs are going to self-discharge against medical advice, whereby the hospital-based social worker and healthcare staff strive to provide patient with resources and supports (i.e., clothing, bus ticket, Naloxone kit, Shelter information) in order to minimize harm.

4. INTEGRATED CASE MANAGEMENT AT DISCHARGE

The recommendations in this category are organized into two sections: i) *Community Case Management*; and ii) *Connection to Community Supports*. The recommendations focus on ensuring a PWLE has access to integrated case management and other community supports to improve post-discharge outcomes.

We recommend that immediate needs, such as safe transportation, healthy food, suitable clothing, and appropriate housing, if possible, be identified and addressed at discharge. It is also recommended that a shelter/housing provider is available at the time of discharge to ensure a safe and successful transition from hospital to shelter/housing. In the long-term, PWLEs should be connected to a case manager at time of discharge as part of an integrated care team that can help with housing and healthcare follow-up.

Recommendation 4.1. Embed a housing liaison or housing outreach worker in the hospital.
Establish a housing outreach worker who is embedded in the hospital and whose primary job is to assist with finding and securing housing for PWLEs at discharge. This position would work directly with key shelter/housing contacts in making referrals and communicating the needs of the PWLE.

Recommendation 4.2. Provide opportunities for shelter/housing staff to engage with PWLEs during their hospital stay.
Ensure the hospital outreach worker connects with shelter/housing staff and provides an opportunity for them to visit the hospital to engage with the PWLE prior to discharge. This will provide an opportunity to begin relationship building and perform an in-person assessment of whether the shelter/housing is appropriate for that individual.

Recommendation 4.3. Expand case management care (i.e., Assertive Community Treatment, Intensive Case Management, Community Transition Team) and ensure other wrap-around health supports and services are available to PWLEs upon discharge.
Develop additional case management services for ongoing post-discharge care for PWLEs who have a range of diagnoses. This approach would involve multi-level support from a case manager who can assist with system navigation to assist with meeting PWLEs' day-to-day needs.

Recommendation 4.4. Connect PWLEs with a case manager who can coordinate follow-up care and services and work with PWLEs post-discharge.
Appoint case managers to assist PWLEs' discharge through connecting PWLEs to: transportation, clothing, food and income security, and medical equipment. Appointed case managers can also ensure access to a range of care and social services including home supports and income and housing support following discharge to support PWLEs in shelter/housing.

Recommendation 4.5. Expand community-based services and healthcare outreach in community, including mobile physicians and nurses.
Increase the availability of after-hours and weekend health services, and establish a community-based health team to assist with post-discharge needs (e.g., medication support) and general healthcare outreach support (e.g., mobile licensed practical nurse and physician to support patients in shelters/housing).

Recommendation 4.6. Ensure portability of primary healthcare services across geographic catchment areas.
Ensure continuity of care for PWLEs who already have established and positive relationships with a care team in one geographic region by providing PWLEs the flexibility to access care teams and health services regardless of their catchment area.

5. DISCHARGE LOCATIONS

The final category of recommendations involves developing and/or expanding the range of discharge locations, such as medical respite, housing, or shelters. Many of our recommendations have focused on improved discharge practices and protocols, increased access to health supports in the community, and other tangible actions to support improved follow-up care for PWLEs after discharge from hospital. However, to be effective, appropriate housing and other facilities, such as medical respite, are needed in order to ensure an individual can get well. Improving discharge planning and processes without addressing underlying resource needs can only go so far in improving health and housing outcomes for PWLEs.

A variety of options along the housing continuum are required, and all of the options should be affordable, accessible, suitable and safe.

Recommendation 5.1. Develop medical respite options.
Establish a dedicated, purpose-built medical respite facility and explore options for expanding dedicated beds at multiple shelter/housing sites. Medical respite provides medical stabilization following hospital stays for individuals to recover and rest before moving to regular shelter settings or to more permanent and appropriate housing.

Recommendation 5.2. Expand priority shelter bed models (such as Metson/Triage/Yukon).
Prioritize shelter beds, with funding from regional health authorities, for PWLEs following hospital discharge. With adequate resources and funding, shelter/housing providers could dedicate beds for hospital referrals.

Recommendation 5.3. Increase supply of housing options, including social and supportive housing, in both congregate and scattered site options.
Create new and varied housing options to meet the diverse needs of PWLEs and provide greater choices for them. Access to safe, secure, and affordable housing is fundamental to health and wellness.

Recommendation 5.4. Ensure new and existing shelters and housing have adaptable and universal design that can support people with a range of needs.
Support adaptable design for all new projects moving forward. In shelters, accessible and adaptable design should accommodate all levels of mobility and have suitable daytime resting spaces for PWLEs with convalescence needs, and offer spaces for nurses and/or physicians to deliver healthcare.

Recommendation 5.5. Expand existing after-care health services in a single location.
Increase the number of community clinics and urgent care centres that offer wrap-around care. These facilities help divert individuals from going to hospital emergency departments for care and should be expanded, as well as be open 24/7, to address complex care and medication support.

Recommendation 5.6. Provide dedicated healthcare staff resources to support shelter providers in meeting the health needs of their guests.
Establish comprehensive, mobile, and specialized nursing and medical care, social work, care aides (who help with bathing, dressing, and feeding), physiotherapy, occupational therapy, dietician services, homemaking, and mental health and addictions services for PWLEs as they transition from hospital to shelter/housing, with extended hours of availability.

RECOMMENDATIONS TABLE

Goal time-frame	Recommendation	Desired outcome(s)	Current initiatives to build on
1. Professional Training and Education			
Short-term	1.1. Incorporate PWLEs in development and delivery of training resources.	1) Increased opportunities for empowerment, involvement, and engagement for PWLEs. 2) Improved understanding for healthcare providers of the experience of homelessness based on engagement and involvement of PWLEs.	
Short-term	1.2. Identify core training and education competencies about homelessness and homeless populations.	1) Improved understanding and awareness of homelessness among healthcare providers. 2) Reduced stigmatization of PWLEs receiving care. 3) Improved awareness of effects of past trauma for PWLEs in healthcare settings. 4) Consistent service delivery based on evidence-informed best practices.	1) Vancouver Coastal Health (VCH) 2nd Generation Strategy: All Downtown Eastside (DTES) staff received training for the following core competencies: cultural safety, trauma-informed practice, harm reduction and recovery-oriented practice. (http://dtes.vch.ca/secondgenerationstrategy/) 2) Maple Ridge Pilot: Fraser Health Authority (FHA) has developed a series of in-person training sessions for staff that is expanding to other hospitals. This training is mandatory for all ER social workers, nursing and front-line staff.
Long-term	1.3. Develop curriculum for Medical, Social Work, and Nursing programs at university and college level.	1) Reduced stigma towards PWLEs. 2) Improved comprehensiveness of education and training to affect future systems change. 3) Increased knowledge and skills among healthcare providers working with PWLEs. 4) Consistent service delivery based on evidence-informed best practices.	1) University of the Fraser Valley has developed a 4-session online course described as "Homelessness 101." 2) Douglas College, BCIT, and CDI College partner with Catholic Charities for nursing and social work practicums. 3) Practicum placements from UBC School of Social Work in Orange Hall supportive housing and UBC School of Pharmacy in The Gathering Place.
Short-term	1.4. Create ongoing professional development training opportunities for healthcare and shelter/housing providers.	1) Enhanced skills and competencies of healthcare and shelter/housing providers working with PWLEs. 2) Improved care continuity.	1) Providence Health Care (PHC) Grand Rounds presentations on topics related to health and housing. Community service and healthcare providers are able to attend. 2) PHC Inservices for Social Worker on topics related to homelessness, housing options and referral processes.

2. Intersectoral Collaboration and Communication			
Short-term	2.1. Develop intersectoral visits/tours to shelters/housing & hospitals, both in person and online/webinar.	1) Increased understanding of role, mandate and function of shelter/housing and healthcare sectors. 2) Improved trust and relationship-building across sectors.	Social workers from St. Paul's Hospital and Mount St. Joseph Hospital periodically tour community shelters and transitional housing, including at Triage, Yukon, Belkin House, Atira, and Portland Hotel Society. Tours of the VCH clinics in the DTES have also been conducted.
Short-term	2.2. Host annual intersectoral dialogue, knowledge translation, and best practices forum at HSABC's annual conference.	1) Enhanced trust, understanding, and relationship-building among health/shelter/housing providers. 2) Increased understanding and knowledge of health/shelter/housing best practices.	
Medium-term	2.3. Develop a healthcare to shelter/housing Community of Practice.	1) Increased understanding of the experiences of workers in both sectors, including the mandate, scope, and limitations of each sector. 2) Improved communication and collaboration across sectors.	
Short-term	2.4. Implement a standardized hospital-to-shelter referral form.	1) Increased efficiency and consistency in communicating relevant health needs of PWLEs being discharged into shelter/housing. 2) Improved information-sharing so shelter/housing providers are informed of the supports needed of PWLEs being discharged, while maintaining privacy and confidentiality standards. 3) Reduced number of inappropriate referrals.	1) FHA Hospital-to-Shelter form. (**See Appendix D**) 2) PHC Hospital-to-Shelter form, adapted from the FHA form.
Short-term	2.5. Utilize MOUs to formalize partnerships.	1) Improved information-sharing among providers regarding PWLEs' needs. 2) Improved intersectoral collaboration. 3) Enhanced accountability through understanding of partners' roles and responsibilities.	
Medium-term	2.6. Develop and maintain an electronic contact list of key positions in each hospital and shelter/housing to improve communication and collaboration in discharge planning.	1) Improved consistency in appropriate PWLE referrals regardless of staff turnover. 2) Improved communication between hospital and shelter/housing staff.	PHC intranet shelter list.
Long-term	2.7. Explore opportunities for a centralized database for sharing health and housing outcomes between healthcare and shelter/housing providers.	1) Improved support and health and housing outcomes for PWLEs as they are discharged from hospital. 2) Improved data collection and information sharing among the health, shelter, and housing sectors to facilitate a systems-planning approach to addressing the needs of PWLEs.	BC Housing's Homeless Individuals and Families Information System (HIFIS 4.0), funded by homelessness services agencies.

