HOSPITAL TO NO FIXED ADDRESS

SERVICE PROVIDER ROUNDTABLE SUMMARY REPORT

SEPTEMBER 2025

University of Manitoba

HOPE
END HOMELESSNESS
WINNIPEG

Acknowledgments

On behalf of the project team, we would like to extend our heartfelt thanks to everyone who contributed to the success of the 'Hospital to No Fixed Address' roundtable held on April 10, 2025. We are especially grateful to participants for sharing their insights and expertise, and for their thoughtful engagement and contributions to the discussion.

A special thanks to the Department of Occupational Therapy for partnering with community in such an authentic and passionate manner.

We also acknowledge the support of End Homelessness Winnipeg and Reaching Home who funded the event, Elder Wally Richards and Running Wolf, and Sergeant Tommy Prince Place whose contributions were instrumental in bringing this roundtable to life.

We look forward to continuing the dialogue and collaboration sparked by this event. Thank you once again for being a part of it.

Disclaimer

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Positionality Statement

Prior to discussing our findings from the roundtable event, it is paramount to acknowledge that this roundtable event took place at Sergeant Tommy Prince Place which is located on Treaty 1 territory, the original lands of the Anishinaabeg, Ininiwak, Anisininewuk, Dakota Oyate and Dene and on the National Homeland of the Red River Métis. Acknowledging the water source of Shoal Lake 40.

Students

As women and future Occupational Therapists collaborating with End Homelessness Winnipeg (EHW), we are grateful for the opportunity to partake in this project. As a group, we come from a variety of different lands, backgrounds, and experiences that have shaped our motivations and intentions for this project. We are united in our commitment to justice and anti-oppressive practices. This roundtable event is one small step to creating a “safer" discharge for people at risk of or experiencing homelessness (PEH). Our goal is to continue to address this topic within practice and pursue further collaboration with the community, until this topic is fully and appropriately addressed. Acknowledging that, this is a systemic issue which cannot be addressed within one roundtable event.

Project Advisor

As an occupational therapist with many years of experience working with individuals with histories of homelessness and the forensic system, I have seen discharges from the hospital where supports and medical needs were not in place upon discharge. A situation from my first clinical role has left a strong impression – a man was dropped off in a taxi outside the shelter, having been sent from the hospital with a taxi chit and nothing but a yellow hospital gown, tied at the back. Since then, it has been my passion to see the discharge process shift, where unhoused individuals leave with dignity and a plan in place that will set them up well. The roundtable was a great starting point to shift towards safer hospital discharges, with dignity and supports in place. Discharges to no fixed address are a health issue. This practice lacks dignity for the patients and is an issue that needs to be addressed at the micro, meso, and macro levels. I am committed to continuing this work towards safer discharges from the hospital for unhoused individuals and to advocating for justice and anti-oppressive practices for unhoused individuals.

Community Partner

As a person who works alongside lived-experts, community organizations and across the four levels of government to prevent people from experiencing homelessness, it was a tremendous opportunity to partner with the Department of Occupational Therapy on this project. I am committed to using my role to amplify the insights of direct staff and people with lived experience. I believe that preventing discharges from hospitals to no fixed address is not only a health issue but a matter of human dignity, and I aim to support policies that reflect that belief. I strive to approach this work with humility, centering the voices of people

with lived experience and recognizing the structural forces—colonialism, racism, poverty—that shape housing outcomes.

Introduction

Hospital discharge into homelessness or “No Fixed Address" exposes a critical and growing gap that indicates there are needed improvements to effectively connect individuals with community supports upon discharge. As Winnipeg's population of people at risk of or experiencing homelessness (PEH) grows (Brandon, 2022) and these individuals place increasing strain on health-care systems due to stark health inequities (Forchuk et al., 2023), neither sector is adequately equipped to address this intersection. Hospitals are not designed for individuals without stable housing, while the homelessness sector is not equipped to support medically complex cases. This leaves vulnerable individuals caught between two systems not designed to work together and service providers feeling like their hands are tied.

The project team facilitated a roundtable event on April 10th, 2025, bringing together community partners to identify contributing factors and create a comprehensive depiction of the current state of hospital discharge into homelessness in Winnipeg. Currently, PEH and those at risk of homelessness face many barriers to recovery post-discharge. The purpose of this roundtable event was to identify the following on micro, meso, and macro levels:

- Barriers and facilitators,
- What's working and what's not working, and
- Potential future-oriented solutions for a safer discharge

By gathering this information our objective was to identify the main themes related to each of these overarching topics. To elaborate on the last purpose listed, our hope was to provide insight into potential steps forward and identify opportunities to support smoother transitions from hospital post-discharge. This will be an ongoing project as our work only begins to dissect the complex systemic issues related to discharge from hospital to "No Fixed Address".

As part of the University of Manitoba Master of Occupational Therapy program, students are paired with community partners to engage in meaningful collaborative work in a community setting. These partnerships are often long-term, with projects typically spanning multiple years and each student group building upon the work of the previous year.

This was End Homelessness Winnipeg 's (EHW) first year partnering with a student group for the Community Partner Projects (CPP). Given the strong relationship we have built, and the important initial work done, we hope this partnership will continue and that this project will be carried forward by future student groups.

