DETERMINING THE FEASIBILITY OF A MEDICAL RESPITE INTERVENTION STUDY FOR OLDER HOMELESS PATIENTS IN METRO VANCOUVER
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Since the mid-1980s, the homeless population in Canada has grown. This is pronounced in Metro Vancouver where the 2017 homeless count identified 3,605 homeless persons—21% of whom were older adults (age 55+ years). This represents a 162% increase in homelessness among persons aged 55+ and a 450% increase among persons aged 65+ between 2008 and 2017. In both research and practice, age 50 has been used to characterize older homeless persons, largely because the mental and physical health of older homeless adults most closely typify those of persons 10 years older. In addition to significant substance use and mental health issues experienced by this population, older homeless adults are often also living with multiple physical health issues. Persons with lived experience of homelessness (PWLEs) often present with acute, communicable diseases, which are spread easily through shared shelter spaces, as well as chronic conditions that worsen over time, including diabetes, foot and leg problems, congestive heart failure, chronic obstructive pulmonary disease, etc. Moreover, respiratory, skin, digestive, and musculoskeletal conditions are frequent medical issues among PWLEs.

The poor health of older PWLEs is challenged by the lack of access to health services, especially primary care. PWLEs frequently receive care in hospital emergency departments, are hospitalized more than the general population, and have lengthy inpatient stays. Health problems, treatments, and care continuity are disrupted by homelessness as individuals often prioritize their basic needs such as safe shelter and food security over healthcare. Likewise, overexposure to environmental elements, nutritional deficiencies, victimization, and negative coping behaviors affect a PWLE’s health management. These difficulties are exacerbated following hospital discharge because of challenges in affording, filling, and refrigerating prescriptions and adhering to instructions for rest, nutrition, and follow-up care. Even when a PWLE secures a shelter bed following discharge, these locations are suboptimal—there is no guarantee that 24-hour rest can be obtained or that shelter staff can assist with healthcare needs. Safe, clean options for post-hospital recovery are rare for PWLEs, increasing the risk for re-hospitalization.

Medical Respite Care
One response to fill the continuum of care gap between hospital discharge and recovery for PWLEs is medical respite care. Medical respite is the provision of post-acute medical care for PWLEs who are not ill enough to justify staying in a hospital bed, yet are too sick or frail to recover from a physical illness or injury on the streets or in a traditional shelter. The first medical respite programs were developed in the mid-1980s in the United States, and today more than 200 Health Care for the Homeless programs operate nationally and are integrated into the US federal healthcare system. In Canada, the first medical respite program was not developed until 1999 and only three programs have been formally recognized, all of which are in Ontario.

As an intervention, the two primary models of medical respite are: 1) dedicated beds within a homeless shelter or 2) a purpose-built medical respite site. The range of medical respite services vary, though they typically include: medical care, medication management, case management (income assistance, benefits acquisition, housing placement, etc.), onsite or referral to mental health and substance use treatment, transportation, and food. Respite patients receive care ranging from one week to one month, though there is significant discrepancy in length of stay across programs. Referrals to medical respite are made by hospital social workers, discharge nurses, homeless service providers, health and drug clinics, detox facilities,
police officers, prisons, or self-referrals.\textsuperscript{6,7,9,16} Program eligibility varies, although most require patients to be adult PWLEs in need of medical treatment who lack family support and are not actively using drugs or alcohol; some programs require patients to have the capacity for basic self-care, while other programs support patients with activities of daily living.\textsuperscript{7,10,17-19}

With the goal of providing safe and supported locations for PWLEs to continue medical recovery, medical respite interventions have resulted in improved health and reduced healthcare utilization and costs for general populations of PWLEs.\textsuperscript{10} Though research on the impact of respite care has found mixed results regarding the mortality risk of respite patients vs. comparison groups,\textsuperscript{6,19,20} medical respite patients have been found to experience improvements in quality of life, medication stabilization, access to health and community care, insurance, income, and housing, as well as reductions in substance use following treatment.\textsuperscript{7,14,19,21} In addition, medical respite programs have demonstrated reduced future hospital admissions, inpatient days, and hospital readmissions among PWLEs, resulting in significant health system cost savings.\textsuperscript{17,22} As a whole, available literature from other jurisdictions with general populations of PWLEs suggests that medical respite can improve both individual- and system-level outcomes. However, despite the unique and growing healthcare needs of older PWLEs,\textsuperscript{23} no research has specifically focused on the effectiveness of medical respite for this population.

In light of the positive outcomes of medical respite in general PWLE populations in other jurisdictions, the current study examined the feasibility of conducting a randomized controlled trial (RCT) to test the effectiveness of a medical respite intervention for older PWLEs in Vancouver, BC. We examined feasibility by exploring 1) access to patient participants; 2) data availability and collection; and 3) how the intervention could be designed.
Methods

Based on principles of community-based participatory research (CBPR), a patient partner was engaged from the outset of study initiation as a key decision maker on the project team. In addition, a project steering committee, known as the Medical Respite Task Force (MRTF) was formed and consulted quarterly (four times) over the course of this one-year study. The 17 members of the MRTF included the patient partner, research trainee (author of this report), two other patients with lived experience, and multidisciplinary professionals in the health and social service sector with experience coordinating the healthcare needs of older adults experiencing homelessness after hospital discharge. This study utilized the expert knowledge of the project team and MRTF as one source of data, and interviews and focus groups with patients and health and social service providers as an additional source. The research trainee carried out day-to-day tasks to ensure project goals were met, coordinated project team and MRTF meetings, and ensured MRTF feedback was incorporated into project processes and outcomes. In addition, the trainee led data collection and analysis, while ensuring project compliance with University research and ethical standards. Ethics approval was obtained from a University Institutional Review Board and participant names have been removed to protect identities.

Recruitment

Both patient and provider participants were recruited with the assistance of members of the MRTF who were asked to invite their colleagues and to inform their clients about the project. Eight of the patient participants were recruited by the patient co-lead, while other MRTF members recruited the other seven patient participants and all 11 provider participants.

Criteria for participation in the study included: being age 19 or older and involved in the direct delivery or receipt of health or social services for older PWLEs in Metro Vancouver; and able to speak conversational English, participate in an interview for up to one-hour, and give voluntary and informed consent. Written informed consent was obtained from all participants prior to the interview.

Participants

Fifteen patient participants (10 male, 5 female) were interviewed (Table 1). Patient participants ranged in age from 36 to 73 years (M: 54 years); five were living in social housing, six were staying in a transitional shelter, three were living in a general shelter, and one patient participant reported unstable housing at the time of the interview. The majority of patient participants reported being Caucasian (n=10), while 4 patient participants identified as Indigenous, Aboriginal, or Metis; one patient participant reported being Asian and one reported being Black.

The eleven provider participants (5 male, 6 female) were professionals working in clinical, healthcare, shelter, or housing sectors across Metro Vancouver. Five provider participants were employed by a health authority, three were shelter workers, two had an academic affiliation and clinical responsibilities, and one worked for a social service agency. No additional demographic data were collected from provider participants.

Data Collection

Efforts were made to utilize a data collection format most appropriate and acceptable to both patient and provider participants. Thus, in consultation with referring providers and patient participants the trainee determined whether one-on-one interviews or focus groups were more appropriate. All participants indicated their preference for either an in-person or phone interview, or focus group setting. All preferences for interview type were accommodated.
Patient participants were interviewed between July and November 2018. Three of these interviews were conducted over the phone and all others were conducted in-person. Eleven of the fifteen participants opted for a one-on-one interview, while one focus group with four patient participants was conducted.

Provider participants were interviewed between September 2018 and February 2019. Nine of the provider participant interviews were one-on-one interviews conducted by phone, while two provider participants participated in an in-person focus group. Patient participants received a $25 gift card to Tim Horton’s (which was donated to this project by Catholic Charities) for their participation; no provider participants were paid for their time in this study.

Prior to data collection, interview questions were developed by the project team and subsequently reviewed and approved by the MRTF. The interview guide incorporated questions from the existing literature, though modified to fit the local context (Metro Vancouver), as well as others that related to the project goals. A semi-structured interview guide (Appendix A) was developed for patient participants and differed from that developed for provider participants. However, these interview guides remained the same for both interviews and focus groups. For five patient participant interviews, in-depth, detailed notes were taken as participants opted out of having their interview audio recorded or the public setting of the interview was too noisy (e.g., coffee shops). All other interviews were audio recorded and transcribed verbatim.

**Data Analysis**

Interview data were analyzed using five phases of thematic analysis\textsuperscript{24}: 1) the project trainee conducted two initial rounds of reading and then re-reading the transcripts to gain familiarity with the data; 2) initial codes were generated and patterns of meaning in the data were examined; 3) all the identifiable codes within themes were collated and re-arranged and re-organized; 4) the initial set of themes were shared and discussed with the MRTF and themes were subsequently refined and further organized; and 5) themes were defined and named, and a final set of themes was reviewed with the MRTF. The qualitative data management software QSR NVivo\textsuperscript{25} facilitated data analysis.
Participants’ reports can be categorized into two primary categories: 1) what a program of research on medical respite should involve; and 2) what a medical respite service should include. First, we describe participants’ reports on the qualities that researchers should have when engaged in research with persons with lived experience (PWLEs) of homelessness who are in a medical respite program and outline preferences for study design, data collection, and participant recruitment and retention. We then turn to participants’ opinions of what should be included in a medical respite program, including the culture of the program, the physical design of a medical respite site, who should be involved in the delivery of medical respite services, and what services should be provided.

1. What a Program of Research on Medical Respite Should Involve

**Desired Qualities of Researchers**

Participants described qualities they felt important for researchers to have in order for a program of research on medical respite to be successful, including qualities that would aide participant recruitment and retention, as well as data collection. In addition to being friendly, empathetic, open-minded, non-judgmental, and patient, a key quality of researchers was reported to be their ability to build trust and ongoing relationships with potential research participants. As one patient participant stated, “Trust is a privilege.”

A provider participant described how building trust and showing potential research participants that the research team cares is highly important. This may particularly be the case for researchers engaged in working with medical respite program participants, some of whom have historical mistrust of the healthcare system and of persons in positions of power.

