HEALTH CARE FOR THE SOCALLY MARGINALIZED: THE ROLE OF SUBSISTENCE SERVICE PROVIDERS

by

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Abstract

People who access subsistence services (food and shelter agencies) are susceptible to multiple and severe health conditions, but numerous barriers limit their access to mainstream health care. Subsistence service providers are, thus, often the primary point of contact for many people who are experiencing poor health. This study utilizes qualitative and quantitative methods to identify support mechanisms for subsistence service providers that would assist in addressing the health needs of their clients and increasing access to health care. Navigation outreach workers, a central directory of services, on-site health professionals and electronic patient care records are policy options that have been successfully implemented in other jurisdictions. This study finds that these alternatives would also be desirable in the short term in the Vancouver Coastal Health region and recommends avenues for expanding them in the long term.
Executive Summary

People who are socially marginalized are susceptible to numerous health problems. Furthermore, accessibility barriers imply that some socially marginalized individuals are more likely to access subsistence service providers (food and shelter agencies) than have regular contact with traditional medical professionals. Increasing numbers of socially marginalized individuals implies that the number of people accessing subsistence service agencies is also increasing. This increased demand limits the ability of agencies to act outside of their primary service sphere and effectively respond to the health care needs of their clients. The policy problem that guides this analysis is: assistance with health care needs is generally outside the mandate of subsistence service providers, yet they are often the principal point of contact for people who are homeless and in poor health.

This study employs qualitative and quantitative methods to answer five research questions that provide context for the policy problem: 1) What are the prominent health conditions that subsistence service agencies often encounter with their clients?; 2) How do subsistence service providers become aware of clients' health problems?; 3) In what ways do subsistence service providers respond to the health care needs of their clients?; 4) What policy alternatives would support subsistence service providers in addressing the health needs of their clients?; and 5) What role and jurisdictional authority is there for the federal government, the provincial government (Vancouver Coastal Health) and regional governmental authorities (City of Vancouver) in supporting subsistence service providers when addressing the health needs of socially marginalized individuals? These research questions were addressed using a mixed method approach. A literature review, survey analysis, case study reviews and informational interviews informed the analysis of the research questions and underlying policy problem.

Recent literature documents an increase in the number of collaborative care initiatives. The growth of these initiatives is attributed to two predominant factors. First is the growing recognition of social determinants of health. Second is the increasing demand and strain on resources. Although constitutional delegation is ill defined it is well established that provincial governments have the primary jurisdictional authority in the provision of health care services.
The Canada Health Act provides criteria for provincial governments to operate with and the federal government provides financial incentives to meet the criteria.

Of survey participants 88% often encounter clients with health problems. The remaining 12% occasionally encounter clients with health conditions. Participants most often become aware of these health conditions from the clients themselves (74%); they also often assess the clients’ appearance or behaviour (53%). There are high rates of referrals to health services, and agencies often adapt their services. Respondent agencies receive funding from the provincial government (61%), Vancouver Coastal Health (44%) and municipal governments (33%).

Case study reviews of three initiatives that aim to meet the health needs of socially marginalized individuals via collaborative approaches provide insight into the overlapping nature of policy and program options. Interviews with representatives from the Ottawa Inner City Health Project Inc. (OICHPI) and the Calgary Urban Project Society (CUPS) revealed administrative data concerning sources of funding (provincial health authorities, non-governmental and fundraising) and key partnerships (ranging from three to 200).

Informational interviews helped to refine four policy alternatives: on-site health professionals, central directory of services, health care navigation support and electronic patient records. The criteria of quality of support, economic, technical and political feasibility were also defined through data collected at interviews. The literature review, survey data, case study reviews and informational interviews assisted in the measurement of the four criteria. These criterions were measured h utilized five point scales tailored to criteria.

All policy options require an increased degree of communication between subsistence service providers and between subsistence services and health professionals. As such, the first recommendation is the establishment of a multi-stakeholder engagement committee. This committee must work to overcome the competitive and fragmented funding environment in which subsistence service agencies are currently forced to operate in and work towards collaboration in caring with prioritized support needs.

Once subsistence service agencies define their needs and address tradeoffs, the implementation of proposed policy alternatives is most feasible on a pilot project basis. Pilot projects are desirable as all alternatives score well in quality of support, and political and technical feasibility, but their economic feasibility is a large concern. The social and health service sectors do not have the additional resources necessary to provide increased support for subsistence service providers. Thus, in the short term pilot projects are necessary in order to assess the effectiveness of alternatives in a cost effectiveness framework. In the long term these
pilot projects can be expanded to a systematic framework that works towards increasing access to health care, recognizing social determinants of health and reducing health status disparities.
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1 Introduction

Poor health is a well-documented phenomenon among various groups of socially marginalized populations. Exposure to weather, nutritional impairments, violence victimization and misuse of drugs contribute to high rates of ill health and chronic disease for people who are homeless (Woodward and Associates, et al. 2002). Furthermore, numerous accessibility barriers to the health care system implies that these marginalized individuals are more likely to access subsistence service providers (shelter and food provision agencies) than have regular contact with traditional medical professionals. Unfortunately, there is little information available regarding the scope of support and services provided by subsistence service agencies when responding to the health needs of their clients.

This study examines the role of subsistence service providers in regards to the health care needs of their clients. The central aim of the policy analysis is to increase the understanding of how these agencies respond to the health issues faced by their clients. This understanding will contribute in the long term by encouraging policy and program changes that increase flexibility, responsiveness and intersectoral care. This will assist in increasing access to health care and reduce current health status disparities.

In order to achieve an informed understanding of the ways that subsistence service providers respond to the health care needs of their clients, the methodology for this study employs a mixed method approach. A literature review, survey data, case study reviews and informational interviews comprise the analytical framework that assists in answering the five key questions that drive this study. The mixed method is preferable due to the intersectoral nature of the policy analysis. The first three questions primarily concern ex-ante policy analysis. These questions seek clarification on potential frames for the policy problem and provide necessary contextual knowledge for the subsequent policy analysis:

1) What are the prominent health conditions that subsistence service agencies often encounter with their clients?

2) How do subsistence service providers become aware of clients' health problems?
3) In what ways do subsistence service providers respond to the health care needs of their clients?

The last two questions, aim to provide insight into courses of action that would reduce the impacts of the policy problem:

4) What policy alternatives would support subsistence service providers in addressing the health needs of their clients?

5) What role and jurisdictional authority is there for the federal government, the provincial government (BC and Vancouver Coastal Health) and regional governmental authorities (City of Vancouver) in supporting subsistence service providers when addressing the health needs of the socially marginalized individuals?

1.1 Policy Problem

As Dunn argues: "a policy problem is an unrealized value or opportunity for improvement which, however identified may be obtained through public action" (2003, p.4). The policy problem in this case aims to achieve improvement via public action targeted to the Vancouver Coastal Health Authority (VCHA). The geographic scope for this study is thus limited to the cities of Vancouver and North Vancouver, which are the central to VCHA service delivery area.

Urban centres are continually documenting increases in the number of socially marginalized individuals. One example of this is documented by the Social Planning and Research Committee of British Columbia (SPARC) which finds a near doubling in homeless individuals in Vancouver between 2002 with 1,121 and 2005 with 2,174. This increase in the number of people who are homeless implies an increase in the number of people who are utilizing agencies targeted to providing services for the homeless. This increased demand on subsistence service providers places a strain on their resources.

This strain on resources is a barrier to service providers when attempting to work outside of their primary service sphere. This strain may also impede their ability to identify and respond to the health needs of their clients. Thus, the policy problem guiding this study is: assistance with health care needs is generally outside of the mandate of subsistence service providers, yet they are often the principal point of contact for people who are homeless and experiencing poor health.
2 Background

The central aim of this study is to better understand how subsistence service providers can respond to the health issues that their clients face. This section defines subsistence service providers, clients of subsistence service providers, health, health inequities, health conditions, variations in health care utilization and jurisdictional responsibility. The section then considers the theory of differentiation and integration as a future possibility for addressing the policy problem.

2.1 Subsistence Service Providers

A list of 109 subsistence service providers within the VCH region has been compiled (Appendix A). These agencies are primarily concerned with providing programs that enable the survival of their clients. Not surprisingly, the largest percentages of agencies contacted provide emergency shelter and/or housing supports. Food banks and meal service providers are the second largest group of subsistence services. A further breakdown of the subsistence service agencies that participated in this study is found in the upcoming survey data section.

For the purpose of this study the terms 'subsistence service providers' and 'homeless assistance providers' are synonymous. A National Survey of Homeless Assistance Providers and Clients was undertaken in the United States in 1995-1996. This survey estimated that there are approximately 40,000 government agencies, non-profit organizations, religious organizations and private individuals that provide subsistence services to people who are homeless. This survey identified that although service providers have learned a tremendous amount in regards to efficient ways of meeting the needs of their clients (via cooperative ventures among agencies providing services, housing options and improved supportive services) there is a lot more to be done in order to reach efficiency goals within and between agencies (Burt, et al., 1999).

2.2 Clients of Subsistence Service Providers

Although a large number of individuals access subsistence service agencies, this study will refer to clients of subsistence service agencies as socially marginalized individuals or the
homeless. This can be attributed to the fact that clients of subsistence services are perceived as being both socially marginalized and often in a state of homelessness. Definitions of homeless encompass two main groups of people. The terms absolute or street homeless comprise the first group (Creative Resistance, 1999:17; Goldberg et al., 2005, p. 9-10). These people live without any physical shelter, often on the street, in parks, in parkades or doorways. Individuals identified as being in a state of absolute homelessness can have trouble accessing emergency shelter services. Barriers to emergency shelter services can include behavioural concerns, drug use, ownership of pets and mobility limitations. Nonetheless, people in a state of absolute homelessness are still inferred to be frequent users of subsistence services and thus are clients of survey participants.

The terms relative and/or sheltered homeless are applicable to the second group of people who are considered to be homeless (Creative Resistance, 1999:21; Goldberg et al., 2005, p. 9-10). This group of people live in physical environments that do not meet basic health and safety standards. Often people from this group rely on emergency shelters for accommodation. Other people from this group live in single room occupancy (SRO) buildings or are classified as 'couch surfers' (2005, p.9). People in this state of relative homelessness are also inferred to be frequent users of the various types of subsistence services.

The two main groups denoted by the term homeless are not homogeneous groups. The diversity within the homeless population is widespread and can include people from all classes of society. Nevertheless, because people who are absolute homeless and relative homeless all utilize subsistence services, this study will refer to them as one group. People who are homeless, the homeless, homeless individuals, socially marginalized individuals and clients of subsistence services are all terms used interchangeably in this study.

2.3 Health

Health is defined as, “a dynamic state of complete physical, mental, spiritual and social well-being and not merely the absence of disease or infirmity” (WHO, 1998). This internationally recognized definition of health alludes to the importance of a holistic and intersectoral approach to health care. Furthermore, when connecting this definition of health to the state of people who are socially marginalized, it is clear that social marginalization translates to poor health. This state of poor health for the socially marginalized is contrary to the term “health for all,” made popular by the advent of the Ottawa Charter in 1986. The Ottawa Charter established “fundamental conditions and resources” for health, which include peace, shelter, education, food, income, a stable eco-system, sustainable resources, social justice, and equity (WHO 1986, p. 1).
Prerequisites for health are now known as social determinants of health (SDoH) or non-medical determinants of health.

"The social conditions in which people live powerfully influence their chances to be healthy. Indeed, factors such as poverty, food insecurity, social exclusion and discrimination, poor housing, unhealthy early childhood conditions and low occupational status are important determinants of most disease, death and health inequities between and within countries. To improve health for the world’s most vulnerable populations and promote health equity requires new strategies for action which take into account these social determinants of health" (WHO, 2004, p.1).

SDoH are interconnected and it can be difficult to isolate individual effects. Policy makers are gradually realizing that the impact of SDoH revolves around the quantity and quality of resources that are available within societies. Thus, policy approaches to address SDoH are increasingly located outside of the traditional health sphere and include income, housing, food, employment, education and programs aimed at reducing social exclusion (Raphael, 2004). The increasing evidence base regarding SDoH and the international recognition of prerequisites for health has furthered the push towards a holistic intersectoral approach to health care.

