HOSPITALS-SHELTERS WORKING GROUP

Gaps and Trends: Challenges Facing Individuals Using Shelters and Hospitals in Hamilton

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HOSPITALS-SHELTERS WORKING GROUP

EDUCATION, COMMUNICATION, COLLABORATION

WORKING TO IMPROVE HEALTH OUTCOMES FOR PEOPLE EXPERIENCING HOMELESSNESS

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INTRODUCTION

In the summer of 2005, the Hospitals-Shelters Working Group determined that data was needed to better understand the population of people moving between shelters and hospitals. The objectives of this data collection process were to learn more about this population, to learn about the patterns and trends in movement between hospitals and shelters and to use this information to understand the potential implications for service.

THE HOSPITALS-SHELTERS WORKING GROUP

The Hospitals-Shelters Working Group (HSWG) came together in November 2003 to address service/system gaps identified by area shelters. The Hospitals-Shelters Working Group was created when those working in the shelter system expressed frustration with lack of adequate communication around discharges from Hamilton's hospitals of people experiencing homelessness. Clients would often arrive, from hospital, at a shelter with complex medical needs, no discharge summary and no follow-up provisions.

Since that initial meeting, the HSWG has forged a strong alliance between the two systems. Communication has increased and discharges are smoother. Since the inception of HSWG, Hamilton has experienced increased integration of health and shelter services. There is now a Hospitals-Shelters Education Coordinator to assist with complex discharges and provide education across both systems; there is a Discharge Beds Program at the Salvation Army, which provides primary health care services to men and women who have recently been discharged from hospital and experiencing homelessness. While not directly involved, the HSWG has been a vocal supporter of the recently opened management of alcohol program, Claremont House – Special Care Unit.
See appendix A for the list of participating agencies.

METHODS

In a four month period – September 1, 2005 to December 31, 2005 – the Hospitals-Shelters Working Group in Hamilton collected data about the travel between shelters and hospitals of people experiencing homelessness. The HSWG enlisted the assistance and incredible support of the Social Planning and Research Council who generously donated time and resources to help with the project from its inception to the completion of this report. During the four month period statistics were collected at shelters and both withdrawal management sites, through a survey (see appendix C). A total of 242 completed surveys were collected. Due to reasons of confidentiality, we did not track the names of clients surveyed. Thus, it is important to note that the statistics collected here are for transfers between shelter and hospital, and not necessarily for separate individuals.

Binders were placed at each shelter and each contained the following materials:

- Surveys
- Hospitals-Shelters Working Group – Data Collection Guide
- Protocol for client transfer from shelter to hospital
- Emergency Department Social Work contact list

The Hospitals-Shelters Education Coordinator offered training to all organization staff members completing the data sheets and collected completed surveys every Friday.

In January we received extremely generous assistance and training from the Community Centre for Media Arts (CCMA), the result of which was the creation of a database and spreadsheet containing the results from the survey. Paul Uy, a McMaster Health Sciences student happily completed the onerous task of entering data, as well as helping to enrich the research with his knowledge, skills and time.

SHELTERS IN HAMILTON

There are approximately 475 shelter beds in Hamilton, including 44 addiction beds that participated in the survey. This translates to approximately 57,000 shelter bed nights being used during that time period.

Shelter	Beds
Mary's Place	**9**
Native Women's Centre	**16**
Wesley's Youth Shelter	**15**
Interval House	**20**
Notre Dame Youth Shelter	**21**
Martha House	**28**
Inasmuch House	**57**
Good Shepherd Centre	**40**
Missions Services	**58**
Wesley Centre	**70**
Salvation Army Booth Centre	**118**
Men's Withdrawal Mgt	**20**
Womankind	**24**

KEY THEMES

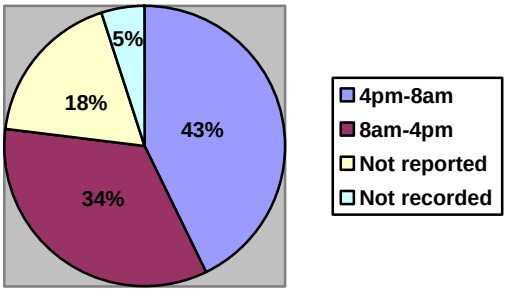
A close look at the data reveals five major items of significance for the Hospitals-Shelters Working Group.

1. The time of day has potential implications for service delivery.
2. The lengths of stay and the last visit to hospital tell us something about the potential connection between hospitals and the lack of family doctors.

