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# Responding to COVID-19 with integrative health and sheltering models for persons experiencing homelessness in Southern Ontario, Canada: protocol for a qualitative study exploring implementation and sustainability

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## ABSTRACT

**Introduction** COVID-19 has disproportionately impacted persons experiencing homelessness in Canada, who are at an increased risk of infection and severe outcomes. In response to the pandemic, several regions have adopted programmes that aim to address the intersecting nature of health and social challenges faced by persons facing homelessness. These programmes adopted during the pandemic may contribute to broader health and social impacts beyond limiting COVID-19 transmission, but the processes involved in developing and implementing these types of programmes and their sustainability after the pandemic are unknown. Our overall goal is to understand the processes of developing and implementing integrative health and sheltering initiatives in Ontario during COVID-19, as well as their sustainability post-pandemic.

**Methods and analysis** This study will use a multiple case study design—two cases over 1 year—enabling us to investigate how integrative health and sheltering approaches have been implemented in two mid-sized cities in Ontario, Canada. Each case will offer a unique narrative; through cross-case analysis, the cases will highlight programme operations, successes and challenges. Data will be collected using semi-structured interviews with programme staff and managers, and document analysis. Project partners will be brought together to further explore and interpret findings, along with co-creating a sustainability action plan and policy documents.

**Ethics and dissemination** Ethics clearance was obtained through the Western University Research Ethics Board and the University of Waterloo Office of Research Ethics. Findings will be disseminated through publications, conference presentations and lay summary reports.

## STRENGTHS AND LIMITATIONS OF THIS STUDY

⇒ This study will be conducted in two mid-sized cities, both with an agenda to address homelessness.
⇒ The selected study sites represent two different integrative health and sheltering models in Ontario, thus providing important lessons around implementation and sustainability inclusive of different environments.
⇒ We aim to interview programme managers and front-line providers who have had a role in implementing health and shelter care models.

## INTRODUCTION

### Background and rationale

COVID-19 has surfaced pervasive systemic and health inequities, which resulted in an increased risk of infection and severe outcomes for persons experiencing homelessness in Canada.[1 2] In Ontario, Canada, people with a history of homelessness were significantly more likely to have a positive test result, to be admitted to hospital for COVID-19, to receive intensive care and to die of COVID-19, compared with community-dwelling people who were not experiencing homelessness.[3] This population's heightened risk during the pandemic is compounded by complex medical conditions and mental health issues associated with homelessness, along with substantially lower use of healthcare from a regular practitioner.[4–7]

While homelessness has been an ongoing health crisis, COVID-19 elicited the need for an unprecedented response to address it through additional funding and interventions.[8] Due to the unique challenges faced by this population, infection control strategies alone were unlikely to prevent outbreaks,[9] suggesting the need for more integrated and holistic interventions to reduce transmission and adverse outcomes for these individuals. One approach adopted in some Canadian

cities is to provide low-barrier non-congregate housing arrangements, often through motels, hotel spaces and community spaces.[8 10] Intersectoral partnerships (ie, social services, public health, medical experts, community care and mental health) were leveraged to develop these programmes, which offer medical and social support on-site, and provide support around housing.[11 12] Embedding healthcare services and trusted care providers within shelters has demonstrated enhanced care provision[1 13]; however, prior to the pandemic, there still remained a lack of health and social integration when supporting persons experiencing homelessness.

The original purpose of these community-based response plans was to mitigate the spread of COVID-19 in settings, such as shelters, where physical distancing and/or isolation is challenging. While these approaches have been largely effective at reducing COVID-19 transmission, preliminary data suggest that these interventions are also having broader health and social impacts, such as reducing overdoses and calls to emergency medical services, and an increased number of participants moving to permanent housing.[14 15]

COVID-19's disproportionate impact on persons experiencing homelessness demonstrates the need for more flexible and integrated approaches to address this population's health and social needs both during and beyond the pandemic. The objectives of this research also align with broader federal recommendations and initiatives to address homelessness in Canada.[16] Given these promising outcomes, a better understanding of how these initiatives were implemented and their sustainability beyond the pandemic is warranted. Our project will specifically highlight programmes implemented in two mid-sized Canadian cities. Our focus is critical given the increasing visibility of homelessness in mid-sized cities, where evidence-informed practices and policies are lacking.[17]

### Aims and objectives

Our primary goal is to understand the processes of developing and implementing integrative health and sheltering initiatives in Ontario, Canada, during COVID-19, as well as the sustainability of these initiatives beyond the pandemic. Our study objectives are to:

1. Understand how programmes were developed and implemented, including implementation barriers and facilitators.
2. Determine what resources and partnerships are needed for implementation and sustainability.
3. Explore how integrative health and sheltering approaches can be scaled to other regions.

