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I'LL TELL YOU WHAT I WANT, WHAT I REALLY, REALLY WANT: INTEGRATED PUBLIC HEALTH CARE FOR HOMELESS INDIVIDUALS IN CANADA

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Modern advancements in travel have led to an unprecedented number of pandemic outbreaks in recent years. As a global city, Toronto has been particularly affected by events such as SARS and H1N1. It is well documented that some individuals fare better than others in these kinds of crises, and that vulnerability is often rooted in pre-existing social inequities. Among the most marginalized and at-risk groups are those who are homeless and/or dependent on social services for subsistence. This chapter takes a critical look at the fragmentation of homelessness and public health services in Toronto, using a study of the H1N1 pandemic. Homelessness is often associated with negative health outcomes, but is less often recognized as being a crisis of public health. Many organizations within homelessness sectors are not designed with public health considerations in mind, meaning that clients are often in congregate settings for extended periods without adequate ventilation and disinfection practices in place. Through this chapter, I argue that the best way to prepare the homelessness sector in Toronto for a pandemic outbreak, such as H1N1, is to redesign it as an integrated public

health and social care sector. This chapter examines the current barriers that prevent full public health applications in homeless agencies and reimagines an approach that foregrounds integrated care and the individual needs of service users.

In the mid-1990s the Spice Girls broke onto the international music scene with their catchy always-in-your-head song Wannabe. Even now, you can probably hear the refrain ringing in your ears: "Yo, I'll tell you what I want, what I really, really want. So tell me what you want, what you really, really want…" (Beckham et al., 1996). These two simple lines could be the anthem of integrated care, the increasingly popular idea that health and care sectors should be coordinated in order to provide the most comprehensive support for clients. The idea of integrated care is thought to be particularly important and useful for marginalized persons, such as those who are homeless and/or who have complex needs (Public Health England, 2015). While the term 'integrated care' is, to date, not well defined or universally used (Kodner, 2009), there is a common underpinning notion that in order for it to

be effective, integrated care needs to be built around the individual client and their particular set of needs (Dorrell, 2015). This chapter draws on research from two studies[1] on homelessness and health to highlight the existing gaps in the Toronto homelessness sector that expose homeless persons to unhealthy conditions.

I begin this chapter by discussing the findings of a study conducted of the Toronto homelessness sector's response to H1N1, a pandemic that affected the city in 2009 and 2010. I argue that this outbreak, while relatively mild in impact, served to highlight some key deficiencies in the homelessness sector resulting from its fragmented nature. Namely, the current separation of the homelessness and public health sectors means that homeless individuals must seek supports in various service agencies that are overcrowded, poorly ventilated and not operating on coordinated schedules. At present, homeless persons experience many communicable and chronic health conditions that are exacerbated by living on the street, in large part because public health considerations are not at the forefront of social service design or delivery in the homelessness sector. In the section that follows, I draw on integrated care literature and interviews conducted with staff of a local health authority to argue that integrated care offers new opportunities for service provision. While the definition of integrated care is contested (as will

be discussed), in this paper I follow Kodner and Spreeuwenberg's (2002) proposed definition:

Integration is a coherent set of methods and models on the funding, administrative, organisational, service delivery and clinical levels designed to create connectivity, alignment and collaboration within and between the cure and care sectors. The goal of these methods and models is to enhance quality of care and quality of life, consumer satisfaction and system efficiency for patients with complex, long-term problems cutting across multiple services, providers and settings. The result of such multi-pronged efforts to promote integration for the benefit of these special patient groups is called 'integrated care' (3).

Evolving past early conceptions of integration as being vertical or horizontal in nature, I argue that we need to rethink the homelessness and public health sectors as one holistic system. In the final section, I draw on Herklots' (2015) three levels of street, service and sector to offer a theoretical sketch of how this integrated care model of homelessness and public health could come into practice.

HOMELESSNESS SECTOR FRAGMENTATION:
THE H1N1 STUDY

In 2010 and 2011, the period following the H1N1 outbreak, researchers in Toronto, Calgary, Regina and Victoria undertook an analysis of the level of pandemic preparedness of homelessness sectors in their respective cities. Given that homelessness has been described as a health inequity cliff, where the health of homeless persons drops significantly on the street (Story, 2013), this project sought to examine how the health of homeless persons was impacted by homelessness sector responses. This chapter reports on some of the findings of the Toronto-based study[2], in which surveys and interviews were conducted with 149 homeless individuals, 15 social service providers working in frontline agencies and five key stakeholders involved in public health and/or homelessness policy.

