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CAEP POSITION STATEMENT & GUIDELINES

CAEP position statement on improving emergency care for persons experiencing homelessness: executive summary

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Homelessness is an emergency

On any given night, about 35,000 people experience homelessness in Canada [1]. Homelessness is associated with substantially higher mortality, with rates up to eight times higher for men [2] and 32 times higher for women compared to people of similar age (Table 1) [3]. Despite this risk, homelessness remains underrecognized. As first responders in public health crises and working at a critical intersection of health systems, emergency department (ED) care providers are in a unique position to intervene.

ED visits are often related to acute exacerbations of chronic health conditions or medical complications of being homeless

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Table 1 Definitions of homelessness and housing exclusion [35, 36] adapted from the Indigenous Definition of Homelessness in Canada and the Canadian Observatory on Homelessness.

Terms	Definition	Examples and descriptions
Homelessness	Lacking stable, permanent, appropriate housing, or the immediate prospect, means and ability of acquiring it	
Indigenous definition of homelessness	First Nations, M tis and Inuit individuals, families or communities experiencing homelessness as described through a composite lens of Indigenous worldviews	Includes isolation from Indigenous peoples relationships to land, water, place, family, kin, each other, animals, cultures, languages and identities
Unsheltered, Absolute homelessness	Lack of housing and residing in places not intended for human habitation	Living on public sidewalks or parks (street homelessness), in tents, vehicles, or unsafe vacant buildings
Emergency sheltered	Residing in temporary, institutional shelters	Emergency overnight shelters, shelters for people impacted by family violence
Provisionally accommodated	Living in temporary housing without a prospect of permanence, including interim housing and hidden homelessness	Residing in prisons, group homes, or other institutions without housing upon leaving; recently arrived immigrants and refugees without means to obtain permanent housing
Hidden homelessness	Living temporarily with others without means to obtain permanent housing	couch surfing , living with an abusive partner; living in hostels, motels, and rooming houses
Transitional housing, Interim housing	Systems-supported bridge housing between living unsheltered and permanent housing, usually offering time-limited housing security	Housing program offering more privacy, employment pathways, and case management; housing for individuals or families impacted by violence offering trauma-recovery support
At-risk of homelessness, Relative homelessness	Living in housing intended for permanent habitation with economic or housing precarity, or conditions that do not meet health and safety standards	Overcrowding, inadequate heating, sudden unemployment, households facing eviction, violent or abusive situation, institutional care that is unsuitable

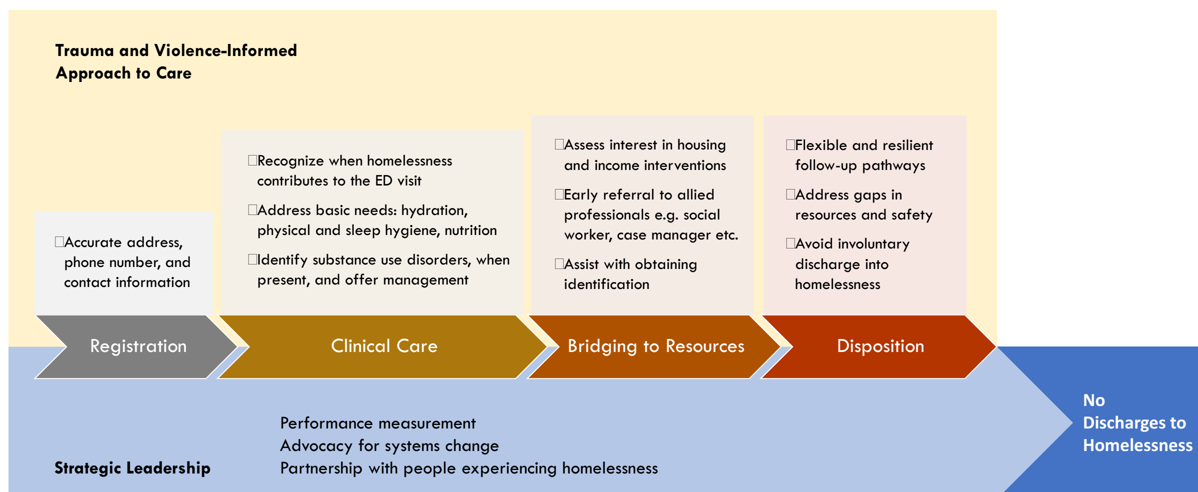

Fig. 1 Summary of interventions along the care pathway

[4]. Compared to the general population, people experiencing homelessness have higher rates of cardiovascular disease, traumatic brain injury, cancer, and other illnesses that are core to emergency care [5–7]. As a result of poor living conditions, they are also at increased risk of exposure to infectious diseases (e.g., COVID-19, HIV, and hepatitis C) yet face barriers to accessing appropriate care [8, 9].