A term that often comes up within hospital settings is the term “safe discharge"; however, given the contextual and subjective nature of safety, we found this term to be an inaccurate depiction of the current state of discharge. Instead, we chose to use the term “safer

discharge” to acknowledge that complete safety is not attainable, as each individual has unique needs that cannot be fully addressed. Furthermore, positioned as occupational therapy students, we aim to work from a harm reduction approach, collaborating with community organizations to help reduce the risks associated with hospital discharge and chronic re-admissions. Our main goal as future occupational therapists will be to work collaboratively from a person-centered approach and trauma informed lens, thus reducing the risk of harm. Having this roundtable event can further inform future opportunities for “safer discharge.”

There were four main sectors that attended the roundtable event. These included representatives in sectors that are Indigenous led, working in hospital, working within community, and working within the housing and homelessness sectors. In addition, lived experts were invited; however, only a limited number were able to attend the event. Gathering multiple community members from various disciplines afforded us the opportunity to collaborate in the roundtable event and create a comprehensive understanding of what is currently happening when PEH are being discharged from hospital. While this phase focused on the experiences of the service providers, the goal for phase 2 is to center the focus around the lived experiences of PEH. This would help to gain further insight into the three main topics that we covered at our roundtable event, including what's working and what's not working, barriers and gaps, and finally, future oriented solutions. These main themes will be discussed further within this report through the dissemination of our roundtable event findings.

Methods & Consultation process

Foundations: Research and Community Engagement

To guide the process, we began by reviewing literature and gaining a basis of understanding about the context surrounding hospital discharge into homelessness. Resources we reviewed included reports issued by EHW and other organizations. Our group also connected with a local community initiative with the intention of better understanding the lived experiences of PEH.

The process of creating questions to guide our initial interviews involved collaboration with the Community Partner and the University Project Advisor. Once preliminary questions were formed, our group conducted initial interviews with lived-experience frontline service providers to gain a more comprehensive understanding of the issue. These initial interviews guided the questions, prompts, and areas of practice that were important to include in this preliminary roundtable discussion.

Preparation: Event Planning and Participant Recruitment

Participant recruitment for the roundtable event involved several steps. Our group generated ideas alongside the Community Partner and with suggestions from the initial interview participants, forming the basis of a list of potential participants. Names were listed alongside their role or organization and contact information, if available. Efforts to obtain contact information were made using several strategies, such as via email, phone calls, and networking. Additional roles and organizations were listed throughout the process, and efforts were made to contact individuals and agencies. We provided information regarding the event and inquired about possible interested participants. Formal invitations were sent out via email by the Community Partner and followed by a reminder email closer to the event date. The invitations included details about the event's time, location, and purpose, as well as the prompt questions they could expect to be asked so that participants had the opportunity to prepare if they chose to do so.

In preparation for the event, we sorted participants that had confirmed their attendance into broad categories based on their primary roles. The purpose of this was to identify areas with less representation and to ensure that each table had participants with varied perspectives and knowledge. Categories included general domains such as “housing,” “indigenous led,” “hospital,” “community,” and “lived experience”. Each participant was assigned two tables. They sat at the first table during the first portion of the discussion and moved to a different table after the break. We decided to rearrange the table groups for the second half of the roundtable with the intention of promoting diverse conversation. However, participants were encouraged to sit where they would be comfortable, and a number brought additional participants to join the roundtable discussion. Each table had approximately five to nine participants, one to two facilitators, and a peer-student notetaker.

Engagement: Roundtable Event and Facilitation

The roundtable event took place on April 10, 2025, from 12:00 p.m. to 4:00 p.m. Participants signed in and were provided with an orientation package which included the schedule, their table numbers, the prompting questions, and the QR code for the exit survey. To open the roundtable, Elder Wally Richard began with a guiding story and a traditional song. Next, we introduced our group, and the Community Partner and University Project Advisor shared the purpose of the project.

Before the group discussions began, each facilitator opened the discussion by thanking the participants for attending and setting out our intentions for the discussion. This included an acknowledgment that not all people who should be included in the discussion were present, and we shared our hopes for the future direction of the project. Participants were introduced to the notetaker and, as facilitators, we shared that the notes would not include any descriptive characteristics and were reviewed following the event to ensure participant anonymity. It was also noted that if participants wished to have their names and quotes included, they could request this at any point.

The event employed a structured three-part discussion format, with each segment exploring a distinct aspect of hospital discharge to "No Fixed Address" including what is currently working, barriers and gaps, and future oriented solutions. Each facilitated session allocated about 25 minutes for in-depth exploration of the designated topic. Facilitators used a structured question matrix with targeted prompts to guide meaningful conversation (detailed in Appendix A).

Participants engaged in their original small groups for the first two discussion prompts. During the food and refreshment break, groups were reorganized to bring fresh perspectives and cross-pollination of ideas to the final solutions-focused discussion.

Participants came together at the end of the small group discussions for a large group synthesis activity using Mentimeter (Mentimeter, 2025). Synthesis questions centered around primary issues requiring immediate attention, key partners and collaborators essential for implementing change, and practical next steps.

The event concluded with a closing ceremony led by Elder Wally and Scaabe, Running Wolf. Lastly, participants were asked to complete an exit survey to evaluate the event.

