Healthcare First:

Improving access to healthcare for the homeless and vulnerably housed in Niagara

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Healthcare First

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HEART

Health and Equity through Advocacy, Research, & Theatre

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Executive Summary

The HEART project demonstrated that there are significant challenges to healthcare for the homeless in the Niagara Region, especially with regard to access and discharge from hospitals, adequate and comprehensive psychiatric and mental health services across service providers, and availability and continuity of care from family doctors. The regional health system, community health leaders, social service agencies, and other stakeholders should consider targeted research and policy interventions to address issues of access to hospital- and community-based care for the homeless in Niagara. The HEART program's innovative 'patient-centered policy-making' approach combines participatory action research, public advocacy, and research-based, 'legislative' theatre to achieve this goal.

This report recommends eight policy solutions that were generated by the homeless community, healthcare providers, and medical and nursing students in St. Catharines, ON. They were assisted by a panel of expert policymakers from the HNHB LHIN, Niagara Health, social service agencies, municipal and regional government, and the community. These policymakers translated the views of the homeless and others into the following policies:

Homeless Community Policies

1. **Mental health triage and 'wrap around' services in the emergency department.**
   Dedicated triage in the emergency department should offer specialized services to patients with mental health concerns, improving connection to outpatient community supports and assisting with social issues.
2. **Mental health and homeless competency training through the LHIN for healthcare providers.**
   Poor therapeutic relationships as well as a lack of understanding and empathy of homelessness should be addressed through a focused training program for providers that is aimed to improve interactions with homeless patients.

Healthcare Provider Policies

3. **Integrated medical and social services and developing a uniform line for provider referrals.**
   Case managers may be effective for primary care practices to develop a "continuum of care" with social services, and interagency implementation strategies can help overcome fragmented services across mental health, substance use, primary care, housing, and social service sectors.
4. **Increased capacity in community agencies such as Start Me Up Niagara and Hope Centre.**
   Increasing the capacity of community agencies such as Community Care and Start Me Up Niagara will increase the ability of the Niagara Region to reach and provide care to the homeless and individuals living in poverty.
5. **A pilot trial to study an alternate funding model for providing primary care to the homeless.**
   Physicians should be incentivized to accept homeless patients into their practice and improve continuity of care through a funding model that compensates for the

increased resources required, and safeguards financially for patients who book but are unable to attend appointments.

6. **A study of the resources and capacity of social services and medical services in Niagara.**
Stakeholders, in partnership with the Niagara Community Observatory at Brock University, should examine the financial benefit of social services to the healthcare system and the impact on health outcomes for those patients accessing healthcare through community agencies.

Medical and Nursing Students

7. **Full examination of all issues of patient care access into the system and upon discharge.**
The region should consider a quality assurance research program to determine the most significant gaps in healthcare for homeless patients, including issues with identification, stigma, harm reduction policies, and housing and care coordination upon discharge.
8. **Qualitative and quantitative impact assessment of the healthcare system on the homeless.**
A quantitative impact assessment should be conducted to provide further support to the qualitative findings of the HEART project and assist in evaluating any future interventions.

This report provides a description and analysis of eight patient-centered policies that provide powerful options for local health system reform that is rooted in multi-stakeholder participation, community knowledge, and rigorous evidence-based research. Serious consideration of these patient-centered policies and a commitment to change can reduce barriers to access, strengthen systems of support, and create the conditions for equity for the severely disenfranchised.

Introduction

Homelessness is a major social issue affecting the entirety of the Niagara Region. The health of the homeless is a persistent, intractable problem that accompanies all of the other social inequalities including housing, employment, and social exclusion. Although incredible effort and meaningful initiatives to improve the condition of the homeless is consistently underway, access to healthcare continues to present challenges for this vulnerable population - but also opportunities.

To date, there has not been a comprehensive understanding of the realities of healthcare experienced by homeless individuals in the Niagara Region. This absence of knowledge translates to the difficulties encountered by the hospital system and providers when attempting to meet the demands of equitable healthcare for socially complex, marginalized populations. Research, especially when produced in partnership with the public, can begin to resolve these issues by generating evidence that is responsive to the needs and demands of the community - and which can provide the basis of an informed discussion and actionable agenda for social progress.

An innovation of the HEART program, 'patient-centered policy-making' combines participatory action research, public advocacy, and research-based, 'legislative' theatre to improve equity in health systems. Patient-centered policy-making is founded upon the idea that citizens who are afflicted by poverty, exclusion, and isolation and have the lived experience of marginalization may be able to offer innovative solutions to the most entrenched social problems, if they were able to access the appropriate mechanisms of decision-making. This unique philosophy was trialled by the Niagara community in October - November, 2016 and produced the patient-centered policies described in this report. Equity is a community project, and we hope to continue engaging patients, providers, and other stakeholders as change agents and partners in the design of healthcare services and policy.

In this report, we will outline:

- An approach to patient-centered policy-making that was piloted in St. Catharines, ON in 2016 with members of the homeless community, healthcare professionals, and medical and nursing students.
- The issues encountered by homeless persons in the healthcare system and the programs and initiatives in Niagara that are targeting these problems.
- The policy recommendations that emerged from the process of patient-centered policy-making with homeless patients, and the analysis and evidence supporting these proposals and their implementation.

Dr. Paul Batalden at the Institute for Healthcare Improvement once famously observed that "Every system is perfectly designed to get the results it gets." Our challenges are not inevitable except as features of a system that does not favour power for the marginalized. People know and understand their problems, and they have the solutions. Let's invite them to make Niagara a better place for all.

Background

Over half of the homeless population has major chronic health conditions and face many daily challenges when accessing healthcare, such as drug and alcohol abuse, lack of housing, and food insecurity (Hwang, Martin, Tolomiczenko, & Hulchanski, 2003). It is critical that healthcare providers focus on making care easily accessible and welcoming for the homeless population. However, homeless patients have experienced discrimination and unwelcome treatment (Wen, Hudak, & Hwang, 2007); they believed that their healthcare providers lacked compassion for their situations (Nickasch & Marnocha, 2009), and felt as if their views about their health were being disregarded (Acosta & Toro, 2000). These healthcare-specific challenges have been noted to negatively influence the desire among homeless populations to seek healthcare in the future (Wen et al, 2007; Nichasch & Marnocha, 2009), and evidence of low usage has been overtly reported (Hwang et al, 2001).