3. We are interested in gender differences in use of hospital services, especially since there are significantly fewer shelter beds for women than for men.
4. Source of income tells us something about potential gaps in our income security system.
5. The themes emergent in the responses around communication between hospitals and shelters indicate a lack of consistent protocol between the hospital and shelter systems.
6. Modes of transportation tells us something about indirect costs.

Time of Day

The study found that a large number (54%) of people accessed the hospital at times outside of traditional business hours. Many clients accessed the hospital between 4pm and 8am during the week and at various times on weekends.



This information is significant for two reasons: first in the way that shelters are staffed; and second in the way that hospital social work departments are staffed.

Often it is evenings, nights and weekends when many shelters rely on single-staff coverage. Mary's Place and Martha House have only one staff working in the evenings/nights and on the weekend. Some of the men's shelters, like Mission Services for example, have one staff working during the evenings/nights and on the weekends as well.

Time of day may also have implications about how emergency social work services are developed. At all major hospitals in Hamilton, coverage extends from 8am to 8pm and on the weekend. According to one key informant who works at a shelter,[1] the availability of social workers at the hospital is a crucial element in discharge planning. The overarching issue is communication. The availability of a social worker facilitates more thorough information sharing, enabling shelter staff to plan appropriate care and supports while the client is staying at the shelter. Our key informant stated that communication with the social worker helps with planning around such issues as accessing medications and drug funding. Having this kind of collaborative relationship with the social workers is important in ensuring a smooth transition from hospital to shelter. The

[1] Charmaine S – Mary's Place

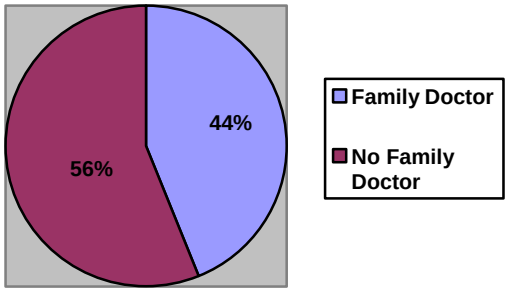
shelter worker noted that when social work is not available the level of information shared is far lower.

Lengths of Stay and Last Visit to Hospital

In total, 54% of respondents visited the hospital for less than one day. Almost half of these visits lasted four hours or less. Of the 54% 1 in 4 had visited the hospital during the preceding week.

The issue of length of stay and last visit to the hospital is a complex one. The short-term and frequent visits identified in this research may suggest that people are using emergency departments for reasons other than actual emergencies. It is in some ways connected to the decision to go to the emergency department instead of a family physician.

This is also the case throughout the general population and cannot just be attributed to homelessness. Long waits to see a family doctor could be one reason, along with difficulties becoming a new patient of a family physician. Of the 242 clients surveyed, less than half (107) reported having a family doctor. The remaining 135 (56%) have no family doctor. Although there have often been only two or three family physicians accepting new patients in the past, at the time of this writing, according to the Academy of Medicine there are twelve family physicians in the City of Hamilton accepting new patients.[2] However, even though a family physician may be listed with the Academy, a client still needs to undergo an intake interview and then may not be accepted. Many physicians require a new patient to be free of all medications in order to be accepted.[3] The Ontario College of Physicians and Surgeons lists a few more physicians accepting new patients, although often a phone call inquiring about an appointment will be met by the disclosure that the physician is not actually accepting new patients after all.[4]



Homelessness and the issues that accompany the harsh realities of survival on the street and in shelters are strong determinants of health in this population. People experiencing homelessness have much higher mortality rates than the

[2] Hamilton Academy of Medicine (2006). URL: http://www.hamiltondoctors.ca/finddoctor/
[3] Hospitals-Shelters Working Group meeting discussion – June 15, 2006.
[4] ibid.

general population.[5] Individuals often access emergency departments because of poor health due to homelessness, i.e. living in crowded shelters, spending whole days out in inclement weather, lack of money for medication, lack of proper storage of medication, poor nutrition, sleep problems, chronic physical and mental health problems, and health problems associated with addictions. Stephen Hwang points out that, "disease severity can be remarkably high because of factors such as extreme poverty, delays in seeking care, nonadherence to therapy, cognitive impairment and the adverse health effects of homelessness itself."[6] He reports that seizures, foot problems, chronic obstructive pulmonary disease, arthritis and other musculoskeletal disorders are prevalent amongst homeless adults, and that hypertension, diabetes and anemia are often inadequately controlled and are can go undetected for a long time. Moreover, oral and dental health is often poor.[7]