## METHODS AND ANALYSIS

### Study design

This study will use a multiple case study design[18] enabling us to investigate how integrative health and sheltering approaches have been implemented in two regional contexts. Each case will offer a unique narrative; and through cross-case analysis, the cases will highlight programme operations, successes and challenges. Further, this study will employ a co-design workshop methodology[19 20] to review research findings and co-create implementation guides and materials that will be helpful for other regions.

### Study setting

This project will take place in two study regions, which are further described below, between June 2022 and December 2023:

1. Waterloo model: 'ShelterCare' was developed in March 2020 at the onset of the COVID-19 pandemic, as a pilot programme. Local hotels were repurposed to provide men experiencing homelessness 24/7 shelter, in conjunction with 'wrap-around' healthcare, mental health support, addiction treatment and housing support. ShelterCare has served 404 individuals since the start of the pandemic.
2. London model: In October 2020, the City of London, along with other partnering health and shelter organisations, created a pop-up shelter programme to support persons experiencing homelessness during the pandemic. The 30-bed shelter programme has provided healthcare and shelter services to individuals through the pandemic.

### Sampling strategy and recruitment

We will use a purposive sampling strategy[21] to recruit individuals at both sites who can speak to the implementation of the health and shelter models. We will include a variety of stakeholder voices, including those involved with the implementation and day-to-day operations of the programmes. We anticipate that this will include front-line health and social care staff, administrators and executives. Inclusion criteria for this study are English-speaking individuals who have worked for/with one of the programmes. Individuals will be ineligible if they are not proficient in English and are not connected to the programmes of interest.

Site champions have been identified in each region, and have agreed to assist researchers with the recruitment process. Selected site champions will have leadership roles in their respective organisations and through their networks will be able to facilitate recruiting eligible staff. Each site champion will approach the staff member and present the study opportunity, which will include a brief overview of the study and project goals. Upon consenting to participate in the study, a date and time to conduct a semistructured telephone interview will be scheduled. We aim to recruit approximately 8–12 participants from each study region (16–24 participants in total) for individual interviews.

Each study participant will be asked during their interview if they would like to attend project co-design sessions to further discuss findings and develop resources. If a participant indicates that they are interested, the local research coordinator will follow up with them at a later

date with co-design session details. Site champions will also contact project partners with information about co-design sessions after individual interviews have been completed.

## Patient and public involvement

During this project, our research team will work in close partnership with organisations and agencies serving people experiencing homelessness. Our community partners have assisted with the development of the research project and data collection materials. They will also assist with recruitment efforts, as well as review analysed data and reports. Our co-investigators with decades of experience working in the homelessness sector have cautioned against collecting data with persons experiencing homelessness, unless absolutely necessary to answer the research question. In some contexts, persons experiencing homelessness have been over-researched, and this can be viewed as extractive.[22] Given that the aims of this research are about implementation and scalability, data collection will focus on the staff members involved in these processes. A few clients who have been actively involved in the implementation of the programme may also be interviewed.

## Study data collection

Data collection will occur in two phases: (1) qualitative semistructured interviews and document analysis; and (2) co-design workshops. We anticipate that data collection will take place during the summer and fall of 2022, and co-design workshops will be held late spring into early winter 2023. Data collection procedures are outlined in further detail below.

### Phase 1: qualitative interviews and document analysis

We will conduct in-depth semistructured telephone interviews with health and social care providers, programme managers and other relevant stakeholders, to gain an in-depth understanding of experiences and processes related to the implementation of integrative health and sheltering models in the two regions. We will aim to recruit 8–12 participants from each region for a total of 16–24 individuals. We will aim for three to four individuals from each stakeholder group—programme managers/administrators and front-line providers (health and social care providers). If we have not reached saturation with this sample size, we will add some additional interviews. With the participant's permission, interviews will be audio-recorded and are anticipated to last 45 min–1 hour in length. If participants do not wish to be audio-recorded, the researcher will take detailed notes throughout the interview to capture the information.

