Evaluation of the Service Coordination Pilot Project for Homeless People Living with HIV/AIDS: Final Report

Deborah Leach + Associates

Team: Dino Paoletti and Deborah Leach

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1. Introduction

This document presents the results of an evaluation of the Service Coordination Pilot Project for Homeless People Living with HIV/AIDS, a partnership of hospital, community and HIV/AIDS agencies and sponsored by the Toronto HIV/AIDS Network (THN) and funded by the AIDS Community Action Program (ACAP) of the Public Health Agency of Canada (PHAC) until March 31, 2010.

Pilot Project Objectives. The pilot project has involved the development and delivery of a service coordination model that serves homeless men, women, transgender and transsexual individuals with HIV/AIDS. The pilot focus is on short-term crisis services, with the following two formal project objectives:

i. To increase access to and enhance continuity of health and community services for People Living with HIV/AIDS who are homeless and have mental health and/or substance use issues

ii. To increase service coordination and integration between HIV/AIDS community agencies and services in the health, shelter, housing and mental health sectors.

Participating Partner Organizations. The project involves a partnership of 12 service provider organizations that includes:

- 2-Spirited People of the 1st Nations
- Casey House
- Fife House
- Fred Victor Centre
- McEwan Housing and Support Services (Loft Community Services)
- Prisoners' HIV/AIDS Support Action Network (PASAN)
- Seaton House Shelter, Infirmary Program
- Sherbourne Health Centre, Infirmary Program
- St. Michael's Hospital, HIV/AIDS Psychiatry
- St. Michael's Hospital, Positive Care Clinic
- The 519 Church Street Community Centre, Trans Program
- Toronto People With AIDS Foundation (PWA Toronto)

The project is also supported by the Toronto HIV/AIDS Network. In addition, St Michael's Hospital Emergency Department and the Health Centre at 410 Sherbourne, St Michael's Hospital joined as informal partners (with written agreements) during the pilot. Referring Agencies Outside Formal Partnership include the Black Coalition for AIDS Prevention (Black CAP), Women's Health in Women's Hands, St Joseph's Health Centre, Shout Clinic, Good Shepherd Hostel, CAMH Rainbow Program , Street Haven at the Crossroads, Fred Victor Centre Women's Shelter and Caledonia Shelter.

Pilot Project Services. The following specific services are offered by the Project:

- coordinated referral/intake among partner agencies
- short term intensive case management (envisioned as the service coordination function among the twelve partner agencies)
- dedicated beds for acute health care stays
- community nursing case management
- dedicated housing reintegration

- mental health support
- psychiatric assessment and consultation
- crisis intervention
- primary care health support/reconnection
- substance use support.

Delivery of short term intensive case management services was initiated on July 15, 2009.

Project Resources. ACAP funding for the project was $142,363 which included salary costs, meetings of the PHA Advisory Committee, PHA transportation and honoraria, and projects that included the needs assessment and the program evaluation. The project involved one full-time case manager for approximately ¾ of a year and a half-time project coordinator (full-time for 6 months). In addition, students were involved in project activities.

2. The Evaluation

This section describes the evaluation purposes and processes.

2.1 Four Evaluation Purposes

The evaluation addressed the following four broad questions:

i. Did the pilot project produce the deliverables set out in its workplan and did it meet its goals with respect to the number of clients served?

ii. Were homeless PHAs who received case management services from the Pilot Project reconnected to primary care and other health and community services including housing, resulting in the stabilization of their heath and a reduction in hospital visits or admissions.

iii. Was there meaningful involvement of homeless PHAs in the development and delivery of the Pilot Project and its services?

iv. Was the Pilot Project partnership and its short-term intensive case management model successful in increasing the integration and coordination of their services and improving the access to these services and the continuity of care for homeless PHAs?

2.2 Guiding Principles

The following 5 principles were used to guide the evaluation:

- Focused and Realistic. The evaluation focused on addressing the evaluation questions in ways that were feasible within the project timeframe and budget. It concentrated on identifying immediate impacts and benefits attributed to the pilot by clients and partner organizations.

- GIPA. The evaluation involved PHAs in the data collection process (as both interviewers and interviewees) and through the PHA Advisory Committee.

- Qualitative. The evaluation drew on the results of interviews, focus groups, project reports and project documentation.

- Confidential. All interviews were confidential. The report contains themes and does not attribute comments to individuals.

- Independent. The report is independent, reflecting the results of the information collected and conclusions drawn from this information.

2.3 Data Collection Process

Information was collected through the following processes:

- A review of project-related documents (e.g., the funding proposal, letters of support, partnership agreements, program data)

- In-person interviews with 12 people who have been clients of the pilot project. These interviews were conducted jointly by a member of the consulting team and a peer interviewer

- A focus group with members of the PHA advisory committee

- Individual interviews with representatives of 12 organizations involved in the pilot project

- A focus group with front line staff of the partner organizations.