A report released by the Canadian Public Health Association one decade ago demanded action:

A major challenge for the public health community and government will be to broaden the parameters of the health policy debate to include economic and social issues. The knowledge base for development and implementation of social and economic policies that could have a positive impact on reducing health inequities is in place. The next step will be to develop innovative policy tools that can translate this knowledge into action. 1997, ¶ 23

In partial response to this challenge, the WHO has created a Commission on Social Determinants of Health (2005). The three-year goal of the Commission is to influence policy change via the compilation of evidence, increased public debate and the proposition of both global and national action-orientated policies. National organizations that address health inequities within Canada strengthen Canada’s involvement in this Commission. These organizations include Canadian Reference Group on Social Determinants of Health, National Collaborating Centre for Determinants of Health and the newly established Centre for Determinants of Health at St. Francis Xavier University.
2.3.1 Health Inequities

Extensive research has documented the numerous health inequities in society. Commonsense and intuition alone generally suggest that people who are homeless will have lower health status than people from higher income levels. An understanding of the SDoH approach further reveals the precarious state of health that affects many people who are socially marginalized. The following sections provide a brief review of the literature concerning this population’s health disparities.

Mental health is often the primary health concern for homeless individuals, but evidence is increasingly identifying high rates of diabetes, seizures, arthritis/rheumatism, epilepsy, skin and foot problems, tuberculosis, HIV, Hepatitis C, chronic obstructive pulmonary disease, musculoskeletal disorders, heart attack, respiratory tract infections, anaemia, hypertension, sexual and reproductive health issues, violence and unintentional injuries (Hay et al., 2006). Other studies have documented rates of alcoholism that are six to seven times higher (Springer et al., 1998). Wright et al. (1998) report that up to 40% of the homeless have chronic conditions, which is approximately two to four times higher than the general population. Tuberculosis is reported at levels 10 times higher for the homeless (Yuan et al., 1997).

The Greater Vancouver Regional District Homeless count in 2005 documented that 74% of respondents self reported at least one health condition (Goldberg, et al., 2005). Data presented in the survey section further demonstrates the grim reality of the local context. Hay et al. posit, "it is beyond obvious to say that the homeless population in particular is in a state of precarious health" (2006, p. 20).

This increased burden of disease leads to the inference that people who are homeless will also incur disproportionate medical services. Duatovich (1998) has found that the average hospital stay for people who are homeless is 15 days as opposed to nine days for their housed counterparts. Accessibility barriers that delay treatment and thus worsen the presenting condition are viewed as being a central contributing factor to this research finding. Other studies have found that patients who are homeless stay 4.1 days longer (46%) than other patients (Salit et al., 1998). More striking is the finding that patients hospitalized for psychiatric conditions stay approximately 14 days, while psychiatric homeless patients are admitted for approximately 84 days (Salit et al.). The health conditions in this population are thus not only inequitable; they also impose a disproportionate cost on the health care system.
2.4 Jurisdictional Responsibility

The Canada Health Act (CHA) is essentially the beginning of legislated provision of health care. The CHA contains five principles for health care in Canada. The principles of accessibility, portability, comprehensiveness, public administration and universality aim to ensure that citizens of Canada are treated for medically necessary services based on need rather than ability to pay. The provinces are in charge of the provision of health services, but the federal government ensures that the five criteria in the CHA are met by providing financial incentives. One important caveat in the provision of healthcare is that it is not constitutionally protected. Health care was not included in the British North America Act, and the CHA does not guarantee access to health care.

Regardless of legislated authority, the responsibility to provide social and health services is shared by federal, provincial and municipal levels. This is demonstrated in the survey and case study section, which shows that respondents receive funding from all levels of government. The convoluted jurisdictional authority and responsibility creates complications for policy and program development. Two main concerns are the competitive and fragmented funding environment and the goals, objectives and priorities may differ among levels of government. The following sections provide a brief overview each level’s current approach to supporting subsistence service providers when responding to the health needs of the homeless population.

2.4.1 Role of Federal Government

The federal government plays a variety of roles in the provision of health care for socially marginalized individuals. This is partly attributed to the population health approach, social determinants of health and the Health Impact Assessment. The concept of population health was redefined by the Canadian Institute of Advanced Research in 1989. This concept furthered the ideals behind the Ottawa Charter and posited that individual determinants of health are complex and it is thus difficult to isolate individual effects. The Government of Canada endorsed this concept in 1994. The government proceeded to propose a population health framework, which emphasized the importance of an intersectoral approach to health (Federal, Provincial and Territorial Advisory Committee on Population Health, 1994). Strategic directions adopted from the report included reducing health status disparities, supporting population health approach among government partners outside of the health sector and developing comprehensive intersectoral population health initiatives (1994).
In 2004, a ten-year plan to strengthen health care via a collaborative process that included provincial and federal governments was developed. Although the focus of this plan was an infusion of federal money transfers to the provinces, other priority areas were identified. One area is “prevention, promotion and public health” (Health Canada, 2004, ¶31). This area includes a commitment from provincial and federal governments to increase collaboration and cooperation in the development of a coordinated response to public health needs (Health Canada).

In 1999, the National Homeless Initiative (NHI) was founded in response to the growing crisis of homelessness. An extension from its initial pilot project phase was granted in 2002 for an additional three years. One component of the NHI is the Supporting Communities Partnership Initiative (SCPI), which funds community services and supports the development of partnerships and collaboration between stakeholders in order to increase access to supports and services (Government of Canada, 2003, ¶2).

The continuing recognition of SDoH by the federal government is further demonstrated by its commitment to the Health Impact Assessment (HIA). The HIA was developed in response to shortcomings of the Environmental Impact Assessment (EIA). Although mandatory EIA legislation currently exists at both a federal and provincial level some critics argue that it does not give due consideration to the various impacts of SDoH. Thus, the HIA is a tool initiated by the federal government in 1995 that may be used to supplement the EIA and assist policy-makers when projecting the intended and unintended consequences of a proposed policy on health (Lurie, 2002, p.95). The importance of the HIA in federal policy development should not be overlooked. This study further demonstrates the need a holistic intersectoral approach to health care services and policy development.

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Lurie (2002) has examined the role of the federal government in addressing the non-medical determinants of health. In the absence of a comprehensive systemic approach, she recommends eight items for immediate action: “(1) Provide leadership and education; (2) develop a surgeon general’s report on non-medical determinants of health; (3) develop standing mechanisms for policy development among sectors; (4) promote collaboration among departments; (5) enhance monitoring and reporting; (6) strengthen the science base; (7) leverage government as an employer; and (8) expand the scope of health policy.” p.96

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2.4.2 Role of British Columbia

The government of British Columbia has documented its findings and commitment to end the homelessness crisis in a four volume set of research reports entitled, *Homelessness — Its Causes and Effects* (2001). This was produced by the office of Housing and Construction
Standards and includes a backgrounder, a literature review, a policy review and an economic document outlining the costs of homelessness.

British Columbia’s approach to tackling homelessness is almost exclusively geared towards implementing affordable housing strategies. This is further demonstrated by an agreement, signed in December of 2004, that aims to “provide a continuum of affordable housing with support services to those who are homeless or at risk of homelessness, people with mental illnesses and physical disabilities, those with drug and alcohol addictions, Aboriginal peoples, youth, and women with children fleeing abusive relationships” (Office of the Premier, 2004, ¶3). Although housing is critical to health, there should be recognition to other social determinants of health and the provision of low-threshold services for people who are homeless. This is of increased importance for this population due to the numerous barriers that prevent housing for all. Low-threshold services mentioned in the agreement did not include health or recognition of many of the social determinants of health.

Housing is a paramount solution to homelessness and its primacy should not be undermined. Thus the affordable housing focus should viewed in a positive manner as the province is committed to tackling the root causes of homelessness, but it is still contrary to the stance of the federal government. The lack of recognition of health disparities confronting people who are homeless is a serious omission. The provincial government needs to renew its approach to policies targeted at reducing the impact of homelessness and consider intersectoral and health care initiatives. This is of increased importance as provincial governments have primary jurisdiction for the provision of health care services.

One benefit of this focus on housing policy has been the success of the Task Force on Homelessness. At the 2004 Union of British Columbia Municipalities conference, a task force on homelessness, mental illness and addictions was created. This task force is mandated to develop strategies that target people with mental illness and addiction in the movement from shelters to long term housing. This task force has since created 533 new supported housing and shelter spaces and increased the funding towards the emergency shelter program by 40% (Office of Housing and Construction Standards, ND, ¶4).

The primacy of housing first is a warranted advocacy stance for this particular task force on homelessness. Nonetheless, the importance of low-threshold services should not be ignored. To increase support for subsistence service providers, there needs to be coordinated efforts to broaden awareness in regards to the multiple dimensions of the problems associated with homelessness.
2.4.3 **Role of the City of Vancouver**

The added imperative of the upcoming Winter Olympics might be the jumpstart that Vancouver needs to adequately address the problem of homelessness. Eby et al. posit, "if no new low-cost housing is built and the current stock of low cost housing continues to close and deteriorate at its present rate, visitors to Vancouver in 2010 will see nearly three times as many homeless people living on the streets" (2006, p. 4). Although municipal governments have not traditionally been involved in the provision of social and health services, there is a unique opportunity for local governments to monitor the quality of life of its citizens (Gates, 2004). The relatively micro nature of municipal governments increases the ability to perform needs assessments at the community level. These needs assessments can be used as an agrumentative and advocative tool in the facilitation of collaboration between other levels of government in the development of an appropriate response to finding support for subsistence service agencies.

The Vancouver Agreement was reached in March 2000 and was recently renewed in March 2005 for an additional five years. This agreement has been recognized by the Institute of Public Administration and received a Public Service Award from the United Nations in June 2005. This agreement is stated to increase responsiveness and transform the current fragmented service environment into an intergrated approach that emphasizes collaboration. This agreement specifically targets the Downtown Eastside and commits federal, provincial and municipal governments to three central goals of community health and safety, community capacity building and economic and social development (Service Canada, 2000).

The Greater Vancouver Regional Steering Committee on Homelessness was formed in 2000. This committee has over 40 members comprised of service providers, all levels of government and community-based organization representatives. In partnership with the Greater Vancouver Regional District and the United Way of the Lower Mainland, the Steering Committee developed a strategic plan to end homelessness in 2000. This plan has resulted in over $50 million of federal funding from the Supporting Communities in Partnerships Initiative being devolved to local agencies (Greater Vancouver Regional District, 2004).

An updated Homeless Action Plan was approved in May of 2005 by the City of Vancouver and identifies the need to address health inequalities within the homeless population as a priority. Although this plan acknowledges that the jurisdiction and financial resources necessary to address the underlying causes of homelessness are located at the provincial and federal level, it continues to assert that the city does have an important role in facilitating collaboration with stakeholders (Davidson, 2005). Further assistance can also be provided by the
City of Vancouver via its annual grants programs, among other funding and procurement mechanisms.

2.4.4 Role of Vancouver Coastal Health Authority

Health authorities in British Columbia work together with the Ministry of Health in the provision of health services. The creation of Vancouver Coastal Health (VCH) in 2001 was a result of the amalgamation of the 52 previous health authorities. This merger created five regional health authorities that aim to increase effectiveness of service delivery and coordination with "regions large enough to recruit and retain health professionals and achieve economies of scale" (Ministry of Health, 2006 §3).

Approximately 1 million or 25% of the population of British Columbia receives services from VCH. The vision adopted by VCH of "we are committed to supporting healthy lives in healthy communities with our partners through care, education and research" is indicative of its progressive commitment to an intersectoral population health service-delivery model. This commitment is articulated in the Health Services Redesign Plan (VCH, 2005, p. 2).

The recommendations in this study are targeted towards VCH, as it is a local representative of the BC Ministry of Health. The location of this policy problem within the boundaries of the VCH area provides a unique opportunity for subsequent knowledge transfer and potentially actionable pilot project initiatives. The increased prospect for knowledge transfer activities is supported by VCH’s urban area, research capacity, large operating budget and progressive commitment to addressing community health needs.

Frankish et al. (2007) have posited that "A major focus of health care reform in Canada has been the regionalization of health services administration. In the 1990s, 9 out of 10 provinces in Canada regionalized the management and provision of health services. As such, health regions are a core organizing structure for most health service delivery in Canada" (p. 2). This realization has lead to an examination of the role of regional health authorities (RHA) in Canada when addressing non-medical determinants of health and in turn promoting intersectoral action. Nonetheless this role remains constrained by the recognition that, "many RHAs are large enough to influence the full range of determinants of health, meaningful positive change in population health outcomes requires intersectoral collaboration between the health sector and other sectors of government and Canadian society" (2007, p. 2).