Analysis: Interpreting and Sharing Findings

Following the roundtable event, our group met several times to discuss the most effective way to interpret and share the information we had gathered from the event. We were mindful of feasibility challenges due to the size of our group and the timeframe of our academic program. The primary resources we used were the notetaker notes from each table. We also used information gathered from our initial interviews, the Mentimeter results, the exit survey results, and an email from a participant who could not attend but responded to the question prompts. We decided to create descriptive codes for recurring topics we identified. This was an iterative and reflexive process, as we continuously added and adjusted our thematic codes and their definitions throughout the analysis (see Appendix B). We applied thematic codes to each statement or discussion excerpt in the notes. This was done individually and was then reviewed by another group member to ensure consistency in interpretation of the codes. Next, we conducted a frequency count, noting the number of times each thematic code string was mentioned. We then reviewed the excerpts of text to identify overarching topics within the most frequently mentioned themes. These themes were then categorized based on their primary thematic code, indicating whether the content reflected something that is working, a gap or barrier, or an opportunity for future directions. Finally, this analysis was collated into a single document that included frequency counts, code strings, main concepts, and excerpts pulled from the various documents.

To share our findings in a way that was both accessible and actionable for a broad audience, we decided to write a “What We Heard” report. This approach allowed us to communicate recurring themes in a clear, organized, and feasible manner. We also recognized the benefit of developing a visual representation to highlight the prominence of emerging topics within

our analysis. The final report and visual materials were shared with all participants and made publicly available through the EHW website.

Principles

During the roundtable event, participants identified several guiding principles that are integral to guiding action and understanding at micro, meso, and macro levels within the context of hospital discharge to “No Fixed Address.” These guiding principles reflect the importance of autonomy, respect, empathy, understanding, and equitable access to health care. The principles detailed below were consistently mentioned across roundtable discussions and are considered instrumental when working with PEH.

Harm Reduction Approach

Key interest parties, and service providers emphasize the importance of using a harm reduction approach with individuals. A harm reduction approach recognizes justice, human rights, and focuses on positive changes without discrimination, judgement or coercion to stop substance use (Harm Reduction International, 2022; Marshall et.al., 2023). During roundtable discussions, participants highlighted that a harm reduction approach is essential; otherwise, people will fall through the cracks. For example, participants identified that individuals are unable to access essential services (e.g., domestic violence shelters) because they use substances. This creates barriers to accessing services, resulting in health care inequities. Additionally, participants spoke about how PEH increasingly struggle to trust the health-care system and service providers due to racism, discrimination and stigma in health care.

> *“They have to fight hard to receive and ask for the care they need and have to disprove the stigma that surrounds them”* – roundtable participant

Participants identified that there needs to be greater emphasis on education surrounding advocacy, de-escalation, cultural safety, and trauma-informed care when considering opportunities to improve hospital discharge to "No Fixed Address.”

Housing First

EHW defines Housing First as a model that “prioritizes finding permanent housing followed by adequate and person-centred wraparound supports for PEH” (Osei-Yeboah, 2024, p. 119). A housing first model is important when considering the systemic gaps that surround hospital discharge to "No Fixed Address." In roundtable discussions, participants emphasized that finding housing is not enough; there needs to be wraparound support available as well.

> *“Not everyone is going to thrive if you just give them a home – staff, accessibility, mobility, and other factors affect someone’s ability to maintain a home”* – roundtable participant

Participants identified how the current institutional system is creating a cycle of individuals needing to return to the hospital due to a lack of access to housing. When considering how

to improve the discharge from hospital to "No Fixed Address", a housing first model must be implemented.

Person-Centered Care

Person-centered care is an integral part of providing health-care services and needs to be adhered to in practice to ensure just and equitable health care. Person-centered care is based on the foundations of treating individuals with respect, dignity and valuing the person's own choice in decisions (Brain Injury Canada, 2024). Person-centered care also values promotion of a therapeutic relationship to build trust and a safe, supportive environment for individuals to be vulnerable (Brain Injury Canada, 2024).

During the roundtable, person-centered care was continually referenced as an important and necessary guiding principle in the context of hospital discharge to "No Fixed Address." Participants identified how crucial it is to follow the client's lead and make time to learn about their preferences. For example, a person may not want housing as they feel a sense of community and belonging in an encampment. If we, as health-care professionals, set our goals of obtaining housing for them first, this will increase social isolation and feelings of loneliness, resulting in future episodes of homelessness.

As service providers, we need to meet the individual where they are and spend time learning about their values, preferences, likes and dislikes to ensure holistic and equitable health care.

Trauma-Informed Care

Trauma-informed care is an approach to care which is important for use among all populations but especially those with high rates of trauma, as it focuses on aspects of the person's life and the injustices they have experienced. It shifts the blame from the person to society and allows for equitable and just provision of services and supports (Canadian Observatory on Homelessness, 2025; Marshall et al., 2023). Trauma-informed care is based on 5 grounding principles: safety, trustworthiness, choice, collaboration, and empowerment (Canadian Observatory on Homelessness, 2025). These principles are used to create a safe and trusting environment for people to be themselves, and not feel ashamed, blamed, or judged.

What We Heard

We heard from many diverse perspectives during the roundtable event, with participants identifying both strengths and shortcomings related to hospital discharge and homelessness. We acknowledge that this report does not capture every topic discussed; however, each conversation was instrumental in building a framework of understanding.

Several key themes were identified consistently throughout the discussions, highlighting areas of shared priorities. When we asked participants about approaches and practices that are currently having a positive impact on those experiencing hospital discharge into homelessness, this is what we heard.