In the 2004 report, Health Needs Assessment and Recommendations for Improving the Health of Those Experiencing Homelessness in Hamilton, the authors note that 80% of respondents to their survey reported using an emergency department in the previous twelve months. They surveyed 302 people experiencing homelessness in Hamilton.[8]

The same report noted the difficulty many people had with follow-up appointments.[9] Although it was not covered in our survey, conversations with outreach workers indicate that people experiencing homelessness do not have watches, clocks or calendars and therefore keeping appointments set weeks ahead of time is very difficult.[10] This would pose a barrier for many of these clients in accessing proper healthcare. If someone is unable to follow up an appointment for a serious health issue, there is a danger that person will end up in the emergency department before long.

In the Health and Homelessness report eighty-five percent or respondents indicated that they had a family doctor.[11] In our survey 107 people or 44% reported the same. While many of the presenting issues could likely only be treated in the emergency department, one reason people may have chosen the emergency department instead of an appointment with their family doctor is the issue of long waits to see their family doctor. When a person has to wait four to

[5] Hwang, S. (2001). Homelessness and health. Canadian Medical Association Journal, 164, (2).
[6] ibid
[7] ibid
[8] Thomas, H, Semogas, D, Gordon, J. (2004). Health and Homelessness: Health Needs Assessment and Recommendations for Improving the Health of Those Experiencing Homelessness in Hamilton. Hamilton, ON.
[9] ibid.
[10] Mental Health/Outreach Team – Community Services Department, City of Hamilton and community partners.
[11] op cit.

six weeks to see his or her family doctor, some might see it as more useful to go to a hospital where he or she will be seen the same day.[12]

Women

As we already know, women have lower incomes than men and are more likely to use healthcare services.[13] Women are also underserved in terms of homelessness. While there are 145 beds for women in Hamilton, there are only nine beds specifically designated for homeless women and it is very difficult to access those shelter beds because they are often full. The Wesley Drop-in has 15 mats for women in its co-ed space.

Significant numbers pertaining to women in the study:

- Fifty-five of the 242 people surveyed were women.
- More than 16% of women cited abuse as their reason for accessing shelter, compared with no men.
- As many as 31% of women claimed 'no income' when asked for their source of income, as compared with 18% of men.
- Mary's Place sent the largest number of women to the hospital.
- More women stated reasons connected to sexual violence than men for their reason for accessing the hospital.

The research noted that of all the women's shelters, Mary's Place sent the highest number of women to hospital over the 4 month period (20 or 36%). Mary's Place is the smallest women's shelter in Hamilton with only nine beds and is the only shelter in the community specifically dedicated to serving the needs of homeless women. Other shelters, such as Martha House, Native Women's Centre and Inasmuch House are funded as 'violence against women' shelters, but none of these will turn away a woman who is homeless for reasons other than violence. It is worth noting that women who are homeless also face violence while living on the street. Interval House is the only women's shelter in Hamilton that has a strict mandate to offer shelter to women fleeing abuse only.

According to the data, three women went to hospital from a shelter because of sexual assault. Others had injuries, but it is not clear how the injuries were sustained; two went because of possible overdoses and one was suicidal. From other shelters that are co-ed, one of the three women who experienced sexual assault went to hospital from Notre Dame Youth Shelter; and one woman, also from Notre Dame went to hospital because of overdose. Most of the women went to hospital for general physical problems, although two accessed Emergency Psychiatry at St. Joseph's (EPT).

[12] Martha Wiles – Mental Health/Outreach Team – May 2006
[13] Statistics Canada (2006). Women in Canada: A gender-based statistical report. Fifth Edition.

Health Issue	Number of women (n=55)
Injury	**9**
Chest pain	**5**
Sexual assault	**3**
Overdose	**3**
Seizure	**2**
Labour	**2**
Psychiatric	**2**
Other medical	**29**

36% of women in this study who went to the hospital have no family doctor. 65% were in the shelter because of homelessness. Often homelessness among women intersects with abuse, mental health problems, or addiction.

Many of the women who went to hospital accessed it during times when shelters have only one staff working. Thirty-three, or 60% were sent to hospital during the evening hours.

