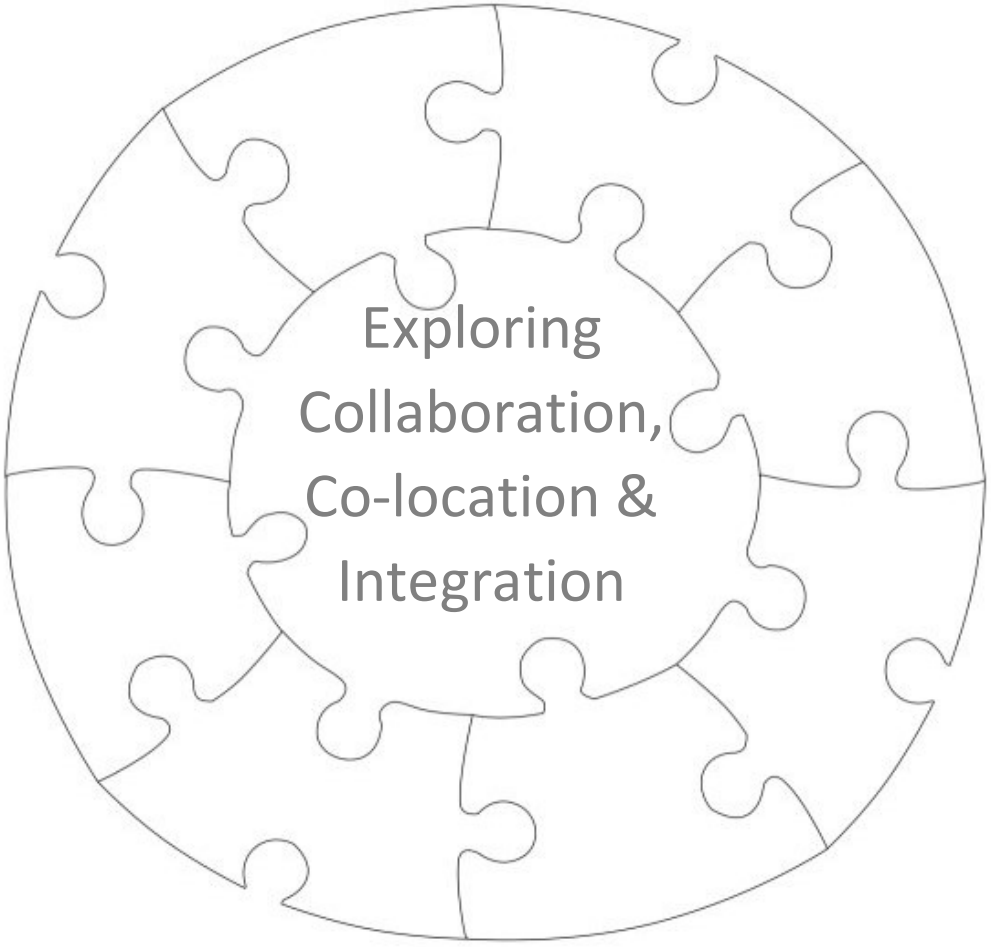
TORONTO HIV/AIDS NETWORK

# Toronto HIV Sector Service Delivery:




February 2020

# Contents




**Suggested Citation:** Toronto HIV/AIDS Network. Toronto HIV Sector Service Delivery: Exploring Collaboration, Co-location and Integration. Toronto ON, February 2020.

*This concept paper was developed with the support of The Ontario HIV Treatment Network*

## *Executive Summary*

The Toronto HIV/AIDS Network (THN) brings together service providers from across the city including community-based agencies and care providers based at Toronto hospitals and community care access centres. The mission – improve access to programs and services for people living with/affected by HIV/AIDS.

People living with and affected by HIV/AIDS in Toronto are facing growing challenges and more complex health needs, and the costs of life in the city is challenging their well-being. While the advent of biomedical prevention options is welcome, access continues to be an issue and clients require more knowledge and more support than ever before to use pre-exposure prophylaxis (PrEP) effectively.

THN members are committed to creating more inter-agency collaboration to better meet the needs of service users. As a central participant in Toronto to Zero, THN is part of the priority setting underway to create new service models and to improve service networks, but it is also engaged in working with members to explore better integration of existing community-based agencies. Co-location is a proposed step towards enhanced integration.