2.4 Limitations of the Evaluation

A number of factors are important to keep in mind while considering the remainder of this report. In particular, the evaluation was not a clinical evaluation or research study. The conclusions that follow are based largely on perceptions of interviewees and focus group participants and data provided by the project. In addition, the evaluation team did not collect original data regarding the use of hospital services (e.g., emergency visits, in-patient beds). Collection of this data was done directly by St. Michael's hospital and involved original data analysis with program participants looking at history of previous hospital use and post project hospital use. This information was provided to the consulting team by project staff.

3. Structure of This Report

The remainder of this report is structured as follows:

- Section 4 presents the evaluation results concerning service levels and deliverables
- Section 5 provides feedback from PHAs who had used the service and participated in the evaluation. This section also includes feedback from the PHA advisory committee
- Section 6 summarizes feedback from service provider
- Section 7 provides a set of conclusions.

An Appendix contains a summary of ideas generated at a meeting on best practices and planning that was conducted at the end of the pilot.

4. Project Service Levels and Deliverables

This section provides an overview of the project's service levels and deliverables (as per the first of the 4 evaluation questions).

Service Levels

Case Management Service Levels. The Pilot Project deliverable was to provide short-term intensive case management mental health/substance use crisis. At the end of March, 2010 project documentation indicates that between July 15 and March, 2010, 28 clients had received intake services, all of whom met the funding criteria (i.e., living with of HIV/AIDS, homelessness, mental health and/or addiction challenges). Another 6 clients were referred who did not receive service, 2 did not fit the mandate, 1 declined service after intake interview, and 3 did not connect with service past intake interview. All clients presented with complex physical and mental health issues and many were dealing with substance use issues, homelessness and behavioural issues. 65% of all clients had concurrent mental health and substance use issues.

As expected, the time spent with each client was high in both frequency and intensity. By the end of the first reporting period (9 weeks of service delivery), ten clients had been served, involving total of 287 one-on-one case management activities that were provided directly by pilot project staff. Active case management in this model has involved a minimum of two to three meetings a week with each client, during the first four to eight weeks of service. At the end of the project there had been 35 weeks of direct delivery of short term intensive case management services and a total of 738 separate one on one case management activities[1] reported for the 28 clients who received service. The average term of service delivery with clients was 3-4 months; approximately 20% of all clients were more complex cases with significant medical health issues, severe mental health and poly substance use requiring 4- 8 months of service delivery. Over half of all clients were referred to ongoing intensive case management at point of discharge, and almost all other clients required and received referrals to other ongoing community support.

Clinical intervention, emotional and physical support were essential components of the services provided. In addition, all of these individuals needed permanent and affordable supported housing. The latter set of services was seen as essential to helping people obtain housing and get connected with the support services they needed to survive and, in some cases, to reclaim a healthier existence.

Community Beds. Service levels with respect to the use of community services for health stabilization utilizing dedicated beds for respite, general admissions, short term care stays were as follows for 333 Sherbourne Infirmary Program, Seaton House Infirmary Program, Casey House, and McEwan House:

Community services for health stabilization using dedicated beds	Number of clients referred by Pilot Project	Total days all clients
333 Sherbourne Health Centre Infirmary Program	4 clients	43 days
Casey House	4 clients	126 days
Seaton House Infirmary and Shelter	9 clients	399 days
McEwan Housing and Support Services	5 clients	150 days

[1] This figure does not include other case management activities including advocacy, phone calls, meetings with service providers, correspondence or documentation.

Hospital Psychiatry Services. In addition, the HIV Psychiatry Clinic St Michael's Hospital has been held 8 times (once every three weeks). Twelve (12) were seen for assessments with numerous seen for on-going follow-up. Recommendations for care in the community were made for most clients and referrals for further assessment and care made.

Housing Status of Clients Served. Of the 28 clients, 18 were housed as part of the services they received from the Pilot Project utilizing dedicated housing beds and housing search options throughout the partnership. More specifically:

- 7 clients were Housed in the Fife House Transitional Housing Units (2 have received permanent housing at Fife House)
- 3 clients were housed within McEwan and Loft
- 4 clients were housed within Toronto Community Housing (utilizing housing resources within the partnership)
- 4 clients were assisted to find housing in the private market place.

Of the remaining ten clients: 3 clients died while receiving service, 3 remain within the shelter system (case management services continue), 2 have moved to other cities and 2 were already housed at intake but fit all other criteria (health and mental health crisis) and at point of intake were at risk of losing their housing or their housing was unsafe.

People Served: Demographics. Of the 28 people served, 4 were women, 1 was a trans woman and 23 were men. Program data also show that 4 of these individuals identified as Aboriginal, 18 as Caucasian, 4 as African, 2 Caribbean and 2 Latin. The median age of people who used the serviced was 40. Three are transitional age youth.

Referral Sources. Program data indicate that about half of pilot clients were referred by hospitals. In particular:

- 5 clients were referred from inpatient medical floors of St Michael's Hospital
- 1 client was referred from inpatient medical floor of St Joseph's Hospital
- 2 clients were referred from Inpatient Psychiatry at St Michael's Hospital
- 5 clients were referred directly from St Michael's Hospital Emergency Department.