As noted above, homeless women experience different kinds of barriers to health care and housing. Many of the women who access Mary's Place are living with mental illness and have a deep mistrust of the health care system. In many cases, these women will not have accessed health care services for a long time, and so medical and mental health conditions may have gone untreated for years.[14]

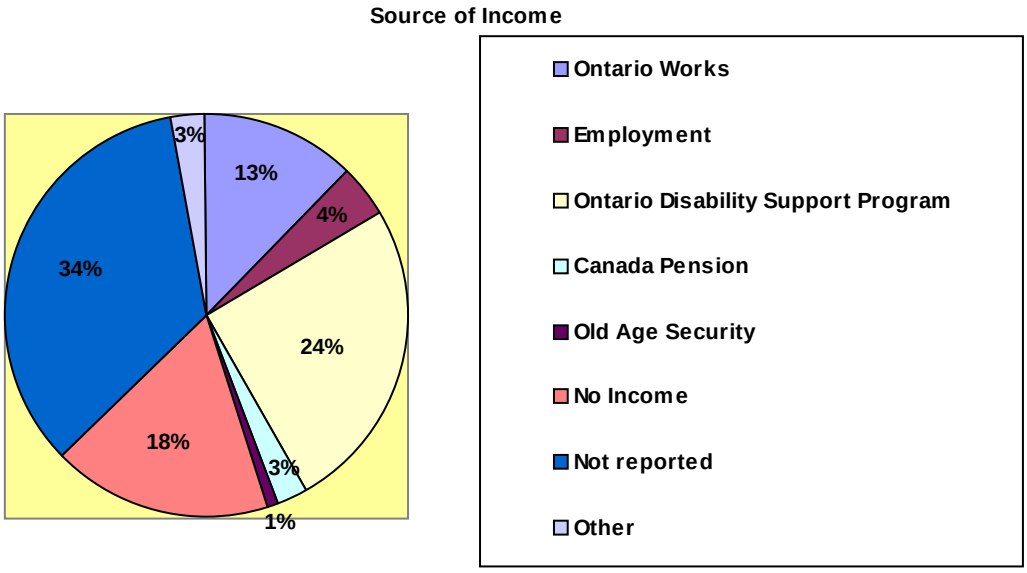
Violence, abuse – whether experienced in a domestic situation or on the street – and homelessness all negatively impact women's level of health and well-being. Yet stigma, fear and lack of access can diminish the likelihood that abused/homeless women will receive essential medical care. The data suggests, however, that women living in shelter do access hospitals, which raises the question of whether women's shelters might serve as an effective gateway to health services for highly marginalized women.[15] Early assessment of the Salvation Army's Discharge Beds Programs suggests that connecting primary healthcare to the shelter system may be an effective, creative response to the health needs of homeless individuals.[16]

Source of Income

Nearly 40% of respondents received income from one of two income support programs. Most of the respondents (25%) reported receiving their income through the Ontario Disability Support Program (ODSP). Twenty-nine (12%) were

[14] Katherine Kalinowski – personal communication.
[15] ibid.
[16] While a formal assessment has not been completed, early statistics indicate the Discharge Beds Program is being well-used. Between September 1 and December 31, 2005 26 new clients were admitted into the Discharge Beds Program at Salvation Army. Forty-two new clients were admitted between January 1 and May 31, 2006. For more information contact the Salvation Army Booth Centre at 905-527-1444.

receiving social assistance through Ontario Works. Almost 1 in 5 respondents reported having no income at all.



It is alarming that so many of the respondents are receiving ODSP. The Ontario Disability Support Program was created to provide people with disabilities and chronic health problems enough of an income to support housing and basic needs. It is evident from this research, however, that many people receiving ODSP are facing homelessness. To be eligible for ODSP a person must be facing significant health challenges, which may be exacerbated by living in shelters, many of which cannot be accessed during the day, have no medical staff and have dormitory-style living conditions. The high number of ODSP recipients using shelters raises questions about the adequacy of ODSP and OW rates. Interventions like the recently reduced special diet supplements, drug coverage and special supports should help to reduce the number of people receiving ODSP and Ontario Works from having to use hospitals to get non-emergency needs met. Other psychosocial factors might also be playing a role, in which case the Discharge Beds Program and the Primary Health Care Clinic at Salvation Army, and projects like Claremont House – Special Care Unit and the Inner City Health Project might help to mitigate overuse of emergency services.

Communication between Shelters and Hospitals

For 175 (72%) clients, the shelter reported no communication between the shelter and the hospital, while in 67 (28%) of the cases there was communication either about discharge plans or communication from shelters to say a client would be arriving in Emergency shortly.

