EVALUATION OF A STRATEGY TO PREVENT DISCHARGE TO HOMELESSNESS FROM MEDICAL UNITS

'NO FIXED ADDRESS' VERSION 2 EXPANSION (NFA V.2X)

Funded in part by the Government of Canada's Homelessness Partnering Strategy's Innovative Solutions to Homelessness.

The opinions and interpretations in this publication are those of the author and do not necessarily reflect those of the Government of Canada.

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ABSTRACT

EVALUATION OF A STRATEGY TO PREVENT DISCHARGE TO HOMELESSNESS FROM MEDICAL UNITS

Homelessness has a detrimental effect on recovery from physical and mental illnesses. However, little is known about the issue of discharge from hospital to homelessness or how to intervene to prevent such discharges from happening. This project sought to evaluate the effectiveness of reducing homelessness by preventing hospital discharge from medical units to “no fixed address” (NFA) or homelessness. Earlier work was successful in reducing such discharges from psychiatric units. However, local shelter data found an increase in discharges from medical units.

Little research exists on preventing discharge to homelessness from medical wards. This study is an evaluation of an intervention that established housing and income supports for hospital inpatients in medical units. Community resources were brought physically to the hospital rather than expecting patients to access these resources in the community. Administrative data and focus groups with community partners and social service providers were sources of data for the evaluation. Client participants accessing the intervention were also recruited for interviews that provided further details on the effectiveness of the intervention.

Results show that people at risk of discharge to homelessness from medical units often have complex comorbidities of both psychiatric and medical conditions. However, the typical length of stay is shorter than in psychiatric units. This short length of stay leaves a short time frame for intervention. Still, 50% of client participants who accessed the intervention were discharged to housing rather than homelessness. Of those who completed an in-depth interview at 3 months post hospital discharge, 50% were housed, 30% had been readmitted to hospital, and 20% had no fixed address. All of those who had been readmitted were discharged to homelessness, and none of those who were discharged housed were readmitted. This clearly demonstrates that hospitals need to address discharge to homelessness.

The intervention focused on supporting housing first initiatives through immediate access to housing and income supports in hospital. This innovative intervention redesigned and streamlined the delivery of social services. For half, this approach was able to break the cycle of homelessness by providing individuals with financial supports and stable housing prior to discharge. This housing first initiative represents a potential best practice strategy, with direct implications for care providers, service delivery, and the wellbeing of the individuals we serve.

Keywords: homelessness, housing first, hospital discharge to homelessness, no fixed address, medical care

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BACKGROUND

HOMELESSNESS & HOSPITALIZATION

Individuals experiencing homelessness often exist at the intersection of multiple social and cultural determinants of health (e.g. poverty, social exclusion, disability, low educational attainment) that result in them experiencing disproportionate burdens of illness (Mikkonen & Raphael, 2010; Frankish, Hwang, & Quantz, 2005). This population is also less likely to have access to regular practitioners and instead rely on hospitals for healthcare (Buccieri et al., 2018; Tadros et al., 2016). Individuals experiencing homelessness are hospitalized for approximately four more days than the non-homeless every year (Highley & Proffitt, 2008). They experience nearly four times the rate of readmission within 30 days of discharge from the hospital compared to populations of low income, housed, individuals (Saab et al., 2016). The cycle of readmission and discharge into homelessness creates a revolving-door effect wherein individuals are discharged to conditions unconducive for recovery (Saab et al., 2016). In response to this, these individuals require increasingly intensive care each time they present to the hospital (e.g., ER services). Along with the health and social implications, there are significant economic ramifications of discharging patients into homelessness. Hospital expenditures are approximately $2,559 CDN higher to care for an individual who is experiencing homelessness (Hwang et al., 2011). The annual cost of all institutional responses to homelessness, including hospitalization, is estimated at $120,000 per person (Pomery, 2005).

Given these findings, hospitals are potential sites to identify participants for cost-effective homelessness prevention interventions. A survey delivered by The Canadian Observatory on Homelessness examined issues impacting discharge planning for patients experiencing homelessness. Ninety-three percent (93%) of the 660 respondents indicated that "hospital discharge planning for patients experiencing homelessness is an issue that needs to be better addressed in [their] community" (Buccieri et al., 2018, p. 9). Twenty-four percent (24%) of respondents said that "hospitals and homelessness sector agencies work well together to coordinate care" (Buccieri et al., 2018, p. 9). Twenty-two percent (22%) said that "persons experiencing homelessness are well supported in health care settings" (Buccieri et al., 2018, p. 9). Survey participants also revealed concerns that hospitals were exacerbating issues of poor health and homelessness, with only 18% saying that "persons experiencing homelessness are usually discharged from hospitals with treatment plans that are clear and easy to follow" (Buccieri et al., 2018, p. 9). Eighty-three percent (83%) indicated that "persons experiencing homelessness are usually discharged from hospitals to the streets or a shelter" (Buccieri et al., 2018, p. 9). Eleven percent (11%) of respondents

thought that “persons experiencing homelessness are usually discharged from hospitals into supportive housing” (Buccieri et al., 2018, p. 9).

TOWARDS A COORDINATED SYSTEM OF CARE

Although Canada’s housing strategy supports “housing first” to end homelessness (Government of Canada, 2017), the healthcare system lacks a coordinated and evidence-based approach for discharging individuals at-risk of homelessness. Housing and financial support remain separate from the healthcare system. However, many individuals experiencing poverty and homelessness are high users of expensive, downstream services (Gaetz, 2012). The problem remains concealed when individuals fear stigmatization for being homeless, and when care providers do not initiate discussions on safe housing (Greysen et al., 2013). This is especially concerning considering services to prevent and resolve homelessness are most effective when coordinated into a continuum of comprehensive, low barrier care (Backer, Howard, & Moran, 2007). To address health and service outcomes in the long-term, discharge planning needs to include provisions for housing and financial support.

Due to the paucity of methodologically sound research in this area, Forchuk and colleagues instigated a multi-phase research program evaluating efforts to streamline housing and social support using on-site hospital access to resources. The pilot of the intervention involved changing standard policies related to housing and start-up fees for a select group of income support recipients from Ontario Works (OW) who were admitted to the psychiatric department of London Health Sciences Centre (LHSC) or Regional Mental Health Care London. The Ontario Disability Support Program (ODSP) and Ontario Works (OW) participated by identifying a key administrative contact person for the project that could be reached by phone. In this first phase, the NFA (No Fixed Address) evaluation found all seven research participants randomly assigned to the intervention continued to be housed at three and six months’ follow-up, while individuals in usual care remained unhoused (6/7) or had entered the sex trade for the first time to avoid homelessness (1/7) (Forchuk et al., 2008).

The next iteration of the intervention, NFA v.1, used direct access to the OW database from hospital units providing psychiatric services in London, as well as access to a housing advocate and housing database (Forchuk et al., 2011; Forchuk et al., 2013). In this phase, only three of the 256 people accessing the service were discharged into homelessness. The costs of implementing and maintaining the intervention were lower than the increased costs associated with homelessness and housing individuals in shelters. Specifically, the total cost to implement the intervention on a hospital unit for three days per week ($3,917 CDN per month) was less than the monthly cost to shelter four individuals who become homeless ($1300 CDN per individual, or $5,200 CDN for a

family of four). According to the findings from the pilot study, these people would likely have been homeless for at least six months if the intervention was not implemented (Forchuk, 2008). Thus, it would have cost at least $292,500 CDN per month if these individuals had entered the shelter system. This figure is non-inclusive of the additional costs saved by diverting participants' dependents from homelessness and the increased likelihood of readmission and emergency room use.