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As part of the study, homeless participants were asked to self-report the health conditions they experienced in the preceding year. Results indicated that the participants reported experiencing fatigue/tiredness (59.7%), coughing up phlegm (51.7%), shortness of breath (36.9%), night sweats (35.6%), chest pain (28.2%), unexplained weight changes (24.2%), chronic lung disease (21.5%), coughing up blood (16.8%), infection (16.2%), fever that persists (14.1%) and diabetes (8.1%). When asked about health conditions overall (not limited to the preceding year), participants also noted experiencing arthritis (13.4%), Hepatitis A, B, or C (12.8%), lung disease (7.4%), cancer (6.7%), HIV/AIDS (4%), tuberculosis (2%) and herpes (1.4%).

It is well documented that the experience of homelessness often creates or contributes to a range of physical health problems, including respiratory illness, fatigue, tuberculosis, traumatic brain and other injuries, sexually transmitted infections, hepatitis and HIV/AIDS (Daiski, 2007; Frankish, Hwang & Quantz, 2005; Haldenby, Berman & Forchuk, 2007; Hwang, 2001; Hwang et al., 2008; Topolovec-Vranic et al., 2012). In a study of 24 homeless participants from one Canadian city, Daiski (2007) found that physical health problems were often chronic, emerged decades earlier than typically expected in those who were younger and were reinforced through

social and structural barriers such as living in poverty and having inconsistent access to health care. Food deprivation and/or inadequate nutrition are common problems among those who are homeless (Gaetz, Tarasuk, Dachner & Kirkpatrick, 2006; Tarasuk, Dachner & Li, 2005). Reliance on soup kitchens and other programs for food (Sager, 2011) combined with a poor diet that is high in processed foods, fats and sugars, create the conditions among homeless persons for the two seemingly contradictory health issues of hunger and obesity (Koh, Hoy, O'Connell & Montgomery, 2012).

Many of the chronic health conditions that homeless individuals experience may be unwittingly related to the design and operation of services within the homelessness sector. For instance, the high rates of coughing up phlegm, shortness of breath and chronic lung disease found in the H1N1 research study could be aggravated by – if not the result of – spending time in overcrowded congregate spaces with poor ventilation. The findings of interviews with key stakeholders in the H1N1 study supported the assertions that public health measures are not prioritized in many service agencies, largely due to a lack of adequate funding and resources. Figures provided by one of the stakeholders suggested that in 2011 (at the time of the interview), there were approximately 3,800 emergency beds

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2. For the full report, please see Buccieri & Gaetz (2015).

available between City of Toronto-operated shelters and purchase-of-service shelters (not including violence against women shelters and domestic hostels). In the same year, the reported average nightly occupancy of emergency shelter beds, according to City of Toronto (n.d.) statistics, was 3,716, producing an average occupancy rate of 97.8%. The consistently high demand for services, combined with a lack of funding and resources, creates the conditions in which addressing public health issues like overcrowding, congregate living and poor ventilation become lower priorities.

According to one stakeholder in the H1N1 study with a background in public health medicine: "Anytime you have a congregate setting it's easier to spread anything. This is the case with drop-ins and shelters. Ideally you should have smaller groups, more rooms, more bathrooms – that would be better and reduce transmissions between groups." Communicable diseases are common in homeless service agencies, a phenomenon not limited to Canada. Researchers in Tokyo conducted a microscopic analysis of body lice from the discarded clothing of homeless persons and found the rates of nymphs and adults up to 643 specimens (Sasaki, Kobayashi & Agui, 2002). According to these researchers, "It is likely that factors such as overcrowding, malnutrition condition, and inadequate access to medical care affect the transmission and spread of louse-borne diseases among the homeless" (Sasaki et al., 2002: 429).

