DOI: 10.5206/ijoh.2023.3.16126 | ISSN 2564-310X |

IJOH International Journal on Homelessness

ORIGINAL ARTICLE
International Journal on Homelessness, 2024, 4(1): page 132-156.

Measuring Lessons Learned from Durham Region's Community Hub Model During COVID-19: A Support Solution for Individuals Experiencing Homelessness and Other At-Risk Populations

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Received: 2 Mar 2023
Accepted: 19 Oct 2023

Abstract
The 2019 Coronavirus (COVID-19) pandemic severely limited the availability of community resources within the Regional Municipality of Durham, Ontario, Canada. It disrupted the lives of persons experiencing homelessness and other vulnerable populations. To address the gaps in resources, community stakeholders developed two pilot community hubs to respond to the unmet health, housing, and support needs of those impacted. This research utilized a mixed-methods research design to determine the effectiveness of the community hubs in responding to the unmet needs of patrons utilizing the services and the scalability of the community hub model as a viable regional service approach. Surveys were administered in person with seventy-five community hub patrons. Fifteen direct service staff completed self-administered online surveys. Interviews were conducted with five community hub managerial staff and two subject-matter experts who collaborated with one of the community hubs. Results from the study showed that the needs of patrons were deep and entrenched and required a progressive, co-located, integrated health and social service response model. Staff described the services as critical and lifesaving for the patrons. The descriptive statistical analysis revealed that 93% of patrons indicated that services offered by the community hubs met their needs. The main challenge for the community hubs was the lack of core funding. Implications of this study include establishing a regional, evidence-informed, integrated system of care that addresses the healthcare, social service, and housing needs of populations experiencing homelessness.

Keywords
Community Hub, homelessness, COVID-19, mixed-methods, public health

Introduction

Homelessness is a significant public health issue affecting over 235,000 Canadians annually, of which approximately 35,000 are homeless nightly (Gaetz et al., 2014). Similar to the high rate of homelessness is the prevalence of mental illness within Canada, affecting one in five individuals; an estimated 19.7% of Canadians experienced a mental illness in 2021, with a projected increase to 20.41% by 2041 (Mental Health Commission of Canada, 2017). A systematic review conducted by Fazel et al. (2014) on the health of homeless people in high-income countries found that 58% of homeless people in three Canadian cities experienced comorbidity, including depression co-occurring with alcohol and post-traumatic disorders with crack cocaine. In addition, a high prevalence of chronic medical conditions, including hypertension, diabetes, respiratory tract infections, neurocognitive impairments, chronic pain, and mortality, were identified among homeless people (Henwood et al., 2015; Hwang et al., 2005; Stergiopolous et al., 2015).

Although individuals who are homeless experience multiple complex physical and mental health issues, they encounter barriers to accessing healthcare services in the community, thus defaulting to hospital emergency departments (Campbell et al., 2015; Stergiopoulos et al., 2015).

Background

Research has shown there is an urgent need for more comprehensive, community-based, low-barrier access models of service delivery that coordinate primary healthcare, mental health, and social services either through a communication model, collaborative model, or integrated model for vulnerable populations, including persons experiencing mental illnesses and homelessness (Malachowski et al., 2019; Moroz et al., 2020; Stergiopoulos et al., 2015). A coordinated intake and assessment process is vital in delivering integrated, time-sensitive, and purposeful services because it eliminates the duplication of assessments and facilitates a seamless transition of clients across different programs (Government of Ontario, 2015). Such an approach expeditiously moves people through the system of care. It aids individuals in obtaining the services they require in a centralized manner instead of having them access multiple organizations to locate the services that best address their needs (Gaetz, 2014).

A systematic review of the literature on behavioural health and primary care found that a collaborative, chronic care model of integrated health resulted in a marked improvement in symptoms of depression, mental and physical health, quality of life, and social functioning in patients with varied mental illnesses (Grazier et al., 2016). Malachowski et al. (2019) reported that offering early intervention programs in community settings resulted in the early identification and resolution of issues and reduced the need for more intensive and costly services. They further relayed that integrated care within community settings is approximately five times less expensive than hospital care; also, people with mental illnesses have expressed a preference to access mental health services within the community (Malachowski et al., 2019). Co-locating services within a single site reduces the stigma of obtaining mental health and addiction services (Abbasi et al., 2021; Government of Ontario, 2015).

One model of service co-location is the community hub. Community hubs are co-located, locally designed, cost-effective focal points where individuals can access various services, including healthcare, social services, and cultural recreational programming (Davidson et al., 2016; Government of Ontario, 2015; Graves, 2011; Pitre, 2015; Thomson & Murray-Sanderson, 2017). Community hubs are usually located in public spaces that are easily accessible, such as neighbourhood centres, libraries, community health centres, schools, and government buildings (Abbasi et al., 2021; Pitre, 2015). Mariano and Harmon (2019), in their assessment of a service model that best-addressed health inequities for homeless people, reported that a patron-centred interprofessional model found at a local library in Philadelphia successfully served its patrons because the location was a social and physical anchor point. The interprofessional team was comprised of a registered nurse, clinical social worker, and librarian or information specialist who assisted the patrons with internal and external participation (Mariano & Harmon, 2019). In examining the retention rates of 358 patrons utilizing the services over nine months, the results showed that prior to being referred to the interprofessional team at the Community Centre, homeless patrons were at a greater risk of missing appointments, not receiving adequate care, and having higher emergency room visits than those who were housed (Mariano & Harmon, 2019). Mariano and Harmon (2019) remarked that the co-located model had the potential to reduce no-show costs due to the involvement of different professionals across disciplines and the sharing of unique perspectives to help mitigate barriers that are associated with access to support services.

Barriers to the success of community hubs as a service model were identified. This included the lack of culturally competent care providers, providers' belief that they lack the necessary tools, skills, and financial resources to implement integrated care, and a shortage of providers to deliver the services (Grazier et al., 2016). Additional barriers included the lack of space and adjustments to integrate primary care into an existing organizational structure, inadequate

time and intentional process to engage community partners in the design, the ongoing operation of community hubs, and limited uptake of the services among homeless populations (Davidson et al., 2016; Scharf et al., 2013; Stergiopoulos et al., 2015).

The literature revealed the scarcity of information on community hub models that integrate healthcare and behavioural services for individuals experiencing homelessness. Identifying and understanding existing community hub models serving this population is critical, given the diverse and complex needs of the population and the service innovations required to respond to those needs. At the start of the COVID-19 pandemic, groups providing services to individuals experiencing homelessness within the Regional Municipality of Durham, Ontario, Canada, raised concerns regarding the closure of social service organizations and places such as coffee shops where they utilized washroom facilities and refuge from the cold and hot climates. Two pilot community hubs were developed as an emergency response to help address health concerns and aid with housing support. In April 2020, the first pilot community hub, using a co-located model, was developed in a pre-existing soup kitchen. A second pilot split over two community centres was established in another city. The same staff operated this community hub on different days. To address the knowledge gap in community hubs for vulnerable and homeless populations and assess the effectiveness of the pilot community hubs, a research study was conducted at the community hubs. The study's objective was to measure the effectiveness of the community hubs in addressing the healthcare and social service needs of patrons who access and utilize the services available.