3. Hospital Admission, Assessment, and Discharge Planning			
Short-term	3.1. Conduct a housing assessment in the hospital, both at the time of admission and prior to discharge.	1) Improved discharge planning. 2) Improved housing and health outcomes for PWLEs.	PHC specialized Hospital Social Work roles complete extensive housing assessments with patients.
Short-term	3.2. Engage with shelter/housing providers to begin planning for discharge as early as possible.	1) Improved ability for shelter/housing providers to plan for and accommodate the needs of PWLEs being discharged from hospital.	PHC roll-out of a hospital-to-shelter referral form as a tool to explore fit between shelter and patient's needs.
Short-term	3.3. Connect or reconnect PWLEs to primary care and community healthcare providers prior to discharge.	1) Improved care continuity and information sharing between providers. 2) Improved health outcomes of PWLEs.	VCH 2nd Generation Strategy: Reorganization of services to streamline primary care services to DTES residents.
Short-term	3.4. Forward relevant health records to primary care and community healthcare providers to ensure healthcare information gets communicated.	1) Improved efficiency of information sharing. 2) Improved care continuity.	VCH and PHC are moving towards using same electronic medical record program.
Short-term	3.5. Establish dedicated professional and peer-navigator positions within hospitals to support successful transitions from hospital to shelter/housing.	1) Enhanced housing and health outcomes for PWLEs. 2) Improved patient flow through various complex systems. 3) Reduced length of stay in hospital 4) Reduced volume of hospital readmission. 5) Improved discharge experience and sense of agency and engagement in process for PWLEs. 6) Increased PWLE access to community resources and information.	1) There is a specialized social work role within FHA aimed to provide additional collaborative support for patients that are frequent users of the Surrey Memorial Hospital emergency department. 2) PHC specialized Hospital Social Work roles focus on housing needs of patients. These roles complete extensive housing assessments with patients and liaise directly with community housing providers to support housing transitions. 3) VCH 2nd Generation Strategy: Peer framework. (http://dtes.vch.ca/wp-content/uploads/sites/6/2016/06/VCH_DTES_Peer_Framework_FINAL_DIGITAL.pdf)
Short-term	3.6. Refine updated bc211 directory to more clearly define available shelter services and supports.	1) Increased information sharing and understanding of available services and supports at shelters. 2) Reduced number of inappropriate referrals.	
Short-term	3.7. Provide PWLEs with sufficient information and discharge summary at discharge.	1) Increased self-determination and ability to make informed healthcare decisions. 2) Increased sense of comfort and engagement in the discharge process for PWLEs. 3) Increased understanding of required follow-up treatment and recovery. 4) Increased adherence with medications and follow-up treatment.	
Short-term	3.8. Apply a harm reduction approach to patient-initiated discharge.	1) Improved continuity of care 2) Mitigation of risks to PWLEs related to self-initiated discharge to the street.	

4. Integrated Case Management at Discharge			
Long-term	4.1. Embed a housing liaison or housing outreach worker in the hospital.	1) Reduced number of inappropriate referrals to shelters/housing. 2) Improved intersectoral communication, planning, and relationships. 3) Improved continuity of care and health and housing outcomes for PWLEs. 4) Reduced hospital readmissions.	1) Through a jointly funded partnership between HSABC and PHC, a hospital social worker at St. Paul's Hospital supports patients to transition from hospital to a shelter, which involves liaising with both unit social workers, shelter staff, and other community services to ensure that PWLEs needs can be adequately met in the shelter. 2) Coast Mental Health comes to St Paul's Hospital Rapid Access Addiction Clinic (RAAC) weekly to provide support to RAAC clients. 3) Carnegie Centre housing outreach visit Vancouver hospitals to meet with PWLEs to support their housing search.
Short-term	4.2. Provide opportunities for shelter/housing staff to engage with PWLEs during their hospital stay.	1) Reduced number of inappropriate referrals. 2) Increased understanding and collaboration between health and shelter/housing sector staff. 3) Improved relationships between PWLEs and shelter/housing providers.	1) Carnegie Centre outreach and Union Gospel Mission outreach visit acute units in Vancouver hospitals to interview patients. 2) BC Housing will visit hospitals to administer a Vulnerability Assessment Tool (VAT) for a patient's housing application. 3) The Community Transitions Team (CTT) visits patients who have a mental health team in hospital to plan housing, which may include the priority shelter beds at Triage and Yukon. (**See Chapter 5**)
Long-term	4.3. Expand case management care (i.e., Assertive Community Treatment, Intensive Case Management, Community Transition Team) and ensure other wrap-around health supports and services are available to PWLEs upon discharge.	1) Coordinated access to a continuum of patient care for PWLEs with diverse health needs. 2) Improved health and housing outcomes for PWLEs.	
Short-term	4.4. Connect PWLEs with a case manager who can coordinate follow-up care and services and work with PWLEs post-discharge.	1) Improved health outcomes for PWLEs through relevant and timely interventions (e.g., access to transportation to follow-up care). 2) Enhanced social support, safety, security, and comfort for PWLEs. 3) Reduced risk of eviction and improved living environment for PWLEs. 4) Increased treatment adherence.	1) VCH 2nd Generation Strategy: One single care coordinator and comprehensive plan for the client. (http://dtes.vch.ca/secondgenerationstrategy/) 2) VCH 2nd Generation Strategy: Three times more teams doing follow-up outreach visits with clients and accompanying clients to appointments, etc., as standard practice. (http://dtes.vch.ca/secondgenerationstrategy/)
Short-term	4.5. Expand community-based services and healthcare outreach in community, including mobile physicians and nurses.	1) Improved access to needed healthcare services. 2) Improved health and housing outcomes for PWLEs. 3) Reduced hospital readmissions. 4) Increased support to shelter/housing staff in meeting the care needs of their guests/tenants. 5) Improved engagement of PWLEs with follow-up and wrap-around services.	1) VCH 2nd Generation Strategy: Six integrated care teams (two at each site) at Heatley, Pender, and Downtown community health centres. (http://dtes.vch.ca/secondgenerationstrategy/) 2) PHC hospital social workers identify and facilitate community connections including case managers, care teams, etc.
Long-term	4.6. Ensure portability of primary healthcare services across geographic catchment areas.	1) Improved health outcomes. 2) Improved continuity of care.	

5. Discharge Locations			
Long-term	5.1. Develop medical respite options.	1) Improved post-discharge care and planning and corresponding health and housing outcomes for PWLEs. 2) Reduced acute care utilization and costs (related to re-presentation to hospital emergency departments and/or hospital readmission).	Sherbourne Health Centre Infirmary Program (Acute Respite Care), Toronto, Canada: 24/7 interdisciplinary care for homeless, under-housed and/or socially isolated individuals (aged 16 and older) who need a safe place to recuperate from an acute medical condition, illness, injury or surgery. (https://sherbourne.on.ca/acute-respite-care/)
Short-term	5.2. Expand priority shelter bed models (such as Metson/Triage/Yukon).	1) Improved case planning and health and housing outcomes. 2) Reduced healthcare utilization and costs.	1) VCH has agreements with RainCity Housing Society for priority shelter beds at the Triage shelter, and with Lookout Health and Housing Society for 5 beds at the Yukon shelter. (**See Chapter 5**) 2) PHC has an agreement with Community Builders Society for 5 beds at the Metson Rooms. (**See Chapter 5**)
Long-term	5.3. Increase supply of housing options, including social and supportive housing, in both congregate and scattered site options.	1) Improved health and housing outcomes for PWLEs being discharged from hospital. 2) Reduced wait times for finding appropriate housing. 3) Improved ability for PWLEs to choose appropriate housing according to their individual needs.	
Long-term	5.4. Ensure new and existing shelters and housing have adaptable and universal design that can support people with a range of needs.	1) Improved ability for PWLEs to access a wide range of appropriate post-discharge shelter/housing to meet their health needs. 2) Improved health and housing outcomes of PWLEs.	BC Housing's *Shelter Design Guidelines* assist non-profit shelter providers with the planning, design, and development processes for upgrading existing shelters, or constructing new emergency shelters. (https://www.bchousing.org/partner-services/asset-management-redevelopment/construction-standards)
Short-term	5.5. Expand existing after-care health services in a single location.	1) Improved access to services through a one-stop location with extended hours. 2) Reduced hospital readmission and emergency department utilization. 3) Increased adherence to after-care treatment.	Heatley Clinic is a one-stop-shop model with primary care, mental health, addictions services, and other support services such as counseling and social work under one roof with extended hours.
Long-term	5.6. Provide dedicated healthcare staff resources to support shelter providers in meeting the health needs of their guests.	1) Improved health and housing outcomes for PWLEs. 2) Reduced hospital readmission and emergency department utilization. 3) Improved ability to meet health needs of PWLEs in shelters.	VCH home supports, including nursing and mental health case managers, are provided by community health centres in priority shelter beds for PWLEs after discharge who need home supports after a hospital stay. (**See Chapter 5**)


BUREAUCRAC ED TAPE
LEGAL BARRIERS
- NO I.D.
- OUT OF PROVIN
DESIGN OF THE OVERALL SYSTEM IS FLAWED
UPPORTS FOR ER CARE
CLIENT-CENTRED APPROACH
transportation
Clothing
inadequate
ADEQUA RESOURCES
INTEGRATION OF HEALTH SERVICES
Difficult
mental health
COMPLEX
SHARING INFO
ISSING
RESPITE CENTRE (POST-DISCHARGE)
SAFETY FOR ALL POST-DISCHARGE
PREVENTI
SPECIFIC

Appendix

METHODS

Guided by principles of community-based participatory research (CBPR), this study examined the health and psychosocial support needs of persons with lived experience of homelessness (PWLEs) following hospital discharge. In alignment with the principles of CBPR, the Homelessness Services Association of BC (HSABC), a non-profit member driven organization representing shelter, outreach, and drop-in and other homelessness service providers secured funding and partnered with academic researchers from Simon Fraser University's Gerontology Research Centre, and Providence Health Care (PHC), a regional healthcare provider in Vancouver, BC. Representatives from these three organizations comprised the multidisciplinary research team, each providing a foundational role in decision-making across all stages of study conception to completion. In addition, a steering committee, inclusive of PWLEs and healthcare and shelter/housing providers, guided this research and provided critical feedback. Ethics approval was obtained from a University Institutional Review Board and participant names have been removed to protect identities.