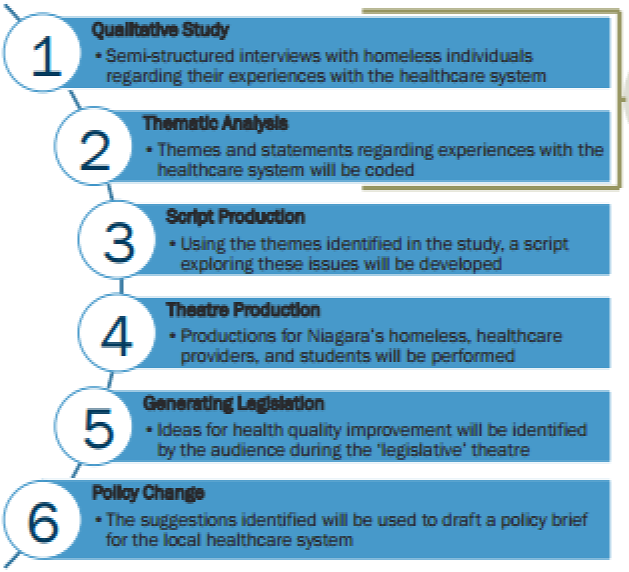
Methodology

Policy reform can mitigate potential gaps in the responsiveness of health systems to ensure vulnerable populations have access to equitable and patient-centered healthcare. The HEART program used an innovative approach to understand issues of health equity faced by homeless individuals in St. Catharines, Welland, and Niagara Falls ("the Niagara Region") to identify areas for social inclusion and policy reform.

Using a qualitative methodology, we interviewed 16 individuals who identified as homeless or vulnerably housed to uncover barriers and facilitators to accessing and navigating the healthcare system. Interview transcripts were analyzed to identify themes, which included 9 barriers and 8 facilitators to accessing healthcare. The transcripts and themes from the interviews were used to develop a theatrical script in partnership with a professional theatre company, Branch Out Theatre. This research-based, 'legislative theatre' play was professionally produced for audiences of students, healthcare professionals, and members of the homeless community and evaluated as a form of knowledge translation and public and patient engagement in health policy decision-making. A video introduction to this method may be viewed online.

The intervention required audiences to initially observe the play, but then invited participation in select scenes which demonstrated key themes and conflicts. Audiences were invited to yell "Stop!" and change the scene by replacing an actor, engaging in roleplay, and suggesting solutions. A panel of municipal, hospital, health system, social service, and community representatives generated policy ideas based on these improvisations, following which the policies were presented for audience discussion, amendment, and vote. The policy ideas endorsed by the audience have been used to inform this policy position paper for future advocacy efforts across the region.

Methodology



1 **Qualitative Study**
- Semi-structured interviews with homeless individuals regarding their experiences with the healthcare system

2 **Thematic Analysis**
- Themes and statements regarding experiences with the healthcare system will be coded

3 **Script Production**
- Using the themes identified in the study, a script exploring these issues will be developed

4 **Theatre Production**
- Productions for Niagara's homeless, healthcare providers, and students will be performed

5 **Generating Legislation**
- Ideas for health quality improvement will be identified by the audience during the 'legislative' theatre

6 **Policy Change**
- The suggestions identified will be used to draft a policy brief for the local healthcare system

Figure 1. Overall study methodology

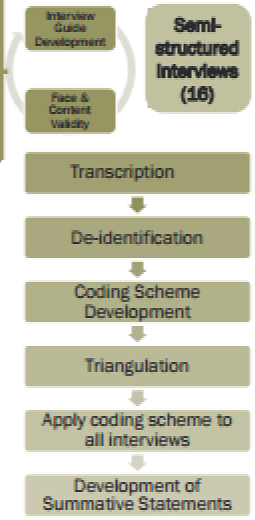


Figure 2. Phase 1 Methodology

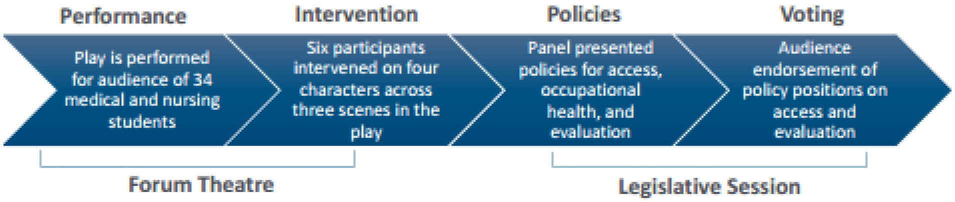


Figure 3. Legislative Theatre Process

Policy Context

In Niagara, homelessness has been identified as a priority issue and there are are multiple strategies being planned and implemented at the national, provincial, and municipal levels.

Niagara is one of 32 communities across Canada participating in the Point-in-Time Counts, a national strategy to define the issue of homelessness, identify the needs of Canada's homeless, and provide initial data for tracking progress. The 'counts' took place during a 24-hour period in April 2016, and included individuals in short-term housing, shelters, and those sleeping without shelter, in order to provide a snapshot of the homelessness situation in Niagara at one moment in time. Thirteen shelters were visited throughout the counts, and 424 individuals were counted as staying in shelters.

As a requirement of the provincial *Housing Services Act*, Niagara developed a 10-year Housing and Homelessness Action Plan (HHAP) for the 10-year period of 2014-2023. The vision of the plan is "a home for all" and outlines multiple goals and action points to address the issue of homelessness in the Niagara Region. The key priorities of this plan are to improve affordable housing options for those without a home, to expand supports to assist individuals in finding and retaining homes, to increase opportunities across the housing continuum, and to increase overall effectiveness of the housing system. This plan identifies five key areas of focus, each of which has a community-based working group.