The remaining referrals were from community based organizations, most of which were involved in the pilot partnership. These community referral sources included PWA Toronto, Seaton House, Casey House, Women's Health in Women's Hands, Fred Victor Centre, 2 Spirited People of the 1st Nations, Fife House and Black CAP.

Project Deliverables

Project reporting confirms that all deliverables to which the project committed were, in fact, produced:

Conduct a Needs Assessment: The needs assessment was completed by an independent team of consultants in the Spring of 2009 and used to inform the design and development of the pilot. The needs assessment involved interviews and two focus group discussions with PHAs, interviews and a focus group with partner organizations. The interviewing process involved a PHA trained on the interview protocol by another member of the needs assessment team.

Develop a PHA Advisory Committee. A PHA Advisory Committee involving six PHAs who are homeless was created early in the project. Six PHA Advisory Committee meetings, involving a PHA facilitator, were held throughout the course of the project.

Design and Deliver The Coordinated Multidisciplinary Case Management Services. In addition to the delivery of services described in the previous section on service levels, the project produced the following:

- a standardized intake/referral form and process for use by all partners
- protocols for medical, mental health, housing search and management roles and activities
- a standardized client consent form for use in the pilot
- guidelines for multi-disciplinary case management meetings
- a primary health care and community services client history tool.

Host a Forum For Sharing Results (e.g., needs assessment, best practices). One meeting was held to share results another focused on best practices.

A number of project management and infrastructure-related deliverables were also delivered, including:

- A partnership working group pilot advisory committee
- Formal partnership statements of commitment, Memoranda of understanding and partnership agreements
- Project promotional information
- Networking and partnership building with health and other community services
- A pilot project client information system
- A pilot project evaluation.

Cost Savings Attributed To the Pilot Project

While the primary focus of the pilot project was on the health and well-being of people who are homeless and living with HIV/AIDS, system benefits were also anticipated. More specifically, it was anticipated that the pilot would lead to reductions in the use of costly hospital service in favour of lower cost community services. Additionally, it was anticipated that coordination might lead to more appropriate use of all services and reductions in service duplication.

Results indicate that substantial savings and efficiency benefits are associated with the pilot.

The following section, based on data collected by project partners (information collected at intake, baseline interviews and documentation provided after admission), indicates that substantial savings have been attributed to the project by participating hospitals. Specifically, it was reported that emergency room visits were reduced by approximately 50%, and compared to the previous year, hospital stays also reduced dramatically. More specifically,

- there was a reduction in average emergency room visits from 2.7 in the previous year to 1.6 over the 8 month period for which project data were available
- compared to the previous year, hospital stays were reduced from 666 (one year prior) to 127 days.

In addition, it appears that the pilot resulted in prevention of hospital admissions, i.e., at intake, 13 people were referred to the program directly from hospital – 8 from inpatient and 5 from the E.R. The following table provides more data indicating reductions in the use of hospital services:

Client Hospital Usage Prior to Intervention of Pilot Project	Before the Pilot		Between July 15, 2009 and March 30, 2010	
Inpatient Mental Health Admissions: Total days all clients in previous year:	90 days (involving 3 clients)	Average= 30 days per client	10 days (involving 2 clients)	Average= 5 days per client
Inpatient Medical Admission Total days all clients in previous year:	576 days (involving 11 clients)	Average= 52.4 days per client	98 days (involving 7 clients)	Average=n14 days per client
Crisis Stabilization Unit Stays Total days all clients in previous year:	40 days (involving 2 clients)	Average= 20 days per client	4 days (involving one client)	Average= 4 days per client
ER Visits All Clients:	30 (involving 11 clients)	Average= 2.7 visits per client	15 visits (involving 9 clients)	Average= 1.6 visits per client

Note : New intakes awaiting service delivery as the transition from The Pilot Project stage to ongoing service delivery continue to be individuals with complex physical health issues who are often quite ill and had a high level of hospital usage both through emergency and inpatient admissions. One women awaiting service delivery was hospitalized 90 days prior to her referral to service.

Anecdotal reports from service providers and service users suggest that this project also assisted as a prison diversion for some participants.

5. Feedback from PHAs Who Used the Pilot Services and Advised The Pilot

During the months of December 2009 and January 2010, the project evaluation team interviewed 12 men who had recently been through the case management pilot program. These men ranged in age from their early twenties into their sixties; represented diverse sexualities; were culturally diverse; and occupied various social classes. Some were more recently homeless, while others had been homeless or experienced housing instability for much longer. For many, knowledge of their HIV status was fairly new. For some, addiction was implicated in their HIV diagnosis, while for others, no substance use issues were noted. Participants described a range of mental health issues; some from earlier in their life history (e.g. trauma or a significant psychiatric disorder); some experienced huge stressors related to immigration (settlement and racism) and homophobia; while all articulated the intense daily stress related to homelessness.