The study was conducted in three phases. The first two phases of the study were part of a comprehensive needs assessment:

- The first phase involved conducting a scoping review of the health supports needed for PWLEs transitioning from the hospital to shelter/housing. This was followed by a community consultation with shelter/housing and healthcare providers to validate findings and uncover gaps in the literature.
- In the second phase, in-depth interviews were conducted with shelter/housing and healthcare providers, as well as PWLEs, to assess the needs and gaps in supporting the health of people who are experiencing homelessness as they transition from the hospital to shelter/housing. This was followed by a second community consultation to receive feedback from healthcare and shelter/housing providers, as well as PWLEs, on possible strategies and services to support PWLEs who are discharged from the hospital.

The third phase involved a case study examination of two existing shelter and transitional housing programs: St Paul's Hospital's Rooms at the Metson and the Vancouver Coastal Health (VCH) Shelter Project. In-depth interviews were conducted with program providers and participants involved in the delivery or receipt of services. Following data collection, a third community consultation was held, in which healthcare and shelter/housing providers, as well as PWLEs, discussed recommendations for improving the health and psychosocial supports for PWLEs being discharged from the hospital and transitioning into shelter/housing.

I. Needs Assessment: Scoping Review

Design

The scoping review used a methodology based on Arksey and O'Malley's (2005) work, which outlines a process for scoping reviews and was written by mental health policy researchers. A scoping review differs from a systematic review in that it is quicker, broader, and begins with a less highly focused research question. According to Arksey and O'Malley, a scoping review seeks to identify all relevant literature, but "does not seek to assess quality of evidence (p.27)." However, the methodology does call for as much rigor and transparency as possible throughout the process. Five steps provided a guiding framework for the scoping review: 1) identifying the research question; 2) identifying relevant studies; 3) study selection; 4) charting the data; and 5) collating, summarizing, and reporting the results. In addition, a sixth 'consultation' step, organized as a knowledge café, followed the initial organization of primary themes from the literature.

Literature Sources

To identify studies relevant to the research question, databases that were searched for 10 years of

publications between January 2007 and July 2017 included: Academic Search Complete; CINHAL Complete; ERIC – EBSCO; ERIC - US Government; Global Health; Google Scholar; JSTOR; MedLine w/ Full Text; ProQuest; Project Muse; PsychINFO; PubMed; Social Sciences w/ Full Text; Urban Studies Abstracts; and Web of Science. In addition, The Homeless Hub and the Greater Vancouver Shelter Strategy websites, which offer a library of research articles and reports on homelessness, including grey literature, were extensively searched for relevant literature. To access a broad range of existing literature, the research team used two keywords ("hospital" and "homeless") in all their English variations (e.g., hospital, hospitalization, hospitalized, hospitalisation, hospitalised) in the search string of titles and/or abstracts (see Table 1 for full list).

We also reviewed the bibliographies of identified publications to uncover additional publications that may not have been previously located. The initial search yielded over 1,300 publications. After duplicates were removed, 782 publication titles and abstracts were screened by two researchers for relevance for inclusion in full text review, resulting in 321 publications.

Study Selection

Two independent reviewers examined the full text of 321 publications for inclusion based on the criteria that the literature: 1) was available to the researchers and in English; 2) was available as a peer-reviewed journal article, report, or dissertation or thesis; and 3) reported primary findings on the types of health supports needed for homeless persons transitioning from hospital settings. A third researcher resolved any discrepancies between the other researchers. Based on the inclusion criteria, 309 articles were excluded because the source was an irrelevant topic = 235; ineligible publication type = 58; unavailable as a full text = 10; or published before 2007 = 2. Articles were considered irrelevant if findings were not directly related to health supports needed for homeless patients transitioning from public or private hospital settings to shelter (e.g., temporary emergency shelter), housing (e.g., short-term, transitional, temporary/interim housing), or the street. Twelve sources were included in the scoping review; as well, one additional journal article that met inclusion criteria was identified through a hand search of references, and was included in the study.

Of the 13 literature sources included in the scoping review, 7 were peer-reviewed journal articles, 4 were reports, and 2 were Master's theses. Mixed methods were used to collect data in 7 of these sources and qualitative methods were used in 6. No sources used only quantitative methods. Seven sources were based on data from the United States, 4 on data from the United Kingdom, and 2 on data from Canada. Finally, participants in these sources included persons with lived experience only (3 sources); shelter staff only (2 sources); hospital staff only (1 source); or a combination of more than one of these three participant groups (7 sources).

Thematic analysis

Two researchers independently extracted data on methodology and outcomes from the 13 studies, including study characteristics and key findings, study design, sample and size, and outcomes (Table 2). Subsequently, the two researchers, who did an initial read-through of each source for general and potential meanings, conducted thematic analysis. Low-level/descriptive coding resulted in units of text that were coded as themes and labeled with a word or phrase closely related to the research findings (Boyatzis, 1998). Through an iterative process of reading and rereading the sources, thematic codes were subject to constant comparative analysis to refine the interpretation and definition of themes and the patterns and relationships across codes (Boeije, 2002; Braun & Clarke, 2006). Six themes were derived from this thematic analysis. These were then presented and discussed during the first community consultation.

II. Health & Psychosocial Support Needs and Challenges Upon Hospital Discharge for Persons who are Experiencing Homelessness

The second phase of the study involved in-depth interviews with shelter/housing providers, healthcare providers, and PWLEs to gain their perspectives on the needs and gaps in supporting the health of people who are experiencing homelessness as they transition from the hospital to shelter/housing.

Recruitment

Multiple recruitment methods were utilized.

1. First, shelter/housing participants were recruited for interviews using an e-mail invitation sent by a project manager for HSABC based on private contact lists.
2. Second, following internal approval from two health authorities (Vancouver Coastal Health (VCH) and Providence Health Care (PHC)), healthcare participants were recruited by e-mail from e-mail lists that were accessed by a PHC Social Work Clinical Practice leader. Recruitment flyers were attached to these email invitations, which were subsequently posted on bulletin boards in approved public areas at St. Paul's Hospitals.
3. Third, members of the project steering committee, inclusive of PWLEs and healthcare and shelter/housing providers, recruited individuals from their networks.
4. Finally, PWLEs were recruited with the assistance of shelter/housing and healthcare providers who were invited to inform clients about the project and were given a flyer to share with potential participants. PWLEs received a $25 honorarium for their participation.

Inclusion criteria for participation were: older than age 19, directly deliver or receive services associated with transitions of persons experiencing homelessness from hospital to shelter/housing in Metro Vancouver, able to speak conversational English, capable of participating in an interview for up to 1 hour, and able to give voluntary and informed consent. Receipt of hospital services (i.e., having visited and been discharged from a hospital in Metro Vancouver within the last twelve months) during a period of homelessness was determined by self-report. PWLEs having multiple visits to a hospital were asked to report on their most recent visit. Written informed consent was obtained from all study participants prior to their interview.

Participants

Participants included ten shelter/housing providers, ten healthcare providers, and twenty PWLEs (Table 3). Twenty-seven study participants were female while 13 were male. All ten healthcare providers worked closely with the homeless population in hospitals across the three health authorities in Metro Vancouver, including PHC (n=5), VCH (n=3), and Fraser Health (n=2). All healthcare participants were registered social workers and worked in hospital settings, both emergency and non-emergency, or in community health centres. Of the shelter/housing participants, 4 worked in managerial or supervisory roles, 2 were employed as case managers, 2 were outreach registered nurses, and 2 were housing outreach workers. Shelter/housing participants carried out their occupational roles in shelters (n=7), non-profit organizations (n=2), and regional health authorities (n=1). PWLE participants ranged in age from 23 to 59 years old (M = 40 years old). At the time of interview, six PWLE participants were housed in a single-room occupancy hotel, four were living in a shelter, two were residing in mental health supported housing, and one was living in subsidized housing. Housing location was unknown for 7 PWLE participants.

Data Collection

Prior to data collection, interview questions were developed by the research team and subsequently reviewed and approved by the project steering committee. The interview guide incorporated questions from extant literature, though modified to fit the Metro Vancouver context, as well as others that related to homeless persons transitioning from the hospital to shelter/housing. As needed during data collection, the research team met to refine the interview guide in an iterative process. The interview agenda can be requested from the first author.

Semi-structured interviews were conducted from October 2017 to January 2018, both in person (n=24) and over the phone (n=16). Six shelter/housing participants were interviewed by phone, while the remaining were interviewed in person. All interviews with healthcare participants were conducted by phone, while all interviews with PWLE participants were conducted in-person throughout Metro Vancouver in locations convenient to the participants. The locations included a teaching and research hospital (n=7), a single-room occupancy hotel (n=6), various shelters (n=4), mental health supported housing (n=2), and a drop-in resource centre (n=1). Length of interviews for shelter/housing participants ranged

from 26 to 89 minutes (M = 53 minutes), while interviews for healthcare participants and PWLE participants lasted between 31 and 56 minutes (M = 50 minutes) and 18 and 60 minutes (M = 36 minutes), respectively. All interviews were audio recorded and transcribed verbatim.

Data Analysis

Data analysis was facilitated by qualitative data management software QSR NVivo and were analyzed using thematic analysis (Braun and Clarke, 2006):

1. Researcher familiarization with the data, which involved the reading and re-reading of transcripts.
2. Initial generation of codes and examination of patterns of meaning in the data.
3. Organization and arrangement of identifiable codes within themes.
4. Review and refinement of themes, including further organization by removing, separating, and collapsing themes through consultation with the project team.
5. Defining and naming a final set of themes.
6. Review of the emerging themes with the steering committee.