“They’ve started to see that nobody is listening to them, nobody is doing anything, then that starts to compound on them as well. And then it starts that mistrust of service providers. Well, so-and-so told me this, but it never happened. So, I think for them to be open and honest and open to listening to what the person has to say.” (Provider participant)

If someone has a trusting relationship with this population, then [engaging some of these folks] probably would be made easier, depending on who’s going to be doing the interviewing. If you just get somebody cold off the street, it may work, but we found that because we knew who to [approach], that was kind of helpful.” (Provider participant)

It was emphasized that researchers be flexible and non-judgemental when conducting research in a medical setting because of the unease that some people may experience when involved with institutionalized care.

“You’d have to be very flexible, because everyone has a different kind of reaction when they’re in a healthcare setting. I think just being mindful of the fact that some people feel like a really kind of, oppressive vibe when they come into healthcare settings and some people are really anxious and scared of it, or and some people are comfortable. And so just being flexible in that, and knowing that it’s not a comfortable environment for everybody, and so some people might require a little more time and like, rapport building and flexibility to be not only in like a medical setting but also participating in a research study. I could see especially for like some Indigenous people, in particular, it could be very challenging, given the history of everything that’s happened.” (Provider participant)
Respecting research participants’ dignity and being mindful of what’s going on in the moment was reported to be important in determining whether people are comfortable during data collection. If discomfort is sensed, participants suggested that researchers stop their line of questioning. As well, questioning potential patient participants about sensitive topics needs to be done with skill so that questions are not perceived as too blunt or abrupt. Outlining protocols for what potential participants can expect over the course of the study in an informed consent document was recommended: “Kind of like the consent form that you sent me [for this study], going over what could happen and what they'll get out of it. If they’re ever feeling overwhelmed, it’s totally fine, just let us know, and we can kind of adjust things and just try to make it as welcoming as possible.” (Provider participant)

Patient participants, in particular, highlighted that having empathy was important because of the trauma and mental pain that often accompany potential patient participants’ physical health. For instance, one patient participant noted that researchers should, “Probably [have] some level of emotional connection with the trauma that’s going on…” Another agreed: “It’s just taking a really skilled person who has a lot of empathy and understands physical illness or injury. Is it going to trigger and bring up other pain that is not physical for that person? Because that’s kind of what hospital is about. So, I think it’s really knowing you’re not just talking to someone who has a physical injury, you’re talking to someone that has a physical injury that’s triggering and bringing up other stuff.”

In describing whether there is any type of information that is too personal for people to be asked about, a patient participant stated, “I don’t know. Sometimes people don’t want to talk about the past, some people want to talk about the past. It’s how you feel about the person [i.e., the interviewer]. Personalities matter, right?”

In addition, being able to convey to potential research participants that their story is heard and valued was considered important to collecting data. “Be mindful of, you’re not just doing this because you want to develop a program, you’re interested in them at that exact moment. There’s nobody else that you’d rather talk to at this moment but them. And ensure that they’re not possibly thinking, ‘She’s only talking to me because I’m in this situation, it has nothing to do with me.’ And you actually convey that their opinion—no matter how ludicrous it may be—is valued at that moment.” (Provider participant)

A patient participant also wanted there to be recognition among researchers that mental illness does not preclude individuals from self-determination and the ability to make decisions: “As a researcher, too, you need to know that just because there are patients in there and they are mentally ill, [it] doesn’t mean that they’re not aware of the decisions they’re making while they’re in there.”

“A peer research assistant would be someone who’s a peer who either is homeless or has been homeless and they’re older and they understand what they’re looking for. Because they can reach out to these people so much easier…”

Peer researchers
Patient and provider participants agreed on the value of having peer researchers involved in the development of future research on medical respite. A peer researcher was described as someone who would be able to relate to potential participants on a more intimate level because they have also experienced homelessness. “Well a peer research assistant would be someone who’s a peer who either is homeless or has been homeless and they’re older and
they understand what they’re looking for. Because they can reach out to these people so much easier than someone walking down the street…” (Patient participant)

Because trust and relationship building are so important to the research process, a peer researcher was identified as being better positioned to create a sense of security and understanding among potential participants and to obtain more honest reports. “I firmly believe in peer-led, peer-based conversations. So, I’ve been a part of research groups and proposals where there’s actually a peer-designated researcher role within the research team to reach out and to talk to people and so there is that level of acceptance and understanding of community, and that’s really a level playing field for trying to get those real conversations and a sense of safety.” (Provider participant)

One patient participant also suggested that peer researchers who have lived through particular experiences may be able to cope better with data collection than researchers in ways that students just out of school may not be able to: “I think a person that’s been through it and then that’s come out on the other side… Or maybe the people that have worked in all the situations [and] are very empathetic—those people would be good too because they’ve been through it. I’m not saying people right out of school because they don’t got the hands on experience. You want people with hands on experience to deal with this. Because [those without the experience are] going to go home, they’re going to be stressed out, these researchers—they can’t believe what they just heard or what they just saw.”

Finally, having a peer researcher was considered an effective way to overcome the barrier of participants being unwilling to engage with persons in positions of power. A patient participant suggested that even at “the expense of a relationship” with hospital or shelter staff, researchers should distance themselves from the groups who hold the power and tell prospective research participants that they do not have an affiliation with the hospital or with the shelter: “In order to get past some of the barriers that are up, you need to [do this]...”
Suggested Study Design
Acceptability of a RCT
In the present study, which was designed as a feasibility study to inform the development of a randomized controlled trial (RCT) study that would test the effectiveness of a medical respite program for older PWLEs, participants were asked directly about the acceptability of an RCT design. Patient participants did not express strong opinions about whether an RCT would be acceptable, stating, “I don’t know how to respond to that” or deferring to the researcher’s knowledge, stating, “You’re the researcher.” When asked whether it is acceptable to have a treatment group that receives medical respite services and compare to a group that does not, patient participants felt that this would be no different than treatment as usual, as expressed by one participant, “I guess it would be sort of business as usual, right? But you would feel slighted somewhat, for sure. But I think that if you’re being part of a study, there can’t be any expectations.”

“I guess what we’d have to see is whether or not that model works, and then once you’ve got the data to show that model works, then you can ask for increased funding.”

Similarly, provider participants supported this sentiment; one stated, “The fact that they don’t get a bed in respite—it’s probably just one more thing that they were expecting.” Another provider participant suggested that this may be what potential research participants would expect, but that in order to keep patients in the control group engaged in the research, there would need to be incentives:

“You’re always more willing to participate in things when you’re actually receiving the treatment... Again, it comes to the incentive piece on the other end. So, if you’re having people in a control group but still giving them an incentive for their time to answer their questions for the purposes of future research, then I think it’s the same. ...I guess from my sense, the engagement and motivation might be a little less if they’re not engaged in the treatment program because it’s probably just run-of-the-mill of what they’ve always been receiving.”

One provider participant described how there will be ‘natural controls’ because a medical respite program would reach capacity with only a limited number of beds, and as a result, some patients will be unable to access the program:

“The respite will have [only] so many beds, right, so many spaces? And there may be people who would have been eligible, but because there’s not any space, you could get consent to follow as just a natural control. Like, this person would have been good to go to respite but...we’re at capacity. So, let’s see if we can engage this individual and say we’re just trying to understand how this affected you and how can we follow you and get permission to see how you do.”

While the limited capacity of a medical respite program and the randomization of potential participants into treatment and control arms was not considered unethical by provider participants, one provider participant felt that if potential participants knew that there were medical respite services that they were not able to access this could be ‘discouraging’:

“That’s so hard. If they know about the possibility of having somewhere to stay versus being discharged to some crappy shelter, then they get the latter option, that can be so discouraging for people. And I would worry that it could cause like all sorts of problems for the person but also for the staff.”

Nevertheless, a RCT was also understood as an important first step on the road to advocating for increased respite beds. One provider participant stated,

“If you’ve got a certain amount of funding to only have a certain amount of beds open and to run it like that - I mean it’s unfortunate, but that’s the way it is. I guess what we’d have to see is whether or not that model works, and then once you’ve got the data to show that
model works, then you can ask for increased funding.”

Provider participants also discussed ideas about alternate study designs that could be considered for a future research proposal, most notably a program evaluation inclusive of a cost-effectiveness analysis. A program evaluation study could look “at processes and some outcomes” of the intervention and could take an individual- or systems-level approach. At the systems-level, provider participants highlighted the importance of being able to study how a medical respite program would impact acute care length-of-stay and discharge planning, and how resources are allocated. Moreover, as one provider participant indicated, there is value in “using a population health data approach to put some monetary value on [medical respite].”

Qualitative, quantitative, or mixed methods?
Participants had a variety of perspectives on whether a future study should use qualitative, quantitative, or mixed methods. Patient participants, in particular, indicated a preference for open-ended, qualitative methods over quantitative designs because the latter often restricted choices without capturing someone’s full experience. One patient participant stated, “Speaking face-to-face, or talking like this, is more advantageous than multiple choice. Because multiple choice, you pick one, whether it’s right or not. And if you’re speaking face-to-face then you’re voicing your opinion and no one is prompting you in one direction or another.”

In addition, in-person data collection was suggested by another patient participant to result in more honest reporting: “By interviewing them, that’s the only way. If you phone me, I’m going to lie to you. If I’m face-to-face, you know what’s lies and what’s not. So, if you interview them [do it] face-to-face…”

One patient participant suggested using mixed methods: “How about doing a survey where you have some questionnaires on a document, you have a group of us and they fill out some of the questionnaires, some of the responses on this document, and then you communicate about them afterwards?” A provider participant who thought that mixed methods would lead to ‘rich’ findings agreed: “I do think some flavour of the patient experience would be great. And it may not be in the standardized measure, it may be more qualitative. It would be selecting people, and … what was successful for them with respite, what it allowed them to do – versus their previous experiences being discharged from hospital.”

However, as one provider participant acknowledged, the methodology should ultimately be informed by the question(s) a future research study would hope to answer: “I guess it depends on how you’re focusing your research, what is the main thing you want to get from it? Because you can get a lot from number crunching, but if you want the story, if you want the story, you’re going to have to talk to them… I would want to see the stories collaborate with the numbers.”

Participants
Eligibility criteria
In discussions of participant inclusion and exclusion criteria for a program of research on medical respite, participants suggested that it depends on what information the research study is hoping to gather.