In the time since NFA v.1 was established and became part of usual care, several system-level changes occurred. All of the hospital psychiatric units in the city were geographically re-located, the OW and ODSP community start-up intervention was cancelled and replaced by a local housing-stability intervention administered through the Salvation Army Centre of Hope, the software used by OW changed, and Canadian Mental Health Association (CMHA) amalgamated with other services and underwent significant organizational changes. Due to these changes in context, a second version of the program, NFA v.2, was designed. This revised intervention re-established Housing Stability Workers (HSW) from CMHA, caseworkers from OW, and Housing Stability Bank workers from the Salvation Army Centre of Hope within hospital psychiatric units in London. Individuals at-risk of being discharged to homelessness were able to access these services in hospital by drop-in or appointment. The model, similar to previous iterations of the intervention, was based on the understanding that for a community to effectively respond to homelessness, there needed to be cross-sector, coordinated responses and preventative measures in place (Backer et al., 2007). Equally important was that these critical community services needed to be accessible for individuals when they are in hospital.

THE INTERVENTION

While past NFA studies significantly expanded the academic literature on effective discharge planning from hospitals, they focused exclusively on client participants from psychiatric units. Very little work had been done to research approaches to reduce discharge from hospital medical units to homelessness. This is a significant gap in research and practice as individuals experiencing homelessness are most commonly treated in medical units. The most common reasons for hospitalization among this population are sprains, strains, contusions, abrasions, and burns (Mackelprang et al., 2014). When adjusted for sex, age, and resource intensity weight, medical hospital services cost $2198 more for individuals experiencing homelessness than housed individuals (Hwang et al., 2011). Longer stays in acute and alternate level of care beds accounted for this disparity in cost (Hwang et al., 2011).

Consequently, a novel intervention was designed for patients of the department of adult inpatient medicine. The corresponding research project was called ‘No Fixed Address version 2x’ (NFA v.2x). The 2 is for the second version and the x represents the expansion of the intervention to medical units. This project evaluated the effectiveness of providing immediate services addressing financial and housing issues prior to client participant discharge from hospital inpatient medical wards. The intervention was established in London, Ontario’s LHSC at 2 sites. This included the LHSC Department of Medicine & Family Services at the Victoria Hospital site, and Department of Medicine at University Hospital site. There are 132 acute-care beds located at Victoria Hospital and 104 acute-care beds located at University Hospital.

One full-time equivalent CMHA Housing Stability Worker divided time between the two sites. The team also included staff from OW and the Rent Stability Bank of the Salvation Army to secure resources for individuals being discharged. The client participants were put into direct contact with the Salvation Army program to assist with financial assistance such as rent and utilities in arrears or first/last months’ rent. CMHA, as well as other agencies, have access to high quality used furnishings and household supplies that can be quickly accessed. CMHA also provided access to a social enterprise that provided cleaning services. OW provided first month’s rent and facilitated access to discretionary funds and referral to the higher monthly income offered through ODSP.

Posters advertising the service were distributed in the hospital units. All referrals were accepted. Referrals were made from the medical units to the intervention team if there were concerns about a potential discharge to homelessness. Social workers and other staff involved in the discharge process from the medical units at LHSC worked closely with the housing stability team in order to identify patients at risk.

METHODOLOGY

Project evaluation was designed to test the effectiveness of this potential best practice to prevent discharge to homelessness. A mixed-method evaluation was selected to look at the intervention's impact on the system from multiple vantage points. Data were collected from a variety of sources including intervention participants, community supports, and healthcare service providers.

QUANTITATIVE DATA COLLECTION

Administrative data from CMHA were collected for all individuals that accessed the intervention between July 2018 to March 2019. This data provided information on mental and physical health issues, and whether participants obtained housing post discharge.

Additional information was collected for a subset of participants who accessed the intervention and agreed to be enrolled in an evaluation study. A two-point repeated measures design was used to assess whether participants were able to obtain housing post discharge from hospital. Data was collected via interviews prior to discharge and at three months follow-up. The number of participants available to complete the second interview was limited since the project was only in place for 9 months. Participant's demographic information, personal and housing history, and information on housing outcomes were collected using the following instruments:

1) **Demographics Questionnaire:** a tool developed in-house to collect relevant demographic data.
2) **Lehman Quality of Life Scale:** measures both objective quality of life (i.e., what people do and experience) and subjective quality of life (i.e., what people feel about these experiences) (Lehman et al., 1994).
3) **Housing History Form:** collects data on previous residences, lengths of stay, and housing satisfaction (Forchuk et al., 2001).
4) **Consumer Housing Preference Survey:** collects participants' housing needs and preferences (i.e. help finding a place to live, accessing support staff, financial supports, transportation supports, and help obtaining furniture and household supplies) (Tanzman, 1990).
5) **Utilization of Hospital and Community Services:** collects data on participants' contacts and visits with service, medical and/or health care providers (UHCS; modified from Browne et al., 1990).
6) **Service Prioritization Decision Assistance Tool (SPDAT):** assess the acuity of need for individuals experiencing homelessness (OrgCode Consulting, 2015).

QUANTITATIVE DATA ANALYSIS

All analyses were completed using IBM SPSS version 26. Descriptive statistics and frequencies were calculated using administrative data and interview data. Analyses focused on demographics and housing outcomes for all individuals that accessed the intervention. Housing outcomes of participants who were followed longitudinally are reported in the sections below.

Few completed a second interview (n = 10) due to the short 9 month project timeline. Comparative analyses of data collected from the Lehman Quality of Life Scale, the Utilization of Hospital and Community Services form, and the Service Prioritization Decision Assistance Tool (SPDAT) was underpowered as a result of the small sample. Thus, comparative analyses were not completed on data collected from these instruments.

QUALITATIVE DATA COLLECTION

Focus groups were conducted with client participants to better understand experiences with the intervention. We also met with some client participants individually, since many had mobility issues that affected their ability to attend groups. Client participant feedback was also solicited through open-ended questions during the interviews conducted at discharge and at three months follow-up. Open-ended questions included asking how participants were introduced to the intervention, how services were executed, whether participants had recommendations about elements of the intervention to keep or change, and any outstanding concerns participants had about the services offered.

Four focus groups at both of the intervention sites were conducted with health care providers. These took place at 6 and 9 months post implementation of the intervention. Focus groups were open to any healthcare provider at the hospital who was involved in the circle of care for client participants who used the intervention (e.g., nurses, social workers, and discharge planners).

One focus group was conducted with community partners. Additionally, the minutes of the weekly implementation meetings were analyzed for issues related to implementation. These meetings were attended by the research team, implementation team (i.e., Housing Stability Worker, Housing Stability Bank worker, OW caseworker, etc.), and other community partners and advisors of the intervention (i.e., LHSC, City of London).

QUALITATIVE DATA ANALYSES

Qualitative data analyses were conducted by two research assistants, who coded the focus group and qualitative interviews independently. Memos and matrices were used to organize quotes into themes, using a thematic analysis approach. Coding and the matrices created were audited by a senior researcher and the principal investigator. The research assistants and primary investigator held discussions to condense, collapse, and expand themes until consensus was reached among the research team.

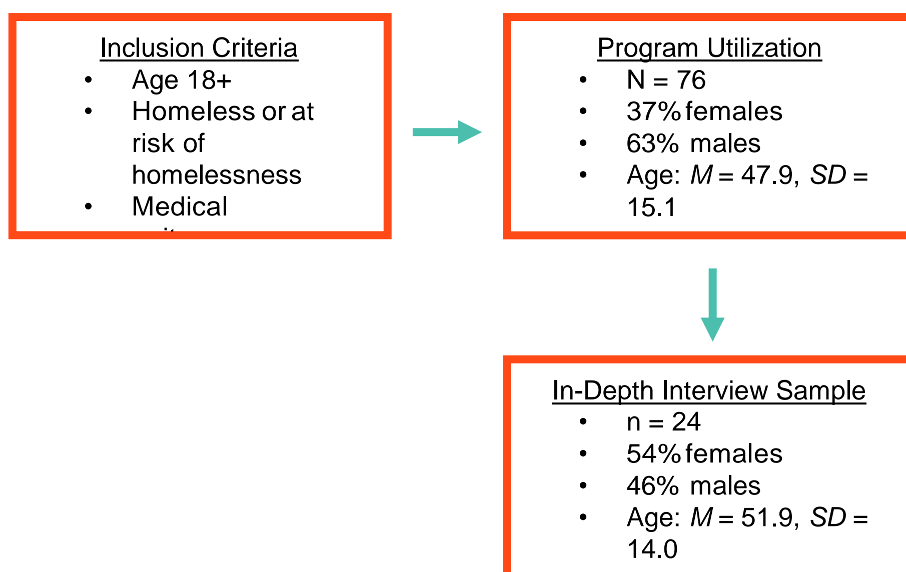
Similarly, a research assistant conducted a thematic content analysis to analyze the feedback forms collected at the baseline interview. Forms were coded and aggregated into themes. Frequency tables were generated for themes identified. A senior researcher then audited these codes, themes, and frequency tables to increase the validity of the analysis.