III. Case Study of Existing Hospital-to-Shelter Programs

The third phase of the study involved in-depth interviews with shelter/housing providers, healthcare providers, and PWLEs affiliated with two existing hospital-to-shelter transition programs that operate in Metro Vancouver: the St. Paul's Rooms at the Metson and the VCH Shelter Project (at the Triage and Yukon shelters).

Recruitment

Two recruitment methods were utilized.

1. First, managers and staff of the St. Paul's Rooms at the Metson and the VCH Shelter Project were sent e-mail invitations by a project manager for HSABC based on their role in the management or delivery of the programs.
2. Second, recruitment flyers were mailed and hand-delivered to program participants who had recently been discharged from the St. Paul's Rooms at the Metson and the priority shelter beds at the Yukon or Triage Shelter. Additionally, the SPH-designated social worker contacted recently discharged Metson clients by telephone to get permission to mail them a recruitment flyer. Shelter providers at the Yukon and Triage also shared recruitment flyers with current program participants. Program participants who wanted to participate directly contacted the project team to express interest in the study. Program participants received a $25 honorarium for their participation.

Inclusion criteria for participation was: older than age 19, directly deliver or receive services associated with transitions of persons from the hospital to the Yukon or Triage Shelter as part of the VCH Shelter Project or the St. Paul's Rooms at the Metson; able to speak conversational English; capable of participating in an interview for up to 1 hour; and able to give voluntary and informed consent. One program participant who was approached to participate appeared to be under the influence of a substance and unable to provide full consent to participation, so he was excluded from the study. Written informed consent was obtained from all study participants prior to the interview.

Participants

Participants included six shelter/housing providers, two healthcare providers, and ten program participants (Table 4). Seven study participants were female while eleven were male. PWLE participants ranged in age from 31 to 74 years old (M = 50 years old). At the time of the interviews, four PWLE participants were housed in permanent housing, one was living in transitional housing, and five were residing in a shelter.

Data Collection

Interviews with providers affiliated with each of the three sites ['provider participants'] explored the following questions: How the projects started, how the partnerships between the shelters and health organizations developed, who initiated the projects and who else was involved in the process. Our overarching research question was: What has been your experience in partnering with healthcare or shelter providers to deliver these programs? Interviews with program participants were based on

the research question: What was your experience with the VCH Shelter Project (or the St. Paul's Rooms at the Metson) and how has your health and housing situation changed as a result of this project?

Semi-structured interviews were conducted with participants from June 2018 to December 2018 in-person (n=12) and over the phone (n=6). Six provider participants were interviewed by phone, while two were interviewed in person. All PWLE interviews were conducted in-person throughout Metro Vancouver in participants' housing locations (except for one PWLE who was interviewed at a hospital). Length of interviews for provider participants ranged from 19 to 37 minutes (M = 29 minutes), while PWLE participant interviews lasted between 10 and 62 minutes (M = 23 minutes). All interviews were audio recorded and transcribed verbatim.

Data Analysis

Similar to data analysis for Phase 2, data analysis was facilitated by qualitative data management software QSR NVivo and were analyzed using thematic analysis (Braun and Clarke, 2006):

1. Researcher familiarization with the data, which involved the reading and re-reading of transcripts.
2. Initial generation of codes and examination of patterns of meaning in the data.
3. Organization and arrangement of identifiable codes within themes.
4. Review and refinement of themes, including further organization by removing, separating, and collapsing themes through consultation with the project team.
5. Defining and naming a final set of themes.
6. Review of the emerging themes with the steering committee.

Community Consultations

After each phase of the research study, a community consultation was held to bring together diverse, cross-sectoral stakeholders in an informal setting to engage in a creative, in-depth conversation and to exchange ideas and experiences around a topic of mutual interest. These consultations were built on the premise that a deeper collective understanding of a subject can be gained through exploring multiple perspectives and building a consensus around an issue (Brown, Homer, & Isaacs, 2009). Designed to foster open and relaxed dialogue in a casual setting, these consultations were held in a community space decorated with a café ambiance and refreshments (Brown, Homer, & Isaacs, 2009). The first community consultation was designed as a Knowledge Café, while the second and third were designed as World Cafés.

Healthcare and shelter/housing stakeholders were recruited to participate in the community consultations through recruitment emails sent by a PHC Social Work Clinical Practice leader and a project manager for HSABC to private contact lists. Anyone interested in participating in the workshop was invited to attend regardless of their level of knowledge or experience.

Each of the community consultation was organized into four consecutive rounds of 25-minute small group discussions. During each discussion round, participants were given the opportunity to discuss and critique information shared by the research team as well as reflect on the ideas of other participants. Table discussions were guided by a set of that had been formulated in collaboration with the steering committee and prompted participants to provide experiential evidence. While each workshop was facilitated by an academic researcher (the 'café host'), concurrent roundtable discussions were led by an assigned facilitator from the research team ('table hosts') and volunteer note-takers who remained at the same table throughout the duration of the workshop.

At all three community consultations, note-takers and audio recorders captured the table discussions. At the end of the consultation, each table host provided a summary of their table's conversation to the large group. Following each workshop, participants were asked to complete an evaluation form and provide feedback on the delivery of the workshop and information learned. Workshop data were transcribed and de-identified to protect identities. All participants provided written informed consent and permission to be audio recorded; and PWLEs were provided with an honorarium for their participation.

Each community consultation had different objectives and different participants (Table 5). However, each cafe was organized and designed with specific goals in mind:

1. Community consultation 1 sought to 1) validate findings from the scoping review that identified the types of health supports needed for persons experiencing homelessness who are discharged from the hospital; and 2) uncover gaps in the existing literature by drawing on the expertise of healthcare and shelter/housing providers. Of the 23 participants who attended this community consultation, 16 were shelter staff and 7 were healthcare staff.
2. Community consultation 2 sought to 1) present possible solutions for supporting persons who are experiencing homelessness and are being discharged from the hospital; and 2) get feedback from healthcare and housing/shelter providers on how to take action to support individuals experiencing homelessness as they are discharged from the hospital. Of the 23 participants who attended this community consultation, 16 were shelter staff and 6 were healthcare staff; there was 1 participant who was a PWLE who is a member of the project steering committee.
3. Community consultation 3 sought to 1) prioritize recommendations for supporting persons who are experiencing homelessness and are being discharged from the hospital; 2) identify related existing best practices, if any; and 3) identify short-term and long-term actions and relevant stakeholders for these recommendations. Of the 26 participants who attended this community consultation, 18 were shelter staff and 6 were healthcare staff; there were 2 participants who were PWLEs, who were members of the project steering committee.

TABLE 1. SCOPING REVIEW DATABASES, SEARCH ENGINES, AND CONTENT-RELEVANT WEBSITES

Databases, search engines, and content-relevant websites	*Search string used*
Academic Search Complete	(ab(hospital*) OR ti(hospital*)) AND (ti(homeless*) OR ab(homeless*))
CINHAL Complete	(ab(hospital*) OR ti(hospital*)) AND (ti(homeless*) OR ab(homeless*))
ERIC - EBSCO	(ab(hospital*) OR ti(hospital*)) AND (ti(homeless*) OR ab(homeless*))
ERIC - US Government	((abstract:hospital*) OR (title:hospital*)) AND ((title:homeless*) OR (abstract:homeless*))
Global Health	(ab(hospital*) OR ti(hospital*)) AND (ti(homeless*) OR ab(homeless*))
Google Scholar+	allintitle: (hospital OR hospitalization OR hospitalisation OR hospitalizations OR hospitalisations OR hospitalized OR hospitalised OR hospitals) (homeless OR homelessness)
Greater Vancouver Shelter Strategy website	one targeted report
JSTOR	(ti:hospital* OR tb:hospital* OR ab:hospital*) AND ((ti:homeless* OR tb:homeless*) ab:homeless*)
MedLine w/ Full Text	(ab(hospital*) OR ti(hospital*)) AND (ti(homeless*) OR ab(homeless*))
ProQuest	(ab(hospital*) OR ti(hospital*)) AND (ti(homeless*) OR ab(homeless*)); publication type: (Scholarly Journals OR Dissertations & Theses OR Other Sources OR Reports) NOT (Newspapers AND Wire Feeds AND Trade Journals AND Magazines AND Historical Newspapers)

Project Muse+	the term [hospital*] in title, and the term [homeless*] in title
PsychINFO	(ab(hospital*) OR ti(hospital*)) AND (ti(homeless*) OR ab(homeless*))
PubMed	(homeless*[Title/Abstract]) AND hospital*[Title/Abstract])
Social Sciences w/ Full Text	(ab(hospital*) OR ti(hospital*)) AND (ti(homeless*) OR ab(homeless*))
The Homeless Hub website	hospital*
Urban Studies Abstracts	(TI hospital* OR AB hospital*) AND (TI homeless* OR AB homeless*)
Web of Science+	TI=homeless* AND TI=hospital*