ED visits are an opportunity to prevent health and housing emergencies. Studies indicate that people experiencing homelessness present to EDs over 8 times more often than matched cohorts [8], but also reveal that hospitals experienced at managing homelessness were less likely to have readmissions or return visits [10]. When people were housed, ED visits declined as well [11, 12].

ED providers are committed to caring for people experiencing homelessness, but may face moral distress in feeling unable to identify effective interventions. This strain can lead to inaction. In working towards ending homelessness and its impact on our patients, we can take advantage of a range of innovative approaches to care, evidence-informed practices, and our health system leadership (Fig. 1).

CAEP position on homelessness

The Canadian Association of Emergency Physicians (CAEP):

1. Recognizes that people experiencing homelessness are at higher risk of acute illness and death
2. Affirms that people experiencing homelessness should receive supportive care and planning in the ED that avoids involuntary discharge into homelessness
3. Encourages ED care providers to:
    a. adopt a trauma-informed approach for all care;
    b. recognize when homelessness or unstable housing contributes to the ED visit;
    c. facilitate access to services that address determinants of health and offer referral to social service providers; and
    d. identify substance use disorders, when present, and offer management and harm reduction.
4. Advocates for system-level policy changes toward an end to homelessness.

This position statement was developed with the participation of people with lived experience of homelessness and applies an ED perspective to the Canadian clinical guideline for homeless and vulnerably housed people [13]. Implementation of the approaches described should occur in partnership with affected individuals and communities and account for local resources, evolving knowledge and innovations in care. The complete statement can be found at https://caep.ca/advocacy/position-statements/.

A "trauma-informed" approach should be the foundation of ED care

The key underlying framework to addressing homelessness and its complications is applying a trauma- and violence-informed approach to all ED care. Whether working in triage and registration, at the bedside, or on ED resources and policies, embedding trauma-informed practices can improve outcomes [14].

Homelessness has severe health and social consequences: surviving despite these challenges requires immense resilience to hardship. Many people experiencing homelessness suffer the

effects of psychological and/or physical trauma which can profoundly affect their interactions with care providers.

Trauma arises from events experienced by individuals or communities as physically or emotionally harmful and has lasting adverse effects on functioning and physical, social, emotional, or spiritual well-being [15]. For example, adverse childhood events are associated with increased morbidity, mortality, and health care utilization [16].

A key feature of traumatic events is the loss of control. To avoid this, ED care providers can empower patients by following four principles [17]:

1. Understand that trauma and violence affect people s lives and behaviors,
2. Create emotionally and physically safe environments,
3. Foster opportunities for choice, collaboration and connection,
4. Provide a strengths-based and capacity-building approach to support coping and resilience.

Taking a trauma-informed approach can also foster safer environments for both providers and patients [18]. Integration of these principles into ED care [19] and nursing education [20] corresponds to key training milestones [21] and reflect a paradigm shift from What is wrong with you? to What happened to you? Care providers may also experience trauma in their own lives, including in the workplace, which contributes to compassion fatigue [19]. Recognizing when behaviors are associated with trauma can facilitate de-escalation, improve the quality and safety of care, and reduce the risk of re-traumatization.

Interventions can be taken to diagnose, manage, and prevent homelessness in the ED

As evidence-based clinicians, CAEP supports the improved identification and management of homelessness in order to improve the health of people at high risk for mortality. Understanding the extent of the problem includes accurate registration of patient demographics, recording relevant social history, and applying a diagnosis of homelessness or inadequate housing when they contribute to the ED visit with standard ICD-10 diagnostic codes Z59.0 or Z59.1, respectively [22].

ED management should address gaps in basic needs, such as dehydration, malnutrition, exposure, sleep deprivation, and poor hygiene. Clinicians should consider whether these complications of homelessness contribute to the clinical presentation. For example, from the patient perspective, extreme thirst and hunger likely take priority over laboratory tests. Attending to these needs is part of the trauma-informed approach and can permit patients to engage with other ED care.