Methods

Study Design

A mixed-methods research design was conducted to examine stakeholders' experiences who are directly involved at the two community hubs. Surveys with close-ended and open-ended questions were administered to gather feedback from patrons and direct service employees. Semi-structured interviews were conducted to solicit the perspectives of managerial employees on the development and operation of the community hubs, and two subject matter experts with knowledge of the People with Lived Experience (PWLE) working group and a unique anti-human trafficking program co-located within one of the community hubs.

Study Sample

Study participants included patrons of the two community hubs (n= 35 + n= 40, Total: n=75), community hub employees that provide direct services to the patrons (n= 15), community hub managerial staff (n= 5), and external subject matter experts (n =2). Patrons were asked to provide demographic information on gender, age range, income source, city of origin, the culture they identified with, first language, and their highest level of education.

Recruitment

The recruitment approach for the participants ensured that only individuals who met the inclusion criteria were selected for the study. Inclusion criteria were current community hub patrons, employees involved in program design and delivery, managers, English speaking, and the ability to provide informed consent. Eligible participants were invited to participate in the research study.

Patron

Patrons were recruited using a poster that was designed by the Research Assistants (RAs), displayed in the community hubs, and distributed by designated employees and RAs. The RAs spent time at the community hubs and became more familiar with the patrons and employees before the data collection began. The eligibility criteria of patrons included being an individual experiencing homelessness or are vulnerably housed, are accessing the services at one of the two community hubs, and can provide voluntary consent. Ajax Patrons are referred to as (AP) and Oshawa Patrons are referred to as (OP).

Direct Service Employee

The recruitment of direct service employees, including Ajax Staff (AS) and Oshawa Staff (OS), began with telephone meetings between the Research Coordinator and the community hub leaders, where the research purpose, procedures, and benefits were explained. The community hubs were provided with the option of either hosting an in-person or a virtual employee information session. The Research Coordinator shared the Staff Information and Consent Letter with the leaders for distribution to their employees. These were reviewed during the information sessions, and employees interested in participating returned their signed consent forms.

Manager and Subject-Matter Expert

The community hub managerial staff participated in the virtual and in-person staff information sessions, where they obtained information on the study. The Research Coordinator reached out to the lead managers and additional recommended participants. Individual meetings were scheduled with those interested, and informed consent was obtained before the interviews.

Data Collection

Before data collection began, approval to conduct the research was obtained from the Research Ethics Board at Ontario Tech University, approval #16339. Data collection occurred for approximately two months. Data collection for the community hub patrons occurred in a private meeting room at the community hubs the same day interest was expressed and lasted 15-30 minutes. After the informed consent, the RAs reviewed the survey (Appendix. A) with the patrons and answered any questions they had. The RAs asked the patrons to complete the surveys themselves and to return the completed surveys. Each patron received a $20 gift card for their time and contribution. Direct service employees completed the survey anonymously online through the Survey Monkey platform. The survey completion took approximately 15 minutes. Next, the Research Coordinator conducted virtual one-on-one semi-structured interviews (Appendix. B) ranging from 30- 40 minutes with the managers. Interviews with the subject matter experts lasted between 15- 20 minutes. Each interviewee was assigned a pseudonym to protect their confidentiality. The responses were recorded in note form. The questions explored the managers' experiences in three main areas; development of the community hubs, operation of the community hubs, and expanding the community hubs to other communities within the Region of Durham. The subject-matter experts were asked questions about their role in the community hub concerning their areas of expertise.

Data Analysis

Descriptive statistics from the patron's survey, including percentages and averages, were calculated using SPSS statistical software. The staff survey results were analyzed based on the question types. Standard methods used to analyze the data were frequency count for close-ended questions, percentage calculation, and an average rating of the ranking questions. The open-ended questions were categorized into themes or response buckets, and the frequency count of the themes was used to analyze the responses. The data were analyzed with Microsoft Excel and Survey Monkey software. Braun and Clarke's (2006) thematic analysis was utilized to analyze the manager and subject-matter expert interview. The interview notes were read repeatedly individually, followed by the generation of preliminary codes. First, the codes were reviewed for patterns, followed by similar patterns or ideas clustered together. The emerging sub-themes were reviewed, and overarching themes were identified and described. The themes were illustrated with quotes from the transcripts that best described them. The final phase of data analysis involved presenting the findings that address the research objective.

Findings

Demographic Information of Survey Respondents

Patron

Seventy-five patrons completed the survey questionnaire consisting of closed-ended and open-ended questions. The questions gathered participants' demographic information noted in *Table. 1.* Questions explored patrons' housing, healthcare, and social service needs, experiences receiving services from the community hubs, and recommendations for the community hubs.

Table 1

Demographic Data of Research Participants

Characteristic	Hub 1	Hub 2	Total
Participants (n)	35	40	75
Gender [%]			
Women	17.1	27.5	22.7
Men	77.1	70.0	73.3
Bigender	2.9	0.0	1.3
Two-spirited	2.9	0.0	1.3
Prefer not to say	0.0	2.5	1.3
Age range in years [%]			
18-24	11.4	7.5	9.3
25-34	20.0	27.5	24.0
35-44	20.0	22.5	21.3
45-54	14.3	17.5	16.0
55-64	25.7	15.0	20.0
65+	8.6	10.0	9.3
Culture identified with top four report groups [%]			
Aboriginal/First Nations	5.7	10.0	8.0
African	8.5	2.5	5.3
Black/Black Indigenous	2.8	2.5	2.6
Canadian	80.0	70.0	74.7
Highest level of education [%]			
Completed college/university	17.1	7.5	12.0
Completed high school	37.1	32.5	34.7
Some college/university	17.1	37.5	28.0
Some elementary school	2.8	0.0	1.3
Some high school	2.5	22.5	24.0

For Hub 2, 27.5% of patrons were younger adults between the ages of 25-34, versus Hub 1, where 25.7% of patrons were older adults between the ages of 55-64 years. Ninety-eight percent of patrons received government income support, such as disability support (55.6%) or pension (21.3%). Most patrons, 70.7%, were from the Regional Municipality of Durham, of which 60% were from the cities where the two community hubs were located. The next largest group, 17%, was from a large urban centre outside the Region of Durham. Regarding patrons' cultural composition, the main groups were Canadians 74.7% Aboriginal/First Nations 8%, African 5.3% and Black/Black Indigenous 2.6%.

Table 2

Direct Service Employee role

Characteristic	Hub 1 (n)	Hub 2 (n)	Total (n)
Income/employment support	3	1	4
Peer support	2	0	2
Harm reduction	1	2	3
Housing location/support	1	1	2
Mental health counselling/addictions	2	4	6
Physical healthcare	0	3	3

Fifteen direct service employees, see *Table 2,* worked in the two community hubs—five in Hub 1 and ten in Hub 2. Some employees worked in multiple roles; therefore, the total number of employees exceeded 15. Each community hub had one unique role, peer support workers in Hub 1 and a healthcare worker in Hub 2 team in the other.