“It boils down to what kind of information you want, who you want to be the one to give you that information, and how do we weed out? So, you’re going to need to weed out people. Same thing happened with the At Home project, they did something that was like the lottery—they had a plentiful amount of questions on a computer and at the end of the whole thing the computer determined whether you were feasible and where you were feasible to fit into this project.” (Patient participant)

Patients who are frequent users of the hospital were identified as one potential group to be recruited for a medical respite program: “Definitely people who are homeless or are not safely housed in the community, for sure. I
Some suggested exclusion criteria include persons with cognitive impairment or a substance use disorder, while suggested inclusion criteria include a predetermined age range and PWLEs who have physical health conditions that require medical supports. There were mixed reports on whether persons engaged in active substance use should be included in this study. While some participants thought all persons should receive an equal opportunity to participate, others felt that persons with substance use disorders would not be cogent enough to participate and/or would not be honest with researchers.

“Well, let me put it this way, there is a lot of drug addicts in places like this [a transitional shelter]. Most of them couldn’t tell you the truth if their life depended on it. These people – and I am one of them, as a matter of fact. Just so you know, I have a history of heroin use. I haven’t been using for 6 or 7 or 8 months or something, I just quit. I was on methadone and I brought it down to zero. I quit using. But, a lot of these people will tell you anything to get what they want, so their word isn’t worth an awful lot.” (Patient participant)
Finally, it was suggested that persons actively using substances should not be included because there are other programs already exist in Metro Vancouver to address their specific care needs.

Participant recruitment
When to recruit?
Participants reported that immediately following hospitalization or discharge was an ideal time to engage potential patient participants in a program of research on medical respite. The immediacy of the experience was identified as key to someone’s willingness to consent to participation and sense of importance in the research.

“For a lot of people, especially in this walk of life, the immediacy of it is probably important. They seem to have a lot more to say, even to us [providers], when they do just get out [of the hospital], rather than when you approach a week later or two weeks later. (Provider participant)”

When one patient participant was asked how willing they would be to be approached about a research study when being discharged from the hospital, they stated, “That would have probably been the perfect time.”

However, participants highlighted the importance of remaining mindful that the experience of hospitalization and discharge can be a challenging time, particularly for those who are marginalized. A patient participant suggested that researchers provide potential participants with information to prepare them for the study and then give them some space while they adjust to their discharge:

“When someone is coming out of the hospital setting, that’s probably, obviously, not the best time to approach someone... Sometimes there’s a lot of pain involved. Just the agony of trying to deal with those immediate needs, for me is a little challenging. I knew about this research prior, so if there were some way to recruit people prior to being discharged, or just as they’re coming out, that might be a little easier because we’re not in that zone yet... I don’t think I would be as available immediately after or while I’m in the hospital, it’s just too crazy in my head. So, now some time has lapsed so I’m experiencing less pain, but I also had some knowledge of this coming up.”

Where to recruit?
Participants overwhelmingly identified the hospital as a primary location for recruitment into a program of research on medical respite and hospital social workers as key to recruitment. “I would say talk to social workers at the hospital, give them the information, and have them pass the information on to the clients before they leave. (Patient participant)”

“Perhaps this could be a task for social workers at the hospital level that says, ‘Here are the criteria of what we’re looking for, as you go through your day-to-day work, if you can identify this person and assess him as a viable candidate for our program, you’re pre-screening at a local level, which entails some degree of training for them or perhaps a protocol—a tick box protocol—assess this, this, this, and this, okay if they meet these tick boxes, then call us.” (Patient participant)

“One provider participant identified that potential patient participants could be identified through hospital codes that identify which patients do not have a location to which they can be discharged:

“Your target would have to be in acute [care in the hospital] for the patients that cannot be discharged. So, I think your best bet would be... Have you heard the term ALC [Alternate Level of Care]? ALC-FS means Family Social, so anyone under the homeless category or someone who doesn’t have a place to live...”
Once they are medically stable, they are ruled ALC-FS. So, your target population within acute care would be the ALC-FS patients.”

Other recruitment sources identified by participants included detox programs, rehabilitation centres that care for high numbers of PWLEs, outpatient clinics, community health nurses, case managers who work for shelter/housing organizations, and outreach workers.

“Finding them, go to the shelters, they’re full of them. And if you go to the shelters and you talk to the Housing First workers or the outreach workers, they’ll go in, they’ll kind of be the conduit. They’ll know the ones that have just come out of the hospital and into the shelters and then they can go and talk to them.” (Provider participant)

**How to recruit?**

Recruitment posters were suggested by several participants who described what information these materials should contain: explain what the study is about, who can participate, what will be required of participants and for how long, whether there is compensation, and two contact names and phone numbers. One provider participant highlighted the need to be mindful that recruitment materials account for PWLEs’ accessibility barriers:

“You see the classic research flyers that are up with a phone number and email. A lot of clients within marginalized populations don’t even have a phone or they have limited access to email if they know how to work the computer at the library. So, it would be great if you’re going to do it, even just to do drop-ins. Say, “Hey the researcher is going to be here from this time to this time on these days if you want to come learn about this.” And then the researchers could go out and actually educate people…versus leaving it up to the clients.”

Finally, participants indicated that peers are an important source of recruitment. Without using the term “snowball sampling,” this was identified as another recruitment source. Regardless of who was doing the recruiting, the importance of it being done by someone with whom the potential patient participant has a relationship was highlighted.

“But you really got to have that connection with them because they get pretty hesitant to participate in yet another study and why are we doing this and what do you want that information for, and all that kind of crap. So, I think it’s really important that somebody has that connection.” (Provider participant)

**Participant retention**

Participants suggested that unstable housing and limited access to digital resources or phones can make participant retention in longitudinal research particularly challenging. For instance, one patient participant described how phones are often stolen or numbers change:

“Your cell phone number—that’s a changeable item with some of them… So, get their telephone number for texting; if that doesn’t work within a reasonable turn, that means they’ve changed their phone number—and that happens on a regular basis because people get their phone stolen…their telephone number changes, so that’s a changeable device, but their emails generally remain static.”

In order to stay engaged with PWLEs over time, participants suggested that study participants be attached to a case management team (e.g., ACT [Assertive Community Treatment]) or an individual caseworker who researchers can contact if they are unable to directly contact the study participant. In addition, it was suggested that multiple forms of contact information be collected from study participants and be regularly updated (e.g., telephone numbers, email addresses). As well, making note of the common locations frequented by study participants can offer additional ways to locate study participants if their telephone number changes or they are unable to access their email. As one provider participant stated, “Catching them in areas where they might be and whether there’s drop-ins where they could flag those folks. The shelters certainly do have a good eye for this because they know these guys need a ton of support.”
Potential participants’ willingness to participate in medical respite research

Participants described both challenges to and motivations for participation in a program of research on medical respite. Challenges identified were the cognitive state and mental health status of individuals, potential participants not wanting to be involved with other people, potential participants not wanting to get in trouble or compromise themselves, and language and cultural barriers. Reportedly, motivations for participating in a medical respite intervention study would range from wanting to help oneself or others in a similar situation and wanting to be heard and acknowledged, to financial incentives such as money, gift cards, or the opportunity to find permanent housing.

Challenges to potential participation

The cognitive status of potential participants was identified by both patient and provider participants as one potential challenge to engaging potential participants in research. Participants suggested that anxiety, active substance use, and cognitive impairment will affect someone’s willingness and/or ability to participate in research. As one provider participant stated, “One challenge with people who are older who are vulnerably housed and homeless is often cognitive impairment.” This provider suggested a way for researchers to overcome this challenge:

“We do an occupational therapy assessment on a lot of these patients, so the data should be in their clinical assessment, like a MoCA [Montreal Cognitive Assessment] or something. There should be something. And it’s interesting, because even if they score low on a MoCA they can still understand, right? It may be just more the higher executive functions, but they can comprehend what you’re saying and doing.”

Participants reported that individuals might be hesitant to participate in research because they fear that their report could jeopardize them. This might be a particularly important consideration for individuals who are vulnerably housed and reliant on others for housing and services. “But then again you can get into trouble talking to some people—they would take what you said and use it against you somehow. I don’t even know that that’s realistic, but it’s possible… I wouldn’t like to be out on the street with one leg—you’re kind of vulnerable you know?” (Patient participant)

Other patient participants reported that regardless of what researchers do to accommodate potential participants, there would be some who are unwilling to participate because they do not want to be involved with other people. When asked who might not want to be involved research, a patient participant stated,

“People who are happy without being under the observation of people like you, they sleep in the bush and come and get a sandwich [from the shelter], there’s a fine example. That guy don’t have to sleep in the bush, but he chooses to because he doesn’t like people.”

Finally, another patient participant suggested that willingness to participate may be affected by an individual’s cultural background or understanding of language and medical or research jargon; researchers should overcome these language and literacy barriers by changing the language used:

“Depending on their cultural situation, research language often can be beyond the scope of a lot of people in general. And when you define older, …depending on their cultural background there might [also] be language barriers. So, are you able to do this research in languages other than English? And, also, just jargon in general—that needs to be tweaked somehow to meet the potential
level of the individual. So, if they are from another cultural background and they are older, you have two variables there that might be challenging in terms of the jargon, the academic language used in research often.”

Motivation to participate in program of medical respite research
As summarized by one patient participant, participants suggested that people engage in research “for the betterment of everybody.” Other patient participants agreed that they would “want to help you help others like me.” Moreover, participating in research studies was identified as a way that people can contribute and feel good about themselves. “It comes down to self-esteem. The more you help others, the better it is…” Participants suggested that older adults may be especially apt to participate if they feel that they can help improve their own circumstances or improve systemic problems. “Most of them actually want to help better themselves and anybody else that’s going to be in that situation. The older people actually see that the system is broken and they want to be a part of fixing it. They would love for people to hear them.” (Provider participant)

The ability for research participants to have their stories heard or to engage in conversations with friendly researchers was also highlighted as a potential motivation for research. As one provider participant stated, “People want to be heard, right? Because a lot of times, no one is paying attention to what they want. Being listened to. Being asked questions. Getting their opinion.” Another provider participant agreed: “There would be a willingness, it’s just that also, time. If it was quick, I’m sure anyone would be interested. I think the patients [in the hospital] would definitely be interested. It would be a conversation – a lot of them just want to have human conversation. So, a study and asking questions… might be something that could pass the time.”