**Service integration and co-location means housing multiple community-based HIV agencies together** (and potentially other partners that serve our priority populations). It may mean sharing administrative resources such as finance or human resources. It may mean offering constellations of HIV services together that best serve clients, and designing spaces around their needs for confidentiality and rapid service access. It could include common intake and reception areas and ultimately it may include integration of programs offered by more than one of the space's partner agencies.

The interest in service integration and co-location is being driven by several factors, including the desire to:

- Simplify service access for clients, and create opportunities to develop new, or at least better integrated, service resources
- Make HIV service agencies part of the policy trend, most recently expressed in the Ontario Health Teams, to create more integrated health services
- Reduce operating costs, particularly for smaller agencies, sharing soaring rental costs and other operational and administrative expenses
- Provide more staff support for HIV service workers through formal and informal networks
- Sustain dedicated community-specific, culturally sensitive supports for vulnerable clients as smaller agencies in Toronto face the increasing pressures of high rents and high-need clients

THN has created a *Toronto HIV Sector Service Delivery & Co-location Models Working Group* engaging partner agencies with an interest in being part of a co-located site with some level of service integration. It has surveyed its members about interest in such an initiative. It has contracted with *StrategiSense Consulting* to develop and lead a stakeholder engagement framework, conduct key discussion meetings and ultimately, present options, requirements and recommendations for moving forward. It is anticipated that the first phase of this work will be completed by the spring of 2020.

The process of co-location will maintain the governance of agencies over the programs they have developed, unless those agencies make decisions to consolidate their work with others. Any programming collaborations will take a step-wise approach, building trust amongst the partners. However, it is an explicit goal of this initiative to create a unified platform(s) to streamline HIV service access for clients and protect their well-being. To be effective in this goal, the conversation must be about more than rental space – and must be driven by the needs of our clients.

## *Background*

Throughout the 30 plus years of the HIV epidemic in Toronto, people living with and affected by HIV have come together to protect each other. Each of Toronto's community-based HIV service organizations was built with the vision and input of specific communities facing the catastrophic effects of HIV/AIDS on their families, friends and their own health.

The Toronto HIV/AIDS Network brings these agencies together to *facilitate HIV/AIDS planning, collaboration, engagement and innovation to improve access to programs and services for people from diverse communities living with and most affected by HIV/AIDS*.[1] THN currently has 44 members including 24 community-based agencies with HIV programming and a range of other health and social service agencies with a strong community-oriented focus (see Appendix 1). THN active membership fluctuates slightly for a variety of reasons and does not necessarily include every agency or program involved in the HIV response in Toronto.

HIV community-based organizations in Toronto are each committed to the greater involvement and meaningful engagement of people living with HIV in the services they provide and to integrating the perspectives and addressing the needs of the specific communities they serve. Community-based member organizations take a social justice and anti-oppression approach in striving to recognize, and where possible, mitigate the structural inequities that clients face on a daily basis. In working together, THN members also strive to recognize and, where possible, mitigate the ways that these inequities create power imbalances among the members.

The ability to understand and direct prevention and support services to specific communities from within, is a tremendous strength of HIV services in Toronto, especially given the remarkable diversity of Toronto's population.[2] Government funders have recognized these strengths: all 23 of the 24 THN-member community-based service providers have at least partial funding from the HIV and Hepatitis C Program of the Ontario Ministry of Health and Long-term Care to provide HIV prevention education to at-risk communities (including harm reduction services) and/or support services to those living with and affected by HIV.[3]

Research has demonstrated that community-based HIV agencies across the province save Ontario taxpayers $5 for every prevention dollar invested.[4] Ontario research has also shown that community-based HIV organizations are uniquely effective in reaching the most vulnerable among our populations.[5]

Toronto has lower rates of new HIV diagnoses than other major cities, with 16.9 new infections per 100,000 population in 2017, compared to New York (29.2 in 2016) and San Francisco (40 in 2015).[6] However more than one person is still newly diagnosed with HIV each day in our city and over half of all new Ontario HIV infections are diagnosed in Toronto.[7] New diagnoses are not declining, despite new prevention options. Most new infections clearly occur in our city, but the high rates of migration to Toronto also mean that some infections happen outside our borders.[8]

THN members recognize that the fundamental purpose of any collaboration, co-location or integration effort must be to improve access and outcomes for HIV service clients and to enable their health and well-being.

## *The Evolving Needs of HIV Service Clients*

Data[3] gathered through OCHART (the Ontario Community HIV/AIDS Reporting Tool used by ministry funded agencies) is discussed below. The data reveals that the complexity of client needs addressed by HIV service agencies is growing and that the intensity of interactions with clients is increasing rapidly.