2.5 Future Directions

If effective policies that support subsistence service providers when responding to the health needs of their patients are not identified, implemented and maintained, it is very unlikely
that the problem will resolve itself. If no action is taken, the policy problem is likely to worsen. The problem is at an increased risk of becoming worse due to the growing number of people who are homeless, escalating strain on subsistence services, increasing strain on health services and the amount of private funds spent on health care (CIHI, 2006). The move towards support for subsistence service providers in the form of integration of increased health services for their clients will likely mitigate some of the current health status disparities found within the homeless population. An examination of the differentiation and integration theory aptly characterizes this move.

2.5.1 From Differentiation to Integration

The differentiation and integration theory as proposed by Lawrence and Lorsch (1967) is a variant on contingency theory and helps illustrate the continual specialization of services and the need to integrate across service areas. Differentiation is the process by which organizations adapt to immediate needs. Integration is the process whereby organizations increase communication and collaborative structures. Within this theory the process of integration is essential to ensure viability within and between organizations. Public health is an excellent example of an inter-organizational structure with high differentiation that also requires high amounts of integration (Axelsson and Axelsson, 2006).

Although this theory was initially targeted towards intra-organizational relationships, a renewed look by Ketokivi et al. has acknowledged the vital contribution that it can make in pursuit of inter-organizational relationships (2006). The identification of factors associated with failed or lack of integration is relevant when brainstorming and measuring policy alternatives that aim to increase integration. Communication difficulties, deficiencies in cooperation and the pursuit of subordinate goals are factors associated with lack of integration (Lawrence and Lorsch, 1967). Furthermore, the concept of requisite integration is important to remember in the analysis process. Requisite integration asserts that the optimal degree of integration varies and argues that, instead of aiming for high integration, organizations should be wary of the requirements of their operating environments (2006).
3 Literature Review

3.1 Urban Homelessness and Health Care Accessibility

The undeniable relationship between homelessness and health was affirmed on the local level in 2005 with the Greater Vancouver Regional Homelessness Count (Goldberg, et al.) which found 74% of respondents had at least one self-reported health condition (p.7). Data from survey analysis that will be discussed in the upcoming section provides further support for the severity of this relationship within the local context. Hay et al. observe that: "marginalized inner city populations often have severe and complex health issues" (2006, p. 20).

The health concerns for homeless populations are further exacerbated by numerous accessibility barriers to the mainstream health care system (Woodward and Associates, et al., 2002). Literature on homelessness generally concludes that health services are best provided at the site of contact, mobile services can also be useful and that care should be respectful of a person’s right to refuse services (Woodward and Associates, et al., 2002; and Goldberg, et al., 2005). Furthermore, accessibility barriers such as traditional operational hours, appointment procedures and transportation need to be eliminated (Ministry of Health Services, 2004; Hay et al., 2006).

3.2 Strategies to Increase Accessibility

A large body of evidence finds that both collaborative mental health care (Pautler and Gagne, 2005; Kates, 2002; Druss, 2002; Holleman et al., 2004; Pawlenko, 2005) and intersectoral health care are growing trends (Lloyd, J. and Wait, 2005; Frankish, J., Hwang, and Quantz, 2005; van Hertern, et al., 2001). The move toward integrated care stems from both recognition of inequities in health status and access to the traditional health care system (Hay, et al., 2006) and the global push towards integrated models of care (WHO, 2003). This push toward collaborative care is timely for this study as one shortfall of previous literature is the lack of initiatives and/or data in regards to socially marginalized populations and health care services (Pauze, et al., 2005).

This relatively small evidence base is currently expanding due to ongoing recognition of successful collaborative and/or integrative care initiatives targeted to vulnerable populations.
These initiatives are increasingly approached on a pilot project basis which provides comprehensive program evaluations. These program evaluations provide further support for the effectiveness of collaborative care and thus add to the evidence base. Masotti et al. (2006) implemented one such pilot project that asked, “is it time for more collaborative relationships between providers?” (p.1). Results from a literature review and evaluation of the pilot project conclude that the answer should be “yes.” The pilot project increased collaboration among homecare agencies, acute care hospitals and physicians. This study found that effective service delivery modality varied with client characteristics, and thus an integration of service outlets was beneficial.

3.2.1 Integration of Health and Social Services

Although previous literature documents a shortage of research and evidence, the call for increased integration of health services for marginalized populations including the homeless is not a new phenomenon. Campos-Outcalt et al. (1994) stated, “three barriers to health care are shared by all vulnerable populations: inaccessibility of care, fragmentation of care, and cultural insensitivity on the part of care providers. In fact, the ability of vulnerable populations to access culturally competent care will in great measure depend on our collective ability to develop integrated, coordinated systems of health and human services” (73). This is supported by a further recognition that the fragmentation of the current health care service delivery model is potentially the most costly and ineffective element of the health care system (1994).

Avenues to address the lack of coordination will need to entail an increase in collaboration both within and between sectors. This horizontal and vertical integration will support the development of an integrated community health care system (Campos-Outcalt et al., 1994). The viability of this integration is dependent upon a shift in envisioning of the nature of service delivery. Furthermore, active policies that provide financial incentives and necessary remuneration for change in practice and organizational structure are necessary in order to ease implementation efforts (1994). Mann (2005) suggests that increased integration will enhance health care system delivery and ensure seamless care. Two techniques to achieve seamless care are increased information sharing systems and a pooling of some funding (Mann).

3.2.1.1 Characteristics of Successful Integration

Studies have begun to examine collaborative care initiatives in order to identify characteristics that influence success. Pautler and Gagne (2005) suggest four characteristics for
success: consumer centredness, accessibility, richness of collaboration and collaborative structures. They posit that there is also a need for adaptation of treatment interventions to reflect the unique needs and cultural experiences of each person accessing services.

3.2.1.2 Characteristics of Failed Integration

In addition to examining successful practice, previous literature is beginning to identify characteristics that are associated with failure. Perhaps most relevant to the target population in this study is the continued reliance on competition for funding services. Plochg et al. (2006) have raised critical questions regarding the sustainability of collaborating while competing. Plochg et al. state that in environments where there is ongoing competition for funding, the primary incentive is to maintain viability via the realization of organizational goals as opposed to taking cooperative action that targets health. Thus, few organizations will likely join collaborative programs that aim to improve health due to limited resources. There is a need for active policies that create incentives for participation. This is consistent with the previously mentioned differentiation and integration theory finding that posits the pursuit of sub-goals (such as funding) will negatively affect attempts to integrate.
4 Methodology

4.1 Study Population and Design

Very little research has examined the role of subsistence service providers in addressing the health needs of their clients. This creates an opportunity to develop appropriate methodology for this research, but it also means that the methodological design for this study has largely been unaided by previous literature. A mixed method approach of survey data, case study reviews and interviews informs the analytical framework for this study. This quantitative and qualitative design supports the development of an inclusive explanation of the ways in which subsistence service providers respond to the health needs of their clients, policy alternatives available to support subsistence service providers and the potential role of the various jurisdictional authorities in assisting subsistent services. The intersectoral nature and the large number of stakeholders associated with the policy problem further necessitated the requirement for a mixed method approach.

Beginning in September, 2006, biweekly informational interviews with community professionals informed the development of the methodological design for this study. This engagement of community professionals from the beginning is a central part of the methodology for three reasons. First, they provide valuable practice knowledge that is not captured by traditional literature reviews. Second, the feasibility of various policy options is a key determinant of their success. Individuals in the community who have the ability to make a policy successful by putting it into practice can best judge this feasibility. Third, it assists in the creation of a personal network that will be crucial in the final knowledge transfer of the study. This also supports the creation of a buy-in from community professionals.

Survey data was the deciding factor in the selection of geographic area and targeted jurisdictional authorities. The use of primary data within the Vancouver and North Vancouver region confines the study to the City of Vancouver, the City of North Vancouver, Vancouver Coastal Health Authority and the Province of British Columbia. To capture the unique social welfare history and experience within British Columbia, it was desirable to limit case studies to Canadian examples.
4.1.1 Survey

A group of Partnering in Community Health Research (PCHR) participants in the Community Health Services research cluster designed the survey in the spring of 2006. The task for the current (fall 2006) PCHR group is to analyze survey data, discover areas of further interest that will be addressed in subsequent focus groups and/or interviews, identify possible policy implications and potential avenues for knowledge transfer activities. This study is one component of this analysis, as a central aim of the PCHR training program is to increase linkages between practice, research and policy.

The sample population for this survey was subsistence service providers within the Vancouver and North Vancouver region. This region is located within the jurisdictional authority of Vancouver Coastal Health. There was an intentional inclusion of VCH jurisdictional authority as approximately one-half of the researchers working in the Community Health Service Cluster of PCHR are professionally connected to and/or employed by VCH.

A list of 109 subsistence service providers within the Vancouver and North Vancouver area from the Red Book of services (list of community, social and government agencies in Vancouver) and the Green Book (list of community, social and government agencies in North Vancouver) was identified. Exclusion criteria that informed the compilation of the list were agencies mandated to provide health care, agencies targeting youth services and agencies operated by VCH or the province. This list is attached as Appendix A.

Researchers telephoned the list of survey participants to confirm mailing address and identify an appropriate contact person to send the survey to. The initial survey was then administered via mail delivery to 106 of the 109 identified agencies. After four to six weeks reminder phone calls were made to non-respondents. In total 49 surveys were completed for an overall response rate of 46%.

The survey aimed to determine to what extent subsistence service agencies encountered clients with health concerns and how they addressed these concerns. The survey also identified how the agencies become aware of clients' health problems and documented practice knowledge in regards to perceived barriers to health care services. Opportunity for in-depth qualitative responses from survey participants aimed to elicit opinions about desirable support mechanisms when responding to the health needs of their clients.

The survey was ten pages and included a cover letter, an explanatory letter and seven sections with a total of 27 questions. The first section, on programs and services, identifies logistics of respondent agencies (provided services, primary service, funding agencies and reliance on volunteerism); it also contains questions on how often their agencies encounter clients...
with health concerns and how they become aware of the concerns. What health conditions and symptoms and how frequently they are encountered is the second section. The third section addresses how the respondent agencies provide health support. How frequently various barriers to health services for their clients are covered in the fourth section. Section five documents the usefulness of potential resources for subsistence service agencies. The last two sections provide an opportunity for additional feedback and participant information. The survey is attached as Appendix C.

4.1.2 Case Studies

To examine the potential feasibility of the four policy alternatives and subsequent recommendations provided in this study, three case studies were selected. The review of case studies advances understanding of policy instruments used in other Canadian jurisdictions that aim to increase collaboration between subsistence service agencies and traditional health care providers. This increased understanding will complement evidence provided in the literature review of program factors associated with successful policy initiatives. Thus, qualitative analysis of case studies aims to uncover the impact of relevant variables such as agency size, services offered, mandate and vision of agency, reliance on volunteer staff, reliability of funding source, length of time since the establishment of the agency and hours of operation.

In order to guard against confirmation bias, the Canadian case studies were not chosen via recommendation or popularity within the field. Instead, case studies were selected from a directory of programs aimed at reducing homelessness. This web directory is operated and maintained by Shared Learnings on Homelessness and was first accessed on November 22, 2006. This project is sponsored by Raising the Roof and co-funded by Direct Energy and the Royal Bank Foundation.

Selection criteria included: programs that involved collaboration and/or partnerships across the health and social service sector; programs that offered health, food and/or housing supports; and programs that are currently in operation. After an initial scan of the 63 initiative profiles available on the directory, six potential case studies were selected. After further investigation, one of the cases located in Montréal contained much information presented in the French language and was eliminated. The other two possible case studies were primarily weighted towards one service such as housing and/or health. As a central goal of case studies was to provide examples of intersectoral care initiatives rather than programs traditionally mandated to provide subsistence services, these two cases were eliminated.
The Ottawa Inner City Health Project (OICHPI), the Calgary Urban Project Society (CUPS) and the Babishkhan program located in Toronto all contain variables that sufficiently demonstrate the diversity of approaches employed by subsistence agencies to respond to the health care needs of people who are homeless. Coincidentally, these agencies also provide a quasi representative sample, as CUPS is denominational, OICHPI is non-denominational and Babishkhan targets First Nations. The three case studies encompass a combination of the four policy alternatives that are presented in this study, which include a co-location of services, a central directory of services, navigation support workers and an electronic patient record. The process tracing of case studies provides a greater understanding of the historical timeline, where significant steps towards the development and maintenance of desired policy are referenced to academic literature.

