Title: Development and implementation of a medical respite program for people experiencing homelessness: An analysis of a cross-sectoral partnership

Background: People experiencing homelessness (PEH) are discharged prematurely from hospital (once their medical issues resolve but before they are well enough to return to a shelter), or they remain in hospital longer than medically necessary for convalescence. A partnership was created between the provincial health authority and a homeless shelter in [city, country] to implement a medical respite program. This was a subacute, transitional unit at the shelter, designed to holistically meet the needs of PEH during convalescence after discharge from hospital.

Objectives: Given the uniqueness of this cross-sectoral partnership, we aimed to describe the elements, qualities or practices that were supportive of the collaboration between the two organizations and those that inhibited its functioning.

Methods: We conducted semi-structured interviews (n=25) with individuals who were involved in the planning and implementation of the program. These were audio-recorded and transcribed. A thematic analysis of the transcripts was performed by two study investigators, through line-by-line coding and constant comparison, and the subsequent collation of these codes into themes.

Results: Using the Bergen Model of Collaborative Functioning as the theoretical framework, the positive and negative features of the partnership were grouped into: 1) Vision; 2) Partner resources; 3) Financial resources; 4) Leadership; 5) Roles and structure; and 6) Communication and interactions. Both organizations shared a desire to address health inequity faced by PEH. However, this could not be translated to a clear vision, resulting in lack of a cohesive program structure and difficulty obtaining buy-in from stakeholders. The shelter contributed significant partner resources, but this was not felt to be valued or recognized. Rather, the contribution of financial resources by the health authority created a power imbalance in leadership and decision-making. Front-line providers felt there was an atmosphere of collaboration and open communication; the stakeholders who were involved in planning and implementation but not delivery felt differently.

Conclusion: Healthcare for PEH needs to be multi-disciplinary and cross-sectoral to be effective, in recognition that stable housing is the root cause for ill-health. The synergies and challenges we describe shed light on how partnerships between very different organizations can be navigated in future innovations.

Keywords: homeless persons; respite care; cross-sectoral partnerships; health equity; delivery of healthcare