The interviews were set up by either pilot project staff or a social work student with the project. The interviews were conducted in person by one of the project consultants in partnership with one of two peer interviewers. The peer staff members are PHAs who had been homeless in the past and had experienced substance use or mental health issues (e.g. homelessness stress). They are both skilled interviewers and reflect the project commitment to meaningful involvement of PHAs throughout the project.

In general, there was a remarkable consistency in perspectives from all project participants with respect to the effectiveness of the project and its impact on their lives. All were enthusiastic in their praise of the services they accessed, the ease of access to those services through case managers and the very real respect and caring shown by the two project staff in the delivery of these services.

All participants felt that the connection to this project and the subsequent referral and connection to other services was very well done. Due to the multiple complexities and difficulties in their lives at the time of initial project connection, some could not remember the specifics of how it actually happened. Specific benefits attributed to the pilot include:

Service connection and reconnection that contributed to stabilization. Participants described important connections or reconnection to health care services including HIV primary care physicians, hospice, infirmary and respite care, a range of housing and supportive housing services, connections to income supports like ODSP, access to mental health and addiction services of various kinds. Participants recognized the importance of all these services in helping to stabilize their lives and health. The assistance of project staff was the essential ingredient in helping participants get connected to services and maintain those connections. Participants described that project staff had a knack of helping them get connected to those services that best met their unique needs. It was not a "one size fits all" approach.

> *"They help me get connected in areas where they see I belong. I don't know how they do it."*

Compassionate and flexible staff providing a rapid response in meeting immediate needs. What also stood out for people was the rapid response to their immediacy needs, the connection to practical and life saving services and the compassionate, respectful partnership that was created by project staff. Most described some initial suspicion and lack of belief concerning the project and its staff.

> *"The world needs more people like them. I thought nobody could reach me and they did. I still don't know how, but they gave 150% support"*

> *"Initially I thought the project was all bullshit. Over time, they earned my trust. I'd be dead without them."*

Some participants recognized that their own behaviors could be difficult as a consequence of their painful life experiences and the necessity of fighting for survival on the street. Many noted the skill, patience and persistence of project staff in dealing with that.

> *"They are straight up with me. They tell me to my face."*

> *"They're organized and seem to do it effortlessly. They never falter or get upset and maintain their composure at all times."*

At the time of service connection, many participants were either close to death or struggling with serious and life threatening illness, experiencing homelessness or housing instability, dealing with pervasive drug use issues, or dealing with cognitive difficulties (mental health issues related to dementia and/or other diagnosed and untreated mental health problems or previously undiagnosed issues). Others had criminal charges and/or histories of incarceration.

> *"I needed to find out why I was so god damn angry. I have been in 38 fights with police over an 8-9 year period. These guys helped me get out of jail."*

> *"I'd be dead if this program did not exist or in prison. They helped me avoid killing myself."*

Improved Physical and Mental Health. All participants reported a visible and positive change in their physical health. In some cases it was measured by improved HIV blood work, while for others it also included treatment of other serious infections. For some, weight gain and increased energy were visible measures of health improvements. All had been referred to community based physicians; many had accessed infirmary and respite beds for health stabilization. All had been referred to housing which has

had a particularly stabilizing effect on their lives. Some had been referred to hospital based psychiatric care for diagnosis and treatment of HIV related dementias and other mental health issues.

All participants reported a positive change in their mental health. For some, it was attributed to being on helpful psychiatric medication and connection to community mental health services. For many, being safely housed reduced enormous stress in their lives and allowed them opportunities to set goals beyond immediate survival needs.

> *"These guys gave me my life back. It feels like I have a future."*
>
> *"I lost everything, now I'm going back to school to get my life back."*
>
> *"I miss them. These guys turned my life around. They gave me hope."*

Substance Use Management. Most participants who described ongoing difficulties with substance use (alcohol, crack cocaine, crystal meth) prior to program participation, have indicated a change in their substance use. For some, it has meant a very noticeable reduction in substance use, for others it has meant a change to more planned use that has resulted in being able to maintain housing for longer. Others have indicated a change in their drug of choice which for some has involved moving from chaotic drug and alcohol use to accessing legal medical marijuana to assist with pain management and appetite stimulus. Others indicated a spontaneous desire to enter drug rehabilitation programs. A few have ceased substance use through abstinence approaches and 12 step programs.

> *"I stopped using drugs because I felt like I wanted to live for the first time in my life. They have given me a second chance. "*

Social Connection and Ongoing Support. Many described feeling a sense of new found or renewed community connections. For some, that meant an identification and connection with a mental health community while for others it related to a connection with other residents in a housing community. For some, it meant connecting with other PHAs through volunteer work in ASOs. This reduced sense of isolation helped create a sense of purpose and meaning for some. Others described an interest in working to help others.

> *"I would love to share my experiences and help others"*
>
> *"No matter how pissed off I am, they make me feel empowered. I would love to get involved in an advocacy committee."*

Many participants feel like they have a team of people now who support their lives and health. Many described the warmth, respect, non-judgemental attitude, remarkable patience and unfailing hope that project staff inspire, even when participants have described recognizing that they themselves might be difficult at times. The practical services like appointment reminders, accompaniment to appointments and the skilful and persistent advocacy partnership that project staff offered were significant in helping participants achieve success.