Financial incentives for participation
Both patient and provider participants suggested that the biggest motivation for research participation would be incentives such as money
or gift cards, or the belief that participation will lead to permanent housing.

“I’m just going to go ahead and say money because this is the most expensive city there is in this country, so what else is there? It has to be something of value. And, unfortunately, barely anyone does anything for free anymore.” (Patient participant)

Financial incentives were thought to be particularly motivating for PWLEs, as one provider participant stated, “Because people that are in that situation don’t have a lot of money and that’s always a struggle.” Another provider participant described this in more detail:

“To be very honest, any sort of incentive-based participation always works well, just because the world of medical respite that I’m sitting in—it is with a very marginalized population. So, there has been a lot of success with some of the programs that we’ve run where there’s gift cards for time, and any sort of food security. I know that’s not always the best approach, sometimes that’s frowned upon, but really, I think we already ask a lot from this population in terms of trying to get ideas and information and try to find ways to help, but we also don’t recognize that sometimes they are not able to provide for themselves…”

Because financial incentives can motivate a larger number of people to participate in research than might otherwise, there were some considerations suggested about the amount of incentive individuals be given. One patient participant suggested, “I would say, depending on what the research study is—if you’re looking for real, down to earth information, I would go with the lower honorarium to bring in the people that are going to do it for [the right motivations].”

In general, when patient participants were asked to put a dollar value on their time, there was some hesitation to do so. Several patient participants deferred to the opinion of the researcher or put a low dollar amount on their time, potentially as a result of historical disempowerment of marginalized populations.

Other patient participants, however, assigned a dollar value to their time, with several suggesting that minimum wage be offered as a minimum. One participant cited the BC Centre for Disease Control peer payment standards as an example:

“The CDC, the Centre for Disease Control, has a standard rate of honorariums and this is their basic flat rate. It’s $25 an hour.”

Provider participants generally agreed that cash honorariums should be offered as compensation to patients participating in a medical respite research project.

“People [who] work on the frontline in the community, they get roughly $20 an hour. So, it’s kind of keeping them in line with that, and just gives them a bit of incentive. I think it’s really important that we value that their time is also important. So [whether] it’s an incentive or an honorarium or however we can do it, I think it’s a win-win. We’re getting paid, why shouldn’t they?”

Others, however, felt gift cards might be more appropriate than cash so that research participants were restricted in how they could spend the honorarium.

“A lot of these people don’t have their own money with them [in the hospital], so if we were to get them a gift card for our Tim Hortons, we know that the person is not using cash to go either purchase alcohol or drugs or anything like that, they are using the money specifically, it’s a gift card at Tim Hortons.”

(Provider participant)

Additional incentives that participants suggested should be incorporated into research proposals include the provision of food and drinks and reimbursement for transportation costs.

“Money, I think, would be the best way. Maybe even bus passes, Compass cards so they can get around. I’m sure some of them would feel good about not having to get on the bus and just say, can I get this ride for free.” (Patient participant)

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Data Collection
Patient and provider participants provided a range of suggestions on what data to collect for a program of research on medical respite (see Table 2), as well as ideas about the willingness of potential research participants to share different types of data. Participants also described other considerations to be mindful of during data collection, including where data collection should take place, potential biases and limitations, and privacy issues.

"If the question is worded correctly, people would be more than willing to tell you because someone is listening, someone is expressing some sort of caring, they’re going to want to open up."

Primary or Secondary Data?
Participants were asked to report on any existing data they were aware of that could be considered accessible for inclusion in a future program of research on medical respite. Though provider participants indicated that shelter providers track PWLE data in HIFIS [the Homeless Individuals and Families Information System] ii or shelter log books; and healthcare providers track PWLE data in PARIS [the health information system for Vancouver Coastal Health Authority], Medi-tech [the electronic health records for Fraser Health Authority], and iTracker [a health surveillance system used in the Fraser Health Authority], these databases are not set up to be compatible with one another. One provider participant stated, “They’re completely separate systems.” Moreover, the administrative challenges involved in overcoming privacy regulations were thought to create barriers to using these data. Instead, one provider participant suggested that a project-specific database would need to be created whereby secondary data from various sources are entered and supplemented with primary data: “You need to establish your own measurement and your own scales [for] what would be appropriate.”

Data collection should be culturally sensitive and trauma-informed
Regardless of the data that would be collected, participants highlighted that the approach to collection should be culturally sensitive. While patient participants mostly felt that there would not be anything too personal to ask, they did indicate that other people may not agree. One patient participant stated that no data would be too intrusive to collect from her perspective, but this may be different for persons of other cultures:

“Not for me. When I initially was hospitalized, maybe there would have been a bit of embarrassment. I still would have shared. There would have been some embarrassment about my situation and the situation that I found myself in, but…I do know that there were—at the time I was in the [name of] clinic and there were people of different cultures there and they did not discuss certain things. So I think it’s culturally sensitive.”

Among the data too personal to collect, participants indicated that people might not want to be asked questions about stigmatized topics (e.g., sex offenses) or topics that would be ‘triggering’ and remind people of past experiences of trauma. Such reports relate to the need for researchers to have empathy, be responsive to participants’ past, and engage with potential participants by building trust using a trauma-informed lens. Patient participants suggested that “it probably comes down to how [the questions are] framed” and “if the question is worded correctly, people would be more than willing to tell you because someone is listening, someone is expressing some sort of caring, they’re going to want to open up.” One patient participant indicated that if there is a question someone does not want to answer, they will let the researcher know:

“You should be able to ask anything you want and if the person doesn’t want to answer, they could say, ‘I’m not telling you.’ Some people have a hard time doing that, but a lot of people don’t.”

Privacy considerations

Participants reported on the importance of having privacy checks in place in any proposed program of research on medical respite. Because some people might only be willing to share their personal information with certain individuals or organizations, potential participants need confidence in how personal data will be used and who will/will not have access. One patient participant reflected on her participation in another study, highlighting her confidence in sharing personal information because she was assigned an anonymous and unique identifier, which was stored in a separate location from the data:

“Because there’s some pretty pointed questions that they ask in the [name of research] study, believe me, on women’s health and how certain medications affect us and a lot of the questions they ask, it’s quite personal… But there is a disclaimer that says, ‘you do not have to answer these questions’ or ‘if you’d like a counsellor present, we will provide one for you’… Most of the women I know, they’re not afraid to answer any of it, but we’re designated [anonymous] numbers, so that nobody out there can get that information because they don’t know who’s what number so you might want to designate…them a number and then add that name to a number in another ledger.”

Though institutional research ethics boards require study investigators to maintain strict confidentiality and privacy of participants, participants agreed that these protocols should be outlined in any research proposal and communicated to potential participants during informed consent procedures.

Background data

When asked what information would be important to collect as part of a program of research on medical respite, participants described a range of data they felt would help inform research on whether medical respite is an effective program. Basic demographic and background information was suggested as important to collect, including the geographical region where patients come from or hope to go to upon discharge from a medical respite.

“You’re probably tracking the basics already, like age group, what region they’re coming from, what type of physical event has happened, I think is important to know, and whether or not they’ve been connected to services once they leave the hospital. That’s a big issue too.” (Provider participant)

One provider participant underlined how some people might be hesitant to disclose their names:

“The biggest one most people don’t want to give in is their name. Most people want to remain anonymous. That’s the biggest issue. They’ll give everything else if their name isn’t attached. Asking for ID—again, because of the name—that’s also a big thing.”

Physical and mental health data

Participants indicated that physical and mental health data would be vital to collect. The patient
participants generally agreed that they would be willing to give permission for their medical records to be accessed for research purposes and thought it would be acceptable to ask this question in future research. In addition to getting patients’ permission before accessing their medical records, one patient participant highlighted the need to obtain permission from the hospital: “I don’t know what the hospitals would say about that. You would need to get a release from the hospital, I guess.” Provider participants suggested that it is possible to look at patients’ health records so long as personal information is not identifiable.

The health needs and follow-up care of patients after discharge from a medical respite program were also identified by a provider participant as important data to collect:

“Also, really their health needs. So, what can be met in the community and any kind of follow-up services that are going to need to be connected in, and those need to be connected before they discharge them and have those connections in place.”

One provider participant indicated that more than knowing patients’ health conditions, it’s necessary to know the current functional ability of patients and what steps need to be taken to improve functional ability:

“I would always not go into too much detail in terms of the medical condition and would more go for the functionality. So, I would use WHO [World Health Organization] scales for instance which are well established, and to measure let’s say, what needs to be done to help people to survive for sure, but also to make them functional, to reintegrate them into their social networks and communities, and stabilize their overall situation.”

Data on healthcare and service utilization and costs
Provider participants described the need to collect data on patients’ healthcare utilization, including hospital admission, emergency department (ED) visits, and length of hospital stays. These data were suggested to be available in patients’ medical records, or from asking patients directly.

“Another way is actually getting permission from the participants to go to health records or get access to the patient information system… Count up how many hospital admissions they had, how many ED visits they had… You wouldn’t get primary care, unless maybe PARIS [Primary Access Regional Information System] might have that? It depends. If they go to a private office you wouldn’t get it. So, that’s where you would lose stuff. But a lot of these people tend to be with community health centres. The other option is interviewing them, too, and a brief question around how many times did you go to ED, how many times did you go to a family doctor, how many times have you been hospitalized. People are actually pretty good. They know when they’ve been in the hospital, they know when they’ve gone to ED.”

Provider participants also suggested examining medical records to understand whether a patient is connected to community services (e.g., outreach workers) or community teams.

“One of the things that should be considered, which was helpful, and we could do it is…a chart review. We actually look at what’s on the chart because some of the things that people had said—one fellow was saying, ‘I’ve never heard of outreach workers. I’ve never touched base with one of them.’ And I checked the chart and there was tons of outreach workers who had touched base with this guy and referrals made. But, obviously, it didn’t take—but it added some perspective as to why things didn’t keep going.”

In addition, provider participants described the ability to use healthcare utilization data to estimate costs involved in a medical respite intervention program compared to costs of hospital stays.

