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"It's certainly someone's job": The roles of health care providers in homelessness prevention

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A thesis submitted in partial fulfillment of the requirements for the Master of Science degree in Health and Rehabilitation Sciences

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Abstract

Comprehensive strategies to end all homelessness must include prevention-focused approaches in addition to the provision of emergency services and responsive housing programs. This qualitative descriptive study examines nurse practitioners' and physicians' perceptions of their roles in homelessness prevention and their current involvement in prevention-oriented activities. Data from interviews with health care providers was analyzed using a blended inductive and deductive approach, guided by a Framework for Homelessness Prevention and findings from a document analysis. The results highlighted health care providers' conceptualizations of poverty, housing instability, and associated risk factors and found that providers consider information about patients' social and economic issues, including housing instability, for the 'purpose' of care and to contextualize medical care and treatment plans. Findings suggest that providers feel they share responsibility for homelessness prevention with other health professionals. Still, there remain opportunities for physicians and nurse practitioners to be involved at all levels of change.

Key Words: homelessness prevention; housing stability; primary health care; qualitative methods

Summary for Lay Audience

Homelessness remains a prevalent issue in Canada involving extreme cases of poverty where individuals lack a consistent or safe place to stay. Individuals experiencing homelessness may sleep in emergency shelters, outdoor spaces, or ‘couchsurf’ with family or friends for some period of time. There are known factors that increase someone’s risk of homelessness, for example, living in housing that is not affordable, experiencing job loss (affecting income), mental illness, other health issues, addictions, family and relationship crises, violence, or incarceration. To decrease overall rates of homelessness, action is needed to mitigate these risk factors and prevent individuals and families from becoming homeless in the first place.

Recognizing that health systems share in supporting individuals experiencing homelessness, this thesis explores opportunities for homelessness prevention within the provision of health care. In particular, this thesis considers the role that nurse practitioners and physicians play in assessing a patient’s risk of homelessness and connecting patients to community supports and services that can help to prevent housing loss.

To this end, nurse practitioners and physicians were recruited to participate in interviews to seek their opinions and perceptions of their involvement in preventing homelessness. Participating health care providers shared similar understandings of poverty and housing instability and demonstrated general awareness of risk factors associated with homelessness. Providers explained that knowing and asking questions about a patient’s housing situation was an important part of providing good health care and individualized treatment plans. This study revealed that nurse practitioners and physicians believe they share in efforts to prevent homelessness but may defer responsibility for patients’ housing issues to other providers (mainly social workers) who they feel have more appropriate knowledge and training. Nonetheless, this study highlights opportunities for health care provider involvement in various prevention-oriented activities, including patient advocacy for increased income supports and healthy housing conditions, supporting eviction prevention, assessing homelessness risk, and enhancing patients’ access to other community supports. Overall, this research contributes to knowledge about homelessness prevention in Canada and the appropriate role of health care providers as partners in this work.

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Chapter 1

1 Introduction

1.1 Background

Homelessness is an extreme manifestation of poverty and generally refers to the experience of lacking safe, permanent, and appropriate accommodation, which is necessary for rest, connections with people and places, and control over one's daily activities (Fowler, Hovmand, Marcal, & Das, 2019; Gaetz, 2009). This form of poverty may result in individuals living on the streets or in emergency shelters (absolute homelessness) or 'couch-surfing' with friends or family (relative homelessness; Gaetz, 2009).

Homelessness remains a widespread problem throughout much of the developed world, despite continued pressure from the United Nations for its member states to address homelessness in their countries and develop domestic policies that embody housing as a fundamental human right (Barile et al., 2018). In Canada, homelessness has become increasingly prevalent over the past 30 years (Fleury et al., 2014). In 2016, it was estimated that at least 235,000 Canadians experienced homelessness to some degree and that approximately 35,000 Canadians are homeless on any given night (Gaetz, Dej, Richter, & Redman, 2016).

The modern rise in homelessness has been linked to increasing rates of poverty – due to declining wages and reduced government spending on social supports – and has most noticeably emerged since the 1980s following decreased government investment in affordable housing (Gaetz, Gulliver, & Richter, 2014; Gaetz et al., 2016). In working to solve this complex social issue in Canada, the homeless-serving sector continues to learn about how to prevent people from becoming homeless and how to effectively rehouse individuals who experience homelessness. Solving homelessness will require partnerships across sectors and support from the federal government for municipalities to develop strategies that reflect local needs (Gaetz et al., 2016). However, any long-term strategies to end homelessness will not be complete without expanded investment and changes to housing policy, with a focus on addressing the lack of affordable housing across the country (Gaetz et al., 2014).

1.1.1 Brief History of Affordable Housing in Canada

“Homelessness may not be only a housing problem, but it is always a housing problem.”

– Dolbeare, 1996

Historic attempts to solve homelessness in Canada have largely been centred around the issue of housing affordability, which has been a national issue shaped by economic events and prevailing ideologies, political climates, urban development, and fluctuating federal leadership (Suttor, 2016).

During eras where Canadians have struggled the most to secure housing, these individuals and families’ challenges have stemmed from rental increases that consistently outpace income increases, cuts to social assistance programs (Federation of Canadian Municipalities [FCM], 2008), spiraling housing costs (Oberlander & Fallick, 1992, p. 151), and federal government focus on incentivizing home ownership, which has undermined rental stock production (Gaetz, Gulliver, & Richter, 2014). In the 1930s and 40s, there was much debate around the need for social housing, despite the federal government’s steady confidence in their already-existing mortgage programs for home ownership (Oberlander & Fallick, 1992, p. 42). Still, in 1948, Toronto led the country's first subsidized housing project, which built housing that is now referred to as social or rent-g geared-to-income housing (Canadian Housing and Renewal Association [CHRA], 2014; Oberlander & Fallick, 1992, p. 42). A subsequent boom in public housing development took place in the 60s, with intensive production remaining into the 80s. In Ontario, between 1965 and 1969, public housing production rose from less than 1000 units annually to more than 10,000 units (Suttor, 2016, p. 177), and by 1973, production had reached 115,000 new units (Suttor, 2016, p.73). By the 70s, Canadians were generally well-housed as the federal government continued to use its “power of the purse” (Oberlander & Fallick, 1992, p. 4).

However, during the early and mid 1970s, Canada’s population continued to grow, the first cohort of baby boomers were looking to enter the housing market, and the trend of urbanization pulled more and more families to cities (Oberlander & Fallick, 1992, p. 63; Suttor, 2016, p. 179). Consequently, there was an increased demand for rentals and pressure for housing policy change in these urban settings. Although public housing production remained high even after the 1970s, simultaneous changes to economic and urban ideologies and contexts more significantly shaped the following two decades. In the 80s, a shift to more neoliberal attitudes led to gradually reduced government spending on social programs, including those of new and

existing affordable housing (Gaetz et al., 2014; Holmes et al., 2018). Then, the 90s brought the devolution of public housing responsibility from the federal government to provincial/territorial governments, and then trickling down to the municipalities (Suttor, 2016). The idea that affordable housing was more of a political matter – rather than a government obligation – began to create a precedent as well, which, as is the case with changes to federal-provincial arrangements (Suttor, 2016, p.182), has proven difficult to reverse in the new millennium.

As a response to rising rates of homelessness and low-income families in the early 2000s, the Affordable Housing Initiative (AHI) was launched as a way for the federal government to re-establish a state leadership role in housing policy (Suttor 2016, p.185). The AHI was later renewed in 2011 as the Investment in Affordable Housing (IAH) agreement (Gaetz et al., 2014). Starting with \$680 million in funding between 2001 and 2002, the AHI was a cost-sharing framework between the federal and provincial/territorial governments to produce new rental housing stock and renovate existing stock (Gaetz et al., 2014). The IAH then brought \$1.9 billion and was to “reduce the number of households in housing need” (Gaetz et al., 2014). However, a large portion of the AHI/IAH money ultimately funded rental unit renovations and provided incentives for private homeowners rather than the construction of new affordable stock for Canada's lowest-earners and homeless populations (Gaetz et al., 2014). As a result, AHI funding only amounted to one-fifth of the public housing production seen in the 60s, 70s, and 80s (Suttor, 2016, p. 185). Overall, the private housing market had expanded during this time, but mainly to encourage homeownership rather than providing more affordable rental options for low incomers (FCM, 2008).

Nevertheless, renting in the private market remains a common avenue for many individuals and families since there continues to be intense demand – and therefore incredibly long wait lists – for social housing (Parkinson & Parsell, 2018). However, at the same time, private rental rates continue to inflate and outpace the income increases of renting households, which effectively leaves more and more Canadians with fewer shelter options and “purchasing power” in rental markets that are already tight (FCM, 2008). In a report by the Federation of Canadian Municipalities (2008) that covered trends in housing affordability from 2001 to 2006, it was determined that a single person earning minimum wage would not be able to find an affordable rental unit in any of the 22 Quality of Life Reporting System (QOLRS) municipalities across the country. Most homes in Canada are owner-occupied, but among the 1 in 3 households

that rent, nearly half are paying over 30% of their income on housing (Gaetz et al., 2014), which is not affordable. Further broken down, it is estimated that 10% or about 380,600 Canadian households are in “severe” housing need (i.e., paying more than or equal to half of their income on housing; Canada Mortgage and Housing Corporation [CMHC], 2018), and it is predicted that this percentage will climb as the cost of living increases. These are the conditions that put individuals and families into vulnerable situations of precarious housing and further at risk of becoming homeless.

1.1.2 Current Policy and Shifting Priorities

Recent progress in addressing homelessness has been marked by the global uptake and demonstrated success of Housing First, a housing model that focuses on providing individuals experiencing homelessness with rapid access to permanent housing, regardless of their mental health status or current addiction challenges (Goering et al., 2011). The use of Housing First gained momentum in Canada after the success of the national pilot project, *At Home/Chez Soi*, which took place from 2009 and 2013 (Mental Health Commission of Canada, 2014; Steffler, 2016). At this time, the federal government provided municipalities with funding to address homelessness under the Homelessness Partnering Strategy (HPS). By 2015, the federal government had officially signalled its adoption of Housing First by renewing the HPS with the requirement that municipalities must implement at least 65% of their homelessness initiatives using a Housing First approach (Richter, Gaetz, & Gulliver, 2014).

In 2017, the federal government released the *National Housing Strategy* (NHS) – a 10-year, \$55-billion plan to invest in affordable housing and transform the way homelessness is addressed in this country (Canada Mortgage and Housing Corporation, 2018). Through *Reaching Home*, an NHS initiative, municipalities are now seeing an increase in resources to address homelessness and have been given more flexibility in how they can use this additional funding (Employment and Social Development Canada, 2018). That is, the requirement to implement at least 65% of homelessness initiatives using the Housing First model has been eliminated. This is an appropriate update for communities in federal funding support since Housing First should not be considered the only way to address homelessness. Conceptually, the rapid rehousing of individuals through Housing First only “manages” the pervasiveness of homelessness, whereas robust *prevention* strategies are critical for helping to end all homelessness. Complementing the

successes of Housing First with prevention-oriented approaches is expected to result in a sharp decline in homeless service usage and overall rates of homelessness (Fowler et al., 2019). While use of the Housing First model continues to be studied and recognized as best practice across the developed world, almost all of these countries have also implemented programs focused on homelessness prevention (Piña & Pirog, 2018). Given this context, it is important that in the assessment of efforts to address homelessness, research not only focuses on the efficacy of responsive models (i.e., Housing First) but asks how to fully evolve a system of both responsive *and* preventative models.

1.2 Research Focus and Objectives

It is well established that individuals experiencing homelessness have poorer physical and mental health than the general public and are some of the most frequent users of emergency room services (Fazel, Geddes, & Kushel, 2014; Frankish, Hwang, & Quantz, 2005; Hodge, DiPietro, & Horton-Newell, 2017; Hwang et al., 2013; Marsh et al., 2000; Stergiopoulos, Dewa, Durbin, Chau, & Svoboda, 2010). Given these known links between housing status, health outcomes, and health care, this study broadly explores the involvement of the health care sector in addressing homelessness, focusing on the prevention-oriented side of this work. In particular, past research suggests that primary health care providers can participate in a range of activities related to homelessness prevention, but this potential is frequently unrecognized.

Given this context, the purpose of this study was to:

- 1) Examine the current involvement of physicians and nurse practitioners in various homelessness prevention-oriented activities, and
- 2) Assess these health care providers' awareness and knowledge of poverty and housing-focused community services that support individuals at risk for housing instability and homelessness.

This project was guided by Gaetz and Dej's (2017) *A New Direction: A Framework for Homelessness Prevention*, which explores a definition for homelessness prevention within the Canadian context and provides a typology to categorize prevention activities (See Figure 1). The Framework supported the development of the current study and largely guided the creation of

data collection tools (i.e., interview guides), data analysis, and informed decisions about how to present the study findings.

Importantly, as the current study is about prevention, this thesis does not include an extensive review of emergency services or best practices for supporting individuals who are experiencing homelessness (e.g., emergency shelter provision, providing health care for individuals experiencing homelessness). Although, it is recognized that these topics are critical for developing comprehensive strategies to end all homelessness.

Figure 1: Typology of Homelessness Prevention



Source: Gaetz & Dej, 2017, p. 45

1.3 Outcomes and Significance of this Research

During one-on-one interviews, health care providers shared their knowledge and opinions on issues of poverty and homelessness and discussed their perceived roles in supporting patients' housing situations. Providers also discussed strategies related to assessing patients' risk of housing instability or homelessness, connecting patients deemed at-risk to external supports, and barriers to supporting patients.

This research involved collecting and synthesizing qualitative data to provide a descriptive summary of health care provider insights and experiences. In addition, this study entailed a document review/analysis about provider scopes of practices, ethical guidelines, professional commitments, and expected competencies from various documents published by professional associations and colleges such as the Canadian Nurses Association (CNA), the Nurse Practitioners' Association of Ontario, the College of Nurses of Ontario (CNO), and the Canadian Medical Association (CMA). With this information, comparisons could be made between the findings from interviews with providers and findings from the document analysis.

Ultimately, four major themes are proposed herein: *Conceptualizing poverty, housing instability, and associated risk factors; Determinants of health as the 'purpose' of care versus to 'contextualize' care; Sharing responsibility and leveraging provider skillsets and knowledge; and Roles for providers at all levels of change.* Findings from this study suggest that health care providers can participate in a range of activities that reflect involvement at various levels of homelessness prevention. Moreover, it was found that engagement with homelessness prevention strategies and interventions will vary between providers depending on their knowledge about risk factors for homelessness, awareness of poverty and housing-focused supports in their practice communities, and their perceived ability to effectively intervene and prevent housing loss.

Outcomes of this research include the practical application of a framework for homelessness prevention and a summary of recommendations for future research and next steps for potential policies and strategies that may lead to increased health care provider participation in this work.

Importantly, the current study is timely as the homeless-serving sector leverages the success of Housing First to open up a broader conversation about prevention. At the same time, primary health care continues to shift its focus from disease prevention to tackling the social determinants of health. This current context offers great potential to uncover opportunities for homelessness prevention within the health care sector. Health professionals are understood to play a crucial role in promoting health through every interaction with the public, and now we seek to better understand their role in promoting housing stability.

1.4 Outline of Thesis

The current chapter provided a brief introduction to common definitions of homelessness, its prevalence, an overview of historic attempts to end homelessness in Canada and recent global responses, and a discussion about Housing First. This chapter also discussed the homelessness sector's increased recognition of the importance of prevention-oriented efforts, to complement the success of responsive models. Additionally, Chapter One outlined the current research focus, objectives, and provided an overview of evidence-based links between housing status and health.

The following chapter (Chapter Two) synthesizes available literature and provides a deeper analysis of the connection between housing and health, Housing First, and key features of homelessness prevention, based on current research, including important prevention-related challenges to consider. The literature review also captures the overarching goals and purpose of primary health care, summarizes previous research on health care providers' care and treatment of individuals experiencing poverty or homelessness, and concludes with a rationale for health care provider involvement in homelessness prevention.

Chapter Three begins with a brief summary about how the primary researcher for this study (KM) became interested in research on homelessness. From there, the chapter details the methodology and framework used for this study and outlines the study design, including data collection techniques and approaches used for data analysis. Two primary methods of data collection were used: document analysis and interviews. Chapter Four then presents a summary of the results from an analysis of documents published by the various professional colleges and associations that represent nurse practitioners and physicians. Chapter Five contains the findings determined by analyzing data from interviews with health care providers themselves. Finally, Chapter Six of this thesis discusses the findings from the current study in light of previous research, findings from the document analysis, and in relation to concepts and categories of homelessness prevention described by Gaetz and DeJ (2017). In addition, this final chapter examines limitations associated with the study, recommendations for future research and practice, and then provides concluding remarks for this thesis.

Chapter 2

2 Literature Review

The purpose of this chapter is to provide a review of literature relevant to the current research topics, including homelessness, prevention strategies, and the role of primary health care. The chapter begins with a short description of the goals of health promotion – framing the issue of homelessness as a problem in this field – and briefly examines the social determinants of health (Section 2.1). Next, Section 2.2 provides an overview of the known links between homelessness and individual health outcomes, followed by a description of the Housing First model (Section 2.3) and an examination of risk factors for homelessness as discussed in past research (Section 2.4). Section 2.5 explores nascent conceptualizations and ideas for homelessness prevention and introduces Gaetz and DeJ's (2017) Framework for Homelessness Prevention, which guided the development and implementation of the current study. An overview of historic challenges associated with homelessness prevention is also presented. Next, Section 2.6 outlines the overarching goals and purpose of primary care and then concludes with a rationale for the present study, which explores the potential for greater health care provider involvement in homelessness prevention.

2.1 Homelessness as a Health Promotion Concern

The negative health impacts associated with homelessness have been well-studied and documented within literature. Given the known links between homelessness and health, the pervasiveness of homelessness presents a problem for health promotion. First, by definition, to be homeless is to lack a home, which is arguably one of the most health-promoting spaces a person can occupy (Oudshoorn, Ward-Griffin, Poland, Berman, & Forchuk, 2013). Moreover, whereas health promotion is defined as “the process of enabling people to increase control over, and to improve, their health” (World Health Organization [WHO], 1986, p. 450), the experience of homelessness undermines an individual's ability to use health as a resource for life (WHO, 1986).

Housing is a determinant of health, and more specifically, is considered a social determinant of health – predicated on understandings of social structures and power relationships from the social sciences (Mikkonen & Raphael, 2010). The social determinants of health –

including income, employment, education, gender, social exclusion, early life, and precarious housing, among others – are essential to consider for population health, as they may promote health and simultaneously, when absent or ignored, contribute to profound health inequities (Marmot, 2005; Mikkonen & Raphael, 2010). In fact, literature suggests that addressing the social determinants of health is conceptually equivalent to treating the root causes of illness and disease (Dutton et al., 2018; Raphael, 2003). Canada is one of the world’s biggest spenders on health care and therefore, has a high capacity to treat illness and disease, yet, as Mikkonen & Raphael (2010, p. 5) put it, “What good does it do to treat people’s illnesses, to then send them back to the conditions that made them sick?”. A lack of appropriate housing is an example of a social determinant of health that adversely affects health.

2.2 Homelessness and Health Outcomes

Extensive research has shown that when compared to those who are ‘housing secure’, individuals experiencing homelessness generally have poorer physical and emotional health than the rest of a population (Fazel, Geddes, & Kushel, 2014). Unsheltered individuals are at an increased risk for developing chronic diseases and acute illnesses – likely attributable to the harsh environments they occupy, which expose them to violence, malnutrition, and extreme weather (Hodge, DiPietro, & Horton-Newell, 2017). The experience of homelessness is also linked to higher rates of premature mortality associated with suicide, unintentional injury, and substance use disorders (Fazel et al., 2014; Frankish, Hwang, & Quantz, 2005).

As well as triggering new illnesses, homelessness can exacerbate existing health conditions, especially chronic conditions that require a great deal of self-management, such as diabetes and HIV/AIDS (Frankish et al., 2005). Individuals without stable housing are forced to prioritize their immediate needs, such as food and shelter, and therefore may find it incredibly challenging to establish and maintain medication routines (Keene, Guo, & Murillo, 2018). Conversely, granting homeless individuals access to housing has been associated with increased engagement in health care plans, including better adherence to medication regimes (Kidder, Wolitski, Campsmith, & Nakamura, 2007). Keene and colleagues (2018) also highlight the “cost of adherence” for individuals who spend more time getting to and from medical appointments (i.e., using public transit), experience longer wait times at clinics serving low-income populations, and have limited funds to spend on needed prescriptions.

The experiences of homelessness and ill-health can create a cyclical cause-consequence mechanism, whereby the negative factors at play exacerbate each other (Hodge et al., 2017). That is, not only can homelessness *lead to* poor health outcomes, but homelessness may be understood as a *consequence* of poor health, given that looking physically well, having energy and being free from illness are often determinants of securing employment and making a good impression on potential landlords. For example, Murria (2018) explains that the experience of homelessness is linked to low access to oral health services. Individuals with poor oral health – perhaps without a conventionally aesthetic smile – may be more negatively perceived by others, including landlords. Through such cycles of poor health outcomes and perpetuated homelessness, individuals in these circumstances are often unable to use good health as a resource for creating new trajectories for themselves.

In contrast to the experience of homelessness, having permanent and suitable housing puts individuals in a better position to take control over their health – a key tenet of the WHO (1986) definition of Health Promotion – and ultimately, gain control over their lives. Housing offers privacy and a sense of constancy (Keene et al. 2018), promotes physical and mental wellbeing, and supports integration (and reintegration) into communities and the larger society (Ziersch & Due, 2018). As an illustration of this, results from an American study of formerly homeless individuals, who began living in independent housing, found that a ‘home’ granted participants a sense of control over their lives, an opportunity to construct and repair self-identities, and perhaps most promisingly, the ability to look beyond daily challenges towards their future goals (Padgett, 2007).

2.3 Housing First

The Housing First model is globally recognized as best practice for the development of programs and services that target homelessness (Goering et al., 2011; Greenwood, Stefancic, Tsemberis, & Busch-Geertsema, 2013; Johnson, 2012). The model views housing as a human right, prioritizing the rapid rehousing of individuals experiencing homelessness without strict prerequisites for housing program participation such as sobriety or mental health stability (Goering et al., 2011). Such conditions for housing placement have been characteristic of traditional ‘treatment first’ approaches, whereby individuals are required to prove “readiness” for housing (by resolving addictions or mental health issues; Gaetz, Scott, & Gulliver, 2013, p. 5)

Past research shows that the provision of housing using the Housing First model leads to increased housing stability, improved health outcomes among previously homeless individuals and families (Kennedy, Forchuk, Arku, & Buzzelli, 2016), and reduced costs incurred by health care and justice systems (City of Toronto, 2007; Gaetz et al., 2013). In Canada, the success of Housing First has given the homeless-serving sector leverage to open up broader conversations about innovative policies and practices that address homelessness (MacLeod, Worton, & Nelson, 2017). We know that Housing First works and that part of its success is owing to the wraparound supports that individuals are offered to help them adjust to new spaces and new independence, as well as supports for mental illness and substance use management (Gaetz et al., 2013; Goering et al., 2011; Pearson, Montgomery, & Locke, 2009). However, even as Housing First continues to re-house program participants, Canada has not seen an overall decrease in homelessness (Gaetz, Dej, Richter, & Redman 2016), which suggests that there is still a need for policy action that works to prevent homelessness from occurring in the first place.

2.4 Risk Factors for Homelessness

Conceptualizing what homelessness prevention might look like in Canada first requires an understanding of the contributing factors and root causes of homelessness, which are inherently complex, dynamic, and interrelated (Barile et al., 2018; Davachi & Ferrari, 2012). Factors contributing to the risk of homelessness exist at both structural and individual levels (Davachi & Ferrari, 2012), though researchers warn against describing the causes of homelessness as simply micro or macro since many factors do not neatly fall into precise categories (Barile et al., 2018). Some researchers describe structural factors as creating the “risk” – for example, characteristics of a country’s welfare state, poverty and income inequality, shortages of affordable housing, reductions in public housing, and other social policies (Austen & Pauly, 2012; Barile et al., 2018; Woodhall-Melnik et al., 2018). Indeed, the increase in homelessness over the past 30 to 40 years has been traced back to drastic reductions in government spending on social programs, such as rental subsidy programs and the construction of affordable housing stock (Buccieri et al., 2019; Gaetz et al., 2013). During this time, and even more dominant in the 90s, the federal government continued to devolve the responsibility of affordable housing to the provinces and territories (Suttor, 2016, p. 183). These changes resulted in suspended federal funding for new social housing programs (CHRA, 2014), and likewise, the

elimination of affordable housing from the national policy agenda (Suttor, 2016, p. 179). Arguably, affordable housing has had the most profound impact on the homelessness crisis in Canada – both in addressing through increased availability of and exacerbating through insufficient funding for (Buccieri et al., 2019; Gaetz et al., 2013).

The risk for homelessness created by structural factors such as housing policy is further compounded by individual-level factors. Individual factors and vulnerabilities are said to be the eventual causes of homelessness (Woodhall-Melnik et al., 2018) and may include mental illness, substance abuse, family disputes, lack of education or job skills, and childhood trauma and neglect (Barile et al., 2018; Fowler, Hovmand, Marcal, & Das, 2019; Woodhall-Melnik et al., 2018). The most disruptive life events that are also predictive of homelessness include job loss, eviction, relationship breakdown, domestic violence, and incarceration (Crane, Warnes, & Fu, 2006; Poole & Zugazaga, 2003; Williams et al., 2010). Since there are several factors that contribute to risk of homelessness, patterns of causes can be identified and used to determine opportunities for policies and interventions that divert individuals from homeless trajectories.

2.5 Prevention

2.5.1 Defining Prevention

Gaetz and Dej (2017) propose a framework for conceptualizing homelessness prevention in Canada, which was inspired by international partners and borrows from public health's notions of primary, secondary, and tertiary prevention. Akin to the most upstream forms of primary prevention, Gaetz and Dej (2017) outline three types of *Structural Prevention*. They categorize prevention activities at the structural level, as many researchers have done, using the 'universal, selected, and indicated' typology (Crane et al., 2006; Gaetz & Dej, 2017, p. 13; Szeintuch, 2017). 'Universal' prevention is a type of prevention that is broadly available and targets drivers of homelessness, such as insufficient affordable housing stock, living wage jobs, and social safety nets, and aims to ensure housing access and stability through legislation that establishes a legal right to housing (Fowler et al., 2019; Gaetz & Dej, 2017; Szeintuch, 2017). 'Selected' or 'Selective' prevention refers to programs or interventions that target individuals who are considered the most high-risk for homelessness due to their membership in a particularly vulnerable group, such as families involved with child protection services, youth aging out of

foster care, Indigenous peoples, individuals and youth leaving prison and detention centres, and veterans (Crane et al., 2006; Fowler et al., 2019; Gaetz & Dej, 2017). Such programs may broadly work to address systemic violence, for example, against women, or aim to increase access to housing, education, and other supports among specific groups that are known to face discrimination (Gaetz & Dej, 2017). Whereas ‘selected’ prevention may target *all* individuals in a particular group, ‘indicated’ prevention requires screening individuals to identify those with specialized risk for housing instability and homelessness who can then be directed to specific prevention programs (Crane et al., 2006). Indeed, homelessness prevention efforts may be categorized as population or high risk-level interventions, similar to the model used in public health.

Gaetz and Dej (2017) also outline *Systems Prevention*, *Early Intervention*, *Eviction Prevention*, and *Housing Stability*, which help categorize prevention activities that are all essential for comprehensive, prevention-oriented responses to homelessness. *Systems Prevention* first requires addressing institutional and systems failures by eliminating policies and procedures that undermine individuals’ housing stability and access to supports (Gaetz & Dej, 2017). Restrictions on the length of time an individual can spend in transitional housing is an example of policy that could ultimately lead to their loss of housing (Gaetz & Dej, 2017). Additionally, *Systems Prevention* involves increasing public awareness about benefits and support, and ensuring that these available resources are accessible to those who need them (Gaetz & Dej, 2017). Further, *Systems Prevention* is also about supporting individuals after discharge from a public institution, such as a hospital, to obtain safe accommodation and reintegrate into their communities (Gaetz & Dej, 2017).

Moving towards a more targeted approach to prevention, policies and interventions that help individuals at imminent risk for homelessness, or those who have recently experienced homelessness, are considered *Early Intervention* strategies (Gaetz & Dej, 2017). These strategies help individuals retain their housing or quickly obtain and move into new housing. To focus on supporting those in greatest need, *Early Intervention* first requires outreach, identification, and intake and assessment mechanisms, then also utilizes shelter diversion techniques and case management practices (Gaetz & Dej, 2017).