What Works

Collaborative Approaches & Community-Building

Many participants shared that interactions built on partnership and collaboration were vital to a successful transition for PEH. Participants identified that community organizations and frontline workers who embrace a person-centered approach to care are best positioned to support and provide high quality care to this population. Community safety hosts, minor treatment centers, mobile overdose prevention sites, and other programs like these were mentioned throughout discussions. Creating and promoting community was also considered to be a key factor when addressing the health concerns of PEH and aligns with a person-centered approach. Community-building might look like bringing resources into an area so that they are more easily accessible, strengthening the community's capacity to serve its members and their collective well-being. Even without consistent shelter or housing, PEH can still be supported by the community.

A willingness to be flexible and provide wraparound support was also mentioned consistently. No single organization or program can provide every form of care a person might require. Strong communication and meeting individuals where they are is crucial. For example, Manitoba Housing may request Sunshine House outreach workers to check in on an individual, and the response was typically felt to be very receptive. Flexibility in care enables providers to meet individual needs. Collaboration between hospitals and shelters was noted to vary but was noted to have consistently increased. A key component was building relationships to promote communication and the sharing of information. This demonstrates how a foundation of trust, communication, and partnership are necessary to provide adequate care across multiple systems.

Addiction Services in Emergency Departments

Participants mentioned the notable benefits of having psychosocial support available in hospital emergency departments. Specifically, addiction services were viewed as helpful for individuals who require the support, which also adds complexity as addiction has been

stigmatized in many settings, and it can be difficult to determine who requires the service. Another valued approach was a 24-hour social work model that provides continuous access to psychosocial support for those requiring immediate services. While some participants noted challenges with this approach, such as staffing limitations, having on-site staff who operate from a psychosocial perspective was considered highly beneficial. Harm-reduction approaches were also highlighted as a key component of effective care, particularly for PEH who seek support through the emergency department. These insights emphasize the importance of integrating consistent and comprehensive care in hospital emergency settings.

Expedited Housing Processes

Another theme that participants frequently identified as a valuable mechanism in supporting PEH was the use of expedited housing processes. Specifically, participants described how hospital-based social workers can initiate priority status applications for housing on behalf of PEH. This allows for accelerated review and implementation of housing support through Manitoba Housing as part of discharge planning. The ability to fast-track housing applications was seen as an essential tool in addressing the complex needs of PEH upon discharge. These processes represent an important initial step in promoting equity in both health care and housing access.

What Doesn't Work

Systemic Operational Barriers & Policy Constraints

A reoccurring theme when it comes to systemic barriers is the operating hours of the local hospitals and being able to make sure the safety of the client is adequately accounted for prior to 5pm. Having limited hours of operations of specific specialists and disciplines not only affects the continuity of care, but the transition into the community. Additionally, many community resources and organizations are closed evenings and weekends making it difficult to organize the care accordingly to ensure a smooth transition.

A large external pressure that stems from operational barriers is the push to discharge individuals due to bed utilization. There is consistent pressure for health-care workers to continue to discharge individuals to increase bed flow within hospitals. However, this often leads to recurrent re-admissions for PEH, thus creating a cycle that further complicates safer discharge practices. Due to these external factors, an already stressful environment becomes compounded for health-care workers when they are pressured to discharge individuals with unmet needs. As a result, service providers experience internal conflict as to whether it is deemed "safe" for individuals to be discharged, especially under extenuating circumstances for PEH.

The system in which hospitals exist presents another key operational barrier. For many individuals, the hospital environment does not feel safe and is not a place they want to be. Many individuals have experienced discrimination, racism, and oppression within the health-care system, therefore making it difficult for people to access care. PEH may

experience mistreatment, frequently resulting in inadequate support for them to be successful upon discharge. Understandably, this reduces the motivation for PEH to seek out health-care services.

The hospital is a natural 'hub' where there is persistent systems overlap, including competing policies and regulations. Many of the existing and intersecting policies are outdated and do not center around the needs of all individuals. For example, if there is an active warrant for arrest, people may be hesitant to attend a hospital, due to a large police and/or security presence. Further, for individuals who are exiting hospitals and who are unable to access employment and income assistance, it is difficult to meet their basic needs without a source of income. This may lead to confusion and feelings of 'risk' for the PEH needing to access medical care, and confusion for the service provider in knowing how to best support the person.

Lack of Housing & Transitional Supports

When it comes to housing, there is a lack of accessible spaces, as well as a lack of sustainability parameters in place to ensure PEH are able to recover "safely." The need for sustainability is a systemic problem. For example, home care services are available within shelters; however, there are limited times in the day that home care staff can access shelters. Some sites are deemed to be "at risk" because the sites are unsafe for the home care staff to access outside of the specified hours. There are additional barriers making it difficult for people to access shelters post-discharge, such as limited availability, hours of operation, and waitlists. Some shelters also have policies that present further barriers such as requirements that individuals not be using substances or have ID cards present.

Within hospital settings, there are several barriers to assisting PEH with securing housing, such as lack of access to income and timeframes to obtain ID. Even when resources are provided, follow-up becomes difficult due to the design of the system. Furthermore, if community-based supports are set up, the probability of individuals being able to access them is questionable. They may face additional barriers due to transportation needs, the geographic location, and accessibility requirements, as there are few shelters within the city that can accommodate mobility aids. There is oftentimes no follow-up from the hospital due to current caseloads and systemic pressures to discharge individuals quickly.