**Prevention and Education**

The 20 organizations funded in the city for prevention activities reach over 11,000 clients each year with presentations and workshops about HIV prevention and transmission. They make approximately 30,000 annual outreach contacts. However, the number of participants engaging in each prevention/education event is

declining slowly, while the demand for more structured interventions to foster improved prevention strategies has increased markedly with nearly 2,700 participants in 2018, a 32% increase over the previous year. These more intensive services are likely being used due to the growing array of current prevention options including oral pre-exposure prophylaxis (PrEP) medications and the dapivirine vaginal ring (likely to be approved this year in Canada).[9] These prevention strategies require access, knowledge and support to be used in effective and sustainable ways, as well as health promotion efforts and support to secure coverage. Structured prevention interventions around mental health and addictions are also a growing focus.

There has been a dramatic increase in harm reduction activities, as the opioid crisis has hit Toronto. Client interactions by Toronto harm reduction teams increased 92% (46,046 interactions in 2016 to 88,509 in 2018). With two newly funded programs joining seven originally funded programs, service sessions have more than tripled from 53,847 to 163,430 in 2018. The impact of opioid overdose and death on several of the key populations served by HIV service organizations continues to grow and cannot be understated.

**Support Clients**

Twenty-two agencies receive Ministry funding to provide supports for clients living with HIV, as well as those affected (largely family members) and those at-risk. HIV specific agencies saw 5,094 clients in 2018, while non-HIV specific agencies used HIV-specific funding to provide services to another 2,056 clients (note that these numbers do not reflect unique individuals as they are drawn from OCHART and so reflects some duplication where a client may access more than one agency) . This was a 7% increase from 2016. Although the median age of those living with HIV has been steadily increasing in Ontario, Toronto service agencies have seen the greatest client growth in the 26-35 age range. These increases are relatively modest (~3%) and may reflect the youth bias of newcomer populations. None-the-less, over 45% of clients living with HIV are over age 45, facing new challenges around aging with HIV.

Two thirds of clients are male. Over the past three years, the total number of male clients living with HIV has remained stable, while the number of female clients and those with other gender expressions has risen modestly. There is also an increase (2.4%) in the number of at-risk men served, likely due to PrEP-related medication supports. The ethnicity data (shown at right) has been relatively stable, with a small increase in Latin American clients.

*Ethnicity of clients (%) seeking HIV support services in Toronto, 2018*

| **Ethnicity** | **Men** | **Women** |
|---|---|---|
| Black | 17 | 75 |
| Latin American | 25 | 6 |
| White | 39 | 9 |
| Indigenous | 2 | 1 |
| Other | 17 | 9 |

Issues related to living with HIV (such as medication access, symptom/adherence management, disclosure, and stigma/discrimination) were the needs most reported by all HIV services clients in Toronto; these needs increased 7% in the past two years. After HIV related support, men are most likely to require assistance seeking health care and mental/emotional/physical health support (46%) while women most often report issues related to immigration, settlement and legal issues (42%) and this form of support is increasingly sought by men. Both men and women often report needs around income and benefits (over 40%) and over a third are now reporting housing challenges.

While the number of housing spaces for people living with HIV has increased in Toronto over the past two years, (Fife House alone now houses more than 300 clients[10]) the escalating cost of rent is having an impact, and many more clients are seeking help. The capacity of Toronto agencies to provide practical supports (i.e. food, financial aid) has largely not changed over the past two years, despite increasing client needs (such as an 8% increase in the proportion of clients seeking food bank access.)

Referrals to other community-based service providers (e.g. food banks, housing, legal aid, settlement services and employment supports) are by far the most common form of referral from HIV service organizations, increasing from 67% of all referrals in 2016 to 80% in 2018. HIV service organizations are also increasingly referring clients for HIV primary care and mental health services.

While HIV service agencies have been able to increase capacity in some areas such as counselling around managing HIV, the biggest change has been a dramatic increase in the delivery of case management services, as HIV service organizations increasingly became a gateway to other agencies. Delivery of case management has increased 250% over the past two years totaling 12,654 sessions in 2018. Clients who are able to be housed by HIV service providers are also using higher levels of in-home services with a 31% increase in the *support within housing* category in the past two years. With the aging of people living with HIV, the need for such services is likely to increase.