> *"I can't do it all alone... I need help."*
>
> *"Other case managers are not like the boys. They go the distance. They get back to me on time with things. They are amazing guys. It takes a lot for me to trust someone. Their follow up is incredible. Nothing seems to upset them and they care. "*

Hope. When considering the future, participants described feeling more hopeful and better able to access resources through this project. Most indicated a far reduced likelihood of need to use hospital emergency rooms or other emergency services.

> *"I don't feel like I'm going to be thrown out to the streets now."*

> *"I'm smiling now. I have not smiled in years. I have hope for the first time in my life. I'm starting to trust people more and to open up more. That somebody cares makes all the difference. It helps me feel like I'm worth something. I'm no longer at the end of my rope. It makes me want to do something. I'm starting to volunteer now."*

Feedback from The PHA Advisory Committee. Greater involvement of PHAs was a key project goal, articulated from the beginning as "meaningful involvement" of people living with HIV/AIDS. A PHA advisory committee was also set up. During the evaluation process, a focus group was conducted with the PHA advisory group to seek their views on the involvement of PHAs in the project and the Advisory Committee itself. The following section outlines the key feedback from this focus group.

- Strengths and accomplishments of The Advisory Group Process. When asked about its strengths and accomplishments, Committee members emphasized that membership diversity (gender, culture, age) was a key strength. During the first phase of the project, the committee completed the groundwork necessary for a functioning group including terms of reference and group guidelines as well as a wish list to guide development. Members also noted that having the peer interviewers as members was helpful.

- Involvement and Participation. Members noted that due to the very busy nature of the project and consequent intensity at which project staff were working, that communication and integration of the advisory committee took a lower priority than they would have liked. They also noted that there were limitations of number of times to meet due to limited project resources. Given the resource limitations, members felt that communication had been good but could be improved and that more two-way information flow would be helpful.

- Future Development. A number of suggestions were made for future involvement of the Advisory Committee and PHAs in general.
  - Increased communication and integration. Members indicated a need for greater communication that could include having an advisory committee member attending partnership meetings as well as receiving minutes from partnership meetings.
  - Increasing membership to include trans people was also indicated, as well as more members to ensure back-up in case of illness. Developing a succession plan for new members was also noted.
  - Greater peer employment. Members also targeted the need for more paid peer roles, including helping with accompaniment of project participants to meetings and appointments. This could be accomplished by greater connections to mentorship training and skill development opportunities (OAN etc) as well as peer training as public speakers (PWA Speakers Bureau) to present to THN and other service providers.
  - Community Forum. Members also discussed the need to develop a larger community forum to share project results and successes.

6. Feedback from Partner Organizations

Feedback from partner organizations was very similar in substance to that of program participants. Most service providers interviewed indicated seeing marked improvements in the health and lives of program participants. Some only worked a short time with participants as part of a chain of service provision and therefore were unable to see the full range of improvements. The noted improvements included visible changes in health and health markers (such as blood work, increased weight and energy) and reduced instability in the lives of participants. They attributed these changes to access to health care, access to mental health supports, stable housing, housing and income supports and reduced substance use or stabilized substance use.

All attributed the changes to a combination of the effectiveness of the short term intensive case management model and to the effectiveness of the partnership.

> *"Case management is the hub. Now it's centralized and more effective, cuts down on duplication and strengthens partnerships".*

Communication and Networking Leading To Improved Efficiency and Effectiveness. Partner organizations indicated increased communication and networking amongst service providers. This has helped inform partner organizations more fully about the work of each organization. An important outcome has been a reduced a sense of isolation amongst service providers and an increased sense of mutual support and direction with advocacy. As one person said:

> *"More service provider connections mean more connection for clients."*

The planning process brought together many players who had never been at the table at the same time. Organizations recognized that they were serving the same people and not doing well doing it alone. As one interviewee said…

> *"Working together works and it makes client sense."*

Both Clients and Service Providers Benefit from Integrated and Coordinated Services. Many providers talked about the client and service system benefits they attribute to the pilot. Housing and support were indicated as significant factors helping people adhere to HIV treatment regimens. Being housed and having a fridge made it easier for some to adhere to treatment (where some meds need refrigeration).

> "*The project has helped reduce the risk of people dying or living hard on the streets. As people are housed, health improves. Where people are warmer, safer, less exposed to violence and therefore have better access to medical services; they have a much greater likelihood to adhere to their HIV medications."*

For some, participation in the project has diverted people from imprisonment. This has also been a benefit where prisoners typically have difficulty getting their mental health needs properly diagnosed and treated. It was also noted, however, that while many people are now thriving as a result of this project, others have not had ideal outcomes.