There are two particularly challenging aspects of homelessness from a public health perspective: the co-occurring factors of containment and mobility (Buccieri, 2014). Both of these issues stem largely from the system design. In regard to containment, many homeless individuals are reliant on services, leaving little choice but to put themselves in high density places like shelters and food-service programs. In the pandemic study, for instance, 61.7% of participants noted they go to drop-in centres for food and that while there, on average, there are more than 20 to 50 others in the room with them. Further, a substantial percentage (41.6%) reported that while in these agencies, it is common to have at least five other people within touching distance at any given time. The current system, in which homeless individuals are reliant on services for the necessities of life, forces them to enter unhealthy situations that contribute to poor health outcomes through overcrowding, exposure to others with communicable diseases and poor ventilation. Shantz (2010), a formerly homeless man, reflects on his own time in emergency shelters, writing:

> *Despite the images conjured up by names like vagabond, drifter, or hobo, being homeless is an experience of bodily and spatial confinement. Going to shelters can leave us beaten up... or contracting tuberculosis, supposedly a disease of the past that is rampant in contemporary shelters... our bodies are time travellers picking up ancient illnesses that the rest of the population only reads about in history books (182).*

The related factor of mobility is caused as service agencies open and close throughout the day, forcing clients into public spaces and/or other services. As Daiski (2007) found, most homeless agencies have restrictions such as early curfews that force people out at certain times of the day. Ali (2010) writes:

> *In the realm of homelessness the exercise of social control is seen in terms of the regulation of other particular forms of individual behaviour, most notably the mobility of the homeless persons, including the spaces they are allowed to occupy and the social relations and associations they are able to pursue (82).*

The politics of mobility is one that makes use of institutional cycling, to move homeless bodies through fragmented services despite the risk to their health (Ali, 2010).

In one Toronto-based study, researchers used shelter data to examine the number of shelter residents who would be potentially exposed to a communicable disease in the event of a public health outbreak (Hwang, Kiss, Gundlapalli, Ho & Leung, 2008). Their findings clearly indicate the inter-related public health challenges of containment and mobility when working with homeless populations. Among a sample of 4,565 shelter residents, they found that individuals had contact with a mean of 97 other shelter users over a one day period and that those who stayed at more than one shelter had contact with an average of 98 additional shelter residents (Hwang et al., 2008). This study highlights the current public health challenges of containment and mobility, as homeless individuals spend time in close proximity to many other service users while also cycling between agencies.

At present, the homelessness sector in Toronto is overburdened with high demands for service coupled with a lack of sufficient funding and resources, producing conditions that lead to chronic health conditions and communicable diseases for service users. According to one stakeholder interviewed in the H1N1 study:

> *The whole issue regarding community infection control in the homelessness sector needs to be addressed, with explicit resources for that. We're getting there. We're trying for funding for a public health infection control position to work with community agencies – someone to draw on in an emergency, pre-existing infrastructure. We already do that with seniors' homes, schools, etc. We need pre-existing infrastructure to carry this out, and the person responsible for infection control in the sector should have a direct line to high level people. That will happen.*

There is a pressing need to better coordinate efforts between the homelessness sector and public health officials. The success of one effort during the H1N1 outbreak, to hold vaccine clinics in shelters and drop-in centres, showed that there is a willingness and ability to bring these two sectors together (Buccieri & Gaetz, 2013).

The difficulty lies in the siloing of public health and social care. A large issue that many agencies faced during H1N1 was not only that budgets were low, but that there were restrictions on how they could spend the money. Agencies are mandated in particular ways and their funding is often tied to the operation of particular programs with limited (if any) discretion for its reallocation. As one stakeholder noted in the H1N1 study:

One of the things that struck me was the difficulty so many organizations had with organizational depth. They just didn't have the staff time to free up to think things through. They are funded in a very strict way that limits their mandate – this is really true in social services. The fact that health issues occur in the realm of social services becomes really difficult, and they are not always able to pick it up.

According to another stakeholder: "Living through H1N1, one of the biggest issues was that so many agencies had not even a generic emergency plan. So in dealing with H1N1, many were starting from scratch." Without the mandates, expertise, funds or resources to address public health issues in their agencies, it is perhaps not surprising (if not expected) that these gaps emerged. What currently exists is a systemic issue, in which service agencies require public health measures to protect their clients but lack the capacity to do so because of limited funding, resources and public health expertise.

The results of the H1N1 study highlighted many strengths of the homelessness sector in Toronto, such as a willingness to work collaboratively within the sector, the dedication of service providers and a keen understanding of the systemic barriers homeless persons experience. Yet, it also highlighted the public health challenges that are currently embedded in the system. Homeless individuals experience many chronic and communicable health conditions that are exacerbated by being contained in over-crowded services they depend on and by having to cycle to other agencies as they open and close throughout the day. The lack of discretionary funding in the homelessness sector means there is limited financial and human capital that can be put toward addressing these public health issues. What is needed is a new approach that builds capacity through holistic integrated care.