Note: ti=title; ab=abstract
+Only titles searched in these databases

TABLE 2. SCOPING REVIEW LITERATURE SOURCES, STUDY CHARACTERISTICS, AND MAIN FINDINGS

Author (year): Title	Publication type (Journal name)	Country	Sample	Methods	Main Findings
Albanese et al. (2016): Towards an integrated approach to homeless hospital discharge	Peer-reviewed article (Journal of Integrated Care)	UK	PWLE (project patients); project staff	Mixed Method	Lack of discharge details in advance leads to rushed discharge process; creates distress and uncertainty around after-care Integrated housing and clinical staff produce better outcomes Availability of accommodation improves housing stability
Drury (2008): From homeless to housed: Caring for people in transition	Peer-reviewed article (Journal of Community Health Nursing)	US	PWLE (homeless, mentally ill adults)	Qualitative	Homeless persons in absolute destitution are often discharged without basic needs (housing, money, food, clothing) which existing systems of care cannot meet Intensive monitoring and support allows homeless clients with multiple co-occurring disabilities to maintain housing
Greysen et al. (2012): Understanding transitions in care from hospital to homeless shelter: A mixed-methods, community-based participatory approach	Peer-reviewed article (Journal of General Internal Medicine)	US	PWLE (recently discharged and currently homeless)	Mixed Method	Communication and coordination between hospital and shelter at discharge is lacking Safe transportation upon hospital discharge is lacking Patients' expectations of suboptimal coordination exacerbate delays in seeking care Hospital staff should assess patients' housing status
Greysen et al. (2013): Improving the quality of discharge care for the homeless: A Patient-centered approach	Peer-reviewed article (Journal of Health Care for the Poor and Underserved)	US	PWLE (recently discharged and currently homeless)	Mixed Method	Fear of inferior treatment prevents homeless patients from disclosing housing status to hospital staff Assessment of housing status by hospital staff is associated with higher patient-reported quality of discharge care Hospital staff should emphasize concern for patients' well-being and safety when assessing housing status

Hauff et al. (2014): Homeless health needs: Shelter and health service provider perspective	Peer-reviewed article (Journal of Community Health Nursing)	US	Shelter and health staff	Qualitative	Appropriate places for discharge are scarce Homeless patients may lack the ability to access appropriate resources and navigate the healthcare system after discharge To better care for discharged patients, shelters require medical and shelter staff, clean space, supplies, and resources Patients' medications are often lost, stolen, or unaffordable Case management personnel, shelter nurses, and adequate transportation funding are needed Healthcare providers require improved cultural competence and understanding of trauma informed care
Lamanna et al. (2017): Promoting continuity of care for homeless adults with unmet health needs: The role of brief interventions	Peer-reviewed article (Health and Social Care in the Community)	Canada	Program service users and staff; PWLE; service providers	Qualitative	Services for traumatic brain injury and mental health are lacking and limit immediate and long-term services Multi-service agencies with integrated case management and primary and mental healthcare can mitigate a lack of comprehensive immediate and long-term services Individualized, low-barrier services and long-term services that promptly follow discharge and get results promote help-seeking and improve continuity of care Planning for patient's individualized and long-term service needs requires knowledgeable, welcoming and engaged staff Patients need and value advocacy and support to independently manage and coordinate unmet needs
Raven et al. (2010): Substance use treatment barriers for patients with frequent hospital admissions	Peer-reviewed article (Journal of Substance Abuse Treatment)	US	Medicaid-insured inpatients; staff	Mixed Method	Homeless patients experience stigma and discrimination and distrust providers as a result of past negative experiences Lack of direct transportation at discharge to after-care for substance use is a barrier to treatment Managing the intensive needs of patients with complex medical and social problems, such as substance abuse, is difficult during relatively brief hospital admissions Programs for medically ill patients with substance use are lacking
Bear (2007): Hospitals discharging patients to emergency homeless shelters in Allegheny County, Pennsylvania: An ecological perspective	Thesis (Master's)	US	Shelter staff and administrators	Qualitative	Reliable, complete, and timely communication between hospital and shelter staff could reduce inappropriate discharges (ie. when patients are transferred from hospitals to shelters despite the shelter's inability to support patient care) Homeless clients are discharged to shelters with complex medical and medication instructions or no instructions at all Hospital staff need better understanding of homelessness

Stallworth (2007): Assessment of hospital discharges to emergency homeless shelters in Allegheny County, PA	Thesis (Master's)	US	Shelter staff and administrators	Qualitative	Reliable, complete, and timely communication between hospital and shelter staff could reduce inappropriate discharges (ie. when patients are transferred from hospitals to shelters despite the shelter's inability to support patient care) Homeless clients are discharged to shelters with complex medical and medication instructions or no instructions at all Hospital staff need better understanding of homelessness Shelters require medical and shelter staff, clean space, supplies, and resources to better care for discharged patients Unmanaged mental health problems can harm patients, disrupt shelter environments, and be stressful for shelter staff
Greater Vancouver Shelter Strategy (2016): Health supports for shelters serving seniors: Needs assessment	Report	Canada	PWLE (older adults); shelter staff	Mixed Method	Nursing, foot care, hygiene, and medication administration support would enable shelter staff to better serve clients Senior clients recommend having a nurse who visits shelters on a weekly basis to provide education on seniors' health issues
Homeless Link (2012): Improving hospital admission and discharge for people who are homeless	Report	UK	PWLE; shelter and hospital staff	Qualitative	Support for complete after-care needs at discharge is lacking Lack of information on clients frustrates outreach and housing staff who can then not best support clients Not knowing discharge details in advance rushes the discharge process and creates distress and uncertainty around after-care Safe transportation at hospital discharge is lacking Rehabilitation beds at hospital discharge are lacking Provider training in homelessness could improve treatment of and respect for the needs of homeless people Housing assessment at hospital admission is needed to best prepare for hospital discharge Homeless patients report poor health at discharge and associate early or inappropriate discharges with worsening health Homeless clients are discharged to shelters with complex medical and medication instructions or no instructions at all Discrimination can lead to lack of priority and poor treatment

Healthwatch England (2015): Safely home: What happens when people leave hospital and care settings	Report	UK	PWLE; homelessness organizations	Mixed Method	Inadequate discharge coordination between health and housing settings affects recovery and can put patients in unsafe situations Support for complete after-care needs at discharge is lacking Not knowing discharge details in advance rushes the discharge process and creates distress and uncertainty around after-care Safe transportation at hospital discharge is lacking After-care for certain patients can be scarce Patients need and value assistance in navigating the service system and in advocating for and coordinating needed services Homeless clients are discharged to shelters with complex medical and medication instructions or no instructions at all Discrimination can lead to lack of priority, poor treatment, and self-discharge prior to treatment completion
The Queen's Nursing Institute (2015): What community nurses say about hospital discharge for people who are homeless	Report	UK	Hospital nurses	Mixed Method	Appropriate accommodation or step-down care for the homeless population transitioning from hospital is lacking Hospital staff need better understanding of homelessness

Note: PWLE = Persons with lived experience

TABLE 3: HEALTH NEEDS INTERVIEW PARTICIPANT CHARACTERISTICS

Housing Service Providers	***n=10***
Gender	
Female	8
Male	2
Job Title	
Manager/Supervisor	4
Outreach – Registered Nurse	2
Outreach - Housing	2
Case Manager	2
Organization	
Shelter	7
Non-Profit Organization	2
Regional Health Authority	1

Healthcare Providers	***n=10***
Gender	
Female	9
Male	1
Job Title	
Social Worker (MSW RSW)	10
Hospital setting	8
Primary Outreach Services	2
Health Authority affiliation	
Providence Healthcare	5
Vancouver Coastal Health	3
Fraser Health	2

Persons with Lived Experience	***n=20***
Gender	
Female	10
Male	10
Age	*M*=40 years
<30	3
30-39	7
40-49	1
50-59	8
*Housing Location at time of Interview**	
Unknown	7
SRO Hotel	6
Shelter	4
Mental Health Supported Housing	2
Subsidized Housing	1

*Data missing for 7 participants

TABLE 4: CASE STUDY PARTICIPANT CHARACTERISTICS

Providers	***n=8***
Gender	
Female	5
Male	3
Job Title	
Manager/Supervisor	2
Director/Executive Director	4
Social Worker (MSW RSW)	1
Case Manager	1
Persons with Lived Experience	***n=10***
Gender	
Female	2
Male	8
Age	*M*=50 years
30-39	2
40-49	2
50-59	4
60-69	2
Housing Location at time of Interview	
Permanent Housing	4
Transitional Housing	1
Shelter	5

TABLE 5: COMMUNITY CONSULTATION PARTICIPANT CHARACTERISTICS

Community Consultation 1	
Shelter/housing staff	16
Healthcare staff	7
Total	***N=23***
Community Consultation 2	
Shelter/housing staff	16
Healthcare staff	6
Persons with Lived Experience	1
Total	***N=23***
Community Consultation 3	
Shelter/housing staff	18
Healthcare staff	6
Persons with Lived Experience	2
Total	***N=26***

GLOSSARY

Activities of daily living (ADLs): Basic activities that are considered necessary to independent living, include bathing, dressing, toileting, mobility and transferring, and feeding oneself (Katz, Ford, Moskowitz, Jackson, & Jaffe, 1963; World Health Organization (WHO), 2004)

After-care: The care and treatment of a patient after discharge from a hospital or other healthcare facility often as part of a discharge plan. Also referred to as follow-up care (Farlex Partner Medical Dictionary, 2012).

Canada Pension Plan (CPP): Provides financial support to contributors throughout Canada (except Québec, which has the Québec Pension Plan) and their families, based on their accumulated contributions, in the event of retirement, disability, or death (Government of Canada, 2018). https://www.canada.ca/en/services/benefits/publicpensions/cpp.html

Case management: A collaborative, client-driven, goal-oriented process for providing PWLEs with quality health and support services within a complex health, social, and fiscal environment (National Case Management Network of Canada, 2009).

Client-centered care: A complementary approach to patient-centered care; as opposed to 'doing for' clients, client-centered care aims to amend the professional-client relationship by involving clients in managing their own health and healthcare with the aim of improving autonomy and agency (Brown, McWilliam, & Ward-Griffin, 2006).

Continuum of care: The range of healthcare services from primary, secondary, tertiary, community, and home-based services which span over the life course (Canadian Medical Association, 2010).

Decompensation: A term used by medical and mental health professionals to refer to the deterioration of the mental or physical health of an individual, which had hitherto been maintained (Disability Secrets, n.d.).

Downtown Eastside (DTES): A community in Vancouver, generally described geographically as bordered by Richards Street to the west, Clark Drive to the east, Prior Street to the south, and the Burrard Inlet to the north. Residents report a strong sense acceptance and belonging in the neighbourhood, which has struggled with complex socioeconomic challenges such as drug use, crime, homelessness, housing issues, unemployment, and loss of business (City of Vancouver, 2018).