**Summary: Client Needs**
Although the rate of new client intake by HIV service agencies is not increasing, all reporting points to a client base with increasingly complex needs. Prevention contacts require more structured and intensive education, while clients living with and directly affected by HIV need more complex support services and more support around practical/financial burdens. Increasingly, these clients receive services through a complicated web of referral spread over time and over multiple locations. Community based HIV agencies spend a growing amount of staff time and resources helping people to navigate between services and ensuring that vulnerable people are not lost in these transitions.

The urgency of these challenges is evident to THN members. The *desire to see more inter-agency collaboration to better meet the needs of service users* was a dominant theme of THN's most recent strategic plan.[11] While some of these issues are structural and largely beyond the control of community-based agencies, changes in how and where organizations work together could simplify service access for clients and reduce challenges for staff. Housing multiple agencies together (co-location) could be part of the solution.

## *Drivers of Collaboration and Co-location*

What are the factors in our current service environment that are leading THN members to think about greater collaboration and co-location? What might be the benefits be?

**Simplifying Service Access**
When HIV service organizations consider service integration, they must also consider service gaps. Where do people get lost? Why do they stop seeing HIV care providers? What barriers make it difficult or impossible for them to live healthy lives or provide secure homes for themselves and their loved ones?

Considering all of these elements requires extensive visioning and planning, a process that is now underway in Toronto through Toronto to Zero. The **Toronto to Zero** action plan, will set priorities for action. THN members are central to creating and implementing this plan.

One of our partners is also currently engaged in thinking about how clients move through the complicated web of referrals that they now rely on. This is at the heart of the PWA PHA Hub project, described at right. PWA welcomes partner participation and engagement in this work.

**PHA hub** - Toronto People With AIDS Foundation (PWA)
The PHA Hub is a key element of Toronto PWA's strategic plan, which aims to enhance the role of the organization's staff as resource experts for PHAs' complex needs and to use peer navigators to support people as they move along the care pathways to access services. PWA is embarking on a plan to map these care pathways: first through their own services and then to outside resources. Ultimately, they hope to build partnerships with other HIV and non-HIV specific providers and to make specialized agreements to speed PHA access.

The PHA hub does not necessarily require physical co-location of care pathway agencies, just increased collaboration between the partners. However, the PHA hub is envisioned as a physical space – a community centre connecting people living with HIV/AIDS to services, community and practical support. It will also be a place for PHAs to connect with each other through drop-in programs and PHA-led programming.

**Timeline:** The mapping process has begun. PWA already uses peer navigators in some roles, but the hub is planned to rollout over the next three years.

We know that 12 percent of all ASO referrals are to other HIV-specific service providers, and that many clients are shared.[3] A woman attending a culturally/linguistically-appropriate support group at APAA may also be securing formula to feed her infant from the Teresa Group. Clients living with HIV using multiple agencies may be accessing food banks all over the city. Would life be easier or better for them if the PWA food bank was located where they access HIV services? Would it be easier for them, if some of the services they used, were multiple elements of the same program? Considering these questions of client access is, and must always be, the deciding factor in any moves made towards collaboration and co-location.

**Promoting Service Innovation**

Co-location of services is also an opportunity to think about innovation. Would some of our clients be better served if the services that they use were linked together or if they were presented to them from a single access point? This is the idea behind the gay men's health hub, described at right, which aims to offer status-neutral services to men who have sex with men. The gay men's health hub involves multiple community-based agencies that are THN members. (Staff from partner agencies will deliver service on a rotating basis but not permanently relocate to the hub.)

**Gay men's health hub** Partners: Hassle Free, PrEP Clinic, ACT, ASAAP, ACAS, BCAP, 2-Spirited People of the First Nations, Casey House, St. Michael's Family Health Team

The hub will be a new model of comprehensive, holistic and non-judgemental care for men who have sex with men (MSM). The hub will offer culturally competent, walk-in services for rapid HIV, STI and HCV testing; PrEP and PEP prescribing/monitoring, as well as HIV prevention counselling. It will also offer comprehensive mental health assessments, mental health and addictions counselling and group programs. It will use health navigators to make warm hand-offs that link clients to primary care services for HIV and other health concerns and to mental health and addiction services. The vision includes social programming to build community and reduce social isolation.

**Timeline:** Space has been secured for the hub. Service delivery partners are in place. It will launch in late 2020.

All 11 of the respondents to the recent THN survey who were interested (or might be interested) in co-location, also stated they were interested in (or might be interested in) developing new models of HIV service delivery. Co-location could be an opportunity to reflect on and streamline client services, locating services together used by the same clients, and consolidating duplicate services to create joint programs that are stronger than the component parts. Planning for a shared reception or intake services could create a single access point for clients, even if the partners elect not to change the governance of the subsequent used services. Consolidating our approach to services might provide all clients with more, while costing less to deliver and might create opportunities to expand the services organizations can provide.