One area of focus is Housing First, a campaign to move those who are chronically and episodically homeless into permanent housing solutions. Other areas of focus include the development of a youth strategy in order to prevent homelessness through support of at-risk youth, and a focus on affordability to improve the availability and quality of housing options for those facing poverty.

The HHAP identified two areas of focus which will address some of the unique barriers faced by homeless patients in accessing and receiving healthcare and other community services. Homeless individuals often lack consistent, coordinated care, thus the "no wrong door" task force is working toward linking services such that individuals receive the appropriate services that they require regardless of where they enter the system of care. This will likely involve a central intake and assessment tool and will avoid bouncing individuals between agencies. The second area of focus is the development of "service hubs" which will offer multiple services in one central location. Homeless individuals are more likely to face transportation as a barrier to accessing care and will thus benefit from the centralization of services.

The Hamilton Niagara Haldimand Brant (HNHB) Local Health Integration Network (LHIN) formed the Health Equity Action Plan (HEAP) Working Group in September 2015 to support its efforts to eliminate health inequities. The homeless population was one of five populations of focus, along with Indigenous peoples, French speaking peoples, migrant agricultural workers, and newcomers. The HEAP working group will assist the LHIN in health equity prioritization and the development of an annual health equity action plan. According to the HNHB LHIN's 2016-2017 Annual Business Plan, the development of this health equity action plan is currently in progress and should be complete by the 2018-2019 year.

At a municipal level, Walter Sendzik, Mayor of St. Catharines, has pledged his goal to end homelessness in the city of St. Catharines through improved transit, affordable housing, and most importantly, a culture of compassion. Mr. Sendzik made a commitment to addressing the issue of poverty and housing in the region, and began the “Compassionate City” initiative which focuses on empowering the community to work together to end homelessness.

Multiple organizations are currently working towards improving access to safe spaces and shelters, including the YWCA which is constructing a transitional housing shelter for families, and the Bethlehem Projects development of a playground for children to engage in safe play.

Current policy for the equitable delivery of healthcare in Niagara includes service delivery from Public Health. The Health Bus and Outreach Nursing programs provide a free, accessible alternative to traditional clinic-based primary healthcare for vulnerable populations, including residents with addictions, mental health issues, homeless residents, and individuals lacking a health card. These services are mobile and can attend to clients in their preferred public locations. Importantly, these programs successfully build trust with individuals who may have experienced past discrimination from traditional service providers.

Services include clean needle exchange, health education, infectious disease testing, mental health referrals, sexual health, basic wound care, and referral to health agencies. The service is currently provided at the following locations: Positive Living Niagara, Salvation Army Booth Centre, Southridge Church, and Start Me Up Niagara in St. Catharines; The Hope Centre in Welland; and Reach Out Food Centre in Port Colborne.

Quest Community Health Centre (CHC), Bridges CHC, and Niagara Falls CHC are part of an Ontario-wide system to provide primary healthcare, health promotion, and capacity building services, particularly targeting communities and individuals experiencing social, economic, and cultural barriers to care, including homeless populations. A principal emphasis on addressing the social determinants of health, health equity, and social justice have tended to ensure programming and services that are responsive to community needs across the region.

There are many opportunities for incorporating the health of the homeless as part of initiatives to improve housing and mental health in Niagara’s communities. The Social Housing Alternative Service Delivery Task Force in Niagara has noted the need for tenants to agree to refer for mental health, addictions, and healthcare supports in an effort to keep people housed, an initiative that will require community hubs and partner program integration to improve service delivery and access to programs.

Similarly, ‘Housing and Homelessness’, ‘Addictions and Mental Health’, and ‘Promotion, Prevention, and Primary Care’ are areas of focus in the Implementation Framework for the Niagara Mental Health and Addictions Charter. The Charter was launched by more than 65 organizations in Niagara to strengthen mental wellness promotion, mental illness prevention, and addictions and mental health services. Explicit recognition is granted to inclusive services and care that must be provided with sensitivity and respect as marginalized people may have difficulty accessing appropriate services.

Discussions regarding implementation of the Charter have produced key themes reflecting those of the Social Housing ASD Task Force, including the need for seamless movement of people through the mental healthcare system; client-centered care; simplified, centralized access to care through service hubs; collaboration among service providers; and reduction in mental illness-related stigma and discrimination in healthcare. The Living in Niagara 2014 report has already identified that collaboration between service providers has been effective in the region, including a collaborative of Community Health Centre Outreach Workers and Niagara Region Community Services homelessness personnel. However, community leaders and service providers have indicated that an overall successful outcome of implementation would be a system "designed for the people, rather than having to make the person fit the system."

The Living in Niagara 2014 Report also identifies the need to focus on addressing the root causes of poverty and the health-related issues of marginalized and vulnerable populations, including through a systems approach to investing in the people of Niagara. One example of such an approach may be the Niagara Prosperity Initiative. Established by the Niagara Region in 2008, the NPI provides $1.5 million in funding annually for poverty reduction and prevention projects proposed by groups in the community.

A number of the projects funded by the NPI emphasize healthcare access for individuals struggling with homelessness:

- The Hannah House Maternity Home was provided $6,113.49 to support "Rock Solid", a 40-week life skills program taught to young, pregnant and parenting women under age 21 who are experiencing or at risk of homelessness. The program reduces risks to the health of the women and their babies.
- Project SHARE of Niagara Falls Inc. received $86,292.01 to fund an intensive case manager specializing in mental health and addictions who can help clients to find and retain housing.
- Community Care St. Catharines and Thorold was funded in 2014 to create a Niagara Region Identification Clinic to assist with obtaining and replacing ID required to access healthcare, income supports, school, employment, and more.

Niagara Connects, in partnership with Niagara Southwest Health Links and the Brock University Goodman School of Business Consulting Group, has prepared a report in July, 2015 titled, "Getting There: Business Case for a Model for Centrally-Dispatched Access to Health and Human Services for Niagara's Most Vulnerable People." This program would ensure that people living in poverty, including those with mental health and addictions challenges, have access to healthcare through a centrally-dispatched, community-based transportation system.