The development of interview questions was guided by the Consolidated Framework for Implementation Research (CFIR).[23] The CFIR highlights five areas to consider when developing and implementing interventions: intervention characteristics, outer setting, inner setting, characteristics of individuals and process. Prior to finalising the interview guides, pilot interviews (n=2) with key stakeholders from each region will be conducted to further refine the guides. Interview guides incorporate demographic and role information questions, along with covering topics related to the development, implementation and sustainability of integrative health and sheltering models. A list of example interview questions is included below in table 1.

Reflexive practices such as taking detailed field notes will be incorporated during data collection to account for the impact of the position, perspectives and presence of the researchers during this process.[24] Along with qualitative semistructured interviews, where possible, we will attempt to obtain and review relevant documents from stakeholders to learn more about the implementation process. Documents could include meeting minutes, partnership agreements, policy documents, reports, and financial data related to programme and personnel costs.

### Phase 2: co-design sessions

Project partners will be brought together to further explore and interpret findings, as well as create a sustainability action plan. Co-design is a solutions-focused, participatory process in which clients/programme users and healthcare and social services staff work together

**Table 1** Sample interview questions for programme managers and providers

| Programme managers | Programme health and social providers |
|---|---|
| ► Prior to the COVID-19 pandemic, what gaps existed in service provision to persons experiencing homelessness in (name of region)?<br>► How was the model developed?<br>► What kinds of information do you plan on collecting as you implement the programme?<br>► What challenges did you encounter while implementing the programme?<br>► What is/would have been needed to sustain this model?<br>► What key insights would you offer to other regions wishing to implement a similar programme? | ► Can you please describe your understanding of the programme and how it serves people in the community?<br>► Can you walk me through a typical day working as a (insert position) with the programme?<br>► How well do you think the (insert name) programme is addressing the needs and preferences of persons experiencing homelessness in your region?<br>► What challenges do you encounter in your role with the (insert name) programme? How do you and your team work to overcome these challenges? What resources and/or kinds of support are required?<br>► What key insights would you offer to other regions wishing to implement a similar programme? |

to co-develop resources.[25] Specifically, we will work with stakeholders (n=40) to co-develop an implementation guide, and plan for programme spread that highlights the key programme strategies that should be scaled to other regions. We will bring together stakeholders to review the findings from phase one and help to determine what information would be helpful for future communities wanting to do similar work. We will co-develop the resource including the success stories, helpful tips and lessons learnt. This will happen through multiple group meetings, led by a facilitator. We will also engage a knowledge translation expert to help ensure the document is easy to follow. The final document will be reviewed and approved by stakeholders before being shared publicly. We will also develop appropriate advocacy and policy documents to reinforce the resource and programme needs for this population in Ontario and across Canada.

## Data analysis

Qualitative analysis of the data will be completed over four steps. First, we will review the data from each study site (case) independently and create the narrative description of the study site (case). In step two, we will analyse the data by applying a comprehensive qualitative analysis procedure. Personal information will be removed from the documents and interview transcripts, and uploaded into NVivo V.12, a qualitative analysis software program. Researchers will read through the dataset, line by line, and create codes. We will then identify themes by combining common codes.[26] Each theme will be given a proposed name, brief description, illustrative quotations from the data and a list of codes that support the theme. In step three, we will review the codes and narratives and cross-reference the findings with the CFIR. In step four, a cross-case analysis of the findings will be completed. We will document similarities and differences among the cases. In our analyses, we will report gender when using participant quotes and data. A summary of analysed data will be brought to the co-design working group for review and interpretation.

### Positionality

We recognise the importance of describing our positionality,[26] and the lens(es) that we, the researchers, will bring to the analysis. Our team includes PhD-trained and Master's-trained qualitative researchers with expertise in homelessness research, mental health, healthcare system redesign, implementation science and research with vulnerable populations. Co-investigators and co-authors for this research will also include those with front-line health experiences. Our team includes men and women, all of whom are white and of relatively high socioeconomic status. Our site champions have decades of experience working in partnership with persons experiencing homelessness.

## Ethics and dissemination

Through the co-design phase (phase 2), researchers, in partnership with community stakeholders, will co-develop resources to help other communities implement health and shelter care programmes. These resources will highlight the lessons learnt from the two study regions. The resource will be disseminated through provincial and national networks aimed at improving services for people experiencing homelessness. Additionally, findings from the study will be disseminated through publications, conference presentations and lay summary reports.

Ethics approval was obtained through the Western University Research Ethics Board and the University of Waterloo Office of Research Ethics.

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**Competing interests** None declared.

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