“We were going to start tracking the amount of time they’ve spent in the hospital. So, say they’ve been ready for discharge since October 1st, but they don’t get a [shelter] bed until the 10th—an additional 10 days that we’re paying over $1000 a night for a [hospital]
Indeed, providers agreed on the need to identify the costs of a medical respite intervention compared to care as usual, which was predicted to be a more expensive option as patients are staying longer in a hospital bed. “Somehow use a population health data approach to put some monetary value on it—people are always interested in that. And that’s the really hard part in healthcare, there’s never a closing off of the bed where you can say, ‘This is how much we save,’ because you’re always filling that next bed. Like, you’re always filling that bed there’s never a close off. So, it’s trying to use a model in a way where you can say, ‘By using this program or approach we were able to save this much that was re-invested in other ways—or could be reinvested in other ways—to meet the needs of our overall healthcare system’ … that also has other points of tension and priorities as well, right?”

Outcome data
A final category of data that participants suggested be collected in a future program of research on medical respite is outcome data, including patient’s quality of life, the effectiveness and appropriateness of the intervention (e.g., did it result in improved health or medication management or access to stable housing?), and patient satisfaction with the treatment. One provider participant stated: “Patient’s quality and satisfaction in their care. That’s not just the treatment, but an opportunity [to ask if they were] feeling cared for. So not just specifically focussing ‘yeah, I was able to get my meds on time, all the time, didn’t need to wait for my appointment.’ But, like, how did you feel cared for? Did you feel safe? Did you feel like you could recover? More around that psychosocial stuff.”

A patient participant offered some questions that future research could consider asking to understand a patient’s perspective on the medical respite intervention: “How did [the medical respite intervention] work out for you, essentially? Did we help you along your way to make your life easier to adjust into a more permanent lifestyle?”

Finally, though provider participants reported that collecting data on outcome measures is important and valuable, these data may not be as effective in changing policies as cost savings data. “Maybe some patient reported outcome measures [PROMs]. I think everyone talks about PRIMs and PROMs being important, but I think ultimately what funders care about is money and less service use. To be honest, I have not seen any changes in policy based on patient reported outcomes…”

“I would make it as easy as possible for them to be included. So, if that means going to them, in their room, with a consent form, and a pen—to make it as easy as pie.”

Data Collection Locations
Participants indicated that when first meeting, the researcher should go wherever potential participants are most comfortable meeting them. Once the researcher and research participant have established a rapport, they can work out new arrangements for follow-up interviews. Importantly, data collection locations need to be accessible for potential participants: “Yeah, so the accessibility part. So, then as well that comes with not only like phone, email for initial contact, but even through transit. So, trying to get to a site to meet the researcher at an office or anything like that, it’s better if the researcher goes to them and to create a safe environment within the space that they’re in because of transit costs or taxi costs or just even depending on where they are, how long it will take them to get to the appointment and then coming all the way back might take up quite a lot of their day. So those are the pieces to become a great barrier for people.” (Provider participant)
**Patient participants also emphasized the importance of conducting research in easily accessible locations to increase participation.**

“I would make it as easy as possible for them to be included. So, if that means going to them, in their room, with a consent form, and a pen—to make it as easy as pie. Yeah, that’s what needs to happen. But if they have to jump through any hoops whatsoever, it just gets too overwhelming.” (Patient participant)

**Barriers to Data Collection**

Participants identified several barriers to data collection, including the mental conditions of potential participants. For instance, substance use disorders were reported to be a potential barrier for some. A patient participant who reported that ‘addiction issues’ will be among the challenges encountered in this type of research stated, “You have great expectations that people are going to show up and all of a sudden something in their life throws them a bone and they don’t show up because they’re gone to get high.” Other participants reported that when interviewing older adults there is a particular need to be patient and allow older research participants to reminisce: “You have to listen to older adults and not say, ‘I have to go now.’” On the other hand, other participants suggested that a lengthy interview could be a barrier to data collection. Either way, it was suggested that researchers be flexible and open-minded to various mental states.

**Opportunities for Data Collection or Pilot Studies**

Participants, particularly provider participants, reported on opportunities for designing a study in Metro Vancouver’s immediate context where a medical respite program does not yet exist. In the current context, one provider participant
suggested that the research team look into a transitional care unit at an area hospital that could potentially be repurposed into a medical respite unit. Another provider participant suggested a pilot study be done whereby some patient PWLEs are ‘attached to’ an outreach worker who will assist these patients navigate the system of housing and supports and have their outcomes compared to PWLEs who do not get attached. A third provider participant acknowledged that there are research groups embedded in the regional health authorities that fund small-scale projects. And a final provider participant challenged the research team “to have a much broader view...you need to answer the question, ‘What are the needs, based on the Canada Health Act, to provide appropriate care to these high-need populations?’ So, what would be the right thing to do—and what do we have the resources to do? And that’s a different question.”

Identified project partners included acute care hospitals (including St. Paul’s Hospital (Providence Health Care), which, according to a provider participant, has “a disproportionate amount of vulnerably housed homeless people”), Vancouver Coastal Health’s Home and Community Care, not-for-profit shelter and housing organizations (including Atira Women’s Resource Society, Coast Mental Health, Lookout Housing and Health Society, PHS Community Services Society, RainCity Housing), the City of Vancouver’s Social Planning Department, and the Streetohome Foundation (which supports housing and employment goals).

2. What a Medical Respite Program Should Include

Though a medical respite program does not yet exist in Metro Vancouver, most patient and provider participants were familiar with the idea. In instances when a participant had not previously heard of medical respite, a general description of these programs was explained. Participants provided their opinions about what should be included in a medical respite program, including the culture of the program, the physical design of a medical respite site, who should be involved in the delivery of medical respite services, and what services should be provided (see Table 3).

**Culture of the medical respite program**

Participants described a number of ideas about how patients should be treated and the culture that should be established within a medical respite program. For instance, participants suggested that the medical respite should be designed as a ‘home away from home’ and that it should be a safe, culturally competent, inclusive space. As one patient participant stated, “It [should be made] more like a home then a hospital.” This participant further explained that because people need time to adapt, the medical respite could be a special ward—a homey place—at the hospital where PWLEs start their transition back to the community so that moving into a new place (e.g., a shelter) is less abrupt and shocking. A provider participant agreed: “What people want is a place where they can feel safe, right? I think that physical safety, obviously, but also psychological safety. For Indigenous people, cultural competence... I guess like a feeling of, even though it is essentially institutional, but feeling more hope, feeling more comfortable, feeling like they have choice and agency... Make it a welcoming space for people. Inclusive. That’s what I would envision.”

Related, a patient participant suggested that patients be given an orientation to the medical respite unit upon their entry so they are aware of what different noises mean and when meals are served. Moreover, as a result of having been treated poorly by healthcare providers
or dismissed by caseworkers, participants recommended that staff have compassion and approach care with a trauma-informed lens. A provider participant stated, “Just because a lot of the clients that I work with from a substance use side, there’s so much trauma there, too. I’m not saying that everyone is going to want trauma-specific services, but how are we asking those questions and making sure that people feel validated? I think we could do a better job with that.”

Both patient and provider participants highlighted the need for staff to have ‘people skills’ and not be condescending or intimidating. “In this situation, you definitely want the hospitality model. Realistically, it’s all about the connection. From obtaining research data, to applying it, to being in the situation once all of that is done and you have the program in place, you need everybody to feel like they’re important. You need people to remember people’s names—they’re not file numbers. You need someone to say ‘good morning,’ you need hellos, you need ‘how are you today,’ you need that kind of stuff. Without it, nothing improves. That’s the single most important thing… if a person hasn’t developed that he actually has some permanence in this world, that there’s a connection, it doesn’t matter what you do for them, nothing is going to change.” (Provider participant)

To ensure the safety and security of patients and their belongings, participants suggested that the medical respite unit include personal cabinets or lockers for valuables, storage units, a private cubicle for staff to screen person’s entering, and a buzzer entry into a locked medical respite unit. “Lockers and locks, that’s right, like they do in the hospital. St. Paul’s [inpatient ward] has lockers in every room. Cupboards that you can get a key and a lock for. If not you can always bring your own. And the nursing staff has keys just in case the person is too sick to have a key. That and having a safe for valuables.” (Patient participant)

In addition, personal bedrooms, with ensuite bathrooms, were thought to be a way to encourage patient privacy and dignity and enable bed rest. Finally, the inclusion of an exercise or games room (e.g., with a pool table) in the medical respite—or locating the medical respite near a walkway or park—was suggested as a way to encourage patients’ physical and mental health.

Who should be involved in the delivery of medical respite?
Medical staff
Participants identified a range of formal and informal support positions that could contribute toward the delivery of medical respite services. First, medical staff, including a doctor or nurse practitioner (whether it be on a drop-in basis or available as-needed by phone), nursing staff (regularly available onsite, e.g., a RN or LPN),

Physical design of a medical respite site
Participants outlined aspects of a physical environment suitable for a medical respite program alongside goals for these design considerations. Participants emphasized an accessible design that will accommodate a range of health and mobility limitations to support: 1) safety and security of patients and their belongings, 2) patient privacy and dignity, 3) bed rest, and 4) physical and mental health recovery. Accessible design features suggested by participants included having a site that is wheelchair accessible and has elevators, beds lifts, and grab bars on beds and near toilets. “First and foremost, one of the biggest issues I think that’s the elephant in the room is the lack of wheelchair accessibility in most of our shelters... BC Housing states that only 4% of your beds in any facility has to be wheelchair accessible. The problem that we’re having right now is that most of these people, and by wheelchair, they don’t actually have to be wheelchair-bound they could have a walker, they could need crutches. Most of the people we are trying to discharge from hospital are going to need wheelchair accessibility and so if your facilities don’t provide it, they’re going to sit here [in the hospital]. So, I would say that it’s important that these respite beds are wheelchair accessible.” (Provider participant)
and a methadone prescriber were noted to be important in providing physical healthcare (e.g., wound care, IV therapy, foot care) through a trauma-informed lens. “To have some sort of clinical staff onsite, a nurse. It doesn’t have to be full-time necessarily, you can create models that are different, that maybe there’s a nurse onsite three times a week, or they know when they’re coming or, to have that tied to the program, versus tied to the person.” (Provider participant)