RESULTS

QUANTITATIVE RESULTS

ADMINISTRATIVE

There were 76 individuals that accessed the intervention on medical units and administrative data were collected by CMHA for all client participants. Hospital staff recruited individuals that accessed the intervention for individual research interviews. Twenty-four client participants enrolled in the study and completed a baseline interview. Ten client participants completed a second interview three-months post discharge from the hospital.



Demographics

Seventy-six client participants accessed the intervention. Ages of the participants ranged from 19 to 87 (*M* = 47.9, *SD* = 15.1). Of these, 37% were female and 66% were male. All client participants that accessed the intervention had a physical health issue and approximately half (54%) had a comorbid psychiatric condition.

Intervention Participants' Demographic Characteristics (N = 76)

Mean Age	47.9 (*SD* = 15.1)
Female	37% (28)
Male	63% (48)
Psychiatric Condition	54% (41)
Physical Health Issue	100% (76)

Housing Stability Outcomes

Administrative records indicate that 50% of client participants who accessed the intervention were able to obtain housing after discharge from hospital.

Housing Outcomes for Intervention Participants (N = 76)

Housing Obtained	50% (38)
No Fixed Address	50% (38)

INTERVIEW FINDINGS

Demographics

Twenty-four client participants agreed to be interviewed for intervention evaluation purposes. Ages of these participants ranged from 26 to 81 (*M* = 51.9, *SD* = 14.0). Fifty-four percent (54%) were female and 46% were male. All participants had a physical health issue and 33% had a comorbid psychiatric condition at baseline.

There was a greater percentage of females in the interview sample (54%) compared to the administrative sample (37%) which included all client participants who accessed the housing intervention. Additionally, the percentage of client participants with self-identified psychiatric conditions was smaller among the interview sample (33%) compared to the percentage obtained from administrative data (54%).

Demographic Characteristics of Interviewees
(N = 24)

Mean Age	51.9 (*SD* = 14.0)
Female	54% (13)
Male	46% (11)
Psychiatric/Developmental Condition	33% (8)
Physical Health Issue	100% (24)

Housing Outcomes

Data on client participants' current residence was collected using the Housing History Survey during the second interview, 3 months post hospital discharge, to determine whether participants in the interview sample obtained housing. Ten client participants completed this second interview. This constituted a 45% rate of follow up, adjusting for the two client participants that died over the course of the study. Five participants (50%) were able to obtain stable housing and were living in their own house/apartment or renting a room. Two participants (20%) did not obtain permanent housing at the time of the second interview. This included one participant who is staying at a friend's place rent-free, and one participant who is living in a shelter. Three participants (30%) were readmitted to hospital. All participants who were in hospital at the time of the second interview were originally discharged to homelessness.

Interviewees' Current Residence
(n = 10)

Housed Obtained	50% (5)
House/Apartment	20% (2)
Renting a Room	30% (3)
No Fixed Address	20% (2)
Friend's Place (not paying rent)	10% (1)
Shelter	10% (1)
Re-Hospitalization	30% (3)

Housing Needs

Responses collected at baseline via the Consumer Housing Preference Survey were analyzed to determine client participants' housing needs. The table below indicates the housing supports participants thought may be helpful. The type of housing supports participants most commonly reported were 'help finding a place to live' (86%), 'money for the deposit' (83%), and 'more income/benefits/rent subsidy' (79%).

Interviewee's' Housing Support Needs (N = 24)

Help finding a place to live	86% (21)
Money for the rent deposit	83% (20)
More income/benefits/rent subsidy	79% (19)
Furniture (e.g. chairs, bed)	75% (18)
Household supplies (e.g. pots and pans)	63% (15)
A telephone	63% (15)
Transportation	63% (15)
Be able to ask staff to come to their home at any time of the day or night	54% (13)
Be able to reach staff by telephone at any time of the day or night	50% (12)
Help getting benefits	50% (12)
Have staff come to their home regularly during the day	33% (8)
Have staff live in their home with them	13% (3)
Roommates or housemates	8% (2)
Help finding roommates or housemates	8% (2)

QUALITATIVE RESULTS

Client participants, health care providers, the intervention's staff, and the intervention's community partners were consulted at multiple points during implementation. Twenty-four (24) client participants filled out feedback forms (24 completed it at baseline, 10 completed it at the three months follow up), and qualitative interviews were conducted with six (6) client participants. Twenty-seven (27) healthcare providers participated in focus groups conducted at both sites, at 6 and 9 months post implementation of the intervention. Five (5) community partners participated in one focus group. Additionally, the minutes of the weekly implementation meetings were a source of qualitative data.

For an overall summary of the qualitative results described below, see the section Qualitative Results Summary at the end of the Results section.

GROUP SPECIFIC THEMES

The following section outlines themes which were observed specifically in each group of respondents (client participants, healthcare providers or community partners).

Client Participant-Specific Themes

Client participants noted that they were most often referred to the intervention through their social worker in hospital.

Interviewees also described experiencing stigma when approaching landlords independently. Although the cause of discrimination was unknown, some participants suspected it was due to their income source (ODSP) or their physical appearance.

> *"It's just my situation, being on disability doesn't look very good, when you go to rent the places you want to rent."*

> *"The landlord took one look at me and didn't want to rent to me."*

Interviewees had mixed feelings regarding their overall experience with the intervention. Intervention perception was highly positive for those participants who found housing through the support of the intervention's team. Other intervention participants did not secure housing and reflected that more time and follow-up from the intervention was necessary.

> *"Well I found a place to live, which I'm pretty content with."*

> *"I feel that I could use more support in finding a place that's within my price range."*

> *"They told me I had to leave the hospital…. And then they make sure I had an address for one month. And never came back and talked to me ever again."*

Health Care Provider-Specific Themes

Health care providers reported numerous times their appreciation for the intervention. They mentioned its helpfulness in filling an information gap in the hospital and providing extra and necessary resources for vulnerable participants. They specifically mentioned assisting participants accessing home furnishings and the transition into their new unit; themes which were not mentioned by other respondents.

> *"[The Housing Stability Worker] had the information which was nice to know there was somewhere, 'cause I don't know what I'm doing in that capacity. So it's nice to know there was somewhere to reach out."*

Health care providers also uniquely commented on the intervention's ability to strengthen relationships between hospital staff and community resources, particularly when they are brought into the hospital.

> *"I think the other piece is like bring other partnerships onto the table, so that Housing Stability [Bank], Ontario Works, being able to access that. And I think they were available before, but that has really been strengthened by the involvement of the [No Fixed Address] program."*

At one hospital site, the referral process was modified. Initially, referral forms were faxed onto the unit, which at times, confused unit clerks. Social workers addressed this issue by altering the process so referrals were photocopied and placed in a binder. The intervention's team was then contacted by phone. Once modified, health care providers found the referral process to be fast and efficient.

Uniquely mentioned by healthcare providers was the length of time it may take to build trust with participants – in particular with vulnerable populations who may be apprehensive and hesitant in sharing their story. Healthcare providers reported the connection and rapport the intervention's staff had with participants was very good, and associated this to the length of time available for the intervention.