Community Hubs Response to Patrons' Housing Needs

Seventy-two percent of patrons from both community hubs were unhoused, of which 82.9% were from Hub 1 and 62.5% from Hub 2. Regarding where they most frequently stayed, 42.9% of the 82.9% unhoused stayed in emergency shelters, and 27.5% stayed on the streets. Among those housed, 9.3% were housed for under six months and 5.3% for over five years. Of the unhoused patrons, 88.4% would like to obtain housing.

Employees ranked barriers to patrons accessing housing, with 10 being the highest barrier and 1 being the lowest, see *Table. 3.*

Table 3
Housing Access Barriers

Characteristic	Hub 1 (n)	Hub 2 (n)	Total (n)
Addictions	7.0	7.3	7.2
High cost of rent and limited housing stock	8.2	6.6	7.1
Mental health challenges	6.4	6.9	6.7
Lack of income	9.2	5.3	6.7
Concurrent disorders	5.6	7.3	6.7
Physical health issues	4.3	5.4	4.7
Fear of change	3.6	4.9	4.4
Lack of identification	3.4	3.4	3.4

In Table. 3, mental health challenges, lack of income, and concurrent disorders were equally ranked. Lack of income and physical health issues were also equally ranked.

Table 4
Support Needed to Obtain Housing

Characteristic	Hub 1 [%]	Hub 2 [%]	Total [%]
Income	71.4	47.5	58.7
Medical	25.7	10.0	17.3
Counselling	25.7	12.5	18.7
Housing search	68.6	50.0	58.7
Mental health/addiction	25.7	40.0	33.3
Employment	17.1	25.0	21.3

When asked what support they needed to obtain housing (see Table 4), 58.7% of patrons noted income and housing search. These expressed high areas of need were corroborated by employee findings in *Table. 3* that lack of income, the high rent cost, and limited housing stock were some of the patrons' highest barriers to accessing housing. Medical support ranked the lowest among the top five supports at 17.3%, which aligns with employees reporting that physical health issue, which was not a significant barrier to housing access, ranked 4.7 out of 10 in *Table 3.*

Table 5

The Percent of Patrons that Reported Each Support as Having Helped them Maintain Housing

Characteristic	Hub 1 [n (%)]	Hub 2 [n (%)]	Total [n (%)]
Having access to medical supports	3 (42.9)	4 (20.0)	7 (25.9)
Having access to case manager/support worker/other support services	0 (0.0)	11 (55.0)	11 (40.7)
Having my rent paid directly to the landlord by ODSP/OW/trustee	1 (14.2)	7 (35.0)	8 (29.6)
Other	3 (42.9)	3 (15.0)	6 (22.2)

All supports that only a single patron reported were included under "Other".

Patrons were asked to report supports that have helped them maintain housing (Table 5). The top three support patrons cited for maintaining housing were access to a case manager/support worker or other support services, 44.0 %, paying rent directly to the landlord from ODSP, OW, or a trustee, 32.0 %, and access to medical support, 20.0%. Obtaining housing was found to be inextricably linked to patrons' sense of security, comfort, and living independently, as one Ajax patron stated: "*More accessible housing options…. I live outside, and winter is coming. We freeze out there now. I think I'll be dead by the time spring comes if I do not find a place"* (AP 28).

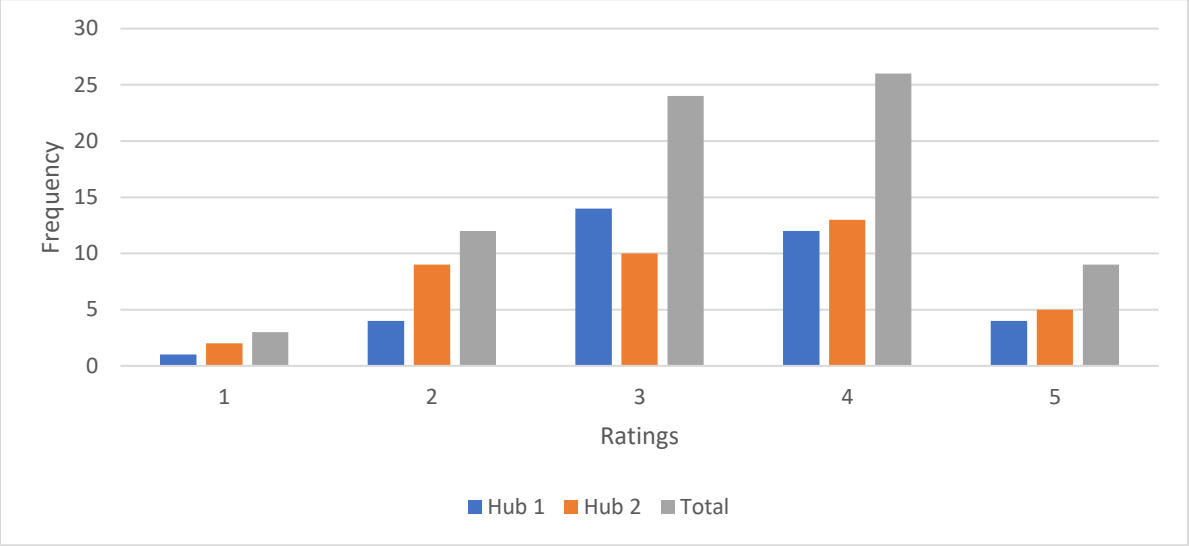
In asking employees to rate how housing-focused the community hubs are, choosing between the options of Not at All, Below Average, Average, Above Average, and Excellent. Hub 1 was rated excellent by 80%. Hub 2 had varying responses; 30% rated the service as excellent, and 10% not at all. It is unclear if the low number of housing locators/support (refer to *Table 2)*, one per community hub, impacted Hub 2 perception of the community hubs' effectiveness in this domain. Connection to housing opportunities that help patrons establish housing was one of the housing outcomes employees wanted to see for patrons: "*connect to possible housing opportunities, housing can be established"* (AS 5).

Community Hubs Response to Patrons' Health Needs

Patrons rated their physical and mental health status on a scale of 1-5, with one meaning very poor and five meaning very good (see Figure 1 and Figure 2).