Gaetz and Dej (2017) consider *Eviction Prevention* to be a form of *Early Intervention*, whereby programs and strategies are “designed to keep individuals and families at risk of

eviction in their home” (p. 70). A number of tools or strategies can help individuals, and groups of individuals, stabilize their tenancies, and these strategies may also have population-wide applications (Gaetz & Dej, 2017). At the individual level, increased housing education, access to rent supplements, or emergency funds offered through non-profits can help tenants avoid housing loss due to eviction (Gaetz & Dej, 2017). At the population level, *Eviction Prevention* can be strengthened through rent controls or amending or enforcing local landlord-tenant laws that govern rental occupancies and landlord-tenant relationships (Gaetz & Dej, 2017). Overall, eviction prevention is about intervening early, during challenging times of unstable housing situations, and offering individuals the right services to remain in their housing (Distasio, McCullough, Havens, & St. Aubin, 2014; City of Toronto, 2016).

Perhaps the broadest category of homelessness prevention outlined by Gaetz and Dej (2017), and most similar to tertiary prevention, is *Housing Stability*. Promoting or ensuring housing stability involves programs and supports for individuals who have experienced homelessness, especially for those who find themselves in situations where the experience of homelessness becomes a “revolving door” (Distasio et al., 2014, p. 4; Gaetz & Dej, 2017). Strategies for promoting and ensuring housing stability can help individuals quickly transition out of homelessness and into permanent housing and reduce the likelihood that they experience it again (Gaetz & Dej, 2017). Programs modelled after Housing First would be included under this category of prevention, given its focus on helping individuals secure permanent housing and providing wraparound housing supports to prevent recurring housing loss.

Since the publication of this framework, other authors have echoed Gaetz & Dej’s notions of prevention, and recent literature suggests that the idea of shifting towards prevention-focused strategies continues to gain recognition in the sector (Distasio et al., 2014; City of Toronto, 2016; Piña & Pirog, 2018). Moreover, other authors recognize that prevention-oriented policies, practices, and interventions will complement the successes made by Housing First (Buchino et al., 2019).

However, authors who have referenced Gaetz & Dej’s Framework continue to see it as largely theoretical. No studies have explored its use as a model to guide primary research.

2.5.2 The Challenge of Prevention

However intuitive it may be to prevent homelessness rather than attempt to mitigate adverse consequences in its incipiency, prevention proves challenging for several reasons. First, there is little evidence regarding the accuracy of screening tools such as the Vulnerability Index – Service Prioritization Decision Assistance Tool (VI SPDAT), which is widely used in the United States and has been adapted for use in Canada to match individuals and families to housing and homeless supports that are appropriate for their level of need (Canadian Alliance to End Homelessness, 2018; Fowler et al., 2019). This tool and others are also known for having high false-positive rates (i.e., false alarms) and for poorly differentiating between households of varying acuity (Fowler et al., 2019; Montgomery, Fargo, Kane, & Culhane, 2014).

Overall, it is difficult to target services to the right people and there is a lack of research demonstrating that prevention programs have successfully diverted households that would have become homeless otherwise (Fowler et al., 2019; Shinn, Greer, Bainbridge, Kwon, & Zuiderveen, 2013). This limits an ability to prove cost-effectiveness and efficiency in programming. In contrast, the effectiveness of Housing First is more evident since it focuses on, and can quantify, the individuals that were re-housed (Nicholas & Henwood, 2018). Some of the most predictive factors of homelessness may be used to “flag” households as at risk – including receipt of social assistance, eviction notices, involvement with child protection services, or previous shelter usage – but when housing insecurity is “hidden”, it is a lot more difficult to target prevention services to those in need. This is another inherent challenge of preventing homelessness through specific programs and services. Households who are at risk for housing loss but are “tucked away” in private market housing may not seek help until their situation is irremediable, due to lacking awareness of available services or an inability or unwillingness to access services because of transportation barriers or fear of discrimination (Crane et al., 2006; Gaetz & Dej, 2017).

Given how difficult it is for prevention-focused services to target the right people and since not everyone with housing needs comes into contact with traditional service providers, there must be a more ‘organic’ way to identify housing insecurity and intervene with appropriate supports before housing loss becomes a real possibility. In working to ensure that at-risk individuals are not overlooked, there is potential for help from the health care sector. Interestingly, in a UK study by Crane and colleagues (2014) that investigated common pathways

into homelessness, it was found that most individuals who became homeless had recently received health care services. This finding suggests that individuals often come into contact with the health care system during times when they are at risk of housing instability and homelessness.

It appears that the health care system may be a critical partner in homelessness prevention. Indeed, Gaetz and DeJ (2017) describe homelessness as a “fusion policy issue” that requires an integrated systems response. For approaches to homelessness prevention to be successful, Gaetz and DeJ (2017) explain that all levels and sectors of government, “and the institutions they support” – which clearly includes health care – must be involved (p. 46). They argue that, given the “politics of scarcity”, it can be especially challenging to ‘make the case’ for expanding prevention when there is already limited funding for emergency services and more ‘reactive’ programming (e.g., Housing First; Gaetz & DeJ, 2017, p. 25). In other words, without partnerships and pooled resources between systems and institutions outside of the homelessness sector, such as health care, available housing and homelessness funding is not sufficient to support both investment in services for individuals currently experiencing homelessness and widespread implementation of prevention strategies (Gaetz & DeJ, 2017).

2.6 Primary Care

2.6.1 Link Between Primary Care and Homelessness

As previously mentioned, research has shown that individuals experiencing homelessness typically have poorer physical and mental health than the general public and are some of the most frequent users of emergency room services (Fazel et al., 2014; Kanak, Stewart, Vinci, Liu, & Sandel, 2018). As such, primary health care plays a central role in supporting these individuals.

Much of the literature related to this involvement of primary health care focuses on health care practitioners’ engagement (or lack of engagement) with individuals experiencing homelessness (Peart & de Leon Siantz, 2017). These studies have investigated health care provided in Community Health Centres (CHC), emergency departments (ED), and in physician offices, and often demonstrate that the health care system does not meet the needs of those experiencing homelessness. For example, Doran and colleagues (2014) examined the care that patients who are homeless receive during emergency room visits. Specifically, they sought to

better understand *what* medical residents learn when caring for patients experiencing homelessness and *how* they learn to care for these individuals. Through interviews with emergency medicine residents, they found that caring for homeless patients taught residents specific knowledge and skills, including about unique disease processes they seldom see in other patients and the benefit of asking patients about their “social problems” (Doran et al., 2014, p. 675). Further, the researchers found that residents learned through experience – as opposed to practicing what they were taught in medical school – by caring for patients who were homeless and modelling the care provided by senior physicians. Doran and colleagues (2014) recommend incorporating more formal training on homelessness (and, specifically, homelessness with substance abuse issues) into medical school curriculum.

Moreover, in another study, the same researchers uncovered more about how physicians engage with and care for individuals experiencing homelessness (Doran et al., 2013). They found that ER physicians were more likely to admit sick homeless patients than patients with the same illness who were not homeless, recognizing that homeless individuals may be uniquely susceptible to some illnesses and often spend a lot of time in unsafe or unclean spaces. In the same study, ED physicians also reported wanting to address homeless patients’ “social needs” or at least consider their shelter and food needs while treating them (Doran et al., 2013, p. S357). This meant that physicians would refer homeless patients to emergency shelters or sometimes allow them to sleep overnight in the ED. However, one major theme of this study was about “Tensions in Navigating the Boundaries of Social Care”, as participating physicians explained they could not assume their medical role while also acting as a social worker (Doran et al., 2013, p. S357). Notably, they believed that homelessness is a problem that stems from larger, systems-level issues that extend beyond their realm of practice.

In addition, literature exists that reflects on one of many barriers to care experienced by homeless individuals: feeling unwelcome by health care providers in health care settings (Lester & Bradley, 2001; Wear & Kuczewski, 2008; Wen, Hudak, & Hwang, 2007). To this end, several studies have investigated medical trainees and faculty’s attitudes towards homeless people. For example, Morrison and colleagues (2012) investigated attitudes toward homeless persons among medical residents across specialties, finding that psychiatry residents held more positive views of homeless persons than emergency medicine residents. In another study by Buchanan and colleagues (2004), the researchers saw positive results with a 2-week rotation for medical

residents on homeless health care, after assessing attitudes toward homeless people after the rotation. Lastly, longitudinal findings from Crandall and colleagues (2007) uncovered that students were more committed to caring for the “medically underserved” when they entered medical school compared to attitudes at the time of graduation. In the authors’ words, students experienced “increasingly negative attitudes over the four-year period” (Crandall et al., 2007, p. 71).

Research on the poor health outcomes of homeless individuals often concludes with recommendations for policies and programs that directly address their health needs, such as tobacco cessation and substance abuse programs (Hodge et al., 2017), or strategies for managing chronic diseases (e.g., diabetes, hypertension) while living on the streets (Davachi & Ferrari, 2012). A feature article in the *American Journal of Health Education* argues that little is known about how practitioners advise their homeless patients about healthy eating and physical activity and that this should be a focus of future work (Peart & de Leon Siantz, 2017). Indeed, there may be a need for policies and more effective practitioner responses to the acute health needs of homeless individuals, but practitioners can also support their patients in ways that prevent homelessness in the first place.

2.6.2 Primary Care and Prevention

Relying on the work of health care practitioners, such as physicians, nurses, and community workers, primary health care aims to provide the majority of health services needed by an individual over the course of their lifetime (“Declaration of Alma-Ata,” 1978; World Health Organization [WHO], n.d.). To address health needs, primary health care involves health promotion as well as disease and injury prevention, treatment, rehabilitation, and palliation (WHO, n.d.). The WHO-led Declaration of Alma-Ata in 1978 endorsed a primary health care approach to attaining global health goals, and states that primary health care also requires education about health problems, including how to prevent and control them, as well as promotion of good nutrition, prevention of infectious disease, and the provision of maternal and child health care. Moreover, the Declaration highlighted how the planning, organizing, and delivering of primary health care services reflects from and changes based on a country’s economic conditions and sociocultural characteristics.

In contrast to traditional, individual-level work, primary health care is increasingly interested in having health practitioners work in teams to respond to the health needs of entire communities. In this way, primary health care continues to shift its focus from disease prevention among individuals to tackling the structural determinants of health afflicting local populations.

Primary health care providers are integral to primary care as they help people become self-determining, experience their right to health, and encourage health-promoting behaviours (“Declaration of Alma-Ata,” 1978; Marval & Townsend, 2013). Moreover, primary health care providers are often the first (or only) point of contact that members of the public have with health services (World Health Organization [WHO], 2018), which further demonstrates how critical patient-provider interactions are for diagnosing and treating illnesses.

In health systems strengthened by integrated referral systems, primary health care providers also refer their patients to secondary and tertiary care when needed (WHO, n.d.). However, providers can also be *proactive* in protecting the health of their patients – perhaps obviating the need for specialist care – by integrating public health-based approaches into their practices. Indeed, a 2018 report by the WHO explores models to integrate public health functions into primary health care. The report recommends “closing the gap” between public health and primary care to more effectively prevent disease and address health needs at the individual and community levels. To do this, it is assumed that physicians and nurses would need to be trained in public health and embrace an approach to care that extends beyond diagnosis and treatment, exploring and assessing the social and economic factors that promote health or, conversely, induce and exacerbate illness.

2.6.3 Study Rationale: The Potential for Health Care Provider Involvement in Homelessness Prevention

Physicians, specifically, are well-positioned to be health advocates for a broad group of individuals in economically and socially vulnerable circumstances, including those at risk for housing insecurity and homelessness. Physician offices are one example of a check-point place that, if physicians can effectively recognize signs of housing insecurity during patient visits, may help prevent incidents of homelessness. In 2015, the College of Family Physicians of Canada (CFPC) released its *Best Advice Guide: Social Determinants of Health*, which provides practitioners with advice on how to incorporate the social determinants of health into their

practice. It outlines specific strategies for physicians to use, at the micro level, such as providing bus tokens for low-income patients to use to get to and from appointments or conducting house calls to examine the living conditions of their patients. Conducting house calls alone may provide an opportunity for physicians to determine a patient's level of housing stability and potentially uncover imminent health risks in the home. The *Best Advice Guide* also recommends use of the simple Poverty Intervention tool developed by Dr. Gary Bloch (2016) for physicians and nurse practitioners, which mainly involves asking patients, "Do you ever have difficulty making ends meet at the end of the month?". The guide also strongly advises physicians to have provincial or territorial social assistance forms in their offices and assist patients in filling out these forms. It is also critical that physicians are aware of their patients' unique personal circumstances and life events, such as loss of a relative or close friend, marital breakdown, or deteriorating mobility, and ask about their coping strategies (Crane et al., 2006).

There is evidence suggesting that physicians and nurses agree that some cases of homelessness are avoidable with the right supports and interventions and that, overall, primary health care could be more involved with assessing patients' risk of housing loss (Crane et al., 2006). Further, health professionals believe it is possible to incorporate questions related to housing and economic stability into routine appointments (Crane et al., 2006). Chhabra and colleagues (2019) found that health care providers "believed in the value of knowing about a patient's housing situation" (p. 1217) and viewed this information as "directly applicable to their clinical care" (p. 1218). Similarly, other authors recognize that medical examinations seldom involve questions about a patient's social history, noting that these questions can contextualize patient care and treatment plans and improve health outcomes for patients (Behforouz et al., 2014). To illustrate this, Behforouz and colleagues (2014) explore the example of a patient with arthritic knees who is not adhering to a daily walk regime prescribed by their primary health care provider. What the provider may *not* know – if the patient's social or economic factors are not asked about – is that the patient may live in a three story walk up and in a high-crime neighbourhood, which makes them fearful to go outside without assistance or company. The authors also note the potential for strengthened patient-provider relationships if clinicians simply acknowledged their patients' struggles with poverty and demonstrated empathy toward their "life circumstances" (Behforouz et al., 2014, p. 1277).

Overall, Behforouz and colleagues (2014) urge medical schools to train students in obtaining “more appropriate and comprehensive” (p. 1277) social histories of their patients, which includes housing. And, after documenting and showing concern for a patient’s situation, the authors recommend physicians be trained in how to respond to this information. For example, physicians can refer vulnerable patients to institution-based and community-based resources and other health practitioners, assess their health literacy, and use motivational interviewing to motivate patients to engage in more health-promoting behaviours.

There is also potential for help from nurse practitioners, who work as advanced practice nurses in a range of community settings. In a scoping review by Grant, Lines, Darbyshire, & Parry (2017), the authors found that the work of nurse practitioners involves “managing the patient’s broad health and wellbeing needs” (p. 53) and attending to their social determinants of health. The review described the advanced skills that nurse practitioners acquire and use to promote their patients’ health, including connecting patients with complex needs to additional health and community services (Grant et al., 2017). In this way, nurse practitioners help their patients with systems navigation and ensure coordinated and consistent care.

All health care providers can participate in a range of activities related to homelessness prevention, specifically at the levels of *Early Intervention* and *Housing Stability*, as described by Gaetz and Dej (2017). At the frontline, physicians and nurse practitioners should consider the health of their patients in the contexts of social and economic circumstances and be perceptive toward their risks of housing insecurity. When patients require housing-related supports, physicians and nurse practitioners should be able to directly assist them, using some of the previously mentioned strategies, but may also help in facilitating warm referrals to external services. Further, by documenting patients’ degrees of housing insecurity and associated health risks and conditions (Sandel et al., 2018), health professionals help in continuing to demonstrate the link between housing and health. Physicians are also in a position to be strong, influential advocates for increased public resources to support tenuously housed individuals and for health care agencies to become more involved with homeless prevention through collaborative work with government and private organizations.

Despite their potential to be key actors in homelessness prevention, there is limited research on how health care providers view their role in assessing patient risk for homelessness, offering direct support to mitigate risk, and their willingness and capacity to refer patients to

external community supports. One relevant study by Morrison and colleagues (2012), found psychiatric doctors and medical residents generally agreed that doctors should address the physical and social issues of individuals experiencing homelessness. Comparatively, the researchers found that less emergency medicine faculty and residents supported this role for providers.

Another study by Chhabra and colleagues (2019) explored clinician perspectives on the use of a homelessness screening tool and investigated how a patient's housing status affects clinical decision-making. From their results, the researchers found that clinicians believed other care team members (e.g., social workers) had the proper knowledge and training to address housing issues among patients, whereas their expertise was more medically based (Chhabra et al., 2019). The researchers generally found that clinicians felt it was more appropriate and beneficial to refer precariously housed patients than to "treat" them themselves, however this study did not investigate clinicians' willingness and capacity to facilitate effective referrals.

2.7 Conclusion

It is clear from the reviewed literature that the pervasiveness of homelessness in Canada is troubling from a health promotion perspective and is certainly relevant to the provision of primary health care. This chapter summarized findings from various studies regarding risk factors for homelessness and links between the experience of homelessness and poor health outcomes.

This literature review has highlighted the need for research on homelessness to move beyond assessing programs that rehouse individuals, to begin investigating the best policies, practices, and interventions that help prevent homelessness from occurring at all. Some of the inherent challenges associated with effectively preventing homelessness were also explored in this review, including the difficulty of developing tools and systems that can accurately identify those at greatest risk and target supports accordingly. In helping to address these challenges, literature suggests that health care providers, such as nurse practitioners and physicians, may be well suited to embrace a greater role in preventing homelessness by assessing patient risk of housing loss and facilitating referrals to external supports that can help to stabilize a patient's housing situation. Lastly, this literature review introduced Gaetz and DeJ's (2017) Framework for Homelessness Prevention, which proposes ideas for conceptualizing prevention within the

Canadian context and categories by which prevention-focused policies and interventions can be organized.

Chapter 3

3 Methods

This chapter describes the methodology and specific methods chosen to facilitate the research in this study. The chapter begins with a brief explanation about how the primary researcher (KM) became interested in conducting research in this field (Section 3.1), thereby reflecting on assumptions or biases being brought to the study. Next, qualitative description is introduced as the chosen methodological approach, and the use of the Framework for Homelessness Prevention (Gaetz & DeJ, 2017) is described as it served as a lens through which concepts of ‘prevention’ could be examined (Section 3.2). Sections 3.3 and 3.4 of this chapter detail the study design, including data collection techniques and approaches to data analysis. Lastly, this chapter outlines strategies used to achieve rigour throughout the research process (Section 3.5) and discusses ethical considerations that are relevant to this study (Section 3.6).

3.1 Development of the Idea for Project

In *Clear as Mud: Toward greater clarity in generic qualitative research*, Caelli, Ray, and Mill (2003) discuss the evaluation of generic qualitative research, such as qualitative description, and propose criteria for researchers to meet in order to establish rigor. The authors stress the importance of documenting the development of the project: examining and explaining the impetus for the research questions and any assumptions brought to the study, so as to be transparent to the reader and evaluator. Further, the authors state that the study should be “designed to be contiguous with the positions and assumptions that led to the research question” (Caelli et al., 2003, p.17). Milne and Oberle (2005) also recommend that researchers reflect upon potential biases they may bring to their study, for enhancing rigor in the qualitative descriptive research and ensuring integrity. For these reasons, a short summary is provided below describing how I – the primary researcher (KM) for this study – became interested in research about preventing homelessness.

I used to volunteer at London Housing Registry, a local organization that helped low-income individuals and families find suitable housing in the private rental market. I volunteered as an Intake Housing Support Worker, which involved meeting with individuals in-person to

discuss their housing needs and checking our database of rental properties to provide them with lists of potential vacancies. It was my experiences as an intake worker that helped shaped my understanding of housing precariousness, the prevalence and cycle of homelessness, and the inadequacy of social assistance programs.

I volunteered at this organization at a time when vacancy rates in London, Ontario were at a historic low. This made it challenging for me as an intake worker to provide clients with ‘promising’ lists of housing options because units were not on the market for long and were often rented by the time my clients contacted the landlords or property management companies. I did my best to avoid referring clients to units I suspected were already rented.

Sometimes clients would also request that I not refer them to places in *that* area, or near *that* intersection, or owned by *that* landlord. I often empathized with them as they expressed these concerns, but with little options to begin with, their individual requests made it even more challenging to find suitable listings.

My experiences as an intake worker also led me to become frustrated with the inadequacy of social assistance programs. Specifically, I learned what “shelter allowances” were from Ontario Works (OW) and the Ontario Disability Support Program (ODSP). Individuals would come in, sometimes with a lot of hope, with knowledge of what their shelter allowance was, and ask me, “What can I get for that?”. It was absolutely frustrating and shameful how few listings we had in our database that could be rented with that allowance alone – perhaps a room in a house but rarely a studio or one-bedroom apartment.

The municipal agency that maintains the social housing waitlist would often refer individuals to our organization as another resource for finding affordable housing. I would constantly hear from our clients and other volunteers about the growing waitlist. This understanding of the provision of social housing – coupled with knowledge about low vacancy rates in the private market – opened my eyes to the intense demand for affordable housing and sobering reality of housing precarity issues and homelessness in my community.

In my role, I worked with individuals who were, to some extent, precariously housed, or by all definitions, homeless, since they were accessing emergency shelters or sleeping rough (without shelter, outdoors). Often, our clients were experiencing homelessness and simultaneously trying to find housing. I saw first-hand the barriers they faced with accessing services and establishing enough stability and structure in their lives to conduct weekly housing

searches. For example, about one week after initial intake meetings, I would call clients to follow up on their progress with housing searches, but a lot of times I was calling the shelters, or someone else they had put down as their contact number, and I assume my messages for them were rarely passed on.

During my training to be an intake worker, I was introduced to Housing First. We were told to tell clients about Housing First and how it was a government initiative “focused on helping you”. However, I did not fully understand the model at that point and did not see how it was relevant to the service I was providing. Later on, I learned to appreciate the evidence behind Housing First once I became curious about strategies and approaches used to address homelessness. I read and became familiar with research on the efficacy of Housing First practices, including where Housing First principles had been adopted worldwide. Equipped with this knowledge, I planned to focus my thesis on the implementation and evaluation of Housing First in my local community. However, after consulting with experts in the field, namely, Dr. Abe Oudshoorn, one my thesis advisors, I realized there was an opportunity to be involved in the sector’s progressive shift from researching reactive approaches to exploring models of prevention.

As I conclude this section about my background and the impetus for this research, I reflect on the knowledge and experience I bring to this project, as the primary researcher, which has shaped my inquiry (Caelli et al., 2003). As mentioned, my experiences as an Intake Housing Support Worker helped shape my opinions about what it means to experience homelessness, or to be precariously housed, and I certainly developed empathy and compassion for individuals in these circumstances. Since researchers’ ‘filter’ or interpret their data through the lens of their prior experiences and perceptions (Rubin & Rubin, 2012; Wolcott, 1994, p. 13), it is important for me to continue to be aware of assumptions or biases that I may have, throughout the entire research process. As Sandelowski (2010) states, “there is no such thing as a view from nowhere” (p. 80).

3.2 Methodology: Qualitative Description

This study employs qualitative description, as described by Sandelowski (2000), which is well-suited for health sciences research and is particularly preferable when researchers seek to understand complex social issues where “variables and concepts are not easily measured”

(Jiggins Colorafi & Evans, 2016, p. 16; Sandelowski, 2010). Qualitative descriptive studies allow researchers to gain insight into a specific topic or phenomenon and *describe* it from the participants' perspectives (Bradshaw, Atkinson, & Doody, 2017; Jiggins Colorafi & Evans, 2016; Neergaard, Olesen, Andersen, & Sondergaard, 2009).

Sandelowski (2010) explains that the development of qualitative description as distinctive from other methods cannot be credited to any one individual. Rather, the methodology is “reinvented” by those who use it (Sandelowski, 2010, p. 78). With qualitative descriptive methodology, researchers can choose from a variety of techniques for sampling, data collection, and analysis (Jiggins Colorafi & Evans, 2016; Sandelowski, 2000), which will be discussed later in this chapter.

3.2.1 The Difference Between Qualitative Description and Other Methodologies

Margete Sandelowski (2000) argues that qualitative description is frequently employed in health sciences research, but seldom cited as the guiding methodology used in these studies. Instead, researchers may claim to use ethnography, grounded theory, or phenomenology even though there is little substantive evidence of these methodologies in their work. Qualitative descriptive research seeks understanding of experiences, events, or processes through the lens of participants (Sullivan-Bolyai et al., 2005), in order to *describe* the findings in everyday language (Sandelowski, 2010). In contrast, ethnography seeks to observe culture (Roberts, 2009), grounded theory discovers or constructs theory (Chun Tie, Birks, & Francis, 2019), and phenomenology studies and describes lived experience (Smith, 2016).

Additionally, qualitative descriptive studies are said to be the least theoretical of qualitative approaches. This is because qualitative description does not require researchers to commit to a particular theory, philosophy, or abstract concept from the outset and then present their findings in terms of that framework or system (Sandelowski, 2000). Qualitative description is less interpretive, in that respect, compared to grounded theory, phenomenology, or ethnography since researchers are permitted to “stay closer to their data and to the surface of words and events” (Sandelowski, 2000, p. 336). However, qualitative descriptive studies should not be considered “atheoretical” (Sandelowski, 2010, p. 79) or regarded as research deprived of theoretical foundations.

3.2.2 Theoretical Orientations with Qualitative Description

At the very least, in terms of theory that drives this type of research, qualitative description adopts a naturalistic approach to inquiry (Bradshaw et al., 2017; Jiggins Colorafi & Evans, 2016; Creswell, 2007; Sandelowski, 2000). In naturalistic studies, there is no manipulation of variables or deception (Sandelowski, 2000), and the researcher does not look for data that confirms his or her assumptions (Guba & Lincoln, 1982). Rather, the researcher is “sensitive to process” (Guba & Lincoln, 1982, p. 235) and observes the target phenomenon in its natural context (Bradshaw et al., 2017). Naturalism also implies the ontological position of relativism: the idea that “reality is subjective” and therefore the experiences – and the meanings that participants ascribe to those experiences – will differ from person to person (Bradshaw et al., 2017).

Additionally, as in any qualitative research project, the epistemological assumption is subjectivism (Bradshaw et al., 2017). Using subjectivism in research approaches such as qualitative description, there is complete reliance on participants’ subjective accounts of a particular phenomenon, as well as emphasis on the role of the researcher involved in seeking that information and analyzing it (Bradshaw et al., 2017). Indeed, qualitative description is often misunderstood to be a method that entails little to no interpretation by the researcher who conducts analyses (Sandelowski, 2010). While qualitative description is characterized by lower levels of interpretation, compared to other methodologies as described above, all qualitative (and quantitative) research involves some level of interpretation (Sandelowski, 2010). As such, this qualitative descriptive study presents findings that are both “data-near” (Sandelowski, 2010, p. 78) – as in, close to participants’ actually-expressed opinions and experiences – and yet still a product of researcher interpretation.

3.2.3 A Framework for Homelessness Prevention

As noted by Jiggins Colorafi and Evans (2016), researchers using qualitative description can choose from a broad range of theoretical orientations and may use the lens of a relevant conceptual framework as a starting point for designing and conducting their study. However, Jiggins Colorafi and Evans (2016) and Sandelowski (2010) recommend that researchers be prepared to “move away” from those initial frameworks, plans, or theories about the target

phenomenon as data is collected. This rejection of a rigid view of the phenomenon in question during the course of the study is also inherent in qualitative descriptive research since it is grounded in naturalism.

Using a qualitative descriptive approach, this study seeks to explore the practical applications of a framework for homelessness prevention. Chapter Two introduced the Framework developed by Gaetz and DeJ (2017), which was chosen to guide the current research since these researchers have been the first to propose a framework for conceptualizing homelessness prevention within a Canadian context. As the Framework outlines a typology for identifying and organizing interventions and activities that are considered critical to homelessness prevention, it also served as a ‘lens’ for examining the various ways that health care providers can be involved in this work.

Moreover, the Framework became especially useful for determining a starting point for data analysis – that is, the Framework helped guide the identification and naming of initial codes. However, analyses conducted in this study began to reveal concepts and themes that were not explicitly covered or thoroughly described in the Framework. Therefore, analyses did in fact “move away” from the initial model used to position the research, and this process is further explained in the data analysis section of this chapter.