These projects demonstrate the importance of equitable access to healthcare and responsive healthcare services for the overall reduction of poverty in the region. The Niagara Poverty Reduction Network has also produced factsheets and has asked for healthcare professionals to take action and help reduce poverty through clinical practice and advocacy.

Findings and Policy Recommendations

Patient-centered care is a concept widely endorsed in current healthcare; it encourages patients to be drivers of their own healthcare, guiding clinical decisions based on their own preferences, needs, and values. Similarly, patients should have the decision-making power to reform the healthcare policies that affect the care they receive. Through face-to-face interviews, the HEART project allowed Niagara's homeless patients to identify the barriers they encounter in accessing and receiving healthcare in the region. Through legislative theatre, audience members from the Niagara community, including the homeless community, were then provided a platform to create and vote upon policy recommendations. The following eight policies are the result of this process.

<u>Homeless Community Policies</u>

1. Petition to the HNHB LHIN and NHS to collaborate to realign resources to allow for dedicated triaging space in the ER that will offer wrap around services for patients with mental health concerns.
    a. This will ensure appropriate resources/staff are available to provide appropriate and compassionate care during the assessments, holding, and admission and to offer a warm hand-off at discharge to community and support services.
    b. This should include offering peer support on a volunteer or paid basis.
    c. Patients with lived experience should be included in the planning for this model.
2. Cultural competency and sensitivity training for health service providers could be made mandatory through the LHIN to improve provider and patient interactions. Training would be specific to mental health and homeless population.

Healthcare Provider Policies

3. Recommend that the Commissioner of Community Services and the Medical Officer of Health facilitate the creation of a system whereby:
    a. Primary practices can give a 'warm hand-off' to community services
    b. Social services can get access to medical care for their clients
    c. 211 is promoted as a one-stop resource for medical offices
    d. Create a Central Access Line which can facilitate connections with mental health addictions services
4. Increase capacity in day programs such as Start Me Up Niagara and the Hope Centre, and increased coordination between practitioners.
5. Fund a pilot trial in the Niagara Region to study an alternate funding model for homeless patients, which recognizes the increased time and complexity of the work to provide service to them.
6. The Brock Observatory should perform an in-depth study of the resources and capacity of social services and medical services in the Niagara Region.

Medical and Nursing Student Policies

7. Recommend a full examination of all issues of patient care access into the system and from the system into follow-up care for stability.
    a. Health card with address
    b. Prevention and harm reduction
    c. Codes of conduct (e.g., How physicians must handle a malodorous patient)
    d. Access to social services such as Start Me Up Niagara and alternative ways to deliver social housing

8. Recommend qualitative and quantitative impact assessment of the healthcare system on the homeless.

Homeless Community Policies

1. Petition to the HNHB LHIN and NHS to collaborate to realign resources to allow for dedicated triaging space in the ER that will offer wrap around services for patients with mental health concerns.
   a. This will ensure appropriate resources/staff are available to provide appropriate and compassionate care during the assessments, holding, and admission and to offer a warm hand-off at discharge to community and support services.
   b. This should include offering peer support on a volunteer or paid basis.
   c. Patients with lived experience should be included in the planning for this model.

A) Mental health triage

Dedicated triage in the emergency department should offer services to patients with mental health concerns. Homeless patients are much more likely than housed patients to access emergency departments for concerns with mental health (Forchuck, Reiss, Mitchell, Ewen, & Meier, 2015). The emergency department is often the first point of contact for patients in mental health crises. However, the ED is designed for rapid assessments and may not be well suited for the current practice of recovery based mental healthcare (Vingilis et al, 2007).

The idea of specialized mental health services within emergency departments has previously been modeled by several institutions, who have cited its benefits and challenges. A common model utilizes mental health nurses or crisis counsellors to triage patients, determine if medical assessment is required, perform mental health assessments, assess factors such as housing, finances, and legal issues, and make appropriate referrals (Vingilis et al, 2007; Sirtoch, Durbin, & Dubin, 2016). The Niagara Health System should implement this model to improve wait times (Vingilis et al, 2007; Osborne, 2003; McDonough et al, 2004), alleviate stress and workload for ED staff (Coristine, Hartford, Vingilis, & White, 2006; McDonough et al, 2004), and improve patient safety (Vingilis et al, 2007) and patient experience (Coristine et al, 2006).

In addition to mental health crises, homeless patients may present to the emergency department in housing crises with nowhere else to go (Forchuck et al, 2015). Such ED visits may be frustrating for ED physicians and do not require medical assessment (Vingilis et al, 2007). Once implemented, mental health workers within the ED could assist such patients with access to housing information and rent, interventions which have been shown to help homeless patients acquire and maintain housing upon discharge, and reduce subsequent ED visits (Forchuck et al, 2015). The presence of specific mental health services within the ED can also bridge the gap between acute and community mental healthcare, facilitating follow-up with psychiatrists and agencies in the community (Vingilis et al, 2007; Sirtoch et al, 2016).

As with much healthcare programming, cost is an obvious barrier since model planning and execution would require significant administrative work and the recruitment of highly trained health practitioners. Other institutions have shown cost effectiveness, however, with a reduction of recurrent ED visits by certain groups served by mental health triage, thus freeing beds for other patients (McDonough et al, 2004).

We anticipate that having specialized mental health services within the ED, which will improve connection to outpatient community supports and assist with social issues, can lead to reduced repeat ED visits. In Ontario, the Ministry of Health and Long-Term Care holds the Local Health Integration Networks (LHINs) accountable to work toward certain targets and monitor health systems indicators. One of the two mental health focused indices is the proportion of mental health emergency visits which are “repeat unscheduled emergency department visits within 30 days for a mental health condition”. This would therefore be a worthwhile investment for improving the performance of the HNHB LHIN, which currently ranks 9th out of 14 LHINs in Ontario on this performance index (Ministry-LHIN Performance Indicators Report, 2017).

