Understanding the hospital discharge process for people experiencing homelessness

Presentation to the Housing and Homelessness Service Planning Forum

Dr. Jesse Jenkinson
February 9, 2021

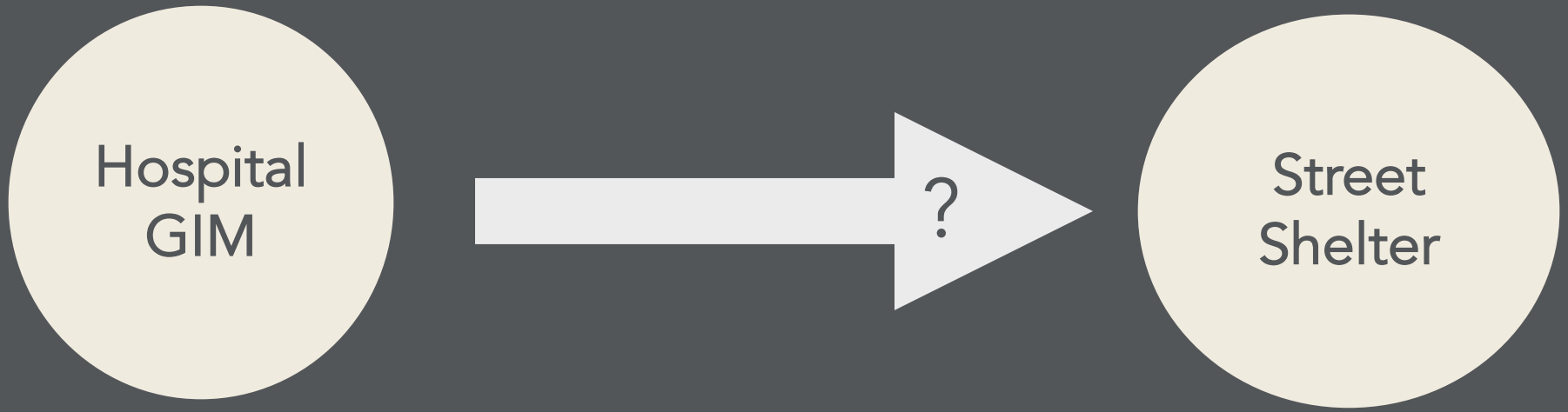
MAP Centre for Urban Health Solutions

Outline:

1. The issue: Failed or inadequate hospital discharges for people experiencing homelessness
2. Research findings: Contextualizing the issue
3. The COVID-19 context
4. Some ways forward

Hospital Discharge

Contextualizing the Crisis in the Hospital Discharge Process for People Experiencing Homelessness in Toronto, Canada: "Danger and Opportunity"