Figure 1

Physical Health Status

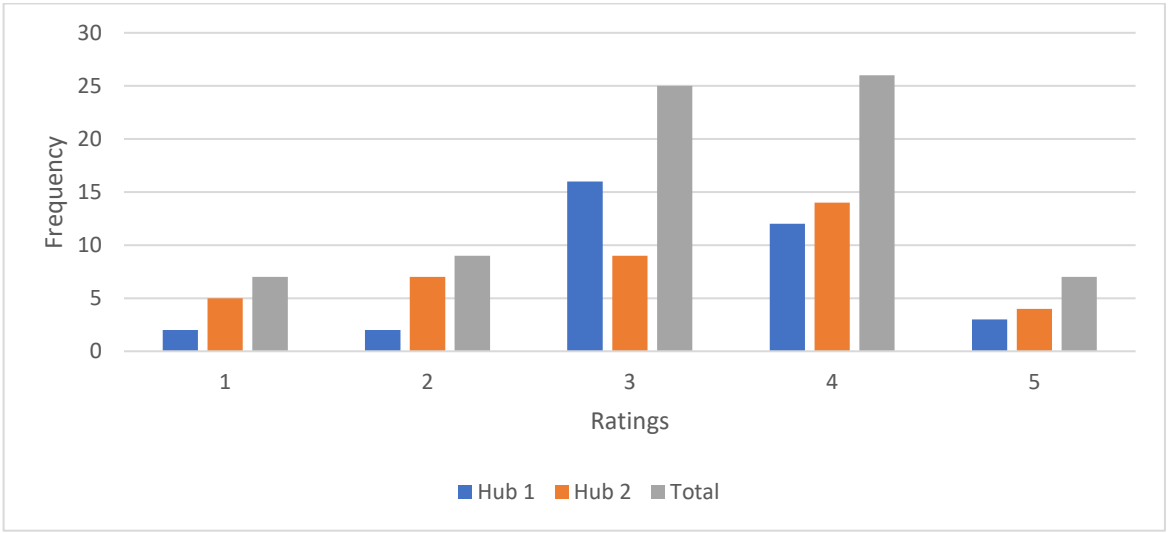


Mean: 3.35; Mode: 4.0

The ratings for physical health differed across the community hubs, *Figure. 1.* Hub 1's mean status rating was 3.40, and its mode was 3. For Hub 2, the mean rating was slightly lower at 3.28, and the mode was one point higher at 4.

Figure 2

Mental Health Status



Mean: 3.23; Mode: 4.0

Regarding their mental health status, in *Figure 2*, differences were seen in the ratings across the community hubs. The mean rating in Hub 1 was 3.4, and the mode 3. For Hub 2, the mean rating was slightly lower at 3.1, and the mode was one point higher at 4.

Most patrons have a family doctor/nurse practitioner as 60% reported from Hub 1 and 62.5% reported from Hub 2. Their last visit with a healthcare provider ranged from more than twelve months for 33.9% of patrons to less than one month for 32.2%. Most patrons from Hub 1, 31.4%, last visited a family doctor more than twelve months ago. They did not have a co-located healthcare provider; instead, they utilized a community-based family doctor with a partnership arrangement with the community hub. On the contrary, patrons from Hub 2 with a co-located healthcare team most frequently reported 32.5% that their last healthcare visit was

less than one month. Patrons were asked the number of times they visited the emergency department within the last six months; 41.1% reported never, an additional 41.1% reported 1-3 times, 12.3% reported 4-6 times, 2.7% reported 7-10 times, and an additional 2.7% reported more than 10 times.

Table 5

Patrons Ranked the Prevalence of Their Health Concerns, with 1 Being the Most Prevalent and 6 Being the Least Prevalent.

Characteristic	Hub 1 [%]	Hub 2[%]	Total [%]
Mental health and addictions	2.5	3.3	2.9
Addictions	2.2	3.7	2.9
Cognitive/neurological brain injuries	3.8	3.7	3.7
Mental health issues	1.9	2.7	2.3
Physical disability	2.1	3.8	2.8
Chronic physical health issues	1.7	3.6	2.6

In *Table 5,* sixty-two percent of patrons in Hub 2 ranked mental health as their top health issue, while chronic physical health issues and mental health issues were ranked most prevalent by 57.1% of patrons in Hub 1. Cognitive/neurological/brain injuries were ranked among the least prevalent 3.7, by 31.4% and 40.0% of patrons across Hub1 and 2, respectively. A patron reported there is a need for more medical services for mental health and chronic conditions, such as diabetes, depression and substance use "*to deal with diabetes; if they have health needs or need further testing, can they set up those appointments so I can just show up*" (OP 9).

Experience with Community Hub Services

Most patrons, 48.6 %, reported using the community hub services for more than seven months. This comprised 46.6% of unhoused patrons and 55% of housed patrons. Regarding service usage frequency, 43.8% accessed services weekly, 41.1% daily, 9.6% monthly, and 5.5% every 2-3 months. Patrons utilizing community hub services experienced complex physical and mental health challenges, substance use, and unmet social needs, including a lack of stable housing and income. The community hubs filled significant service gaps. In some instances, providing life-saving interventions. The community hubs were mainly crisis-driven and not designed to address patrons' longer-term healthcare and social service needs as:

> "*People with severe mental illness and substance use desperately need help. People are dying from overdoses. Many of the people we work with are so ill or impaired it is difficult to engage them. They are brought into the hub and stabilized before they are engaged about other services*" (Managerial Interviewee #2).

The community hubs extended beyond service co-location to incorporate service integration. The service model evolved to respond to the needs of the community. Programs continuously assessed patrons' unmet needs and brought new services to respond to identified needs. Service delivery was flexible and could quickly mobilize within the community hubs instead of engaging in lengthy service planning. The onsite medical team at one community hub was integrated into the service model as one manager highlighted: "*The model identifies gaps and services of what is needed for the population, those requiring low barrier entry to services with a pathway to treatment, housing and self-improvement*" (Managerial Interviewee #3).

Patrons were asked to rank out of nine, with nine being the highest and one being the lowest in their areas of need. The top five needs are noted below in Table 6.

Table 6
Patrons' Main Areas of Need

Characteristic	Hub 1 [%]	Hub 2 [%]	Total [%]
Help to find housing	4.8	6.2	5.3
Medical care	6	3.6	5.2
Instrumental needs (food, identification, other)	4.6	6.4	5.2
Addictions counselling	4.6	4.6	4.6
Mental health and addiction counselling	4.8	4	4.5

Instrumental needs, including food, shower, hygiene assistance and obtaining identification, were ranked second, along with medical care, see *Table 6*. Instrumental needs were identified as the primary reasons many patrons initially visited the community hubs. Once there, they become exposed to other offered services. Regarding the community hubs addressing their instrumental needs, patrons reported there is a need for service expansion to include offering meals more frequently, ensuring more overnight safe sleeping spaces, providing personal hygiene services such as dental care, and making available more showers and bathtubs to facilitate longer shower time to help improve patrons' health and experiences. "*It would be great to access the hub in the evenings and also have dinners at the hub*" (AP 4).

Patrons were asked to rate their level of agreement with statements about the community hubs' help to address their mental health and addiction needs (see *Table 7)*, from strongly disagree, disagree, neutral, agree, strongly agree and not applicable.

Table 7
Patrons' Level of Agreement with the Statement: "The community hubs help me address my mental health and or addiction needs."

	Hub 1 [%]	Hub 2 [%]	Total [%]
Strongly Disagree	5.7	5	5.3
Disagree	5.7	5	5.3
Neutral	20	17.5	18.7
Agree	17.1	32.5	25.3
Strongly Agree	22.9	30	26.7
Not Applicable	28.6	10	18.7

Over half of the patrons, see *Table 7,* agreed and strongly agreed that the community hubs helped patrons address their mental health and or addiction needs, versus 11% who strongly disagreed and disagreed with the statement. Over twice the percentage of patrons from Hub 1, 28.6% noted this statement did not apply to them versus 10% from Hub 2. These responses align with responses from *Table 5*, where patrons from Hub 1 ranked their mental health and addiction concerns as less prevalent at 2.5 out of 6 than patrons from Hub 2, whose ranking was more prevalent at 3.3 out of 6.