People experiencing homelessness who use substances may benefit from support resources or pharmacologic interventions. Patients face barriers to housing when emergency shelters, long-term care facilities, or social programs prohibit substance use or possession of harm reduction supplies. Appropriate management of intoxication, withdrawal and pain can mitigate premature discharges and facilitate linkage to resources [23, 24]. For example, patients with an opioid use disorder can be offered a naloxone kit and opioid agonist therapy; patients with alcohol use disorders can be offered medications for craving reduction [25, 26].

Inclusion of people with lived experience of homelessness in developing ED care pathways and providing care directly can promote a safer environment, increase the effectiveness of care, and improve trust [14, 27, 28]. For these reasons, hospitals have begun to employ peer workers to support patients in the ED.

A selection of additional interventions can be found in Table 2 and the supplementary materials and a recent literature review in *CJEM* includes examples of ED initiated programs [29].

EDs provide a bridge to essential resources

Along with addressing health needs, ED care providers can assess patients experiencing homelessness for interest in housing and/or income resources. Early referral to providers familiar with these resources, such as social workers, case managers, and community agencies, can help to optimize care.

The diversity of homelessness experiences requires tailored strategies for different needs in the same way that arrhythmia management is tailored to clinical features and risk factors. Resources may be available based on factors such as housing situation, age, gender, sexual orientation, parenthood, exposure to violence, migration status, disability, or ethnicity (Table 2). Respectful inquiry or screening can help to avoid cognitive biases that lead to medical errors or under-identify forms of homelessness [30].

Bridging to resources is also an important perquisite for safe disposition from the ED that avoids unnecessary return visits. For example, patients may need assistance with replacing identity documents, developing linkages to follow-up care, obtaining income and health benefits, and obtaining medications. Clinicians play an important role in collaborating with patients to anticipate and identify these challenges to support disposition plans.

Table 2 Selected ED interventions. A complete summary and examples can be found at https://caep.ca/advocacy/position-statements/

Situation	Context	Interventions and Examples
All ED care	Promote safer environment for patients and providers	Trauma-informed approach e.g., avoid rigid enforcement of rules that are not immediately needed for safety, allow flexibility in management plans to establish trust, attend to basic needs. More examples: Alberta Health Services module [34]
All ED care	Homelessness is associated with severe deprivation	Attend to basic needs: address dehydration, malnutrition, sleep deprivation, personal hygiene, e.g., offer food, access to shower facilities, appropriate clothing
All ED care	Homelessness is underrecognized	Identify homelessness through accurate registration of demographic, screening when appropriate (Do you have a safe place to go?), and as the diagnosis when contributory
Person identifies as experiencing homelessness	ED visit may be signal of high unmet needs	Assess interest in housing and income interventions. Early involvement of allied health professionals and community resources when appropriate
Person identifies as Indigenous	May experience effects of racism and inter-generational trauma	Culturally appropriate care to advance good relations, e.g., applying protocols for clinical care: situating one s self , visiting , hospitality , and treat people as you would treat your own relative [37], implementing TRC recommendations for health care [38], San yas training program: sanyas.ca
Person identifies as a woman	More likely to experience poverty, sole parenthood, sexual abuse or trafficking	Consider screening for gender-based abuse and violence Consider resources available for women and families
Person who uses drugs / substance use disorder	Risk of complications from substance use. May have barriers to housing	Management of substance use, withdrawal and untreated pain, e.g., offer naloxone [24], information on supervised consumption, anti-craving medications, etc
Individual or family at high risk of homelessness	e.g., couch surfing , recent eviction notice, sudden loss of income, etc	Early referral to social worker, case manager, housing coordinator, or community agency. Application for income supports, rent bank funds, access to housing for families, etc
Disposition planning	Effective planning can improve quality of care and reduce length of stay and return visits	As needed, facilitate access to identity documents, alternate pathways and back-up plans for follow-up, medications, and resources to manage illness in the community, e.g., dispense supply of medications, program to supply reused mobile phones [39], referral to respite care, etc
ED policies and pathways	Promote trust and positive interactions, reduce stigma [14, 27, 28]	Involve people with lived experience of homelessness to provide insights, inform design, and establish community relationships. Appropriately compensate participation
Advocacy to end homelessness	Upstream action is needed to prevent housing emergencies	Advocate and partner with individuals and communities for structural change by leveraging ED care provider professional skills, relationships, and resources

