Healthy Hearts for the Homeless (HH4H): Cardiovascular Care Experiences of People Experiencing Homelessness and the Co-Design of a New Care Management Pathway

Interim Results for a Community-Based Study

Background & Objective

• People experiencing homelessness experience a disproportionate burden of cardiovascular disease (CVD) morbidity and mortality compared to housed individuals. This is due to complex, intersecting socioeconomic factors, competing priorities, comorbidities, and discrimination (Figure 1, below) 1,2,3

• Minimal consideration has been given to understanding the challenges of people experiencing homelessness and CVD to managing CVD and accessing mainstream cardiac care while homeless individuals. This is due to complex, intersecting socioeconomic factors, competing priorities, comorbidities, and discrimination (where participants take photos to reflect on their care experiences) with:
  - 1) adults experiencing homelessness and CVD (e.g., heart failure, coronary artery disease, endocarditis, arrhythmias, valvular disease) and;
  - 2) multi-disciplinary care providers (e.g., primary care providers, cardiologists, nurses, social workers, shelter staff, case workers, others)

• Transcripts are coded for themes and analyzed using Interpretive Description 4,5

Conclusion & Significance

• A trauma-informed approach, peer researchers on the study team, and longer-term recommended values/practical elements of a new care program to the community.

• We aim to co-design a new care Toronto CVD program in the future (where participants take photos to reflect on their care experiences) with

• Common recommendations and solutions include:
  1. Reform hospital-based cardiac clinics to be more trauma-informed/anti-racist;
  2. Psychiatric training for all cardiac staff;
  3. Bring cardiac specialist care to shelters and community health centres where patients feel safer;
  4. Have a cardiac specialist join an already-established medical outreach team;
  5. Include the essential role of case managers/navigators in clinical clinics;
  6. Set up communal shelter-based remote telemonitoring stations (e.g., University Health Network’s Medly technology), where patients can be assisted in inputting daily measurements/symptoms and cardiac clinics can monitor/intervene when necessary.

Challenge and Competing Priorities of people experiencing homelessness managing CVD leads to crisis-oriented cardiac care in the emergency department.

Approach & Methods

• We are working in partnership with various community organizations (e.g., shelters, community health centres, outreach programs, hospital wards) and four peer researchers with lived experience of homelessness.

• We are conducting a critical ethnographic needs assessment.

• This includes observational fieldwork, demographic surveys, one-on-one interviews, community resource mapping, and photovoice exercises (where participants take photos to reflect on their care experiences) with:

  1) adults experiencing homelessness and CVD (e.g., heart failure, coronary artery disease, endocarditis, arrhythmias, valvular disease) and;

  2) multi-disciplinary care providers (e.g., primary care providers, cardiologists, nurses, social workers, shelter staff, case workers, others)

• So far, we have interviewed 17 people experiencing homelessness and CVD – including 7 photovoice exercises – and 24 multi-disciplinary providers (Table 1, below).

Interim Results

Table 1: Multi-Disciplinary Provider Participants

<table>
<thead>
<tr>
<th>Characteristic</th>
<th># of Participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age (mean/SD)</td>
<td>58 years (20.50)</td>
</tr>
<tr>
<td>Gender</td>
<td>7 Females 4 Males</td>
</tr>
<tr>
<td>Responsible</td>
<td>Social Worker</td>
</tr>
<tr>
<td>Location</td>
<td>Mainstream Care</td>
</tr>
<tr>
<td>Population</td>
<td>Homeless Pop.</td>
</tr>
<tr>
<td>Setting</td>
<td>Hospital wards</td>
</tr>
</tbody>
</table>

References


Conclusion & Significance

• Challenges and competing priorities of people experiencing homelessness managing CVD leads to crisis-oriented cardiac care in the emergency department.

• We will translate these findings of lived experience perspectives/needs and recommended values/practical elements of a new care program to the community.

• We aim to co-design a new care Toronto CVD program in the future (where participants take photos to reflect on their care experiences) with

• Common recommendations and solutions include:
  1. Reform hospital-based cardiac clinics to be more trauma-informed/anti-racist;
  2. Psychiatric training for all cardiac staff;
  3. Bring cardiac specialist care to shelters and community health centres where patients feel safer;
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• We can learn a lot from other large Canadian cities such as Ottawa and Calgary.

• A tension exists on the use of technology in healthcare delivery for the homeless population, where patients are enthusiastic and determined while providers are hesitant of its feasibility and commitment.

Contact

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