IT'S A BIRD,
IT'S A PLANE,
IT'S INTEGRATED CARE

Redesigning an integrated system-wide response to homelessness is no simple task. Yet, as the H1N1 study highlighted, the current fragmented nature of the homelessness sector may be contributing to the poor health of homeless clients. In the same way that Albert Einstein defines insanity as doing the same thing over and over and expecting different results, Dorrell (2015) notes that, "we run partitioned services and wonder why we fail to deliver integrated care" (13). Perhaps the complexity of planning and operating an integrated care model for high-needs clients, such as the homeless, seems too daunting a task to undertake. Van Laere and Withers (2008) counter this view when they write:

> *Services are organized and managed in such a complex manner that policy makers and managers tend to think that homeless people do have complex needs. This is not true. Needs are not complex at all. Tackling the health issues of the homeless requires a systematic approach by dedicated homeless health care professionals (5).*

Shifting the ideology to one that sees the homelessness and public health sectors not as separate and distinct but as one holistic system brings with it the prospect of adopting better ways of working together, of addressing the current gaps and of considering the needs of the service user in different ways.

In the United Kingdom, integrated care has been considered the holy grail of policy making for several decades (Burstow, 2015; Keohane, 2015). As such, the UK has formulated a nationally agreed upon definition of what integrated care means for an individual, which is that, "I can plan my care with people who work together to understand me and my carer(s), allow me to control, and bring together services to achieve the outcomes important to me" (Public Health England, 2015: 4). This definition indicates a strong, collaborative relationship between care and cure sectors, while emphasizing the client's ability to formulate their own service needs.

In Canada, to date, there is no comparably recognized national definition of what integrated care means. Canada is not alone in this definitional ambiguity. Even within the UK, integrated care is known by several names, including 'personalized care,' 'patient-centered care,' 'joined-up care,' and 'whole person care' (Keohane, 2015). "Like a Rorschach test, integrated care has many meanings;" Kodner and Spreeuwenberg (2002) note, "it is often used by different people to mean different things" (1). Integrated care may be considered the Superman of service provision. Not only is it lauded as a saviour, but it is an entity that appears in shapeshifting forms. In a recent conceptual analysis of integrated care, Kodner (2009) highlights its ambiguity by comparing it to a tree, a precise surgical procedure, a country and the proverbial elephant that everyone touches but no one can fully grasp. Reading this article brings to mind the old line, "It's a bird, it's a plane, it's Superman!" Only now, it has been changed to (the much less catchy), "It's a tree, it's a country, it's an elephant, it's integrated care!" Over time the concept of integrated care has changed and developed, leaving it under-defined and open to interpretation.

As part of a larger study, in the summer of 2015 interviews were conducted with three staff members of a local health authority in Ontario pertaining to issues of health, homelessness and integrated care. The research participants were senior level officials who

work in health systems policy and planning with a focus on marginalized populations. When asked what integrated care means to them, one participant stated:

Well, I see it as, as integrated around the client. So I think you look at what people who use services need from a holistic perspective and then those services should be integrated around that person. To varying degrees I think people that have very high needs, need a higher level of the same services but I think generally speaking looking at anyone from a holistic perspective should provide that integrated system. I think what's really important... is that it shouldn't be a series of systems, it should be one system that works together.

Despite this definition of integrated care as being one holistic system, it was also noted that this understanding has evolved slowly over time. One interview participant stated:

In the beginning within integration it was, "Are we talking horizontal integration like hospital to hospital to hospital? Or are you talking vertical integration... that would move through... home and community, to hospital, to tertiary care?" So there's a bit of both, and I mean there's still both but now increasingly we have less of the conversations about this being a horizontal or vertical integration and more about it being a system integration for the client's needs.

Dorrell (2015) has noted that our current systems are inherited from history, creating institutional boundaries that partition services in ways that can be highly disruptive to users. He continues by stating: "Above all we must ensure that we develop a care sector which delivers services which are built around the needs of the individual rather than inviting individuals to mould their needs to the services available from the inherited institutions" (Dorrell, 2015: 14). A lack of integrated services may be particularly problematic for homeless individuals. One health authority staff member agrees with Dorrell by stating:

I think often times people are homeless because they haven't had that integrated system around them to support them. And for lots of reasons they're not the customers that the system wants to serve and so I think that that's the notion that really needs to be turned on its end. Is it's not about the people providing the service; it's about the person who needs the service. And the work should be in making that adapt to the individual, not the individual having to make that adapt. So I think that those people who are homeless are those who are the most in need who just simply have not been able to have their needs addressed for reasons that don't relate to them specifically.