In-depth interviews on this topic were conducted with a men's shelter and an addiction treatment program.[17] Both facilities have a communication protocol. The addiction treatment program has an actual 'transfer record' that they send with the client to the hospital. There has to be communication about discharge before the client is able to return to the program. At the men's shelter the communication is via phone – once as the client is travelling to the hospital and two hours later for follow-up. There is no information about discharge planning.

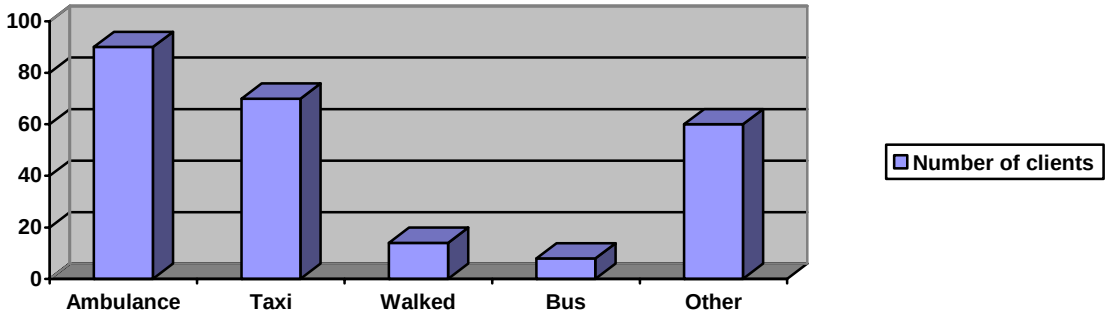
Interestingly, neither the shelter nor the addiction program stated that there is an actual protocol in place. Both stated they have a protocol in the works and both agreed that the protocol used in this research project is a good model. The shelter trains new staff in communication procedure when they begin their job.

A key informant at one of the hospitals told us that any patient presenting in the emergency department who has arrived from a shelter or is returning to a shelter should be an "automatic referral" to social work.[18] She also stated that her data tells her that on evenings/weekends the social workers are not getting the referral. The obvious gap raised by this statement may be addressed by a consistent communication protocol.

According to these key informants, it would appear that a consistent communication protocol might be useful. Further discussions will have to take place at the Hospitals-Shelters Working Group table, but it is clear that communication between the shelters and hospitals benefit the client.

Transportation

Most people (90) went to hospital by ambulance and 70 travelled by taxi. A small number (14) walked to the hospital themselves and a few (8) caught a bus. The rest travelled in cars of friends or were accompanied on foot.



In terms of transportation, both the shelter and the addiction program reported calling an ambulance when the client is experiencing an acute health problem, or is having a seizure. The addiction program stated that taxi is the most common

[17] Salvation Army Booth Centre and Womankind.
[18] Leslie Starr, Chief of Social Work, St Joseph's Healthcare – personal communication – May, 2006

mode of transportation, whereas the shelter uses taxis when the client experiences difficulty walking or is disoriented. The addiction program distributes bus tickets for follow-up appointments. The shelter uses them if there is no walk-in clinic open, and if the client requests to go to emergency alone.[19]

An ambulance trip costs $45.00 and taxis are usually paid for by the shelter or an outreach worker. The Salvation Army Primary Health Care Clinic is a good option in diverting non-emergencies from the hospital and Emergency Medical Services. While many clients are members of local community health centres, there are still those who are not attached to a family physician anywhere. Expansion of the Primary Health Care Clinic Services, along with continuation of the Salvation Army Discharge Beds Program and Claremont House – Special Care Unit would help to alleviate the kind of indirect costs associated with ambulance and taxi trips.

CONCLUSIONS, RECOMMENDATIONS AND NEXT STEPS

This report is a very preliminary glance at the issues people experiencing homelessness and health problems in Hamilton are facing. The alliance that has been built between the hospital and shelter systems is strong. Both systems recognize the challenges in providing effective health care to this very vulnerable population.

Homelessness is a social determinant of health. People experiencing homelessness, living on the street and in shelters and surviving in an environment that can be brutally harsh use health services differently and more often that the mainstream population.[20] The issues are complex. There are issues around survival, respect and the principles of the social safety net that our country values. Universal healthcare is a privilege that Canada is fighting to maintain. People who suffer from a lack of affordable housing – housing that responds on a continuum to the needs of marginalized people – experience poor health as a result of being homeless. Hwang points out that mortality rates for men in are higher by approximately 8 times than the general population.[21]

So, the problem is two-fold and affects us all. First, people experiencing homeless will die sooner and experience poorer health throughout their time being homeless. Second, the health care system itself experiences challenges due to the higher cost of ambulance trips, emergency department use and increased hospital admissions of this population.