Table 8
Patrons' Satisfaction with Services Received: Medical Treatment/Medication Adherence

	Hub 1 [%]	Hub 2 [%]	Total [%]
Extremely Dissatisfied	0.0	2.6	1.4
Dissatisfied	0.0	5.1	2.7
Neutral	11.8	2.6	6.8
Satisfied	11.8	38.5	26

Very satisfied	29.4	41	35.6
Did not use this service	35.3	10.3	21.9
Did not know about this service	11.8	0.0	5.5

Patrons were asked to rate their satisfaction with services they received from the community hubs concerning medical treatment and medication adherence, see Table 8, from extremely dissatisfied, dissatisfied, neutral, satisfied, very satisfied, did not use this service, to did not know about it. Approximately 80% of patrons from Hub 2 were satisfied and very satisfied with the services received, versus 41.2% from Hub 1. Also, a significant percentage of patrons from Hub 1, 47.1%, either did not use the service or did not know about the service, as opposed to 10.3% of patrons from Hub 2 who did not use the service. No patrons from Hub 2 reported not knowing about the services. There may be an association between Hub 2's level of service satisfaction and having a healthcare team that was integrated and co-located within the community services, versus Hub 1 patrons who obtained healthcare services in the community.

Employees reported they would like to see service outcomes that improve patrons' housing access and physical health and support them in establishing trusting relationships as one Oshawa staff member noted: "*Trusting relationships are formed and built upon. Patrons absent from the Hub are identified and re-engaged"* (OS 10). Essential service outcomes employees would like for the community hubs included creating and advocating for opportunities for patrons, enhancing partnership collaboration and expanding community connections for patrons *"referral and connection to ongoing supportive case management, financial support"* (OS 4). Strategies to strengthen partner relationships within the community hubs were improved communication, enhanced service coordination as mentioned by one Ajax staff member: "*Having some partners donate more time at the Hub, some come only once or twice per week*" (AS 5) and reduced service duplication.

Employees reported challenges working in the community hubs included systemic barriers. *"The barriers in the shelter system are punitive, and people are being barred from accessing service"* (OS 4) and limited resources, "*short timeframe with which to provide service to some members who don't return regularly"* (AS 4). Employees would also like to have a better work-life balance. Rewarding aspects of working in the community hubs included improved quality of life for the patrons and service satisfaction; one Oshawa staff member highlighted: "*When someone does accept change and take responsibility for themselves and access our services. It is nice to see people take our hands and climb out of their pits once in a while"* (OS5).

Facilitators and Barriers to Develop and Operate the Community Hubs

Facilitators and barriers were identified as integral to the community hubs' development, operation, and sustainability. Facilitators included strong community support, community hub leadership and vision, partnership collaboration, commitment and transparency, and ongoing communication. The barriers were precarious funding, communication gaps and role clarity, inadequate physical space, community opposition, reliance on volunteers, and community opposition.

Facilitators

Local community support was identified as vital for developing and sustaining the community hubs. Support included acknowledging the work of the community hubs, donating physical spaces to develop and operate the community hubs, providing food, clothing, and hygiene kits, assigning employees with a range of skills and experiences to staff the community hubs, and individuals volunteering their services. One community hub has an on-site volunteer team of physicians and nurses. Both community hubs offer washroom facilities, workstations for multiple organizations, private staff offices, and meeting rooms, one manager noted: *"The shower facilities provided are a valuable resource for a local emergency shelter that transports clients to the community hub for the use of these facilities"* (Managerial Interviewee # 1).

Strong leadership and vision facilitated the expeditious development of the community hubs. Given the circumstances and short timeframe, the traditional program design and implementation processes were foregone. Individuals involved in developing the community hubs were described as straightforward, strategic thinkers with confidence in others borne from years of working within their respective sectors and collaborating with community partners. They had the skills and ability to engage and mobilize community organizations to buy into the vision and commit staffing resources for the community hubs. One community hub had a designated manager who led the development and operation of the community hub. The other was developed and initially operated by a five-member working group of community partners engaged in advocacy and system planning on homelessness.

Partnership collaboration and commitment to address the needs of Durham Region's most vulnerable began at the system level before developing the community hubs. Entities such as the Gap Committee, the Community Development Council of Durham, the Canadian Mental Health Association Durham, and Durham Mental Health Services brainstormed services. They required resources each organization would contribute to help fill the identified service gaps. *"We developed a basket of services that would address all the clients' needs"* (Managerial Interviewee #1). Identifying service gaps and how to address them was described as ongoing work among partnering organizations. Most partnering organizations established a Memorandum of Understanding (MOU) with their community hub.

Transparent and ongoing communication across all levels within the community hubs and with external partners was considered integral to the community hubs' success. Onsite managers oversaw the operation of the community hubs. Partnering organizations were responsible for the personnel management of their assigned staff, which was necessary for unionized organizations. Daily staff meetings were convened to strategize for the day. Frequent partnership meetings offered program updates and opportunities to identify and address concerns. *"During the morning rounds, some details may seem irrelevant; however, once information is out there, we see how it all fits together"* (Managerial Interviewee #4).

Barriers

Funding precarity was described as a significant threat to the community hubs' daily operations and long-term sustainability. The community hubs were pilot projects funded by the Ontario Provincial Government. "*There is no sustained funding. Current funding ends in March. The hub was responding to a crisis. The challenge is to move beyond a mash mentality [operating with uncertainty] and move into a start-up to stabilize the operations"* (Managerial Interviewee #2).

Communication gaps and role clarity were described as areas for improvement. In addition, privacy legislation reportedly impacted employees' ability to share information regarding patrons' care, which was critical to patrons' successful service outcomes.

> *"Privacy legislation places gags on agencies talking to each other about services. We have posted a sign that providers within the building will be sharing information to help the patrons. This is a barrier for some health providers who are part of the circle of care. The circle of care is the key concept for informed consent. Some people do not have the mental capacity to sign informed consent. The vehicle is there through the concept of care"* (Managerial Interviewee # 2),

or the circle of care where the care providers assume the patron's implied consent to collect, use, and disclose their personal information for the purpose of providing care.

Inadequate physical space prevented the community hubs from operating at their full potential while experiencing an increase in the number of new patrons and high demands from existing patrons. The lack of adequate space affected patrons who required private spaces for confidential meetings such as virtual court hearings. Hub 1 required additional space to host healthcare providers, which was a significant concern given the multiple healthcare needs of the patrons and the reluctance of some patrons to utilize healthcare services within the community.

The community hubs relied on volunteers who played critical roles. Strong reliance on volunteers was concerning because some services were not offered in their absence. "*Volunteers play*

a crucial role in providing services such as hair cutting, supervising the sleeping safe area, coordinating showers" (Managerial Interviewee #4). One community hub had sixty volunteers operating two shifts per day, seven days per week.

One community hub experienced community opposition because of an increase in the number of persons accessing the services and a more significant concentration of homeless people. Positive community relations were necessary for the community hub's daily operation and long-term sustainability. One strategy applied to address community concerns was providing education on the role of the community hub in addressing patrons' needs.