As integrated care becomes more recognized and implemented at the higher system planning levels, it will require an equal shift in mindset from front line workers in the care and cure sectors. This is a task many are willing to take on, as one health authority staff noted:

Certainly the service providers want to be able to meet the needs of such high-needs clients. They recognize it's a drop in the system, it's a weakness, it's high potential for a fail in the system when the full needs of folks are not addressed. Ending up on the street homeless is a fail, it's just not easy to address in the health system alone.

However, there exist many structural barriers that must be addressed before full integrated care is possible. Among the most pressing of issues to be sorted is the original question of how to define integrated care. As a tree, surgical procedure, country and elephant (Kodner, 2009), integrated care is not universally conceptualized or enacted. Reflecting on conversations about how to best use integrated care for complex-needs clients, one health authority member stated:

Those hardest-to-service clients have been the ones that are most tricky for our service providers to serve in a coordinated and integrated fashion because they're looking for, in my opinion, "It would be nice if there were an easy answer, an easy fix." And what we've learned over time is that it's not that. And then when we started with discussions about complex clients and high-needs clients, service providers would gravitate towards the most medically complex individuals. When we'd talk complexity they would say, "Are these the folks who are in our ICU, that are intubated and you know, end of life... all resources on hand? That kind of thing. And [what] we've learned over time is, those aren't the ones that are as hard to serve. There are systems to support, and protocols, and resources to support those individuals. It's the ones that are socially complex that are challenging the system response the most.

In Canada we are witnessing a promising ideological shift toward integrated care that builds from the service user's perspective. This uptake may be particularly important for meeting the cure and care needs of homeless individuals through one holistic system. The Calgary Homelessness Foundation (2012), is one such example of progress, as in its system planning framework it acknowledged that, "when a client's complexity is not assessed, or when the programmatic intervention chosen does not match their risk and resiliency factors, there is a higher likelihood of poor outcomes" (2). The movement toward integrated care is likely to continue to grow in the years to come. "Tell me what you want, what you really, really want" (Beckham et al., 1996) will not just be a Spice Girls lyric, but a mantra for integrated care providers all over. The final section of this chapter imagines how a holistic system of integrated public health care could be developed in line with homelessness sectors, from the ground up.

A THEORETICAL SKETCH OF INTEGRATED PUBLIC HEALTH AND SOCIAL CARE FOR HOMELESS PERSONS

An integrated care approach is one that brings together the system, service and street levels to advance the health and social support of individual service users (Herklots, 2015). Dividing these levels is in no way meant to suggest that they are distinct mutually exclusive categories. To the contrary, successful integration at any level depends on successful integration at every level. The discussion that follows is not meant to be an exhaustive guide on how to implement integrated public health and social care in homelessness sectors in Canada. Rather, it highlights the key features that need to be considered and addressed on each of these levels before integrated care can be achieved. For each level below, the discussion focuses on what needs to be considered for improved public health measures in the social service provision offered to homeless persons.

Successful integration at any level depends on successful integration at every level.