The potential for improved patient care while improving ED function and reducing workload for ED staff should prompt support of this policy from hospital staff and administration. The potential benefits of this model, both for ED functioning and patient care, are well documented and we anticipate the implementation of this policy to be a cost effective means of improving patient care.

B) Peer support

Based on their own experiences within the emergency department, homeless patients suggested the establishment of a peer support system simultaneous with the implementation of mental health-specific services in the ED. With experience presenting to the ED for mental health concerns, homeless participants believed that they would have benefitted from the support of a peer amidst a chaotic and sometimes frightening environment.

Peer support has become a topic of high interest for mental health recovery, and has been shown to benefit both consumers as well as providers (Migdole et al, 2011). The benefits of peer support programming include feelings of empowerment and hope, increased social support and social functioning of providers, increased sense of acceptance and empathy of consumers, improved patient satisfaction, and reduced feelings of stigma (Repper & Carter, 2011).

Despite its numerous benefits, there may be challenges to implementing peer support programs. Previous research has cited logistical issues with peer support workers with regard to boundaries, appropriate dress, and absenteeism (Migdole et al, 2011). The work stress and environment of crisis can also trigger peer support workers into recurrence of their own mental health disturbances (Repper & Carter, 2011). To accommodate such challenges, peer support workers require extensive training and close support, for instance, by a healthcare provider acting as a primary supervisor and liaison with hospital staff. As it will affect ED functioning and utilize workspace, the success of a peer support program requires significant buy-in from hospital staff and administration.

With proper implementation, a peer support system can provide benefit to both the patient in crisis in the emergency department, as well as the patient in recovery who is the peer supporter. At the HEART research-based theatre performance, seven homeless audience members immediately expressed interest in being a peer supporter and provided their contact information, suggesting that we can expect engagement from this community.

While this policy suggestion was made with the intention of improving patient experience, experience from trials in other institutions suggest that improvements to hospital function can also be anticipated. Peer support workers in mental health services lead to reduced admissions among clients, as well as earlier discharge when utilized in inpatient settings (Repper & Carter, 2011). A peer support program for inpatients in an Australian hospital facilitated earlier discharge and hospital avoidance in patients, saving 300 bed days, equating to savings of $93,150 after costs of the program (Lawn, Smith, & Hunter, 2008).

C) Involve patients with lived experience

The planning and implementation of mental health triage and peer support programs should continue to actively involve homeless individuals with lived experience. Successful community-based programs incorporate the context of homelessness, including socio-economic environment, psychological difficulties, and life experience, into their design and planning (Coles, Themessl-Huber, & Freeman, 2012). Through the HEART program, homeless community members made the suggestion for dedicated mental health services and peer support within the emergency department based on their experiences as marginalized patients accessing care in this setting.

2. Cultural competency and sensitivity training for health service providers could be made mandatory through the LHIN to improve provider and patient

interactions. Training would be specific to mental health and homeless population.

Training specific to mental health and the homeless population should be made mandatory for all health service providers. Cultural competency, sensitivity, and safety training has gained increasing awareness and interest as a potential method to improve both healthcare provider and patient outcomes.

The qualitative phase of the HEART project identified poor therapeutic relationships as well as a lack of understanding and empathy of homelessness as major barriers to care perceived by homeless patients in Niagara. These barriers should be addressed through a successful, focused training program aimed to improve provider and patient interactions.

Although cultural competency training has recently gained popularity in health settings, the field is challenged by a lack of uniformity in definitions and frameworks of cultural competency, lack of consensus on the most effective type of training intervention and methods for measuring outcomes, and a lack of high quality research with objective evidence (Truong, Paradies, & Priest, 2014). Despite this, cultural competency training has continued to gather interest as there is increasing recognition of a need for such programs, and it holds promise as a tool for addressing health inequities (Guerra & Kurtz, 2017). Cultural competence training interventions significantly increase the cultural competence level of healthcare providers, increase patient satisfaction of minority groups (Govere & Govere, 2016), and improve provider outcomes such as knowledge, skills, and attitudes, as well as improved healthcare access and utilization (Truong et al, 2014).

Cultural competence models within mental healthcare lead to positive outcomes such as healthcare provider intention to modify practice, changes in behaviour of healthcare providers following training, and healthcare providers perceiving improved communication, empathy, and alliance with patients (Bhui, Warfa, Edonya, McKenzie, & Bhugra, 2007).

Progress is currently being made in Niagara in implementing cultural safety training interventions. The HNHB LHIN is one of fourteen LHINs working with the Ministry of Health and Long Term Care to offer cultural safety training to health personnel specific to Indigenous Health. The training cost is covered by the LHIN and the ministry, and it is part of a broader strategy aimed at reducing health inequities faced by Indigenous patients. The existence of this framework proves the feasibility of this policy, and suggests that a similar approach can be considered to address disparities experienced by patients facing mental health and homelessness.

Cultural competency and sensitivity training specific to mental health and homelessness may offer an effective means of improving healthcare experiences and outcomes of homeless patients. Further research is required to develop the most effective intervention method that can yield the best outcomes efficiently, and in a cost effective manner.

Healthcare Provider Policies

3. Recommend that the Commissioner of Community Services and the Medical Officer of Health facilitate the creation of a system whereby:

a. **Primary practices can give a 'warm hand-off' to community services**
b. **Social services can get access to medical care for their clients**
c. **211 is promoted as a one-stop resource for medical offices**
d. **Create a Central Access Line which can facilitate connections with mental health addictions services**

A) Primary practices to community services

Family physicians should be supported when assisting homeless patients with access to community services as this facilitates access to healthcare. Housing, social assistance, mental health, substance use, dental and eye care, education, occupational training, legal services, child and parenting help, and basic necessities such as food and clothing are as important as primary healthcare services for ensuring the health of the homeless (Zlotnick, Zerger, & Wolfe, 2013).