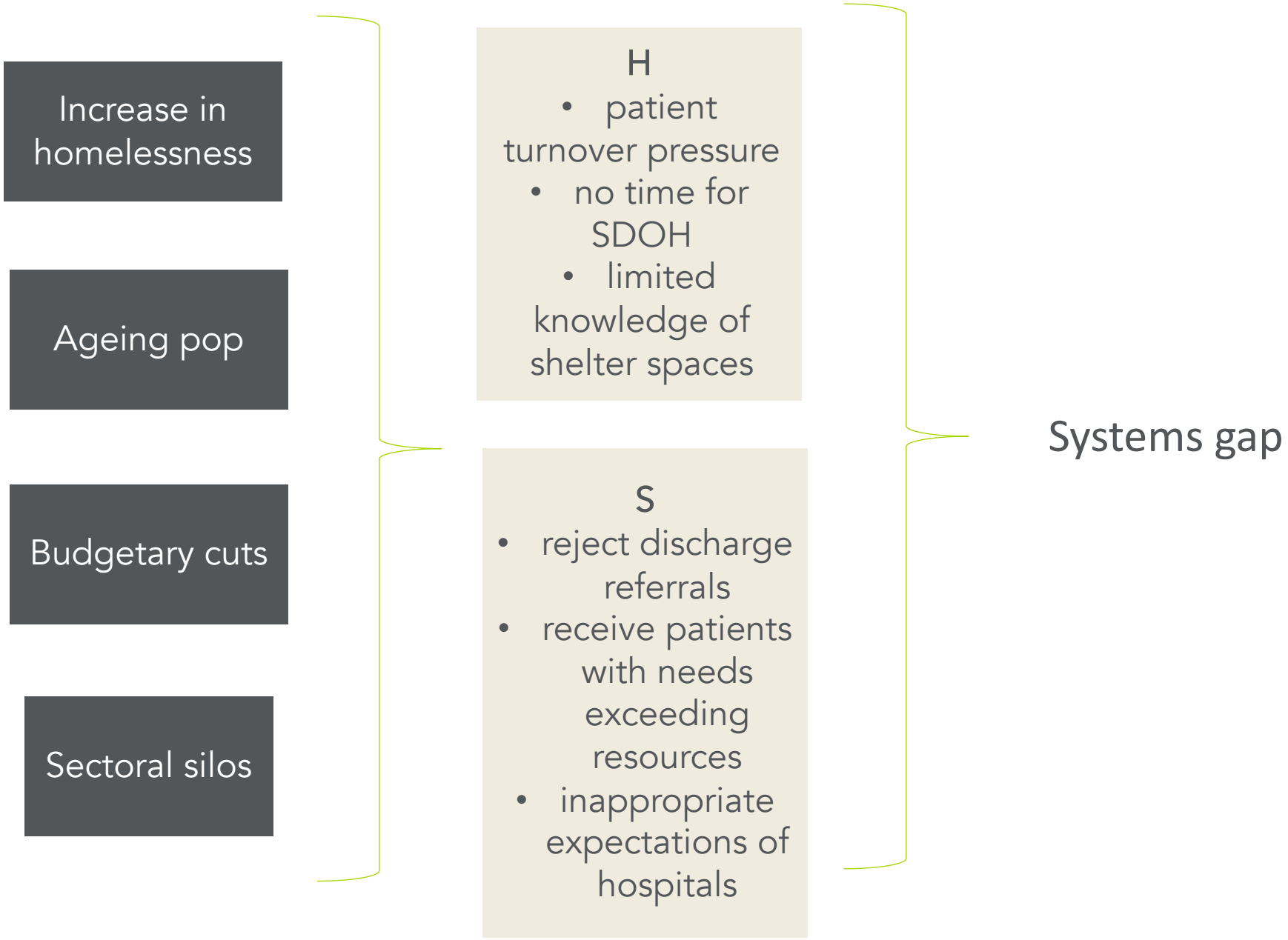


Study Design

Methodology	Qualitative Study
Participants (33)	Hospital Workers (16, from 3 hospitals), Shelter Workers (6), Key Informants (11)
Sample	Purposive and snowball sampling strategy
Recruitment	November 2018 – April 2019
Settings	Toronto, Ontario, Canada: 3 urban hospitals
Data generation	Semi-structured interviews + field notes