FIGURE 1 *Three Levels of Integrated Care*
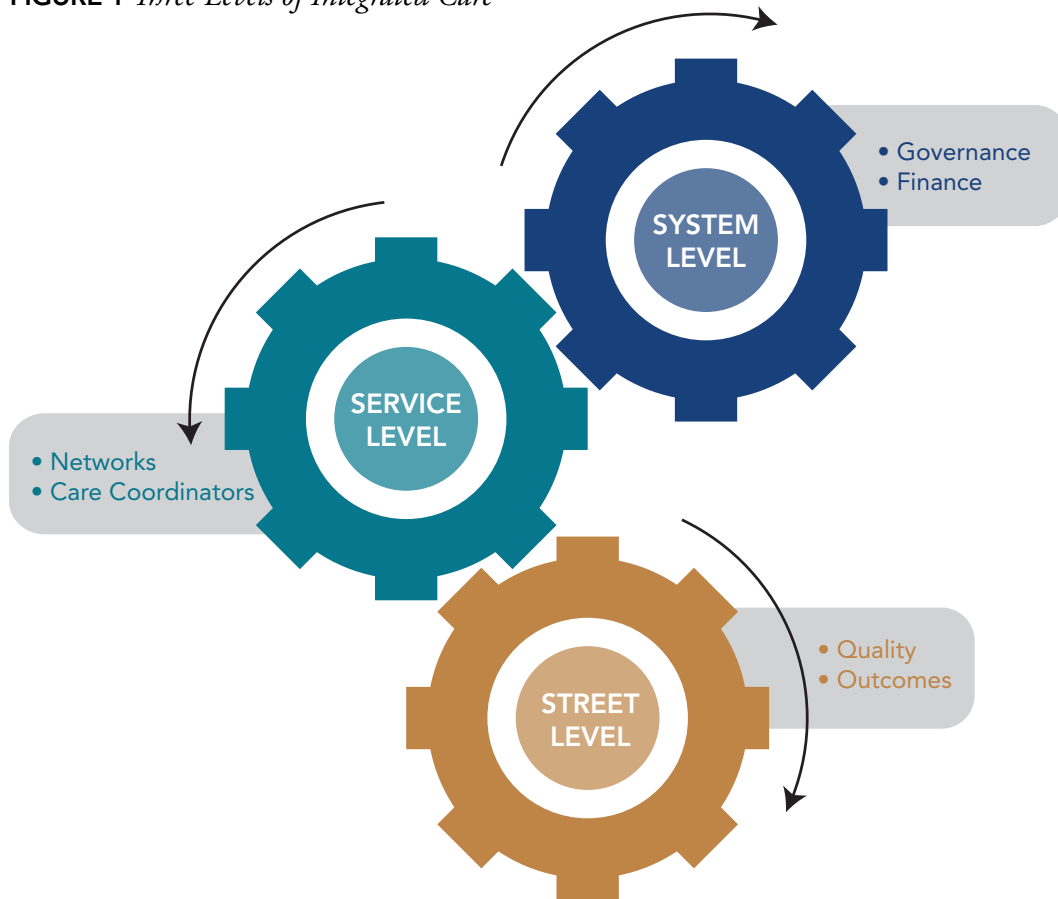
Street Level

The level of the street encompasses the service user and their caregivers, such as family members and/or significant others. There are two key considerations at this level – quality and meaningful outcomes. Public Health England (2015) writes, "ultimately, it will be people who use the services who will decide whether partnerships are working and are relevant to their needs" (20). As such, the quality of the services and supports being integrated is essential to their success (Herklots, 2015). The intent of integrated care is to enhance the quality of services and provide a more comprehensive level of support, particularly for those with complex and multiple service needs (Kodner & Spreeuwenberg, 2002).

At the street level, the emphasis is on the quality of service provision for the user with effectiveness being demonstrated by meaningful and measureable outcomes. There is considerable literature that shows there are high rates of chronic and communicable illness among homeless populations. Further evidence suggests that many homeless individuals do not actively seek health care until a medical issue is at an advanced stage (Homeless Link, 2014). Participation is key, as having a sense of control over one's own health care has been shown to be an important factor in improving outcomes (Kelsey, 2015). Measureable outcomes of integrated public health and social care for individuals would include an improvement in self-reported health and wellness, reduction of chronic and/or communicable illness and earlier help-seeking behaviour. Starting with the needs of the individual service user and aiming for quality of services and meaningful outcomes is the goal of the street level. It also sets the foundation for both the service and system levels to be built upon.

> *At the street level, the emphasis is on the quality of service provision for the user with effectiveness being demonstrated by meaningful and measureable outcomes.*

Service Level

The service level focuses on professionals and agencies that work with homeless individuals to provide care. It is these individuals who are responsible for working directly with homeless persons to achieve the best possible outcomes, such as improved health and well-being. The factors that need to be addressed at the service level for successful integrated care are those of networks and care coordinators. The notion of networks builds upon existing relations within the sector and aims to strengthen and enhance them through digital strategies. The service level is perhaps where there exists the most promise for an integrated care system that prioritizes public health. This is evident in the Calgary Homeless Foundation's (2012) system planning framework which includes key elements such as having eligibility criteria for homeless-serving programs and formalized eligibility criteria to support streamlined referral and the matching of clients to services. The coordinated intake and referral of clients through the system and between agencies means that individuals may be less likely to seek assistance from multiple sources. Among the findings of the H1N1 study was that homeless individuals spend a great deal of time seeking to have their care needs met in various social service agencies (where they are in congregate settings with poor ventilation and at risk of exposure to communicable diseases). Streamlined coordination around intake and referral has the potential to reduce these public health risks by ensuring homeless individuals do not have to wander between agencies in search of appropriate care.