EDs can be a source of leadership to end homelessness

Homelessness is an unacceptable condition for health and human dignity, especially in a nation as wealthy as Canada. Across the country, nearly 1 in 8 households live with unsuitable, inadequate or unaffordable housing [31]. Although meaningful steps can be taken to mitigate its harmful complications in the ED, a permanent end to homelessness must be achieved with broader support. Beyond high-quality ED care in safe spaces, upstream systemic approaches are necessary to prevent crises of homelessness from becoming emergencies.

ED care providers can leverage their professional skills, insights, and resources to advocate for an end to homelessness to health institutions and governments at all levels [32, 33]. As influential members of society, we are privileged with the trust of the public and can enact change in partnership with patients and communities. Partnership ensures that resources are directed towards priority needs. Advocacy in this spirit is facilitated by amplifying marginalized voices and providing ownership, opportunities, credit, and adequate remuneration to people with lived experience of homelessness.

From our position as clinicians, we can also correct misrepresentations and promote understanding of the strengths of people experiencing homelessness. Leveraging our knowledge of science, we can call attention to evidence-based interventions such as Housing First [34], which emphasizes the expansion of permanent supportive housing to improve both housing and health system outcomes.

As ED care providers, we bear witness to problems created by failures of prevention, gaps in policy, and inter-generational inequities of health and well-being. CAEP recognizes opportunities for action outside the ED and advocates for system-level change to prevent and end homelessness.

Conclusion

Housing is necessary for health. By addressing this key social determinant, ED care providers have an opportunity to manage a crisis condition that often triggers ED visits. Collectively, we should strive to never discharge a patient from the ED into homelessness. While we work towards this goal, we can intervene to provide high-quality patient-centred acute illness management, facilitate access to essential resources, and demonstrate leadership to prevent and end homelessness.

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Author contributions Edward Xie conceived the idea for the position statement. All authors contributed to manuscript drafts and revisions. Edward Xie created the figure and tables. Thara Kumar created Box 1. Edward Xie conducted discussions with reviewers.

Declarations

Conflict of interest No funding was provided for this manuscript. Edward C. Xie received reimbursement for costs as an executive member of Global Health Emergency Medicine, a non-profit academic institution based at University Health Network, Toronto. Kathryn Chan declares no potential conflicts of interest. Jaspreet K. Khangura is co-lead of the health equity working group and a member of the anti-racism / colonialism committee of the Canadian Association of Emergency Physicians and a member of the EZMSA opiate poisoning crisis committee. She is a research scientist in health equity at the University of Alberta. Justin Jek-Kahn Koh declares no potential conflicts of interest. Aaron M. Orkin declares no potential conflicts of interest. Hasan Sheikh declares no potential conflicts of interest. Kate Hayman receives a stipend from the UHN Emergency Department as a "Disadvantaged Populations Co-Lead". In 2020 21, she was also employed by Inner City Health Associates, Toronto. Sahil Gupta is the lead of the health equity working group of the Canadian Association of Emergency Physicians. Thara Kumar declares no potential conflicts of interest. Jennifer Hulme is a co-director of Global Health Emergency Medicine and receives a stipend from the UHN Emergency Department as a "Disadvantaged Populations Co-Lead". May Mrochuk declares no potential conflicts of interest. Kathryn Dong has received research support from the Canadian Research Initiative in Substance Misuse, committee honoraria from the College of Physicians and Surgeons of Alberta and the Edmonton Zone Medical Staff Association, and receives a medical leadership salary from Alberta Health Services.