3.2.4 When to Use Qualitative Descriptive Methods

Qualitative description is particularly useful when researchers wish to collect data directly from those experiencing particular phenomena (Bradshaw et al., 2017; Caelli et al., 2003). First, an objective of this study was to collect information about two processes: how health care providers assess risk for homelessness, and how they facilitate referrals. Additionally, we collected data to describe health care providers’ perspectives on poverty, homelessness, and housing stability, as well as how they perceived their overall role in homelessness prevention.

Moreover, qualitative description is considered to be useful and relevant to health sciences research since it can provide clear information on how to improve care, patient-provider relationships, or address specific health issues (Neergaard et al., 2009; Sullivan-Bolyai et al., 2005). The findings of qualitative descriptive research also demonstrate internal validity since data is typically collected from the providers themselves (i.e., is based on their professional

experiences) and is presented using language that does not deviate too far from their own words (Sullivan-Bolyai et al., 2005).

Qualitative description is also cited as a qualitative approach that may be more practical than traditional, high-inference methods, for refining interventions aimed at reducing health disparities among vulnerable populations. Sullivan-Bolyai and colleagues (2005) discuss this and suggest that, for example, grounded theory, phenomenology, and ethnography may be useful for “understanding focused disparity issues” (p. 129), but their analyses move too far away from participants’ actual experiences to be directly applicable to intervention development. On the other hand, qualitative descriptive studies can provide rich descriptions of vulnerable patients’ experiences, health issues, and concerns. The findings are context-specific and can be readily understood by non-researchers and acted upon by the general community (Sullivan-Bolyai et al., 2005). This study neither focuses on vulnerable patients’ direct experiences with health care (e.g., access barriers experienced by vulnerable individuals) nor aims to refine an existing health intervention. However, it more broadly aims to improve practice and explore opportunities within the health care sector to intervene before vulnerable patients find themselves in precarious housing situations or experience homelessness.

3.3 Study Design

3.3.1 Sampling

Purposeful sampling is a cardinal feature of qualitative descriptive studies, in which participants are selected based on possessing certain qualities, expertise, or experiences that relate to the research problem (Bradshaw et al., 2017; Creswell, 2007; Jiggins Colorafi & Evans, 2016; Neergaard et al., 2009). This study targeted nurse practitioners and physicians who either mainly provide care for individuals of lower socioeconomic backgrounds or individuals experiencing homelessness or precarious housing, or those providers who simply practice in the medical field and do not necessarily provide care for these groups. Overall, recruitment for this study aimed to capture responses from physicians and nurse practitioners who collectively work with diverse client bases.

In general, sample sizes in qualitative research tend to be small and focus on collecting information-rich data from participants (Bradshaw et al., 2017; Sandelowski, 2000). In this

study, one (1) physician and three (3) nurse practitioners participated. The target sample size was a maximum of eight (8) participants, which was considered the most feasible for a single interviewer (primary researcher; KM). In accordance with comments made by Fawcett and Garity (2009), it was assumed that a sample size of eight (i.e., eight one-hour long interviews) could sufficiently address the research objectives and add knowledge to the field in a meaningful way. Ultimately, a sample size of four was achieved, which is a limitation discussed in Section 6.4 of this thesis.

3.3.2 Data Collection

Qualitative descriptive methodology aligns well with many data collection methods to explore the “who, what and where” of a given research problem (Sandelowski, 2000, p. 338). Data may come from a variety of sources, such as minimally to moderately structured interviews and focus groups, document analyses, health records, and observation (Sullivan-Bolyai et al., 2005).

Document Analysis

Data collection for this study involved the examination of documents relating to the scopes of practice of physicians and nurse practitioners, as well as standards and ethics guidelines developed by their respective regulating bodies and other policy documents published by their associations.

The purpose of the document analysis was to determine the extent to which issues of poverty, precarious housing, socioeconomic status, and other social determinants of health and risk factors for homelessness are discussed in these types of documents. Where nurse practitioner or physicians’ scopes of practice were outlined in these documents, we searched for explicit or ‘implicative’ reference to these health care providers’ involvement in prevention-oriented activities, such as assessing a patient’s risk for homelessness or facilitating patient referrals to other health or social supports.

The following set of questions acted as a guide while reviewing the documents, for identifying and extracting relevant information:

- What other health care providers or allied health professionals do physicians and nurse practitioners commonly work in partnership with?
- What tools, if any, do physicians and nurse practitioners use to screen patients for poverty and/or risk of homelessness?
- Are health care providers expected to/have an ethical obligation to conduct social history assessments of their patients, or ask questions about social and economic factors that may be influencing their patient's health?
- To what extent are health care providers trained in and expected to integrate responses to the social determinants of health into their practices?
- Do the respective colleges explicitly recognize the implications of the social determinants of health, and specifically housing?
- How are health care providers involved in community-level responses to precarious housing and homelessness?
- What practices related to homelessness prevention fall outside the scope of practice of health care providers?
- What types of social or community services do health care providers refer patients to?
- Do health care providers consider their patients' socioeconomic statuses?

The documents included in this review were also analyzed for key words related to income supports, referrals, social and economic factors in patients' lives, broader social issues and the mere use of terms such as "social inequity", "vulnerable populations", and "systemic issue". The following key words or terms were also searched for: income or low-income; poverty; housing; homeless; social history/histories; referral; social service; vulnerable (or underserved or disadvantaged or marginalized); socioeconomic or SES; tax credit; pension; determinants or health; social context; social support; intervention; ODSP; and disability form.

To identify documents to include in the analysis, first, a list of physician and nurse practitioner associations and colleges was created, which was informed by experts in the field. Then, the websites of these organizations were searched for relevant documents including practice guidelines, standards, and frameworks as well as documents outlining policy statements. After reviewing the websites, the documents chosen for analysis included publications by the Canadian Nurses Association (CNA), the Nurse Practitioners' Association of Ontario, the

College of Nurses of Ontario (CNO), the Canadian Medical Association (CMA), and the College of Family Physicians of Canada. A physician learning resource, developed by a group of medical educators and practitioners affiliated with the Faculty of Family Medicine at the University of Toronto, was also analyzed as it found in the references of one of the other documents. The search for documents to include in the analysis was ended when it appeared that we had downloaded all relevant documents that were available on the selected websites. Therefore, the document review was ended due to the *limitation* of only having access to publicly available documents. As the primary purpose of the document analysis was to inform the development of a coding manual while also adding ‘prescriptive’ context to findings from interviews with health care providers, reaching the point of ‘saturation’ was not a particular goal – however, it did appear that, ultimately, the richness of data obtained from the included documents sufficiently answered the guiding research questions (listed above).

Interviews

Data collection also involved semi-structured interviews with physicians and nurse practitioners. Each interview took approximately one hour to complete and there are no follow-up interviews with participants. Participants were asked open-ended questions about their knowledge and opinions on issues of poverty and homelessness, their role as a health care provider in supporting patients’ housing situations, and strategies they used (if any) for assessing a patient’s risk of housing instability and connecting them to external supports (See Appendix A for a copy of the interview guide).

Participant Recruitment

Initially, local organizations, clinics, and family medicine departments were contacted through publicly available email addresses and asked to circulate this study’s invitation to participate among their physicians and nurse practitioners. Specifically, we contacted the Health Zone Nurse Practitioner clinic, Dundas East Walk-In Clinic, and London InterCommunity Health Centre.

However, recruitment for this study began and continued during the COVID-19 pandemic, which made it challenging to connect with health care providers, and perhaps especially difficult to engage with them through their work emails. In order to scale up

recruitment during this time, we also utilized the investigators' social media accounts (Facebook and Twitter) to further promote the study.

3.4 Data Analysis: Content Analysis

Both sets of data collected for this study were analyzed using content analysis: an analysis technique that is commonly used in qualitative descriptive research (Jiggins Colorafi & Evans, 2016; Sandelowski 2000) "to provide knowledge and understanding of the phenomenon under study" (Downe-Wamboldt, 1992, p. 314). Specifically, two types of content analysis, *conventional* and *directed*, were used to analyze text document data and interview transcripts, respectively. Thus, this study takes a blended inductive and deductive approach to data analysis.

3.4.1 Analyzing Document Review Data: Conventional Content Analysis

An inductive, conventional approach to content analysis, as described by Hsieh and Shannon (2005), was used to create codes and emergent themes in the document review data. Conventional content analysis is a flexible method for analyzing text data, involving inductive category development whereby researchers do not start with a list of predetermined codes (Cavanagh, 1997; Kondracki, Wellman, & Amundson, 2002). Rather, codes "flow from the data" and therefore category names often come directly from the text (Hsieh & Shannon, 2005, p. 1279). This approach is suitable when researchers wish to gain information about a topic directly from text data, and it can be useful for developing initial coding schemes or coding manuals, as was done with this study. This approach may be used when existing theory or research on a topic is limited. However, often found within the discussion section of a study, findings from analyzing data using a conventional approach can certainly be compared to other research findings or discussed in terms of a relevant/existing theoretical perspective.

As advised by Tesch (1990), the documents were read the first time "to obtain a sense of the whole" (as cited in Hsieh & Shannon, 2005, p. 1279). In the second read, text that appeared to capture key ideas and concepts was highlighted, and reflections and first impressions of the text were written in the margins. A third read involved creating a list of key terms and words, based on the highlighted text, to search for (Ctrl-F) in the other documents (see above for list of these key words and terms). Then, any sections with those key terms, words, or previously

highlighted text were read to understand the use of the phrases or terms in context. Upon reading the text in context, some sections became irrelevant for the purposes of the document review/analysis. For example, in the CMA's *Health in All Policies*, it is mentioned that "the federal government has significant control over areas such as... income security ...". The key word "income" is used, but not in a way that is interesting for this document analysis. Where "income" was used in a way that sheds light on health professionals' attitudes towards considering patient income within the context of care, that text would have been further analyzed and potentially coded.

Initial codes were applied to highlighted text and copied into a new word processing document. For example, the following text was extracted from the *CanMEDS-Family Medicine 2017 A competency framework for family physicians*, along with the initial codes, "Incorporating patient's life context into care plan" and "Considering patient's socioeconomic status":

Together with the patient, the family physician integrates this knowledge and develops a shared plan that incorporates the patient's needs, values, and preferences, as well as their life context, including culture, socio-economic status, medical history, family history, stage of life, living situation, work or school setting, and other relevant psychological and social issues. (Shaw, Oandasan, & Fowler, 2017, p. 7)

Then, codes similar in meaning or overall concept were grouped together and given a new or more abstract category name. Organizing, grouping, and renaming codes and categories became an iterative process where text and codes were moved around to determine which broader category they fit under, or if a creating a new category was needed. Further, as new categories emerged, text originally included under existing categories may have appeared to better relate to the new category and was moved accordingly.

The outcome of this review is a synthesis of information gathered from documents relevant to this study – in the form of fully defined and described emergent themes and subthemes – which then informed the development of an initial coding manual for analyzing interview transcripts.

3.4.2 Analyzing Interview Transcript Data: Directed Content Analysis

In comparison to the document analysis, the analysis of interview transcripts took a more *directed* approach to content analysis, which is used when prior research or theories exist about

the particular phenomenon in question (Hsieh & Shannon, 2005). That is, directed content analysis is used when existing research and relevant theories and frameworks may inform hypotheses about answers to the current research questions. In this study, a coding manual was developed prior to the analysis of interview transcripts, containing a starting list of codes that were derived from findings from the document analysis and concepts from Gaetz & Dej's (2017) Framework for Homelessness Prevention (See Appendix B for a copy of the coding manual). Importantly, functional definitions and examples of each code were noted in the margins of the manual, to provide clarity and context (e.g., the code, "Place-based supports" (a prevention strategy) was defined by Gaetz and Dej as "assessment and case management strategies designed to help people stay in their communities").

3.4.3 Memoing

After developing the coding manual, the next step involved considerations about when to start coding the interview data. Whereas in some studies the researcher may want to "identify and categorize all instances of a particular phenomenon" (Hsieh & Shannon, 2005, p. 1281), the aim of this project was not simply to find examples of health care providers referring to the risk factors and prevention-oriented activities described in the Framework (Gaetz & Dej, 2017). Rather, using directed content analysis was used to explore 'supporting' and 'non-supporting' or 'new' evidence of the Framework (Gaetz & Dej, 2017) as well as concepts emerging from the document analysis. Given this research objective, the primary researcher (KM) did not code immediately after developing the coding manual. Instead, analysis began with a round of memoing, guided by Birks, Chapman, and Francis' *Memoing in qualitative research: Probing data and processes* (2008) and Jiggins Colorafi and Evans' description of memoing in qualitative descriptive research (2016).

During a first read of the interview transcripts, KM wrote memos to become familiar with the data – recording reflections, first impressions, and exploring potential relationships. At this stage, and during subsequent stages of analysis, memos were written to remain focused on exploring "What is actually happening in the data?" (Birks et al., 2008, p. 70). Birks and colleagues (2008) consider this question to be part of *Extracting meaning from the data*, which is one important function of memoing. By writing memos in the early stages of analysis, KM began

to explore the ‘fit’ between the interview data and findings from the document analysis and Framework (Gaetz & Dej, 2017).

As advised by Birks and colleagues (2008), reflective memos written during the initial review of interview data were logged in a new document, separate from the interview transcripts themselves. This practice is important for preventing the researcher’s recorded interpretations from obscuring the original meaning behind participants’ comments, which could impact later rounds of analyses (Birks et al., 2008). With too much ‘exposure’ to the researcher’s recorded perspective and interpretations during the coding process, the results may end up drifting ‘too far’ from the data, which is contrary to the purpose of qualitative description.

Birks and colleagues (2008) explore *Maintaining momentum* as a second function of memoing, where memos can provide “a snap-shot of thought processes at a given stage of the research that facilitate an understanding of what perspectives were held and why decisions were made” (p.71). This function of memoing was seen in this study during later stages of analyses during which decisions were made about assigning codes, grouping codes together, and exploring potential themes that incorporated many related codes.

Moreover, the memos written while assigning codes and generating themes documented KM’s thought processes about when to ‘stay close’ or ‘stray’ from the coding manual (i.e., assigning codes from the coding manuals versus creating new codes). In this way, memoing helped inform analyses ‘decision-making’ in the context of a blended inductive and deductive coding process.

3.4.4 Coding Interview Data

During a second read of the interview transcripts, KM hand-coded the data by highlighting and applying one or more new or existing codes to meaningfully similar segments of text – an approach referred to by Jiggins Colorafi and Evans (2016) as first-level coding. At this stage of analysis, it became especially important to consider the balance between inductive and deductive coding. KM focused on letting the data ‘speak for itself’, coding segments of text using an inductive approach (i.e., applying ‘new’ codes). Where needed, the coding manual was used as a guide to help contextualize and make sense of, or ‘confirm’, sentiments shared by participants. The predetermined list of codes offered suggestions as to what was being seen in the data. While some participant quotes were easily ‘codable’, other quotes appeared to be

meaningful – containing seemingly important information and warranting further analysis – but an applicable code was not immediately clear. In these cases, where the codes to assign were not obvious, the coding manual became especially useful. Indeed, many codes applied to interview text were derived directly from the coding manual. For example, during first-level coding, the code, “[Lack of] considering the wider patient context” from the coding manual was directly applied to the participant quote, “I feel like these people often suffer because... their context is not completely considered when they're being treated” (Participant 4). As another example, the coding manual offered the code suggestion, “Failed transitions from public systems” for the following quote from Participant 4: “The new term is ‘transitional aged youth’, which is sort of where [they are] graduating out of CAS care, and [the system is] sort of like "good luck" when they're 18.”

After first-level coding all of the interview transcript data, the transcripts were read a third time, during which codes were extracted (i.e., copying them into a new document) and grouped together if they appeared to be similar in meaning. This is referred to as second-level or pattern coding, where the data is condensed into a smaller number of constructs or groups (Jiggins Colorafi & Evans, 2016).

At this stage, there was not always a clear “new” or slightly more abstract code name to apply to each group of codes. Therefore, codes may initially be grouped together with no “group name”. However, as codes were added to growing groups, ideas for group names often emerged. For example, once the code, “Increasing patient access to housing” was added to the group of codes including, “Building therapeutic relationships to encourage continued access of health care services” and “Helping patients secure additional income supports”, the clear group name became “Increasing patient access to services and resources”. In other cases, the group name was clear from the code names that comprised the group – for example, the code, “Interdisciplinary, team-based care” and the code, “Benefits of team-based practice” were originally grouped as “team-based care”.

The grouping of codes became an iterative process of creating, merging, and collapsing groups, refining code and group names, and continuously reviewing the original quotes from participants to ensure their quotes were understood in context. For example, reviewing quotes in context became important when considering the preliminary group name “Advocacy”, which had been derived from the coding manual. Upon reviewing specific examples of how providers

discussed these “advocacy” efforts, it became clear that codes in this group related to providers’ comments on advocacy at the patient level, where they reported directly helping patients access income and housing supports. Given this context, it was determined that these codes would fit under the more precisely defined code, “Helping to increase patients’ access to health and social services and other community resources”. Elements of “advocacy” came up in various prevention activities that providers discussed (e.g., increasing patients’ access to supports, encouraging patients to access care, facilitating referrals, demonstrating need for better housing conditions, etc.), but “advocacy” on its own did not represent a distinct group, at this stage, nor an overall theme.

In addition to providing suggestions for initial code names, the coding manual was also used during this iterative process of moving around codes and groups to inform the generation of new group names. Although, KM continued to stay focused on only assigning code and group names derived from the manual when they truly “earned” their way into the analysis (Smith, 2017, p. 120) and remained open to revising codes to reflect “newly identified categories” (Hsieh & Shannon, 2005, p. 1283).

3.4.5 Creating Categories and Realizing Themes

With several groups of codes to work with, KM continued to merge groups to condense the data, creating ‘categories’ with slightly broader, more abstract labels applied to them. Eventually, a total of 14 ‘categories’ were identified, which were considered to still “hold true” for the interview data (Miles & Huberman, 1994, as cited in Neergaard et al., 2009, p. 3). Following consultation with the other researchers (thesis committee members) and after further examining these categories, four major themes were proposed. These themes are developed with the goal to comprehensively and meaningfully capture the existing categories and their components. These four themes represent the main findings of this study and are fully described in Chapter Five.

A Note about Organizing and Presenting the Results

Originally, the plan for analysis involved organizing categories related to provider involvement under the two headings, “Types of Homelessness Prevention included in the Framework” and “Other Strategies Providers Use to Promote Housing Stability Among their

Patients”. However, later it was decided not to organize the results simply by type or level of prevention as described in the Framework. Many of the prevention-oriented activities and strategies mentioned by providers did not neatly fall within the Framework’s five categories: *Structural Prevention*; *Systems Prevention*; *Early Intervention*; *Eviction Prevention*; and *Housing Stability* (Gaetz & Dej, 2017). In fact, many fell under a combination of *Systems Prevention*, *Eviction Prevention*, and *Housing Stability*. It seemed that the true meaning behind participant quotes would have been lost if strictly categorized according to the Framework, or there was not enough contextual information to confidently determine which “type” of prevention they were alluding to.

Moreover, when determining which themes to include in the results, those which were the most robust and captured the most responses (preferably from all or most participants) were included, and these themes may or may not have been originally informed by codes from the coding manual. Thus, a flexible approach to organizing and representing final themes was used – one that is expected to provide “meaningful information” (Jiggins Colorafi & Evans, 2016, p. 24) for the readers of this thesis.

3.5 Establishing Rigour

While there is debate regarding the key concepts to consider for establishing rigour within qualitative research, focusing on demonstrating quality and “trustworthiness” within the research process and findings remains important for such studies (Bradshaw et al., 2017; Jiggins Colorafi & Evans, 2016; Milne & Oberle, 2005). In the current study, several strategies were used to meet the criteria by which qualitative descriptive research is evaluated, including *credibility*, *confirmability*, *validity*, and *dependability* (Bradshaw et al., 2017).

A particular focus of the study was to ensure *credibility* by “staying true” to participants expressed opinions and perceptions during analyses and accurately representing these perspectives within the results (Milne & Oberle, 2005). As mentioned, memoing was used throughout the research process, which demonstrates significant engagement with the data and provides an “audit trail” of decisions made about coding, grouping codes, creating themes, and organizing and presenting the results (Finlay, 2006; Jiggins Colorafi & Evans, 2016, p. 23). Moreover, memoing supports “interpretive validity” or an accurate depiction of ‘what is truly meant’ by the experiences and expressed opinions of participants (Sandelowski, 2000).

Whereas member checking was not used, which is considered a means to support credibility, it was important to ensure the results were presented in a way in which participants would recognize their experiences (Baxter & Eyles, 1997). This is to ensure “descriptive validity”, or a description of the results that both researchers and participants would read and agree is accurate (Sandelowski, 2000). Likewise, staying ‘close’ to the data and providing rich descriptions of the resulting themes and subthemes promoted *credibility* and *confirmability* in this study (Bradshaw et al., 2017). Direct quotes from participants are included throughout the results section to demonstrate that participant voices are reflected in the themes and subthemes.

Additionally, employing triangulation strategies (i.e., using more than one source of data) is expected to enhance the credibility of the overall study and the reliability of the results (Jiggins Colorafi & Evans, 2016; Neergaard et al., 2009; Stavros & Westberg, 2009). In this study, two data collection techniques were used: semi-structured interviews with health care providers and document analysis. By employing a second technique, comparisons could be drawn between the results of the document analysis and the results from interviews, which offers an opportunity to triangulate the data. We could explore and compare conceptualizations of poverty, risk of homelessness, and health care provider roles in homelessness prevention as described in relevant ethical and practice guideline documents and as described by health care providers themselves. To further strengthen the credibility and trustworthiness of the findings, a preliminary list of themes and the supporting codes and quotes were shared with the thesis advisory committee, which represents a second triangulation strategy: use of multiple investigators (Baxter & Eyles, 1997). The committee discussed the themes and made suggestions for renaming, merging, and collapsing themes. After these discussions, the committee was able to confirm that the findings “rang true” based on their research expertise and experience in the field (Jiggins Colorafi & Evans, 2016, p. 24). Triangulation strategies also help to improve the *validity* of qualitative study findings (Qazi, 2011).

Generally, *validity* is concerned with approaches used to legitimately investigate the research question and considers whether the study findings have wider implications for policy, practice, and future research (Bradshaw et al., 2017; Jiggins Colorafi & Evans, 2016). As advised by Jiggins Colorafi and Evans (2016) and Qazi (2011), to enhance validity, the methods and techniques used in this study are described in explicit detail and the process of data collection, analysis, and decisions about organizing and presenting the results are well-

documented and were routinely shared with other members of the research team. Moreover, as reflexivity is important for enhancing validity (Qazi, 2011), the primary researcher disclosed prior volunteer experience in a related field – recognizing potential predispositions or biases – and explained how she became interested in the research topic (Creswell, 2007; Jiggins Colorafi & Evans, 2016).

Specifically, *catalytic validity* also aligns well with qualitative research, which considers the extent to which studies lead to social change (Robson & Sumara, 2016). Lather (1986) states that efforts (e.g., research studies) “to produce social knowledge that is helpful in the struggle for a more equitable world” demonstrate rigour and relevance (p. 67). The current study aims to meet the criteria for catalytic validity as knowledge generated about health care provider roles in homelessness prevention can be used to “redirect policy” (Lather, 1986, p. 72) and practice towards greater system-level involvement in disrupting cycles of poverty and homelessness. Moreover, the findings from this study create knowledge within a prevention framework (Gaetz & Dej, 2017) that is theoretically situated within a right-based and equity perspective. Indeed, Lather (1986) outlines elements of rigour that should be evident in studies demonstrating catalytic validity, including the use of theories as well as triangulation methods and documentation of the researcher(s)’ assumptions.

Dependability is related to reliability or auditability and can be achieved by demonstrating consistency in data collection procedures and analysis techniques (Jiggins Colorafi & Evans, 2016). Miles and colleagues (2014) outline strategies to foster this consistency, many of which were employed in this study, including: using the same interview guide across participants (with questions asked in the same order); having the same researcher conduct interviews; using a conceptual framework to aid in developing interview questions, and creating a coding manual to guide data analysis. Having used a particular framework to guide the implementation of this study, it was possible to “test” it during early analyses, that is, continuously assessing its ‘fit’ with the study data, which later informed the presentation of the results. Dependability can also be demonstrated through triangulating study data, which was earlier discussed as part of credibility.

3.6 Ethics

When conducting a study with human participants, it is important to consider potential ethical concerns related to various stages of the research process. Prior to initiating data collection, this study was granted ethics approval from the Western Ethics and Review Board (WREM; see Appendix C for ethics approval letter). The approved documents appended to the WREM application included: the study protocol; interview guide; email script for recruitment; and the Letter of Information (LOI). The purpose of the LOI was to give eligible health care providers enough information about the study to make an informed decision about whether to participate. As such, an explanation of potential risks and benefits associated with participation were included in the LOI, as well as a description of steps taken to ensure their confidentiality (See Appendix D for a copy of the LOI). All interviews were audio-recorded with the consent of participants. Also, all participants indicated on their consent forms that they agreed to the use of direct quotes where any identifying information removed.

Chapter 4

4 Findings from Document Analysis

This chapter presents a summary of the results from a document analysis that involved examining documents published by physicians' and nurse practitioners' professional associations and colleges. The documents included in the analysis mainly focused on these health care providers' scopes of practice, professional commitments and competencies, standards of care, and ethical guidelines, as well as system-wide 'visions' for improving health care (See Table 2 for a list of the documents). As mentioned, the purpose of the document analysis was to investigate the extent to which issues of poverty, precarious housing, socioeconomic status, and other social determinants of health and risk factors for homelessness are discussed in these types of documents. Further, this analysis was used to explore the extent to which health care provider involvement in addressing the social determinants of health, whether at the patient or population level, is explicitly discussed (or reasonably implied) in these documents.

The chapter begins with a summary of information pertaining to physician and nurse practitioner competencies, values, commitments, and patient-provider relationships (Section 4.1). This type of information was extracted from the analyzed documents if deemed relevant to the current discussion. Then, Section 4.2 contains descriptions of each of the main themes uncovered during the analysis, including:

1. Considering the wider patient context;
2. Directly responding to patients' social determinants of health;
3. Health care providers responding to community needs;
4. Advocacy;
5. Collaborative relationships and systems integration;
6. Appropriate use of health care resources for responding to social and economic issues;
7. Ensuring health care providers are equipped with tools to address patients' social determinants of health;
8. Recognizing the impacts of the social determinants of health; and
9. Exploring how disadvantaged groups access care

These identified themes from the document analysis also helped inform the coding manual for analyzing interview transcripts, which is included in Appendix B. Lastly, this chapter concludes with a brief discussion about the findings from the document analysis.

4.1 Physician and Nurse Practitioner Competencies, Values, Commitments, and Patient-Provider Relationships

In addition to analyzing documents for references to health care provider involvement in prevention-related activities, information about physician and nurse practitioner competencies, values, commitments, and patient-provider relationships was extracted if deemed relevant to this discussion. A brief summary of this information is presented below.

Nurse Practitioners

The work of nurse practitioners is deeply rooted in nursing theory and its associated values, medical expertise, and skills. As such, NPs in Ontario abide by the Code of Conduct developed by the College of Nurses of Ontario (CNO), which includes six principles:

1. Nurses respect the dignity of patients and treat them as individuals;
2. Nurses work together to promote patient well-being;
3. Nurses maintain patients' trust by providing safe and competent care;
4. Nurses work respectfully with colleagues to best meet patients' needs;
5. Nurses act with integrity to maintain patients' trust; and
6. Nurses maintain public confidence in the nursing profession.

(CNO, 2019a)

Their work is also guided by principles of primary health care, which, as stated by the Canadian Nurses Association (CNA), is important for ensuring “equitable, timely, and accessible health care”, helping individuals make the best decisions for their health, and for healthy public policy within communities (CNA, 2015, p.1). In the same position statement on primary health care, the CNA also acknowledges the importance of the social determinants of health and recognizes the significant impacts of social inequities on individual and population health outcomes (CNA, 2015). The CNA believes that all levels of government should adopt a “Health

in all Policies” approach to decision-making and policy development, which the medical profession also supports (CNA, 2015, p. 2).

Nurse practitioners provide a full range of health care services to diverse client populations (Spence, Agnew, & Fahey-Walsh, 2015). They often work with vulnerable groups such as refugees, seniors, Indigenous Peoples, low SES groups, or individuals living with substance abuse issues and/or mental health challenges (CNA, 2019). Nurse practitioners serve these individuals and communities using a client-centred framework that focuses on conducting advanced assessments of client needs and using various intervention strategies to optimize health (CNA, 2019). Further, nurse practitioners work in a wide range of practice settings (e.g., hospitals, emergency departments [ED], Community Health Centres [CHC], primary care clinics, long-term care, rehabilitative care, nurse practitioner-led clinics, palliative care) and form partnerships with physicians, registered nurses, social workers, midwives, pharmacists, and mental health professionals (CNA, 2016; Spence et al., 2015).