> *"This project builds bridges for clients with the most complex lives. Despite our best work, a woman participant died this week. However, she died housed and not alone. This has not always been the case in the past where people died alone in parks for example."*

Most partner organizations noted that participant use of hospital emergency rooms and inpatient hospitalization has been noticeably reduced. This has been attributed to people now being housed, supported and having access to health care in the community. Others noted less use of shelters and

more use of long-term housing which results in systemic cost savings. Given these observations, service providers predicted less frequent use of hospital ER services and better use of hospital services when necessary. These kinds of directions have other tangible benefits.

> *"Specialized services are now able to function due to case management. This results in much better use of skills and resources of other clinicians and services. This is a much more competent way now than the previous piecemeal approach. This project is the glue."*

> *"One way I know the project is working is that I'm not being asked to do as many things outside of my job description. Patients tell me about all sorts of services that they are now linked up to. It's quite remarkable to hear all these things after many years in the field working with this population."*

> *"This is probably one of the most innovative and successful projects I've ever dealt with. The fact that it involves working with a challenging population makes it all the more amazing."*

Key Success Factors. A variety of factors were seen to the high level of success accorded to the project. These included:

- Early involvement in project planning leading to high levels of "buy-in". Several organizations noted that the project and partnership planning process was significant to success. It helped identify overlapping service and service gaps. It also helped foster better communication and therefore better service delivery for those most in need.

  > *"We now have way better communication. We know what's going on and work better together as a result. We can just phone the pilot and it's dealt with. Previously we would not know where to turn to serve complex people and their needs."*

  Others noted the value in planning included an increase in trust.

  > *"Much as clients take time to build trust with service providers, so do partnerships take time to build trust, too."*

  Many partner organizations noted the spirit of authentic collegiality that is a hallmark of this project.

  > *"What a difference it makes when you have a partnership that acts as a net and is interwoven as opposed to rivalry and competition."*

  Partner organizations noted that part of the success of the project related to initial buy in from partners as well as the ongoing development of the partnership.

  > *"This project is not just about working together, but includes monthly meetings to share info and network, and to tweak, change, help and support. It also helps with a sense of equal stakeholder commitment at the table. The parity between ASOs, hospitals and housing providers has meant a flattened hierarchy which has made an important difference."*

  Some partner organizations also noted that not only has the partnership produced better work externally, but it has also increased communication and effectiveness within organizations.

"An unanticipated outcome has been the positive effect on how our own services are integrating and functioning, particularly given the economic concerns of service provision today."

- Dedicated Beds and Services. One key success factor that came from the initial planning was creating dedicated beds and services for this particular population. This has significantly reduced wait times and has improved access. This has been particularly important with a population of people who have intense immediacy needs.

  "The planning and partnership work has resulted in much faster access for people. Service access time has been reduced to days or weeks versus months or years. Historically, the longer people have to wait, the less successful the outcomes."

- Compassionate, Qualified, Persistent and Flexible Staff. Partner organizations noted that the two project staff brought a combination of extensive knowledge of the complexity of issues facing this population, knowledge of services and the referral network, capacity to respond quickly and effectively to the immediacy needs of this population, time availability to work intensively with people (inclusive of accompaniment to referral appointments) and persistence and patience when dealing with complex behaviors and crisis issues in people's lives. Some noted the compassion and humanity of the two project staff as being significant factors in building trust with participants.

  "The project staff have made the difference. They work super hard, in a timely way, follow through, keep a cool head and are strong advocates."

  This has been also noted in a wwillingness to work with people no matter how difficult they are to work with.

  "Persistence in dealing with difficult behaviour and things like missed appointments has resulted in a huge benefit"

- Housing is Fundamental. A number of partner organizations noted positive impacts for people and their substance use. This was particularly connected to housing.

  "A safe home and support in a safe home has resulted in a reduction in drug use."

  While it was noted that some participants had stopped their substance use, other partners noted significant reductions in substance use related to being housed.

  "His behaviour continues to be erratic, but there is a change in how it is erratic. He has become less socially difficult. His previous drug use had been angry and violent. Now he is housed and happy for it, so his use has shifted. His use pattern and drug of choice has changed. He is now more euphoric, more loving and happy about being housed."

- Partner Organization Commitment and Flexibility. The dedication of all partners to making the pilot work and the commitment they all made to serving project clients in a flexible manner was seen as critical to the project success. It was noted that all participating organizations and staff "went beyond the call of duty" to serve the clients and overcome systemic barriers to support the achievement of greatest client benefits. Additionally, their commitment to advise on the project's development by attending regular partnership meetings was seen as invaluable.

7. Conclusions and Recommendations

This section provides the conclusions and recommendations drawn from the evaluation, grouped into three key headings:

- Service levels, deliverables and outcomes
- Key success factors
- Future needs and directions.