Working across the sector between agencies is not a new idea. In the H1N1 study it was found that many service providers already have informal networks with colleagues working in other organizations. Integrated care seeks to build upon these relationships by making them more formal and standardized. Best practices that have been shown to be effective in this regard include communication between service providers, practitioner familiarization with the range of homeless services in the community (Hwang & Burns, 2014),

single point of entry for all homeless services and multiservice centres where services can be accessed by homeless persons in one area without the need to travel extensively (Hambrick & Rog, 2000). Integrated care at the service level has the potential to improve public health outcomes for homeless individuals by reducing the number of clients who are mobile in search of care and through the streamlining of institutional practices like intake and referral. As Public Health England (2015) notes, there is something incredibly powerful about different professionals being linked into each other's services.

In today's digital age, perhaps among the most important tools are electronic data collection and record sharing. A study of 28 homeless agencies in North America, conducted by Cavacuiti and Svoboda (2008), found that nine used electronic medical records for outreach and that they were important for providers to access medical information and to collect aggregated client data for the purposes of planning, evaluation and advocacy. Further, this study showed that having these records available at multiple locations could be a powerful tool for improving coordination, safety, efficiency and the quality of care provided to homeless clients (Cavacuiti & Svoboda, 2008). Electronic records can help to provide common intake, assessment, referrals and service coordination (Calgary Homeless Foundation, 2012), while sharing information through electronic networks can allow different locations and services to communicate and coordinate (Hambrick & Rog, 2000). The comprehensive adoption of data and digital strategies may have a significant impact on the productivity and effectiveness of service agencies by streamlining the process, although issues of transparency, privacy and access need to be considered and addressed (Kelsey, 2015).

Navigating an integrated system in which intake and referral processes are coordinated across the sector

The comprehensive adoption of data and digital strategies may have a significant impact on the productivity and effectiveness of service agencies by streamlining the process, although issues of transparency, privacy and access need to be considered and addressed (Kelsey, 2015).

through electronic records is perhaps a daunting task. The Calgary Homeless Foundation (2012) notes in its systems planning framework that technical support will be made available for their service providers to assist them in using the software. While this is certainly essential, supports also must be put in place to help service users navigate a high-tech integrated system as well. Here the notion of care coordinators (borrowed from the UK model for elderly person care) offers some promise. Care coordinators work one-on-one with an individual to help them identify their goals and then broker a wide range of supports to achieve them, working intensively with the client for three or more months to connect them to ongoing sources of support, so they can sustain any advances made (Abrahams, 2015). This notion is not unlike case management, which is a staple of homeless service provision in Canada as well. The key here is that the care coordinator would not be affiliated with any particular service agency but instead would work as a liaison across the sector to help individual service users understand how the services are integrated and coordinated.

Through enhanced networks and the use of care coordinators, the service level holds many opportunities for reducing communicable disease and chronic illness among the homeless. While many of these initiatives – such as coordinated intake and referral – may not on the surface seem like public health initiatives, they do have an impact on critical factors such as service capacity, who is admitted into a shelter or agency and how long that person stays. These measures are particularly important when public health issues, like outbreaks of influenza or tuberculosis, arise. For instance, having access to this information can prevent the discharge of a person who is ill into another agency. Addressing public health issues at the service level is key, but depends on support from above and below.

System Level

The system level is the overarching structure that operates, governs and funds the homelessness sector. At present, the results of the H1N1 study indicate that public health is not a top priority within the sector, given the high rates of chronic and communicable illness, overcrowding of many agencies, poor ventilation and the twin conditions of containment and mobility. An ideological shift toward integrated care at the system level is needed in order to identify the public health risks to homeless service users and begin to address them in a systemic way. For integrated care to happen there needs to be strong governance that prioritizes public health, coupled with a shared finance strategy that supports these aims.

Within the context of public health and homelessness, this means that those in positions of power, such as agency executive directors, city directors and public health leaders, need to come together to put public health issues at the forefront of social and public policy agendas.

Research by Pearson (2015) indicates that there are four critical factors for success, that include: one, a clearly articulated and widely shared vision of why, how and for what benefits; two, a medium- to long-term financial strategy that is realistic about costs; three, flexible organizational arrangements that support a common purpose; and four, attention to matters of culture through effective leadership. This research shows the importance of having strong commitment from system leaders and the backing of financial support. Within the context of public health and homelessness, this means that those in positions of power, such as agency executive directors, city directors and public health leaders, need to come together to put public health issues at the forefront of social and public policy agendas.