In addition to registered nurse competencies, nurse practitioners are authorized to autonomously diagnose, prescribe treatment, and perform specific medical procedures that fall within their legal scope of practice (CNA, 2016, 2019). In some provinces/territories, nurse practitioners are authorized to admit, treat, and discharge hospital patients and in some jurisdictions can autonomously treat outpatients (Spence et al., 2015). The scope of practice of a nurse practitioner will further depend on their practice setting and their employer or the organization they work for (CNA, 2019).

Another key part of nursing practice is developing professional patient-provider relationships. As defined by the CNO in ethics and practice standards, nurse-client relationships are built on trust, respect, professional intimacy, empathy, and power (CNO 2019a; 2019b). CNO highlights *trust* since clients are often in vulnerable positions when seeking care and *respect* since it relates to the uniqueness and worthiness of every patient (CNO, 2002, 2019a, 2019b, 2019c). The CNO also describes the inherent power imbalance between patients and their health care providers and warns against provider abuse or misuse of this power (CNO, 2019a, 2019b, 2019c).

Lastly, the CNO (2019c) provides an ethical framework for all nurses to refer to for navigating ethical dilemmas and conflicts related to patient care. It restates the ethical values and principles important to the nursing profession and illustrates several scenarios based on real life

situations, followed by relevant behavioural directives (i.e., expected behaviours for nurses; CNO, 2019c).

Physicians

According to the Canadian Medical Association’s (CMA) *Code of Ethics and Professionalism* (2018), physicians exemplify five virtues: compassion; honesty; humility; integrity; and prudence. The table below lists these virtues and includes each definition from the CMA.

Table 1: Physician Virtues as Described by the Canadian Medical Association

Virtue	Definition from the CMA
Compassion	<i>A compassionate physician recognizes suffering and vulnerability, seeks to understand the unique circumstances of each patient and to alleviate the patient’s suffering, and accompanies the suffering and vulnerable patient.</i>
Honesty	<i>An honest physician is forthright, respects the truth, and does their best to seek, preserve, and communicate that truth sensitively and respectfully.</i>
Humility	<i>A humble physician acknowledges and is cautious not to overstep the limits of their knowledge and skills or the limits of medicine, seeks advice and support from colleagues in challenging circumstances, and recognizes the patient’s knowledge of their own circumstances.</i>
Integrity	<i>A physician who acts with integrity demonstrates consistency in their intentions and actions and acts in a truthful manner in accordance with professional expectations, even in the face of adversity.</i>
Prudence	<i>A prudent physician uses clinical and moral reasoning and judgement, considers all relevant knowledge and circumstances, and makes decisions carefully, in good conscience, and with due regard for principles of exemplary medical care.</i>

(CMA, 2018, p. 2)

The CMA has also established the following “Fundamental Commitments of the Medical Profession”, including:

- Commitment to the well-being of the patient;
- Commitment to respect for persons;
- Commitment to justice;
- Commitment to professional integrity and competence;
- Commitment to professional excellence;
- Commitment to self-care and peer support; and

- Commitment to inquiry and reflection

(CMA, 2018, p. 2-3)

In addition, the College of Family Physicians of Canada (CFPC) defines therapeutic relationships between physicians and patients (and patient families) as “characterized by understanding, trust, respect, honesty, and compassion” (Shaw et al., 2017, p. 7).

Similarities between the two professions

While the differences between nurse practitioners and physicians may come down to specific competencies, educational requirements, and separate legislated scopes of practice, information from their respective associations and colleges indicates that *both* professionals are expected to: promote overall patient well-being; form partnerships with other health care professionals and colleagues; and develop therapeutic relationships with their patients built on trust, respect, and compassion.

Moreover, research has investigated health outcomes when care is provided by physicians versus nurse practitioners. A meta-analysis by Maier, Aiken, and Busse (2017) showed that both professionals provide similar levels of care, with nurse practitioners producing health outcomes that are as good or better than those produced by physicians.

The similarities between the guiding values, goals, approaches to care, and scope of practice of both professionals helps support the decision to limit this study to nurse practitioner and physician involvement in homelessness prevention, as opposed to including additional professions. Further, as mentioned in Chapter Two, both professions are well-positioned to promote housing stability among their patients given that an essential part of their work is to interact and ‘check in’ with members of the public. When individuals access health care at nurse practitioner or physician-run clinics, they may view these providers as the ‘face’ of the health care system, especially since these two types of providers are often the first point of contact that individuals have with health services (WHO, 2018). Indeed, patient-provider interactions become even more critical and opportune for physicians and nurse practitioners when meeting with at-risk individuals who are not tied to any other health or community supports.

4.2 Descriptive Themes in Analyzed Documents

In this section, descriptions of the nine major themes that emerged from the document analysis are presented. These themes are based on the analysis of the 20 documents (See below Table 2).

Table 2: Documents Included in Document Analysis

Document Title	Authors or Published by:
<i>Health Equity and the Social Determinants of Health: A role for the medical profession (2013a)</i>	Canadian Medical Association (CMA)
<i>CMA Position Statement: Ensuring equitable access to care (2013b)</i>	
<i>Health in all Policies (2015a)</i>	
<i>CMA Policy Improving Efficiency in the Canadian Health Care System (2015b)</i>	
<i>CMA's Recommendations for Effective Poverty Reduction Strategies (2017)</i>	
<i>CMA Code of Ethics and Professionalism (2018)</i>	
<i>Position Statement: Primary health care (2015)</i>	Canadian Nurses Association (CNA)
<i>Position Statement: The Nurse Practitioner (2016)</i>	
<i>Advanced Practice Nursing: A pan-Canadian framework (2019)</i>	
<i>Family Medicine Professional Profile (2018)</i>	College of Family Physicians of Canada (CFPC)
<i>A New Vision for Canada: Family practice the patient's medical home (2019)</i>	
<i>Practice Standard: Professional Standards, Revised (2002)</i>	College of Nurses of Ontario (CNO)
<i>Practice Standard: Nurse practitioner (2019a)</i>	
<i>Therapeutic Nurse-Client Relationship (2019b)</i>	
<i>Practice Standard: Ethics (2019c)</i>	
<i>Preventive Care Checklist Form (2010)</i>	Dubey, V., Mathew, R., & Iglar, K.
<i>Poverty and Health: Key issues in patient care (2014)</i>	Gazeley, S., & Ter Kuile, S.
<i>CanMEDS-FM 2017: A competency framework for family physicians across the continuum (2017)</i>	Shaw, E., Oandasan, I., & Fowler, N.

<i>A Pan-Canadian Environmental Scan of the Scope of Practice of Nurse Practitioners (2015)</i>	Spence, L., Agnew, T., & Fahey-Walsh, J.
<i>Triple C Competency-based Curriculum Report of the Working Group on Postgraduate Curriculum Review – Part 1 (2011)</i>	Tannenbaum, D., Kerr, J., Konkin, J., Organek, A., Parsons, E., Saucier, D., Shaw, L., & Walsh, A.

4.2.1 Considering the Wider Patient Context

As gathered from the analyzed documents, health care providers can demonstrate consideration and understanding of a patient’s wider context by conducting a ‘social history’ assessment – and recognizing the health implications associated with assessment results – and by generally contributing to overall patient well-being.

According to the CFPC and the CMA, providers contribute to overall patient well-being by using a patient-centred approach to care, which includes supporting patients with self-management and decision-making. Importantly, supporting patients through this approach can lead to enhanced financial and social wellbeing in addition to ‘physical’ wellbeing (CFPC, 2019; CMA, 2018). In particular, health care providers can conduct comprehensive ‘social histories’ to gain better understandings of their patients’ social, cultural, and economic contexts.

A comprehensive social history is essential to understand how to provide care for each patient in the context of their life. (CMA, 2013a, p. 5)

Information revealed to providers through these assessments could be highly relevant to the patient’s health and important to consider for diagnoses and the development of treatment plans (Shaw et al., 2017). Moreover, as part of their roles as ‘communicators’, providers *should* engage with patients and their families in discussions about important life events and cultural influences that are relevant to the care they are receiving (Shaw et al., 2017). Currently, however, there is no single tool used by providers across health care settings for assessing and documenting a patient’s social history (CMA, 2013a).

Gaining information to understand the wider patient context is also critical to decision-making around treatment and care plans. For example, a provider should consider a patient’s ability to pay for non-insured services or needed medications and alter treatment plans accordingly (CMA, 2018). As stated in the CFPC’s *Family Medicine Professional Profile*,

providers should think “creatively” to solve complex health issues by looking at the larger picture and considering all patient factors (CFPC, 2018).

Keeping with a focus on patient-centred care, this approach should also require exploring a patient’s ability to self-manage, in the context of their health condition, and the conduciveness of their environment to self-management (CFPC, 2019). As well, providers should ask patients about *their* health priorities and seek a patient’s perspective on their overall health.

[As ‘communicators’, physicians] elicit and synthesize accurate and relevant information from, and perspectives of, patients and their families. (Shaw et al., 2017, p. 7)

PMH [Patient’s Medical Home] team members should always consider recommendations for care from the patient’s perspective. (CFPC, 2019, p. 26)

Providers can then compare *patient* priorities with the priorities that *they* have identified using their medical skills and expertise.

[As part of] performing patient-centred clinical assessments and establishing management plans, [providers] identify relevant priorities for assessment and management, based on the patient’s perspective, context, and medical urgency. (Shaw et al., 2017, p. 5)

It is also important to note that for providers to gain more complete understandings of patient context, a therapeutic patient-provider relationship must be established. This relationship should be characterized by mutual trust and rapport that has been built over time (CFPC, 2018). To form these types of patient-provider relationships, it is recommended that the same provider sees a particular patient over the course of their care, for both minor and major health issues (CFPC, 2019).

Trust in these relationships is important so that patients feel comfortable sharing potentially sensitive and private information about their medical and social histories. Providers should demonstrate respect for their patients by reserving any judgement based on a patient’s social determinants of health and seek to “recognize, understand, and mitigate” their individual ‘illness narratives’ (CNO, 2019; Shaw et al., 2017, p. 2).

4.2.2 Directly Responding to Patients' Social Determinants of Health

Filling out income support forms is a practical step that health care providers can take to help their patients access needed resources to improve their social determinants of health (CNA, 2019; Gazeley & Ter Kuile, 2014). In fact, most federal and provincial/territorial income support programs *require* that a physician or nurse practitioner completes at least one type of form in order to demonstrate an individual's eligibility (CMA, 2013a).

Within their legal scope of practice, nurse practitioners can certify patients for income supports, such as “the medical expense tax credit, the child care expense deduction, the student disability tax credit, and the disability savings plan” (CNA, 2019, p. 26). Nurse practitioners can also fill out forms related to certifying spouses for pension plans and survivor benefits and can be asked to complete medical reports that demonstrate eligibility for the Canada Pension Plan (CNA, 2019). In some jurisdictions, nurse practitioners can complete Worker's Compensation and short-term disability forms (Spence et al., 2015).

In addition to these income supports, physicians are often asked to complete forms for disability tax credits, Employment Insurance, non-insured health benefits (for First Nations people and Inuit), the Veterans Disability Pension, compassionate care leave, Exception/Limited Use Drug Requests, and the Interim Federal Health Program (CMA, 2015a). Physicians can also help their patients gain access to transportation funding and dietary supplements and get coverage for prescription drugs through government programs (Gazeley & Ter Kuile, 2014). Simply by completing these forms, health care providers can help patients decrease their poverty, which is expected to improve their health.

Another way that providers can directly respond to patients' social determinants of health is by educating patients about various resources and supports in their communities and by facilitating referrals to these services when necessary (CMA, 2013a). Providers can play a role in increasing patient knowledge about social programs and benefits they are eligible for.

Physicians noted their work in helping their patients become aware of and apply for the various social programs to which they are entitled. (CMA, 2013a, p. 6)

They may even choose to have information about these resources available in their offices for patients to review on their own or take home with them (Gazeley & Ter Kuile, 2014).

Health care providers also directly respond to patients' social determinants of health when they work in an 'advocate' role at the patient level (Gazeley & Ter Kuile, 2014). Providers can act as advocates by facilitating access, which may include physically helping patients obtain a benefit or support by writing a letter, referral, or directly providing a patient with a contact at a social service (e.g., housing worker, social worker, government assistance worker; CMA, 2013a; Gazeley & Ter Kuile, 2014).

4.2.3 Health Care Providers Responding to Community Needs

Pillar 5 of the *Patient's Medical Home*, developed by the CFPC, is "Community Adaptiveness and Social Accountability", which requires that patients' needs are met through "interventions at the patient, practice, community, and policy level" (CFPC, 2019, p. 17). The CMA also recommends that physicians be "encouraged and adequately supported to participate in community-based interventions that target the social determinants of health" (CMA, 2013b, p. 12).

Health care providers are also encouraged to be involved in community planning – that which is rooted in equity and based on specific community needs and community-level determinants of health (CMA, 2013b; Gazeley & Ter Kuile, 2014). Physician involvement in community planning, for example, should include identifying underlying determinants that are impacting the health of individuals within their practice population (CMA, 2013b; Shaw et al., 2017). More specifically, planning should also seek to understand the specific needs of the most disadvantaged groups within the population (CMA, 2013b). After these critical determinants and needs are identified, care and programming can be tailored accordingly. Moreover, the CMA recommends that physicians plan in consultation with various sectors, since even sectors outside of health care have the power to influence the health of their patients (CMA, 2013b).

In short, health care providers are encouraged to develop deeper understandings of the challenges faced by the members of the communities they practice in and adopt greater awareness of broader societal needs.

4.2.4 Advocacy

Health care providers can participate in a range of activities related to advocacy for improved living conditions – and thus, improved health – for patients and members of the communities in which they practice. First, health care providers can help in demonstrating the links between poverty and health, for the specific purpose of influencing policy and requesting government action on the social determinants of health. Indeed, a team of educators and practitioners from the Faculty of Family Medicine at the University of Toronto agree that physicians are well-positioned to educate policy makers on the health effects of poverty and advocate for change and more evidence-based decision-making around public policy (Gazeley & Ter Kuile, 2014). Moreover, the CMA believes that “the stories entrusted to family physicians in daily practice are powerful tools for healthy change” (CFPC, 2019, p. 19). Both nurse practitioners and physicians can improve health through understanding legislative and socio-political issues and then advocating for healthy public policy decisions.

[Family physicians] form partnerships with patients, families, and communities to advocate when necessary for improvements to living conditions, resources, access, and care. (Shaw et al., 2017, p. 4)

[Advanced practice nurses] advocate for clients in relation to care, the health system and policy decisions that broadly affect health (e.g., determinants of health) and quality of life. (CNA, 2019, p. 31)

In the humanitarian realm, physicians are concerned with the welfare of their entire patient population and seek to improve human welfare through healthy public policy (such as reducing income inequality, supporting equitable and progressive taxation, and expanding the social safety net). (CFPC, 2019, p. 18)

Likewise, according to the CMA, influencing policy to address homelessness is a "creative" way that physicians can be health promoters and work on disease prevention (CFPC, 2019, p. 19).

Representative bodies as a whole, such as the CMA, also continue to urge governments to acknowledge the impacts of social determinants of health and address them through targeted action. For example, the CMA has published statements outlining its recommendations for governments to implement a “Health in All Policies” approach to policy development and decision-making (CMA, 2015a). The CMA also advocates for a basic income guarantee to help

individuals meet basic needs, and to reduce poverty overall (CMA, 2017). In addition, the CMA expresses its recognition of a need for more government-led research on the social determinants of health and continues to push for more widespread use of Health Impact Assessments (CMA, 2013a). Interestingly, the CFPC confirms that family physicians are indeed very aware of the influence of social and economic factors on patient health and suggests that society ultimately requires physicians' specific expertise to effectively address the social determinants of health (CFPC, 2019).

In other ways, health care providers can take practical steps to demonstrate involvement in advocacy efforts. For family physicians, advocacy may require outreach, direct engagement with patients and families, speaking up about issues in their communities, helping to mobilize financial and human resources to create change, and seeking other ways to demonstrate leadership (CFPC, 2018; Gazeley & Ter Kuile, 2014; Shaw et al., 2017).

One meaningful way that health care providers can demonstrate leadership in advocacy efforts is through participating in or conducting research on the health impacts of poverty and the social determinants of health, and then sharing research findings with other practitioners and policy makers (CMA, 2013a). Since best practices for health equity in clinical settings remains an underdeveloped body of research, the CMA also recommends that physicians explore innovative ways to promote health equity in their practices, if not also directly participating in or leading research on health equity (CMA, 2013a).

All of these activities and practices discussed above represent high-level strategies that physicians can and *have* adopted as part of advocacy at a 'macro' level. At a more micro level, physicians can offer support that is "game-changing" for patients and communities (CMA, 2013a, p. 6). In terms of advocating for realized housing needs, physicians can describe and document the links between inadequate housing and health. For example, physicians can write letters that detail the medical harm of certain exposures and housing conditions (e.g., mold in the case of asthma), which could lead to significant improvements in community housing (CMA, 2013a). Family physicians can also act on behalf of patients to secure increased patient resources, namely income. This level of advocacy, at the patient level, requires compassionate, patient-centred care where health care providers conduct assessments to learn about patient concerns and circumstances. Providers should also try to empower patients to advocate for

themselves when accessing social services and other community supports (Gazeley & Ter Kuile, 2014).

While there are known advocacy-focused activities that physicians can participate in, such as the ones discussed above, medical residents report limited opportunities to work in an advocate capacity during their training (CMA, 2013a). According to a CMA Policy document outlining *A Role for the Medical Profession* in health equity and the determinants of health, medical residents would like to have a greater role in patient advocacy and gain more practical experience working with diverse and disadvantaged populations during residency programs (CMA, 2013a).

In the general sense, *Advocacy* is included in the Family Medicine Professional Profile developed by the College of Family Physicians of Canada and is defined as a “primary responsibility” of the discipline (CFPC, 2018, p. 1). The Profile discusses advocacy in terms of patients having equitable access to high quality and comprehensive health care, but also outlines physicians’ professional commitment to advocating for the “social conditions that promote health” (CFPC, 2018, p. 1).

Moreover, in relation to the principle of family medicine being ‘community-based’, the CFPC states that it expects family physicians to be competent as health advocates (CFPC, 2019). It is, again, mentioned that physicians and nurse practitioners are often the first point-of-contact that community members have with the medical field and wider health care system, and therefore, must support individuals in every interaction and are expected to be a “reliable medical resource” in their communities (CFPC, 2019, p. 1).

4.2.5 Collaborative Relationships and Systems Integration

Within the context of health care and other community-based systems, there continues to be a need for more integration, collaborative work, and coordinated care, which is expected to result in greater system efficiency and improved patient outcomes.

Two common system-level barriers to health care access include coordination between primary care and speciality care and between health care and community services (CMA, 2013b). The CMA recommends standardizing referrals to specialists and social services to address this barrier (CMA, 2013b).

As discussed by the CMA, another approach to coordinating care and integrating services is establishing CHCs. The model of a CHC simplifies access to care for patients and may obviate the need for referrals to external services.

CHCs offer a number of different health, and sometimes social services, under one roof making access to many different types of care more convenient for patients. (CMA, 2013b, p. 7).

Similarly, the *Patient's Medical Home* (PMH), a 'vision document' for the future of family medicine developed by the CFPC (2019), states that PMHs are committed to offering patients coordinated and continuous care.

To achieve this, each PMH should establish, maintain, and use defined links with secondary and tertiary care providers, including local hospitals; other specialists and medical care clinics; public health units; and laboratory, diagnostic imaging, physiotherapy, mental health and addiction, rehabilitation, and other health and social services. (CFPC, 2019, p. 12)

For nurse practitioners, a standard accountability or expectation is that they will consider and plan for support to meet a patient's needs even after the "termination of the nurse-client relationship" (CNO, 2019b, p. 3). In other words, nurses must practice effective discharge planning, which includes communicating discharge plans to patients and facilitating referrals to community supports.

Also related to coordinated care are inefficiencies in how the health care system interacts with other systems, such as social support services. For example, in the CMA document, *Improving Efficiency in the Canadian Health Care System*, there is explicit reference to "a lack of services to address homelessness" (CMA, 2015b, p. 6). Recognizing that the health care system shares in preventing and responding to homelessness, health care providers may find it difficult to make effective referrals and coordinate care if there are insufficient services and a limited number of social service providers to engage with.

Community-level partnerships, such as with community agencies and resources, will also promote health care system efficiency and can even strengthen advocacy efforts for patients living in poverty (CMA, 2013a). It is recommended that physicians engaged in such advocacy efforts develop partnerships with community organizations, administrators, and policy makers (Shaw et al., 2017).

Within the reviewed documents, there are several discussions about physicians' and nurse practitioners' participation in interdisciplinary, team-based practices and, in general, collaborative relationships with other providers (CFPC, 2019; CMA, 2013a; CMA, 2018; Spence et al., 2015; CNO, 2019a), including providers “whose services [also] impact the determinants of health” (CNA, 2019, p. 29). These collaborative relationships should be characterized by shared decision-making, with consideration given to each provider's scope of practice and specific competencies, and shared accountability for patient care (CNA, 2019).

Moreover, nurse practitioners are expected to consult with other providers when a patient's needs extend beyond their legal scope of practice, or when a patient would benefit from seeking the expertise of another provider (CNA, 2019; CNO, 2019a). In general, effective collaboration and communication with other health care providers is considered fundamental to nursing practice (CNA, 2019).

A primary function of the PMH model is “Comprehensive Team-Based Care with Family Physician Leadership” (CFPC, 2019, p. 20). In jurisdictions where the PMH model is adopted, it is expected to increase patient access to health and social services and improve the quality of care. Both *Family Health Teams* in Ontario and the *Healthy People, Healthy Families, Healthy Communities* framework in Newfoundland and Labrador were built on PMH principles, focusing on team-based care within the clinical setting and maintaining connections with colleagues in local social support services (CFPC, 2019).

4.2.6 Appropriate Use of Health Care Resources for Responding to Social and Economic Issues

Many of the documents included in this analysis discussed the need to support patients at-risk of some of the negative health impacts associated with the social determinants of health while, at the same time, maximizing health care system efficiency and considering the scopes of practice of health care providers.

For example, there is concern about whether asking patients questions about the social aspects of their lives falls outside the role of the physician (CMA, 2013a). However, as noted in the CMA policy document *Health Equity and the Social Determinants of Health: A Role for the Medical Profession*, the CFPC suggests otherwise. According to the CFPC's Four Principles of Family Medicine, the role of physicians *does* include asking questions related to the ‘social

aspects' of patients' lives (CFPC, 2019, CMA, 2013a), which is also confirmed within the description of the "Health Advocate" role for physicians (Shaw et al., 2017, p. 13).

The CMA asserts that health care resources are scarce and therefore, should not be used where little to no health benefit is expected (CMA, 2015b). According to the CMA, there are times when care by a physician is considered an inappropriate use of health care resources, for example, when hospitalizing patients who would be better supported by a community-based resource or service (CMA, 2015b). Where these community-based services operate with insufficient capacity to support those in need, it represents a systems-level issue that leads to individuals inappropriately accessing emergency health services (CMA, 2015b).

Ultimately, the CMA recognizes that missed opportunities to prevent health issues attributable to the social determinants of health negatively impact a patient's life, their care, and the efficiency of the entire system (CMA, 2015b). It is recommended that health care providers refer patients to other service providers and community-based services, where needed, as part of promoting the proper use of health care resources (Tannenbaum et al., 2011). However, where these external services are unable to proactively identify and respond to individuals' social determinants of health, the health care system will ultimately be relied on to diagnose and treat consequent health issues (CMA, 2015b). Lastly, while the CMA endorses the Health in All Policies approach, the Association suggests that a lot of health promotion and prevention efforts needed will be led by government sectors and other services that fall outside of medicine and health care (CMA, 2015a).

4.2.7 Ensuring Health Care Providers are Equipped with Tools to Address Patients' Social Determinants of Health

The analyzed documents revealed ideas for promoting greater health care provider involvement in addressing patients' social determinants of health, which generally relate to medical education and curricula, establishing provider "checklists" and assessment tools, and ensuring providers are equipped with information about community resources and supports.

First, an overall need to educate physicians about the social determinants and health, and concepts of equity, was identified in the documents (CMA, 2013a; Shaw et al., 2017). According to the CMA:

Medical education is an effective means to provide physicians with the information and tools they require to understand the impact of social determinants on the health of their patients and deal with them accordingly. (CMA, 2013a, p. 4)

Indeed, residency programs increasingly incorporate education on the social determinants of health into their curricula (CMA, 2013a). It is recommended that medical students be encouraged to learn about how to reduce barriers to care for marginalized patients. Moreover, recognizing that barriers to care can stem from physician behaviours, medical students should be taught about how to “communicate with patients from diverse backgrounds” (CMA, 2013a, p. 4). To do this, the CMA recommends that “service learning programs” (or experiential learning) for medical students be expanded to help them learn about supporting patients’ social determinants of health (CMA, 2013, p. 4).

In addition to training for medical students, practicing physicians can be educated on these topics through Continued Medical Education (CME).

CMA recommends that CME on the social determinants of health and the physician role in health equity be offered and incentivized for practising physicians. (CMA, 2013a, p. 4).

According to the CMA (2013a), it is also important to keep interested physicians informed about interventions related to the social determinants of health, innovations that address health inequities, and emerging literature on these topics.

Second, as part of a wider call to “screen for poverty” in primary care, it is recommended that health care providers be equipped with tools to assess patients’ social and economic wellness (CMA, 2013a; Gazeley & Ter Kuile, 2014, p. 5). The CMA also suggests that these tools be used to determine the impact of patients’ social and economic factors on “treatment design” (CMA, 2013a, p. 6). For example, physicians are encouraged to routinely ask their patients about their income, as well as other determinants of health such as housing, food, and education (Gazeley & Ter Kuile, 2014), and record patients’ demographic information. Indeed, the Family Health Team at St. Michael’s Hospital collects sociodemographic data on their patients, including income and housing, and this information is recorded on their medical record (CFPC, 2019).

To support assessment and the recording of demographic information, the CFPC has developed a “Preventative Care Checklist” for physicians, which includes one question about whether a patient’s income is below the poverty line (Dubey et al., 2010).

Lastly, as identified by the CMA and a group of researchers and physicians at the University of Toronto, health care providers need to be informed about services offered in their practice communities, as well as resources available at federal and provincial levels (CMA, 2013a; Gazeley & Ter Kuile, 2014). The CMA recommends that physicians be provided with lists or databases of community services and resources, including social service supports (CMA, 2013a). Likewise, physicians should also be informed about government assistance programs that their patients may be eligible for (CMA, 2013a). In the context of clinical practice, physicians having this “community knowledge” and awareness is particularly helpful for patients who may benefit from being referred to one of these services (CMA, 2013a, p. 5; Gazeley & Ter Kuile, 2014).

4.2.8 Recognizing the Impacts of the Social Determinants of Health

The documents included in this analysis demonstrate that the associations and colleges representing the medical community understand the social determinants of health and can recognize their impacts, including links to chronic diseases and specific links between one’s housing situation and health outcomes.

In the *CMA’s Recommendations for Poverty Reduction*, being ‘disadvantaged’ is discussed in terms of having a low income, which is correlated to poorer overall health compared to those with higher incomes (CMA, 2017). In another document, the CMA explains that low income is linked to higher rates of social isolation and thus, poorer mental health since, “without financial resources, it is more difficult for individuals to participate in cultural, educational and recreational activities” (CMA, 2013a, p. 2).

Additionally, the CMA recognizes that low-income populations are more likely to develop chronic diseases such as high blood pressure, obesity, diabetes, and heart disease, and are also more likely to smoke and engage in less physical activity (CMA, 2013a; CMA, 2017). In fact, research suggests that children from low SES backgrounds experience higher rates of these diseases in their adult life, compared to children from higher SES backgrounds (CMA, 2013a).

It is also noted that several of these chronic conditions that low-income individuals are at risk for can be attributable to housing instability and factors related to housing location (e.g., exposure to pollution, proximity to healthy food options, neighbourhood safety; CMA, 2017).