> *"When we only have a week, or sometimes less than a week, lots of time the folks we're working with aren't even going to open up to her on that*

> *first visit. They're apprehensive, they're not sure that they're going to trust [the Housing Stability Worker]."*

One hospital site in particular commented on the challenge of sharing one Housing Stability Worker between two sites. Staff disclosed that waiting for the Housing Stability Worker at times created a gap in care, despite prompt service, which they felt could be mediated by having the worker on-site more often.

> *"I think trying to do it in two different hospital sites was difficult, that [Housing Stability Worker] was kind of all over the place."*

> *"How does a person go back and forth but meet both needs? So I don't know if it should be the same person [at different sites]."*

Community Partner-Specific Themes

Community partners felt that they were able to connect with some of the most vulnerable populations through the intervention. Living with no fixed address results in an inability to be contacted regularly and to maintain or set up follow-up appointments. As such, community partners reflected that an on-site service was ideal.

> *"It is absolutely successful in the clients that we're able to see. We're getting the most vulnerable of vulnerable. They're not even able to come through our doors and we're giving out money. So the fact that we're at least able to catch them in hospital … is phenomenal"*

Service providers, as noted above, described many features, or housing ingredients, which are necessary to secure and maintain stable housing. They include ID, income, credit rating, rental history, personal and landlord references, bank account, relationships with others (to co-sign, for support, etc.), as well as furniture and household appliances. Community partners reported that they were concerned about the intervention's resources and scope to be able to assist participants to acquire these supports.

> *"There are things you need to get housed. You need to have a credit rating, you need to have a rental history, you need references, personal and an old landlord, and you have to have an income. And if you don't have those 6 things, you're kind of right behind." (Community Partner)*

Unique from other groups, the community partners presented concerns regarding some participants' ability to maintain housing without support. They mentioned that there have been repeat participants to the intervention, seen back in hospital, due to an

inability to maintain housing. This was identified as being an issue especially with participants who have been chronically homeless and may face significant challenges in navigating relationships with their landlords on an ongoing basis, for example.

> *"A lot of individuals that got referred didn't have any community supports, so even if we were able to house them I almost felt like it was in the way setting up for failure. If someone's been chronically homeless, just to give them housing isn't always a solution. They do need supports as well."*

The intervention's service providers further added that an increase in intervention awareness throughout the hospital would be helpful to assure that all those who are at risk of being discharged to homelessness will be referred to the intervention.

A lack of awareness of the intervention was also manifested in unclear expectations of the Housing Stability Worker's role. Community partners presented concerns surrounding role clarity both within their team and within their relationships with various healthcare providers. Within the intervention team, a lack of organized structure and clearly defined role left many questions about the scope of the position. For example, service providers described a lack of knowledge about whether or not it was appropriate to move a participant's boxes into their new unit. Such cases included both resource (ie. time of the Housing Stability Worker) and safety concerns. Additionally, intervention team members were sometimes unsure of who was responsible for various participant needs; whether the social worker, Housing Stability Worker, medical team, or other service providers.

Within the hospital, the intervention's scope was also unclear. This resulted in inappropriate referrals (e.g. from units which are not included in the intervention) and/or requests for inappropriate services (e.g. aiding a patient to obtain ID who was securely housed).

> *"There's a lot of grey zones where it's like 'whose job is this?'"*

SHARED THEMES

The following section outlines major themes which were mentioned by multiple groups of respondents, organized into *Benefits, Facilitators, Barriers for Client Participants* and *Challenges for Providers.*

Benefits

A major benefit of the intervention was securing housing for discharge from hospital. The intervention was involved not only in finding a place to rent, but also in accessing a

furniture package and providing other household essentials. Another important piece of the intervention was its ability to support individuals to obtain housing ingredients.

> *“[Client Participant] came in, she was going to be here for quite a period of time…and [the Housing Stability Worker] worked really diligently. We were able to get her a home, we were able to get her connected with some furnishings and actually on the day of discharge [the Housing Stability Worker] was actually able to take her to the facility, take her on a tour of the facility, and actually help with that transition home. So that was actually quite a great success story.”* [Healthcare Provider]

All stakeholders found that the intervention brought together multiple material and informational resources, including housing lists, connections to other organizations, and the knowledge on navigating ODSP applications. Having all these resources within one intervention was viewed as particularly beneficial.

> *“[I] got ID, got on housing list, got on OW”* [Client Participant]

> *“It’s nice to know that you’ve got a resource, you’ve got a person that’s connected to the community who has eyes on the listings for what housing resources are available.”* [Healthcare Provider]

While client participants were admitted to hospital for physical health issues, demographic information solicited via interviews revealed that most also struggled with their mental health. This intervention provides support to a vulnerable population that struggles with comorbid physical and mental health challenges. Included in this support is participant advocacy with landlords and for income support.

> *“I think there’s an increase in the number of elderly patients that are coming in and have been affected or are from the shelter system and are struggling with housing, and then you also get our other group - populations with substance use or mental health.”* [Healthcare Provider]

Having connections with an OW worker also helped streamline financial assistance. The worker was able to write and submit applications for financial assistance while client participants were still in hospital, thereby fast-tracking access to OW or ODSP from several months to a few weeks. This enabled client participants to consider a broader range of housing opportunities.

> *“What I found successful with this program specifically is that I’m able to do the appointment, have the ODSP package ready to go, all the medical forms, and that’s saving the client the steps of A) having to find a doctor and B) having to take that paperwork to be filled out, and then have it sent*

> *off. It's sign here, sign here, and that's the ODSP package right to the social worker, and it's done and I know it's in the right hands"* [Community Partner]

Both hospital healthcare providers and community partners were very satisfied with the opportunity for collaboration. Healthcare providers felt that collaboration with community partners was beneficial to them and the patients. Community partners also mentioned that collaboration between partner organizations was very positive and rewarding.

Facilitators

Essential to collaboration is effective communication, which was found to be a key facilitator for the intervention. Having an interdisciplinary team encouraged different approaches and ways to problem-solve that various stakeholder groups felt they could not accomplish on their own. Additionally, having on-site support facilitated the communication and collaboration integral to the success of an interdisciplinary team.

> *"It's lovely working with [the Housing Stability Worker] and I can always say that [they're] always responding very promptly to [their] phone calls, or phone messages, [they're] always retrieving the new referrals, [they're] calling or trying to keep [them] in the loop. It's been really effective that way: communication."* [Healthcare Provider]

All groups found that access to transportation to view housing through the intervention was needed for client participants to successfully secure housing. Client participants were able to view homes and meet landlords with the Housing Stability Worker as their advocate.

> *"Another strength, I think is that [the Housing Stability Worker] is willing to bring people to see apartments. That's been huge for people"* [Healthcare Provider]

Barriers for Client Participants

Client participants faced many barriers to successful housing post discharge including lack of affordable and accessible housing within the city, lack of housing "ingredients", financial barriers, as well as physical and mental health challenges. For some client participants, many of these barriers compounded or amplified each other. For instance, a client participant can come into hospital for a physical health issue and lose their source of income while in the hospital. This, in turn, can create a new mental health

barrier (e.g., the onset of depression), which can compound the difficulties associated with finding affordable housing.

Although in hospital for physical ailments, many described challenges with their mental health which made finding housing difficult. Client participants also faced significant financial constraints, which were echoed as a barrier by all groups of respondents.

> *"I've been kind of down and depressed. Really I haven't had the motivation to do enough that I would normally do on my own. And it's difficult for me to get around with this walker, which is a problem."* [Client Participant]

Numerous systems barriers that could not be addressed through the intervention were evident as well. All groups of respondents commented on the lack of affordable, accessible and safe housing options. Affordability was of utmost concern, given limited incomes on OW or ODSP. Accessibility barriers were mentioned by healthcare providers who found that many affordable units were those with stairs, which their patients were unable to manage when leaving the hospital. There was also a lack of safe units, or those which would allow someone to recover. Housing options were often located in areas that were not conducive for recovery. As one healthcare practitioner noted in the quote below, some client participants may choose homelessness (e.g. urban camping) given the lack of appropriate housing options in the city.