“Pharmaceuticals, you need to have that relationship at the hospital because if [the patients] have prescriptions, if they have blister packs, if they are on methadone, you need to have a methadone prescriber. If they have medication, who’s going to be on staff to give them those medications? The patient can’t give them themselves, so the hospital would have to be able to send over their med rec [medication reconciliation form] and it’s for the medications the patient is on. We’d have to send the med rec over to the respite center; and then, do we send the medications with the patient? Or does your centre pick up the prescriptions? Or does the patient have to pick up the prescription before they get there? There’s all these fine-tunings. And when we have doctors’ orders to change the dressing every other day, we have to fax that to your staff.” (Provider participant)

Having onsite allied health professionals, such as occupational therapists and physiotherapists, was identified as needed to assist medical respite patients with physical rehabilitation and recovery from stroke, as well as improve functional ability and encourage independent living. “Well, it would make it more simple. I’m going to [name of] hospital for physio, so I’ve got that going on. But if it was done here [at the shelter], of course it would make it easier.” (Patient participant)

“Stroke is the biggest one that I’m seeing, recovering from stroke. So, they may not have lost a limb or something, but their ability to walk or move like they used to has been impaired, so now they’re maybe using a walker, or they have to use a cane or there’s a limp involved. Those types of things are the ones that we see the most.” (Provider participant)

Mental health therapists and drug and alcohol counsellors
Mental health therapists and drug and alcohol counsellors were considered valuable to the treatment of medical respite patients. One patient participant described the desire to have someone to talk to: “Yeah, I’d like to have a counsellor to talk one-on-one with and tell them what I’m going through. That would be nice.” Another patient participant acknowledged that a medical respite stay could serve as the first step in patients’ withdrawal from drugs, so having access to drug and alcohol counsellors who can support patients in their recovery, would be important for a medical respite program. Assistance from allied staff to find stable housing at the same time would also support this process:

“We do a poor job as well around pain management, and I think pain management—whether it’s physical, emotional, spiritual—in the state of a substance use and opioid crisis—needs to be front and center of all care planning.”

Allied health professionals
It was also noted that health professionals beyond doctors and nurses, including allied health professionals, are needed in order for the program to be successful.

“If you’re going to do it well, you should probably make sure that it’s not just a doctor, NP [nurse practitioner], and a nurse. I think there’s some folks in other health professions that could probably add some real value to something like that when you look at a full scope respite area.” (Provider participant)
“You want to have addiction people available to them, [and] housing placement because if they’re going to be 3+ months of not into their addiction, they’re pretty much clean at that point. Counsellors, home assessment, it has to be a one-stop shop.”

In addition, it was acknowledged that mental and physical pain management should be central to patients’ care plans.

“We do a poor job as well around pain management, and I think pain management—whether it’s physical, emotional, spiritual—in the state of a substance use and opioid crisis—needs to be front and center of all care planning.” (Provider participant)

Social worker, case manager, housing coordinator
Patient and provider participants described the importance of having a social worker embedded within the medical respite program. This social worker could act as a case manager or housing coordinator; alternatively, additional case managers or housing workers could be employed. A provider participant stated, “You also want—perhaps not full-time—but you want someone of a social working, advocacy [role]... so while [the patient is] resting, just because they’re resting their legs, their files are still progressing, they’re not stopped.”

One provider participant suggested that a Housing First worker could be employed through the medical respite program. This provider participant also stated:

“The other thing that I think would be important is case managers. So, people that would sit down with them and say, ‘What are your goals?’ And that’s really important. It’s never about what our goals are for them, what we think they should do. It’s what are your goals and how can we help you move forward with them. Because they can’t figure out that stuff on their own. Most of them need somebody to hold their hand and help get them back on that track, right?”
Patient participants described their desire to have individualized supports to find housing and services:

“I wish I had support—help finding housing. They say they do it, but they don’t. Housing, one, is most important. Having an apartment block, like [anonymous], and being able to move in there where it’s furnished. I don’t care what kind of furniture. I’ll fix it up or do it—just having a place that’s mine. That’s it.” (Patient participant)

“More could be done when - if anything bothers you, you should be able to go to the office and talk to your case worker and expect them to do something about it or at least address the problem.” (Patient participant)

An important consideration reported by participants, however, was that appropriate staffing ratios be developed so that patients can be adequately supported.

“A 1-to-10 ratio is high enough for people to deal with, especially when you’re working on housing as well too and a lot of the seniors have more physical health needs. So, you’ve got to think about those things when you’re trying to get them out into the community to look for housing.” (Provider participant)

“Peer support, so you develop a continuum where you actually help people to recover and then train them to help other people to recover.”

Non-professional supports and auxiliary staff

Finally, participants described the importance of having non-professional support persons in medical respite, including peer support, peer navigators, and volunteers who could provide social support for patients and assist patients to navigate the system:

“Definitely peer support, so you develop a continuum where you actually help people to recover and then train them to help other people to recover. But you need training and supervision and also some form of remuneration or money to make them [a] very significant component of our healthcare continuum.” (Provider participant)

“Peer support would be good, because I know like for a lot of people, some of the reasons they end up leaving [the hospital] is because they have a smoke or they need to go get their welfare check, and stuff like that. If they had someone to accompany them out on visits or who could support to go pick up those things for them, that would help them stay longer.” (Provider participant)

In addition, cleaning and food service staff were identified as key considerations for a successful medical respite program:

“You could ask for volunteers. It’s not part of your staffing model, but it could be part of your plan. I know there’s a lot of volunteers out there that are wanting work, and it could be something that they could do. I can help with serving the food, they could help with making people comfortable, helping clean. You’ll need a few cleaners, someone for food.” (Provider participant)

Research team member

If a program of research is to be attached to the medical respite program, it was suggested that the research team be onsite and embedded into the program. According to participants, this could be done in one of two ways: 1) the medical respite staff (i.e., the frontline workers) could be trained in data collection; or 2) researchers could be onsite to build relationships with patients. Having a researcher available to patients on a regular basis would enable “getting that extra intimate research that all these bigger people might not have thought of.” (Provider participant). Another provider participant agreed:

“It would be really nice to have a researcher within the team so the [medical respite patients] get to know that that person is part of the team versus it being another just another adjunct referral… It’s that relationship on the receiving end to get the client to buy in.”
What services should be provided in a medical respite program?

One-stop shop

Patient and participant providers described an ideal medical respite program as one that would serve as a ‘one-stop shop’ for patients where they could access health and social supports, including onsite medication dispensing, nutritious meals, basic clothing (including shoes, undergarments, incontinence pads), and laundry services.

“The [building] where I lived was a one-stop shop, an in-house pharmacy, in-house doctors, in-house nurses, and three meals a day, so it was a one-stop shop. Twice a week there was a regular doctor, twice a week there was psychiatrists, and peer support, it had everything.” (Patient participant)

“Everything needs to be in-house. That is so important... When you’re in that situation, for you to hop on a bus and change twice and get to a psychologist support appointment—when you’re sick, you’re not mobile, your meds aren’t working properly. And then they want you to go to income assistance office to make sure you get your cheque, but the line-up’s too big and you’re too tired, and your bus was late.” (Provider participant)

Participants suggested that the food offered at a medical respite should be individualized to patients’ dietary restrictions (e.g., vegetarian, sugar free) and food preferences (e.g., spicy foods) and patients should be allowed to bring or heat up their own food. Individualized diets were identified as particularly important for patients who are diabetic or who have specific dietary requirements.

In addition, onsite medication dispensing was highlighted as needed in a medical respite program, particularly the ability to dispense daily methadone, which several patient participants appreciated about their current shelter locations:

“Obviously, having the medications onsite would be a good thing, other than having patients having to go down to a pharmacy to get them. They bring up medications for me...” (Provider participant)
“Oh yeah, I need medical. I’m on a methadone maintenance program. I’ve been on it for 25 years… They give it to me every morning, my pharmacy comes here.”

Transportation
Participants expressed the value in having transportation services to get patients from the hospital to the medical respite location, as well as to any supports that will not be provided onsite (e.g., follow-up appointments). Providing transportation was also reported to enable patients to go on housing searches:

“Making sure there’s a vehicle to transport them if they need to go anywhere. We do have a van that if they want to go look at housing and stuff like that. If a lot of that stuff is in-house, that eliminates part of that.” (Provider participant)

Providing transportation was also considered important for people who do not have family and friends that can support them in getting to community-based medical services and follow-up care.

“You’ll need a couple computers. What I like when I saw [the shelter], I just toured them, is that they have three computers in their main foyer so that the people that are there, part of their contract is, you could live here as long as you’re actively pursuing something. Every day, you’re allowed to stay here as long as you’re pursuing something – you’re working on a resume and distributing it out, or you’re looking on Craigslist for housing, it’s got to be doing something.” (Provider participant)

In addition to having technology available to support medical respite patients, it was suggested that life skills training and a variety of leisure and educational programming be offered.

“Access to computing devices—and not ones that are going to take an hour to load something. It’s tools to allow someone to interact with the outside world or his internal world, through reading or whatever—allowing someone’s brain to function and not dwell on whatever is going on in their life. A little bit of escapism goes a long way. Instead of picking up a bottle of vodka, he can sit down at the computer and maybe reconnect with his genealogy or family or friend or someone on Facebook.” (Patient participant)

Opportunities for social engagement, mental stimulation, and life skills development
Aspects of the medical respite that participants considered central to patients’ recovery included opportunities to engage in meaningful and mentally stimulating activities, to develop life skills, and to connect with supportive social networks. For example, patient and provider participants consistently reported that access to computers and the Internet at any hour of the day served as a conduit to social engagement, mental stimulation, and life skills development.

“I firmly believe, too, people need to have purposeful and meaningful time in how they spend it, so I don’t know if that’s through leisure activity and giving people opportunity to participate in things during the day—whether it’s leisure or whether it’s groups or substance use related groups, life skills groups, like cooking groups or OT, that type of stuff. But, also, has anybody ever asked them questions about what their goals are, like if they were to get over this, what would be their ideal? Would they like to volunteer? Do they want to be connected with family again? Or community?” (Provider participant)

“I’d love to be in a place where I’m recovering, but with other people who have some sense...
of consciousness or areas of interest that I want to talk about as I’m recovering. I don’t necessarily want to be in an environment with people who are talking about things that have no interest to me or could be triggering to me… The social aspect is going to be important too—having well-designed programs. Like I said, myself, I wouldn’t necessarily want to join an arts and crafts group because I’m just not into that… Programming and having those social programs will be important, but don’t tokenize that intervention. It can come across as condescending, I think, for people who are in pain, but are not dumb, they’re not illiterate, they’re just in pain and they may not want to talk, but they can engage in other ways.”