Moreover, there is recognition by the CMA that to be absolutely or relatively homeless puts individuals at heightened risk for physical and mental illness (CMA, 2013a).

Specifically, the CMA acknowledges health consequences faced by Aboriginal people in relation to poverty and housing insecurity.

Canada's Aboriginal people face the greatest health consequences as a result of the social determinants of health. Poverty, inadequate or substandard housing, unemployment, lack of access to health services, and low levels of education characterize a disproportionately large number of Aboriginal peoples. (CMA, 2013a, p. 2)

These documents also suggest that providers themselves are expected to understand the significant influences of patient environment and other determinants such as income. For example, within the CMA Code of Ethics and Professionalism, it describes commitments of the medical profession, including to:

Recognize that social determinants of health, the environment, and other fundamental considerations that extend beyond medical practice and health systems are important factors that affect the health of the patient and of populations. (CMA, 2018, p. 7)

According to physician educators, addressing the social determinants of health is “essential” to primary health care (Gazeley & Ter Kuile, 2014, p. 13). Likewise, the CMA considers collecting longitudinal health indicator data over time to be “essential to the task of describing underlying health trends and the impacts of social and economic interventions” (CMA, 2013a, p. 3). Nurse practitioners are also encouraged to work collaboratively to collect and synthesize data about the social determinants of health, as part of further investigating their impacts (CNA, 2019).

Indeed, factors related to the social determinants of health are known to impact the effectiveness of injury or illness treatment provided by the health care system, which can undermine its efficiency (CMA, 2015b). On a larger scale, the CMA policy documents suggest that any national or global plans to improve the health of patients and populations will be futile without targeted action to address the social determinants of health. In fact, these determinants may even influence health to a larger degree than “biological factors or the health care system” (CMA, 2013a, p. 6).

4.2.9 Exploring How Disadvantaged Groups Access Care

Present in these documents were references to differential rates of service use between low-income and high-income groups, including recognition of the challenges low-income individuals face in terms of barriers to access, following treatment plans, and taking other steps to improve their health.

First, the CMA highlights where rates of service use are lower among ‘disadvantaged’ groups (i.e., low SES), even where system access is available. Whereas it may be assumed that lower SES groups utilize more health services than higher SES groups, due to a higher burden of disease, individuals in these groups are less likely to: have a primary care physician; receive appropriate testing and monitoring for chronic health conditions; and access screening procedures, such as pap smears and mammograms (CMA, 2013b). In contrast, it is noted that higher income individuals typically have greater access to day surgery and are more likely to get access to specialist services.

There is a correlation between higher income and access to day surgery. A Toronto study found that inpatient surgery patients were of much higher income than medical inpatients... As the evidence demonstrates, access to specialist services are skewed in favour of high-income patients. (CMA, 2013b, p. 2, p. 9)

In terms of increased service use, the CMA notes that Canadians with the lowest incomes are some of the most frequent users of family practice, mental health, and ED services (CMA, 2013a). Research suggests that these higher rates of service use may be linked to lower compliance with medical treatment plans that may, for example, lead to individuals being hospitalized for conditions that could have (or should have) been prevented (CMA, 2013a).

The CMA indicates that “Work needs to be done to ensure that disadvantaged groups are aware of the services that are available to them and the benefits of taking preventative steps in their health” (CMA, 2013b, p. 5). However, this work may not necessarily address some of the known barriers to accessing health care that these disadvantaged groups experience, or other reasons for poorer compliance with medical treatment plans and engagement with preventative health services. Indeed, the CMA highlights research in the U.K. and U.S. that found poor adherence to treatment plans among disadvantaged groups, mainly in terms of filling prescriptions and having tests done, are likely related to cost constraints (CMA, 2013a).

The CMA recognizes that poverty is a barrier to accessing needed health care (CMA, 2013b). According to the Association, individuals from disadvantaged groups or low-income neighbourhoods report having trouble getting to appointments with primary care physicians for urgent health issues, due to transportation-related barriers (e.g., transportation costs) or system navigation challenges (CMA, 2013b). To address some of the known barriers to care, the CFPC recommends that health care providers be flexible and accommodating for low-income patients by extending clinic hours and spending additional time with patients to help them better understand the system and available services (CFPC, 2019).

According to the CMA Code of Ethics and Professionalism, as part of the commitment to justice, physicians should always strive to improve access to care and reduce health inequities (CMA, 2018). Physicians are expected to accept patients without discriminating based on SES, identify their unique needs including barriers to care, and provide culturally appropriate care (CMA, 2018). Likewise, a “professional responsibility” of physicians, as outlined by the CMA, includes:

Contributing, individually and in collaboration with others, to improving health care services and delivery to address systemic issues that affect the health of the patient and of populations, with particular attention to disadvantaged, vulnerable, or underserved communities. (CMA, 2018, p. 7)

Notably, the CMA also makes a general recommendation for governments, specifically, to examine methods for ensuring greater health care access for low-income groups, including within “rehabilitation services, mental health, home care, and end-of-life care” (CMA, 2013b, p. 6).

4.3 Conclusions and a Brief Discussion about the Document Analysis

In conclusion, this document analysis has revealed how various associations and organizations conceptualize poverty and other social determinants of health and the extent to which they value and incorporate this information within patient care. This analysis has also explored ideas about health care provider roles in responding to these determinants and patients’ social issues.

The findings from this analysis are expected to add ‘prescriptive’ context to the findings from interviews with providers themselves. That is, findings from the document analysis may

provide a starting point as to the knowledge that providers *should* have, according to their professional bodies, or the prevention-oriented activities that providers *should* incorporate into their practices.

For example, it was found that providers *should* be aware of the serious health consequences associated with unaddressed social determinants of health and appreciate the value in having information about a patient's wider social, economic, and cultural contexts when providing care and designing treatment plans. Findings from this analysis also discussed provider involvement in advocacy efforts, provider responses to community needs, strategies providers can use for responding to a patient's social determinants of health, and ways to ensure that providers are equipped with the appropriate knowledge and tools to engage in this work. Moreover, these findings suggest that providers should collaborate with other health professionals and community-based services, partner with administrators and policy makers, and support coordinated care within and between primary care, specialists, and other sectors. This focus on collaboration and coordination is expected to improve efficiency in the health care system, which should address some concerns related to the system's engagement with other sectors and the appropriate use of health care resources to address social issues.

While the 'prescriptive' context that these findings provide will be more thoroughly explored in the discussion of this thesis (Chapter Six), here, a few critical reflections on the document analysis findings are briefly discussed.

Pertaining to physician and nurse practitioner values and principles that guide practice

Nurse practitioners, specifically, may be key partners in homelessness prevention since, as stated in the Advanced Practice Nursing Framework, they often work with vulnerable populations, such as low SES groups and individuals with addictions or mental health challenges, who are particularly at risk for housing instability and homelessness. Also, it appears that the principles of nursing practice, as outlined by the CNO, further illustrate how nurses, including nurse practitioners, play a role in responding to patients' economic and social needs. For example, two of these principles include, "Nurses work together to promote patient well-being" and "Nurses work respectfully with colleagues to best meet patients' needs", and presumably this work extends beyond simply addressing patients' *health* needs (CNO, 2019a). Likewise, according to the CMA, the medical profession is committed to the well-being of the

patient, which conceivably encompasses multiple ‘types’ of well-being including physical, emotional, social, and economic wellbeing (CDC, n.d.).

Moreover, while it is assumed that most of the ‘virtues’ outlined by the CMA are to guide physicians’ *medical* practices, some of these virtues suggest that physicians need to be aware of a wide range of factors and issues in their patients’ lives (e.g., a compassionate physician “seeks to understand the unique circumstances of each patient”; CMA, 2018, p. 2). Additionally, the virtue of *Humility* suggests that physicians seek support from other providers (and perhaps external services) when patient issues or needed care falls outside their scope of practice.

Providers recognizing the impacts of the social determinants of health and barriers to care

As previously discussed, it appears that the professional associations (e.g., CMA and CNA) demonstrate an understanding of the significance of the social determinants of health and *do* specifically describe links between unsuitable or precarious housing situations and health outcomes at the patient and population levels. However, some of these documents only include vague comments about physician and nurse practitioners’ ‘commitments’ to promoting patient wellbeing, reducing health inequities, or contributing to knowledge and understanding about the determinants of health. For example, the Advanced Practice Nursing Framework states that, “an advanced practice nurse is able to work with others to gather and synthesize qualitative and quantitative information on the determinants of health from a variety of sources” (CNA, 2019, p. 34). In this example, and throughout some of the other documents, there is only general acknowledgement of these understandings and commitments without further description about how they translate into or are demonstrated in practice.

With many of the documents indicating a professional understanding of how ‘disadvantaged’ groups experience barriers to accessing health care, it appears that providers are encouraged to participate in reducing these barriers within their own practices while also calling on the larger system and responsible government agencies to consider barriers and expand care. Importantly, with greater understanding about the barriers that individuals face, there may be less ‘blaming’ of individuals for their poor health outcomes, their lack of engagement with preventive health services, and their overall challenges with gaining control over their health.

The potential value of provider advocacy

One of the most robust themes revealed through analyses was *Advocacy*. In particular, the documents recommended that health care providers work to influence public policy and legislation and continue to request government action on the social determinants of health. This type of advocacy may be one of the most meaningful ways in which physicians and nurse practitioners can help change the current structures and systems that create risk of housing instability and homelessness. As noted in the findings, providers also engage in *Advocacy* through leading and participating in research and can advocate at the patient level by demonstrating a patient's need for more suitable or safe housing.

Why providers should seek and consider information related to the wider patient context

According to the documents, nurse practitioners and physicians should consider a patients' cultural and social context when providing care. Interestingly, it was mentioned that there is not currently a tool for assessing and documenting patients' social histories that is suitable in all health care settings. Thus, the need for this type of tool or set of guidelines is recognized by the professional associations and colleges. Although, it appears that this tool would be used by providers primarily for enhancing their understanding of disease processes and diagnoses in the context of a patient's social situation. That is, the need for the tool is not necessarily recognized as an assessment aid that would prompt providers to facilitate patient referrals to appropriate social supports.

There may be multiple reasons for providers to seek more complete understandings of their patients' social and economic circumstances. As evident in the document analysis findings, this type of contextual information is relevant to care and can help providers develop treatment plans. For example, the documents recommend that providers consider a patient's ability to pay for certain medications, their ability to follow treatment plans, and their ability to self-manage. Whereas considering patient context in those examples relates to ensuring patient adherence to treatment plans and, arguably, for improving health care efficiency, the analyzed documents do not explicitly recognize that this contextual information is also important for assessing patient risk of further social or economic vulnerabilities. Certainly, providers may initially be interested in learning about a patient's social and economic factors as they relate to the health issues they are experiencing and seeking care for. However, we may also wonder whether providers value this type of patient information for 'prevention' purposes – that is, using it to identify potential

indications of risk or considering it as ‘evidence’ that an intervention is needed before the patient experiences further social, housing, or economic-related issues.

Lastly, a few of the documents discussed concerns about the appropriate extent of health care system involvement in responding to population and patient-level social and economic issues. As described in these findings and in the literature review, the overall purpose and goals of primary health care and providers’ scopes of practice and expected competencies seem to align well with this work. Moreover, it appears to be widely understood within health care that almost all social and economic issues and vulnerabilities are related to health and will eventually lead to poor health. While the health care system and providers themselves may be needed to prevent housing instability and homelessness, perhaps it is still difficult to determine how much they should be relied on. The following chapter provides additional insights on this subject as revealed through interviews with physicians and nurse practitioners.

Chapter 5

5 Discussions with Providers

This chapter presents the main findings from this study, determined by using a blended inductive and deductive approach to analyzing transcripts from interviews with nurse practitioners and physicians. As discussed in Chapter Three, this study employed qualitative descriptive methodology, which involved seeking insights from participants (health care providers) themselves. Thus, the study findings included in this chapter are described from health care providers' perspectives and are the result of qualitative data analysis that involved lower levels of interpretation than typically seen in grounded theory, phenomenology, or ethnography research (Sandelowski, 2000).

The current chapter begins with a summary of participant characteristics (Section 5.1). Then, in Sections 5.2 to 5.5, rich descriptions of the four overarching themes are provided, which pertain to providers' opinions about issues of poverty and homelessness, and their perceptions about their professional roles in homelessness prevention, including barriers and facilitators to this involvement. The four descriptive themes are as follows, some of which had subthemes (Table 3): *Conceptualizing poverty, housing instability, and associated risk factors*; *Determinants of health as the 'purpose' of care versus to 'contextualize' care*; *Sharing responsibility and leveraging provider skillsets and knowledge*; and *Roles for providers at all levels of change*. Throughout this chapter, quotes extracted from interview transcripts are included to illustrate the themes and provide examples of provider sentiments.

5.1 Participant Characteristics

A total of four health care providers participated in this study, including three nurse practitioners and one family physician (See Table 4). Three participants identified as female and one participant identified as male. Two of the nurse practitioners worked at Community Health Centres (CHC) and one worked at a nurse practitioner-led clinic, and the one physician was part of a Family Health Organization (FHO). Two of the nurse practitioners specified that part of their practice focuses on HIV and Hepatitis C prevention and treatment and one of these nurse

practitioners reported participating in a program that specifically provides care to individuals who use drugs or are involved in sex work.

Nurse practitioner #3 (NP #3) indicated that they provide care for a roster of patients, of which they estimated 60-70% experience poverty. They also stated that they lead a speciality clinic for individuals experiencing homelessness and engage in outreach to rooming houses and emergency shelters. When providing care in these contexts, this participant estimates that 100% of the patients are experiencing some level of poverty, since “most of them are homeless, or on ODSP [Ontario Disability Support Program] or OW [Ontario Works]” (NP #3). NP #1, based on the percentage of her patients who receive social assistance, estimated 90% of her patients experience poverty. NP #2 estimated that 100% of her patients experience poverty and the family physician provided an estimate of 10-20% but said “[it’s] really hard to say” (Physician #1).

Table 3: Descriptive Themes and Subthemes

Theme	Subthemes
1. Conceptualizing poverty, housing instability, and associated risk factors	
2. Determinants of health as the ‘purpose’ of care versus to ‘contextualize’ care	1. Seeking to understand the wider patient context, including social and economic factors in patients’ lives 2. Challenges associated with assessment of social and economic factors 3. Building therapeutic patient-provider relationships and practicing patient-centred care
3. Sharing responsibility and leveraging provider skillsets and knowledge	1. Establishing community-level partnerships and engaging in collaborative relationships with other health care workers 2. Leveraging providers’ specific competencies and determining the ‘most responsible provider’ to respond to patients’ social and economic issues 3. Ensuring health care providers possess the knowledge required to effectively promote Housing Stability among patients
4. Roles for providers at all levels of change	

Table 4: Demographic Characteristics of Participants

Profession	Participant Identifier	Highest Level of Education	Practice Focus	Type of Workplace	Gender	Estimated percentage of patient load experiencing poverty
Nurse Practitioner	NP #1	PhD; Nurse practitioner certificate	Primary care; HIV, Hep C, and Hep B	Nurse Practitioner-Led Clinic	Female	90%
Nurse Practitioner	NP #2	MSc Nursing; PhD (c)	Primary care; HIV and Hep C	Community Health Centre	Female	100%
Physician	Physician #1	MD	Family medicine	Family Health Organization	Female	10-20%
Nurse Practitioner	NP #3	MSc Nursing	Primary care	Community Health Centre	Male	60-100%

To protect anonymity, participants are referred to by their corresponding number in the remaining sections and chapters, including where example quotes are provided to illustrate themes and subthemes. As well, names that participants used in quotes were changed to pseudonyms.

Though the primary focus of this thesis is to explore health care provider involvement in homelessness prevention, it is important to first consider providers' conceptualizations of risk factors associated with homelessness and their general opinions about poverty and housing instability. The following theme is therefore described in depth as these views provide context for other findings described in Sections 5.3 to 5.5. Moreover, while the documents included in the document analysis were found to generally discuss the social determinants of health and their impacts, the documents did not explicitly describe or 'prescribe' expectations around provider knowledge of housing instability and homelessness. Thus, the depth of information provided in the following section is further warranted.

5.2 Conceptualizing poverty, housing instability, and associated risk factors

During interviews, health care providers were first asked to discuss their opinions on what it means to experience poverty, housing instability, and homelessness. Providers were also asked to identify risk factors associated with these experiences and, similarly, explain which groups and populations they felt should be prioritized or targeted for homelessness prevention efforts. However, as these topics and conceptualizations of risk became a common theme throughout interviews, the codes that informed this theme were derived from provider responses that were shared at any point during the interviews (i.e., not necessarily when questions specifically about poverty and risk were posed).

Income and ability to meet basic health needs

All providers defined poverty in terms of income, including source of income, and described low income as a risk factor for poverty and homelessness. Providers recognized that poverty is driven by one's financial situation, including an individual's level of income and how much money they receive each month from all sources. Further, they defined poverty in terms of how much money an individual can spend on rent. Most participants also described poverty and risk factors in relation to receiving social assistance.

Here we're dealing with absolute poverty... everyone that we work with is on Ontario Works, or OW, or has some sort of alternate income. (NP #2)

If you wanted to say, "risk factor for poverty", well unfortunately being on OW and ODSP is a risk factor for poverty because it's not close to anything of a livable wage. (NP #1)

It [estimate of percentage of patients' living in poverty] would be near 100% because most of them are homeless, or on ODSP or OW. (NP #3)

Cost constraints were identified as risk factors for poverty and homelessness, in terms of individuals having difficulty "making ends meet" (Physician #1). It was a particular risk factor for priority populations, such as women and newcomers to Canada.

Women as a general group have different risk characteristics that are associated with homelessness [because of] some of the costs associated with children. (NP #3)

Immigrants, refugees for sure... They're at risk for homelessness. They have limited funds when they get here. (NP #3)

Providers also explained that not being able to meet basic health needs is an indication of poverty. For example, not being able to afford medications, healthy food, or have access to health-promoting activities (e.g., gyms), are individual circumstances that providers linked to poverty. According to one provider, poverty can be “relative” since individuals can have similar income levels but varying levels of need (NP #2).

Housing insecurity and homelessness

There was shared agreement among providers that the experience of poverty generally relates to one’s housing situation and, in extreme cases, can result in homelessness. To further explore these links, two providers shared personal opinions about what they consider ‘homelessness’. They felt that the experience of homelessness included accessing emergency shelters, sleeping in cars, couchsurfing, or using ‘survival’ sex in exchange for a place to stay.

I call shelters 'homeless'. So, people that are living in shelters, I feel are homeless... Anyone sleeping in their car, or couchsurfing, all of those people I would certainly say are homeless. (NP #3)

Two providers described precarious housing as housing that either lacks permanence, adequacy, or affordability. Moreover, providers identified factors that can negatively impact housing stability – and therefore represent risk factors – including poor housing conditions (e.g., mold), overcrowding, and family size. While one provider mentioned that “it’s quite difficult to get out of poverty if you’re a single mom with six children” (NP #1), another provider discussed family size as a protective factor, suggesting that multi-generational homes can provide “some buffering” in terms of economic stability (Physician #1). That is, multi-generational homes may be more likely to have higher total household incomes.

In addition, two providers recognized that the long-term stability of one’s housing situation can be undermined by social isolation or a lack of services and supports attached to housing.

People are worse off [in rooming houses] than in shelters, in some cases, because there's zero services that go to them. (NP #3)

I think a number of people who've been in shelter for a long time do better with some sort of congregate housing... housing that allows some socialization, because we see people failing out of independent housing because they're kind of lonely and disconnected. (NP #2)

These providers believe that there should be greater focus on promoting social inclusion and supporting individuals through transitions into new housing, which can be achieved by leveraging peer support and offering life skills supports, respectively.

To further enhance stability, one provider recommended organizing housing in ways that group individuals together who share similar backgrounds, religions, or cultural identities, or who share similar addiction-related struggles (e.g., opiates or alcohol). Providers also pointed out that if housing is not culturally appropriate for some groups, “you're setting [them] up for failure” (NP #2).

Persistent and disabling conditions

All providers identified mental illness, substance use, and addiction as some of the most significant individual risk factors for poverty, housing loss, and homelessness. These risk factors are also described in the Framework for Homelessness Prevention and are categorized as *Persistent and Disabling Conditions* (Gaetz & DeJ, 2017, p. 22).

Providers explained that individuals with untreated mental health conditions are at an increased risk for housing loss and suggested that these diagnoses can make it challenging for individuals to find and secure housing if they *do* become homeless.

Mental health [is] probably the biggest one that we see that keeps people in housing loss. (NP #2)

[There is] some avolition that happens with mental health diagnoses. If you have a history of schizophrenia, or borderline personality, or bipolar, you have a low mood, you do lack motivation. It's part of the illness. (NP #1)

In addition to mental illness, providers indicated that individuals who use (and abuse) substances are at risk of homelessness and therefore should be prioritized for prevention efforts. Notably, one provider explained that when addressing substance use as a risk factor, or as an

issue contributing to homelessness, it is critical to explore *why* someone is using substances in the first place.

Using drugs [is] a risk factor for poverty or homelessness... people are using drugs for a reason, and it's almost always related to early childhood events... People inject drugs, but it's still going to be related to, why are they injecting drugs? (NP #1)

Similarly, one provider highlighted mental illness and substance use in relation to why someone may be experiencing poverty.

“Why is someone poor” [is] certainly a different question. Mental illness, substance use, all of those things contribute to somebody's poverty. (NP #3)

Crises and interpersonal and relational problems

Providers described personal crises, unexpected life events, and interpersonal or relational problems as risk factors for housing instability and homelessness. These risk factors are also identified in the Framework for Homelessness Prevention and categorized as *personal or family crises* (Gaetz & DeJ, 2017, p. 21). As noted by providers, an unexpected event in an individual's life may be an unplanned pregnancy, job loss, or other significant change to employment. Most providers indicated that relationship breakdown, including breakups in romantic relationships, or sudden family conflict can lead to homelessness.

I have one person right now that I saw yesterday, and she and her baby have been living with her parents. And then [they] had a falling out. And so, at the end of this month, she'll be moving into shelter. So just family, relationship loss for sure. (NP #2)

Risk factors, I think, violence at home... perhaps not violence at home but issues with interpersonal relationships... those would be the main ones. (Physician #1)

One participant felt that men, specifically, can become vulnerable and at risk of homelessness shortly after a break-up with a partner.

Men, they're [at the] end of a relationship, and boom, they're in the shelter... I guess everybody kind of couch surfs for a while. But men, it's much faster. They are very precarious, I find, because they often live with girlfriends. And you just think, “You're not on the lease. Are you thinking about the next month?” (NP #2)

Interpersonal violence

Related to interpersonal and relational problems, providers recognized that violence and abuse create significant risk for poverty and homelessness. Providers discussed violence against women, including intimate partner violence and early childhood abuse, and also indicated that an individual's trauma from such violent or abusive experiences can further compound their risk. As such, providers found that women and any individuals who have experienced abuse or intimate partner violence should be prioritized for homelessness prevention efforts.

One provider shared the following story of a patient whose housing situation became unstable due to a combination of unexpected life events, relationship breakdown, and violence.

[A patient] was living with her partner and the partner was abusive. But together, they had enough income to pay for [a] regular apartment for them. And then she got pregnant. And then there was a domestic violence situation. He was arrested... there was a moment where she came in for her prenatal visit and said, "Next month, I will not have enough rent money". That was an urgent, imminent housing issue... like, "in one month I will be homeless". (NP #1)

Systems failures

Risk created at the systems level was also discussed by providers. Specifically, providers recognized that failed transitions from public institutions, siloed systems, gaps in services, and other systems-level barriers can create risk by impacting individuals' access to services and supports, which makes it difficult for them to find stability in their lives. Indeed, "failed transitions from publicly funded institutions and systems" is a systems-level risk factor identified in the Framework (Gaetz & Dej, 2017, p. 20).

In particular, providers noted that unsupportive or unplanned discharge from emergency departments (ED) or other health care services can put individuals at risk of homelessness. Similarly, one provider explained that individuals are at risk of homelessness upon release from incarceration, if planning around their transition into permanent and appropriate housing has not occurred.

The jail, people getting discharged on Friday afternoon, or Friday at five... They're just discharged with no plan at all, like, "see you later". And how do you think that plays out? Of course, they're homeless already. (NP #3)

This provider also discussed the need to better support youth transitioning out of foster care.

The new term is "transitional aged youth", which is sort of where [they are] graduating out of CAS care and [the system is] sort of like "good luck" when they're 18. This group is at risk for homelessness, at risk for increased drug use, at risk for poor education, at risk for entrenchment into poverty. (NP #3)

Providers similarly described issues around siloed or “disjointed” systems and sectors (NP #1), which makes systems navigation challenging at the individual level and impacts coordination and communication at the systems level. For example, one provider reported a lack of communication and coordination between EDs and primary care. Moreover, this provider felt that when care between services is not coordinated, the patient may feel “in the middle” and responsible for “note-passing”.

One thing that I dislike about the OW/ODSP situation is that there's a lot of "note passing" between... the worker tells the patient this and then the patient tells me something and it's not always correct... I always write "This is my perspective on this", "This is why we're not doing this. I understand you're recommending it. That's not what the patient and I have decided as a collaborative plan". And then I usually give it to the patient to give to them. [But] we are trying, as a clinic, to have better connection, where the patient doesn't feel in the middle. (NP #1)

In the Framework, all of these issues are categorized as, “Silos and gaps both within and between government funded departments and systems, and also within non-profit sectors” (Gaetz & Dej, 2017, p. 20).

In addition, providers mentioned reported gaps across the province in terms of comprehensive and coordinated care – that is, these care models are not “universal”.

The team-based model of healthcare that they rolled out, I think, [in] the mid-2000s. A FHT is a Family Health Team and a FHO is a Family Health Organization... Something that's always bugged me... the provincial government rolled these out and then stopped them a few years ago. It's not universal care for patients across the province. My next-door neighbor could have a different family doctor who's not part of a FHT or a FHO... It's so fragmented in the province [as to] who belongs to these little comprehensive care groups and who doesn't. (Physician #1)

At the individual level, providers identified barriers to service access and use, which can exacerbate the risk created by systems failures. A common thread across many of the individual-level barriers mentioned by providers was systems navigation challenges. Providers believed that newcomers, in particular, find it challenging to navigate health care and social services in this

country, in part due to language barriers, low “health care literacy” (NP #3), and as a result of the overall complexity of the system.

I think the barriers are pretty easy to identify in our population. Language is first and foremost, among our newcomer folks. The system, the medical system and the social system, is so complicated. How can they possibly figure this out on their own? (NP #1)

One provider suggested developing “maps” of health care and social services, that are specific to each city, as part of enhancing systems navigation support.

Providers further discussed systems navigation, describing challenges related to attending multiple appointments, which may be common for patients with complex health needs who require care from specialists.

I feel like this whole idea of appointments is very difficult with the population we work with. It kind of drives me crazy... some of the processes to get services. It's very difficult for some people. (NP #2)

One of the biggest things is just healthcare navigation. And, if you have a serious problem, in terms of seeing specialists... in those cases, their poverty causes lower access, [and] in terms of navigation, they're unable to get to where they need to go. (NP #3)

Two additional individual barriers to service use and access, as identified by providers, included: cost barriers for refugees, who have limited access to health services for a period of time after arrival; and individuals not having access to phone or internet, which may be required to connect with providers or for an individual to follow up with a service they were referred to.

Overall impacts and relevance of the social determinants of health

Discussions with providers about poverty, housing instability, and homelessness often opened up into broader conversations about the social determinants of health, or more generally about why the presence of poverty is relevant to health care. For example, when asked, “In your opinion, what does it mean to experience poverty?”, one provider began their response with, “I would mostly look at the social determinants of health because... I'm a health care provider” (NP #3). As another provider stated, “I think that, because I provide health care, I think of poverty in terms of how it affects [a patient's] health” (NP #2).

In some of these discussions, providers shared agreement that their scope of practice *should* include assessing risk for housing stability and homelessness since, as one provider stated, “It’s so fundamental to health promotion and disease prevention” (Physician #1).

Moreover, providers highlighted some of the negative health impacts associated with specific determinants of health, or generally shared knowledge about how environmental, economic, or social factors influence health outcomes.