Harm reduction: Although there is no universally accepted definition of harm reduction, the harm reduction approach refers to policies, programs, and practices that focus on positive change without judgement, discrimination, or requiring people to stop using substances as a precondition of support and aim to reduce negative health, social, and legal risks related to substance use (Harm Reduction International, 2019).

Homelessness: A state of being without permanent or appropriate housing, or being at immediate risk of losing one's current housing, which includes those living on the streets, in places not intended for human habitation, in emergency shelters, or with family or friends on a non-permanent basis (Gaetz et al., 2012).

Home and community care (also referred to as home care or home health): Services delivered by regulated healthcare professionals (e.g., nurses), non-regulated workers, volunteers, friends, and family caregivers, to help people receive care at home, rather than in a hospital or long-term care facility, and to live as independently as possible in the community. Services could include nursing, personal care (i.e., help with bathing, dressing, and feeding), physiotherapy and occupational therapy, speech therapy, social work, dietician services,

homemaking, and respite services (Government of Canada, 2016).

Housing Continuum: A sequence, or progression, of housing ranging from low assistance (i.e. homeownership and private market rentals) to high assistance (i.e. emergency shelter, transitional supportive housing, and assisted living). For information on supply across the continuum see BC Housing's housing continuum diagram here (BC Housing, 2019).

Housing First: An approach that aims to end chronic homelessness by providing immediate access to permanent housing and working with program participants to promote ongoing recovery and wellbeing. Core principles of Housing First include immediate access to housing with no housing readiness requirements; consumer choice and self-determination; individualized, client-driven, and recovery-oriented supports; separation of housing and services; harm reduction; and community integration (Polvere et al., 2014). http://housingfirsttoolkit.ca/wp-content/uploads/Module1-Overview.pdf

Instrumental activities of daily living (IADLs): Tasks that allow an individual to live independently in the community, such as food preparation and grocery shopping, taking prescribed medications, maintaining a clean home, mobility within a community, and managing finances (Lawton & Brody, 1969; WHO, 2004)

Integrated Case Management (ICM): Professional teams that serve individuals with substance use and mental health issues by addressing their health, social, and housing needs. ICM teams can include clinicians, nurse practitioners, addiction physicians, psychiatrists, and housing outreach workers; and services can include housing support, access to medical care, substance use counselling, life skills support, grocery shopping, connection to community resources and income assistance, money management, and medication assistance (Fraser Health, n.d.).

Low-barrier: Low or minimal barrier shelter/housing and services means providers minimize eligibility requirements (e.g., there is not a prerequisite on persons for abstinence from substances, pets are allowed, couples are allowed) to ensure their services are as accessible and user friendly as possible. It should be noted, however, that low or minimal barrier does not mean there are no rules or behaviour expectations of people accessing services and each service and shelter/housing provider may define their approach differently. (BC Partners for Mental Health and Addictions, 2007).

Medical respite (also referred to as intermediate or convalescent care): Post-acute medical care for homeless persons who are too ill or frail to recover from a physical illness or injury on the streets, but who are not ill enough to be in a hospital (Doran et al., 2013; National Health Care for the Homeless Council, 2011).

Medical Services Plan (MSP): The public health insurance in BC which covers the cost of medically-necessary and insured health care services. BC residents pay monthly premiums which contribute to the costs of healthcare in the province. Premium assistance is offered to BC residents who have financial need (adjusted net income less than $42,000) and are unable to afford to pay the regular premium (Government of BC, n.d.). https://www2.gov.bc.ca/gov/content/health/health-drug-coverage/msp

Modular housing: Temporary housing that can be constructed more quickly than permanent housing and provides supports for residents, such as life skills training, as well as health and social services. In Vancouver, temporary modular housing has been developed as a response to the housing crisis (City of Vancouver, 2019).

Naloxone: A medication available without a prescription in British Columbia, which can be administered to an individual experiencing an opioid overdose to immediately reverse the effects (Toward the Heart, 2018).

Old Age Security (OAS): A Government of Canada pension program that provides supplemental income to eligible lower-income Canadian residents over 65 in the form of a monthly payment (Government of Canada, 2018). https://www.

canada.ca/en/services/benefits/publicpensions/cpp/old-age-security.html

Occupational therapists: Occupational therapists provide a wide range of services to individuals who are dealing with injury, chronic conditions, cognitive impairment, or mental health issues and require support in order to lead independent lives. The services offered include: (i) assistance and training with activities of daily living (ADLs), instrumental activities of daily living (IADLs); (ii) physical exercise; (iii) assessment and training for using assistive devices; and (iv) guidance for caregivers and family (HealthLinkBC, 2017).

Patient-centered care: A complementary approach to client-centered care; service provision for patients that involves individual choice based on unique, individualized needs and challenges, with the aim of promoting agency and autonomy in one's own health management (Pauly, Reist, Schactman, & Belle-Isle, 2011).

Persons With Disability (PWD): A government-designated title for an individual who has a severe mental or physical disability that is, in the opinion of a medical practitioner or nurse practitioner, likely to continue for at least two years, directly and significantly restricts the person's ability to perform daily living activities, and as a result of those restrictions, the person requires an assistive device, the significant help or supervision of another person, or the services of an assistance animal to perform daily living activities (Government of BC, n.d.). https://www2.gov.bc.ca/gov/content/family-social-supports/services-for-people-with-disabilities/disability-assistance

Precarious Housing: A housing situation that is untenable because it is not affordable, it is over-crowded, and/or it is unsafe or does not meet public health standards (Wellesley Institute, 2010).

Psychosocial Assessment: Psychosocial assessments are completed by hospital-based social workers. They are patient-centred, strengths-based, and comprehensive in scope. They include bio-psycho-social-spiritual dimensions and are intended to identify what patients want/need for a functional and safe discharge from the hospital. Interventions and plans are implemented to support these goals (Graybeal, 2001).

Social Housing: Social or non-market housing is typically subsidized by government and targeted to low-income renters who can live independently. Rents are based on 30% of household income (BC Housing, 2019). https://www.bchousing.org/glossary#S

Subsidized Housing: Long-term housing for which the provincial government provides financial support or rent assistance (BC Housing, 2019).

Supportive Housing: Subsidized housing with both onsite and off-site services and supports, to ensure the health needs of tenants are met and housing stability is maintained. The housing is typically targeted to individuals with mental health and substance use issues (Metro Vancouver Regional Housing, 2012).

Single Room Occupancy (SRO): A type of housing where the residence consists of a single room in a shared building that has shared facilities (BC Housing, 2019). https://www.bchousing.org/glossary#S

Trauma-informed care: Trauma-informed care is a framework that orients the delivery of care and services in various settings which places a priority on individual safety, choice, and control to promote a care culture of nonviolence, learning, and collaboration (Arthur et al., 2013).

Welfare (also referred to as social assistance): Income assistance provided by the government as a social safety net to individuals and families to meet basic needs. Each province and territory in Canada has its own welfare system (Government of Canada, 2009).

Wrap-around support (also referred to as wrap-around care): A philosophy of care in which a co-ordinated team of informal and formal supports collaboratively develop and implement a comprehensive healthcare plan for an individual using a strengths-based and client-centered approach, usually in one location (Homeless Hub, 2018).

COST-BENEFIT ANALYSIS LITERATURE REVIEW

Prepared by Brett Dimond for HSABC

Homelessness costs Canadian taxpayers between $4.5 and $6 billion annually (Laird, 2007). In Calgary, the annual cost of serving homelessness is $72 million, while in Edmonton, the cost is $51.8 million (IBI Group, 2004). And in British Columbia, it costs $30,000 to $40,000 annually to support one homeless person (Eberle et al., 2001). As demonstrated by these figures, the persistence of homelessness imposes significant costs on society. As Gaetz (2012) reminds us, "the status quo is actually really expensive (p. 3)." As a deliverable for the research project, "Supporting Partnerships Between Health and Homelessness," we have reviewed the literature in order to articulate the costs of hospital stays by homeless individuals who lack adequate housing, healthcare, and other supports. This review initially reviewed four articles to achieve this goal and subsequently expanded the review to other literature.

Persons experiencing homelessness are heavy utilizers of emergency rooms, tertiary treatment, psychiatric institutions, and emergency shelters. In many cases, these options are more costly to government and result in less effective outcomes for the individual, or society in general, than would more purposeful preventive and supportive options (Pomeroy, 2005; Shapcott, 2007). Rather than rely on these reactive and costly support systems, better outcomes could be achieved through proactive programming (Pomeroy, 2005). As Gaetz (2012) asks:

> Does our current approach actually save us any money, or is it cheaper to address the root causes of homelessness? That is, is it more cost effective to house people and/or prevent them from becoming homeless in the first place, than to let people languish in a state of homelessness, relying on emergency shelters and day programs? (pg. 2)

Costs of Institutional and Emergency Services

People experiencing homelessness have been documented as having higher rates of emergency room use (Chambers et al., 2013; Kushel et al., 2002). Hwang and Henderson (2010) found that, as a result of their less frequent use of this type of healthcare service, the total cost of emergency-room visits by non-homeless persons was only 13% of homeless persons' costs. Similarly, in the United Kingdom (UK), overrepresentation of homeless patients in unscheduled care costs the National Health Service eight times more than the general population (Faculty for Homeless and Inclusion Health, 2013).

Hwang and Henderson (2010) estimated the total annual cost of hospitalizations among the general population at 21% of the cost of people experiencing homelessness. After adjusting for covariates, Hwang et al. (2011) found that homeless patient admissions cost $2,559 per patient more than the general population. One factor explaining higher healthcare costs among people experiencing homelessness is their high rate of hospitalization (Bharel et al., 2013; Russolillo et al., 2016; Sadowski et al., 2009). Martell et al. (1992), found that people experiencing homelessness were admitted to the hospital five times more often than the general population. Moreover, Hwang and Henderson (2010) found that office visits among the homeless population were 1.7 times higher for single males, 1.9 times higher for single females, and 1.8 times higher for family adults.