> *"And then the other piece is the location of some of the accessible housing. So for example, like some of the individuals who are trying to stay away from an area, which at times may have a higher substance use and they don't want to go into housing where that's quite prominent. So, then that leaves them really with urban camping, as one of the resources available. Which we've had a few urban campers as well as, and they prefer to go there rather than some of the boarding houses or shelters."* [Healthcare Provider]

Challenges for providers

One of the biggest challenges that arose throughout the intervention's delivery was the narrow window for intervention. A participant may be identified as being at risk of homelessness too close to discharge, the participant may also only be in hospital for a very short period (some only one day), or there may be a sudden unexpected discharge.

Similarly, stakeholder groups felt that the lack of community follow-up posed a challenge to securing and maintaining housing. If participants were unable to maintain housing, they were sometimes re-admitted to the hospital.

There were also unclear expectations regarding the role of the Housing Stability Worker. This led to resources being misused and potential participants being missed. This confusion was perpetuated by the transience of the Housing Stability Worker; there was no designated office space for healthcare providers to access, and the Housing Stability Worker had no space to work with confidential information or have meetings. On some areas of the hospital, people involved in discharge planning were not aware of the intervention until close to the end of the study despite brochures and launch meetings describing the intervention.

Finally, obtaining all the housing "ingredients" was also a challenge for providers, since oftentimes these ingredients are intertwined. For instance, it is not possible to apply to ODSP without an ID, but client participants without housing often lose their ID or it is stolen from them. While in hospital with serious physical illness, it is often not possible for client participants to leave the hospital to procure a new ID, or set up a bank account. Consequently, these client participants could not apply for more income support.

> *"Whenever we send anything to LHSC, it just seems to be lost and then the headache after that is then [the participants] need to report it lost or stolen to the police, but they're not able to do that because they're in the hospital" [Community Partner]*

> *"People just lose their ID so fast and then it's trying to restore it, and then who takes them down to get their ID?" [Community Partner]*

QUALITATIVE RESULTS SUMMARY

GROUP SPECIFIC VIEWS

CLIENT PARTICIPANTS

- Referred mostly by social worker, as opposed to other hospital staff (nurse, discharge planner, etc.)
- Experienced stigma from landlords
- For some, service was very successful – housed, income support
- For some, more supports were needed

HEALTHCARE PROVIDERS

- Fast and efficient referral process
- Takes time to build trust with clients
- Appreciative of NFA as a source of knowledge and link to community resource
- Sharing one Housing Stability Worker between sites created a gap in care

COMMUNITY PARTNERS

- Accessing some of the most vulnerable and hard to reach people
- Identified housing "ingredients"
- Concerns regarding clients ability to maintain housing without support
- Need increased program awareness and more efficient program network
- Unclear expectations of the Housing Stability Worker role

THEMES SHARED BY ALL STAKEHOLDERS

BENEFITS

- Securing housing and housing supports
- Supporting individuals with obtaining housing "ingredients"
- Material resources and informational resources
- Supporting vulnerable populations with both physical and mental health challenges
- Advocacy for individuals, with landlords and for income support
- Collaboration between hospitals and community partners, as well as between community partner organizations
- Streamline financial supports

FACILITATORS

- Communication between hospital and community partners, as well as between community partner organizations
- Interdisciplinary team approach
- Transportation to view units
- On-site support
- Support to obtain housing "ingredients"

BARRIERS FOR CLIENT PARTICIPANTS

- Lack of successful housing "ingredients"
- Lack of housing within the city
- Financial barriers
- Physical and mental health challenges

CHALLENGES FOR PROVIDERS

- Narrow window for intervention prior to discharge
- Lack of follow-up in community
- No designated office in hospital
- Unclear expectations of the Housing Stability Worker role
- Obtaining housing "ingredients"

DISCUSSION

OVERALL EFFICACY

As previously mentioned, administrative data showed that 50% of client participants who accessed the intervention were able to obtain housing before discharge. Of those who completed an in-depth interview at 3 months post hospital discharge, 50% were housed, 30% had been readmitted to hospital, and 20% had no fixed address. All of those who had been readmitted were discharged to homelessness, and none of those who were discharged housed were readmitted. This clearly demonstrates that hospitals need to address discharge to homelessness.

There were an intervention and control group (7 each) in an earlier iteration of the preventing discharge to homelessness from psychiatric wards. None of the sample had a prior history of homelessness. The seven who received the intervention were all housed and remained housed 6 months later. The usual care/control group had 6 of 7 discharged into homelessness and still homeless 6 months later. The person with housing “success” avoided homelessness by entering the sex trade for the first time, and 6 months later was still in the sex trade. This suggests that people at imminent risk of discharge to homelessness, without specific intervention, are likely to become homeless. (Forchuk et al., 2008). This previous study focused exclusively on participants in psychiatric hospital units with stable income and no prior history of homelessness. Consequently, the findings cannot necessarily be generalized to participants receiving acute care in medical units, who may have income instability, or with a history of homelessness. In other words, likely a far needier group. However, based on the earlier study, it is likely all would have been discharged to homelessness without the intervention. Therefore, although we are not satisfied with 50% of this group discharged to homelessness, it is a large improvement over the likely 100%. This success is likely the result of the intervention focusing on the needs, or housing ‘ingredients’, that study participants identified as being most important to securing housing – help finding a place to live (86%), money for a deposit (83%), more income/benefits/rent subsidies (79%), household supplies (63%), and transportation (63%).

INTERVENTION RECOMMENDATIONS

For an overall summary of the recommendations described below, see the section Recommendation Summary at the end of the Discussion section.

PILLARS OF THE INTERVENTIONS

There are several aspects of the intervention that went well and should be seen as pillars for its success:

1. Regular communication across the intervention team.
   - This may be conducted through phone or in-person meetings.

2. On-site, low-barrier services and supports.
   - Due to the complex needs and challenges experienced by client participants (e.g. mental health challenges, mobility limitations, limited energy), it is imperative that services are flexible and mobile.

3. Active participation from healthcare providers to identify those at risk of homelessness.
   - As some patients may not willingly disclose that they are at-risk of being discharged to homelessness, healthcare providers must explicitly pose the question.

ROLE CLARITY AND ORIENTATION PROCESSES

Time and resources to clarify roles and responsibilities within and outside the service provider team is needed. We also reccomend that new team members, including community partners, have an in-hospital orientation. This orientation should include a tour of the hospital to become familiarized with the layout and units they will be servicing, as well as an introduction to hospital staff and hospital work culture. It is recommended that the intervention is promoted widely and at numerous locations within the hospital and points during participants' stay.

Most client participants were referred to the intervention by their social worker. While this is an excellent referral resource, there is a wide range of healthcare providers who may be privy to the housing status of their patients and may play a role in discharge planning. Nurses, physicians, discharge planners, and other in-hospital care providers should all be included in training and information sessions about the intervention. This would prevent patients' homelessness status from being missed while they are

receiving care. It may be that the admission clerk if noting someone has no ID, such as a health card, could also flag the person for assessment of housing risk.

IN-HOSPITAL NETWORK

The intervention's team comprises of a Housing Stability Worker and caseworkers from other community social services. Having an in-hospital network would facilitate the intervention's efficiency and accessibility, to both participants and hospital staff. This network would include private office space, where participant documents can be secured. This space would also be available for regular meetings within the team and with hospital healthcare providers.

Sharing a Housing Stability Worker between two hospital sites at times created gaps in care and significant travel time between sites. At times, the demand in one site was too great for a single Housing Stability Worker. Consequently, it is recommended to increase the number of intervention team members, particularly for the role of Housing Stability Worker. The housing stability worker is the usual referral point and should also include program coordination duties. However, this was difficult with only one person in the role across the sites. This coordinator role is a liaison between the various members of the team and the hospital system. Coordination can provide guidance to community partners and new team members in navigating the physical space of the hospital, as well as the network of hospital staff. Additionally, they can help hospital staff access the various resources included in the intervention.