(Patient participant)

Who should be able to access a medical respite program?

When asked to indicate who should be able to access a medical respite program, participants identified that it could be dedicated to serving older adults. (Notably, this was the focus of the current study.) There was less consensus among participants on whether patients should be given the freedom to use alcohol and drugs. While some felt that patients would be too ill to use substances, so it would not be an issue, others felt that the medical respite should not tolerate any use. Others, still, felt that the program should be low-barrier (accepting of anyone regardless of their substance use behaviours), but that it could have a separate area for persons who use alcohol and drugs or have mental health disorders.

In addition, a provider participant highlighted the need for program or patient admission criteria (e.g., specific healthcare needs) to be a guiding force in who is eligible for the medical respite. One provider participant suggested that one criterion would require patients to agree to predetermined rules and regulations:

“You could even have a contract that you had with that patient that you’re going to have the rules that they’re going to need to abide by, like curfews and tolerances of what they’re able to do and what they aren’t able to do, like use of drugs, use of alcohol, things like that—where they sign this contract and if you do not abide by these rules then you are no longer allowed here. You’d have to have for legality stuff like that.”

Patient participants identified the importance of getting to know potential patients well enough prior to their transition into a medical respite program because understanding patients and their needs is key to understanding whether they will be a good fit for the program. For instance, people who may not do well in a group setting or may not like being around other ill people,
would likely be less suited to a single-site medical respite facility.

“Everyone should have access, but whether that’s the place for them [is another matter]... They may not recover well around a bunch of other people who are recovering as well. Maybe they would prefer being around people who are not struggling in that way—as a motivation.” (Patient participant)

**Existing models of post-acute care for PWLEs**
Participants described other programs they believed had a worthwhile model of caring for PWLEs who were transitioning from the hospital:

1. **Dr. Peter Center, Vancouver, BC:** “If you need a model, the best one that I can think of is upstairs at the Dr. Peter Center. It’s smaller but it is a good model to work with. It’s a three-month respite and that’s pretty much enough to help them find a place.” (Patient participant)

2. **PHS Community Transition Care Team (CTCT), Vancouver, BC:** “Portland [Hotel Society] has the beds and they have a medical staff there for people who need the IV [intravenous antibiotic therapy].” (Patient participant)

3. **Patient Assessment and Transition to Home (PATH) unit:** “So, places like Queen’s Park has something called ‘the Path Unit’, which is basically a rehab for seniors coming out of hospital. So, they rehabilitate in there and then go back home, or sometimes they’ve lost their housing while they’re there and then we end up working with them.” (Provider participant)

4. **Parachute NYC:** “There is a very nice program in New York - I hope it still exists, you never know these times - which is called ‘Parachute’ and they actually tried to create an alternative to acute care for young psychotic patients. And they included a respite opportunity and peer support programs into their program. And I think that is the way to go from my perspective because it fits the needs and it is far cheaper than inpatient beds.” (Provider participant)
Discussion

This study explored the feasibility of conducting a RCT to test the effectiveness of a medical respite intervention for older PWLEs in Vancouver, BC. Persons with lived experience of homelessness, as well as provider participants, described what a program of research on medical respite should involve, and what should be included in a medical respite program.

Participants reported the need for researchers to build trust and ongoing relationships with potential research participants. This suggestion was one that acknowledged that persons who are experiencing homelessness are situated in vulnerable positions and may mistrust the healthcare system and persons in positions of power. Previous research with other vulnerable groups, including mental health service consumers or youth who are experiencing homelessness, has similarly described the need to develop trust with research participants as a way to build mutual respect and understanding.\(^{26,27}\)

Indeed, the process of trust building is especially important for studies that hope to remain engaged with participants over time.\(^{28}\)

‘Meeting people where they are at’ is a common sentiment that describes how practitioners should engage with persons who are experiencing homelessness by providing them with services in the manner that they determine, regardless of pre-determined standards that might preclude them.\(^{29}\) Participants suggested a similar philosophy be used by researchers when approaching potential research participants or collecting data. This included the need to be flexible in where data collection occurs and sensitive to how research questions are posed. Inherent in this suggestion is that researchers remain empathetic and understanding of the mental and physical pain that patients experience, as well as the potential for this pain to trigger past experiences of trauma. Thus, as suggested for service delivery to persons experiencing homelessness,\(^{30}\) researchers should utilize trauma-informed and culturally safe practices.\(^{31}\)

In order to build trust and to engage persons who might be hesitant to share their experiences with researchers or other persons situated in traditional positions of power, participants suggested that peer researchers be a part of the research team. This suggestion aligns with previous research that has benefited from the involvement of peer researchers in project development, data collection and interpretation, and knowledge dissemination.\(^{32}\) The unique contributions of peer researchers include the ability to create a sense of security among their peers and to produce data that is more relevant to communities that most benefit from the research knowledge.\(^{32}\)

Discussions about the acceptability of patient randomization in a future RCT trial revealed that while participants felt that it would be more equitable to provide everyone equal service, it would not be unethical to only serve some patients given limitations of available resources. Similar to previous research describing medical respite trials as no less unethical than the ‘current status quo,’\(^{17}\) participants indicated that a control group would occur ‘naturally’ when the program was at capacity. In this scenario, the goal of the RCT would be to monitor the health and housing status of patients who were able to access medical respite (the experimental group), as well as those who were unable to access medical respite because it was at capacity (the control group). Though not suggested by participants in the current study, previous research has suggested that future research blind researchers to the patients’ treatment condition in order to reduce bias in outcome measurement.\(^{10}\)

Key to the development of a medical respite RCT, participants noted the need for members
of both the experimental and control group to be followed over time. While participants thought that it would be easier to stay engaged with patients who receive the intervention (i.e., medical respite) over time, participants also thought that even members of the control group would remain engaged with the research team given the appropriate incentive. **Financial incentives** were a strong motivation for ongoing engagement with researchers—highlighted by both patient and provider participants—regardless of whether the patient was receiving the intervention. Reflecting on financial incentives, participants provided a range of perspectives on the dollar value that was considered appropriate—ranging from a $5 gift card to $25 cash per hour, based on the minimum wage standards outlined by the BC Centre for Disease Control for payment of peers.\(^1\)

The ability to stay engaged with researchers was also described as potentially challenging for patients who have unstable housing or limited access to digital resources. Suggestions for maintaining contact were offered, including getting contact information on close others and identifying regular locations in which the PWLE spends time. Prior research with persons experiencing homelessness has cited similar challenges and has suggested overcoming these tracking challenges by developing a [comprehensive plan for maintaining regular contact](#) with PWLEs—for instance, by asking participants to provide a list of people who might know where they are and places where they frequent.\(^{33,34}\) Of note, prior longitudinal research has found that the collection of comprehensive tracking data at baseline, as well as the study participant’s relationship with the interviewer, are key factors in participant retention.\(^{33,35}\)

Data that participants felt would be of interest to collect in a medical respite RCT included patient demographic and background information, current and historical physical and mental health conditions, current health needs, healthcare and service utilization and costs of treatments, and quality of life, patient satisfaction, and treatment effectiveness following the intervention. As in previous research,\(^{19}\) participants of the current study suggested that these data could be collected through in-person self-reports or verified through the review of medical records. While participants described a range of existing data systems that collect some of the data of interest for inclusion in a medical respite RCT, no single data source that could serve as a comprehensive database for analysis was identified. Instead, participants suggested that a new database be developed for a medical respite RCT so that researchers could ensure data quality that would sufficiently evaluate the effectiveness of a medical respite intervention compared to care as usual.

Ultimately, it was acknowledged that the research question that will be asked in a medical respite RCT would inform the proposed study design and methods, as well as participant eligibility criteria. However, regardless of the proposed research question, participants highlighted the need to **ensure data confidentiality and patient privacy.** It was recognized that a research ethics boards should provide oversight to a proposed study to help maintain confidentiality and privacy. Without these ethical considerations in place, participants recognized that potential participants would not be willing to participate or share personal information. Participants also provided suggestions for what an ideal medical respite program would entail, including the culture of the program, the

design of the space, the people involved, and the services provided. Similar to the movement to create homelike settings within long-term care,\textsuperscript{36} participants suggested that a medical respite program be designed in a manner that helps patients feel comfortable and ‘at home.’ The medical respite should be a location where patients can rest, but also feel safe and be surrounded by persons who they trust and who care for them. Developing a medical respite program that adheres to the tenets of trauma-informed, patient-centered care aligns with the evidence base that acknowledges the mistrust and traumatization that homeless patients often present with.\textsuperscript{4}

With these care principles at the core of medical respite, the program itself could take on a variety of formats, be offered in various locations, and have a mix of staffing.\textsuperscript{7} Regardless of how the program is designed (i.e., dedicated beds in a shelter or a stand-alone care facility), medical (nursing) services need to be provided.\textsuperscript{1,7} In addition, it is common for case management and housing support services to be offered to medical respite patients, as well as meals, medication assistance, and transportation.\textsuperscript{13} Participants of the current study concurred with this previous research and detailed ideas of what a medical respite program could entail in the local context (Metro Vancouver). Moreover, participants brought forth the idea to have a researcher embedded within the program of medical respite so that the researcher is viewed as a team member who has built a relationship with patients.

**Study Limitations**

A notable limitation to these findings is that patient participants of the current study may represent a biased perspective on the willingness of other potential persons with lived experience to engage in research. That participants of this study were willing to be interviewed suggests that they may be more open to sharing personal information than others. Indeed, most of the patient participants suggested that they would be willing to share any information about themselves, while simultaneously acknowledging that other people may be more hesitant.

In addition, the interview agenda was slightly modified following the first few patient participant interviews because these participants viewed the researcher as the professional who was more knowledgeable about how to design a future research study and what data to collect. To better situate the researcher as a learner, the researcher then started each interview by acknowledging the inherent awkwardness that participants might feel in answering some of the questions, and emphasized the value in researchers understanding the perspective of persons who may have never designed or participated in a research study. The most challenging ideas that needed to be described to patient participants involved explanations of what RCTs involve, including randomization. Nevertheless, following an adjustment to how questions were prefaced, with patient participants were more forthcoming with suggestions and ideas about the research design and process.