Discussion

The primary goal of this study was to evaluate the community hubs' effectiveness in responding to their patrons' health, housing, and social service needs. The study highlighted that the community hubs filled significant service gaps that were left when community services and private entities, such as coffee shops that provided washroom facilities and shelter from the cold and heat, closed their services in response to the COVID-19 pandemic. The organic development of the community hub pilots as an emergency community service response illustrated the tenacity of community service organizations within the Region of Durham. They mobilized like-minded individuals, organizations, and groups engaged in system-level discussions and advocacy to help alleviate the dire circumstances of vulnerable populations, including homeless people. Twenty-one organizations delivered co-located services within the community hubs, of which five organizations provided services across both community hubs.

This study indicated an age difference between patrons from the two community hubs (see *Table 1)*. For Hub 2, patrons tended to be younger, with the largest age group being 25-34 years of age, whereas Hub 1 had older patrons, with the largest group being 55-64 years of age. Studies have also shown that older homeless adults experience chronic health conditions, including geriatric syndromes, some as early as their 50s (Fazel et al., 2014; White & Newman, 2015). Our study's patrons rated their physical and mental health slightly above average. However, patrons from the community hub with a higher percentage of older adults reported a lower prevalence of health concerns in areas of mental health and addictions, addictions, mental health issues, physical disability, and chronic physical health issues than patrons from the other community hub. The information given was self-reported and not corroborated by organizational or system-level data. This is an area of ongoing debate within scholarly discourse. Garibaldi et al. (2005) reported that there continues to be a lack of clarity on older homeless adults' perspectives of their health and healthcare needs and the extent to which their self-reported usage of healthcare services differs from those of younger homeless persons.

Over 60% of patrons from our study reported they had access to a healthcare provider. When asked, many respondents from the community hub that did not have onsite healthcare services stated they visited a primary care provider within the past 12 months. Most patrons from the community hub with onsite healthcare personnel reported monthly visits. Within our study, patrons frequently used the onsite medical services hubs offered at one of the community hubs. These patrons reported almost twice the level of satisfaction with medical treatment and medication compliance, 79.5% versus 41.2% of patrons from the other community hub with no onsite medical services. The managers described the onsite medical services as saving patrons' lives and diverting patrons from emergency departments. The effectiveness of collaborative services in reducing emergency department visits by homeless persons is corroborated by Stergiopoulos et al. (2015).

While these findings require further exploration using qualitative methodology, the results began to illuminate some of the benefits of embedding healthcare services with social services such as meals, income support, and housing support that address patrons' social determinants of health, which are consistent with findings from O'Toole et al. (2016). Fully understanding the health status and service utilization of community hub patrons require a coordinated regional strategy between the community hubs, community health services, and the hospitals. Tracking service usage across

the healthcare system can help service providers gain insights into the service needs of this population to facilitate service planning and the allocation of resources to address existing and emerging needs effectively and efficiently.

Eighty-eight percent of patrons expressed interest in obtaining housing. Both community hubs prioritized adding patrons' names to the Regional Coordinated Access to Housing waiting list and had successfully housed some patrons. They also worked with patrons to remove housing access barriers by providing mental health and addiction services and assistance in obtaining income support and identification. Patrons and employees identified help to find housing as an ongoing area of unmet need, exacerbated by limited affordable housing stock and the high rent costs. Equally essential to obtaining support to locate and access housing is ongoing support to retain housing, including having rent paid directly to the landlord by the patron's primary support agency, or their government income support program, and obtaining medical support and case management services. Conversely, employees from one community hub reported that the organization needed to prioritize housing services. The extent to which limited staffing resources impacted this service area is unclear. Each community hub employed one housing locator/ housing support employee. Additional strategies that could be considered to enhance housing access and retention include:

a. embedding housing roles in case management services and providing housing as part of a hospital discharge plan (Fitzpatrick-Lewis et al., 2011);
b. fostering close working relationships between social housing and organizations serving homeless populations, and eliminating the credit check and landlord reference check, thereby allowing applicants a new start (Hierlihy & Connelly, 2005); and
c. applying the Housing First approach that offers rent subsidies, intensive community-based treatment and rapid access to housing without prerequisites of sobriety and compliance with psychiatric treatment (Tsemberis et al., 2021).

Furthermore, client-driven supports that are culturally appropriate and unique to the needs of individuals are required to foster recovery and housing retention (Canadian Observatory on Homelessness, 2021).

Our findings indicate that many patrons had their instrumental needs of meals, bathing, and hygiene met by the community hubs. Restrictions, such as the closure of coffee shops during the COVID-19 pandemic, significantly impacted patrons' access to washroom facilities and refuge from the cold during the winter and summer heat. This area of unmet need was one of the main impetuses for developing the community hubs. For example, one of the community hubs added the service of partnering with a local shelter to transport clients to the community hub to access the shower facilities, because the shelter lacked this service. One community hub identified that the meals brought many patrons to the program; once there, they learned that other services, such as medical care, help to obtain housing, and social assistance, were also offered. Our findings show that patrons benefitted from co-located low-barrier access services such as instrumental needs, including meals and shower facilities, healthcare, housing location/support, harm reduction supplies, counselling services including mental health and addictions, referral to income support, and long-term case management. These results are supported by O'Toole et al. (2016) observational study of the Homeless Patient Aligned Care Team program. The program, developed to address homelessness among veterans, found that integrating healthcare services and addressing social determinants was instrumental in facilitating homeless veterans' engagement with healthcare services. Participants' support needs addressed included mental health counselling, harm reduction supplies, transportation, vocational training, assistance accessing income support, referral to housing services, and legal aid. Participants were, therefore, able to prioritize their mental and physical healthcare needs.

Effective collaboration within the community hubs and with external service providers was critical to creating a robust, coordinated care system for the patrons. Patrons reported that referrals provided by the community hubs met their needs. The community hub pilot continuously evaluated patrons' needs and available services to address identified needs. Adopting a person-centred approach ensured

that patrons' needs dictated what new services were brought into the co-located model. Such an approach positioned the community hubs as caring, flexible, and nimble, intensely focused on service connectivity, continuity, and calibration (Hamovitch et al., 2018). Patrons indicated strong satisfaction with the overall services they received from the community hubs. The employees described being able to help the patrons as one of the most rewarding aspects of their job. This finding is consistent with studies that have shown a connection between the application of person-centred care and the quality of the service experienced by clients (Hamovitch et al., 2018; Santana et al., 2018).

The needs seen in the communities where the community hubs were located extend to other cities within the Region of Durham and beyond. Findings from the study show that 40% of patrons were not local residents. The community hub pilots offer a co-located, integrated service model that can be developed throughout the region using existing infrastructures such as libraries and community centres that are known and utilized by local residents. Expanding the community hub model throughout the region requires the coordinated effort of healthcare, social services, housing providers, and strong leadership from the Regional Municipality of Durham.