EARLY RISK IDENTIFICATION

Early identification of an individual's risk of discharge to homelessness is essential to maximize the length of time supports can be provided while still in hospital. This extra time could increase the likelihood that intervention's participants are discharged into housing. Healthcare providers suggested that the referral sources be expanded to include other units such as non-medical units (e.g. the Emergency Department, Critical Care Trauma Center, Intensive Care Unit). Although it may seem that client participants in these units would be unable to begin looking for housing, all intervention respondents felt that it may be helpful in some cases to begin the referral here to maximize time to intervene.

It was also recommended that patients be screened for housing as soon as they are admitted to hospital. This could include asking if the patient has an OHIP card or a permanent address. Patients can consequently be flagged as possible participants for the intervention immediately upon intake and the process to find stable housing can happen sooner.

A basic referral tool can be administered once a participant has been flagged as requiring the intervention. This tool would ask the client participant the information required by team members in order for them to begin application or referral processes. Additionally, the client participant will only have to provide the information to one person, instead of repeating their needs to multiple service providers. Ideally, this tool would be placed in an in-hospital office space, where team members can discuss client participants and access client participant information as necessary.

INGREDIENTS FOR SUCCESSFUL HOUSING

There are elements that are key "ingredients" required for successful housing. Without one or more of these ingredients, it is very difficult, or near impossible, to secure housing. Consequently, it is recommended that interventions be well equipped to address these ingredients within the intervention. For instance, the intervention's team should include enough financial resources and personnel to accompany participants to set up bank accounts or apply for an ID. There were other necessary ingredients identified by client participants via the Consumer Housing Preference Survey that were not addressed in this iteration of the intervention. These ingredients included access to a telephone and access to housing that had higher levels of supports for participants' increased needs (i.e. onsite clinical staff during the day time).

The service integration process should be working towards a streamlined, low-barrier way to secure client participants' necessary ingredients. For example, respondents suggested negotiating an agreement with Service Ontario to fast track identification applications coming from the hospital's intervention. Inclusion of such processes and services can impact waiting periods and facilitate a smoother journey to securing housing.

TRANSITION OUT OF HOSPITAL

It was highly recommended by participants, healthcare providers, and community partners to include a transition piece from hospital to community. Community supports should be facilitated by the intervention while the participant is still in hospital. A transition worker or another member of the intervention's team should be involved before and during the transition out of hospital. Wrap-around supports are required to maintain housing or to continue to search for housing if the participant has been discharged to homelessness. This is especially important for medical units that often have shorter patient stays than the psychiatric units, in which previous iterations of the intervention were implemented. Referral to housing first agencies can be supported by the transition worker for those with ongoing needs.

Additionally, it is imperative to actively follow up with participants in the community. This means searching for participants, rather than waiting for them to reach out to the NFA intervention, since it is the most effective way to reach this population. Actively following up could be through a link with a community partner in the homelessness sector, or it can be program embedded.

PILLARS OF THE INTERVENTIONS

PILLARS OF THE INTERVENTION

- Regular communication across the intervention team
- On-site, low-barrier services and supports
- Active participation from healthcare providers to identify those at risk of homelessness

EARLY RISK IDENTIFICATION

- Screen patients as soon as they are admitted into hospital – ask if patient has an OHIP card or a permanent address other than a shelter
- Include a referral tool which collects information that can be accessed by the entire NFA team, in order to streamline financial application processes

ROLE CLARIFICATION AND ORIENTATION PROCESSES

- Increase clarity and awareness of the Housing Stability Worker role and the NFA intervention
- Include a wide range of health care providers
- In-hospital orientation for NFA team members (Housing Stability Worker, and community partners)

INGREDIENTS FOR SUCCESSFUL HOUSING

- ID; Income; Credit rating; Rental history; Personal and landlord references; Bank account; Relationships (to co-sign, support, etc.) and; Furniture and household appliances
- All need to be addressed when trying to find, secure, and maintain successful housing

IN-HOSPITAL NETWORK

- Include one Housing Stability Worker for each hospital site, to increase intervention efficiency and accessibility
- Host regular meetings within hospital
- Provide private office space

TRANSITION OUT OF HOSPITAL

- Community supports established before discharge
- Wrap-around support to maintain housing or continue housing search
- Active community follow-up, either a link with a community partner in the homelessness sector, or program imbedded

LIMITATIONS & SUGGESTIONS FOR FUTURE RESEARCH

Future development and evaluation of the intervention could benefit from longer intervention implementation and evaluation timeframes. The current funding was for only 9 months to establish and evaluate the intervention with a new population. Implementing an intervention and effectively having it adopted by client participants and staff takes time, given the scale and complexity of hospital systems. Some key stakeholders in patient discharge planning had not been aware of the intervention's existence until the intervention's final month. Allowing for a longer intervention delivery timeframe would also allow for the recruitment of more intervention and evaluation participants.

A longer evaluation timeframe, meaning following up with participants past 3 months, could help generate greater insight into the efficacy of the intervention. Client participants sometimes have challenges maintaining housing even when it is initially obtained, as identified in focus groups and qualitative interviews. Consequently, having a longer timeframe for evaluation could potentially elucidate the need for integrating a continuum of service as client participants transition from hospital to community.

As with all voluntary studies, there are also likely biases in the pool of study participants who self-selected for participation. There is no baseline data available about how many individuals are at-risk of discharge to homelessness in hospital medical units. Consequently, the proportion of at-risk individuals reached is unknown. It would be helpful to be able to determine this number and begin to evaluate the intervention's reach and accessibility for future evaluations

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APPENDIX A

QUESTIONS FOR STAFF FOCUS GROUPS & CLIENT PARTICIPANT QUALITATIVE INTERVIEWS

1. What has gone well with NFA v2?

2. What were some of the barriers (problems) you faced?

APPENDIX B

NFA V.2X BROCHURES

Housing Stability Program

An on-site program designed to meet the housing and financial needs of individuals receiving inpatient services from London Health Sciences Centre's Department of Medicine, University Hospital.

Patients are encouraged to use this service in coordination with their treatment team.

Housing Stability Program

To book an appointment, call:

CMHA Housing Support Worker:
(519) 709-0172

Ontario Works:
(519) 661-2489 ext. 4621

Do you need help finding or keeping HOUSING?

The Housing Stability Program can help

Date of brochure: June 18, 2018

What is The Housing Stability Program?

The housing stability program is a service that can assist individuals receiving inpatient health services on a medical unit at London Health Sciences Centre with their housing and financial needs.

Patients can meet one-on-one with a housing advocate from the Canadian Mental Health Association (CMHA) for help with finding or keeping housing.

Patients also have the option of meeting one-on-one with an Ontario Works or Housing Stability Bank caseworker if their situation would benefit from this service.