Homeless persons also tend to have longer hospital stays than the general population: 2.32 days longer in acute care and 1.14 days longer in alternate level of care (Hwang et al., 2011). In New York City, Salit et al. (1998) found that homeless patients stayed an average of 4.1 days (36%) longer in hospital than their housed, low-income counterparts. Costs of additional days per discharge averaged $4,094

for psychiatric patients and $2,414 for all patient groups. Since inpatient care is so expensive, even modest differences in use can translate into substantially different rates (Goering et al. 2012).

People with severe and persistent mental illness often experience homelessness (Goering et al., 2000), and homeless persons are more likely to be admitted to the hospital for mental illness or substance misuse (Bonin et al., 2010; Fazel et al., 2008). These patients tend to have high healthcare costs. Rosenheck and Seibyl (1998) found that the average annual cost of care for homeless veterans with mental health and/or substance misuse issues was $3,196 higher than that for housed patients from the same subgroups. The higher costs were explained by the greater use of inpatient services both before and after participation in general psychiatry and substance-misuse programs. Hwang et al. (2011) found that homeless psychiatric patients cost $1,058 more per admission than housed patients, even after adjusting for length of stay. They postulated this result is likely explained by disease severity at admission and could reflect the limited availability of community mental health services for people experiencing homelessness (Hwang et al., 2011; Kirby & Keon, 2006; White et al., 2014).

Savings through Preventive Approaches to Homelessness

Shifting from a reactive, response-based approach to homelessness—one heavily reliant on emergency services—to a proactive, prevention-focused approach can, if implemented correctly, save money (Gaetz, 2012; National Council on Welfare, 2011). A core tenet explaining the potential for preventive approaches to result in cost savings is that, while homelessness in general is expensive, chronic homelessness is particularly expensive (Gaetz 20126; Pomeroy, 2005). In Calgary, the annual cost of supports—including healthcare, housing, and emergency services—for the chronically homeless was $134,642, compared to $72,444 for the transiently homeless (Calgary Homeless Foundation, 2008). In their study of people experiencing chronic homelessness with mental illness and/or substance-misuse issues in Vancouver, Russolillo et al. (2016) found that, over a 10-year period, average rates for annual hospital admission increased from 0.3 to 1.2 per person per year, and annual average rates for length of stay in hospital increased from 2.4 to 16.9 days per person per year. Not only did the number of admissions increase, but the length of stay per admission increased drastically resulting in higher costs.

Various preventive approaches to addressing homelessness have been piloted in an attempt to improve outcomes and reduce costs. A 3-year care-management pilot program, initiated in New York City, targeted complex and costly Medicaid patients (Evans, 2012). Preliminary results for homeless patients in the pilot showed a reduction in monthly Medicaid spending by one-fifth (from $855 to $3,426) per person. Overall, hospitalizations dropped by 47%, and emergency room visits fell by over half. Spending for hospital care fell by 27% and emergency room spending by 30% (Evans, 2012). In an evaluation of a Super Supported Independent Living (SSIL) program, a support program targeted to individuals with serious and persistent mental illness that offered participants access to housing and wrap-around support services, the MPA Society found that pre- and post-SSIL total bed-days used per year declined from 1,293 to 340. The number of bed-days in a short-stay psychiatric crisis treatment center also declined from 48 to 31 days. All 15 clients secured an independent apartment within one year, and 13 out of 15 maintained their ability to live independently in the community (MPA Society, 1999).

A study examining the effectiveness of an Assertive Community Treatment program in Ontario found a reduction in total bed-days from an average of 86 days in each of the two years prior to program enrollment to 28 days in the first year after enrollment and 15 days four years after enrollment. The program also witnessed 67% more clients living in a home of their own after enrollment. Individuals living in a private residence or non-profit housing increased 45% and 114%, respectively, while those that were experiencing homelessness or living in institutions declined 64% and 84%, respectively (Ontario Ministry of Health and Long-Term Care Technical Advisory Panel, 2004).

Given that people experiencing homelessness have higher rates of hospital readmission compared to the general population (Martell et al., 1992; Doran et al., 2013), developing a safe and effective hospital-discharge protocol can provide immense financial benefits to hospitals (Social Planning, Policy, and Program Administration, 2013; Gaetz 2012). A discharge model implemented in New York City, which involved hospitals hiring housing coordinators to assist homeless patients navigate housing subsidy applications, saw spending for both hospital and emergency room care reduced by 27% and 30%, respectively (Evans, 2012). The Hospital Discharge Project at Arrowe Park Hospital in Wirral, UK estimated savings of £45,000 due to a reduction in delayed discharges for 27 patients experiencing homelessness/housing issues over a 6-month period in 2011 (Homeless Link and St. Mungo's Peer Researchers, 2012). Insufficient discharge planning, including not completing a housing-status evaluation while hospitalized, have been associated with increased days spent hospitalized among the homeless (Greysen et al., 2013). Russolillo et al. (2016) highlighted specific diagnostic risk factors associated with hospital admission and length of stay. Use of screening questionnaires to identify these risk factors upon hospital admission could be an effective way to facilitate appropriate interventions and reduce costs.

The London Pathway pilot program in London, UK utilized a specialist health nurse practitioner to help secure housing for homeless patients prior to discharge. The resulting 3.2-day reduction in patients' average length of stay saved the hospital £100,000 per year in net costs (Homeless Link and St. Mungo's Peer Researchers 2012). This outcome is consistent with the Regional Municipality of Waterloo's assertion that "the costs associated with hiring housing or discharge coordinators is negligible when compared with the cost savings they will provide to the hospital" (Social Planning, Policy, and Program Administration, 2013, p. 7).

The Access Project was an initiative designed to facilitate the discharge of up to 125 mental health patients at Riverview Hospital in BC by enhancing the capacity of lower-mainland secondary mental health services. The Project witnessed a significant reduction in psychiatric care facility readmission rates, from a previous rate of 25% to 7.5% 29 months after program completion. The total annual investment per discharged patient was $28,000 per year (BC Mental Health Society, 2004), which is more cost effective than individuals falling into homelessness or being cared for in a psychiatric-care facility.

An alternative to keeping homeless patients in expensive alternate level of care hospital beds, respite care facilities, which consume far fewer resources per patient per day than acute-care facilities, have the potential to reduce overall healthcare costs for people experiencing homelessness (Hwang et al., 2011). In medical respite patients experiencing homelessness who receive respite care typically spend fewer days hospitalized than those who do not (Buchanan et al., 2006; McGuire & Mares, 2000).

Savings through Housing

The transitional and supportive capacity within the homelessness system is currently insufficient in Canada (Gaetz, 2012; Pomeroy, 2005). Being unable to transition shelter clients into transitional or supportive housing results in extended stays in emergency shelters, typically at higher cost (City of Toronto Auditor General, 2004; Pomeroy, 2005). Supportive housing can alleviate demand and pressure across an institutional and emergency system (Pomeroy 2005) and produce significant cost savings (Berry et al., 2003; Patterson et al., 2007; Shapcott, 2007; The Lewin Group, 2004). Culhane et al. (2002) found that persons placed in supportive housing experienced marked reductions in shelter use, hospitalization, and time incarcerated, with a 40% reduction in the total cost of services utilized. Poulin et al. (2010) found that the cost of supportive housing for the chronically homeless was substantially offset by the reduced use of acute-care services. Eberle et al. (2001) calculated cost savings of 30% through the provision of stable housing. Goering et al. (2012) saw an average annual savings of $2,184 due to reduced inpatient stays. For high-service users, average annual savings reached $25,899. Palermo et al. (2006) predicted that investments in social housing in Halifax would generate per person savings of 41%.

Pomeroy (2005) examined the relative cost of addressing homelessness through institutional and emergency-response systems compared to purposefully-designed, community-based supportive and affordable housing in four Canadian cities. Overall, he found that costs tended to be significantly higher for both institutional services and emergency responses than for community-based residential options, even with a fairly high level of service provision in the latter. This pattern holds even when estimates account for the costs of developing new facilities. Under this scenario, supportive housing with a high level of support involves 70% of the cost of institutional tertiary care, and the cost of supportive or permanent housing with minimal supports ranges between 30% to 73% of the cost of operating emergency shelters. Savings for emergency shelters are especially pronounced when families can be diverted into residential options.

Pomeroy (2005) claims that the cost advantage of supportive and affordable housing options becomes especially meaningful in addressing future demand, which will inevitably increase as populations expand. Directing new investments to lower-cost supportive options is likely to be more cost efficient than investing in institutional and emergency responses. As current resources are consumed by existing facilities, and these are operated and funded in different jurisdictions and by different departmental budgets, increased cross-sectoral collaboration and capital planning between health and social-service ministries, along with housing providers, will be required to implement these options.

Averaged across the study's four cities, Pomeroy (2005) calculated the following annual per-person costs in existing responses to homelessness. Institutional responses, including prison/detention facilities and psychiatric hospitals, ranged from $66,000 to $120,000. Emergency shelters—consisting of a cross-section of youth, men's, women's, family, and victims of violence—ranged from $13,000 to $42,000. Supportive and transitional housing registered between $13,000 and $18,000 and affordable housing without supports—for singles and families—cost between $5,000 and $8,000. Using a similar approach, Shapcott (2007) calculated the average monthly cost of different housing arrangements for a homeless person in Toronto at $10,900 for a hospital bed, $4,333 for a provincial jail, $1,932 for a shelter bed, $701 for a rent supplement, and $200 for social housing. These studies are consistent with Wong et al.'s (2006) finding that shelter costs for homeless persons were much higher than the rental costs of market housing. Of the nine cities examined by The Lewin Group (2004), most saw jail and prison costs at least double that of supportive housing, mental health facilities at least 10 times higher, and emergency-room stays significantly higher still.

A review of the City of Toronto's Emergency Homelessness Pilot Project (EHPP) saw housing costs lower than those in either city-operated shelters or private rooming-house accommodations, despite EHPP tenants receiving larger and fully self-contained units (Gallant et al., 2004). Additionally, support costs were roughly half those for comparable levels of support in shelters. Participants in the EHPP were also more likely to have health cards and to have seen a doctor within the past year, while being less likely to have used emergency wards or to have been hospitalized.