Finding discharge destinations

Finding discharge destinations



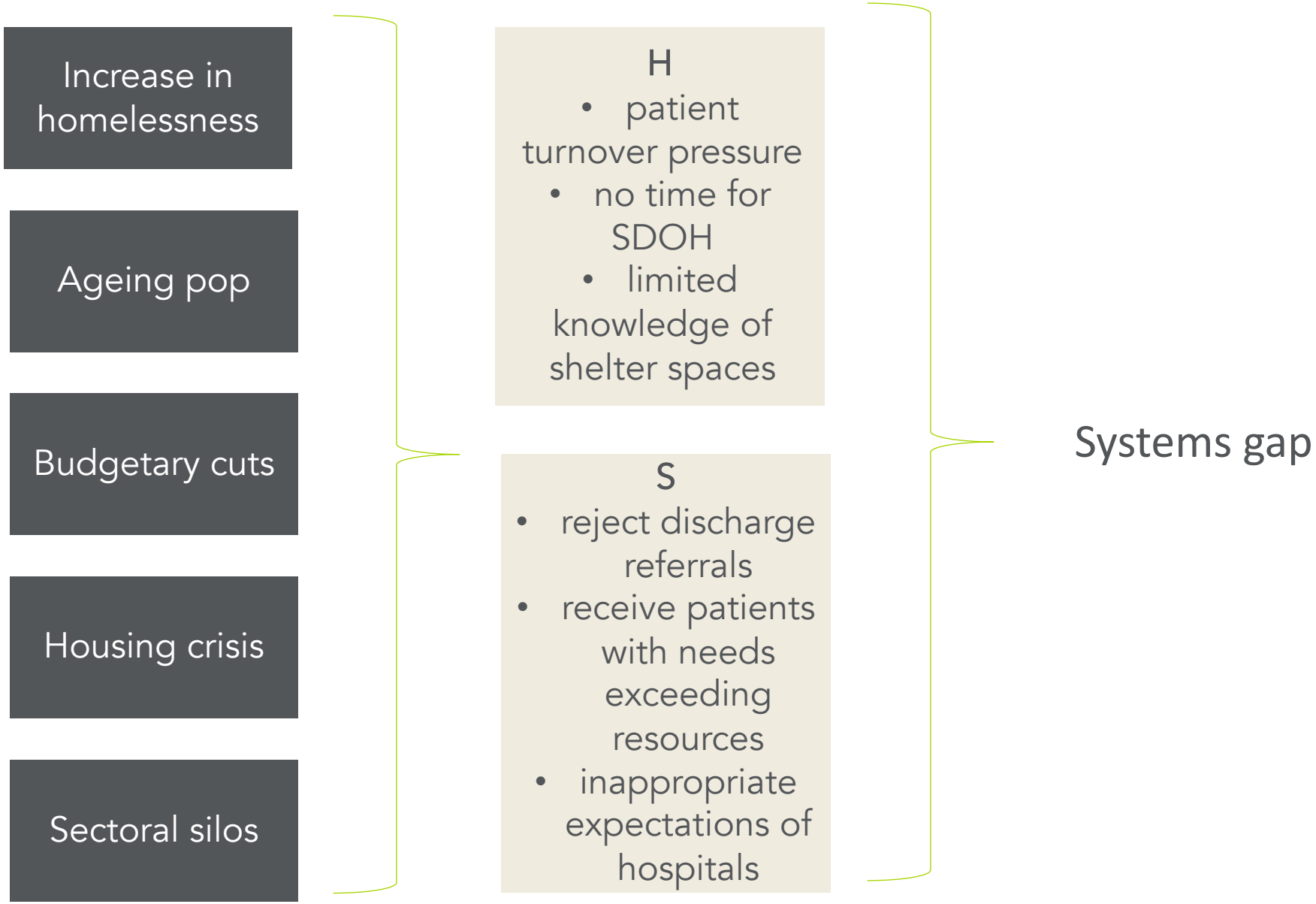
Some of our patients who come in frequently [pause] there isn't the same patience once they've been in a few times … I had someone the other week who management encouraged me not to see because so many other things had been tried in the past, so once he was stable, they told me that I had an hour before he would be leaving the hospital, which with housing [laughs] you could spend a week on something and still not have somewhere for someone to go.

(P_1b, Hospital)

The community will always say to us, "but you guys are all so well resourced, you have everything you should. Why can't you do it [get patients into housing]?" To which our response is, "**we are an acute care hospital, we have a length of stay that we have to manage, you know how many people are in my emergency room right now?**" … [H]ousing is not acute care … I'm not going to be able to suddenly find housing for him after however long, so … the person is going to go back to the community as is.

(P_3, Hospital)

Finding discharge destinations



We become **the last stop** and there's no other option and we **wouldn't always be in the best position to adequately service the needs of people** who present, but with no other option that is what happens and that is a challenge.

(KI_2b)

I don't think that hospitals really understand our capacity for caring for people. Sometimes people will get these follow up care plans that we don't have the capacity to support. I can't help you shower; I can't do this and this. [I]t's frustrating for us because, if that's the care plan, then why did the hospital send you back here instead of putting you in a program where they can actually do that?