Reactive Health-care Systems

From a systematic lens, the hospital is built upon a medical model; through the roundtable event this was apparent when it comes to the approach used within hospitals on a macro level. The contrast between the approaches and models used in the community was highlighted throughout discussions. The recovery model is often used at the forefront of practice in community, coming from a trauma-informed and harm-reduction approach. This approach allows PEH to be properly connected to resources and to have the time and designated space to be able to recover. This model allows individuals further autonomy on how they would like to proceed when dealing with complex medical conditions.

Through further discussion, participants identified concerns about how people with complex medical needs are often discharged without having their outstanding needs addressed. This typically occurs when their needs are not considered acute, resulting in discharge without appropriate resources. Additionally, PEH may have difficulty accessing various services post discharge. Participants noted that many barriers persist, as the medical model is not conducive to meeting everyone's needs within the current system.

Workforce & Staff Burnout

With some overlapping points of discussion, the staff who are at the forefront of working with PEH, whether in hospital or in the community, commonly experience burnout. This stems from a systemic issue of lack of funding resulting in staff shortages. These shortages can lead to staff turnover and affect the continuity of care for many PEH. Additionally, this affects the sustainability of positions within the community and creates barriers for health-care and community workers. Staff shortages lead to larger caseloads impacting the approach being used by staff, making it difficult to use a person-centered approach. Participants also identified barriers when it comes to advocating on behalf of their clients due to systems in place and discharge pressures to increase bed flow.

Communication & Care Coordination Failures

Throughout the roundtable event, participants discussed the repercussions of hospital protocols, such as role constraints limiting service providers' ability to follow up with individuals post discharge, making it difficult to determine if individuals have successfully accessed recommended supports. As a result, this may lead to chronic re-admissions and worsening health outcomes for PEH.

Furthermore, participants noted the difficulty of navigating communication with other service providers in a timely manner and being able to share information without violating the Public Health Information Act (PHIA). Participants emphasized the importance of using respectful, objective language when charting or speaking about clients. They noted that service providers should be mindful of potential biases in their documentation. Using inclusive and objective language was identified as essential for accurate and appropriate client documentation.

Another challenge related to care continuity is the challenge in locating PEH post-discharge to provide follow-up. Specifically, PEH who have sexually transmitted and blood born infections (STBBIs), or who are undergoing testing, are difficult to locate in the community after testing. This makes it challenging for PEH to be aware of their current health status. As a result, they are oftentimes uninformed of their test results.

Opportunities for Action

During the large group synthesis activity using Mentimeter[1] (Mentimeter, 2025), a visual representation (Figure 1) was generated using participants' responses to the question "Who needs to be involved in implementing effective change?". Participants emphasized the importance of continuing this discussion as a feasible next step in understanding and addressing hospital discharge to "No Fixed Address".

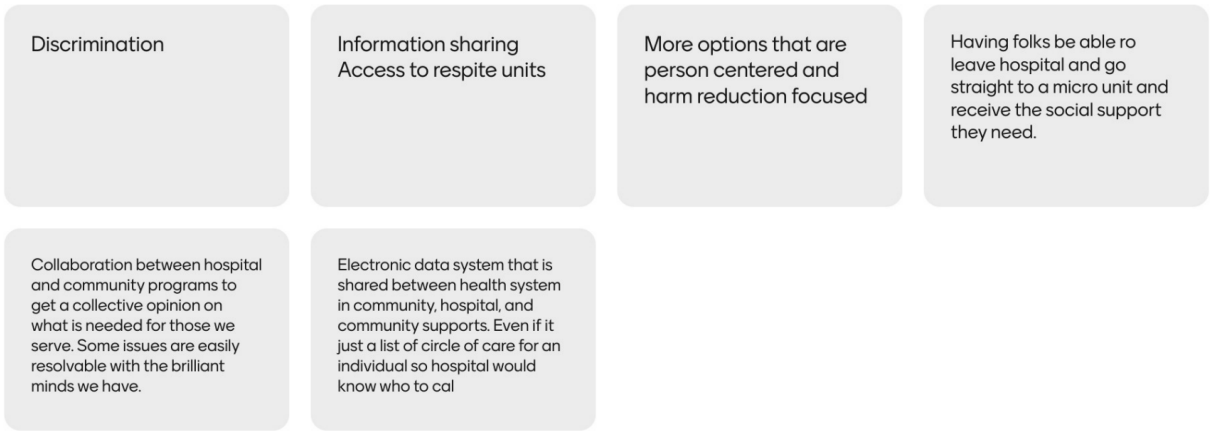
Figure 1: Who Needs to be Involved in Implementing Effective Change

Note. Larger text represents greater frequency of concept in participants' responses.

Participants were then asked, "What is the primary issue you hope you to see addressed, regarding safer hospital discharge processes for those experiencing homelessness?", the following visual representation was created:

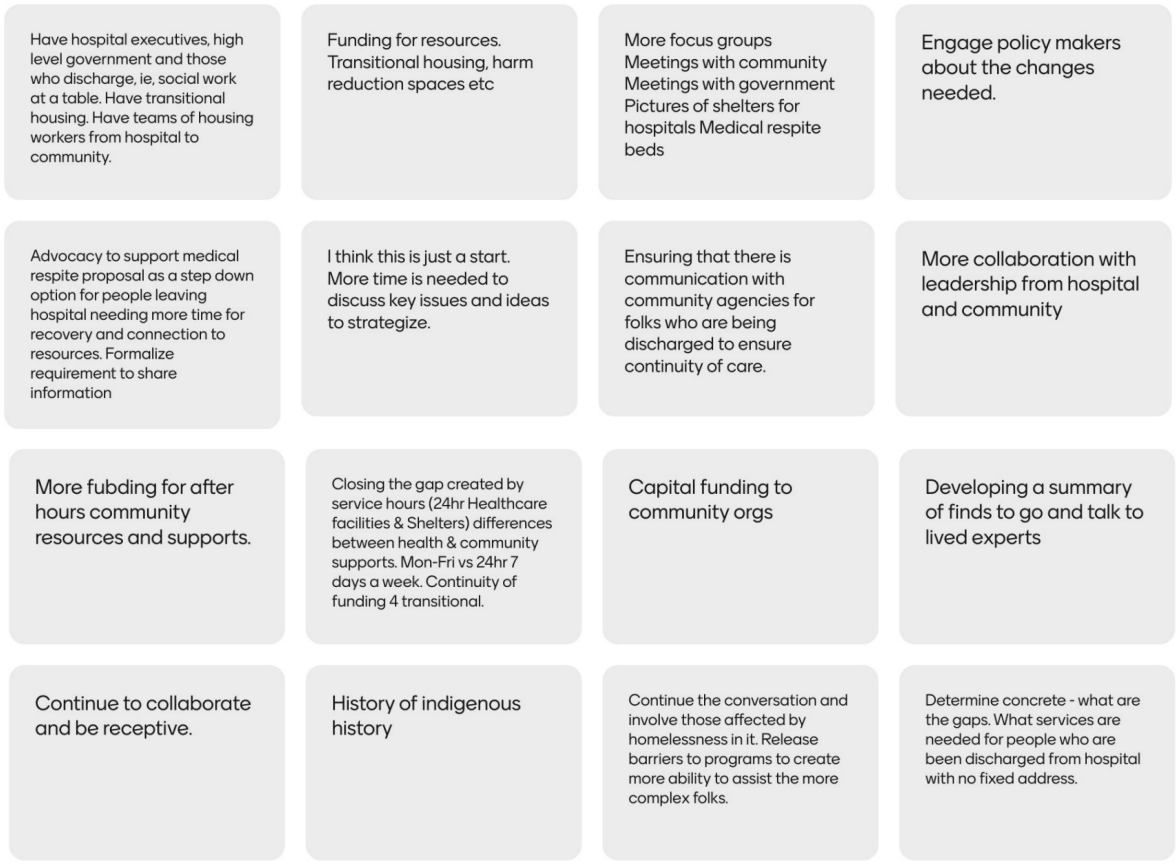
[1] Please note that all Mentimeter results are verbatim.

Figure 2: Primary Issues to Address



Finally, participants were asked, "What are the reasonable 'next steps' to move this work forward?". The responses are reflected in Figure 3.

Figure 3: Reasonable Next Steps



Short-Term (1 year or less)

Reflecting the breakout discussions, participants identified several short-term opportunities (1 year or less) to bridge the gap between hospital and community services. The most prominent theme was improving communication and care coordination pathways, with providers calling for increased collaboration between hospital and community leadership to establish and maintain these connections. Supporting networking opportunities was noted as an effective strategy, allowing providers to build relationships with key contacts across organizations. Additional recommendations centered on creating designated liaison roles in both hospital and community settings to facilitate care coordination and serve as site contacts.

Participants identified practical solutions such as establishing donation-based in-hospital clothing depots to address individuals being discharged with insufficient clothing, and identified provision of basic needs and transportation as ways to increase safety upon discharge. Additionally, they suggested creating visual resources such as videos and pictures of local emergency shelters to help providers better understand community options and inform discharge planning.

Medium-Term (1-2 years)

Building upon the short-term opportunities to improve communication and care coordination, participants highlighted the need for proper consultation between hospital, home care, and community agencies to ensure the feasibility and sustainability of discharge plans within community settings. This includes providers working together across systems and agencies to support individuals in maintaining housing. To further support inter-agency communication and care coordination, providers need increased access to basic individual

information without breaching PHIA. For example, when discharging people who are connected to community agencies, hospitals should notify those agencies that their client is hospitalized, enabling the community organization to prepare for continuity of care rather than starting from scratch upon discharge.

Related to systemic operational barriers and policy constraints, participants identified the need for more equitable partnerships and flexibility within practice. Providers cited challenges with rigid guidelines that impede their ability to be person-centred and respond to complex situations, calling for more freedom for direct service workers to make decisions about client needs rather than strictly following policies and protocols that may not fit individual circumstances.

Long-Term (up to 5 years)

Long-term opportunities center around systemic changes requiring the involvement of government officials, policy makers, and institutional leaders. Participants consistently highlighted the need for increased funding to community agencies, supportive housing organizations, and health care. Participants recommended dedicated funding and restructuring to support more 24/7 care models including after-hours community resources and supports.

Participants called for increases in the number and variety of housing and transitional supports, including more specialized beds such as low-acuity units, transitional care units, detox facilities, and Rapid Access to Addictions Medicine (RAAM) beds. There is also demand for greater availability of low-barrier intermediate care options that employ psychosocial and harm reduction approaches to support people in recovery post-hospital. This could help "get the ball rolling" by obtaining identification, submitting applications for housing and supports, and navigating systems during their transition. Participants emphasized the importance of creating these housing and transitional supports in partnership with community agencies such as emergency shelters and home care.