We have a lot of little kids, like babies and infants, that are born to houses where they're underhoused. So, there's six kids in the house, [and] they have frequent Otitis media, bronchiolitis... because, just the environment. (NP #1)

Having more money will do more for your health than almost anything else... We dish out pills like there's no tomorrow, but if you exit poverty it [will] improve health... more than any other intervention we could do. (NP #2)

Socioeconomic status, I think, is probably the biggest driver in terms of health and wellness... it affects so many different aspects of what we see and do day-to-day from a health promotion standpoint. (Physician #1)

In summary, this theme has illustrated that providers share similar conceptualizations of poverty and housing instability and, importantly, can identify several risk factors associated with poverty and homelessness. According to these results, providers consider the experience of poverty as relating to an individual’s level of income, source of income, ability to meet basic health needs, and level of housing stability. Further, providers recognize factors that can undermine one’s overall housing stability, such as unaffordable housing, inappropriate or unsuitable housing (e.g., overcrowding or housing that is not culturally appropriate), social isolation, or housing without supports. In terms of relevant individual-level risk factors, providers identified mental health challenges, addictions, personal crises, relationship problems, and violence as potential causes of homelessness. Providers also demonstrated an understanding of risk created by systems, relating to siloed systems, gaps in services, or caused by a lack of planning around discharging patients from hospitals or releasing individuals from incarceration. It appears that providers also recognize individual-level barriers to accessing systems, mainly reflective of the complexity of health and social systems across the country, which further contribute to the risk of individuals ‘falling through the cracks’ and into situations of housing instability and homelessness.

As seen in the findings above, providers also generally recognize how the social determinants of health, namely housing and income, can significantly influence health, thus acknowledging their relevance in health care settings.

5.3 Determinants of health as the ‘purpose’ of care versus to ‘contextualize’ care

From the analysis of interviews, a second major theme emerged related to providers seeking to understand more about a patient’s life, including their housing situation, sources of income, ability to pay for medications, and other social factors and determinants of health. Providers stated that these factors and determinants could be formally assessed or informally assessed simply by getting to know a patient more.

5.3.1 Seeking to understand the wider patient context, including social and economic factors in patients’ lives

Overall, providers discussed the importance of being aware of ‘the wider patient context’ for two reasons: first, because addressing social or economic factors in a patient’s life can be part of comprehensive care (i.e., the ‘purpose’ of care); and second, because these factors contextualize care (e.g., inform treatment plans).

Addressing social or economic factors as part of care

Providers generally acknowledged that asking patients about other issues going on in their lives (besides health issues) was their responsibility. One provider felt that considering patients’ social contexts was “fundamental” to nursing practice (NP #1). Another provider said that this responsibility fell on him, as a nurse practitioner, but also added, “I mean, it’s on our team” (NP #3).

Providers emphasized the importance of knowing the “right” or important questions to ask patients when trying to identify their needs and which referrals to make.

It's important that a health care provider knows that you need to ask when they're 64 [years old], "Have you done your taxes?" (NP #2)

Are you [as a provider] asking the right questions, every time, to know if you should refer?
(NP #1)

Moreover, providers suggested that with knowledge about a patient's current situation, they can be more perceptive of that patient's needs and better understand factors that are influencing their health.

Another thing that's interesting about housing, and people living in poverty, is the animal confounder, where a lot of people who live in poverty have animals... I always find that to be really interesting because it can lead to respiratory infections.... I just find it to be a conundrum, for me as a healthcare provider, because I'll try to counsel around like maybe it's the animals that are contributing to some of the respiratory illness. (NP #1)

Another provider shared a story from when they worked at an emergency shelter: an individual had come into the shelter, who had just been to emergency for a broken jaw and was discharged with antibiotics and a pain killer. The provider felt that staff at the ED had not considered how that individual was going to take their medication, or how they were going to eat. Specifically, he wondered why they had not been given a prescription for Ensure (a meal replacement/nutritional shake).

Overall, providers felt it was critical for all health care workers to consider the larger patient context, as part of efficient care and to improve patient outcomes.

Sometimes [providers] don't ask questions, like "Should [I] check the Ontario drug benefit to see if this medication, that I'm prescribing this person that's waited three hours to see me, is covered?" And then, [the patient] finds out when they get to the pharmacy, "Oh, actually, that's a \$60 medication", and that provider that prescribed it to them could have chosen a medication that was covered, but didn't consider their context... I feel like these people often suffer because... their context is not completely considered when they're being treated. (NP #3)

One provider mentioned that when she is aware of certain challenges or "life circumstances" that her patients are experiencing, part of the care she provides will involve motivational interviewing to support healthy behaviour change (Physician #1).

To assess for social and economic factors that can put patients at risk for poverty and homelessness, providers may use formal tools or simply ask their patients general questions about important life events and their living situations.

We use a tool, called the PCAM¹, which is a patient complexity tool. And we're trying to do that yearly in our practice. I think by using those tools, we're doing a pretty good job. (NP #1)

"[Asking patients] what's going on here? You dropped out of school?" (Physician #1)

I often use questions like, "Where are you staying?" , "Where are you living now?" , [or] "Where have you been living?" (NP #3)

According to providers, they also consider other patient factors, such as their motivations, abilities, or their overall attitudes toward health care.

Transportation is obviously a barrier to seeking services... and not just transportation because they don't have a bus pass. [It's] the piece around trauma in transportation... people can't manage being on a bus... they just find it so dysregulating [and] chaotic. (NP #1)

She [patient] had a lot of self-efficacy. So, I could just give her the number [to a community support] and give her the website. (NP #1)

We [providers] all are here because we're selling health care to people [for whom] it's not a priority. (NP #2)

Addressing or asking about social or economic factors to contextualize care

According to providers, they also believe that understanding more about patient context is critical for developing treatment plans and overall, for informing care. Providers discussed housing instability and homelessness as generally informing medical care.

I tend to view [housing precarity] as a medical issue that informs so many aspects of care. (Physician #1)

One provider explained that they should be aware of a patient's living situation, or financial situation, in order to "tailor an intervention" to their unique context – that is, an intervention or solution to the problem that is "suitable, acceptable, [and] feasible" for the patient (NP #3).

¹ The Patient Centered Assessment Method (PCAM) is an instrument used by health care providers to evaluate "patient complexity" as part of conducting comprehensive assessments that consider patients' social dimensions of health (Pratt, Hibberd, Cameron, & Maxwell, 2015).

Moreover, providers gave examples of other important questions to ask patients and discussed housing instability and homelessness in terms of how these experiences can impact a patient's ability to follow a treatment plan.

[Health care providers] write a prescription for people and they don't bother to ask, "Do you have a health card so that you can get this filled?" or, "Do you have drug coverage?". It's fascinating to me the questions [providers] don't ask... it just makes your health care plan, like, what was the point? Do you have a refrigerator? I'm telling you to buy fresh food. Do you have money? (NP #2)

It's so difficult to treat someone that's homeless... How are they going to get these medications? Where are they going to keep them? They're constantly losing a lot of their identification, or being robbed, or not having access to good food... Not having a place to cook it... Not being able to keep up [with] hygiene. (NP #3)

5.3.2 Challenges associated with assessment of social and economic factors

While all providers recognized that they should seek to understand their patients' wider contexts – if only to contextualize care – some providers identified challenges or ethical issues they had with asking patients for this type of information.

Within the description of the third theme, *sharing responsibility and leveraging provider skillsets and knowledge*, the issue of providers not knowing 'what to do' with information about a patient's experience of poverty or housing instability is explored. In contrast to these sentiments, some providers suggested that, because they do not want to become responsible or feel obligated to, for example, help a patient with their housing situation, they are less likely to ask about it.

On a similar note, two providers referred to the already high number of patient assessments they must regularly conduct and identified time as a barrier to gaining more comprehensive understandings of a patient's context.

Time is a huge barrier... And even if there was some sort of homelessness screening tool, I think the number of screening questionnaires and things that we have to do on a regular basis... you know, it's impossible to actually keep up with all of them. (Physician #1)

For us to, every time, make sure we have the patient's next-of-kin up-to-date, we're asked to... You could have entire visits where you never get to the issue that the patient wants because there are so many people that want a piece of what you do in that visit. (NP #2)

Additionally, providers described potential ethical issues with asking patients about any housing or income-related challenges they were experiencing, specifically if they did not intend on addressing those challenges or know how to respond. In other words, providers felt that if they could not directly help patients with those types of issues, they should not purposefully ask about them.

If you ask [the patient] and don't have an answer... it's not really fair to ask people to relay such personal, horrible information... "Is it difficult for you to [make] ends meet at the end of the month?" Like, "Are you going to offer to finish my ODSP application?", "Are you going to find housing for me?" (NP #2)

I think there's this sense that you can't fix people's social situations, necessarily. So, there's a bit of helplessness there. Why delve into it if you can't really help, or have not much to offer? (Physician #1)

Similarly, one provider suggested that it was “inappropriate” to ask patients for sensitive information about their lives if it was not obviously relevant to the care they were receiving.

If I'm talking to them about their blood pressure, I don't think it's appropriate for me to be asking about their sexual health, unless they have brought that up as a topic, or if it relates to what I'm asking. (NP #2)

Lastly, being unaware of existing screening tools or guidelines was discussed as a barrier to more frequently assessing level of poverty or risk of homelessness.

I am not aware of any screening tools that may be out there. I would imagine that there are, and it's just not something that I've necessarily looked into or incorporated into my day-to-day practice... but I would be curious to know if there was anything more formalized that's been validated. (Physician #1)

5.3.3 Building therapeutic patient-provider relationships and practicing patient-centred care

As part of seeking a more complete understanding of patient context, all providers recognized the importance of building therapeutic relationships with their patients over time and delivering patient-centred care. According to providers, therapeutic patient-provider relationships are characterized by mutual trust, good communication, compassion, and healthy boundaries.

Providers explained that therapeutic and trusting patient-provider relationships take time to establish, especially for developing trust.

It comes [down] to the experience of knowing your patients, and knowing them over time, and having sort of off-the-cuff chit-chats. Like, "Hey, what's going on here? You dropped out of school? What's happening, where are you living these days?" (Physician #1)

When I started here, people would come in and I was a nurse practitioner, [so] I thought they came to see me... Then you'd get in the room and they'd be like, "Where's Danielle?²". That was the outreach nurse. They would never come to see me. They had this relationship with Danielle. Danielle's built it over years. Danielle got them into this building for a specific reason and Danielle better be there to explain it to me because I'm not a trusted person. So, those relationships need to be built and that takes time. (NP #3)

In terms of boundaries, one provider stated that if they ask too many questions about a patient's life, the patient may start to consider the provider as "their person for all problems", which is not a "healthy relationship" to have (NP #2).

Additionally, as part of therapeutic relationships, providers explained that they should be conscious of power dynamics between them and their patients and understand that patients may have past trauma from accessing services within certain systems, which may impact their engagement and willingness share personal information.

[I] don't really want to have people relive something... As I am an entitled, you know, white, middle class person, to just be like, "How difficult is it for you?", "Tell me how you can't feed your family every day". (NP #2)

Especially people that are vicariously housed or with a lot of trauma, the system's traumatized them. (NP #3)

Otherwise, providers mentioned that asking patients questions about their situations *does* help to improve patient-provider relationships and promote service use. For example, it shows patients that the provider cares about certain issues or factors in their lives, which encourages them to share more about their "history" and attend more appointments with that provider.

Sometimes, if you make the effort to ask them what's going on, it really makes your relationship better, as a health care provider. It's like, "Oh okay, [my provider] actually cares about this. So then I'm going to make giving my history easier" or, "I really want to show up for your appointments more". (NP #2)

Asking people about their true situation is part of building a therapeutic relationship, so they come back, and they trust you, and they ask for you. (NP #3)

² Name changed for anonymity purposes.

In addition, providers discussed approaches to care that consider the wider patient context while also representing elements of patient-focused care. For example, one provider felt that the role of all health care providers was to deliver individualized care and propose solutions to health problems that are “feasible” and “acceptable” to each patient (NP #3). Another provider mentioned that they try to engage patients in “collaborative plans” (NP #1). Similarly, one provider said that they ask patients to contribute to health plans and priority setting.

If you're coming up with a plan for health, it has to be with the patient, and so you need to ask what they can contribute... I may want you [the patient] to take some blood pressure medications, but if your priority is to fill out your Special Diet form, great, we'll start with that... I often say to patients, “I just sit in this little chair. So, this is about you. What would you like out of this?” (NP #2)

In conclusion, this theme has highlighted two ways in which providers view patients’ social determinants of health – or risk factors for housing instability and homelessness – within health care contexts. First, it appears that providers find this type of information to be critical for the ‘purpose’ of care, since many social and economic factors (e.g., overcrowding in housing, access to medication, access to healthy food, complex trauma) can influence individual health outcomes. Second, providers recognize the need to have contextual information about a patient’s life when considering care options (e.g., medications to prescribe) and developing treatment plans, which further underscores the importance of providers knowing what types of questions to ask their more vulnerable patients. However, these results also outlined some of the challenges associated with obtaining such information about patients’ social and economic contexts, including time constraints and ethical issues with asking ‘sensitive’ information that may or may not be relevant to care.

Finally, it appears that providers practice patient-centred care and focus on building therapeutic relationships with their patients, which can create an atmosphere where patients feel comfortable sharing information about any challenges they face related to financial or housing insecurity. Moreover, through these relationships and approaches to care, it seems that providers encourage their patients to access more health and social services that can further stabilize their situations.

5.4 Sharing responsibility and leveraging provider skillsets and knowledge

During discussions with providers about their perceived roles in preventing homelessness, the following topics came up, all of which reflect the third theme, *sharing responsibility for prevention and leveraging provider skillsets and knowledge*.

5.4.1 Establishing community-level partnerships and engaging in collaborative relationships with other health care workers

Overall, all providers recognized the value of having collaborative relationships with other health care workers and forming partnerships with community-based services and organizations. Providers explained that they worked closely with other health care providers and allied health professionals, such as social workers, or at least had “access” to social workers who they could make referrals to.

I work in an interdisciplinary team that includes social workers and support workers.
(NP #3)

The LHIN... they have social workers that you can refer to... I used to work at a Family Health Team and it was helpful to have a social worker. (NP #2)

If you happen to be the patient of a doctor who's lucky enough to have been part of a FHT or a FHO, you may have access to social work supports... we get access to different supports like a social worker or maybe a nutritionist, a pharmacist, [or] counseling services. (Physician #1)

According to providers, having a team to work closely with allowed for providers to consult with other team members about patient needs, especially for patients who were deemed “at risk”, which streamlined communication, improved care coordination, and simplified the process for patients.

In addition to engaging in team-based care or being connected to other providers due to involvement in a particular care model (i.e., FHT, FHO, or CHCs), providers indicated that they had formal partnerships with community-based organizations and external services. For example, providers were connected with and made referrals to Children’s Aid Society, the Canadian Mental Health Association (CMHA), addiction-specific services and detox programs, supports for youth, emergency shelters, and the Local Health Integration Networks (LHIN). One provider

reported that they were well-connected to a youth-focused service in the city, which appeared to perform “magic” when it came to finding housing for youth (NP #1). Another provider explained that while the CHC they worked in offered a lot of their own services and programming, they formed partnerships with other teams and providers who could fill in the gaps.

These partners, they know us... we built those relationships. So, other outreach teams, some of the services... are being delivered or replaced by other partners. (NP #3)

Providers also mentioned that it was helpful to be connected to, personally know, and have the direct phone numbers of individual service providers in the city – for example, OW or ODSP case managers. In fact, one provider believed that, as a health care provider, your ability to intervene and prevent homelessness largely depends on “who you know” (NP #2). Similarly, another provider believed that referring patients to external community supports was a necessary practice, given that they worked on a small team of providers with caseloads that are “very complex” (NP #1).

5.4.2 Leveraging providers’ specific competencies and determining the ‘most responsible provider’ to respond to patients’ social and economic issues

Overall, providers agreed that health care teams share in responsibility for assessing risk for homelessness and generally promoting housing stability among their patients.

So, when you say, “other people who have a role in it”, as a health care team, I think we’re all equal in that: the nurses I work with, [and] the physicians. (NP #2)

In doing this though, several providers commented on the decision-making around who would be the ‘most responsible provider’, within a clinic or on a team, for cases where a patient was deemed at risk for housing loss or vulnerable to housing instability. That is, providers suggested that there are processes for determining which provider is deferred to for responding to patients’ housing or income-related issues.

There was common agreement among providers that ultimately ‘someone’ would be responsible for responding to patients’ social or economic issues.

It's flagged [patient's housing problems], like we certainly discuss it. It's certainly someone's job. (NP #3)

In fact, providers used different terms to describe the providers that would take on that responsibility. For example, one provider stated that someone on the team would be the “quarterback” of responding to a particular patient’s issue (NP #2). Another provider referred to “those point people” who can be deferred to for homelessness prevention – for example, social workers (Physician #1).

According to providers, in some cases, what had to be determined was which team member would facilitate a referral to an external support or service. One participant mentioned that their team does a lot of “warm referrals” (i.e., provider contacts the referral organization or service on the patient’s behalf and makes an appointment for them), which take extra time set up. As a result, *who* facilitates a referral or directly helps a patient with a social or economic issue they are experiencing may largely depend on provider availability.

Who's going to take care of that, within the team? Is it going to be the nurse practitioner? Is it going to be the registered nurse? Is it going to be a social worker? And it's so much more guided on availability... If I have a swamped day, I will try to triage it to another team member who has more time. (NP #1)

Similarly, providers discussed their limited capacity and the lack of incentivizing around physician and nurse practitioner engagement in risk assessment, outreach, or coordinated care plans (e.g., Situation Tables). For example, one provider said that a rostered patient may end up having to wait “another two weeks for an appointment” when she attends a Situation Table as a health provider (NP #1). Providers also explained they have accountability to “see” a certain number of patients. Moreover, providers stated that physicians “shadow bill”³ which incentivizes having high caseloads, whereas they are not compensated for time spent organizing coordinated care plans.

We have accountability to our LHIN for how many people we're seeing, how many people are getting their paps and immunizations. (NP #2)

I think we would do much better if we [providers] could go to these different roundtables and community groups [Situation Tables] ... I'm salary, but physicians don't get paid to

³ Shadow billing is commonly used by physicians who practice under Alternative Funding Plans and involves submitting information to their provincial health authority about the services they provide (HealthForceOntario, 2015). In contrast to fee-for-service agreements, physicians who shadow bill may be paid a percentage of the full fee-for-service claim outlined in their Schedule of Benefits (HealthForceOntario, 2015).

do that... They're taking out of their own billings. Even Family Health Teams, they still shadow bill. So, they still get some incentive to see patients. (NP #1)

In considering the “best use” of their time, providers also discussed the importance of leveraging each provider’s specific strengths, training, and competencies when deciding who would take on a patient’s housing or income-related issues. While there was agreement that NPs and physicians are *capable* of supporting homelessness prevention, providers explained that they are trained in providing “medical care” and are relied on to do so.

Ultimately, the things that come to me [are] medication renewals, or chronic disease management, or mental health management, [and] that is medically based, right? No one else can do it... Everyone knows housing and food insecurity is what drives all of these medical issues. But again, am I the best person on the team to be doing that work? I don't know. Sometimes. Sometimes not. (NP #1)

Similarly, providers discussed how their scopes of practice must be limited to some extent, again, due to time constraints and capacity.

I think it's a fine line between feeling like you're a social worker and a nurse practitioner. And you don't want to get too involved in some of that. It can be very labour intensive to enter down that road. (NP #2)

Whereas certainly nurse practitioners and primary care physicians have the knowledge, skill, judgment, [and] tools to be able to do that work, but when are they going to do it? (NP #1)

One provider mentioned that when involved in coordinated care plans, for example, for those individuals at risk of losing their housing, health care providers often get “pigeon-holed” into handling the medical aspects of the care plans (e.g., medication renewals), whereas the team may not even want that provider to help with housing: “they have got that covered” (NP #1).

Moreover, the one physician highlighted that their medical training has prepared them to diagnose and treat medical issues and suggested that their approach to dealing with medical problems may be meaningfully different from approaches to addressing homelessness.

Homelessness doesn't always fit into our medical model of training. Like, you've got X symptom, I diagnose you with Y, send you for these tests, and then I refer you to Z... It's a different way thinking about a medical problem [which] doesn't necessarily fit the traditional training kind of framework... Homelessness, what do I do with that information? (Physician #1)

According to providers, they often rely on the training and competence of the social workers they work with, including their knowledge about community resources and services.

What my practice pattern tends to be that I refer to our social worker and she seems to take care of it. So these may be things [community supports] that she's tapping into. (Physician #1)

Our social worker... she's an MSW-prepared, trauma-informed social worker, so she's very valuable. (NP #1)

It was helpful to have a social worker that you could just be like, "You know what, this is not my area of expertise". (NP #2)

In terms of actual housing problems, I don't deal with them that much because... social workers do that. (NP #3)

5.4.3 Ensuring health care providers possess the knowledge required to effectively promote housing stability among patients

Following up on the summary above regarding providers' diverse skillsets and expertise, providers further emphasized the importance of having knowledge about available resources and services in their practice communities. Providers equipped with this knowledge could more effectively help some of their most vulnerable patients by facilitating service access and educating patients about community supports, including relevant eligibility criteria.

There are places that do free tax clinics, you just need to know, or ask somebody... [Asking patients] "Do you know how to get your birth certificate for free so that you can get ID to open a bank account?"... The fact that you know they exist [community services] is key... [In this city] the Salvation Army runs a program to help you pay for your power if you're overdrawn and your power's cut off, or at risk of being cut off... There is a program to pay for heat in the winter... [Asking patients] "Do you know that, when you turn 65, you're automatically put in the highest income bracket, [if you have not done your taxes]". (NP #2)

However, providers also noted that, again, social workers are often more knowledgeable about available services in the community.

Indeed, lack of knowledge and awareness of community resources and services was also discussed by providers as a barrier to facilitating more referrals. One provider stated that physicians on her team are provided with lists of shelters and other services, which they keep on

their desks, but also acknowledged that that was the extent of her awareness of “what resources are available” (Physician #1).

Providers also described some challenges associated with responding to a patient’s social determinants of health. As previously mentioned, they do not always know ‘what to do’ with information about a patient’s housing or economic situation.

I think, ‘what to do with that information’ is a challenge for many [providers] as well. What do I do with the information of somebody's precarious situation? (Physician #1)

I don't want to deal with all [of] those things that I'm not sure what to do with. I feel like that [with] housing, a bit... If you find out someone is [homeless] and then you don't even know the numbers to call for finding a bed at a shelter, then you don't even ask. (NP #2)

Generally speaking, providers also described feeling incapable of preventing homelessness, either because they felt it was “out of their control” (Physician #1) or because they did not consider themselves to be “experts” in preventing someone from losing their housing (NP #3).

As seen in the findings above, health care providers engage in collaborative relationships with other allied health professionals, such as social workers, and establish formal partnerships with community-based services, both of which serve to complement the care they provide to patients. With this, there appears to be a tendency to defer responsibility for patient issues related to their social and economic contexts, perhaps due to time constraints, lack of knowledge, generally feeling unequipped to address risk factors, or because of a lack of incentives, for example, to conduct risk assessments or to engage in coordinated care planning. Rather, it seems as though providers feel that, within health care teams, each providers’ strengths, expertise, and training should be considered and leveraged to maximize efficiency in practice and to ensure patients receive care from the most appropriate person.

Finally, while other health or social service providers may be better suited to assess and address risk factors for housing loss, it is evident that nurse practitioners and physicians still believe it is important for them to be equipped with knowledge about resources and services in their communities, including eligibility criteria for certain supports, and have general knowledge about how to prevent homelessness.

5.5 Roles for providers at all levels of change

A primary objective of this thesis is to explore health care providers' perceptions and ideas about their involvement in homelessness prevention. In interviews with these providers, they identified a range of prevention-oriented activities that they are aware of and participate in, which can be categorized at various levels of prevention (as defined in the Framework; Gaetz & Dej, 2017), including *Structural Prevention*, *Systems Prevention*, *Early Intervention*, and *Eviction Prevention*. Moreover, providers described strategies they use and actions they take to generally 'steer' individuals in the direction toward resources and supports that focus on housing stability. Overall, these findings represent various roles for providers at all levels of change.

Structural and Systems Prevention

First, according to providers, they can engage in advocacy efforts that may lead to increased funding for income supports or improved conditions in housing. For example, one provider shared a story about a patient living in community housing with a "tremendous amount of mold" (NP #1). This provider explained that she had worked closely with the patient's housing support worker for years, including "three years of incessant phone calling" (presumably, to the housing provider) to continuously advocate for the patient to move into appropriate housing. However, ultimately, the patient and her family ended up moving into appropriate housing because of a fire, which was unrelated to the mold issue.

Providers identified other ways they advocate for their patients in terms of their housing stability. Although, again, these efforts do not always lead to change.

A lot of times OW can help... OW often has funds, they will pull it out... If you can explain how a patient is going to lose their housing. Often, they can help and try to ensure people don't lose their housing. (NP #3)

If we were to say to the Ministry, "90% of our patients are underhoused and therefore we need another social worker", that's not something that they've typically been responsive to... [We] try to demonstrate how complex our patients are, which is a crappy thing to have to do... We have to justify needing more hands, if you will, like more people to help out. (NP #1)

Providers also highlighted the benefits of having integrated health services or having a range of services and service providers in their clinic or health centre (i.e., 'under one roof'). The

structure and organization of CHCs, for example, or FHOs is conducive to streamlined referral processes and generally improves access for patients.

[In] Community Health Centres in Ontario, and probably across the country... the access that we have at the tips of our fingers... there's nobody else that can match that... Family Health teams, of course, they don't have some of these services right at their fingertips. So, they would have to write a referral or something. [Whereas] my referral might be talking to the person beside me, to go into room five and talk to the person about housing. We do that all the time. (NP #3)

Because we're part of a Community Health Centre, we're so lucky that we have addictions counsellors and foot care and referrals within the Community Health Centre. (NP #2)

As another example of “on-site” supports, another provider mentioned that her clinic is actually situated within Community Housing.

Additionally, one provider gave an example of improved integration between health and community services. Through an initiative in her city, referrals are automatically “triggered” to community services, namely, mental health organizations, when patients have had multiple visits to EDs in the last 30 days.

Early Intervention and Eviction Prevention

In addition to more structural or systems-level prevention, a few providers discussed their involvement (or overall thoughts on provider involvement) in helping to prevent evictions or addressing imminent patient risk factors which indicate a need for early intervention.

As outlined in the Framework for Homelessness Prevention, health care providers can be involved in *Eviction Prevention* through supporting tenants with mental health challenges (Gaetz & DeJ, 2017, p. 74). One provider did specifically acknowledge that the “mental health piece” can contribute to an individual’s risk of housing loss (Physician #1). Recognizing this, they counsel around “addressing and treating” – or helping patients manage – mental health issues (Physician #1).

Similarly, another provider explained that imminent risk of housing loss is not always related to affordability issues or, in other words, is not always “going to be fixed by more money” (NP #3). Recognizing the ways in which mental health issues can create risk of housing loss, he noted that he is involved in a lot of crisis counselling. This provider indicated that there

is an opportunity to intervene and prevent eviction even after an individual has received an eviction notice, during which he can offer support. He also noted his involvement in planning to prevent women from experiencing homelessness upon fleeing situations of intimate partner violence.

Notably, while some providers may not have specifically described their involvement at these levels of prevention, one provider did indicate that she disagrees that nurse practitioners and physicians should be relied on “entirely” for eviction prevention. This provider agreed that “a lot of people have a role” in homelessness prevention but felt that it was unfair to ask health care teams “to do” eviction prevention “intensively” (NP #2).

Assessing risk

Often, health care providers’ ability to intervene and prevent housing loss first depends on their ability to identify patients at greatest risk. As such, providers were specifically asked about strategies or guidelines they use, if any, to assess patients for risk of housing instability or homelessness.

First, providers described informal strategies they use to assess risk, such as asking patients specifically about their housing situations (e.g., “Where are you staying?”; NP #3). One provider indicated that current events and some individual factors influence the ‘social history’ questions she asks. For example, this provider has been more likely to ask patients, particularly older adult patients, about their financial situations since the beginning of the COVID-19 pandemic.

Second, most providers did not explicitly refer to formalized tools or guidelines that they use to assess risk, but generally discussed considerations as to when and where formal approaches may be most useful. However, NP #1 did indicate that there is a “demographic template” that is used within her clinic to record patient information such as income, size of household, first and second languages, and patient’s perceived mental and physical health status.

Some providers generally indicated that they were aware of formalized tools or guidelines but did not use them.