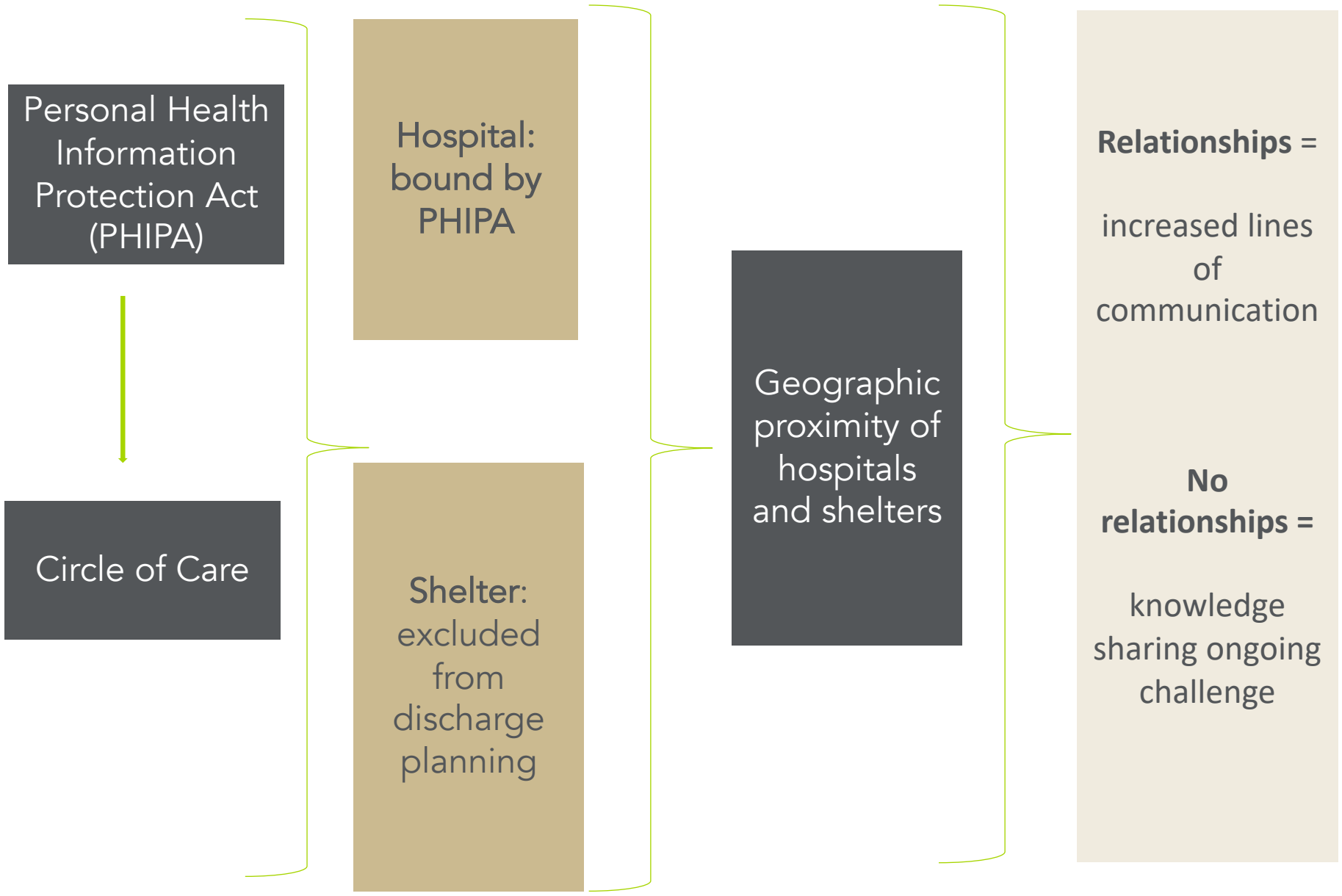
(P_S8, Shelter)

Recently I had a homeless patient who jumped off a fence and broke both of his heels. [He] needs total care … most places that provide that total care for the 6-8 weeks … require a discharge disposition [a guaranteed place he will go after his stay at this interim facility]… [W]e can't send him there without knowing that he has housing afterwards; this patient is also not able to go to a regular homeless shelter because he can't physically care for himself and he has to be in a wheelchair for the next 6 weeks, even though he's 25 years old.

(P_2, Hospital)