<table>
<thead>
<tr>
<th>Table 1: Summary of Case Study Context</th>
</tr>
</thead>
<tbody>
<tr>
<td>OICHPI</td>
</tr>
<tr>
<td>City Size</td>
</tr>
<tr>
<td>Approximate Homeless Count</td>
</tr>
<tr>
<td>Number of Subsistence Services**</td>
</tr>
<tr>
<td>Provincial Government Approach to Health Policy</td>
</tr>
</tbody>
</table>

*Ottawa did not conduct a comprehensive homeless count; thus the best conservative estimation of the number of people who are homeless in Ottawa is provided by the Alliance to End Homelessness. However, this number does not take into account people on the street.

**Number of services is taken from the Shared Learnings on Homelessness directory of organizations.
4.1.3 Interviews

When feasible the interviews were conducted in person. However, pragmatic concerns related to the proximity of people well informed in regards to case studies required that some interviews be conducted via phone or email. All interviews were semi-structured in order to ensure opportunity for respondents to interject personal and practice knowledge.

The first objective of informational interviews was to gain contextual understanding of the field of service provision, develop an appropriate methodology and gain insight into survey results. These interviews took the form of semi-structured meetings. A group of Partnering in Community Health Research participants met on a bi-weekly basis from September 11, 2006 until February 15, 2006. These meetings were one and a half hour long and focused on discussion of survey results, community engagement and potentially actionable pilot projects.

The second objective of interviews was to gain further insight into case studies. Analysis of available public data enabled the development of questions for the semi-structured interviews. Representatives from all three case studies volunteered to participate in interviews conducted via email. The inclusion of open ended questions afforded the opportunity to obtain further clarification regarding the relevant dimensions of program and personal practice knowledge.

The third objective of the interviews was to reality test the policy alternatives and recommendations. The viability, ease of implementation, longevity, technical and political feasibility of alternatives is dependent on the reaction of field professionals. Thus, predetermined interview questions were developed by examination of the literature review, survey results, case studies and policy analysis. Five people agreed to participate in in-person interviews. One employee of VCH, one professor from the University of British Columbia, one professor from Simon Fraser University and two community representatives. The interviews ranged from 30 minutes to two hours.
5 Survey Results

5.1 Objective

The primary objective of the survey was to identify opportunities for VCH to facilitate collaboration when meeting the health needs of socially marginalized individuals. Information regarding profiles of the respondent agencies clientele was collected and is helpful when conceptualizing policy options. In addition, the survey provided insight in regards to the first three research questions addressed in this study.

5.2 Sample Characteristics

Although exclusion criteria for survey participants included agencies operated by VCHA, the Authority remained a significant financial contributor to respondents, as shown in Figure 1.

Figure 1: Source of Funding and/or Space

<table>
<thead>
<tr>
<th>Source</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provincial</td>
<td>63%</td>
</tr>
<tr>
<td>VCH</td>
<td>43.50%</td>
</tr>
<tr>
<td>Municipal</td>
<td>32.60%</td>
</tr>
<tr>
<td>Not for profit</td>
<td>32.60%</td>
</tr>
<tr>
<td>Other</td>
<td>32.60%</td>
</tr>
<tr>
<td>Federal</td>
<td>23.90%</td>
</tr>
<tr>
<td>Private</td>
<td>19.60%</td>
</tr>
<tr>
<td>NGO</td>
<td>13%</td>
</tr>
</tbody>
</table>
As seen in Figure 2, the range of services currently provided by agencies versus their primary services vary significantly. At the time of the survey, three of the top general services provided by the respondents were on-site meal service, emergency shelter and women's services. Yet the top three primary services were emergency shelter, supported/supportive housing and addiction services. For example, 70% of agencies provided on-site meal service, but only 6% identified it as their primary service. Figure 2 also illustrates that even though agencies that were primarily concerned with health service provision were deliberately excluded, 14 respondents indicated that they provide health services and three respondents viewed it as being their primary service. This wide range of services offered provides contextual understanding to the previously noted pressure on subsistence service providers to work outside of their primary service area. This pressure is inferred to further exacerbate the policy problem.
Figure 2: Primary Service versus Services Provided
5.3 Health Conditions and Symptoms

A striking 88% of respondents often encountered clients with health problems. Table 2 further illustrates this as the remaining 12% occasionally encountered clients with health conditions and 0% of respondents rarely, never or did not know.

Table 2: Encounter Clients with Health Problems

<table>
<thead>
<tr>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Occasionally</td>
<td>6</td>
</tr>
<tr>
<td>Often</td>
<td>43</td>
</tr>
<tr>
<td>Never</td>
<td>0</td>
</tr>
</tbody>
</table>

The principal way that respondent agencies became aware of clients' health problems was from the clients themselves. Table 3 shows that 74% of respondents are informed of health conditions by the clients. This is followed by 53% who often assess clients' appearance or behaviour for noticeable health conditions.

Table 3: Awareness of Health Conditions

<table>
<thead>
<tr>
<th></th>
<th>Never</th>
<th>Rarely</th>
<th>Sometimes</th>
<th>Often</th>
</tr>
</thead>
<tbody>
<tr>
<td>Client Tells Me</td>
<td>0%</td>
<td>2%</td>
<td>24%</td>
<td>73%</td>
</tr>
<tr>
<td>Colleague Tells Me</td>
<td>0%</td>
<td>12%</td>
<td>53%</td>
<td>24%</td>
</tr>
<tr>
<td>Clients File</td>
<td>20%</td>
<td>18%</td>
<td>18%</td>
<td>29%</td>
</tr>
<tr>
<td>Shift Log Book</td>
<td>18%</td>
<td>16%</td>
<td>24%</td>
<td>20%</td>
</tr>
<tr>
<td>Clients Appearance/Behaviour</td>
<td>0%</td>
<td>6%</td>
<td>39%</td>
<td>53%</td>
</tr>
<tr>
<td>Other Clients Tell Me</td>
<td>6%</td>
<td>29%</td>
<td>45%</td>
<td>14%</td>
</tr>
<tr>
<td>Other</td>
<td>2%</td>
<td>0%</td>
<td>6%</td>
<td>10%</td>
</tr>
</tbody>
</table>

5.4 Health Support

Two predominant responses to clients' healthcare needs are the adaptation of services and the referral to healthcare professionals. Cross-tab calculations show that agencies will adapt their services to meet clients' health problems much more readily if the agency provides that service.
For example, agencies providing meal services will provide modified diet or meal for their clients and agencies providing health services will assist clients with their medications.

About one-half of the agencies refer their clients often to the following four health services: addiction services, mental health team, walk-in medical clinics and community health centres. Figure 3 displays the percentage of referrals often completed by respondents.

Figure 3: Often Referrals to Health Services

5.5 Barriers to Health Services

In order to conceptualize policy alternatives that would assist subsistence service providers when trying to increase access to health care service, an understanding of the context is necessary. Figure 4 displays the percentages of respondents who frequently encounter the listed barriers. Nearly two-thirds (65%) of respondents indicated that the clients they encounter often
or always do not have a GP or regular doctor and lack transportation to health services. Issues related to housing (for example, unsafe housing, no fixed home address, and housing policies) are also significant barriers.

Figure 4: Frequently Identified Barriers

5.6 Strategies to Improve Clients’ Health

When asked about the usefulness of various strategies to improve the health of their clients, a large proportion of respondent agencies ranked a variety of simple brochures as very useful. Table 4 ranks the usefulness of brochures from very useful to not very useful.
On-site services for clients were also ranked as very useful. Lifeskill training, visiting dentists for check-ups, addiction support groups, harm reduction and mental health support groups were ranked most often as being very useful. Table 5 ranks on-site services in hierarchical order.
5.7 Qualitative Responses

One question posed to respondents was “what interagency or program relationships would you like to strengthen?” Of participants, 74% of them responded health, mental health, addiction and/or counselling services. One respondent stated, “more appropriate emergency/semi-emergency health services could really be more efficient/cost effective/respectful”. This understanding that health services provided by or with subsistent service providers would be both more cost-effective and more client-centred and is consistent with findings from the literature base.

One respondent stated, “better sharing of information between institutes (--, --), community services (--, --) and contracted agencies (-- and --) to avoid repetition and duplication of services.” This links findings from the literature and is consistent with the policy options of creating a central directory and an electronic patient care system.

Another respondent noted, “The -- -- has so many groups with common goals who have evolved individually. Only now are we starting to realize how the services we provide can complement each other’s efforts. Collectively all the agencies can be very effective in the community. I think it is something we are moving towards at this time”. This is consistent with differentiation and integration theory. This also corresponds to recent literature that finds the swing from silos to seamless care can increase the capacity of the health care system without additional financial resources.

Another identified link is between “funder and program.” The establishment of this link would be beneficial for agencies’ goals and strategic planning. The literature identifies that the environment of financial uncertainty for many social services results in the pursuit of narrowly defined goals with clearly identifiable deliverables. If the relationship between funder and agency were expanded, it might allow increased flexibility and collaboration in caring. Another respondent characterizes this link as, “between governmental services and non-profits, between non-profits in general.”

Other respondents noted that interagency partnerships were already in existence. For example one participant stated, “we work with -- -- and it’s great. I would love to see onsite baby clinics return.” Another participant noted, “a lot of agencies do work together to strengthen relationships/programs. Would like to strengthen more health services (i.e.: foot care, basics GP care and dental) with housing, shelter, detox and food.” These recognitions of successful partnerships support the policy options and subsequent recommendations proposed in this analysis.
6 Case Studies

This case study review section briefly illustrates how the programs and services offered by the case studies overlap with policy options presented for analysis in this study. Process tracing of case studies will include an emphasis on linking potentially influential factors within individual cases to theory. The information presented in the OICHPI and CUPS reviews has been clarified via email interviews with agency representatives. The information regarding the Babishkhan case study has limited reliability as it is exclusively internet based. A representative did initially agree to a phone and/or email interview but did not respond to further contact past December, 2006.

6.1 Ottawa Inner City Health Project Inc.

The Ottawa Inner City Health Project, Inc. (OIHCP) was established in 2001. However, the bottom-up approach to this program’s development entailed a visioning of the project that dates back to 1998. This bottom-up approach is consistent with enhanced success within the literature base (Pautler and Gagne, 2005; van Hertern, et al., 2001).

In 1998, a group of managers who ran services for people who are homeless met and reached a consensus that many chronically homeless individuals had unmet health needs. Although some of these people who are homeless frequently utilized health services, a combination of their complex health concerns, addictions, mental illness and challenging behaviour resulted in a failure of the system to adequately address their needs. This group thus prioritized a need to provide services to people who are homeless on an equal basis to their housed peers. This need was combined with an advocacy role that promoted the rights of the homeless to access mainstream services and was balanced by a desire to prevent unnecessary use of resources.

In 1999, the City of Ottawa developed its first action plan to end homelessness. This plan identified the need for increased capacity for community resources to provide necessary convalescent, palliative, addictions and long term care for people who are homeless. The homeless action plan proposed an interagency network aimed at improving access to care for homeless accompanied by a model that emphasized collaboration, communication and
coordination. The differentiation and integration theory proposed by Lawrence and Lorsch (1967) best illustrates this need for integration. Thus, a governance model at the corporate and service delivery level established a collaborative relationship between the social, health, legal and housing sectors.

The numerous and complex health needs of people who are homeless required that this initiative identify priorities. Palliative, convalescent, addictions and mental health care were identified as priority areas. Provision of primary health care in shelters was already occurring on an ad hoc basis and thus not deemed a priority.

With funding from the Supporting Communities in Partnerships Initiative (SCPI) the OIHCP measured a pilot project in 2001. The initial funding was scarce and did not include compensation for doctors or nurses, so fund-raised dollars were used to support health professionals. Other financial difficulties stalled the renovation of office space for administrative staff; this resulted in a one-year loss of programming. The pilot project’s implementation remained successful, as within six weeks of opening the program experienced a 100% utilization rate. Furthermore, the program was able to expand from 35 beds to 55 beds in the first year and then to 75 beds by the end of the third year without any additional funding mechanisms. Program evaluation of the pilot project verifies that the cost savings of the entire pilot project were approximately $3,302,353 to $4,855,413.

The SCPI funding ended in March 2003. Founders and service partners continued operation via donations and one-time funding allocation from the Ontario Ministry of Health and Long Term Care, Human Resources Development Canada and the City of Ottawa. A partnership with the Ottawa Hospital was critical in the identification of funding sources available from the Ministry of Health. The OIHCP has been incorporated as a non-profit organization and is awaiting charitable status. The commitment of service providers to the sustainability of the project in the absence of stable funding may have positively influenced potential funding sources. This is demonstrated by the recent commitment by the Ontario Ministry of Health and Long Term Care to find a solution to the project’s funding requirements.