Limitations

The measures of patrons' unmet health, social service, and housing needs and the community hubs' service utilization and service delivery were self-reported by patrons and employees at a single point in time through the administered surveys; hence, there could be potential limitations to the self-reported study findings. Another research limitation was the limited qualitative data gathered from patrons and employees. Although open-ended questions were included in the surveys, some patrons did not answer the questions or sparsely responded to them. The intent was to address this gap by convening focus groups with the patrons to probe their experiences with housing access and retention, healthcare utilization, and case management support. Due to unforeseen circumstances, the research team could not proceed with the focus groups. Likewise, employee responses to the open-ended questions were limited to offering in-depth insights into their experiences providing services within the community hubs. Further qualitative research is recommended with the patrons and employees to gather experiential data. Our study findings provide baseline data for the community hubs that can be utilized for future studies to measure change over time.

Conclusion

This study adopted a mixed-methods design to examine the experiences of patrons, employees, and key informants in developing, delivering, and using two community hub pilots. The findings reveal that the community hub pilots were organically developed by committed individuals and organizations concerned with the health and well-being of vulnerable populations, including homeless persons who lost access to various health, social service, and community resources during the COVID-19 pandemic. The results show that the patrons experienced diverse areas of need, including healthcare and social services, that address their social determinants of health. Through the coordinated, co-located service models, patrons obtained low-barrier access to healthcare, help to find housing, assistance with instrumental needs, including meals and shower facilities, and mental health and addiction counselling. The community hubs' application of a person-centred approach that was flexible and responsive to patrons' needs and strong partnership relationships resulted in patrons' and employees' high satisfaction with service outcomes. To facilitate the ongoing effective operation and long-term sustainability of the community hubs, factors such as adequate and sustained funding, less reliance on volunteers, improved partner collaboration, and a stronger focus on housing access must be addressed. Overall, the findings illustrate that the community hub pilots are helping to fill systemic healthcare and social service gaps for vulnerable and homeless patrons; however, the healthcare, housing, and social needs within the Regional Municipality of Durham exceed the resources and capacity of the community hubs. Future directions for the community hub pilots include scaling the pilots to other regional communities, providing

sustained funding, and developing service evaluation and performance measurement frameworks.

Acknowledgments

We thank the research participants and Research Advisory Committee members for their insightful contributions. City Studio Durham and Mitacs Accelerate provided funding for the study. In addition, we would like to thank the article reviewers for their time and contributions to revising and enhancing this manuscript.

Ethics Approval

Ontario Tech University Ethics Board provided approval to conduct the research. REB#16339.

Conflict of Interest

We have no conflict of interest to declare.

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Appendix A

Measuring Lessons Learned from Durham Community Hub Model during COVID-19: Client Survey

In April 2020, Durham Region established a community hub to provide support services to Durham's vulnerable populations, including people who are homeless. The community hub would like to hear about your experience accessing and using its services. This research study is a partnership between Ontario Tech University and the Region of Durham. Your response to this survey will help staff understand what services are working well for you, what services need to be improved, and/or added, and how to use learning from the community hub to create new community hubs in Durham.

You are not required to include your name on the questionnaire. Your responses will be combined with responses from others. Only grouped and anonymous responses will appear in the final report. Your participation in this study is voluntary and will not affect the services you receive at the community hub. You may only answer questions that you are comfortable with. You may end your participation in this study at any time.

After you have completed answering the questions, please return your completed questionnaire to the student, or place your questionnaire in the envelope provided and drop it in the drop box, provided at the community hub.

As a thank you for your time, you will receive a $20 gift card.

A. ABOUT YOU

A1. What is your gender? (check one of the following)

- Male
- Female
- Transgender
- Other (please specify) _____
- Prefer not to say

A2. What is your age range? (check one of the following)

- Under 18 years
- 18-24 years
- 25-34 years
- 35-44 years
- 45-54 years
- 55-64 years
- 65+ years

A3. What is your highest level of education? (check one of the following)

- Some elementary school
- Completed elementary school
- Some high school
- Completed high school
- Some college/university
- Completed college/university

A4. What is your source of income? (check all that apply)

- ODSP
- Ontario Works
- CPP-old age security
- CPP- Disability
- Private Income
- Private Pension
- Other (please specify) _____

A5. Which city are you originally from? (check one of the following)

- Ajax
- Bowmanville
- Courtice

- ☐ Oshawa
- ☐ Peterborough
- ☐ Toronto
- ☐ Whitby
- ☐ Other (please specify) _____

A6. In what culture do you identify yourself? (check one of the following)

- ☐ Aboriginal/First Nations
- ☐ African
- ☐ American
- ☐ Australian/New Zealander
- ☐ Canadian
- ☐ Central American
- ☐ East Asian
- ☐ European
- ☐ French Canadian
- ☐ Middle Eastern
- ☐ South Asian
- ☐ West Asian
- ☐ Other (please specify) _____

A7. What is your first language? (circle one of the following)

Aboriginal language	Chinese-Mandarin	Farsi	Gujarati	Korean	Romanian	Tamil
Arabic	Cree	French	Hindi	Portuguese	Russian	Urdu
Bengali	Dutch	German	Italian	Polish	Serbian	Vietnamese
Chinese-Cantonese	English	Greek	Japanese	Punjabi	Spanish	
Other: (please specify)						

B. ABOUT YOUR HOUSING

B1. What is your current housing situation? (check one of the following)

- ☐ Housed for 5+ years
- ☐ Housed for 3-4 years
- ☐ Housed for 1-2 years
- ☐ Housed for 6 -11 months
- ☐ Housed for under 6 months
- ☐ Not housed

B2. If you are housed, what has helped you maintain your housing? If you are not housed, please write "NA" in the "Other" section. (check all that apply)

- ☐ Having access to medical supports
- ☐ Having access to case manager/support worker/other support services
- ☐ Having my rent paid directly to the landlord by ODSP/OW/trustee
- ☐ Other: (please specify) _____

B3. If you are not currently housed where are you staying? If you are housed, please write "NA" in the "Other" section. (check one of the following)

- ☐ Emergency shelter/homeless shelter
- ☐ On the streets
- ☐ Couch surfing

- Motel
- Other: (please specify) _____

B4. Would you like to obtain housing? (check one of the following)

- Yes

Please provide the reasons: _____

- No

Please provide the reasons: _____

B5. What kind of support do you need to help you find housing? (check all that apply)

- Income
- Medical
- Counselling
- Housing search
- Mental health/addiction
- Employment
- Other: (please specify) _____

C. ABOUT YOUR HEALTH

C1. How would you rate your physical health? (circle one of the following)

Very Poor	Poor	Fair	Good	Very Good
1	2	3	4	5

C2. How would you rate your mental health? (circle one of the following)

Very Poor	Poor	Fair	Good	Very Good
1	2	3	4	5

C3. Do you have a family doctor/nurse practitioner? (check one of the following)

- Yes
- No

C4. If you have a family doctor/nurse practitioner when was the last time you had a visit (this includes appointments by telephone and video calls) with your doctor/nurse practitioner? (check one of the following)

- Less than one month
- 1-3 months
- 4-6 months
- 7-12 months
- More than 12 months

C5. Within the last 6 months, how many times have you visited the emergency department the following times? (check one of the following)

- Never
- 1-3 times
- 4-6 times
- 7-10 times
- 10+ times

C6. Please rank the following prevalent health issues that you are having. On a scale from 1 (most prevalent) to 6 (least prevalent).