[19] op. cit.
[20] Hwang op cit.
[21] ibid.

Recommendations and Next Steps

1. In order to better understand this population, more research needs to be conducted to determine if other interventions (beyond emergency room trips) are possible for people who face homelessness and health issues.

2. Shelters and hospitals will benefit from a coordinated communication protocol.

3. If more information is gleaned from shelters around transportation, a recommendation might be to increase funding to shelters for transportation, in order to cut down on ambulance trips.

4. The HSWG is committed to collaborating on further research and discussing ways to collaboratively address some of the emergent issues.

5. The HSWG will distribute this information widely.

6. The HSWG is committed to building upon its collaboration between shelters and hospitals

APPENDIX A

Hospitals-Shelters Working Group Members

Wesley Urban Ministries
Mission Services of Hamilton
Salvation Army
Good Shepherd Centres
Hamilton Health Sciences Corporation
St. Joseph's Healthcare, Hamilton
Mental Health/Outreach Team
Community Schizophrenia Services
Womankind
Men's Withdrawal Management Program
Ontario Works (Special Supports; RCF and Hostels)
Emergency Medical Services
Community Care Access Centre
YMCA
McMaster University Faculty of Health Sciences (student volunteer)
Social Planning and Research Council

Many thanks to the following individuals and organizations for their encouragement, suggestions and support:

Jennie Vengris and the Social Planning and Research Council, Katherine Kalinowski, Paul Uy, Charmaine (staff at Mary's Place), Gwen Jamieson, Candice Babbey, the staff of Wesley Centre, Mission Services, Salvation Army Booth Centre, Good Shepherd Men's Centre, Mary's Place, Martha House, Interval House, Native Women's Centre, Inasmuch House, Womankind, Men's Withdrawal Management Centre, Irina Andriychuk at Community Centre for Media Arts, Valine Vaillancourt, the Mental Health/Outreach Team at City of Hamilton, Pauline Kajiura of Sexual Assault Centre of Hamilton and Area, Karen Elliott, the membership of the Hospitals-Shelters Working Group, Lori Issenman, Leslie Starr and especially all the people who participated in our survey.

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APPENDIX B

HOSPITALS-SHELTERS WORKING GROUP – DATA COLLECTION GUIDE

Why are we doing this research?

The Hospitals-Shelters Working Group (HSWG) is embarking on some research to better understand some of the trends and patterns in the population of homeless people who are moving between the hospitals and shelters. We are asking each shelter in Hamilton to keep some basic statistics on these particular clients. We will be collating and analyzing this data so that we can produce reports to the HSWG to increase awareness of the client population and potentially impact on service design. Eventually this information might inform a larger evaluation of the HSWG and the communication relationship between the hospitals and shelters.

In order to complete this project we need your help and cooperation. This is a guide to answer any questions you might have about the process. If you have a question that is not answered through this sheet, please contact Patricia Medeiros (Hospitals-Shelters Education Co-Ordinator) at 905-527-1444 Ext 27 or email medeiros@sallyann.net.

When should this form be filled out?

- The form is divided into two sections:
  - Section A) To Be Completed When Sending a Client to Hospital – this should be filled out as soon as possible after sending the client.
  - Section B) To be Completed When the Client Returns From Hospital or When a Client Arrives at the Shelter from Hospital – this should be filled out soon after you see the client return.

What should I do if the client doesn't return?

- If the client does not return from the hospital, you can complete the form by checking the box "No further information known" in Section B – question #11.

What should I do if I hear that a client has come from the hospital to our shelter but we didn't send them there?

- If you did not send the client to the hospital from your shelter, fill out only Section B.

Some of these questions are very personal – what if the client does not want to answer them?

- Some of the questions may be difficult or intimidating for a client to answer (particularly questions about country of origin and citizenship). We are asking these questions because we don't want to miss out on potentially important experiences that diverse people are facing. You should explain at the outset why were are asking these questions (see "Why we are doing this research" above) and always explain that <u>they can choose to not answer any question without any impact on their ability to stay at the shelter</u>.

What does it mean when it says "client self-identification" and "specify if not identified here"?