Successful healthcare for the homeless projects in other regions have relied heavily on case managers to provide a range of services, including information, advocacy, and guidance with navigating the healthcare system (Zlotnick, Zerger, & Wolfe, 2013). Case managers have been effective in helping chronically mentally ill persons achieve better social service outcomes, especially when providing such homeless patients with access to a network of agencies with a "no-wrong-door" approach (Gordon et al., 2007).

Within this model, accessing one service provider gains access to the full network of services to meet a wide range of needs, including healthcare services, and is the preferred policy for agencies in the region (Implementing the Niagara Mental Health and Addictions Charter (INMHAC)). A case manager may be effective for primary care practices to develop a "continuum of care" between their individual health services and social services. However, it may not be economically feasible for private practices to each be responsible for a case manager for their respective patients.

B) Social services and access to medical care

Systemic integration of services should be implemented in the region as a well-studied and positively evaluated initiative for improving the functioning, quality of life, and housing outcomes of patients who are homeless and mentally ill. Community collaboration is crucial to meeting the depth and breadth of the needs of patients experiencing homelessness. Community agencies in Niagara have studied this issue and determined that the ideal for service-level collaboration would be the development of protocols to create a more standardized, consistent system (INMHAC).

This may be achieved through the following strategies (Cocozza et al., 2000):

- An interagency coordinating body involving the major providers and stakeholders convened to exchange general information, coordinate services, perform needs assessment, devise formal agreements on reducing barriers to services, eliminate duplication of services, and promote access to comprehensive services.
- A systems integration coordinator position that can identify stakeholders,

liaison with other systems, coordinate the development of service contracts and joint proposals, facilitate communication among partner agencies, build relationships with policymakers, and provide overall assistance for implementing systems integration. The addition of this role can spur other strategies even with consideration of limited resources.
- Interagency agreements/memorandums of understanding which may include formal and informal agreements to collaborate, make or accept referrals, share client information, or coordinate services.

Assigning responsibility for someone at a senior level to be responsible for system integration and convening a body involving the major providers and stakeholders are steps that Niagara healthcare, social services, and government agencies can immediately implement to begin considering and guiding efforts at improving integration, coordination, and/or access to adequate healthcare and other services. Homeless integration projects can be challenging to sustain, however, and should be viewed and undertaken as a long-term effort (Gordon et al., 2007).

Importantly, the experience at other sites has demonstrated that "homeless service agencies can originate and sustain medical and behavioural health integration initiatives" (Gordon et al., 2007). Implementation strategies brokered by agencies had a positive impact on integration in the service system across five service sectors: mental health, substance abuse, primary care, housing, and social assistance (Morrissey et al., 2002). Significantly, integration can help to overcome the fragmentation of services.

Effective 'healthcare for the homeless' projects in other regions have also built innovative collaborations to address the need for acute and postacute medical care for homeless patients who are too ill to recover on the streets but no longer require hospitalization (Zlotnick, Zerger, & Wolfe, 2013). These facilities vary depending upon the creativity, flexibility, and availability of community resources, and may range from beds set aside within homeless shelters for treatment by visiting clinicians to stand-alone medical respite facilities.

Community groups have recognized that the ideal for service-level collaboration would include the creation of "one-stop shops" and the facilitation of "warm transfers" by building relationships with other agencies and adopting shared language and terminology (INMHAC). Collaboration can be complicated by resistance from 'mainstream' organizations due to stigma and lack of sufficient funding or knowledge to address the additional time and complexity of needs in this vulnerable population (Zlotnick, Zerger, & Wolfe, 2013). However, analysis suggests the possibility of a less costly and more effective 'bottom-up approach' to changing a system of services for homeless individuals with mental illness - without the need for additional funding and technical assistance (Morrissey et al., 2002).

C) 211: a one-stop resource

Primary care practices should consider integrating 211 into their routine clinical practice for patients who may be struggling with the social determinants of health and who may therefore be at risk for increased morbidity and mortality, increased healthcare use, and worsened health outcomes. Ontario 211 is a helpline that provides information and referrals regarding Ontario's community, social, health-related and government services for individuals and planners (Ontario 211).

The 211 Central South service, operated by the St. Catharines non-profit, INCommunities, received 88,004 calls in 2014 from Niagara, Hamilton, Waterloo, and surrounding regions (INCommunities). The 211 service is available 24/7/365 with interpretation in 150 languages. Information is available regarding over 60,000 community and government programs and services, including meals for homeless, low income, or unemployed individuals; homeless shelters; street outreach; supportive housing; housing assistance; transitional housing; emergency financial assistance; social assistance; support groups; addiction treatment; addiction counselling; in-person crisis services; crisis lines; and community mental health centres.

Through the 211 service, a comprehensive range of services can be arranged for homeless patients with no upfront investment of time or money on behalf of the provider, minimal interruption to clinical care or patient flow, and with the possibility of effecting maximum change in the economics and patient outcomes of the emergency room or other settings 'downstream'.

The HEART research findings have also established the importance of a family physician understanding and supporting patients who struggle with homelessness and financial precarity. The availability of information through 211 regarding meals, shelter, housing support, and emergency financial assistance should help allay physician's concerns regarding the time and resources necessary to manage the totality of their patient's concerns within the limitations of a patient visit.

As 211 becomes an increasingly prominent resource for primary care clinicians across the region, Ontario 211 Services is able to collect data about caller and user needs in the community that can help government planners and other decision-makers inform their investment and policy decisions regarding social, health, and government services. This on-going source of quantitative data can describe health and healthcare needs in the Niagara Region and help Niagara Health and the HNHB LHIN decide how best to prioritize and allocate their healthcare funding.

D) Central access line

A central access line should exist for healthcare providers to facilitate connections with mental health, addictions, and other community services. Healthcare providers may feel helpless when faced with complex homeless patients requiring coordinated biopsychosocial interventions, and require support to provide holistic care to such patients. As a community construct, helplines can promote community development, strengthen community cohesion, and contribute to community empowerment (Azaiza, 2008). A uniform access point would streamline access to services and reduce wait times.