Housing Stability Program staff can provide:

- Resources and information to help you **find or keep housing**
- **Support with housing searches**, including transportation
- Help applying to **Ontario Works** or the **Ontario Disability Support Program** for financial assistance to cover basic needs and housing
- Help applying to Salvation Army's **Housing Stability Bank** for financial assistance with Rental Arrears, Last Month's Rent and Emergency Utility Assistance (Hydro, Union Gas, and Water)

To book an appointment, call:

CMHA Housing Support Worker:
(519) 709-0172

Ontario Works:
(519) 661-2489 ext. 4621

Date of brochure: June 18, 2018

APPENDIX C

STAKEHOLDERS INVOLVED

LIST OF COMMUNITY AGENCIES

1) Canadian Mental Health Association Middlesex
2) The Salvation Army Center of Hope, Housing Stability Bank
3) City of London, Ontario Works

PARTICIPATING HOSPITAL SITES

1) London Health Sciences Centre, Victoria Hospital
2) London Health Sciences Centre, University Hospital

APPENDIX D

PARTICIPANT QUALITATIVE INTERVIEWS LETTER OF INFORMATION & CONSENT

Letter of Information and Consent
(For Potential 'No Fixed Address' Version 2 Focus Group Client Participants)
Study Title: No Fixed Address Version 2 (NFA v2)

Principal Investigator: Cheryl Forchuk
Lawson Health Research Institute
Parkwood Institute Main Building
550 Wellington Road Suite B3-110
London ON N6C 0A7
(519) 685-8500 x 77034

As someone who participated in an interview for the No Fixed Address Version 2 (NFA v2) study, you are being invited to participate in a focus group examining a program to reduce discharge to homelessness. The No Fixed Address Version 2 (NFA v2) program allows on-site access at the hospital to housing resources such as the Ontario Works database and housing databases that list available rental units in London in an effort to reduce hospital discharge to homelessness. The purpose of this letter is to provide you with information to make an informed decision on participating in this research. In other words, this letter contains information to help you decide whether or not to participate in this study. Please take the time to read this carefully. Feel free to ask questions if anything is unclear or if there are words or phrases that you do not understand. This letter is yours to keep.

Description of Project

This study is looking to test the effectiveness of a program designed to prevent discharge into homelessness. Focus groups with clients will occur at 3 and 9 months post-implementation of the NFAv2 program, and include questions about your perceptions of the intervention, strengths of its implementation strategy, and suggestions for improvement. You may attend one or both focus groups. The focus group will take approximately 1 hour to complete. The information from the focus groups will be used to help contribute to the development of evidence-based recommendations for responsive, client-centered options in the future.

LAWSON
HEALTH RESEARCH INSTITUTE

Risks
There are no known risks for participating in this study.

Benefits
You may benefit from having an opportunity to voice your concerns and opinions about how well the program has worked for you. Your input may have an effect on how initiatives to promote housing stability, health outcomes and community integration are can be improved for the future.

Confidentiality
We will collect your name and contact information during the focus group in order for you to sign the consent form. No information that discloses your identity (e.g., your name) will be released or published. The focus groups will be audiotaped with a digital voice recorder. Audio recording of the focus groups is mandatory. The data and audio files from the focus groups will only be seen and heard by investigators and the research team, and will be kept on a password-protected computer at Parkwood Institute, behind a hospital firewall, with no personal identifying details. Members of Western University's Health Sciences Research Ethics Board and Lawson quality Assurance Education Program may also access the study records. The recordings will be destroyed after the study is complete. The transcripts and the other information collected about you will not have your personal identifying details (such as name or address) and will be kept under lock and key and on a computer with a protected password behind a hospital firewall at Parkwood Institute. The data (audio recordings and transcripts) will be retained for 15 years following the end of the study and will then be destroyed. If you would like to receive a copy of the overall results of this study or participate in our annual community forums, please put your name and contact information on a blank piece of paper and give it to the investigator conducting the focus group. Focus group members are asked to keep everything they hear confidential and not to discuss it outside of the meeting. However, we cannot guarantee that group members will maintain confidentiality. Absolute confidentiality cannot be guaranteed as we may have to disclose certain information under certain laws (i.e. duty to report suicide thoughts, child abuse, abuse by a regulated professional or intention to harm another person).

Compensation:

A light meal and refreshments will be provided during the focus group to thank you for your time

Voluntary Participation
Joining this study is voluntary. You may refuse to join, refuse to answer any questions or leave the study at any time with no effect on your care. You can ask to take a break, or refuse to answer any question. You also have the right to request the withdrawal of your data. You do not waive any legal rights by signing the consent form and being in the study.

Representatives of the Western University Research Ethics Board and Lawson's Quality Improvement and Education Group may have access to study-related information. They may contact you or require access to your study-related records to monitor the conduct of the research. If you have any questions you may direct them to the principal investigator or the research coordinator at the contacts below:

Cheryl Forchuk RN PhD
Professor, (Nursing) Western University
Scientist, Lawson Health Research Institute
Mental Health Nursing Research Alliance
Parkwood Institute Main Building
B3-110 550 Wellington Road
London, ON N6C 0A7
(519) 685-8500 x 77034

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Anne Skelton
Research Coordinator
Mental Health Nursing Research Alliance
Parkwood Institute Main Building
B3-110 550 Wellington Road
London, ON N6C 0A7
(519) 685-8500 x 77096

For St. Joseph's Health Care London:
If you have any questions/concerns about your rights as a research participant or the conduct of this study, please contact: St. Joseph's Health Care London Patient Relations Consultant at 519-646-6100 ext. 64727

For London Health Sciences Centre:
If you have any questions about your rights as a research participant or the conduct of this study, you may contact the Patient Experience Office at LHSC at (519) 685-8500 ext. 52036 or access the online form at: https://apps.lhsc.on.ca/?q=forms/patient-experience-contact-form.

Preventing Discharge to 'No Fixed Address' Version 2 (NFA v2)
Consent Form

I have read the Letter of Information, have had the nature of the study explained to me, and I agree to participate in this interview. All questions have been answered to my satisfaction.

Name (Print): ________________________

Signature: ________________________

Date: __________________, 20___

Name of Person Responsible for Obtaining Informed Consent (Print):

____

Signature of Person Responsible for Obtaining Informed Consent:

____

Date: __________________, 20___

APPENDIX E

SERVICE PROVIDER FOCUS GROUP LETTER OF INFORMATION & CONSENT

Letter of Information and Consent
(For Potential 'No Fixed Address' Version 2
Service Provider - Focus Group Participants)

Title: Preventing Discharge to 'No Fixed Address' Version 2

Principal Investigator: Cheryl Forchuk
Lawson Health Research Institute
Parkwood Institute Main Building
550 Wellington Road Suite B3-110
London ON N6C 0A7
(519) 685-8500 x 77034

The No Fixed Address Version 2 (NFA v2) project offers direct access to the Ontario Works database from hospital along with access to a housing advocate and housing database in order to prevent discharge from hospital to homelessness. As a healthcare provider who has utilized these services, you are being invited to participate in a study examining the NFA v2 program. The purpose of this letter is to provide you with information to make an informed decision on participating in this research. In other words, this letter contains information to help you decide whether or not to participate in this study. Please take the time to read this carefully. Feel free to ask questions if anything is unclear or if there are words or phrases that you do not understand. This letter is yours to keep.

Description of Project
This study is looking to test the effectiveness of a potential best practice to prevent discharge to homelessness. Specifically, we are looking to examine a program designed to prevent discharge into homelessness. Focus groups with healthcare professionals, social service providers, and the Housing Stability Worker will occur at 3 and 9 months post-implementation of the NFAv2 program, and include questions about your perceptions of the intervention, strengths of its implementation strategy, and suggestions for improvement. You may participate in one or both focus groups. The focus group will take approximately 1 hour to complete. The information from the focus groups will be used to help contribute to the development of evidence-based recommendations for responsive, client centered options in the future.

Risks
There are no known risks for participating in this study.

Benefits
You may benefit from having an opportunity to voice your concerns related to how well our initiatives to promote housing stability, health outcomes and community integration work to prevent hospital discharge to homelessness.

Confidentiality
We will collect your name and contact information during the focus group in order for you to sign the consent form. No information that discloses your identity (e.g., your name) will be released or published. The focus groups will be audiotaped with a digital voice recorder. Audio recording of the focus groups is mandatory. The data and audio files from the focus groups will only be seen and heard by investigators and the research team, and will be kept on a password-protected computer at Parkwood Institute, behind a hospital firewall, with no personal identifying details. Members of Western University's Health Sciences Research Ethics Board and Lawson quality Assurance Education Program may also access the study records. The recordings will be destroyed after the study is complete. The transcripts and the other information collected about you will not have your personal identifying details (such as name or address) and will be kept under lock and key and on a computer with a protected password behind a hospital firewall at Parkwood Institute. The data (audio recordings and transcripts) will be retained for 15 years following the end of the study and will then be destroyed. If you would like to receive a copy of the overall results of this study or participate in our annual community forums, please put your name and contact information on a blank piece of paper and give it to the investigator conducting the focus group. Focus group members are asked to keep everything they hear confidential and not to discuss it outside of the meeting. However, we cannot guarantee that group members will maintain confidentiality. Absolute confidentiality cannot be guaranteed as we may have to disclose certain information under certain laws (i.e. duty to report suicide thoughts, child abuse, abuse by a regulated professional or intention to harm another person).