- Some peoples' identities (especially around gender, Aboriginal status) do not fit into a certain category. This provides the opportunity for the client to say how they identify. If a client answers something different than the answers provided, write their response in the

blank line. It is important that clients know that their answer will be honoured, even if the worker suspects the answer is different (so, if someone chooses to identify as female, when the worker thinks it's clear that the client is a male, the client needs to know that his or her response will be taken seriously).

What should I do if a client has more than one answer?

- Check them all – clients may have more than one response for a question and that is fine, indicate all of the responses given on the form.

What are all of the acronyms in the "source of income section"?

- OW – Ontario Works, ODSP – Ontario Disability Support Program, CPP – Canada Pension Plan, OAS – Old Age Security, GAINS – Ontario Guaranteed Annual Income System

What does "left hospital to alternative location" mean?

- Staff would check this box when it is discovered that a client did indeed leave hospital but ended up somewhere other than the shelter that sent him or her. Oftentimes, staff will not know this information and will check "no further information known".

What is the comments section for?

- This section gives clients and staff the opportunity to indicate if any further information is known. This might include the experience of the transfer between shelter and hospital, important information that is not captured in the questions or feedback on the form. Don't hesitate to make comments and don't worry if you can't decide if they are worth mentioning – they likely are, so indicate them and the researchers can decide if the comments fit with the information we are trying to collect.

What do I do when this form is completed?

- Place it with the other Hospital/Shelter Working Group – Data Collection Forms in the binder provided. Bi-weekly, Patricia Medeiros will pick the forms up from your shelter.

Thank you so much for your cooperation with this project. Please don't hesitate to contact Patricia if you have any questions at all. Again her contact information is:

Patricia Medeiros
Hospitals-Shelters Education Co-Ordinator
905-527-1444 Ext 27
medeiros@sallyann.net

APPENDIX C

HOSPITALS-SHELTERS WORKING GROUP – DATA COLLECTION SHEET

Shelter:

□ Good Shepherd □ Mission Services □ Wesley Centre □ Salvation Army Booth Centre
□ Martha House □ Mary's Place □ Inasmuch House □ Native Women's Centre
□ Interval House □ Notre Dame House □ Wesley Youth Shelter
□ Men's Withdrawal Management Centre □ Womankind Addiction Service

SECTION A
TO BE COMPLETED WHEN SENDING A CLIENT TO HOSPITAL:

1) Client initials: _____
2) Date: _____
3) Reason sent: _____
5) Sent By:

□ Ambulance □ Taxi □ Accompaniment □ Walked □ Other_____

6) Hospital:

□ St. Joseph's Hospital □ St. Joseph's Healthcare Hamilton – Mountain Site
□ HHSC - General Hospital □ HHSC – McMaster □ HHSC - Henderson Hospital Medical Centre

SECTION B
TO BE COMPLETED WHEN THE CLIENT RETURNS FROM HOSPITAL OR WHEN A CLIENT ARRIVES AT THE SHELTER FROM HOSPITAL:

QUESTIONS ABOUT YOUR TRIP TO THE HOSPITAL:

1) Which hospital did you go to?
□ St. Joseph's Hospital □ St. Joseph's Healthcare Hamilton – Mountain Site
□ HHSC - General Hospital □ HHSC - Henderson Hospital Medical Centre □ HHSC – McMaster

2) What part of the week did you go to hospital?
□ Weekday □ Weekend

3) Approximately what time did you go to the hospital?
□ 8-4 p.m. □ 4-12 a.m. □ 12-8 a.m.

4) How long were you in the hospital?
□ Less than four hours □ Less than one-day □ 1-3 day's □ Up to 1-week □ 1-3 weeks
□ 1 month or more

5) Before this time, when was your last visit to the hospital?
□ within 1 week □ 2-4 weeks □ 1-3 months □ 3-6 months □ 6–12 months □ 12 + months □ Unknown

6) What was the outcome of the hospital visit?
□ Discharged from hospital □ Left hospital to alternative location
□ No further information known □ Left without medical attention □ Left against medical advice

7) Did the hospital visit meet your needs?
□ Yes □ No Explain _____

OVER ➡

QUESTIONS ABOUT YOU:

1) Age range

□ > 16 years □ 16-21 □ 22-44 □ 45-64 □ 65+ □ No answer

2) Gender (client self-identification)

□ Male □ Female □ Transgender □ Specify if not reflected here _____ □ No answer

3) Source of income (client self-identification)

□ No income □ Work □ OW □ ODSP □ CPP □ OAS □ GAINS □ Other _____
□ No answer

4) What is your 1st language? _____ □ No answer

5) What is your country of origin? _____ □ No answer

6) □ Permanent resident? □ Refugee? □ Recent immigrant? □ Canadian citizen □ No answer

7) Are you Aboriginal (First Nations, Metis, Inuit)? □ Yes □ No □ No answer

8) Why are you coming to the shelter? (Client self-identification)

□ No where else to go □ Addiction □ Mental Health □ Employment □ Education □ Abuse □ Housing
□ No answer

9) Do you have a family doctor?