The project is committed to remaining inclusive amongst all cohorts of the homeless population and aims for sensitivity to gender, race, language, ability, culture and sexual orientation of the clients. Three main program sites offer 20 hospice beds, 30 special care unit beds and 25 alcohol management program beds. In addition, other health care services provided by the project take the form of community beds and are accessible at various other shelter locations. The annual budget is greater than $1,000,000 and there are more than 18 employees.
Primary affiliations include the University of Ottawa Faculty of Medicine, Victorian Order of Nurses Ottawa and Ottawa Hospital.

The Vision of OIHCPI of "a community in which individuals who are chronically homeless have equitable access to the supports and services they require to maintain or improve their health" is operational in its programs and services and measured by its impacts/deliverables. Numerous operating principles support the mission of OIHCPI "to increase Ottawa’s capacity to address the health care needs of the chronically homeless at both a systems and an individual level, within the ultimate goal of ending homelessness." These operating principles inform frontline service delivery and administrative decisions and have an effect on the success and sustainability of the program.

6.2 Calgary Urban Project Society

The Calgary Urban Project Society (CUPS) is the longest standing case study. This project has developed programs in health, education and social services. CUPS was established in the late 1980s and became operational with the purchase of its first building in 1988. The Central United Church purchased this building and initially provided referral and health services on a volunteer basis. Alberta Health was the first major funder and assisted in the development of a community health centre. The United Way and other non-governmental sources of funding are also significant sources of funding (personal communication). The project expanded its services over time based on the needs and requests of the targeted population. This increase in intersectoral care is consistent with findings in the literature that community needs assessments are the clearest indicators of barriers to services (Barker, et al., 1994).

In 1996, the Calgary Interagency Committee for the Absolute Homeless emerged to provide a coordinated response to the growing concerns associated with homelessness. In 2003, the Committee developed a three-year plan for co-operative solutions; this plan recognized the necessity of prioritizing the responses needed to alleviate concerns related to homelessness. With a focus on advocacy, collaboration in research and strategic planning, the Committee aims for sustainability and increased transparency. These are important goals and priorities as literature echoes the finding that increased collaboration of strained resources will improve efficiency (Masotti, et al., 2006). CUPS has been an active member of the Committee, and the current chair of the committee is also the Director of Operations at CUPS.

The targeted service population at CUPS includes people who have a low or fixed income, people living with mental illness, substance abuse concerns and Aboriginals. In 2005, approximately 250 people volunteered their time to CUPS services. Utilization of volunteers
continued in 2006 with a conservative count of 11,040 recorded volunteer hours (personal communication). CUPS had an operating budget of over $4,000,000 in 2005 and employed approximately 80 staff members (personal communication).

The mission of CUPS is to “seek through compassionate health care, social and educational services to nurture and promote healing to those that have rejected or have been rejected or neglected by society” (¶ 1). This goal is stated to stem from its Christian denominational background which asserts that “at the heart of all religious faith is a deep affirmation of the worth and dignity of every human being” (¶ 2). The collaborative and holistic services offered by CUPS emphasize a spiritual component of care.

The CUPS health clinic employs a multidisciplinary primary health care team and offers women’s health, including prenatal, well-woman and maternal child clinics, chiropractic care, dentistry, shared mental health care, foot care, hepatitis C and eye care. An outreach team at CUPS provides crisis counseling, referrals, home visits, advocacy and mediation, emergency transportation, work apparel, housing assistance, including financial supports for people transitioning into housing, basic needs services (such as food hampers, clothing and toiletries). This outreach team is mandated never to refuse service. Also, relationship building between outreach workers and clients has given CUPS the ability to offer skill-building workshops that promote stability in their clients’ lives.

The Housing Registry Network (HRN) operated by CUPS links landlords and tenants. The HRN also provides computer training and links to numerous social services in Calgary. In 2005, the HRN had 32,000 visits. A child development centre, a family resource centre and a monthly newsletter are other services offered by CUPS.

6.3 Babishkhan

The Babishkhan is a street patrol project administered by Anishnawbe Health in Toronto. Anishnawbe Health was established in 1984 with a realization that there was a need for an increased comprehensive approach to health care for members of the Aboriginal community. The Anishnawbe Health Centre employs a multidisciplinary approach with Traditional Healers, Medicine people and Elders. The practice of ancient traditions and ceremonies are central components to their health care model. Services have evolved from the crisis intervention model employed in 1984 to working with people in all aspects of their lives who are trying to leave homelessness.

Funding from the City of Toronto and the United Way enabled the Babishkhan program to become operational in January 1989. This program developed in response to Toronto’s large
homeless population, of which the Aboriginal population is disproportionately represented. Only 2% of Toronto’s population comes from Aboriginal descent whereas 15-25% of people who are homeless in Toronto are Aboriginal (Wente, as cited in Glogger, 2004, p. 18). This program actively seeks out people who are homeless and responds to their most important needs. Thus, the program operates from 5 pm to 1 am. Sixteen full and part-time people are employed amounting to an equivalent of nine full-time employees. The late-night operational hours and outreach approach to service delivery are consistent with findings from the literature that identify barriers to services as traditional business hours and lack of transportation (Goldberg et al., 2005; Ministry of Health Services, 2004; Varga-Toth and Hines, 2006; Woodward and Associates, et al., 2002).

This program is growing rapidly. In 2000-2001 the program documented 42,752 contacts with people who are homeless on the streets of Toronto, up 70% from 1992-1993 levels. Approximately 10% of encounters resulted in transportation to shelter, and 90% received supplies such as food, clothing and medical necessities. Additionally, 0.5% of encounters resulted in transportation for medical help.

The emphasis on escaping as opposed to surviving homelessness reinforces the long term care modality that the Babishkhan program utilizes. The consideration of spirit, mind, body and the emotional requirements of the clients they serve provides an in-depth understanding of the individual causes of homelessness. This understanding is a joint venture between clients and staff and informs appropriate routes to end the cycle of homelessness.

The holistic and long term service model involves a number of services. Intake, information, treatment referrals, supportive counselling, cultural and traditional supports, legal advocacy, financial advocacy, mobile case management, after-care programming, training opportunities, support with addictions management, teaching circles, healing circles, health care, mental health services, crisis intervention and management, housing supports, employment supports and home visits are services provided as listed on the web page (Anishnawbe Health, 2005). Also as part of the Babishkhan program, the O Ta Ti Baen program provides employment placements for people wishing to escape homelessness. These placements can be at Anishnawbe Health Toronto or other community organizations. Individuals earn credits, which apply towards, housing, clothing, furnishing or other needs.

The program’s vision is “we seek a strong, independent and self-sufficient Aboriginal community in Toronto” (Anishnawbe Health, 2005, ¶1) Their vision is supported by operating principles that reiterate the need for a healthy community. The recognition of necessary and
accessible resources within the community is linked to the ability of community members to reach their full potential.

6.4 Cross Case Review

The case studies utilize a multitude of program and policy tools to achieve their goal. The four policy alternatives presented in this study are electronic patient records, on-site services, directories of services and navigational support/outreach programs. The case studies demonstrate that a diverse style of policy options is feasible, sustainable and cost-effective. Figure five illustrates that, of the four options presented in this study, CUPS utilizes three and OICHPI and Babishkhan each use two different approaches.

Figure 5: Cross Case Approach
7 Interview Findings

Three reasons motivated the interview process. Informational meetings provided an opportunity for unstructured conversation regarding context of field, methodological design, goal of research and survey results. Semi-structured email interviews furthered insight into case studies. The results of these interviews were presented in the previous case study section. The third form of in-person interviews enabled the refinement of policy alternatives, criteria, measures and evaluation. These interviews were confidential and will be referenced as ‘personal communication’ throughout the alternatives and analysis sections.

7.1 Informational Meetings

Meetings with the Community Health Services Research Cluster in the Partnering in Community Health Research program provided many opportunities for unstructured conversation regarding current field environment, organizational structure of VCH, individual goals associated with survey research, potential pilot projects and desirable courses of action. Through these meetings I have noted nine key themes: responsiveness of care, continuity of care, early intervention practices, communication and/or collaboration, resources, sharing of resources, North Vancouver, Downtown Eastside and the decision-making process at VCH.

These themes resulted in a questioning of how to conceptualize the policy problem. A diagram (as proposed by Dunn, 2003, p. 21) that demonstrates variations of policy argumentation is attached as Appendix B. This policy argumentation tool was derived from conversations at information meetings due to the diversity of opinion. The recognition of the variation between views was critical to the formulation of the final policy problem.

7.1.1 Responsiveness of Care

Although shelter providers in Vancouver are recognized for their innovative Cold and Wet Weather Strategy (Pratt, et al., 2001), there remains an identified need for subsistence service providers and health care professional to be able to adjust care on an individual basis. Affirmation of this point appeared in the literature review, which finds that the emphasis on deliverables and agency goals and mandates driven by funding bodies often dissuades service and health care
providers from individualizing care needs (Ploch, et al., 2006). Survey findings document that 60% of respondents are often or sometimes unable to adapt their services.

7.1.2 Continuity of Care

One concern repeatedly identified was the lack of collaboration between health care services and subsistence service agencies. The survey documented that 26% of respondents often and 23% sometimes received referrals from emergency room/hospitals. Furthermore, 28% often and 64% of respondents sometimes refer their clients to the emergency room. Other high rates of referral documented in the survey analysis section allude to the flow-through system of support that may be in place. Discussions identified the need for a network analysis to measure the extent of the referral and communication process within subsistence service providers and between subsistence service providers and health care professionals and facilities.

Discussion at informational meetings also identified the desirability of a pilot project. A potentially actionable item would be to approach key decision-makers within VCH with a need for a standardized referral process. One first-hand example of a client dying on the street outside of a hospital waiting for transportation back to emergency shelter was a central driving force behind the identified need for increased continuity in care.

7.1.3 Early Intervention

The variability of the length of time it takes to identify health problems for clients of subsistence services is a concern. Length of time spent on waitlists and barriers to service utilization evolve around early intervention. These concerns are repeated in the survey's quantitative and qualitative findings. One respondent states, "I strongly feel that we are failing miserably in this area and the 'so called' stats are in no way an accurate representation of the level of need in the community. People aren't reaching out for help with their addictions because we have none." Another respondent noted, "We are working way out of our mandate trying to serve a very marginalized group of women in Vancouver who have severe addiction, mental health, abuse, violence issues. Any help/improvement would be welcome. My experience in the 10 years working in the downtown eastside is that it has steadily gotten worse in all of these areas and we continue to do research?" The aggravation implied in this quote denotes the necessity of increasing resources when implementing policies aimed at supporting subsistence service providers.
7.1.4 Communication

A large service delivery area, organizational structure and broad mandate compounds the concern of lack of communication within VCH. Discussions at informational meetings identified the need for sharing of information between departments. VCH recently received an Organization of the Year award from the International Association of Public Participation. This international award recognized the community engagement efforts. Yet, the work of the community engagement committee is viewed by some as being underutilized.

A need for increased communication between VCH and subsistence services was supported by survey data. One such qualitative response is, “we would like to strengthen our relationship with Vancouver Coastal Health because so many of our clients have health-related issues.”

7.1.5 Resources

The lack of resources combined with a growing homeless population is a concern. Informational meetings discussed the fixed budget reality within VCH. If additional funding is to be secured to assist subsistence service providers, there are questions regarding what other areas of VCH programming might have to be cut back. One argument against increased support for subsistent service providers is that if poor health is the problem, then it is more cost-effective to increase mainstream health services. Literature, case study reviews, survey data and informational interviews all conclude that the accessibility barriers experienced by subsistence service clients undermine this position.

7.1.6 Resource Sharing

This concern stems from both the lack of communication and the lack of resources. Duplication of similar research was also identified as a concern. This duplication of research appears to occur on an inter-departmental and inter-agency basis. Strategies to increase resource sharing include the development of a network or virtual library of resources similar to the one previously initiated by the Institute for Health Promotion and Research at the University of British Columbia.

7.1.7 North Vancouver

The lack of resources available on the North Shore was also repeatedly identified. This often results in people who are homeless in North Vancouver migrating to the Downtown
Eastside of Vancouver in search of appropriate services. This migration causes negative personal and community externalities that exacerbate prevalent social issues in the downtown core. Furthermore, the lack of resources in North Vancouver also results in increased social isolation for all stakeholders.

7.1.8 Downtown Eastside

Conversely, some assert that the situation in the downtown eastside is the exact opposite. Discussions at informational meetings showed many people involved in the provision of service to the homeless who feel that the area is hyper-serviced. This exorbitant amount of service provision attracts increasing numbers of people who are homeless and thus results in increased strain and demand on services. Consequently, this increased demand results in inflated needs assessments that advocate for increased services in the downtown eastside.