I know that they exist, but I don't typically use them. (NP #3)

There are poverty guidelines that were produced for primary care... They're not something that are handy. (NP #2)

According to these providers, there are some practice contexts where formalized tools to assess risk are helpful and some contexts where they are not. For example, such tools may be useful in instances where a provider does not know a particular patient well or if they have not been informed by another provider about that patient's situation. Providers also mentioned that tools or guidelines to assess level of poverty and consequent risk may be most helpful to providers who have less experience working with vulnerable patients.

I feel like guidelines are more useful to providers who don't know what to ask... I use guidelines for things that are not something I see every day. For poverty, it's just part of our lives every day. (NP #2)

Moreover, one provider explained that formalized tools for assessment, and resources created to outline “next steps” after determining patient risk, would have to vary by region and be community-specific, since providers would need to know “what services are available to refer people to, to help with preventing eviction or loss of housing” (NP #2).

Enhancing access to public systems, services, and appropriate supports

The following results can be categorized as ways in which providers *Enhance patient access to public systems, services, and appropriate supports*. These prevention-oriented activities described by providers are also captured under *Systems Prevention* in the Framework for Homelessness Prevention (Gaetz & Dej, 2017, p. 55-61).

For example, providers commonly described their role in helping patients secure income supports such as government assistance.

She [patient] had never been on OW, ODSP, anything like that. She wasn't sure how to do any of that... I could give her the number and give her the website. And, by the next time I saw her, she was on OW. (NP #1)

Primary care providers fill out forms like special diet forms and OW forms, to say that [an individual] doesn't need to be looking for a job... ODSP applications, exceptional access to certain medications... The forms go on and on. Bus passes and disability tax forms, it just goes on and on. (NP #3)

I do an ODSP clinic here for people who don't have a family doctor or a primary care provider. (NP #2)

One provider highlighted how important it is for individuals to have access to good primary care, given that NPs and physicians are often the only service providers that are authorized to complete government program and support forms.

If you don't have access to a primary care provider, to fill out all these forms, who do you go to? They're the only people that can fill them out, according to the form. And, if you're not going to a Community Health Centre, some of these forms cost money to have filled. So I think that's a barrier in itself. So, having a good primary care access in terms of filling out some of these things... access to somebody that's going to be able to help you move forward in terms of getting some of the income supplements that could be available to you. (NP #3)

In addition, providers reported that they can help increase patient access to housing, social services, and crisis supports, for example by recommending patients for “urgent status” on community housing waitlists, directing patients to supports for victims of sexual assault or domestic violence, or referring them to the CMHA.

Providers also explained that part of their role is to encourage and empower patients to advocate for themselves and actually access the services and supports they have been referred to.

[With] counselling and mental health resources, it's amazing to me how many times it takes [to refer a patient], and then when and if they get to the service, they're like, "Oh, yes, I should have done this some time ago", or, "Oh, this was really helpful. And I see it now, but I wasn't ready then". (NP #3)

It's really important to do things together. Certainly, giving someone a number might not lead to them being successful... To be able to make phone calls together with patients, that's the best way to do it. So that the next time they have had some role modelling on how to make these phone calls. (NP #1)

As mentioned, providers can enhance patient access to public systems and community supports through facilitating “warm referrals”, and providers generally agreed that this aligned with their scope of practice. Specifically, providers also described their role in educating patients about services and helping patients make “concrete” connections, for example, by introducing them to other providers or giving them specific contact names and numbers.

I feel like a lot of my job is to introduce people to where they can get help... Sometimes when they're here in the clinic room, I'm like, "We'll just call this number and connect you". And then that worker was great and came down and they connected... They

actually made a concrete connection as opposed to a loosey goosey, like “Someone's gonna call you, but you don't have a phone, so try to be at your friend's on Friday to answer the phone”. For any referral or connection, to do it at that visit, to introduce them by phone or in person, I feel like that is very critical to success of a referral... as opposed to, "Here's an address, go find it". (NP #2)

Lastly, this provider shared another example of how they can advocate for their patients to access the supports they are entitled to. Although there is a long waitlist to get a CMHA worker in their community, the provider knows what the criteria is to be prioritized for a worker and therefore, can identify which patients are eligible for priority status.

Scope of practice and general willingness to be involved

Whereas the results outlined in this section have summarized the ways in which providers discussed their involvement in a range of prevention-oriented activities, it is also interesting to analyze providers’ initial responses to two key questions asked during interviews:

- Thinking about your scope of practice, do you think it includes assessing a patient’s risk of housing instability or homelessness? Why or why not?
- Thinking about your scope of practice, do you think it includes referring patients to additional/external services that may support their housing situations? Why or why not?

While follow-up prompts were used to encourage more in-depth discussion on these topics, Table 5 includes some of providers’ initial responses to these questions.

Table 5: Provider Responses to Key Questions Asked During Interviews

	Assessing Patient Risk of Housing Instability or Homelessness	Referring Patients to Additional Services that may Support their Housing Situations
NP #1	“We do it every visit.”	“We have to [refer to external supports] because we're a really small team. We're only eight clinicians, so we have to use external services.”
NP #2	“Yes.”	“I think it's a fine line between feeling like you're a social, a social worker, and a nurse practitioner. And you don't want to get too involved in, in some of that, like, it can be very labour intensive to enter down that road.”

Physician #1	“I think it does, it should... I don't know that we necessarily do a great job of that in family medicine, in general, and myself, personally, but I think it should.”	“Mhmm. Yep.”
NP #3	“Yeah, absolutely, yeah. I mean, like I was saying earlier, it informs your intervention.”	“Yes, yes”.

In conclusion, this theme reveals many prevention-oriented activities that providers *can* and *do* participate in, which implies their involvement at all levels of prevention. Aligning with *Structural and Systems Prevention* (Gaetz & Dej, 2017), it appears that providers feel they can advocate for increased income, housing, and crisis supports for their patients. Moreover, they may work where there are multiple health and social services available to patients ‘under one roof’, or where there is infrastructure in place that allows for systems integration (e.g., nurse practitioner clinics in community housing).

It also became clear that providers recognize risk factors for housing loss that are not necessarily related to ability to pay. As such, they suggested some involvement at the level of *Early Intervention and Eviction Prevention* (Gaetz & Dej, 2017), including through supporting patients with ongoing mental health challenges and mental health crises.

In terms of assessing patient risk for housing instability and homelessness prior to offering prevention supports, it is evident that most providers did not use formal assessment tools or guidelines. Instead, they opted for more informal strategies, such as simply asking patients about their financial and housing situations.

It also appears that a critical part of providers’ roles in homelessness prevention involves directly helping to increase patient access to a number of public systems, services, and supports, including government assistance, primary care, community housing, and mental health supports. Notably, providers enhancing patient access may also involve *encouraging* or *empowering* patients to access certain supports.

Lastly, while providers may not always be equipped with assessment tools or knowledge about community resources and supports, overall, it appears that providers agree that assessing

patient risk for housing stability and homelessness and facilitating external referrals all fall within their professional scopes of practice.

Chapter 6

6 Discussion

The primary purpose of this project was to explore the involvement of physicians and nurse practitioners in homelessness prevention, mainly by assessing their patients' risks of housing stability and homelessness and facilitating patient referrals to external community supports. Moreover, this study examined health care providers' awareness and knowledge of these types of poverty and housing-focused community services, which may further support a patient's housing stability.

This final chapter provides a discussion of the findings from the current study in relation to the research objectives. Section 6.1 discusses the research findings in light of previous research in the field. Then, Section 6.2 compares the study findings to the major themes from the document analysis. Section 6.3 discusses the findings in terms of the theoretical concepts and categorizes of prevention outlined in Gaetz and Dej's (2017) Framework for Homelessness Prevention. In Section 6.4, limitations associated with the current study are outlined. Section 6.5 includes considerations for practice based on the study findings and provides recommendations for future research that could further explore the involvement of health care providers in efforts to prevent homelessness. Lastly, Section 6.6 provides a conclusion for this thesis.

6.1 Study Findings in Light of Previous Research

This study contributes to a relatively new body of literature on homelessness prevention and adds to limited research on health care provider participation in a range of prevention-oriented activities. While this potential for health care provider involvement is frequently unrecognized, past research has generally investigated cycles of poverty, homelessness, and poor health outcomes (Distasio et al., 2014; Fazel et al., 2014; Gaetz & Dej, 2017; Hodge et al., 2017) and systems-level risk factors for homelessness, which were topics discussed in this study. Results from this study demonstrate that providers conceptualize poverty and housing instability in terms of how these circumstances affect health. Providers identified cycles of poor mental health, addictions, and homelessness, given that mental health issues may cause homelessness and also perpetuate homelessness (i.e., make it difficult for individuals to find and secure housing and transition out of homelessness). Similarly, Fazel and colleagues (2017) describe the

strong links between substance abuse and the “persistence of homelessness” and identify mental health issues as risk factors for chronic homelessness (p. 1530).

Interestingly, findings from Crane and colleagues (2006) suggest that individuals who become homeless have often recently received health care services, which highlights issues around poor discharge planning from emergency services and in-patient care. In terms of related systems failures, the current study found that providers believe there can be a lack of planning around patient discharge from emergency departments (ED). However, provider concerns about unplanned or unsupported discharge were not necessarily related to what a patient’s housing status would be following discharge. Rather, providers expressed concerns about the patient’s ability to obtain and take needed medications and self-manage during recovery, which has more to do with treatment efficacy and the prevention of further health complications.

Previous research has also informed evidenced-based practice for addressing patients’ social determinants of health, the provision of health care to individuals experiencing homelessness, and has explored health care provider views and attitudes toward addressing and preventing homelessness. This study cannot confirm that providers use the strategies described in the CFPC’s *Best Advice Guide* for responding to patients’ social determinants of health, including conducting house calls to examine a patient’s living conditions or providing low-income patients with bus tokens to help them get to appointments. Although, providers in this study did recognize transportation as a barrier that some patients may face when trying to access health care. The current study also found that providers may ask their patients about their finances and significant changes to income, depending on other information they have about the patient. Indeed, the need to inquire about patients’ financial situations is reflected in work by Dr. Gary Bloch (2016) focused on provider participation in screening for poverty.

In addition to finances, literature suggests that providers consider information about a patient’s housing situation to be valuable and directly applicable to health care (Chhabra et al., 2019). However, research also suggests that medical practice does not typically involve providers asking their patients about housing-related factors and other social issues in their lives (Behforouz et al., 2014; Crane et al., 2006). Similarly, the current study found that providers believe that knowing about a patient’s social and economic circumstances is important for what they prescribe – both in the literal, medication prescription-sense and for considering more general treatment options. But, at the same time, providers in this study identified a need to fill

gaps where health care services in certain contexts (e.g., emergency departments) are not mindful of patients' wider contexts including their housing situations and ability to follow treatment plans.

The current study adds new findings to the literature about factors that encourage or deter providers from using formal guidelines or tools to assess risk of homelessness. Specifically, this study suggests that providers who regularly engage with patients experiencing varying degrees of poverty – perhaps, providing care for individuals in these groups on a daily basis – become skilled at assessing risk and addressing social needs simply through practice and experience. As such, providers in these contexts may not necessarily find formal guidelines or assessment tools helpful or applicable and instead, rely on their accumulated knowledge and experience. This concept of provider knowledge and experience gained over time is also reflected in a study by Doran and colleagues (2014) who found that medical residents learn to care for patients experiencing homelessness through experience and emulating practices observed by senior physicians, instead of through formal curricula.

As stated in the literature review, the current study was, in part, inspired by previous research suggesting that physicians and nurses believe in the efficacy of homelessness prevention strategies and realize the potential for greater primary care involvement in this work (Crane et al., 2006). However, a common thread running through the current study relates to a sense of 'helplessness' that providers feel in terms of their ability to effectively assess, intervene, and ultimately prevent homelessness. Similarly, Doran and colleagues (2014) describe provider frustration related to not being able to "do enough" to help patients in particularly vulnerable contexts (p. 676).

Considering these findings, there may be an important distinction between provider feelings of 'hopelessness' and 'helplessness'. In Doran et al. (2014), providers reported feelings of "frustration" and "hopelessness" (p. 676) when it came to providing care for individuals who, for example, repeatedly came into the ED intoxicated and with nowhere else to go (i.e., were homeless). On one hand, 'hopelessness' may imply pessimism about a patient's ability to make a change in their life, suggesting that providers have 'given up hope' that a patient will transition out of poverty and homelessness. However, providers in Doran et al. (2014) also describe feelings of sadness and guilt related to wanting to make a meaningful difference in their patients' lives but feeling unable to meet their needs. On the other hand, providers in their study, and in

the current study, appear to feel more ‘helpless’ in the sense that they feel personally unable to act in helpful ways.

While the findings from Doran and colleagues (2014) surround the provision of care for individuals who are already homeless, the current study suggests that providers may also feel ‘helpless’ when trying to prevent homelessness, which may be related to structural factors that are known to “create” risk and arguably, exist beyond health care providers’ control. However, it is important to note that such upstream or structural risk factors for homelessness are often context-specific and largely depend on policies and practices found in various jurisdictions. The providers in Doran et al. (2014) either practiced in a New York state medical centre or a New York City public safety net-hospital. It would be expected that, if feelings of ‘helplessness’ or frustration among health care providers in that study stemmed from systems-level issues that are specific to New York (or the U.S.), they may be different from issues impacting providers in the current, Canadian-focused, study.

In addition, there may be important contextual differences to consider in terms of how health care, including ED care, is delivered in the U.S. (or in that specific public hospital) compared to most Canadian jurisdictions. Doran and colleagues (2014) found that “emotions seemed stronger” and the “emotional burden” felt by health care providers caring for homeless patients was greater among those practicing in the public safety net-hospital (p. 677). The researchers explained that providers in this setting have more frequent exposure to homelessness – compared to those practicing in the state medical centre – because they provide health care for individuals who have low-incomes or are uninsured. Indeed, both American and Canadian-based research shows increased rates of ED use among individuals experiencing homelessness. However, in Canada where health care is universally free, the rates at which ED providers see vulnerably housed and homeless individuals will be less dependent on the ‘affordability’ of care at their hospital and more dependent on rates of poverty and homelessness in the area where it is located.

At any rate, Behforouz and colleagues (2014) argue that health care providers need to be properly trained in responding to patient’ social determinants of health and, evidently, the current study findings suggest that providers often struggle with knowing ‘what to do’ with information about a patient’s social or economic circumstances.

As previously mentioned, much of the research at the intersection of health care and homelessness focuses on how care is provided to individuals experiencing homelessness. In contrast, this study contributes to knowledge about how health care services can support homelessness prevention. Despite their divergent research aims, similar concepts and themes emerge in both types of studies. For example, in an earlier study by Doran and colleagues (2013) surrounding health care for homeless individuals, the researchers describe the theme, “Tensions in Navigating the Boundaries of Social Care” (p. S357), which relates to the theme in the current study, *Sharing responsibility and leveraging provider skillsets and knowledge*. Both themes capture providers’ opinions about the differences in scopes of practice between physicians and social workers and highlight the importance of considering their respective training and specific skillsets.

Doran and colleagues (2013) describe tensions in determining how far health care services “extend into the social realm” (p, S358), but generally found that physicians did incorporate “social care” into their practices to varying degrees (Doran et al., 2013. p.S358). Similarly, the current study found mixed opinions from providers about how far their roles should encroach onto the ‘territory’ of social work and therefore did not find evidence of a generally accepted boundary between these professions. Although, findings from the current study mirror findings from Doran and colleagues (2013), in that providers express concerns about how their time spent on addressing patients’ social needs takes time away from providing medical care for other patients (discussed in the subtheme, *Leveraging providers’ specific competencies and determining the most responsible provider*, in Chapter Five).

Such concerns about providers’ limited time – during which they are primarily responsible for providing medical care – may help with determining limits to provider scopes of practice and thus, establishing parameters around their roles in preventing homelessness. Moreover, while health care providers’ knowledge and skills are more medically based, research has demonstrated that these providers believe social workers have more of the expertise required to respond to patients’ housing-related issues (Chhabra et al., 2019). Describing similar views on the most appropriate provider to handle non-medical issues, such as risk of housing instability and homelessness, the current study found a common practice pattern of health care providers deferring responsibility to social workers.

6.2 Study Findings in Relation to Document Analysis Findings

As reflected in both the document analysis findings and findings from interviews, health care providers *should* and *do* demonstrate an understanding of poverty as a social determinant of health and can make connections between the stability of one's housing situation and their experiences of health. In other words, providers have the knowledge that the documents 'prescribe'. According to physician educators who created the module, *Poverty and Health: Key issues in patient care* (Gazeley & Ter Kuile, 2014), addressing patients' social determinants of health is "essential" to primary health care (p. 13). Likewise, the physician in this study used similar language, describing issues of housing instability and homelessness as "fundamental to health promotion and disease prevention". As another example of findings reflected in the document analysis, the Canadian Medical Association (CMA) highlights common barriers to health care specifically for low-income populations, namely, transportation costs and system navigation challenges. Similarly, providers in this study identified difficulties with systems navigation and getting to and from appointments (i.e., transportation) as representing significant barriers to care.

Additionally, findings from the current study relate to a major theme from the document analysis, *Considering the Wider Patient Context*. As seen in the previous section, the idea that providers should aim to gain more comprehensive understandings of patient contexts is further supported by past research. Providers in this study emphasized how critical it was for providers in their roles to know what questions to ask, in order to consider a patient's circumstances and treatment plans in context. For example, findings from the document analysis suggest that providers should consider a patient's ability to pay for non-insured health services or prescription medications and adjust treatment plans accordingly. Then, gathered from the current findings, providers affirm this responsibility to, in particular, consider their patient's ability to obtain and pay for needed medications. Interestingly, providers explained that they did not believe that most providers knew the 'right' questions to ask – presumably, the types of questions that elicit the most relevant and revealing information from patients.

As explored in Chapter Five, providers may seek information about social and economic issues in a patient's life as a way to contextualize their care and treatment plans, which may be meaningfully different from these issues being considered the 'purpose' of care. In other words, some providers may intentionally assess a patient's risk for economic or social vulnerabilities

because those factors can impact care (e.g., undermine a patient's ability to self-manage during treatment), while other providers assess risk for the purpose of ensuring housing stability among their patients. Arguably, in the former case, assessing risk or gaining contextual information represents a more downstream effort, where the intention is to prevent further health complications in already-sick patients. Whereas, the latter case demonstrates provider engagement with more 'upstream' prevention: promoting housing stability among patients and aiming to disrupt (or avoid all together) cycles of poor health, housing insecurity, and homelessness.

The current study findings describe what therapeutic patient-provider relationships should look like, especially for providers seeking more information about their patients' contexts. This study found that providers recognize the importance building therapeutic relationships with their patients over time, since patients tend to trust and ask for the providers they know. Similarly, in the document analysis, it was recommended that providers see the same patients over the course of their care and establish relationships that are characterized by mutual trust and rapport, which may be critical when planning to ask patients to divulge sensitive or personal information. Moreover, the document review/analysis discussed patient-centred care and found that the professional colleges and associations recommend providers consider their patients' personal health priorities and perspectives. Likewise, the current study findings found that providers embrace patient-centred care by encouraging patients to contribute to priority-setting during appointments and express their own concerns and ideas for care plans.

Moving beyond assessment, the current study's findings pertaining to providers knowing 'what to do' with information about a patient's housing instability align with two themes from the document analysis. First, as captured in the document analysis theme, *Collaborative Relationships and Systems Integration*, providers confirmed that working on interdisciplinary teams, or being well-connected to other providers and supports in their community, is particularly helpful when they suspect a patient is at risk for housing instability but are unsure of how to respond. In this way, team-based health care and service integration allows for more knowledge sharing and streamlined referrals, which is one way to address the issue of providers not knowing what to do about patients' housing problems. In fact, the current study found that systems and service integration was particularly evident in Community Health Centres (CHC), Family Health Teams (FHT), and Family Health Organizations (FHO). In both the document

analysis and findings from interviews with providers, it became clear that the structure and design of CHCs, FHTs, and FHOs is conducive to enhanced care coordination, streamlined referral processes, and overall, increased access for patients. Given this potential to integrate services and promote coordination and collaboration, CHCs, FHTs, and FHOs may represent critical ‘models’ to use for envisioning the future of health and social services delivery.

Second, findings from the document analysis highlight a need to ensure that providers have access to information about community resources and supports, as described in the theme, *Ensuring Health Care Providers are Equipped with Tools to Address Patients’ Social Determinants of Health*. While providers in the current study seemed to be knowledgeable about community-based services, they believed that providers, in general, are often unaware of these supports and eligibility criteria, which may explain the tendency to defer responsibility for making referrals and may be linked to missed opportunities for early intervention.

While a theme from the document analysis focused on health care provider involvement in community planning and responding to community needs, the current study did not find evidence of this in practice – at least not in ways that would align with homelessness prevention efforts. Although, the physician in this study did appear to be aware of some of the common housing arrangements and more common risk factors for homelessness in her practice population. For example, this provider explained that there is a lot of multi-generational housing in her community. Given the prevalence of this living arrangement, this provider found that interpersonal and domestic violence was more of a concern in the community, in terms of risk factors for homelessness, than housing loss due to significant change to income or job loss. This finding may demonstrate this particular provider’s awareness of a community ‘need’ (e.g., expand prevention-oriented services to support victims of violence), but overall, this study did not find that providers were involved in community-focused needs assessments, community planning, or programming specifically designed to tackle an underlying determinant of health.

The document analysis findings detailed steps that providers can take to directly help patients address particular social determinants of health (Section 4.2.2), including by filling out income support forms, educating patients about other resources and supports available in their communities, and facilitating referrals to these services when needed. Importantly, findings from the document analysis also highlighted the fact that helping patients transition out of poverty can significantly impact their health. Indeed, the current study found that providers help patients

secure income supports – namely, government assistance – and recognize that increased income for individuals in poverty can greatly improve their health. Additionally, as highlighted in the document analysis findings, providers can support patients by connecting them with various supports and services that exist outside of health care. To add to this discussion, the current study’s findings detail important considerations, facilitators, and barriers related to making referrals, including: determining which provider (within a health care team) should make referrals; the level of integration and connections between health services and systems; and provider knowledge and awareness of community services.

A major theme revealed in the document analysis findings related to health care provider involvement in Advocacy (Section 4.2.4), which also represents a category of homelessness prevention-oriented activities. As described in the document analysis findings, providers can participate in advocacy efforts at a more structural level, including advocating for changes to housing policy and legislation and requesting government action on the social determinants of health – perhaps through, among other things, educating policy makers on the health effects of poverty and homelessness. It was also recommended that providers lead or participate in research of their own that surrounds these topics. While providers in the current study were asked about other ways they could support homelessness prevention (beyond assessment and referrals), they did not indicate their involvement in advocacy efforts at the structural level, as described in the document analysis findings. Although, one of the nurse practitioners in the current study briefly noted that, as she was completing a PhD, her doctoral research focused on rooming houses. Exploring providers’ perceptions about their roles in preventing homelessness at a more upstream or structural level is a future area for research.

6.3 Findings in Light of a Framework for Homelessness Prevention

The development and implementation of the current study was guided by Gaetz and Dej’s (2017) *A New Direction: A framework for homelessness prevention*. Specifically, this Framework supported the development of interview questions, coding and analysis processes, and informed decisions around how to organize descriptive themes and present the findings of this study.

While the Framework has been described as largely theoretical, the current study findings provide a detailed account of how the Framework can be practically applied to primary research

and used to categorize prevention-oriented activities in a particular setting (i.e., health care provision). Thus, this study deepens an understanding of where and by whom some of these prevention strategies can be used. Specifically, the current study contributes to evidence of the current and potential involvement of health care providers in prevention-oriented activities described in the Framework. While not all of the strategies and practices discussed by providers in this study were categorized using the Framework – and similarly, the study findings do not reflect significant provider involvement at all levels of prevention – the Framework nevertheless proved to be highly applicable to this type of research.

As noted in the Framework (Gaetz & Dej, 2017) and discussed in the literature review (Chapter Two), prevention first requires an understanding of risk factors associated with housing instability and homelessness and ideas about which groups to prioritize for prevention efforts. In other words, addressing homelessness through prevention inevitably requires an understanding of the factors that lead people to become homeless in the first place (Gaetz & Dej, 2017). As such, it may be expected that all partners in homelessness prevention must fully grasp known risk factors and eventual causes of homelessness. Therefore, in anticipating greater health care provider involvement in homelessness prevention, provider knowledge about risk factors and priority groups must be considered. To this end, the current study contributes findings regarding providers' conceptualizations of poverty and provider perceptions of risk factors for housing instability and homelessness. Specifically, the current study found that health care providers demonstrate knowledge of many of the structural and individual-level risk factors described in the Framework (Gaetz & Dej, 2017; p. 18-22) including income and not being able to “get basic needs met” (found within “Poverty” as a risk factor; p. 18), housing insecurity, persistent and disabling conditions, crises and interpersonal and relational problems, interpersonal violence, and systems failures.

Moreover, findings from the current study reflect categories of prevention and specific prevention activities described in the Framework (Gaetz & Dej, 2017). In particular, the subthemes within the fourth theme, *Roles for providers at all levels of change* (Section 5.5), align well with the Framework's definitions of *Systems Prevention*, *Early Intervention*, *Eviction Prevention*, and *Housing Stability* (Gaetz & Dej, 2017). For example, increasing access to income support and health care is categorized under *Systems Prevention* in the Framework (Gaetz & Dej, 2017, p. 56). Similarly, findings from the current study highlight links between

access to primary care and access to income supports, mainly since health care providers are often required to complete forms for government assistance programs. Further, this study found that providers recognize issues related to transitions for youth after foster care and transitions for individuals leaving incarceration, which are also focus areas outlined in the Framework (i.e., “Stop the flow of people from mental health care, child protection, and corrections into homelessness”; Gaetz & Dej, 2017, p. 36). In describing such systems failures, however, providers in this study did not necessarily make suggestions as to how these issues could be solved, or about how they could help.

Additionally, the findings from the current study reflect provider involvement at the defined levels of *Early Intervention* (Gaetz & Dej, 2017, p. 61) and *Eviction Prevention* (p. 70). First, the study findings suggest that providers primarily assess patient risk through the use of informal strategies, such as asking patients about recent changes to their income, employment status, living arrangement, and overall housing situation. Providers may also be involved in outreach and engagement with particularly vulnerable groups (e.g., individuals at risk or needing treatment for HIV/AIDS or Hepatitis C). As outlined in the Framework (Gaetz & Dej, 2017), such strategies used to assess and identify individuals at risk for homelessness, as well as outreach and engagement practices, support homelessness prevention as they are critical for *Early Intervention*.

Related to *Eviction Prevention* (Gaetz & Dej, 2017), this study adds findings pertaining to provider involvement in supporting individuals with mental health challenges and addictions. For example, this study found that providers’ practices may include a focus on mental health, with counselling offered to individuals at risk for housing loss because of issues related to their mental health. Certainly, mental health issues are understood to comprise a significant part of the risk associated with housing instability and homelessness, and therefore, mental health care can be considered an important prevention-oriented activity. Given that the provision of mental health care is obviously ‘health’-related – for which nurse practitioners and physicians have the relevant skills and training – perhaps addressing this category of risk is an area of prevention that most appropriately falls on health care providers.

Recently, the authors of the Framework (Gaetz & Dej, 2017) and other prominent researchers in the field conducted a scoping review that provides an evidence base of research reflecting homelessness prevention at the five levels described in the original Framework (i.e.,

Structural Prevention, Systems Prevention, Early Intervention, Eviction Prevention, and Housing Stability; Oudshoorn, Dej, Parsons, & Gaetz, 2020). In this paper, Oudshoorn and colleagues (2020) theorise an additional domain of homelessness prevention surrounding ‘empowerment’. As indicated by the authors, an additional focus on empowering individuals stems from knowledge about how “accessing health and social services has the potential to be a disempowering experience depending on how services are delivered” (Oudshoorn et al., 2020, p. 1755). In proposing *Empowerment* as a sixth domain of homelessness prevention, Oudshoorn and colleagues (2020) highlight the importance of ‘choice’ – that is, allowing individuals to exercise choice in housing but also in health care settings through practicing patient-centred care. Indeed, the current study found that health care providers embrace principles of patient-centred care by encouraging patients to contribute to priority setting and treatment plan design. Moreover, the current study found that providers can use motivational interviewing to encourage healthy behaviours, a practice which is primarily led by the client/patient and thus is considered to be an empowering experience for individuals.