References

1. Gaetz S, Dej E, Richter T, Redman M. State of homelessness in Canada. Toronto: Canadian Observatory on Homelessness; 2016.
2. Hwang SW. Mortality Among Men Using Homeless Shelters in Toronto, Ontario. JAMA, J Am Med Assoc. 2000;283(16):2152 7.
3. Cheung AM, Hwang SW. Risk of death among homeless women: A cohort study and review of the literature. Canadian Medical Association journal (CMAJ). 2004;170(8):1243 7.
4. Aldridge RW, Story A, Hwang SW, Nordentoft M, Luchenski SA, Hartwell G, et al. Morbidity and mortality in homeless individuals, prisoners, sex workers, and individuals with substance use disorders in high-income countries: a systematic review and meta-analysis. The Lancet. 2018;391(10117):241 50.
5. Fazel S, Geddes JR, Kushel M. The health of homeless people in high-income countries: descriptive epidemiology, health consequences, and clinical and policy recommendations. The Lancet. 2014;384(9953):1529 40.
6. Fazel SP, Geddes JRP, Kushel MP. The health of homeless people in high-income countries: descriptive epidemiology, health consequences, and clinical and policy recommendations. The Lancet (British edition). 2014;384(9953):1529 40.
7. Hulchanski JD, Campsie P, Chau SBY, Hwang SH, Paradis E, editors. Finding home: policy options for addressing homelessness in Canada. Toronto: Cities Centre Press, University of Toronto; 2009.
8. Hwang SW, Chambers C, Chiu S, Katic M, Kiss A, Redelmeier DA, et al. A comprehensive assessment of health care utilization among homeless