To further support communication and care coordination, participants discussed the potential benefits of a universal electronic charting and medical record system. This would enable providers across systems and agencies to gain a greater understanding of what supports an individual has in place and what steps have been taken or missed in obtaining safe housing and other supports. However, this was tempered by concerns regarding PHIA and the importance of honouring autonomy.

Participants emphasized the need for greater uptake and application of psychosocial models, calling upon institutional leaders in health care and education to support this shift through curriculum changes and system restructuring. Specifically noting that the medical model is insufficient when working with individuals experiencing or at risk of homelessness. As an example, the health-care system must recognize that for PEH or at risk, obtaining

identification and access to EIA are high priorities. Additionally, hospital social workers should be given more time by prioritizing psychosocial issues, not just discharging based on medical model perceptions of health.

Finally, participants emphasized the importance of increasing the role of community in problem solving while simultaneously reducing the role of government. Calling for more community-driven solutions that recognize and build upon the capacity of the community to produce creative, sustainable, and realistic solutions to address issues centering around hospital discharge and homelessness.

Limitations of the Project

As with any first effort to address a complex topic, our project contains gaps and limitations of its own. One of the greatest limitations of this project was that it lacked the involvement of people with lived experiences of homelessness. When we had begun discussing the roundtable in the fall, as a group we decided to focus on including direct service providers at our roundtable discussion. Our decision was mostly due to the initial focus of being discharged from hospital to "No Fixed Address", as a health-care systems issue.

Another limitation of our project is related to feasibility. Our project was limited to the ten months of our school year, which has constrained the depth of our analysis of the roundtable and dissemination of our findings.

It is also important to note that the roundtable event was held in a wide-open location within a community center where noise made it difficult to hear. This created challenges for notetakers in transcribing discussions, and therefore the breadth and depth of conversations may not have been fully captured.

Conclusion

The topic of hospital discharge into homelessness or “No Fixed Address” warrants conversation, intention, and action. In this project, we were able to generate a more comprehensive depiction of the issue and stimulate discussion on what is working, what the gaps are, and what opportunities for action might help to bridge the gap. Moving forward, future CPP student groups might intend to add to the momentum created in these discussions. Our hope is that future work will be centered around those with lived experience of hospital discharge into homelessness, providing them with a platform to elevate their voices and share their valuable perspectives on the issue.

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Appendix A: Roundtable Event Prompting Questions

Main Theme/Stem	Prompts
1. <u>What's working right now</u> ***Regarding the process of hospital discharge for those experiencing homelessness, what is working right now?***	***Micro*** What formal and informal strategies are working right now to reduce the harms associated with discharge?
	Meso What is a person-centered approach that could be enhanced or supported? (harm-reduction approaches, methods for decision-making, skill building, helpful organizational policies, social action)
	Macro How do government policies or initiatives positively impact hospital discharge practices for those who are at risk of experiencing homelessness? (Indigenous self-government, City of Winnipeg, Government of Manitoba, federal) How has universal health care positively impacted people who are at risk of experiencing homelessness?
2.<u>Barriers and Gaps</u> ***What are the barriers and gaps…***	***Micro*** that impact your ability to provide quality care that aligns with your values?
	Meso that derive from organizational policies and practices? that derive from organizational and/or community factors? (lack of staffing, geographical location, etc.) that lead to re-admission and/or deteriorating health conditions? that impact continuity of care? (Interagency, collaboration, transition)
	Macro that are a product of systemic issues?

	What systemic issues are you seeing? (availability of mental health resources, housing supply, physical health care, colonialism and racism in health care, organizational funding structures, food insecurity)
3. <u>Future oriented solutions</u> **What's needed to ease the transition to create "safer" discharges for people at risk of or experiencing homelessness?**	***Micro*** What are the needs of someone leaving hospital? - E.g. As someone leaving hospital without stable housing or who is unable to return to their home upon discharge - What do clients need to feel safe upon discharge? What are some strategies to increase individuals' (staff) capacity (skill development, staff development, benefits)?
	Meso What does a "safer" discharge process look like? - Who needs to be involved? What changes could take place in the next 1-2 years? Changes needed within organizations? (policies, practices, funding structures, staffing)
	Macro Housing supply - What types of housing are needed? Changes at the government level (4 levels) (policies, funding, supports, etc.) Transitional health care (continuity of care, smooth and safe transition, coordination of care)

Appendix B: Roundtable Event Analysis Coding Framework

1. Status Code (Primary Code)

- **WRK** - Working well/positive aspect, promising practices
- **GAP** – Gaps, barriers, unmet needs
- **OPP** – Recommendation, solutions and
    - **OPP-S** (up to 1 year)
    - **OPP-M** (1-2 years)
    - **OPP-L** (up to 5 years)