In their review of literature examining strategies and interventions at the five originally proposed levels of homelessness prevention, Oudshoorn and colleagues (2020) found the most evidence related to *Housing Stability*. The authors explain that the large amount of research on elements of *Housing Stability* is attributable to the widespread implementation and investigation of Housing First, a tertiary-level intervention that focuses on rehousing and stabilizing individuals in their homes. With regards to these findings, the current study did not find that providers were particularly involved in Housing First initiatives, although some providers expressed criticisms of the model, including that Housing First programming took funding away from the emergency services that they often referred to (e.g., emergency shelters). Moreover, findings from the current study suggest that some health care providers do not believe in the efficacy of Housing First – specifically, the housing programs where housing supports are not offered.

In both the Framework by Gaetz and Dej (2017) and accompanying paper by Oudshoorn and colleagues (2020), similar concepts of “social integration” and “social inclusion” are explored in relation to promoting *Housing Stability*. Specifically, in Gaetz & Dej (2017), “enhancing social inclusion” is described as an importance element of *Housing Stability*, which includes supporting individuals to develop social relationships, make connections, participate in

their communities, reconnect with their families, and participate in cultural and other meaningful activities (p. 83). Offering housing supports is also discussed as part of promoting *Housing Stability*, which includes – in addition to helping individuals find housing – helping people maintain their housing and offering rent supplements, “supports when things go wrong”, eviction prevention, and aftercare (continued engagement with housing and support workers; Gaetz & Dej, 2017, p. 79). Likewise, findings from the current study suggest that providers understand these elements and important factors that are predictive of housing success and retainment. For example, providers recognized the importance of housing supports (specifically for those who have been homeless for some period of time) since continued access to supports, including peer supports, is critical to their success. In general, providers highlighted the need to ensure that the organization and provision of housing is conducive to long-term stability.

6.4 Limitations

While several strategies were used to enhance rigour in the research process (as outlined in Chapter Three), the findings from this study should be considered in the context of the following limitations.

The main limitation of this study is its low sample size. Although small sample sizes tend to be characteristic of qualitative research studies (Bradshaw et al., 2017; Sandelowski, 2000), and the sampling process utilized still yielded a significant volume of data, this study had considerably fewer participants than anticipated. In total, four health care providers participated in this study, while the target sample size was eight.

As recruitment for this study was initiated near the beginning of the COVID-19 pandemic and concluded prior to the end of the pandemic (recruitment period was April 2020 – July 2020), it proved difficult to connect with health care providers during this time in order to generate interest in this project. Several attempts to contact primary health care teams, clinics, and individual providers were made to promote the study. In further attempts to reach the sample size, the investigators made posts to their social media accounts with links to information about the study and spaces where interested providers could enter their contact information. This recruitment strategy was helpful in increasing interest in the study, but a number of these interviews did not materialize – that is, providers did not end up responding to our follow up emails enquiring about their availability to meet (virtually). There was, therefore, greater interest

in this study than the attained sample size, but challenges with participant follow up signified greater priorities among this target population.

Originally, it was thought that data analysis would involve comparing responses (and the resulting themes) between physicians and nurse practitioners. However, given that only one physician participated in the study, making these comparisons would not have been feasible or appropriate from a methodological standpoint. Therefore, similarities and differences between the opinions and experiences shared by each type of provider were not explored. Instead, the findings presented in this thesis are focused on consistencies across all participants, including common perspectives they shared.

Despite a low sample size, the findings from this study are valuable as they provide insights about the prevention-oriented activities that providers do or could participate in. The practical applications of this small study may be limited, but the findings still offer general considerations for practice and suggestions for future research, both of which are outlined in the following section.

Additionally, it was anticipated that this study would explore the perspectives and knowledge of providers who, collectively, had diverse caseloads of patients. However, among the four participating providers, three had patient caseloads that were mainly comprised of individuals who they knew were experiencing poverty. Only one provider (Physician #1) estimated that a low percentage of her patient caseload was living in poverty. This is important to consider in the context of findings from this study because, whereas the extent of health care provider involvement in homelessness prevention may vary significantly across providers and practice settings, providers who specifically work with at-risk (or perceived to be at-risk) individuals may be more likely to embrace a larger role in this work. Given this potential for disparate involvement – depending on the demographic characteristics of patient caseloads – future research may explore the perspectives of providers who do not specifically work with at-risk individuals. This research would add to the current study’s findings and further our understanding about roles for all providers along the continuum of homelessness prevention.

6.5 Considerations for Practice and Remaining Questions for Future Research

Findings from this study highlight considerations for health care practice, but the future involvement of health care providers in homelessness prevention still merits further research.

First, as discussed in the document analysis findings, there may be opportunities for provider involvement in advocacy efforts that can lead to increased housing stability for their patients. To embrace this role in supporting more upstream homelessness prevention, it is recommended that providers continue to demonstrate the links between housing and health and advocate for public policy that reflects a right to housing. Also, more generally, it is recommended that providers be incentivized to lead and participate in research on the social determinants of health.

Second, it may be important to expand team-based models of health care, such as those seen in FHTs and FHOs, since they promote service integration and increase provider connections to social and other support workers. Future studies might seek to further explore whether patients are more likely to receive comprehensive health care and more likely to be flagged ‘at-risk’ for housing instability or homelessness within these care settings. Through strengthened collaboration and service integration, there can be a real concerted effort to ensure that vulnerable individuals’ risk of housing stability or homelessness is not overlooked. For example, the practice of providers making “warm referrals” for patients in need of extra support is likely to increase the probability that these individuals actually access and benefit from the services they were referred to, which, in turn, is expected to decrease their risk of homelessness.

Another practice consideration relates to fee-for-service physician compensation models, which do not necessarily incentivize physician involvement in risk assessment, outreach, or coordinated care plans since there are no “codes” for billing these activities. Instead, this study suggests that more widespread use of Alternative Payment Agreements may encourage provider involvement in practices associated with homelessness prevention, but more research would be needed in this area.

Additionally, it is important to recognize that provider engagement with homelessness prevention strategies and interventions may vary across speciality, practice population, and clinical setting. Likewise, there may be various factors that impact a provider’s capacity to obtain ‘social history’ information from their patients, make referrals, and offer vulnerable patients

more intensive support. In fact, an important finding of the current study was that providers sometimes do not want to become obligated or feel responsible for helping patients address their housing issues and as a result, they may not ask about these types of problems. However, this finding does not necessarily imply that providers do not ‘care’ about these patient challenges. Rather, the findings reflect the potential complexity of some patients’ social issues, where addressing them may become cumbersome and take time away from providers helping other patients with more medical needs. It is in these instances that providers may begin to question the limits of their scopes of practice and consider their abilities to address non-medical issues.

This study explored other barriers to providers seeking more information about their patients’ wider contexts, including time and lack of knowledge or experience. Since provider consideration of a patient’s wider context appears to be critical for risk assessment and the prevention of homelessness, future research should continue to investigate these barriers and explore how to address them most effectively within clinical contexts.

Moreover, it is important to recognize that health care providers, such as physicians and nurse practitioners, acquire experience and medical knowledge overtime that allows them to diagnose a range of complex symptom combinations that their patients present with. In contrast, it is assumed that these providers do not accumulate the same degree of expertise related to risk factors for homelessness or obtain the same level of first-hand experience with correctly identifying and mitigating those risk factors. It is not expected that physicians, for example, who train for years to correctly diagnose illness and develop treatment plans, will also be experts in ‘diagnosing’ and ‘treating’ homelessness or risk of homelessness. However, when physicians screen patients for risk of homelessness, there is an element of diagnosis that will happen.

In this discussion, it is interesting to consider the traditional “medical model” of care in a comparison between assessing risk for homelessness and diagnosing a medical condition. Recognizing risk factors for homelessness (and providing referrals accordingly) may be analogous to health care providers recognizing patient symptoms of disease or illness and sending patients for further testing. For example, as a known risk factor for homelessness, relationship breakdown may be considered a “symptom” for housing loss, in terms of the medical model for symptom recognition and diagnosis. If a patient presents with this “symptom”, a provider may choose to further screen or assess this patient’s risk of housing loss, using whichever available tool, depending on other information they have about this individual.

Alternatively, in this example, the health care provider may refer the patient to another team member or community service provider to do the assessment, much like they do when referring patients for other tests or to see specialists. At some point during this process, a “diagnosis” of “at risk for housing loss or homelessness” may be determined.

However, the current study found that providers may lack knowledge about the ‘right’ questions to ask patients, as part of assessing risk for housing loss, and may not be aware of external services and resources in their practice communities that can support housing stability. Given these findings and recent comments from other authors about vulnerable individuals’ interactions with health care services, there may be a need for Continued Medical Education and medical school curricula that involves greater focus on patients’ experiences of housing instability and homelessness and more broadly, the social determinants of health. Future research may explore opportunities for implementing or mandating this type of training and education, which could teach providers about how individuals in unstable housing situations are best served and help increase provider knowledge and awareness of the most helpful poverty and housing-focused services.

Interestingly, past research and findings from the current study suggest that many health care providers believe that *social workers* are better suited to support broad homelessness prevention efforts, mainly because of their social care training and vast knowledge about community supports. These findings present opportunities for future inquiry that could involve asking social workers about their perspectives on their role in homelessness prevention or seek their opinions about the extent to which this type of work is relevant to various health care providers’ scopes of practice.

Finally, to improve assessment processes, health care practices may consider expanding their use of more formal and validated tools such as the Patient Centred Assessment Method (PCAM), which evaluates patient complexity and the “social dimensions of health” (Pratt et al., 2015, p. 110), clinical checklists where providers can indicate patient poverty, or Gary Bloch’s (2016) Poverty Intervention Tool. Findings from the current study suggest that physicians and nurse practitioners typically use more informal strategies to assess patient risk for housing instability and homelessness, but future research should continue to examine the most appropriate and effective assessment ‘tools’ and strategies for use in various health care settings.

6.6 Conclusion

This qualitative study was conducted to examine a role for health care providers in homelessness prevention, a focus area for responding to homelessness that the sector continues to emphasize. Specifically, this study aimed to explore physician and nurse practitioner participation in a range of prevention-oriented activities and assessed their knowledge of risk factors for homelessness and awareness of poverty and housing-focused community supports.

This study found that indeed, providers are generally knowledgeable about risk factors for housing instability and homelessness, which is critical knowledge to have for any partner involved in this work. To most effectively assess patient risk of housing instability and homelessness, it is also necessary that providers are aware of the unique circumstances in their patients' lives, including social and economic factors that may contribute to their precariousness. Further, this study revealed potential barriers to providers' more active participation in prevention efforts, such as being unaware of social services and community-based supports (to which patients could be referred), concerns about their ability to effectively prevent homelessness, and understandings of the boundaries between health care and social work.

While homelessness prevention certainly does not fall entirely on the medical profession, this study contributes to knowledge about opportunities for the health care sector to share in responsibility for this work, including through assessing patient risk and facilitating referrals where needed. Moreover, given the interdisciplinary nature of health care, social work, and social services, and the understanding that housing (or lack of thereof) is a powerful predictor of health and well-being, the health care system appears to be a natural partner in efforts to prevent housing precarity and homelessness. Health care providers themselves acknowledge that patient housing issues are important for health and should be addressed, but there is a tendency to defer responsibility for these issues, mainly to social workers. As one provider from this study stated, "It's certainly someone's job" (NP #3).

Ultimately, while the homelessness sector pushes for greater investment and focus on prevention efforts, there will continue to be discussions about which service providers are best positioned and equipped to lead this work as well as ongoing negotiations regarding the roles and responsibilities of partnering sectors and systems. In turn, with more integrated and collaborative approaches to homelessness prevention, more individuals and families should be able to remain stable in their homes and thus, maintain greater control over their health.

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Appendices

Appendix A: Interview Guide

Hi, my name is Kayla. I am a graduate student at Western University conducting a research project that explores the involvement of health professionals in preventing homelessness. At this point, you have reviewed the Letter of Information and have signed the Consent form and sent it back to me. Would you like to go over the letter again or do you have any questions about it? If not, is it ok if we begin the audio recording?

Can you please confirm that you have read and understand the Letter of Information, agree that the nature of the study has been explained to you, and agree to participate and be audio-recorded during the interview?

Second, do you consent to the use of direct quotations that have had identifying information removed?

Questions used to describe the sample of participants:

1. To help our research team describe our sample, we would like to know, first, what is the highest level of education you have completed and what is your current profession?
2. (Experience) How long (how many years) have you worked as a physician/nurse practitioner?
3. What type of workplace do you practice in? Are you part of a primary care team? Community health centre? Or practice mainly at a walk-in clinic?
4. Who are your patients, and do you know approximately what percentage of your patient load is experiencing poverty?
5. Lastly, we would like to know what gender you identify with?

Main Interview Questions:

1. In your opinion, what does it mean to experience poverty?
 - Prompts:
 - What does poverty “look like”?
 - What are some ways that poverty is related to health and wellness?
2. In your opinion, what does it mean to experience housing instability or precarious housing?
3. In your opinion, what are individual risk factors for housing instability or homelessness?
 - Prompt: *Who* is at risk for housing instability? What groups do you think should be prioritized or targeted for homelessness prevention initiatives?
4. Could you explain whether you believe your scope of practice includes assessing patients’ risk of housing instability or homelessness?
5. Could you explain whether you believe your scope practice includes referring patients to additional services that can support their housing situations?
6. Do you have any ideas about how you, as a [insert profession] can help in preventing homelessness?
7. What types of strategies could you use to assess a patients’ risk for housing instability or homelessness?

8. If you do suspect that one of your patients is at risk for housing instability or homelessness, what are some ways you can intervene or steer them in the direction of extra housing supports?
 - Prompt: Barriers to this?
9. Who are the other partners in homelessness prevention? Are there any other health care professionals who could/should incorporate homelessness prevention strategies into their practice?

Appendix B: Coding Manual for Interview Transcript Analysis

Initial Codes Derived from Themes Found in Document Analysis

These codes were organized using domain analysis as exemplified by Jiggins Colorafi and Evans (2016). The table headings used below include a domain name and then indicate the semantic relationship between the themes listed in the tables and the corresponding heading/domain. It is read from the bottom up. For example, the first theme and domain combination would be read as, “Considering the Wider Patient Context” “is a way in which” “health care providers can participate in homelessness prevention activities”. Components of each theme are listed below the theme, in point form.

Health care providers can participate in homelessness prevention activities ^ is a way in which ^
Considering the Wider Patient Context <ul style="list-style-type: none"> ○ Contribute to overall patient well-being ○ Conducting ‘social history’ assessments/ask about these things ○ Larger patient context is important for care considerations, treatment plans, and related health implications (encompasses decisions about treatment and care plans, patient-provider relationships/establishing trust and rapport, and patients’ social and cultural contexts)
Directly Responding to Patients’ Social Determinants of Health <ul style="list-style-type: none"> ○ Completing income support forms ○ Educating patients about other community resources or supports, and facilitating referrals

Homelessness prevention that health care providers can be involved in ^ is a broad area of ^
Advocacy <ul style="list-style-type: none"> ○ Helping to demonstrate the link between health and poverty ○ Health professionals addressing the social determinants of health ○ Health professionals want to work in an advocate capacity ○ Advocacy at the patient and community levels (micro level) ○ Influencing policy and requesting government action (macro level) ○ Advocacy through engagement with research on social determinants of health and health equity
Health Professionals Responding to Community Needs <ul style="list-style-type: none"> ○ Health professionals engaging with community-based interventions ○ Base community planning on community needs and community-level determinants of health
Collaborative Relationships and Systems Integration <ul style="list-style-type: none"> ○ Integration of services ○ Systems integration and coordinated care ○ Community-level partnerships ○ Collaborative relationships with other health care providers and allied health professionals/partnerships to support patient needs

Considering health care provider involvement in homelessness prevention ^ is an important factor when ^
Appropriate Use of Health Care Resources for Responding to Social and Economic Issues
Ensuring Health Professionals Are Equipped with Tools to Address Patients’ Social Determinants of Health <ul style="list-style-type: none"> ○ Medical curricula and residency training ○ Continued Medical Education (CME) ○ Record patients’ demographic information and provide health professionals with tools to assess patients’ social and economic wellness ○ Provide health professionals with information about external supports and community resources [that their patients can access]
Recognizing Impacts of the Social Determinants of Health <ul style="list-style-type: none"> ○ Impact of housing situations on individual health outcomes

<ul style="list-style-type: none"> ○ Impacts of the social determinants of health ○ Social determinants of health and chronic disease ○ Defining, understanding, and further investigating the social determinants of health
Disadvantaged Groups Accessing Health Care <ul style="list-style-type: none"> ○ Where rates of service use are lower among disadvantaged groups ○ Where rates of service use are higher among disadvantaged groups ○ Barriers to accessing health care services, including addressing these barriers ○ Ability to follow treatment plans and take control over one’s own health ○ Improving access to care

Initial Codes Derived from the Framework for Homelessness Prevention (Gaetz & Dei, 2017)

These codes were organized using domain analysis as exemplified by Jiggins Colorafi and Evans (2016). The left column contains the domain names and indicates the semantic relationship between the theme and domain. The second/middle column contains the themes, which are bolded. It is read starting with this column of themes, for example, “Poverty” “is a” “risk factor for homelessness” “at the structural level”.

Risk factor for homelessness <i>^ is a ^</i>	Poverty	At the structural level
	Discrimination	
	Lack of affordable housing	
	The impact of colonialism on Indigenous Peoples	
	Barriers to accessing public services	At the level of systems failures
	Failed transitions from publicly funded institutions and systems	
	Silos and gaps both within and between government funded departments and systems, and within non-profit sectors	
	Personal or family crises	At the level of individual and relational factors
	Housing insecurity	
	Persistent and disabling conditions	
	Interpersonal violence	
Trauma		

Prevention strategy ^ is a broad ^	Poverty reduction	At the level of Primary Prevention
	Build and maintain affordable housing	
	Anti-violence campaigns	
	Early childhood supports	
	Anti-discrimination	At the level of Secondary Prevention
	Stop the flow of people from mental health care, child protection, and corrections into homelessness	
	Coordinated assessment; case management; and shelter diversion strategies (early intervention)	
	Family mediation; rent banks, and landlord-tenant mediation (key supports)	At the level of Tertiary Prevention
	Housing First (reducing the recurrence of homelessness)	

Typology of Homelessness Prevention Activities

Prevention strategy ^ is a specific ^	Promote poverty reduction/anti-poverty strategies, access to appropriate housing, safety, and wellness	At the level of <i>Structural Prevention</i>
	Support and advocate for policy and legislation that enhances housing stability and inclusion	
	Anti-discriminatory policy; anti-discrimination training for health care professionals	
	Advocate for Increased Income Supports	
	Ensuring adequate supply of affordable housing	
	Early childhood interventions	
	Violence prevention	
	Addressing the social, cultural, and economic exclusion of Indigenous individuals, families, and communities	
	Supports for individuals facing discrimination	
	Supports for families in which there is interpersonal violence	
	Supports for individuals with addictions and mental health challenges	
	Increase access to needed health care	At the level of <i>Systems Prevention</i>
	Address cost barriers to supports/health care (e.g., medication cost)	
	Enhancing access to public systems, services, and appropriate supports	
	Address system navigation challenges	
	Expand community hubs, outreach, system navigator supports	
	Reintegration support: facilitate effective transitions from public institutions or systems	
	Ensure people ‘discharging’ from institutional care have planning support prior to release and immediate access to housing and supports	At the level of <i>Early Intervention</i>
	Outreach, identification mechanisms, and engagement	
	Intake and assessment (incl. screening procedures, coordinated assessment)	
	Case management and systems navigation	
	Place-based supports	
	Shelter diversion	
	Family mediation and reunification	
	School-based early intervention programs	
	Intimate partner violence victim support	At the level of <i>Eviction Prevention</i>
	Consider landlord/tenant legislation and policy	
	Rent controls, rent supplements, and emergency financial assistance	
	Crisis supports for those imminently at risk of eviction	
	Social service and health care providers supporting tenants with mental health challenges, addictions, violent tendencies, hoarding, etc.	
	Provide information and advice/housing education (on rental housing issues and legal rights)	At the level of <i>Housing Stability</i>
	Offer housing supports	
Access to good primary care, diagnostic testing, mental health and/or learning disabilities supports, trauma-informed care, and substance use and addictions-related care		
Support individuals’ access to income and education		
Complementary supports: Life skills (including self-care); Advocacy; systems navigation; peer support; and legal advice and representation		
Enhancing social inclusion		

Appendix C: Ethics Approval



Date: 28 January 2020

To: Dr. Jacob Shelley

Project ID: 114887

Study Title: Exploring Health Care Providers' Roles in Homelessness Prevention

Application Type: HSREB Initial Application

Review Type: Delegated

Full Board Reporting Date: 11Feb2020

Date Approval Issued: 28/Jan/2020 14:18

REB Approval Expiry Date: 28/Jan/2021

Dear Dr. Jacob Shelley

The Western University Health Science Research Ethics Board (HSREB) has reviewed and approved the above mentioned study as described in the WREM application form, as of the HSREB Initial Approval Date noted above. This research study is to be conducted by the investigator noted above. All other required institutional approvals must also be obtained prior to the conduct of the study.

Documents Approved:

Document Name	Document Type	Document Date	Document Version
Email Script For Recruitment	Email Script	08/Jan/2020	2
Email Script to Contact Person	Email Script	20/Jan/2020	2
Interview Guide - Exploring Health Care Providers' Roles In Homelessness Prevention	Interview Guide	07/Jan/2020	3
Letter Of Information And Consent	Written Consent/Assent	20/Jan/2020	3
Research Plan - Exploring Health Care Providers' Roles in Homelessness Prevention	Protocol	07/Jan/2020	2

No deviations from, or changes to, the protocol or WREM application should be initiated without prior written approval of an appropriate amendment from Western HSREB, except when necessary to eliminate immediate hazard(s) to study participants or when the change(s) involves only administrative or logistical aspects of the trial.

REB members involved in the research project do not participate in the review, discussion or decision.

The Western University HSREB operates in compliance with, and is constituted in accordance with, the requirements of the TriCouncil Policy Statement: Ethical Conduct for Research Involving Humans (TCPS 2); the International Conference on Harmonisation Good Clinical Practice Consolidated Guideline (ICH GCP); Part C, Division 5 of the Food and Drug Regulations; Part 4 of the Natural Health Products Regulations; Part 3 of the Medical Devices Regulations and the provisions of the Ontario Personal Health Information Protection Act (PHIPA 2004) and its applicable regulations. The HSREB is registered with the U.S. Department of Health & Human Services under the IRB registration number IRB 00000940.

Please do not hesitate to contact us if you have any questions.

Sincerely,

Nicola Geoghegan-Morpeht, Ethics Officer on behalf of Dr. Philip Jones, HSREB Vice-Chair

Note: This correspondence includes an electronic signature (validation and approval via an online system that is compliant with all regulations).

Appendix D: Letter of Information and Consent



LETTER OF INFORMATION AND CONSENT

Study Title

Exploring Health Care Providers' Roles in Homelessness Prevention

Principal Investigator

Jacob Shelley, SJD, Assistant Professor
Western University, Faculty of Law & School of Health Studies, Faculty of Health Sciences &
Schulich Interfaculty Program in Public Health, Schulich School of Medicine & Dentistry

Co-Investigators

Abe Oudshoorn, RN, PhD, Assistant Professor
Western University, Arthur Labatt Family School of Nursing

Maxwell Smith, PhD, Assistant Professor
Western University, School of Health Studies

Student Investigator

Kayla May, BHSc, MSc Student
Western University, Faculty of Health Sciences

Conflict of Interest

There are no conflicts of interest to declare related to this study.

INVITATION TO PARTICIPATE IN RESEARCH

You are being invited to participate in this research study about primary health care providers' involvement in homelessness prevention. To help you make an informed decision regarding your participation, this letter will explain the purpose of this study, what involvement in this study will entail, possible risks and benefits, and how confidentiality will be ensured. If you do not understand something in the letter, please ask one of the investigators before consenting to participate in this study.

Introduction

Individuals experiencing homelessness typically have poorer physical and mental health than the general public and are some of the most frequent users of emergency room services. As health systems share in supporting these individuals, there is potential for assistance from the health

care sector in ending homelessness. In particular, past research suggests that primary health care providers can participate in a range of activities related to homelessness prevention and consequently protect the health of their patients.

This study is being conducted for a Master's student's final thesis project. The purpose of this study is to:

- 1) Examine the current involvement of physicians and nurse practitioners in homelessness prevention at the levels of *Early Intervention* and promoting *Housing Stability* among their patients, and
- 2) Assess health professionals' awareness and knowledge of poverty and housing-focused community services that support individuals at risk for housing instability and homelessness.

Previous plans to end homelessness in Canada have not always been sufficient, but the field is changing. This research is important and timely as the homelessness sector opens up a broader conversation about efforts to prevent homelessness rather than only "managing" it with responsive models.

Procedure and Eligibility

Up to eight physicians and nurse practitioners are being asked to participate in this study, who may or may not provide medical care for individuals at risk for housing instability and homelessness. To be eligible to participate in this study, you must be a practicing physician or nurse practitioner.

Interviews

This study primarily consists of one-on-one interviews with physicians and nurse practitioners. Each interview will take approximately one hour to complete and there are no follow-up interviews.

If you agree to participate in an interview, you will be asked open-ended questions about your knowledge and opinions on the issue of poverty and homelessness, your role as a health care provider in supporting patients' housing situations, strategies you use (if any) for assessing patients' risk for housing instability and connecting them to supports, and barriers to supporting at risk individuals.

Voluntary Participation

Participation in this study is voluntary and you are free to withdraw at any time. However, data collected in this interview cannot be withdrawn after it has been published or presented. You may also refuse to answer any question(s) during the interview. If you refuse to be audio-recorded during the interview, please let one of the investigators know and they will withdraw you from the study. If, during the interview, you decide you do not want to be audio-recorded, please let the interviewer know and the recording will be stopped. Should you wish to stop the

recording before the interview is over, please let the interviewer know whether you would like the recording to be destroyed or if it can be used by the research team.

Risks

A possible risk to you is a privacy breach. To address this risk and protect sensitive information, identifiable information including your name and contact information will be removed from the study data and a unique ID code (e.g., 001) will be used instead. Also, interview data may contain names or unique events that could be linked to you. Such indirect identifiers will be altered or removed in all documents from the study (e.g., published results).

Benefits

You may not receive direct benefit from being in this study. Information learned from this study is expected to lead to increased knowledge about why people become homeless and how to mitigate the risk factors for housing instability, as well as potentially uncover opportunities for early intervention by health care providers.

Confidentiality

Interviews will be audio-recorded. The audio files will be stored on a server maintained by Western University, under a private project site that only the researchers will have access to. Data will be destroyed after 7 years as per Western University policy. Your interview data will be assigned a unique ID code and the master list linking your ID code to your identifiable information (name, contact information) will only be available to the research team. However, the Western Health Sciences Research Ethics Board may require access to research records for monitoring purposes.

Questions About This Study

If you have questions about this research study, please contact the Principal Investigator: Jacob Shelley, [REDACTED]

If you have any questions about your rights as a participant, please contact the Office of Human Research Ethics at [REDACTED]

This letter is yours to keep for future reference.

CONSENT FORM

Exploring Health Care Providers' Roles in Homelessness Prevention

Principal Investigator: Jacob Shelley SJD

Co-Investigators: Kayla May, Abe Oudshoorn RN PhD, Maxwell Smith PhD

I have read and understand the *Letter of Information*, have had the nature of the study explained to me, and I agree to participate and be audio-recorded during the interview. All my questions have been answered to my satisfaction.

- I consent to the use of direct quotations that have had identifying information removed. YES NO

Print Name of Participant _____

Signature _____

Date (DD/MM/YYYY) _____

I have explained the nature of the study to the participant named above. I have answered all questions.

Curriculum Vitae

Name: Kayla May

Education: *Western University – London, Ontario*
Master of Science, Health Promotion
2018 – Present

Bachelor of Health Sciences, Honors Specialization with Biology
2013 – 2018

Honours and Awards: Health Ethics, Law and Policy (HELP) Lab Graduate Fellowship
Western University, London, Ontario
2020 – Present

Joseph-Armand Bombardier Canada Graduate Scholarship
Social Sciences and Humanities Research Council of Canada
2019 – 2020

Related Work Experience: Graduate Research Assistant
Western University, London, Ontario
2019 – 2020

Research Assistant
Kovacs Group, London, Ontario
2019

Graduate Teaching Assistant
School of Occupational Therapy, Western University
2018

Intake Housing Support Worker
London Housing Registry, London, Ontario
2017 – 2018