Service Levels, Deliverables and Outcomes

1. The pilot project has not only met but exceeded its targets in relation to service levels and the deliverables to which commitments were made in the funding proposal.
2. The project has contributed to significant and unique benefits for individuals who have used its service, for individual service provider organizations. Without the services, many people who are now housed and stabilized would not have been. Nor would they have been connected or reconnected with health and support services.
3. Inter-organizational coordination, communication and understandings that partner organizations attribute to the project would not have occurred in its absence. There are concerns that while relationships have been established that will benefit clients in the future, these benefits will be difficult to sustain in the absence of the pilot service.
4. The project has resulted in substantial savings, particularly with respect to the use of costly hospital resources. In addition, it is considered to have increased efficiency as providers have a clearer sense of the services of others; service duplication is said to have been reduced and more appropriate referrals being made.
5. Participation of PHAs in the pilot. The pilot has had substantial involvement of PHAs. However as some suggested, it could benefit from even greater communication with the PHA advisory committee, involvement of PHAs as peer workers and enhanced integration between the Advisory and the partnership committee.

Key Success Factors

6. Many factors are considered to be critical to the project's success. These included:
    - Early involvement of all partner organizations in the planning of the pilot
    - Knowledgeable, compassionate, flexible and persistent staff. Being treated with patience, compassion and respect by project staff was essential in building a trusting partnership with clients
    - Housing as a core. Housing provides a stable base from which to realize other positive outcomes. Safe housing together with income supports are crucial to success, health and opportunities to build hope and consider a future
    - The capacity of project staff to respond rapidly to immediacy needs

- Practical supports like appointment reminders and accompaniment to appointments
- Dedicated community beds and psychiatric services
- The range of services offered that was essential to stabilizing lives and health
- Clarity of project staff about what they could and could not do and what the services of the pilot included and did not include
- The commitment and flexibility of all partner organizations to find ways to address the service needs of project clients and to overcome barriers, sometimes systemic, to addressing these needs. In addition, their commitment to guiding the project development through participation in ongoing meetings was essential.

Future Needs and Directions

7. There is a greater service need than current project resources can accommodate. The project requires ongoing funding and increased staffing resources to meet community need. The level that project staff have been working is not sustainable in the longer term. At a minimum there is a need for two case managers to address service needs and provide back filling for vacation and illness.

8. The project could benefit from involvement of a wider range of service organizations of relevance to the needs of the population served. These would include services that address the broad determinants of health, including addictions services, youth services and other shelter services. There continue to be important housing gaps. The project might also reach out to include the City of Toronto and other housing organizations such as Streets to Homes.

9. Program participants indicated a need for 24/7 service access, social gatherings for PHAs, more peer workers. Needs were also identified for long term case managers.

10. Given its many benefits and its unique partnership, the pilot project could be considered a model that might offer a blueprint for serving other vulnerable populations with complex needs. Continuation of activities to communicate the project model and its benefits remain important.

11. During a meeting that involved representatives from the partner organizations, program clients, the PHA Advisory Committee and project staff, the following were identified as key priorities for the future of the pilot service, as service components, partners and/or advocacy initiatives:

    i. Involving a continuum of safe and sustainable housing (including private sector owners and property managers).

    ii. Increasing the human resource capacity of the services. This would include more short term case managers, a long term case manager, increased involvement of students and building peer capacity and training.

    iii. Focusing on sustainability of the service (i.e., including its ongoing funding) while retaining the values, principles, flexibility and other key defining features that have been so important to its success to-date.

    iv. Expanding, maintaining and continuing to nurture the partnership. Expanding the partnership would include other organizations that provide services such as, but not

limited to: housing, addiction management and treatment services, services for people in conflict with the law, that focus on youth, private sector landlords. In addition, continuing to nurture the partnership in order to maintain the current level of involvement and commitment of current members is critical.

v. Reducing barriers and promoting even greater access for PHAs as clients, advisors and staff.

vi. Promoting the pilot model and services to a range of audiences (e.g., funders, potential service users, other health and community services, other sectors) through a variety of communications resources and strategies. This priority is an integral component of priority iii above, sustainability.

Appendix: Lessons Learned Through The Project About Critical Success Factors and Potential Improvements

The following were identified in each of two small groups at a meeting that focused on best practice identification and that involved partnership organizations, services users, members of the PHA Advisory Committee and project staff

Group One:

Success Factors

Partnership

- The partnership preparation and building along with commitment and honouring the history and expertise that exists
- Transparency between all players
- Articulation of a clear and shared vision in the planning was helpful
- The project improved overall organizational case management abilities and improved organizational strengths
- The effectiveness of partner organizations communicating the partnership to all their front line staff and what each partner organization was providing and continuity in communication
- Modeled broader community building with partner agencies and with participants
- The vision of the project helped meet an identified sector gap
- The needs were identified as a community project as well.

Staff

- No judgments of people due to their histories or current drug use or actions
- Sincerity of the staff and their hard work and commitment
- Staff worked on top of the system rather than in the system. They are positioned to be able to
- see an overview big picture and respond effectively to serve people rather than serve system needs
- A true client centred approach
- The staff created a safe environment to talk about all my issues and they empower me to succeed
- Felt welcomed from the first contact and made changes from the start. Despite participant initial reservations, people were not slotted into categories but were treated individually and uniquely
- The quality of the staff was an essential element
- Sharing hope with people and inspiring a sense of direction and goals
- Staff were good planners, organized and problem solving in all the necessary areas
- Provided individualized care and different ways to have needs and goals met.