**Future Directions**

Based on findings from this feasibility study, it is suggested that the current project’s research team develop a subsequent proposal for a medical respite intervention study. To achieve this goal, an organization that is currently engaged in developing a purpose-built medical respite facility has been identified as a potential avenue for future study. Alternatively, a newly initiated transitional accommodation available to some patients discharged from St. Paul’s Hospital (the Transitional Care Centre [TCC])\textsuperscript{ii} has been identified as an opportunity to engage in pilot research. Finally, there is the need for future research to include a cost effectiveness element to examine the costs that can be attributed to a medical respite intervention compared to treatment as usual.\textsuperscript{7} Based on findings from this study, patient partners should be considered integral to the development of any follow-up study proposal.

\textsuperscript{ii} http://www.providencehealthcare.org/vpftcc
References


### Table 1. Patient Participant (n=15) Characteristics

<table>
<thead>
<tr>
<th>Category</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Gender</strong></td>
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<td>Female</td>
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</tr>
<tr>
<td>Male</td>
<td>10</td>
</tr>
<tr>
<td><strong>Age (years)</strong></td>
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</tr>
<tr>
<td>36-49</td>
<td>4</td>
</tr>
<tr>
<td>50-59</td>
<td>7</td>
</tr>
<tr>
<td>60-73</td>
<td>4</td>
</tr>
<tr>
<td><strong>Race/Ethnicity</strong></td>
<td></td>
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<tr>
<td>Caucasian</td>
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</tr>
<tr>
<td>Indigenous/Aboriginal</td>
<td>4</td>
</tr>
<tr>
<td>Other</td>
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</tr>
<tr>
<td><strong>Housing Location at time of Interview</strong></td>
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<td>Unstable</td>
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</tr>
<tr>
<td>Shelter</td>
<td>3</td>
</tr>
<tr>
<td>Transitional Shelter</td>
<td>6</td>
</tr>
<tr>
<td>Social Housing</td>
<td>5</td>
</tr>
</tbody>
</table>

*Note: One participant identified as both Caucasian and Indigenous*
Table 2. Participant Reports on Data to Collect

<table>
<thead>
<tr>
<th>Data Category</th>
<th>Data Point</th>
<th>Data Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Background information</td>
<td>• Age</td>
<td>• Interview patient</td>
</tr>
<tr>
<td></td>
<td>• Geographical region</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Housing/shelter status</td>
<td></td>
</tr>
<tr>
<td>Physical and mental health</td>
<td>• What health event led to hospitalization</td>
<td>• Hospital medical records</td>
</tr>
<tr>
<td></td>
<td>• Physical functionality</td>
<td>• Interview patient</td>
</tr>
<tr>
<td></td>
<td>• Health needs and needs for follow-up care</td>
<td>• World Health Organization Index</td>
</tr>
<tr>
<td>Healthcare and service utilization and costs</td>
<td>• Hospital admissions</td>
<td>• Hospital medical records</td>
</tr>
<tr>
<td></td>
<td>• Emergency department visits</td>
<td>• Interview patient</td>
</tr>
<tr>
<td></td>
<td>• Length of hospital stay (according to ALC designation)</td>
<td>• Medi-Tech: <a href="https://ehr.meditech.com/">https://ehr.meditech.com/</a> Interview patient</td>
</tr>
<tr>
<td></td>
<td>• Connection to formal and informal supports</td>
<td>• Patient health information system?</td>
</tr>
<tr>
<td></td>
<td>• Costs of services</td>
<td>• PARIS</td>
</tr>
<tr>
<td>Outcomes of the medical respite intervention</td>
<td>• Treatment effectiveness and appropriateness</td>
<td>• Interview patient</td>
</tr>
<tr>
<td></td>
<td>• Health change</td>
<td>• Index developed in HIT study</td>
</tr>
<tr>
<td></td>
<td>• Medication management</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Access to stable housing</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Quality of life</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Patient satisfaction with treatment</td>
<td></td>
</tr>
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### Table 3. Participant Reports on What to Include in a Medical Respite Program

<table>
<thead>
<tr>
<th>Medical Respite Program Features</th>
<th>Goal</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Built Features</strong></td>
<td></td>
</tr>
<tr>
<td>• Wheelchair accessibility</td>
<td>Accessible design to meet a range of health and mobility limitations</td>
</tr>
<tr>
<td>• Grab bars on beds and near toilets</td>
<td></td>
</tr>
<tr>
<td>• Beds lifts</td>
<td></td>
</tr>
<tr>
<td>• Elevators</td>
<td></td>
</tr>
<tr>
<td>• Personal cabinets or lockers for valuables</td>
<td>Safety and security of patients and their belongings</td>
</tr>
<tr>
<td>• Storage units</td>
<td></td>
</tr>
<tr>
<td>• Private cubicle for staff to screen entry</td>
<td></td>
</tr>
<tr>
<td>• Buzzer to enter the locked medical respite unit</td>
<td></td>
</tr>
<tr>
<td>• Personal bedroom</td>
<td>Patient privacy and dignity; enable bed rest</td>
</tr>
<tr>
<td>• Ensuite bathrooms</td>
<td></td>
</tr>
<tr>
<td>• Exercise room</td>
<td>Encourage physical and mental health</td>
</tr>
<tr>
<td>• Games room (pool table)</td>
<td></td>
</tr>
<tr>
<td>• A nearby walkway or park</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Human Resources</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>• Medical staff</td>
<td>Physical healthcare provided through a trauma-informed lens; wound care; IV therapy; foot care</td>
</tr>
<tr>
<td>• Doctor (drop-in, available by phone)</td>
<td></td>
</tr>
<tr>
<td>• Nursing (regular onsite RN or LPN)</td>
<td></td>
</tr>
<tr>
<td>• Methadone prescriber</td>
<td></td>
</tr>
<tr>
<td>• Mental health therapists</td>
<td>Mental health and addictions treatment; mental and physical pain management</td>
</tr>
<tr>
<td>• Drug and alcohol counsellors</td>
<td></td>
</tr>
<tr>
<td>• Allied health professionals</td>
<td>Physical rehabilitation; recovery from stroke; improve functional impairments; rehabilitate activity limitations; encourage independent living</td>
</tr>
<tr>
<td>• Occupational therapists</td>
<td></td>
</tr>
<tr>
<td>• Physiotherapists</td>
<td></td>
</tr>
<tr>
<td>• Social worker</td>
<td>Case management; ensure referrals to supports (community services and housing); assist with paperwork (to organize finances and make applications); serves as the link between healthcare and shelter/housing to walk alongside patients in their transition out of the medical respite program</td>
</tr>
<tr>
<td>• Case manager</td>
<td></td>
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<tr>
<td>• Housing coordinator (e.g., Housing First worker)</td>
<td></td>
</tr>
</tbody>
</table>
### Program Services

<table>
<thead>
<tr>
<th>Category</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Peer support&lt;br&gt;Peer navigators&lt;br&gt;Volunteers</td>
<td>Provide social support for patients; assist patients navigate the system</td>
</tr>
<tr>
<td>Cleaning staff&lt;br&gt;Food service staff</td>
<td>Provide non-clinical supports</td>
</tr>
<tr>
<td>Research team member</td>
<td>Patients are comfortable sharing their personal information and perspectives on the medical respite program</td>
</tr>
</tbody>
</table>

**Program Services**

<table>
<thead>
<tr>
<th>Service</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clothing and laundry services&lt;br&gt;Nutritious meals and food security&lt;br&gt;Medication on site</td>
<td>One-stop shop to meet patients health and social needs and provide for basic needs and nutrition</td>
</tr>
<tr>
<td>Program vehicle&lt;br&gt;Contract with HandyDart or Hospital Transfers (SN Transport Ltd.)</td>
<td>Being able to transport patients from the hospital to the medical respite location; to any support that is not provided in house; to follow-up appointments; to search for housing</td>
</tr>
<tr>
<td>24/7 computer and Internet access (Wi-Fi)&lt;br&gt;Well-designed programming (e.g., life skills training, nutrition and financial education programs, employment services, discussion groups, pet therapy)</td>
<td>Mental stimulation; learn life skills; rebuild patients’ social connections</td>
</tr>
</tbody>
</table>
Appendix A

Semi-Structured Interview Guides

Patient Interview/Focus Group Agenda
1. In your opinion, how can we most successfully recruit older patient participants into another research study that would examine their health and healthcare use outcomes?
2. What would affect older patient participants willingness to participate in this research?
3. What data should we propose to collect for the next stage of research? (Probe: What are your ideas on the primary qualitative and quantitative data to collect from older patient participants?)
4. Which data do you think older patient participants would be willing and able to complete?
5. What barriers would there be to the collection of this data?
6. What is your opinion on whether one or two treatment arms would be feasible?
7. What should be study participant inclusion and exclusion criteria?
8. Which health and social services do you feel should be offered to an intervention (vs. comparison) group?
9. How acceptable would it be (or not be) to randomize older patient participants into treatment or non-treatment groups?
10. What barriers can you envision regarding why older patient participants may or may not participate?

Provider Interview Agenda
1. In your opinion, how can we most successfully recruit older patient participants?
2. As a clinician/health provider, how willing would you be to refer older patient participants into a future research study?
3. Are there any specific barriers to referral (to the provider referring older patient participants to the study) that you can envision?
4. What would affect older patient participants willingness to participate in an intervention study of medical respite?
5. What data should we propose to collect for the next stage of research? (Probe: What are your ideas on the primary qualitative and quantitative data to collect from older patient participants?)
6. What data do you know of that we could access for secondary use in a future study? (Probe: How do we best maintain patient privacy and anonymity with the use of this data?)
7. What is your opinion on whether one or two treatment arms would be feasible?
8. What should be study participant inclusion and exclusion criteria?
9. How acceptable would it be (or not be) to randomize older patient participants into treatment or non-treatment groups?
10. Which health and social services do you feel should be offered to an intervention (vs. comparison) group?
11. What barriers can you envision regarding why older patient participants may or may not participate?