In reality, Hughes (2015) notes, implementing integrated care requires the highest level of commitment from the system leaders such that it filters down to all levels of staff and becomes an organizational goal in itself. This mental shift in putting public health at the forefront of service design and provision is an ideological necessity. While most individuals who work in the care sector do so because they want to be involved in caring for the vulnerable (Dorrell, 2015), it must be recognized that change does not happen simply because the right sorts of structures are in place, but requires the imagination of those who can see how structures can be improved upon (Public Health England, 2015). To that end, an integrated care system level approach to public health and homelessness is one in which a common governance structure regulates the opening and closing of agencies throughout the day and service hours are coordinated such that individuals are not forced out of agencies and into a cycle of service-seeking mobility. This goal of common oversight does not require that agencies dispense with control over their own governance, but that they are held to a high legally binding standard of collaboration, such as through the creation of a sector-wide oversight board that would hold responsibility for ensuring accountability, coordination and transparency. Given the unique positions of each agency, a coordinating board or council is one proven best practice approach that can serve as a deliberative body that provides policy and provision advice across the sector (Hambrick & Rog, 2000). A board of this nature would include members of the homelessness sector, as well as public health officials providing a key opportunity for cross-sector learning and collaboration.

In order to achieve a goal of integrated public health and social care, financial support will be imperative. Bowden (2015) notes that a funding challenge exists in designing long-term services around the needs of individual service users, but that the answer lies in joined-up budgets that care for people's care regardless of what part of the system the care comes from. Within the homelessness sector, the reality of

underfunding is reflected in the results of the H1N1 study. High demands for service mean that many agencies are operating at or beyond capacity and have little control over discretionary funds. Expecting individual agencies to take on the challenge of funding coordination outside their own agency is unrealistic.

The UK offers one promising model and example of funding for integrated care that could be adopted elsewhere. In May 2013 the UK government announced an investment of £10 million for a national Homeless Hospital Discharge Fund in which voluntary sector organizations, working in partnership with the National Health Service and local authorities, could bid for capital and review funding to improve hospital discharge procedures for people who were homeless. Subsequent program evaluations showed this integrated care approach to be highly effective at improving health and care outcomes (Homeless Link, 2014). The approach of funding integrated care initiatives at a higher governmental level is one that could be considered in Canada, such as through the Homelessness Partnering Strategy. This is not to suggest that any program or initiative can be directly implanted from one location to another seamlessly. A program of this nature would

require a rethinking of funding and partnerships at the federal, provincial/territorial and municipal levels of government, but may offer new ways of working collaboratively that the existing model does not allow for.

Decreasing the rates of communicable and chronic illness among homeless individuals is a goal that can be achieved through integrated care. Creating a board of public health officials and homelessness sector workers is one way to improve collaboration, not only within the sector but between the sectors as well. Offering shared funding sources that depend on collaboration could improve the quality of services put forth, while also providing an opportunity to invest in improving the physical design of shelters and other agencies. The UK example shows that having a joint funding strategy that depends upon service coordination is an effective approach. Further, given findings of Toronto-based research that showed that within shelters indirect health care costs, such as personnel and supplies, are consistently much greater than the direct cost of providing health care (Hoch, Dewa, Hwang & Goering, 2008) – having a unified funding approach could serve to reduce the financial burden on individual agencies through cost and resource sharing.

CONCLUSION

Integrated care is a promising approach for meeting the complex needs of homeless individuals. While it is becoming increasingly popular among health planning authorities, the term remains ambiguous and lacks a clear definition. How to best understand and apply integrated care is a valuable discussion that Canada's cure and care sectors need to continue to engage in for the benefit of system clients. For those who are homeless, an ideological and operational shift of this nature has the potential to greatly improve their health and wellness. Public health issues are, at present, not given enough priority in a homelessness sector that is strained and constantly operating at capacity. Changes at the street, service and system level are needed in order to create a holistic system of public health and social care that is based on the needs of the individual. While full system integration may be a challenge (Midgley & Richardson, 2007), we must strive for a culture in which boundaries are sought to be overcome (Herklots, 2015). Or, as the Spice Girls would say, "tell me what you want, what you really, really want…"

Decreasing the rates of communicable and chronic illness among homeless individuals is a goal that can be achieved through integrated care.

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