In Niagara, there are existing central access line programs that serve patients. For example, the Mental Health & Addictions Access Line offers confidential support, information, connection to services, and follow-up. Crisis Outreach And Support Team (COAST) Niagara provides over-the-phone crisis intervention services and follow-up plan, which may include referral to community networks and organizations. Evidence on rheumatology, Alzheimer's Disease, and family support helplines suggests that a primary function for any helpline is the provision of information on available services, diagnoses and symptoms, treatments, referrals, and other resources (Mccabe et al., 2000; Shor & Birnbaum, 2012; Silverstein & Flaherty, 1994; Silverstein, Kennedy, & Mccormick, 1993). Importantly, helplines would also facilitate access to healthcare services, such as scheduling outpatient appointments or offering admission to hospital.

For professionals, research on an Alzheimer's Disease helpline found that 67% of professionals felt that the helpline was "very helpful" and 85% reported that they would very likely use the helpline again (Silverstein & Flaherty, 1994). Information was usually provided regarding clinical symptoms or educational material. The development of specialized information packets to suit the needs of a variety of professionals, such as social workers, medical specialists, and allied health professionals, could enhance the effectiveness of a central access line for healthcare and social service providers (Silverstein, Kennedy, & Mccormick, 1993). A central access number could also facilitate the ability of social service and healthcare professionals to refer clients to residential beds, day or community withdrawal programs, and provide direct connections to other services (Toronto Withdrawal Management Services System).

This initiative is supported by consensus among providers in the region (INMHAC). A central access line for healthcare providers should be developed to function as an access point for case consultations when collaborating between services, and allow clients to ask questions, have informal discussions, and determine the best fit for a program, among other possible services as required by the community.

4. Increase capacity in day programs such as Start Me Up Niagara and the Hope Centre, and increased coordination between practitioners.

The region should invest additional resources towards increasing the capacity of community agencies that provide programs and services for the homeless and vulnerably housed. Local services with active outreach to homeless people have greater success in engaging individuals who are resistant to care (Hwang & Burns, 2014).

A network of agencies provide food, clothing, places for social connection, and employment assistance for individuals at the extremes of poverty or who require additional physical or social supports. Agencies often involve many volunteers and the contributions of those who receive assistance and themselves begin to participate in the work of the agency.

Although funding is available locally from organizations such as the United Way and the Niagara Community Foundation, community leaders recognize that there is too little funding available from the provincial and federal governments for the programs and services required.

The United Way currently provides funding for organizations in Niagara that provide prevention and responsive community action (United Way). Grant recipients for 2016-2017 received variable amounts from $7,500 to $111,897, and included the Alcohol Recovery in Dignity (ARID) Group Homes, Bethlehem Housing and Support Services, Canadian Mental Health Association, Hope Centre, Meals on Wheels, Port Cares, Positive Living Niagara, Women's Place of South Niagara, and YWCA Niagara Region.

Similarly, the Niagara Community Foundation has provided funded ranging from $400 to $7000 or more in support of programs including an Adult Respite program, Community Soup and Culinary Training Kitchen, client and data management software, a Food Services Program, marketing materials to increase awareness, installation of phone and computer lines, and constructing office space, among many other initiatives (Niagara Community Foundation).

Increasing the capacity of community agencies such as Community Care and Start Me Up Niagara will increase the ability of the Niagara Region to reach and provide care to the homeless and individuals living in poverty. Unfortunately, few community services have resources for highly specialized staff or comprehensive treatment programmes that may be needed for intensive care (Hwang & Burns, 2014). Recourse to generic services can become necessary, where the risks of miscommunication, discrimination, negative experiences, and 'falling-through-the-cracks' become a reality.

5. Fund a pilot trial in the Niagara Region to study an alternate funding model for homeless patients, which recognizes the increased time and complexity of the work to provide service to them.

Physicians should be incentivized to accept homeless patients into their practice by creating a model of funding which compensates them for the increase in resources these patients require, as well as a safeguard financially for patients who book but are unable to attend appointments.

Homeless patients tend to have more chronic medical conditions and challenging social situations which require physicians to dedicate more time to provide comprehensive care (Frankish, Hwang, & Quantz, 2005). Under the current funding model in Ontario, physicians do not have alternate billing codes that compensate them for this increased resource demand. Additional difficulty with regard to transportation issues may also lead to an increased number of 'no-shows' at the office, that, while normally billed to patients directly for loss of time, cannot be charged to the homeless population for risk of further alienating and limiting access to healthcare. These factors may dissuade physicians from taking on homeless patients, which will negatively affect health outcomes.

Continuity of care is one of the most significant positive factors affecting healthcare outcomes, especially when followed by a primary care physician (Cabana, 2004). The HEART project findings also demonstrate that the subjective healthcare outcomes of Niagara's homeless population are positively influenced by continuity of care and access to primary care. In order to achieve these positive healthcare outcomes, physicians need to be incentivized to accept more homeless patients.

Short et al. (2008) had previously suggested three alternative healthcare systems for the homeless, including dedicated health centres, health centres in shelters, and mobile care, which are represented through the Shelter Health Network in Hamilton, Inner City Health Associates in Toronto, Ottawa Inner City Health, and the Health Bus in Niagara. However, the possibility of alternative compensation models for physicians was not examined, and information or data on alternative funding models is currently lacking in Canadian health services research.

In order to secure access to timely, compassionate care for Niagara's homeless population, which is achieved through continuity of care by primary care physicians, there must be a system which safeguards the physician's time and provides adequate reimbursement. Funding a pilot study will allow data to be collected on efficacy as related to healthcare outcomes for the homeless, and provide a stepping stone to potentially larger, multi-site studies.

6. The Brock Observatory should perform an in-depth study of the resources and capacity of social services and medical services in the Niagara Region.

Stakeholders in the region, in partnership with the Niagara Community Observatory at Brock University, should examine the financial benefit of social services to the healthcare system and the impact on health outcomes for those patients accessing healthcare through community agencies. The HEART project findings demonstrate that a main facilitator for accessing healthcare in the Niagara Region is the interaction of community agencies (e.g., Start Me Up Niagara in St. Catharines) and primary care providers.