7.1.9 Decision Making

The decision-making process at VCH complicates the dilemma of how to initiate the knowledge transfer to affect change. VCH has responded to the challenge of its broad mandates by creating specialized departments targeted at specific needs. This process of differentiation is necessary, but a move towards integration also needs to occur. As previously noted, interdepartmental communication has been characterized as minimal.

7.2 Policy Forecasting Interviews

Five semi-structured, confidential interviews were completed. These interviews provided insight and measurement regarding the desirability and feasibility of the policy options. Furthermore, these interviews enabled the revision of policy options to include relatively inexpensive short term policy and program choices.
8  Policy Alternatives

Background information, the literature review, survey analysis, informational interviews and case study reviews suggested four policy alternatives for consideration. These alternatives have been refined by consultation with field professionals. These sources are consistent with the methods Patton and Sawicki (1993) posit for identifying alternatives. These alternatives are: increase the number of on-site health professionals, create a central directory/wait list for services, establish health care navigation support program and develop a patient care network. A fifth policy option of maintaining the status quo is also discussed. The following sections provide operational definitions, key issues and rationales for presenting the proposed policy options.

8.1  Status Quo

Pal (1997) has referred to public policy as "a course of action or inaction chosen by public authorities to address a given problem or interrelated set of problems" (p. 1-2). Therefore, the choice to do nothing is always an alternative. However, if the status quo were chosen, there would likely be undesirable consequences.

If no action is taken to address health disparities for homeless populations, it is unlikely that these disparities will improve. On the contrary, it is more likely that these disparities will increase and continue to burden our society at the personal, community and economic levels. In addition, inaction will reflect poorly on Canada's national and international commitment to achieve health for all, implement active social policies that address determinants of health and reduce health disparities.

8.1.1  Current Field Context

VCH does provide and subsidize health initiatives targeted to low-income and homeless populations. Community nurses are one example. The Active Community Treatment (ACT) teams are another program example found in Vancouver that provides health care to the homeless.

The current level of support from VCH is viewed as being minimal. One interview respondent noted displeasure with the current community nurses program and stated that the
program would be more effective if they were centrally located on the street. This is consistent with informational interview findings that current program capacity for the ACT team is dismal and in turn ineffective.

The Green Book for Vancouver and Red Book in North Vancouver are internet-operated directories of services. These comprehensive listings of services include more than health care provision agencies. Issues surrounding maintenance and broad scope of services limit these directories' ability to provide a central directory of health service available to clients of subsistence services.

There is no coordinated response by subsistence service agencies and the degrees to which the health needs of their clients are met vary widely. However, it is important to note that some survey respondents did acknowledge working partnerships with health care professionals. Steps taken by various subsistence service agencies in Vancouver and North Vancouver region have had beneficial results. One participant noted:

Again at the level of service we provide at the residence, interagency support is a very high level and disagreements do get worked out in a positive manner. We primarily work with mental health team, geriatric mental health team, ACT Bridging and a number of well-established community physicians such as Dr. --, Dr. -- and Dr.--. (a) Pharmacy provides all of our pharmacy needs. -- do all the blood work. The mental health teams have assisted with finding other medical support such as family doctor, dentists, OT's, etc. -- Dental Clinic has been very good about providing dental care.

Nonetheless, if the status quo is chosen, innovative initiatives and program partnerships will likely be implemented in a sporadic fashion. This will result in many subsistence service agencies without any support when responding to the health needs of their clients.

8.2 Alternative One—On-Site Health Professionals

When supporting subsistence services in responding to the health needs of their clients, their strained administrative environment is a paramount issue. The non-profit nature of subsistence service provision implies that support will need to be in the form of additional resources. Thus, the first step should be increasing access to on-site health care professionals. Short term limitations of policy implementation imply that on-site health professionals will take the form of mobile health supports. Moreover, these mobile health supports would likely be in the form of community nurses providing no more than primary health care. However, in the long term this policy alternative seeks to establish homeless care centres that would see subsistence services and professional health care services be co-located.
8.2.1 Operational Definition

In the short term, this policy seeks to increase the number of hours that visiting health professionals spend providing care at subsistence service agencies. In the long term this policy would see the co-location of subsistence service providers and health care centres (community health centres) in order to increase access to multi-disciplinary care teams.

8.2.2 Rationale

CUPS, OICHPI, Babishkhan and some subsistence service providers in Vancouver have successfully implemented this alternative. Literature has also identified that barriers to health care services are significantly overcome if care is provided at the point of contact, in a supportive and culturally appropriate environment. One can infer that if people are accessing other services from subsistence service providers, they feel supported by these agencies and would not be opposed to increased health care service availability at these points of contact.

8.2.3 Key Issues

- Of survey participants 94% ranked visiting nurses, 88% visiting dentists and 76% visiting pharmacists as either being very or probably useful.
- It will not be feasible to co-locate health services with all food and shelter providers in Vancouver. The decision-making process will need to consider spatial considerations, capacity, stigma, operational hours and culturally appropriate services.
- There needs to be an identification of central field locations that could accommodate larger facilities.
- If services are centralized, there is increased concern that they will cut off services for some and in turn increase various accessibility barriers (stigma, transportation) that this policy aims to reduce. Careful consideration needs to paid to spatial and in turn environmental context of central locations (personal communication).
- A central communication board aimed at coordinating collaboration between stakeholders needs to be established. This communication board would be consistent with the current public engagement group in the community engagement department of VCH. The process of multi-stakeholder consultation would need to be redefined with ongoing commitment and consensus building as critical components.
- Continuity of care would largely remain unchanged in the short-run as visiting and on-site health professionals would likely offer primary health care services and would thus
require subsistence service providers to refer clients to other medically necessary health providers. The two primary requirements for continuity of care cards and a GP would remain unchanged (personal communication).

- Continuity of care would likely increase in the long run if health facilities and subsistence service providers are able to co-locate, as the referral process between health and social services would be streamlined. The co-location of services would also decrease the mobile nature of professional health care provision and have an increased probability of attracting regular GPs.

- The level of collaboration would need to increase in the long run in order to ensure a streamlined referral process. With increased collaboration, there is an increased probability of deficiencies in cooperation and communication.

- This is amplified in the case of denominational subsistence service providers and medical professionals. The varying mandates/visions of these groups would likely create tension (personal communication).

- There is a need for active policies such as a pooling of funding and stable funding commitments to negate stakeholder concerns and encourage cooperation.

- A disproportionate share of the economic benefit is likely to accrue. Dentists and GPs will exercise greater demand for resources over other groups, raising questions about cross-subsidization and financial instability (personal communication).

- This program would be an expensive venture in both the short and long term (personal communication). The costs of on-site health professionals can be minimized in the short term if VCH established an in-depth volunteer/university partnership. This stems from one survey participant’s request to extend volunteer opportunities in the downtown eastside. Students in professional health fields could be solicited from local universities to implement outreach care centres as part of their training. The overhead costs to community groups, universities and students would need to be taken into account. There is a huge temporal investment, and voluntary programs need to be well-maintained and well-resourced (personal communication).

- In the long run the large scale construction costs should also be approached on a partnership level. The city of Vancouver in accordance with the Vancouver Agreement should approach both the provincial government and the federal government for additional funding from the Supporting Communities in Partnership Initiative.
8.3 Alternative Two—Central Directory

A central directory of services would primarily be administered via the telephone. The operator would assist callers in identifying available services. If services were fully booked, the operator would initiate the waitlist process and further referrals. A central directory of services could easily be expanded to web, brochures and kiosk booths in order to increase awareness. Also, a central directory of service is an important tool for managers and lobby groups, as it documents the amount of service availability.

8.3.1 Operational Definition

In the short term this policy alternative would be administered via the telephone and would initiate the referral and waitlist procedure (based on first come, first serve). It would expand to include internet, brochures and kiosk advertising service availability. In the long term it would transfer certain waitlisted services from a first-come, first-served basis to need (as determined by a multi-disciplinary care team).

8.3.2 Rationale

The success of the VCH pilot project of Access Central demonstrates the large unmet need for information among clients accessing health services. Survey results also document that the lack of information sharing is a barrier for clients of subsistence service providers.

8.3.3 Key Issues

- Of survey respondents, 89% identified a directory of services as being either very or probably useful.
- Funding implications of what agency maintains the directory need to be addressed. This is important since a central directory has an increased likelihood of shipping the burden to supply services to another jurisdiction (personal communication).
- Need to be cognizant of what services are listed in the directory. The critical question of what one lists in the directory (will the mandate of the agency, the primary service or the actual services provided be listed) and if agencies' commitment varies with what is listed in the directory (personal communication).
- This alternative is partially implemented by VCH. The Access Central Line was implemented on October 17, 2006. Access Central provides information regarding recovery and addiction housing services and detox and day treatment.
• The implementation of Access Central may have been the result of program evaluation data collected from the pilot phase of the project in April-October 2006. During this time VCH recorded 10,352 calls. Of these calls 50% were for information, 231 for access to addiction housing (77 of calls were booked into addiction housing and 1512 were for access to detox (1428 of callers were booked into detox). In addition, operators from the line coordinated 92 referrals to support recovery.

• This directory of services is a low-cost option for increasing access to care. Awareness of program availability is the first step towards increased accessibility (posters and wallet cards were distributed advertising the Access Central line also a kiosk at the Health Contact Centre on East Hastings).

• Low literacy levels limit the effectiveness of internet and brochures components (personal communication).

• Early intervention and continuity of care would likely remain largely unchanged.

• Increased access remains constrained by current resource limitations.

• The basis of waitlists is also a contentious issue. Will it simply be a first come, first serve basis, or will it be determined by need?

• If waitlists are determined by need, how is need defined and who assesses it? The creation of a multi-disciplinary care team could develop criteria to assess need, but it would drastically increase the cost of this policy option and is thus a long term objective.

• People who are homeless often have a dual diagnosis that would further complicate the identification of available services (personal communication).

• Traditional accessibility barriers to health care services also remain unaffected by this policy option. Problems connected with appointment procedures and operational hours might be further exacerbated by this option.

• The continuation of consultation by the Access Central line could assist in the creation of a buy-in from subsistence services. This buy-in is required to ensure that people placed on waitlists are given priority and avoid any deficiencies in cooperation.

• Representatives from subsistent services would have to collaborate in order to document a comprehensive list of service availability and target population.

8.4 Alternative Three—Health Care Navigation Support

The health care navigation outreach program would employ support and outreach workers to assist people who are utilizing subsistence services with accessing necessary health
care. This alternative recognizes the large cost associated with moving health professionals on-site and thus assists in bringing service users to them.

8.4.1 Operational Definition

In the short term, this policy would provide outreach support for clients of subsistence services when accessing health professionals. In the long term, this would be expanded to ensure navigational support in accessing services targeted towards non-medical determinants of health (education, legal, work, social assistance).

8.4.2 Rationale

This policy alternative takes into consideration the current strain on healthcare professionals. The long term goal to provide navigational support for all services outside the traditional health sphere is consistent with the repeated finding of the impact of social determinants of health. The Sheway program located in the downtown eastside of Vancouver currently operates one such navigation program for drug-addicted pregnant women.

8.4.3 Key Issues

- Of survey respondents, 65% identified no general practitioner, 65% ranked transportation and 61% ranked no personal support as often or always being a barrier for their clients when trying to access health services.
- Two key components of this alternative are helping people access services and ensuring that services are there to access (personal communication).
- There is a need for out-reach support workers to have broad knowledge of service availability.
- Health authorities in BC already run programs similar to this although not explicitly targeted towards supporting subsistence service providers.
- In order to achieve quality of care objectives this policy would need to target all clients of subsistence service regardless of mental health and addictions issues. This is a requirement in response to interview and survey respondents who have identified that the targeted population base of initiatives already in place may be too small.
- This alternative is not concerned with direct health care provision, so there is an increased probability that funding from all levels of government could be sought and
maintained (although there are still concerns regarding the level of commitment from the federal government).

- Outreach support workers could assist in the provision of medically necessary services (e.g. Band-Aids) that may assist in prevention and early intervention.
- There is a higher probability that outreach support workers would be available to fulfil the staffing requirements of this policy alternative rather than professional medical personnel as the requisite education and experience is much less.
- It is recommended to hire outreach support workers that are on a peer level with people who are homeless to ensure support (personal communication).