Proscio (2002) found that annual hospital inpatient days fell by 57% for homeless people after they moved into supportive housing. Average annual visits to the emergency room declined from 2.24 to 0.99 two years prior to and one year after being placed in supportive housing, reducing healthcare costs from an average of $107,642 to $54,242 per year. Additionally, total annual days of residential mental health treatment fell from 316 two years prior to being placed in supportive housing to zero days, reducing the annual cost from $39,195 to $0.

Arthur Andersen LLP et al. (2002) found that housed patients decreased their utilization of expensive acute health services—predominantly medical inpatient services. Housed patients also increased their utilization of necessary ongoing healthcare and support, experienced high rates of satisfaction, and saw a marginal increase in employment. This last finding is consistent with a study by Berry et al. (2003), which found that housing the homeless increases the likelihood

of employment, thereby increasing income and reducing dependency on government income support. Lewis and Rowlatt (1996) determined the net benefit to society of making a shelter allowance payment in the UK available to a potentially homeless young person to be approximately £7,700 over a two-year period, derived from increased taxable income and reduced unemployment benefits. When viewed from the taxpayer's perspective, providing housing support reduced net costs by over 50% over a two-year period.

People with complex health needs, especially mental health, who are homeless impose greater cost burdens on support services, compared to housed clients with similar needs (Berry et al., 2003). In British Columbia, one homeless person with substance abuse and/or mental health issues costs the public system in excess of $55,000 annually (Patterson et al., 2008). Providing this population with adequate housing and supports would reduce the cost per person to $37,000 annually, saving the province $211 million per year (Patterson et al., 2008).

The Limits of Cost-Benefit Analyses

When considering cost-benefit analyses, it is important to keep in mind their methodological challenges. For example, mainstream services may not accurately capture or report on the housing status of people using their services (Culhane et al., 2011). Hwang et al. (2011) and Tsai et al. (2005) confronted this challenge in their use of healthcare administrative data. Additionally, access to administrative data is often restricted and assessing the true cost of shelter stays can be a challenge due to inconsistencies in reporting operating costs (Gaetz, 2012; Gallagher, 2010). These challenges can result in the true costs of homelessness being underestimated (Gaetz 2012). Culhane (2008) and Rosenheck et al. (2003) highlight that some studies use the chronically homeless subpopulation to represent the entire homeless population, thus biasing results.

It is also important to note that proactive approaches to homelessness do not always reduce costs (Gaetz 2012). Culhane et al. (2011) present evidence from the United States that housing people who are homeless may actually increase healthcare costs by improving access to and use of healthcare services. Rosenheck et al. (1993) found that use of residential and outpatient services by homeless mentally ill veterans increased substantially after enrollment in an outreach program, increasing total annual costs by 35% (from $6,414 to $8,699) per veteran per year.

It is also difficult to determine the causal attribution of a policy intervention. For example, Hwang et al. (2011) note a limitation of their study is that it does not address the extent to which hospitalizations of homeless individuals were potentially preventable through adequate primary care. So, cost-benefit analyses tend to focus primarily on costs. Pomeroy (2005) also identifies this as a limitation of his study. Unless cost-benefit analyses provide equal treatment to both sides of the accounting ledger, using them to assess preventive approaches to homelessness may not fully capture the latter's value.

When thinking about the costs of homelessness, then, we need to do more than calculate dollars and cents; we need to consider the human costs of allowing people to languish in homelessness (Gaetz, 2012). Despite the utility for policy-makers of objectively structuring trade-offs in terms of monetary units, we must bear in mind that not all aspects of a decision can be quantified, and that, at some point, we will have to engage our capacity for moral reasoning, choosing right from wrong. Echoing Gaetz (2012), proactive and preventive approaches to homelessness not only appear in many instances to be cost-effective, they are also the right thing to do.

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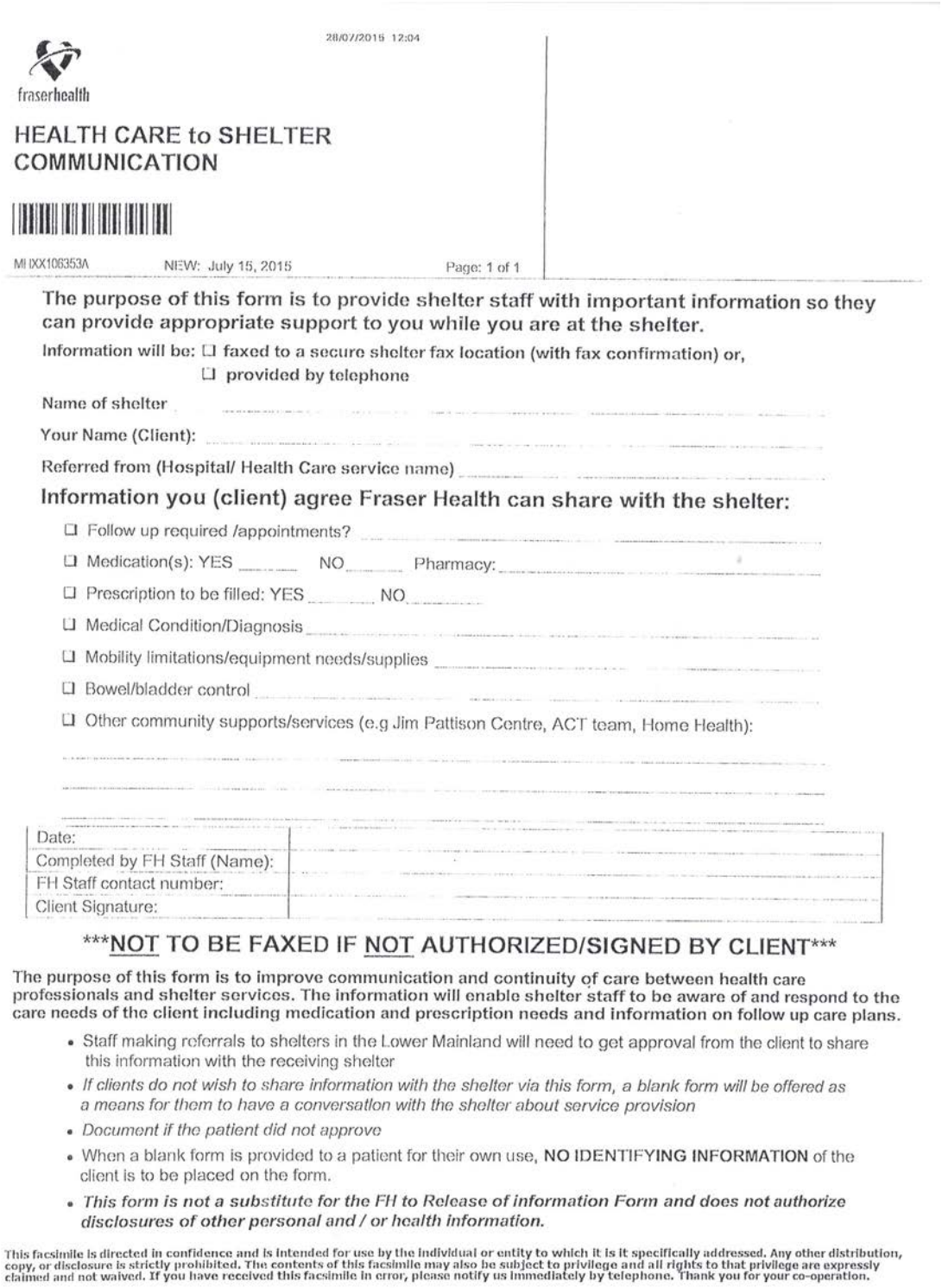
HOSPITAL-TO-SHELTER FORM



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fraserhealth

HEALTH CARE to SHELTER COMMUNICATION

MI IXX106353A NEW: July 15, 2015 Page: 1 of 1

The purpose of this form is to provide shelter staff with important information so they can provide appropriate support to you while you are at the shelter.

Information will be: ☐ faxed to a secure shelter fax location (with fax confirmation) or,
☐ provided by telephone

Name of shelter _____

Your Name (Client): _____

Referred from (Hospital/ Health Care service name) _____

Information you (client) agree Fraser Health can share with the shelter:

- ☐ Follow up required /appointments? _____
- ☐ Medication(s): YES _____ NO _____ Pharmacy: _____
- ☐ Prescription to be filled: YES _____ NO _____
- ☐ Medical Condition/Diagnosis _____
- ☐ Mobility limitations/equipment needs/supplies _____
- ☐ Bowel/bladder control _____
- ☐ Other community supports/services (e.g Jim Pattison Centre, ACT team, Home Health):

Date:	
Completed by FH Staff (Name):	
FH Staff contact number:	
Client Signature:	

NOT TO BE FAXED IF NOT AUTHORIZED/SIGNED BY CLIENT

The purpose of this form is to improve communication and continuity of care between health care professionals and shelter services. The information will enable shelter staff to be aware of and respond to the care needs of the client including medication and prescription needs and information on follow up care plans.

- Staff making referrals to shelters in the Lower Mainland will need to get approval from the client to share this information with the receiving shelter
- *If clients do not wish to share information with the shelter via this form, a blank form will be offered as a means for them to have a conversation with the shelter about service provision*
- *Document if the patient did not approve*
- When a blank form is provided to a patient for their own use, **NO IDENTIFYING INFORMATION** of the client is to be placed on the form.
- ***This form is not a substitute for the FH to Release of information Form and does not authorize disclosures of other personal and / or health information.***

This facsimile is directed in confidence and is intended for use by the individual or entity to which it is it specifically addressed. Any other distribution, copy, or disclosure is strictly prohibited. The contents of this facsimile may also be subject to privilege and all rights to that privilege are expressly claimed and not waived. If you have received this facsimile in error, please notify us immediately by telephone. Thank you for your co-operation.

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