adults under a system of universal health insurance. Am J Public Health. 2013;103:S294 301.
9. D Amore J, Hung O, Chiang W, Goldfrank L. The epidemiology of the homeless population and its impact on an urban emergency Department. Acad Emerg Med. 2001;8(11):1051 5.
10. Miyawaki A, Hasegawa K, Figueroa JF, Tsugawa Y. Hospital readmission and emergency department revisits of homeless patients treated at homeless-serving hospitals in the USA: observational study. J Gen Intern Med. 2020;35(9):2560 8.
11. Jaworsky D, Gadermann A, Duhoux A, Naismith TE, Norena M, To MJ, et al. Residential stability reduces unmet health care needs and emergency department utilization among a cohort of homeless and vulnerably housed persons in Canada. J Urban Health. 2016;93(4):666 81.
12. Wiens K, Nisenbaum R, Sucha E, Aubry T, Farrell S, Palepu A, et al. Does Housing Improve Health Care Utilization and Costs? A Longitudinal Analysis of Health Administrative Data Linked to a Cohort of Individuals With a History of Homelessness. Medical Care. 2021;59.
13. Pottie K, Kendall CE, Aubry T, Magwood O, Andermann A, Salvalaggio G, et al. Clinical guideline for homeless and vulnerably housed people, and people with lived homelessness experience. Can Med Assoc J. 2020;192(10):E240.
14. Purkey E, MacKenzie M. Experience of healthcare among the homeless and vulnerably housed a qualitative study: opportunities for equity-oriented health care. Int J Equity Health. 2019;18(1):101.
15. Substance Abuse and Mental Health Services Administration. Trauma and Violence Internet: U.S. Department of Health & Human Services; 2019 [cited 2021 April 19]. https://www.samhsa.gov/trauma-violence.
16. Sekharan V. Adverse Childhood Experiences and Adult Homelessness. Toronto: York University / Canadian Observatory on Homelessness; 2016. https://www.homelesshub.ca/blog/infographic-adverse-childhood-experiences-and-adult-homelessness.
17. Public Health Agency of Canada. Trauma and violence-informed approaches to policy and practice Internet: Government of Canada; 2018 [cited 2021 April 19]. https://www.canada.ca/en/public-health/services/publications/health-risks-safety/trauma-violence-informed-approaches-policy-practice.html#s5.
18. Drummond A, Chochinov A, Johnson K, Kapur A, Lim R, Ovens H. CAEP position statement on violence in the emergency department. Can J Emerg Med. 2021.
19. Fischer KR, Bakes KM, Corbin TJ, Fein JA, Harris EJ, James TL, et al. Trauma-informed care for violently injured patients in the emergency department. Ann Emerg Med. 2019;73(2):193 202.
20. Cochran CB. Infusing the principles of trauma-informed care into emergency nursing: a comprehensive approach to change practice. J Forensic Nurs. 2019;15(4):206 13.
21. Royal College of Physicians and Surgeons of Canada. EPA Observation Templates: Emergency Medicine Internet: RCPSC; https://www.royalcollege.ca/rcsite/cbd/assessment/wbas/cbd-assessment-templates-e.
22. Canadian Institute for Health Information. Homelessness. 2018. In: Canadian Coding Standards for Version 2018 ICD-10-CA and CCI Core [Internet]. Ottawa: CIHI,; [596 7]. https://secure.cihi.ca/estore/productFamily.htm?pf=PFC3668&lang=en&media=0.
23. Brothers TD, Fraser J, Webster D. Caring for people who inject drugs when they are admitted to hospital. Can Med Assoc J. 2021;193(12):E423.
24. Koh JJ, Klaiman M, Miles I, Cook J, Kumar T, Sheikh H, et al. CAEP position statement: emergency department management of people with opioid use disorder. Can J Emergency Med. 2020;22(6):768 71.
25. Hulme J, Sheikh H, Xie E, Gatov E, Nagamuthu C, Kurdyak P. Mortality among patients with frequent emergency department use for alcohol-related reasons in Ontario: a population-based cohort study. Can Med Assoc J. 2020;192(47):E1522.
26. Wiercigroch D, Sheikh H, Hulme J. A rapid access to addiction medicine clinic facilitates treatment of substance use disorder and reduces substance use. Substance abuse treatment, prevention and policy. 2020;15(1):4-.
27. Barker SL, Maguire N, Bishop FL, Stopa LL. Expert viewpoints of peer support for people experiencing homelessness: A Q sort study. Psychol Serv. 2019;16(3):402 14.
28. Miler JA, Carver H, Foster R, Parkes T. Provision of peer support at the intersection of homelessness and problem substance use services: a systematic state of the art review. BMC Public Health. 2020;20(1):641.
29. Formosa EA, Kishimoto V, Orchanian-Cheff A, Hayman K. Emergency department interventions for homelessness: a systematic review. Can J Emergency Med. 2021;23(1):111 22.
30. Doran KM, Vashi AA, Platis S, Curry LA, Rowe M, Gang M, et al. Navigating the boundaries of emergency department care: addressing the medical and social needs of patients who are homeless. American journal of public health. 2013;103 Suppl 2(Suppl 2):S355-S60.
31. Canadian Mortgage and Housing Corporation. Core housing need Internet: CMHC,; [cited 2021 Feb 11. https://www.cmhc-schl.gc.ca/en/data-and-research/core-housing-need.
32. Canadian Association of Emergency Physicians. Advocacy Internet: CAEP,; [cited 2021 April 19]. https://caep.ca/advocacy/.
33. Collins A. We need to protect and value the advocacy role of physicians Internet: Canadian Medical Association; 2021 [cited 2021 April 19]. https://www.cma.ca/news-releases-and-statements/we-need-protect-and-value-advocacy-role-physicians.
34. Baxter AJ, Tweed EJ, Katikireddi SV, Thomson H. Effects of Housing First approaches on health and well-being of adults who are homeless or at risk of homelessness: systematic review and meta-analysis of randomised controlled trials. J Epidemiol Community Health. 2019;73(5):379.
35. Gaetz S, Barr C, Friesen A, Harris B, Pauly B, Pearce B, et al. Canadian definition of homelessness. Toronto: Canadian Observatory on Homelessness; 2017.
36. Thistle J. Indigenous Definition of Homelessness in Canada. Toronto: Canadian Observatory on Homelessness Press; 2017. Available from: http://www.ontarioaboriginalhousing.ca/wp-content/uploads/2019/05/Thistle_Definition-of-Indigenous-Homelessness-in-Canada.pdf.
37. Thistle J, Smylie J. Pekiwewin (coming home): advancing good relations with Indigenous people experiencing homelessness. Can Med Assoc J. 2020;192(10):E257.
38. Richardson L, Murphy T. Bringing Reconciliation to Healthcare in Canada: Wise Practices for Healthcare Leaders. Ottawa: HealthCareCAN; 2018. https://www.healthcarecan.ca/2018/04/11/healthcarecan-releases-wise-practices-to-address-the-health-related-truth-and-reconciliation-commission-trc-calls-to-action/.
39. Department of Family and Community Medicine. Internet: Department of Family and Community Medicine, University of Toronto. 2020. [cited 2021]. https://dfcm.utoronto.ca/news/old-phones-are-lifeline-vulnerable-patients-during-covid-19.
40. Jenkinson J, Wheeler A, Wong C, Pires LM. Hospital discharge planning for people experiencing homelessness leaving acute care: a neglected issue. Healthc Policy. 2020;16(1):14 21.