Service Range, Strengths And Outcomes

- The portability of the staff and capacity to provide the services wherever needed
- The capacity of staff to respond quickly to service needs of participants
- Real accessibility to a range of great services
- Strength of program infrastructure
- Commitment to quality, and how to know that changes were improvements. There were "process improvements" activities that worked
- Outcome was a noticeable quality of life improvement
- Having the pilot staff as the one point of contact made it more efficient and helpful for all

- Case management and working intensively in collaboration
- Providing consistency of health care
- Being the central point of record keeping of health information of appointments and keeping track
- Produced positive health results and quality of life AND reduced costs to the health care system
- Participant patience with the process and with their service providers as various organizations worked hard to put things in place for people.

Improving the project looking ahead

- Expand the partnership to include: more addiction providers, Involve Harbour Light in-patient addiction services, youth services, other housing providers, more aboriginal services,
- women's services (Women's Health in Women's Hands, Voices of Positive Women, The Teresa Group, Native Child and Family Services, nutritionists through Positive Care Clinic and 410 Sherbourne
- Increase PHA involvement through volunteer and paid positions
- Include more trans sex workers
- Consider youth and sex addiction issues
- Work on development of access to effective pain management for people with substance use histories and current drug users through contact with: HPCNet, Palliative Care at Mt Sinai
- Include more service provider training on these issues with police, EMS.
- Develop a more overall communication strategy about the service at THN housing working group
- Include contacts with police community mental health response team
- Include case conference with all providers once goals have been set. Then once goals in place include mental health such as Mdot, COTA, CRCT
- THN to develop community forum to include poz spaces/health places
- Integrate research
- Host a community panel
- Include LHINs and other funders
- Include CCACs,
- Carry out outreach to OHA (This is great model for one health record direction of the Ministry of Health and Long Term Care)
- Promotion and outreach using twitter, facebook… Casey House has started this already
- Consider name, branding and logo the service.

Group Two:

Success Factors

- Seamless case management that reduced workload and increased overall resources available to service clients
- Staff from all partner organizations going beyond the call of duty
- Flexibility is a key throughout (and must be consciously built in as a feature as should 'above and beyond the call of duty" which is part of flexibility)
    - Of partners (front line and management, e.g., in relation to hours of service, responding to client needs in a holistic approach, to meet needs as they arose, to respond to emerging needs)
    - Working with partners to increase flexibility increased their capacity over time and changed

    - Of the project to change practices over time based on ongoing analysis of what worked and what was not as effective
    - Ongoing expansion of the partnership

- Respect for limitations of what each organization could do
- Central capacity/hub (i.e., the coordinator and case manager) that knows what each organization does, the capacity of each and how much pilot service demand is being put on any one of the partner organizations at any one time. This latter aspect made it possible to "balance the distribution of the workload" among partners when doing new referrals.
- The non-judgemental approach. Open to intakes and have never said flat out "no" to anyone who meets the eligibility criteria, although service may not be immediate due to capacity. Furthermore, for those who do not then referrals are made.
- Strong follow-up at discharge. Organizations to whom referrals are made benefit because many of the services have been put in place, they where the client is and the supports they have. Don't have to start from scratch
- Commitment by all partners to meet on a regular and ongoing basis to guide the development of the project.
- Ground work on partnership development on both an individual and group basis, including the creation of MOUs
- The needs assessment that was conducted at the beginning and involved PHAs who had experience with homelessness
- Most appropriate services at the time and place of need (able to do this because of flexible model that was based on needs assessment, involvement of the right partners and understanding and respect for the limits of each partner). Built around client need
- PHA and PHA Advisory Involvement, including the flexible way interviews were done in the evaluation and needs assessment. Contributions of PHAs really added depth
- The staff themselves (clear about explaining roles, patient and flexible, commitment is inspiring to others, they bring case mgt backgrounds, are empathetic, professional, follow-up and follow through, creative, capacity to case manage lots of people and see the bigger picture to balance demands on the p[partners, individual situation is the focus, passion to fight for injustices, regard for clients for many who come from experiences of lack of respect)
- Flexibility of the case management staff to help each other out/spell each other off

Improvements/Looking Ahead

- Housing: One time funding for first and last month rent, housing advocacy, involvement of private sector landlords and property managers, more housing providers involved in the partnership

- Regular communication (at least) with criminal justice system (e.g., the Don) in order to contribute to continuity of services and to keep someone's service moving forward so they do not have to start over once they return to the community
- Go beyond short term intensive case management to include long term case management. 60% of clients go to long term case management
- Systemic issues in some larger partner organizations (e.g., hospitals). Need for pilot to continue to bring various departments together to promote dialogue and then change
- Funding to support GIPA, community activities, opportunities to break down isolation
- Quick access to doctors is key.
- Other partners could include organizations serving: women, youth, immigrants; HALCO, substance use services, withdrawal management, interpreters, also medication management in the community for people who are not housed.