2. Theme Category (Secondary Code)

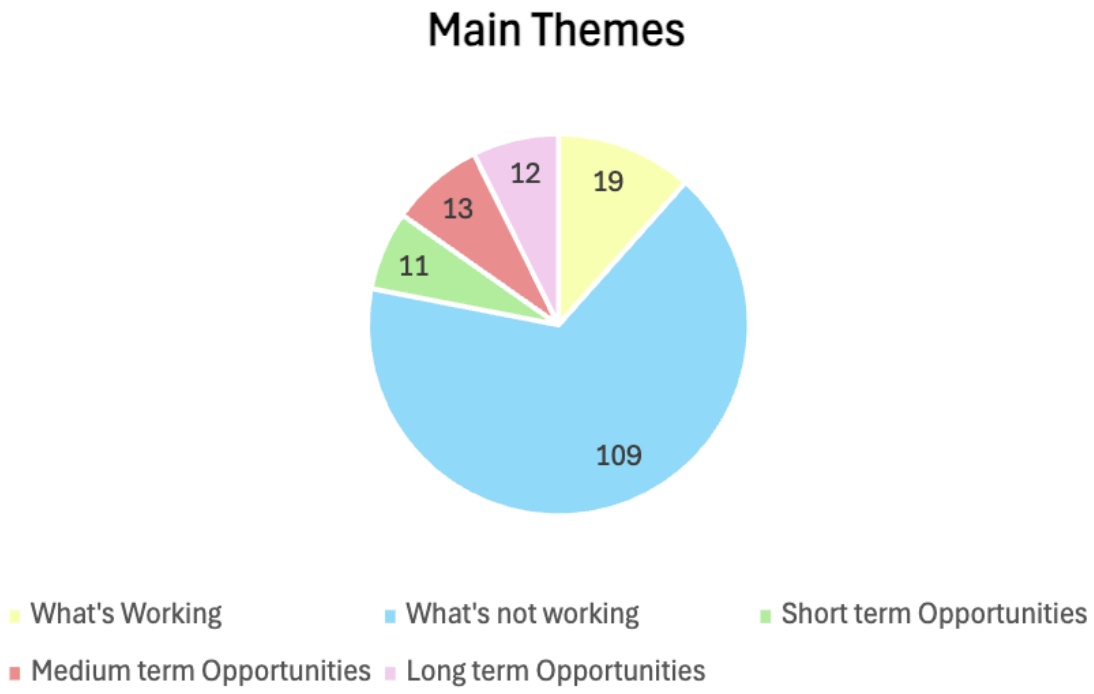
- **COM** – Communication, collaboration, and coordination between practitioners, clients, organizations, systems and hospitals, privacy barriers (PHIA)
- **HSE** - Housing-related, type, availability, level of support
- **CSM** – Case management; pressures to go beyond scope (i.e., into a case-management type role)
- **CAR** - Care approaches and quality, harm reduction, culturally safe practices, medical model, person centered, interdisciplinary team approaches, diagnostics
- **TRN** – Transitions, sub-acute care/recovery spaces, respite, specialized beds/units, and continuity of care
- **SYS** - Systemic and structural factors, time constraints, siloing of services, institutional, discharge pressures, hierarchical health care structure, hours of operation, disconnection between hospital and community, funding, institutional racism
- **STF** - Staffing, capacity, staff wellness/supports, role constraints, scope clarification, workplace cultures, and training
- **WAI** – waitlists and wait-times (e.g., emergency visits)
- **NET** – networking, having contacts in places, dependence on networking for information and access to services
- **RUR** - Rural/remote considerations e.g. geographic location, medical relocation
- **MOB**- Mobility/accessibility issues, built environment (e.g., shelters not having accessible washroom for W/C transfer)
- **INDIG** - Indigenous-specific considerations, colonialism
- **POP –** population-specific; queer people, women, youth, discrimination
    - **POP-M** - Mental health specific
    - **POP-S** - Substance use specific
- **CPX** – Complex Needs, Clients with multiple co-occurring needs (mental health, substance use, cognitive or developmental disabilities)

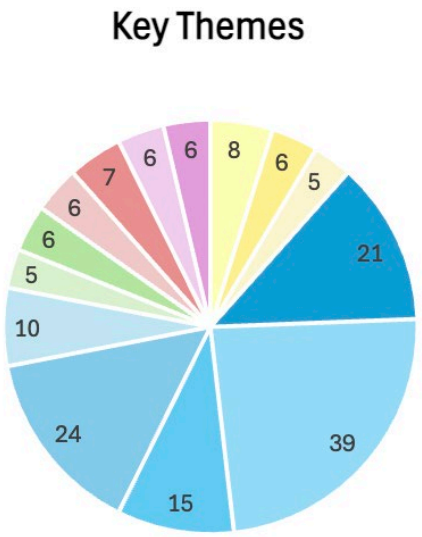
- **TRU** – Trust, Importance of relationships, rapport, and continuity for effective engagement, especially discharge

Appendix C: Visuals

These visuals are a representation of the various codes that were identified from the roundtable event based on participants' discussion and preliminary interviews that were conducted prior to the event. These visuals were created by 5 different occupational therapy students using an informal thematic analysis to best capture the essence of the themes that emerged throughout discussion. The main themes are further explained within the written report.

Note: *All information was gathered and kept confidential. ChatGPT was used as a tool to aid in grouping common themes after the students manually coded the discussion notes from the roundtable event and preliminary interviews.*





What's Working (Yellow)	Frequency
Collaborative Approaches & Community-Building	8
Addiction in Emergency Departments	6
Expedited Housing Processes	5

What's Not Working (Blue)	Frequency
Housing and Transitional Supports	39
Workforces & Staff Burnout	24
Systemic Operational Barriers & Policy Constraint	21
Reactive Health Care Systems	15
Communication & Care Coordination Failures	10

Short Term Opportunities (Green)	Frequency
Collaboration Between Hospital and Community	5
Networking Opportunities & Continuity of Care	6

Medium Term Opportunities (Red)	Frequency
Funding & Continuity of Care	6

Equitable Partnerships & Access to Services	7

Long Term Opportunities (Purple)	**Frequency**
Funding & Community Supports	6
Advancements and Changes in Policies	6