- Chronic physical health issues
- Physical disability
- Cognitive/neurological/brain injuries
- Mental health issues
- Addictions

– Mental health and addictions

D. EXPERIENCE WITH COMMUNITY HUB SERVICES

D1. How did you first hear about the community hub? (check one of the following)

- ☐ Doctor
- ☐ Other health care professional (counsellor, nurse, therapist)
- ☐ Shelter staff
- ☐ A friend
- ☐ Family member
- ☐ Street outreach worker
- ☐ Other: (please specify) _____

D2. How long have you received services at the community hub? (check one of the following)

- ☐ Less than one week
- ☐ Less than two weeks
- ☐ Two weeks to one month
- ☐ One to three months
- ☐ Three to five months
- ☐ Five to seven months
- ☐ More than seven months

D3. How frequently do you use community hub services? (check one of the following)

- ☐ Daily
- ☐ Weekly
- ☐ Once a month
- ☐ Every 2-3 months
- ☐ Every 4-6months

D4. Please rank the community hub services you use. 1 (most frequently used) to 7 (least frequently used)

__ Medical care
__ Mental health counselling
__ Addictions counselling
__ Harm reduction supplies
__ Housing location
__ Meals
__ Sleeping safe
__ Bathing and hygiene
__ Accessing social services (Including Ontario Works, ODSP)
__ Other: (please specify) _____

D5. Please indicate how much you agree with the following statements. Please check only one box for each statement.

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
I feel welcome at the community hub					
I feel comfortable asking questions about community hub services					
I feel included at the community hub					
I feel my feedback about services is valued					

I feel respected by the staff at the community hub					
I feel services are available at times that are suitable for me					
I feel the location of the community hub works for me					
The mixture of services that the community hub offers meets my needs					
The referrals that the community hub provides meet my needs (Please check here ___ if you have not received a referral)					
I need the services that the community hub offers					

D6. Please rate your level of satisfaction with the service(s) you receive at the community hub. Please check only one box for each statement.

	Extremely Dissatisfied	Dissatisfied	Neutral	Satisfied	Very Satisfied	Did not use this service	Did not know about this service
Intake assessment							
Practical assistance (bus tickets, food, clothing, obtaining ID, income support)							
COVID Testing COVID information							
Counselling							
Medical treatment/medication adherence							
Help with finding housing							
Help with maintaining housing							
Drop-in programs							
Bathing and hygiene							

Referrals							
Individual advocacy (e.g., help with forms to access other programs)							
Other: (please specify)							

D7. Please tell us about your experience using these services:

_____
_____
_____
_____

D8. What medical services do you believe are most needed at the community hub?

_____
_____
_____
_____

D9. What other services would you like to see at the community hub?

_____
_____
_____
_____

D10. Please rate your level of agreement with the following statements. Please check only one box for each statement.

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Not Applicable
Community hub programs help me feel less alone						
I have made friends through the community hub						
The community hub helps me address my physical healthcare needs						
The community hub helps me address my mental health, and or addiction needs						
The community hub helps me manage my medications						
The community hub helps me access housing and, housing support services						

The community hub helps me access other social services I need in the community						
The community hub helps me access food						

D11. Please tell us how we can improve the community hub services, and provide any other comments that you may have for us.

_____
_____
_____
_____

D12. Would you recommend the community hub to family members, a friend, others? (circle one of the following numbers)

Not at all likely Extremely likely

1	2	3	4	5	6	7	8	9	10

Thank you for taking the time to complete the survey and provide your input.
Your feedback will help us improve our service and grow the community hub.
Please place your questionnaire in the envelope provided

Appendix B

Management Key Informant Interview Guide: Community Hub Research Study

Welcome and purpose of the key informant interview

The purpose of the key informant interview is to gather the views and perspectives of management employees of the Oshawa and Ajax Hygiene HUBs. Management staff are individuals who are in leadership and key decision-making roles regarding the governance and the operation of the community hubs.

- Thank you for agreeing to participate in the key informant interview. My name is XXX. I am the Research Coordinator for the Oshawa and Ajax Hygiene HUB evaluation project. I will be speaking with you today.
- As you may be aware, Ontario Tech University is partnering with the Region of Durham to evaluate the Oshawa and Ajax Hygiene HUBs. The project's main objective is to explore the effectiveness and long-term viability of the community hub model in addressing the needs of Durham's vulnerable populations.
- The project is being funded by City Studio Durham and Mitacs Accelerate. The project consists of two components; the first is the review of relevant literature, best practices, and models of community hubs for vulnerable populations. The second is the survey of patrons and staff of the Oshawa and Ajax Hygiene HUBs.
- The purpose of this interview today is to learn more about your experiences with developing, implementing, and sustaining the Oshawa or Ajax Hygiene HUB.
- The interview will last 30 minutes to 45 minutes.
- Did you have a chance to read the information and consent form?
- Do you have any questions related to the information and consent form or the project more broadly?

Privacy and confidentiality

- Information that you share will be confidential. Your name will not be connected with anything that you share to protect your privacy.

- At any time during our conversation, please feel free to let me know if you have any questions or if you would prefer not to answer any specific questions. You can also stop the interview at any time for any reason.
- This interview is to collect your perspective on the Oshawa or Ajax Hygiene HUB.
- I will be taking notes to record your responses.

Background information

I would like to start by asking you a few questions about your role at the Oshawa or Ajax Hygiene HUB.

1. Which organization are you affiliated with?
2. What is your position at the community hub?
3. How long have you been involved with the community hub?
4. What are your major responsibilities in this position?
5. How did you become involved with the community hub?
6. How many employees do you have working at the community hub?
7. What is your staff schedule at the community hub?

Now, let us talk about the community hub.

8. What was the impetus for your organization co-locating at the community hub?
    - 8a. How did your organization become involved with the community hub?
9. What processes did your organization undertake to provide services at the community hub, and who was involved?
    - 9a. Why were those processes selected?
10. What is the governance/decision-making structure of the community hub?
    - Why was that structure selected/chosen?
    - How would you describe the operation of the selected structure?
    - What do you see as the advantages of such a structure?
    - What do you see as the disadvantages of such a structure?
11. How does the community hub partnership model/approach work?
12. Why was that partnership model selected?
13. How would you describe the experiences of your organization (self and staff) working within a co-located service model?
14. What differences have co-locating at the community hub made in the:
    - Type of services delivered?
    - How are services delivered?
    - Client service experience/outcomes?
    - staff experience?
15. Why do you think these differences have occurred?
16. What are the top three or four things that you would say are working well at the community hub
    - Why do you believe these things are working well?
17. What are the top three or four things that you believe can be improved with small changes?
    - How would you go about making these improvements?
18. What are the top three or four gaps, if any, that you have identified?
    - How did these gaps develop?
19. Do you have any suggestions/recommendations on how these areas of improvement and gaps can be addressed?
20. In thinking about the larger system or the Region of Durham more broadly, what differences would a region-wide community hub system make in addressing the needs of vulnerable populations?
    - Why would it make those differences?
    - How could a regional community hub system be implemented?
21. In closing, is there anything else that you would like to add that may have been missed?

Thank you for taking the time to share your experiences with me.