8.5 Alternative Four—Electronic Patient Care Network

The establishment of a patient care network is something that has been previously recommended by the City of Vancouver and numerous research reports conducted on homelessness (Woodward and Associates, et al., 2002; Social Planning and Research Council of BC, 2003; Goldberg, et al., 2005). An electronic medical health record that is available to subsistence service providers is currently being utilized by the Ottawa Inner City Health Project Inc. This form of electronic patient record ensures continuity of care and provides more opportunities for early intervention.

8.5.1 Operational Definition

In the short term, an electronic patient care network would link patient care records of community subsistence service providers and health professionals in the VCH area. In the long term, this shared electronic patient record would be available throughout the province of BC.

8.5.2 Rationale

Electronic patient care records are already in place. The Homeless Individuals and Families Information System (HIFIS) is used by some subsistence service providers. In contrast, community health services utilize their own electronic record systems. Many jurisdictions have found the sharing of information between health and social service providers to be beneficial. In Canada, the Ottawa Inner City Health Project Inc continues to grow and document success. The Indiana Network for Patient Care and Research is a United States example but is useful for long term visioning as it has shown the capacity of such initiatives to work on such a large scale.
8.5.3 Key Issues

- This form of electronic medical record increases continuity of care and provides more opportunities for early intervention.
- Implementation procedures are a concern; problems associated with the acquisition of computers, secure internet accessibility and training are a few considerations that may hamper stakeholder commitment (personal communication).
- The design of an electronic patient care network is highly contentious. Stakeholder requirements and opinions vary regarding the need for consistency with the existing system. If the existing system is used as the base for expansion, there are concerns regarding compatibility and availability of necessary fields (personal communication).
- Traditional accessibility barriers to health care will remain largely unchanged. The opportunity for increased early identification of health concerns by subsistence service providers combined with a streamlined referral process that emphasizes continuity of care would likely minimize the impacts of transportation, stigma and traditional operational hours and appointment procedures.
- A patient care network would encourage long term changes that incorporate collaboration in caring. This collaboration would be strengthened by an enhanced referral network and standardized patient care forms.
- A large degree of integration, collaborative structures, avenues for communication, cooperation is necessary to ensure the success of this option.
- The cost of establishing an electronic patient care record is high and it is unlikely that VCH would be able to cover the cost of implementing this alternative (possibility of establishing this policy alternative as a research initiative similar to the Indiana Patient Care and Research Network, this would provide increased funding and professional resources. Interest from academic collaborators, community partners and institutions such as Vancouver General and UBC hospital provides an opportunity to move this alternative forward under the auspice of research and development).
9 Assessment

9.1 Criteria for Assessing Alternatives

This section identifies four criteria utilized when assessing the viability of policy options. This study uses criteria of political, technical and economic feasibility that are commonly used in policy analysis. The fourth criterion of quality of support draws from equity and effectiveness criteria.

The use of criteria in assessing policy alternatives is helpful in measuring the various dimensions of policy options. The use of evaluative criteria is not intended to directly judge the policy alternatives, but rather to assess the projected outcomes of the policy alternatives (Bardach, 1996, p. 99). Unfortunately outcomes are generally associated with qualitative results and are difficult to measure. Thus, measurements used in the upcoming evaluation are concerned with projected outputs of the proposed alternatives (personal communication).
Each criterion will be assessed using approximate measurements. These measurements will rate each alternative on a five-point scale in relation to the other alternatives. Although the five point scale is used to measure all criteria equally, not all decision makers will value criteria equally. It is up to individual decision makers to impart their own preference in the assessment process and add weights where desirable. Table 6 provides an overview of the numeric rankings that are assigned to alternatives in the upcoming assessment.

Table 6: Criteria, Definition and Measurement

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<th>Criteria</th>
<th>Definition</th>
<th>Measurement</th>
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<tr>
<td>Political Feasibility</td>
<td>The alternative should ensure support from decision-makers and other stakeholders</td>
<td>Interest groups (0-1)</td>
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<td>Federal (0-1)</td>
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<td>Provincial (0-1)</td>
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<td>VCH (0-1)</td>
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<td>Municipal (0-1)</td>
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<td>Technical Feasibility</td>
<td>The alternative should be able to be enacted within a given time-frame with support from subsistence service providers and health professionals.</td>
<td>Physical Space (0-1)</td>
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<td>Staff time (0-1)</td>
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<td>Long term (0-1)</td>
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<td>Quality of Support</td>
<td>The alternative should provide support to subsistence service providers such that their environments experience improvement.</td>
<td>Culturally appropriate (0-1)</td>
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<td></td>
<td></td>
<td>Collaborative structure/evaluation Procedure (0-1)</td>
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9.1.1 Political Feasibility

Measurement for this criterion utilizes a discourse analysis and thematic coding of qualitative data gathered from survey participants, interview respondents and review of VCH, City of Vancouver, British Columbia and the federal governments' policy positions. Inclusion of a political feasibility criterion is essential for this policy analysis, as the health care sector is a public service. Thus, in order to recommend policy change that would affect public sector spending there needs to be consideration of how political actors (both elected and unelected) will react to the proposed policy alternatives.
A measure of political feasibility ensures that policy recommendations will be acceptable to key decision makers. Although the matter of health care is a provincial responsibility, the analysis for this alternative must be cognizant of attitudes and commitments at all levels of government. Approximate levels of support and opposition in the implementation of proposed alternatives will be gauged through the separation of stakeholders within the political process. Interest groups, VCH, and the federal, provincial and municipal governments are the five stakeholder groups.

9.1.2 Technical Feasibility

Technical feasibility refers to the ability to enact the policy. The move from policy rhetoric to policy action is the key determinant for measuring success and a necessary criterion. Measurement for this criterion uses qualitative data gathered from the literature review, case study reviews, survey participants and interview respondents. The physical space, availability of staff time, additional resources and varied requirements between the short and long term are considerations assessed via this criterion.

Each of the policy alternatives will receive one point if the estimated physical space is available and up to two points if staff time and resources are available. The remaining two points will be given based on time frame: up to one point if the alternative can be implemented within a short period. The short term time period in this study will be defined as within three years. An additional point is awarded if it can be expanded in the long run. For the purpose of this study the long-run will be defined in approximate terms of anywhere between three and ten years.

9.1.3 Quality of Support

This criterion aims to ensure that the subsistence service agencies will not be worse off after the implementation of the proposed policies. This is important as the overall goal of increasing access to health are while central to the proposed policy objective it is not the exact policy problem addressed in this analysis. Rather, this analysis seeks mechanisms to provide support to subsistence service agencies when responding to the health care needs of their clients. This criterion is thus concerned with the tangible outputs of proposed policy options and how the policies will support subsistence services.

Five considerations are assessed in regards to the ability of the proposed policy options to ensure improvement. These five considerations are cultural awareness, collaborative structures/evaluation procedure, equal representation in the decision-making process, an agreed
upon dispute resolution process and share of resources. The assessment process will award up to one point for each of the above considerations. These considerations ensure that there is a move towards true partnerships between subsistence service providers and health professionals. The capacity to undertake collaborative initiatives needs to be provided to the agencies. Also health professionals and in turn the health authority need to move past doing programs for agencies to doing programs with agencies (personal communication).

9.1.4 Economic Feasibility

The financial costs of implementing the policy options are measured via the economic criterion. This analysis will measure the economic feasibility of the proposed policy alternatives for both VCH and subsistence service agencies separately. Consideration of direct costs requires measurement of the quantifiable costs of the alternatives. The public data available from the case study reviews provide a rough estimate of the operating budgets.

The measurement of indirect and overhead costs is difficult. Fortunately, the prediciative nature of this analysis enables an estimation of relative indirect costs. Inferences regarding indirect costs are drawn from case studies, interviews and the literature base.

Program size and expected utilization rate are also important factors when discussing economic feasibility. This considers the number of people seen by a health care professional relative to cost. Is this likely to increase or decrease and by how much per dollar spent. The evaluation procedure will not provide an exact cost estimate. Rather it will analyze where policy alternatives lie on a five-point scale, thus presenting the relative costs of each alternative.

9.2 Evaluation

The following evaluation matrix assesses how each policy alternative meets the cited criteria. The ranking at the bottom of the evaluation matrix provides estimates of the projected outcomes of policy options in relation to each other.
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<thead>
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<th>Criteria</th>
<th>Indicator</th>
<th>Measurement</th>
<th>Quality of Support</th>
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**Table 7: Evaluation Matrix**
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<td>Direct Costs (6)</td>
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<td>Program Size (6)</td>
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**Economic Feasibility**

- Short Lm
- Indirect Costs Program

**Evidence from Literature and Case Studies**

- Long Lm
- Short Lm
- Program Size

**Electronic Patient Record**

- Navigation Support
- Central Directory
- On-line Health Professionals

**Measurement**

- Indicator
- China
9.3 Discussion

The above evaluation matrix summarizes advantages and disadvantages of the proposed alternatives. This assessment also provides an approximate ranking of policy alternatives. The status quo was not evaluated alongside of the alternatives, as steps to address the policy problem presented in this analysis will require some action. The navigation support program and a central directory have the highest scores; the following discussion will illustrate that this can be attributed to lower economic costs, greater quality of support and technical feasibility.

All alternatives fare well in the political feasibility category. The accessibility criterion in the Canada Health Act is partly accountable for this political feasibility. This can also be partly attributed to Canada's national and international commitment to reduce health disparities. The question of why, if all alternatives are politically feasible, are they not implemented in a systematic framework can be attributed to two main reasons. First is the need for increased resources. In the social and health service sector the additional resources needed to support subsistence service providers are lacking. Questions regarding tradeoffs are thus a limiting factor in political action. Second is the lack of clarity around the issue. Key decision makers are often unaware of the span of services that subsistence service agencies offer and the interaction with health (personal communication).

Technical feasibility is higher in the short term than the long term. The increase in resource requirements and increased need for collaboration are the two main reasons. A central directory and navigation support program are evaluated as being more technically feasible. This can partly be attributed to the relatively smaller need for professionals (either technological or health).

The navigation support program and the central directory of services had higher results with respect to quality of support as well. A relatively smaller amount of time and resources is required by subsistence service providers in respect to these alternatives in both the short and long term. However, in the short term, an increase in the number of hours of visiting health professionals is also evaluated as being desirable.

Implementation of any of the proposed alternatives would require increased resources. The need for increased resources necessitates a discussion of tradeoffs both within and between proposed policy alternatives. This is furthered by the acknowledgement that the effectiveness of all of the proposed policy alternatives is inextricably linked to the available amount of funding.
There is thus a need for increased understanding regarding the needs of subsistence service providers. The establishment of a multi-stakeholder engagement committee could guide the policy and program implementation process of proposed policy alternatives. This is desirable as all of the above policy options require increased collaboration. Also representatives from subsistence service agencies are best able to judge the resources they would be willing to curtail in order to receive increased support when responding to the health needs of their clients.

Economic feasibility is greater in the short run for both subsistence service providers and the health sector with the exception of the electronic patient care network. Due to the significant cost to both subsistence service providers and the health sector, there will likely be difficulty in obtaining increased resources as health and social service budgets are relatively fixed. However, an understanding of the previously noted health inequities and in turn disproportionate share of health resources leads to an important argument regarding cost-effectiveness. If stakeholders can demonstrate that support targeted towards subsistence service providers would reduce costs to the health care system, there is an increased probability of securing funding.

The argument that increased health supports for subsistence service agencies would be more cost effective could be strengthened by a combination of two factors. First, subsistence service providers could work collaboratively with health professionals in advocating for a shift from funding emergency and reactive health care services to preventative and health promotion strategies at the subsistence service level. Currently, health professionals control a disproportionate share of resources and likely have more clout in the decision-making process. Thus a collaborative relationship between health professionals and subsistence service providers is essential when advocating for changing priorities from key decision makers and funding bodies.

An increasing evidence base that documents not only the disproportionate share of health resources targeted towards confronting health inequities but also the inefficient allocation of resources is the second factor that strengthens the cost-effectiveness argument. One example of this is emergency room visits. Costs associated with non urgent emergency room visits are two to three times higher then visits to health care professionals in other settings (Baker and Baker, 1994). Peterson et al. (1998) further posit that not having a regular general practitioner is highly correlated with the use of emergency departments for non urgent conditions.
10 Recommendations

The relative equality of alternatives in the above analysis combined with findings from the case study reviews suggest that alternatives should not be implemented in a mutually exclusive manner. Rather, implementation of alternatives should consider the unique interactions of alternatives and options for joint implementation. The Venn diagram below (Figure 6) illustrates the overlapping nature of policy alternatives. This diagram is reminiscent of the Figure 1 Overlap of Case Study Services that illustrated the intersecting nature of policy and program tools employed in the case studies.