The HEART research demonstrated that healthcare experiences and outcomes are improved for homeless patients when there is increased capacity and access to resources by community social service providers. However, there was no examination of the quantitative impact of these services on the healthcare system. Cost and benefit to the healthcare system should be evaluated, with attention to the resources required for homeless individuals to access care on their own or through social service agencies and the resultant health outcomes.

The Niagara Community Observatory would be able to assist with producing this objective, credible evidence-based research to support community-based knowledge and decision-making around these issues. Results of this study may indicate that community agencies, when utilized fully, can greatly improve healthcare outcomes for Niagara's homeless population, as well as save the healthcare system resources and money through their operations and the centralization of services. Such results could spur consideration of funding increases and the development of services to further enhance healthcare and access for everyone in the Niagara Region.

Medical and Nursing Student Policies

7. Recommend a full examination of all issues of patient care access into the system and from the system into follow-up care for stability.

- **a. Health card with address**
- **b. Prevention and harm reduction**
- **c. Codes of conduct (e.g., How physicians must handle a malodorous patient)**
- **d. Access to social services such as Start Me Up Niagara and alternative ways to deliver social housing**

A thorough review of homeless patients' access to the healthcare system and issues with discharge would provide invaluable information regarding current challenges; it would also identify opportunities to address inadequate healthcare services.

It is well documented in the literature that homeless individuals have poorer overall health compared to the general population (Hwang et al, 2003). Homeless individuals also have higher rates of emergency department usage and hospitalization. One study reported that as many as half of the homeless individuals in one city use the emergency department as their sole source of healthcare (Kushel et al., 2002; LeMoine, 2015). Although the literature makes suggestions for interventions to improve the health of homeless individuals, there is a relative paucity of recommendations for improving the structural factors contributing to homelessness, and by extension, these individuals' health (Hwang & Burns, 2014).

Problems can be as simple as a lack of awareness in an emergency department regarding the full range of local services, or recognition that there may be regular contact between a homeless patient and a primary care team, shelter worker, outreach programme, or case manager to facilitate smooth transitions of care.

The region should consider a quality assurance research program to determine the most significant gaps in healthcare for homeless patients in the region, including issues with identification, issues with stigma, harm reduction policies, and housing and care coordination upon discharge from hospital. Quality assurance is commonly used in the healthcare field and would be very feasible to conduct in our regional system. Observers would be present during clinical encounters with homeless individuals, allowing for contributions from the perspective of the patient and the healthcare provider.

It could be argued that an in-depth evaluation of the current system may not be necessary. The HEART project findings represent barriers in the healthcare system that were identified following theoretical saturation of the data, and therefore should be comprehensive. In addition, barriers identified in the findings are consistent with barriers to access and discharge identified in other healthcare systems (Saab, Nisenbaum, Dhalla, & Hwang, 2016; Greysen et al, 2014; LeMoine, 2015; White & Newman, 2015). Nevertheless, data derived from semi-structured interviews may be limited by the 'recall bias' of participants. Therefore, an in-depth evaluation would allow for an objective, detailed examination and strengthen the foundation from which to mitigate or eliminate the gaps otherwise identified.

8. Recommend qualitative and quantitative impact assessment of the healthcare system on the homeless.

Research, innovation, and policy should aim to capture the patient factors, healthcare provider factors, and system factors which contribute to healthcare disparities faced by the homeless population in our region. Knowledge and understanding of the impact of systems, policies, and practice on homeless individuals is crucial to identify the factors that can be modified to reduce healthcare disparities (Kilborne, Switzer, Hyman, Crowley-Makota, & Fine, 2006). Health disparities research has three phases: detection, understanding, and reduction in disparities (Kilbourne et al., 2006). Health disparity in the homeless population compared to the general population has already been detected in current research (Hwang et al, 2003). Efforts should thus be focused on the understanding and reduction phases of health disparity research.

A qualitative impact assessment of the healthcare system on the homeless would be highly beneficial in better understanding the systemic factors, patient factors, and provider factors which contribute to the disparity in healthcare experienced by homeless individuals (Kilborne et al, 2006). The HEART qualitative research findings identified barriers and facilitators to accessing and navigating care faced by this population. Although interviews were continued until reaching theoretical saturation, the generalizability of the findings is limited by the qualitative methodology.

The research was focused on the perceptions and experiences of homeless individuals, thus no interviews were conducted with healthcare providers. As well, differences in the barriers and facilitators identified by individuals of varied age, gender, and ethnic backgrounds were not elucidated. Future research should aim to expand the qualitative findings by including interviews with healthcare providers to identify challenges encountered by clinicians. Future research should also include participants from diverse backgrounds, including more representation from patients who identify as being female or transgender.

A quantitative impact assessment should be conducted to provide further support to the qualitative findings and assist in evaluating any interventions designed based on the qualitative data (Kilborne et al, 2006). This could include the collection of demographic information on homeless individuals including, but not limited to, age, gender, and ethnicity.

Some quantitative measures reported in the literature include evaluation of hospitalization costs in housed individuals versus homeless individuals, rates of emergency department visits, and rates of chronic illnesses (LeMoine, 2015), all of which should also be assessed in the Niagara Region to determine patterns of use and the areas of intervention with the highest yield for improving homeless health.

Conclusion

This report provides a description and analysis of eight patient-centered policies, generated by members of the homeless and medical communities, that provide powerful options for local health system reform that is rooted in multi-stakeholder participation, community knowledge, and rigorous evidence-based research. In particular, two of these policies give voice to homeless individuals who struggled with a system that does not always favour positive experiences for vulnerable people and can sometimes predispose them to harm.

Interest in reversing these social, systemic, and structural factors must be matched with action. Otherwise, the problems of poor health, mortality, and quality of life of homeless patients as reported and recognized in the region will persist. This status quo is simply not sustainable. However, these challenges have produced an opportunity within these proposals to pursue targeted, high yield reform and other strategies for improving healthcare for the homeless. Serious consideration of these patient-centered policies and a commitment to change can reduce barriers to access, strengthen systems of support, and create the conditions for equity.

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