□ Yes □ No □ In the process of getting one □ No answer

STAFF:

1) Was there any communication between shelter staff and hospital staff during the client's stay at hospital (i.e. contact with emergency room staff, discharge information)? □ Yes □ No □ I don't know

Please specify what sort of communication:

_____

COMMENTS (STAFF OR CLIENT):

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

APPENDIX D

PROTOCOL FOR CLIENT TRANSFER FROM SHELTER TO HOSPITAL

CLIENT OR SHELTER STAFF IDENTIFIES NEED FOR CLIENT TO GO TO HOSPITAL

↓

CALL 911
(If necessary)

↓

- Attempt to get consent from client to share information with hospital staff
- Give paramedics any medical information and/or medication list of client to take to hospital
- Ensure paramedics inform shelter staff which hospital client is being taken to

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SHELTER STAFF CONTACT ER SOCIAL WORKER (See Contact Sheet) or ER FRONT DESK/CHARGE NURSE (after-hours)

- Provide any further information necessary to establish plan of care and discharge plan i.e. medical history, behaviors, medical needs.
- Provide any client next-of-kin information (if available).
- Hospital staff will contact next-of-kin
- Please inform hospital staff whether client is unable (barred) or able to return to shelter (if known at that time).

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ER SOCIAL WORKER CONTACTS SHELTER STAFF

- Gain patient's consent to share any medical/personal information with shelter staff
- Social Work to contact shelter staff once medical issues have been addressed to discuss discharge planning i.e. transportation arrangements, accessibility, follow-up care requirements, medical needs etc.

APPENDIX E

EMERGENCY DEPARTMENT SOCIAL WORK CONTACT LIST

HAMILTON GENERAL HOSPITAL	ST. JOSEPH'S HOSPITAL	MCMASTER MEDICAL CENTRE	HENDERSON HOSPITAL
SOCIAL WORK HOURS: MON-FRI: 8-8 WKNDS & HOLIDAYS: 10-6 GENERAL MAIN #: 905-527-4322 ER Social Work Office: ext#: 44589, Pager # 1478 ER Front Desk: ext. 46251 Full-Time Social Worker: Bethany Sprowl (day: 830am-430pm) Occasional Part-Time (evening 4-8/weekend 10-6) Mark Coupland Pat Hitchcock Malene Stewart Martha Wiles Heidi Zimmer-Holloway	SOCIAL WORK HOURS: MON-FRI: 9-5 No Evening/Weekend coverage ST. JOE'S MAIN #: 905-522-1155 ER Social Work Office ext#: 5042, Pager # 997 ER Front Desk ext: 3997 Full-Time**:** John O'Neill (day 9-5) Effective **February 20th, 2006** the Social Worker in ER at SJHH provides **increased coverage** on an on-call basis follows: **Weekdays** – 5:00 to 9:00pm **Weekends** – 10:00 to 6:00pm	SOCIAL WORK HOURS: MON-FRI: 8-8 WKNDS & HOLIDAYS: 10-6 MUMC MAIN #: 905-521-2100 ER Social Work Office ext#: 73421, Pager # 1030 ER Front Desk ext: 75020 Full-Time: Gwen Jamieson (day: 8-4pm) Regular Part-Time: (evening/weekends) Sarah Goodman (mat leave) Meredith Moore Ellen Robinson Occasional Part-Time: Josie Cirella Kelly Kilbreath Carol Chartrand Anna Gualtieri Mark Coupland Jennifer Dunlop	SOCIAL WORK HOURS: MON-FRI: 8-8 WKNDS & HOLIDAYS: 10-6 HENDERSON MAIN #: 905-389-4411 ER Social Work Office ext: 42294, Pager # 7364 ER Front Desk: 73800 Full-Time: Leah Driscoll (day: 8-4) Regular Part-Time: (evening: 4-8pm) Joy Stephenson Dawn Prevost Occasional Part-Time: (evening/weekend) Dawn Prevost Sandy Yuen Alyson Marshall Catherine Phillips Tracey Clark