Compensation:
A light meal and refreshments will be provided during the focus group to thank you for your time

Voluntary Participation
Joining this study is voluntary. You may refuse to join, refuse to answer any questions or leave the study at any time with no effect on your care. You can ask to take a break, or refuse to answer any question. You also have the right to request the withdrawal of your data. You do not waive any legal rights by signing the consent form and being in the study.

Representatives of the Western University Research Ethics Board and Lawson's Quality Improvement and Education Group may have access to study-related information. They may contact you or require access to your study-related records to monitor the conduct of the research. If you have any questions you may direct them to the principal investigator or the research coordinator at the contacts below:

Cheryl Forchuk RN PhD
Professor, (Nursing) Western University
Scientist, Lawson Health Research Institute
Mental Health Nursing Research Alliance
Parkwood Institute Main Building
B3-110 550 Wellington Road
London, ON N6C 0A7
(519) 685-8500 x 77034

Chrissy Court
Research Coordinator
Mental Health Nursing Research Alliance
Parkwood Institute Main Building
B3-110 550 Wellington Road
London, ON N6C 0A7
(519) 685-8500 x 75719

Anne Skelton
Research Coordinator
Mental Health Nursing Research Alliance
Parkwood Institute Main Building
B3-110 550 Wellington Road

London, ON N6C 0A7
(519) 685-8500 x 77096

For St. Joseph's Health Care London:
If you have any questions/concerns about your rights as a research participant or the conduct of this study, please contact: St. Joseph's Health Care London Patient Relations Consultant at 519-646-6100 ext. 64727

For London Health Sciences Centre:
If you have any questions about your rights as a research participant or the conduct of this study, you may contact the Patient Experience Office at LHSC at (519) 685-8500 ext. 52036 or access the online form at: https://apps.lhsc.on.ca/?q=forms/patient-experience-contact-form.

Preventing Discharge to 'No Fixed Address' Version 2.
Consent Form

I have read the Letter of Information, have had the nature of the study explained to me, and I agree to participate in this interview. All questions have been answered to my satisfaction.

Name (Print): ___________________________

Signature: ___________________________

Date: ____________________, 20___

Name of Person Responsible for Obtaining Informed Consent (Print):

____

Signature of Person Responsible for Obtaining Informed Consent:

____

Date: ____________________, 20___

APPENDIX F

CLIENT PARTICIPANT LETTER OF INFORMATION & CONSENT

Letter of Information and Consent for Participants

Study Title: Preventing Discharge to 'No Fixed Address' Version 2x (Medical Wards)

Principal Investigator: Cheryl Forchuk RN PhD
Labatt Family School of Nursing, Western University
Lawson Health Research Institute
550 Wellington Rd, Suite B3-110
London, Ontario N6C 0A7
Tel: 519-685-8500 ext. 77034

You are being invited to join a study. The study looks at a program to reduce discharge to homelessness from medical wards. The program allows access at the hospital to housing resources. These include the Ontario Works and housing databases that list rental units in London. This letter contains information to help you decide whether or not to join this study. You can get the service even if you do not join the study. Please take the time to read this carefully. Feel free to ask questions if anything is unclear or if there are words or phrases you do not understand. This letter is yours to keep.

Description of Project
This study looks at issues related to housing for recently discharged patients. We are looking at issues of people with housing challenges. Approximately 160 people who took part in the program will also join this study.

Procedure
We would conduct interviews at the location of your choice. The interviews will last from one to two hours. We would ask you questions about your physical and mental health, social services use, and housing history. The first interview will be near the time of discharge. The second interview will occur 3 months after you are discharged. We will need your phone number, address, e-mail, and the contacts of people close to you to help us find you. You may also call our office to set up the interviews. Our phone number is listed at the end of this letter. It is also listed on a lanyard that we will give to you.

You will be given $20 for each interview and focus group. Joining the study is voluntary. You may refuse to join, refuse to answer any questions, or leave the

study at any time with no effect on your care. You do not waive any legal rights by signing the consent form.

You will receive a copy of the letter of information and signed consent form. You can join the program even if you do not wish to join the research. The research will not involve any extra costs to you.

If you are part of another study at this time, please inform us to see if it is appropriate for you to join our research.

Risks
There are no known risks for joining this study.

Benefits
People in this study may benefit from having a chance to voice their concerns about income and housing support. The project should help prevent homelessness for people leaving hospital find housing.

Confidentiality
No information that reveals your identity will be released. This includes your name, address, and date of birth. The data from the interviews will only be seen by the research team. It will be kept on a password protected computer with no personal identifying details at Parkwood Institute. A master list will be used with identifying information and will be kept apart from the data. A unique number will be used to identify people, but keep responses confidential. The list of identifiers (including your full name and date of birth) will be destroyed 15 years after data collection is complete. Data with no identifying information will be retained in perpetuity. This will allow for the research team to conduct further analysis to answer additional questions from the data provided in the future.

If you would like to receive a copy of the results of this study please put your name and contact information on a piece of paper and give it to the person interviewing you. Absolute confidentiality cannot be guaranteed. We may have to disclose certain information under certain laws (i.e. duty to report suicidal thoughts, child abuse, and abuse by a regulated health professional or intention to harm another person).

Western University's Health Sciences Research Ethics Board and Lawson Quality Assurance Education Program staff may also access the study records.

Voluntary Participation
Joining this study is voluntary. You may refuse to join, refuse to answer any questions or leave the study at any time with no effect on your care. You can ask to take a break, or refuse to answer any question. You also have the right to request the withdrawal of your data. You do not waive any legal rights by signing the consent form and being in the study.

Representatives of the Western University Research Ethics Board and Lawson's Quality Improvement and Education Group may have access to study-related information. They may contact you or require access to your study-related records to monitor the conduct of the research. If you have any questions you may direct them to the principal investigator or the research coordinator at the contacts below:

Cheryl Forchuk RN PhD
Professor, (Nursing) Western University
Scientist, Lawson Health Research Institute
Mental Health Nursing Research Alliance
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B3-110 550 Wellington Road
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(519) 685-8500 x 77034

Research Coordinator
Mental Health Nursing Research Alliance
Parkwood Institute Main Building
B3-110 550 Wellington Road
London, ON N6C 0A7
(519) 685-8500 x 77097 or 77096

For St. Joseph's Health Care London:
If you have any questions/concerns about your rights as a research participant or the conduct of this study, please contact: St. Joseph's Health Care London Patient Relations Consultant at 519-646-6100 ext. 64727
For London Health Sciences Centre:
If you have any questions about your rights as a research participant or the conduct of this study, you may contact the Patient Experience Office at LHSC at

(519) 685-8500 ext. 52036 or access the online form at:
https://apps.lhsc.on.ca/?q=forms/patient-experience-contact-form.

I have read the Letter of Information, have had the nature of the study explained to me, and I agree to participate in this interview. All questions have been answered to my satisfaction.

Name (Print): ________________________

Signature: ________________________

Date: __________________, 20___

Name of Person Responsible for Obtaining Informed Consent (Print):

____

Signature of Person Responsible for Obtaining Informed Consent:

____

Date: __________________, 20__

In this study, some of the people who do an interview will be asked to participate in a focus group at a later date. If you are interested in being contacted to attend focus groups, please indicate yes or no: yes___ no__