Knowledge sharing

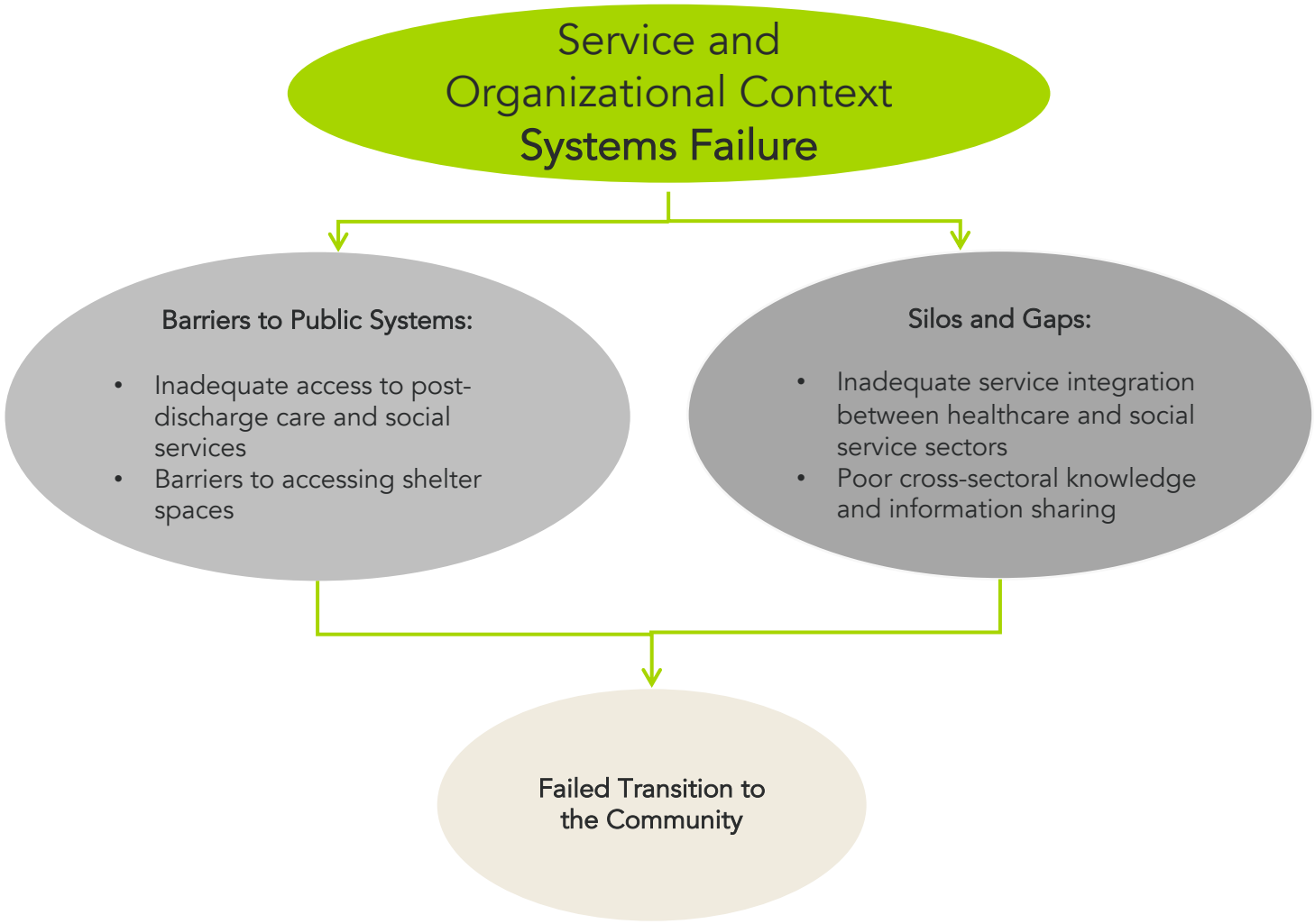
Knowledge Sharing



If you rewind the clock 10 years ago, we had full access and were fully able to communicate with each other and share information. Then … PHIPA, … and we had no access for five or six years and it put some strain on our relationship with healthcare providers because it was like, who's part of the circle of care and who isn't? And then this whole business of, "Well, we're not gonna share information with you because you're not a clinician. You're a shelter worker." And it's like, "Well, we understand … but this man lives with us. Anything you can provide would be really helpful."

(P_S19, Shelter)

Overarching systems failure



We're funded to support [people] that are here, living in a bed, actively. When somebody ends up … in the hospital, they get discharged from the shelter. They're not here. A new client takes that bed and then that case manager has a full caseload again … It's the same as the discharge planner. Once that person's acute health care crisis is over and they're out of the hospital, their role is done and they have to move on to the next patient that needs them.

(P_S19, Shelter)

COVID-19 Pandemic

- Challenged to connect to community services (lockdowns, reduced capacity)
- Hard to find shelter space

St. Michael's Hospital Emergency Department				
Date	# seeking shelter	# cold-related injuries	# leaving w/out shelter	Temperature
Jan. 25, 2022	5	2	6	-8
Feb.4, 2022	4	1	2	-11
*there has been some improvement in the last week. These numbers are likely an undercount.				

- Warming centres at capacity
- Shelter hotels – private space for people to recover

St. Michael's Hospital, Toronto: The Navigator Program

Interventions

Good Shepherd, Hamilton: Intensive Supports Program

Inadequate discharges: complex explanations

- Hospital discharge policies tailored to unhoused patients
- Formalize and systematize hospital-shelter relationships
- Interim facilities
- Continuity of care
- Affordable housing

Thank you!

Acknowledgements

- Dr. Erica Di Ruggerio, Dr. Stephen Hwang, Dr. Carol Strike
- Study participants, site PIs
- Community workers, hospital workers, city workers, advocates, and everyone else working tirelessly to try and protect the lives and overall wellbeing of people who are without safe, secure housing.

This work was supported in part by the **Social Sciences and Humanities Research Council of Canada (SHHRC)** (752-2017-1416), the **University of Toronto Open Fellowship,** and the **Canadian Institutes of Health Research (CIHR)** (FDN-167263). The views expressed in this presentation are the views of the presenter and do not necessarily reflect those of the funder.