Figure 6: Overlap of Alternatives

In order to fully appreciate the unique possibilities of joint implementation, the costs and benefits associated with various programming options need to be identified. These results need to then be embedded in a cost-effectiveness framework that stakeholders and decision makers can consider in their decision-making process. Stakeholder involvement in the decision-making process is central to any implementation of the proposed policy alternatives. Thus, the first recommendation is the establishment of an ongoing multi-stakeholder engagement committee.
10.1 Recommendation One—Stakeholder Engagement

A central step prior to the implementation of alternatives is the creation of a multi-stakeholder engagement committee. If subsistence service agencies can overcome the competitive and fragmented funding environment in which they are forced to operate and commit to collaborate with health professionals and their clients, there is an increased probability that funding bodies, decision-makers and representatives from all levels of government will provide support. This is critical as the current administrative environment in which subsistence service providers operate is driven by broader funding decisions (at provincial and federal levels) which will be difficult to overcome if approached on an individual agency basis.

The assessment of policy alternatives demonstrates that collaborative structures and equal representation in decision making are likely to be concerns. These concerns can be addressed promptly if there is an active engagement committee in place. A stakeholder engagement committee can also work to mitigate concerns regarding the economic feasibility of policy alternatives, aim to achieve consensus regarding necessary tradeoffs and work to inform key decision makers and the general public of the breadth of services that they offer.

An immediate action item is the implementation of a multi-stakeholder engagement group specifically concerned with assisting subsistence service providers in responding to their clients’ health problems. The process of stakeholder engagement would benefit from one central body that could facilitate initiation and act as a subsequent mediator in the collaborative process. The unique opportunity for VCH to take a lead role in establishing such a committee is supported by findings within the literature review. Evidence suggests that collaboration within a competitive environment is assisted when there is a central manager that clearly defines goals and commitments from stakeholders.

10.2 Recommendation Two—Commitment and Complexity

The degree to which alternatives should be implemented is aptly characterized along a continuum of support. This support can also be considered as commitment and complexity. As level of support increases, the commitment needed to enact and maintain the policy as well as the complexity surrounding the relevant dimensions of the policy increases.

The case study reviews provide further insight on unique ways that other Canadian jurisdictions are responding to the policy problem via a compilation of policy and program choices. A diverse style of policy implementation will achieve the best results when addressing
the policy problem. This also provides key decision-makers flexibility in implementing policy changes in both the short and long run.

A continuum of commitment and complexity is a flexible and innovative policy tool, as each alternative will provide a variation of support to subsistence service providers. The support that subsistence service providers receive is essential in achieving the overarching goal of increasing access to health care for people who are socially marginalized. In the long term, policy and program changes have the opportunity to create a systematic framework of low-threshold services for these socially marginalized individuals.

Figure 7: Commitment and Complexity

This figure characterizes the desirable steps based on the evaluation of alternatives. The arrow is not linear as the relatively equal ranking of the evaluation implies that these steps are interchangeable. Furthermore, the actual implementation of policies and programs will be dependent on informed consensus of the stakeholder engagement committee and decision makers.
10.3 Recommendation Three—Short Term Goals

A unique visioning process needs to occur. This process needs to be cognizant of long term requirements and short term limitations. The development of pilot projects that include an extensive program review and evaluation component is essential. These evaluation reports will act as tools that demonstrate increased cost-effectiveness to approach key decision-makers with and enable the expansion of pilot-projects in the long term.

Obtaining secure funding to implement the programs associated with the proposed policy alternatives is likely to pose difficulties. It is recommended that the program be relatively small and approached on a pilot-project basis in the short term. This basis necessitates evaluation and output reports in order to ensure that refinements are made to programs before expansion occurs. The OICHPI provides an example of how pilot projects can be refined to ensure maximum outputs (expanded from 35 beds to 55 beds in the first year and then to 75 beds by the end of the third year without added funding).

Horizontal integration of local services is a key component of short term goals. Horizontal integration aims to increase intersectoral care at the service delivery level. This will likely take the form of collaboration between health professionals and subsistence service agencies. The four policy alternatives presented all include short term goals that promote such horizontal integration and should be implemented in accordance with stakeholders' preferences. When presenting alternatives for implementation there needs to be recognition of the variety of options for joint implementation.

My evaluation of the alternatives indicated that the first step should be to implement a navigation support program. Expansion of the Access Central should be the second goal. The third is visiting health professionals. Realizing all of these goals will hinge on the ability to secure and maintain funding.

10.4 Recommendation Four—Long Term Goals

The viability of reaching long term goals is contingent upon the relative success of the short term pilot-project initiatives. Nonetheless, long term goals remain a critical aspect of the development of a systematic framework of support for subsistence service providers. Additionally, long term goals can be used as lobby tools to influence the priorities of various funding bodies.

Long term policy alternatives are concerned with both horizontal and vertical integration. Vertical integration will require a commitment from municipal, provincial and federal
governments for on-going collaboration. Thus, the need for a multi-stakeholder collaborative committee is sustained in the long term. Furthermore, the overall goals of the committee should be broadened to include SDoH.

The policy alternatives can all be expanded in the long term. The analysis suggests that the navigation outreach support program first be expanded to assist clients of subsistence services when accessing services outside of the traditional health sphere. The central directory of service should then be expanded to include an interdisciplinary care team that could establish criteria to assess need and expedite the waitlist process for those in most need. A co-location of community health centres and subsistence service providers should also be at the forefront of long term goals. The multi-stakeholder collaborative committee will need to be aware of any new plans to build community health centres and advocate that they are established alongside of highly utilized subsistence services. Also, increased vertical integration in the long term will assist in the expansion of a province-wide electronic patient care network.
11 Conclusion

This study provides an introduction to the opportunity for increasing access to health care for socially marginalized individuals by targeting subsistence services. Qualitative and quantitative findings from the literature review, survey data, case study reviews and informational interviews all support the development of health care strategies that target subsistence service providers at a systematic level.

Increased support for subsistence service providers is justified by economic and ethical reasons. Currently barriers to health care worsen health conditions and result in more expensive treatment approaches. The Canada Health Act aims to ensure that Canadians receive health care based on need rather than ability to pay, and numerous international agreements commit Canada to decreasing health status disparities. All levels of government and unelected officials have further expressed the desire for accessible health care and the elimination of health status disparities. Therefore, the status quo should not be considered a viable option when addressing the policy problem.

The present analysis identifies four policy alternatives that would reduce the impacts of the policy problem—that assistance with health care needs is generally outside of the mandate of subsistence service providers, yet they are often the principal point of contact for people who are homeless and in poor health. The evaluation of the presented alternatives suggests that they would best be implemented on a continuum of complexity. A critical first step is establishing stakeholder support. The development of a multi-stakeholder committee will assist collaboration and in turn support the development of a systematic framework of low-threshold services that support subsistence service providers and increase access to health care for socially marginalized populations.

To ensure effectiveness, this committee should include clients of subsistence service providers and work alongside decision makers to identify the most desirable course of action. The analysis supports the following order of implementation: navigation support program, expansion of the Access Central, increase in the number of hours of visiting health professionals and the creation of an electronic patient care record. The implementation of these alternatives is flexible and can include various combinations. These alternatives were assessed via political, technical
and economic feasibility criteria. Quality of care was the fourth criterion used in the assessment process and aimed to ensure that subsistence services benefit from proposed policies.

The biggest barrier to implementation of these policy alternatives is large economic costs and a need for increased collaboration among service providers. I thus recommend that a central goal of the multi-stakeholder engagement be funding advocacy. The stakeholder engagement committee must work to demonstrate to the broader funding community, key decision makers and politicians that supporting subsistence service providers would be more cost-effective in the long run. VCH has a unique opportunity in this committee as literature had identified that clear roles and a central facilitator can enhance success. Also, an interview with OICHPION documented the success of its partnership with regional hospitals as hospital administrators identified many avenues for solicitation of funding.

Recommendations in this study are targeted towards VCH as it is responsible for local health service delivery. Nonetheless, important roles remain for stakeholders from subsistence service providers and all levels of government to move from policy rhetoric to policy action. This move will be characterized by prioritized support needs and increased collaboration in caring.
Appendices
## Appendix A: List of Subsistence Service Providers

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<th>Program</th>
<th>Organization</th>
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<th>Organization</th>
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<td>Daycare</td>
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<td>Financial Administration and Adult Guardianship</td>
<td>Saint James Community Services Society</td>
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<td>Aboriginal Mother Centre Society</td>
<td>North Shore Youth Safe House-YOUTH</td>
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<td>Outreach</td>
<td>Aboriginal Mother Centre Society</td>
<td>Powell Place Emergency Shelter for Women</td>
<td>Saint James Community Services Society</td>
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<td>Sustainability</td>
<td>Aboriginal Mother Centre Society</td>
<td>Saint Elizabeth's Home</td>
<td>Saint James Community Services Society</td>
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<td>Tuesday Morning Breakfast</td>
<td>Agape Street Ministry</td>
<td>Saint James' Home Support</td>
<td>Saint James Community Services Society</td>
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<td>Bridge Emergency Shelter</td>
<td>Atira Transition House Society</td>
<td>Santiago Lodge</td>
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<td>BC/Yukon Society of Transition Houses</td>
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<td>The North Shore Salvation Army</td>
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<td>The Gathering Place - Volunteer Program</td>
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Appendix B: Policy Argumentation Tool

**Warrant:** Practice professionals are equipped with first-hand knowledge on avenues best suited to meet the needs of their clients.

**Info:** Subsistence service providers often encounter individuals with health problems. This results in high rates of referrals to health and community services. Also it entails that service providers often adapt their service to clients' health problems.

**Claim:** The subversion of policy by subsistence service providers is adequate in addressing the health needs of their clients.

**Claim:** Subsistence service providers could use increased support in addressing the health needs of their clients.

**Claim:** There is an opportunity to increase continuity of care for the overall health benefits of clients by redefining interagency relationships.

**Rebuttal:** Limited resources and possible opposition from providers makes increased field partnerships technically and politically unfeasible.

**Warrant:** Increased interagency relationships could streamline the referral process.

**Warrant:** High rates of disease among clients can lead to expensive medical bills/inefficient use of resources. These high rates of disease are unlikely to change unless explicitly addressed.

**Rebuttal:** Support should be prioritized to health services.

**Rebuttal:** Subsistence service providers are not always able to adapt their services to meet the health needs of their clients.
Appendix C: Survey Instrument

1. WHICH ONE of the following best describes the primary service provided by your program? Check one only.
   - Emergency shelter
   - Transition housing/care
   - Supported/supportive housing
   - Seniors' services
   - Women's services
   - Youth services
   - Sex worker services
   - Aboriginal services
   - On-site meal service
   - Food bank
   - Community kitchen
   - Meal delivery service
   - Health services
   - Mental health services
   - Addiction services
   - Other: ______________________

2. From which organization(s) does your program receive funding and/or space? Check ALL that apply.
   - Vancouver Coastal Health
   - Municipal/city government
   - Provincial government
   - Federal government
   - Non-governmental organization
   - Private foundation
   - Non- or not-for-profit society
   - Other: ________________
   - None of the above

3. In your best estimation, what portion of your staff is unpaid, volunteer? Check one only.
   - None
   - Less than 25%
   - 25% to 75%
   - More than 75%
   - Don't know

4. How often do you encounter clients with health problems? Check one only.
   - Often
   - Occasionally
   - Rarely
   - Never
   - Don't know

5. Check the boxes that best describes how you become aware of the health conditions of your clients? Check ALL that apply.
   - The client tells me
   - A colleague tells me
   - It is in the client's file
   - It is in the shift log book
   - I can tell by the client's appearance/behaviour
   - Other clients tell me
   - Other: ________________
Appendix D: Survey Sample Characteristics

Due to the social welfare nature of subsistence service provision, the reliance of participant agencies on volunteerism is not surprising. Figure 5, shows that significant proportions of staff are unpaid or work as volunteers. For example, only about 39% of agencies do not have unpaid or volunteer staff.

Figure 8: Percentage of Volunteers

![Percentage of Volunteers Diagram]

- More than 75%, 11%
- 25-75%, 9%
- Less than 25%, 41%
- None, 39%
Appendix E: Survey Responses Health Conditions and Symptoms

The three most frequently encountered symptoms by respondents were anxiety, antisocial behaviour and foot problems.

Figure 9: Often Symptoms Encountered
Eighty five percent of respondents encounter clients with addiction, while 78% encounter clients with serious mental illness.

Figure 10: Conditions Often Encountered
Bibliography


