Service Coordination Pilot Project for Homeless People Living with HIV/AIDS

BACKGROUND, OBJECTIVES, PROJECT DELIVERABLES, AND OUTCOMES

LOFT COMMUNITY SERVICES/MCEWAN HOUSING AND SUPPORT SERVICES

North American Housing and HIV/AIDS Research Summit V
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A: Project Background

The purpose and intent of the *Service Coordination Pilot Project for Homeless People Living With HIV/AIDS* is to serve homeless people including aboriginals living with HIV/AIDS (A/PHAs) in the City of Toronto who are facing both physical health and mental health crises and/or substance use issues.

Homeless A/PHAs commonly develop complex medical conditions, seek medical care from hospital emergency rooms, and have inpatient admissions, they are often discharged to the street, from where they often to repeat the cycle.

A: Project Background

In early 2007, several community partners identified the need to provide an immediate and intensive intervention with referrals they were receiving from hospitals. Modeling clients through an intensive case management process with a focus on continuity of care began in late 2007. From the early success, the original partners and members of the Housing Working Group, of the Toronto HIV/AIDS Network sought funding to formalize and expand the partnership.

The Public Health Agency of Canada's AIDS Community Action Program funded this Pilot Project from April 1, 2009 to March 31, 2010 to assess the value of a coordinated short term intensive case management system to try to interrupt the cycle of repeated hospitalizations and reconnect homeless A/PHAS with care and services in the community.

B: PROJECT OBJECTIVES

1) To increase access to and the continuity of health and community services for People Living with HIV/AIDS who are homeless.

2) To increase coordination and integration of services between HIV/AIDS based community agencies, and the health, shelter and housing services, and the mental health sector.

C: PROJECT DELIVERABLES:

Comprehensive Needs Assessment: Interviews and focus groups were conducted with a cross section service providers and homeless A/PHAs.

Formalize Partnership Agreement: A comprehensive partnership agreement was developed between 12 partner agencies defining roles and contributions, communication process, intake and referral, case management, privacy, and conflict resolution process.

Development of A/PHA Advisory Committee: A committee of six A/PHA's with lived experience with homelessness was developed who advised on the the development, delivery and evaluation of services.

C: PROJECT DELIVERABLES:

Development of Delivery Case Management Model and Tools: Develop standardized referral and consent forms, agency and client pamphlets, negotiate protocols for referral and shared case management. Deliver intensive case management services to **20** homeless A/PHAs.

Development and Implementation of Evaluation Plan: One on one survey tools and focus groups with clients and service providers, and analysis of data gathered from Client Information System.

D: Model of Service Delivery

Services included: coordinated referral/intake among formal and informal partner agencies; short term intensive case management; 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.

All twelve partner agencies provided service as usual care to the partnership while also providing commitments, resources, and dedicated ‘beds’ which were outside of their service as usual models.

E: Pilot Partners

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Casey House
Fife House
Fred Victor Centre
McEwan Housing and Support 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 St Community Centre, Trans Program
Toronto HIV/AIDS Network
Toronto People with AIDS Foundation

All partner agencies provide senior management participation in partnership development meetings.

Since the Pilot Project began additional informal partnerships have been developed with 410 Sherbourne Health Centre, St Michael's Hospital, St. Michael's Hospital Emergency Department and Sherbourne Health Centre LGBT Program and Services.

F: Outcomes

Intake From July 15, 2009 - March 31, 2010, *28 clients* received short term intensive case management services. 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. Half of all referrals came directly from hospitals, while the remainder came from partner and community agencies.

F: Outcomes

Case Management 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* reported for the 28 clients who received service. The average term of service delivery with clients was 3-4 months, and the intensity of service delivery averaged 2 to 3 meetings per week per client in the first 4 to 8 weeks. 60 % of all clients were referred to ongoing case management and supports upon discharge

F: Outcomes

Housing. Of the 28 clients, 18 were housed as part of the services they received from the Pilot Project utilizing either dedicated housing beds and housing search options throughout the partnership: 10 clients were housed in transitional and supportive housing, 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.

F: Outcomes

Utilization of Health Stabilization Beds and Reduction in Hospital Usage Four partner agencies committed to dedicated beds or fast tracked access to beds for respite or general admission in the community for health stabilization upon discharge from hospital. 16 clients utilized these beds for a total of 718 days over the 8 months of service delivery.

In the year prior to intake, there had been a total of 666 inpatient hospital days (general medicine, psych, and crisis stabilization) involving 16 clients; during the eight months of service delivery this number was reduced to 127 days involving 13 clients. There was also a reduction in average emergency room visits from 2.7 per client in the previous year to 1.6 per client over the 8 months of service delivery.

F: Outcomes

HIV Psychiatry Clinic The HIV Psychiatry Clinic St Michael's Hospital has been held 8 times (once every three weeks). 12 clients were seen for assessments and 6 clients were seen for on-going follow-up.

Recommendations for care (including medications) in the community were made for most clients and referrals for further assessment and care made. 45 % of all clients were referred for comprehensive nuero-psych testing.

Access to these assessments and referrals played a crucial role in the health stabilization of clients, resulting increased capacity to actively engage in the intensive case management process, and achieve goals the set.

G: Key Findings Evaluation Clients

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 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. As one client said:

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

G: Key Findings Evaluation Clients

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. 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. As one client said:

"These guys gave me my life back. It feels like I have a future."

H: Key Findings Evaluation Partners

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."

G: Key Findings Evaluation Clients

Another participant said:

"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."

H: Key Findings Evaluation Partners

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. As one participant said:

"***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.***"

H: Key Findings Evaluation Partners

Early involvement in project planning leading to high levels of "buy-in". 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."

Thank-you

St. Michael's
Inspired Care.
Inspiring Science.

TORONTO

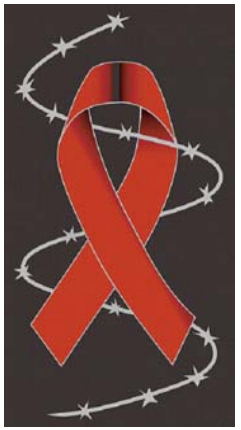
Fred Victor Centre

519 Church Street Community Centre

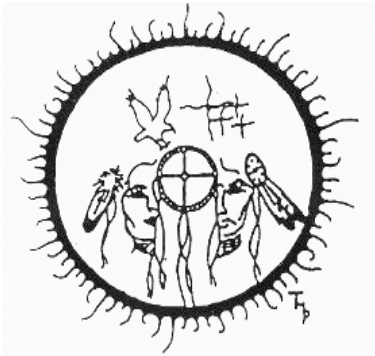
PEOPLE WITH AIDS foundation

LOFT Community Services

SHERBOURNE Health Centre



FIFE HOUSE



CASEY HOUSE