Community-based HIV service agencies have a history of working together to create needed resources. For example, the ETSN: Peer Treatment Counselor Training Program was created as a collaborative project amongst ACAS, APAA, ASAAP, BCAP, CATIE and CSSP. It became a program of CAAT in 2010.[12] Similarly, the THN Volunteer HIV Core Training[13] offers baseline training for agency volunteers thus reducing the cost of volunteer training for all participating agencies, and allows in-house volunteer training to focus on the specific tasks and mandates of individual organizations. These collaborative training resources help organizations create better service providers with a standardized knowledge base. While these past initiatives have focused on organizational needs, this co-location initiative is an opportunity to think about collaborative programs, that participating agencies might create for clients. What are the possibilities to strengthen existing programs, better target client needs, and use scarce resources more wisely?

**Government Policy**

Better integration of health and social care has been a policy initiative of successive governments in Ontario (regardless of party affiliation). In fact, integration in the health and social sector has been advocated for by governments and policy leaders from many countries with a similar socio-economic status to Canada (e.g. Accountable Care Organizations in the US, Integrated Health and Social Delivery Systems in the UK, and Integrated Health Organizations in Spain).

In Ontario, the trend toward consolidation and greater integration of services has included many parts of the public services sectors over the last 30 years:

- Hospital restructuring in the 1990s to reduce the number of individual hospital corporations across Ontario.
- Establishment of hospital shared services in the 1990s to deliver better value for money in such things as linen services, back-office services (HR, Finance, IT) and contract management.
- The development of Community Care Access Centres to provide and coordinate medical services and personal supports as well as access to long-term care.
- The creating a single coordination agency for children's health through the Liberal government's Special Needs Strategy[14] in 2015 along with coordinated service planning for children and youth with multiple and/or complex special needs and integrated access to speech-language therapy, occupational therapy and physiotherapy services.
- The development of Ontario Health Teams[15] in 2019 to create a better connected health system (one integrated team) and improve patient experience and system navigation.

Some of the above initiatives are sector specific and some broad in nature, but they all demonstrate the desire of governments to create better linkages across and within health and social services. This policy agenda has been driving many health and social care organizations to examine partnerships that create greater efficiencies in providing services, and that create integrated services. Partnerships may be horizontal (within their sector) or vertical (linking places where their clients come from or go to after an interaction) or both. All are intended to create better value for clients, staff or the organization as a whole.

**Containing Operating Costs, Particularly Rent**

Housing is a challenge for HIV service clients, but it is also a growing challenge for community-based HIV organizations. Rents have risen quickly in the past several years. Toronto Real Estate Board (TREB) data[16] for the third quarter of 2019 suggests space costs of $22.42-22.58 per square foot depending on the size of space leased in Toronto Central. However, disclosure of these rates is voluntary. Other sources of data[17] suggest an average rate of $33.40 downtown and $28.13 midtown. A recent survey of 11 THN members with interest in co-location revealed that three members already pay more than $33.40. Six of these organizations will need to end or renegotiate their leases before March 31, 2021.

Combining organizational buying power may help manage rental costs, although the space needs will be extensive and difficult to secure. Likely space requirements would be in excess of 25,000 square feet, if all currently interested services co-located together. Co-location would help smaller organizations secure meeting space that they could not otherwise afford, and may give them access to administrative resources through larger partners.

The majority of potential partners in a co-located facility, who responded to the recent THN survey (11 organizations), were also interested in sharing broader administrative services including

**Existing Co-location Partnerships**

A number of smaller scale co-locations already exist in our sector, which facilitate access to administrative resources for smaller agencies. Examples include the location of Action Positive VIH/SIDA at ACT, and Latino Positivos and THN at Toronto PWA. These trustee partnerships provide space, financial services, IT and reception services to the smaller partner, at a lower cost that would otherwise be possible letting these organizations focus time and resources on their service mandates.

accounting, IT, payroll, human resources and support systems for fundraising activities. Consolidating these services for multiple organizations would have upfront costs, but would produce cost efficiencies over the long term. (The Canadian non-profit resource agency, Charity Village has published a review[18] comparing different forms of non-profit administrative partnership, which may be helpful in these discussions.)

**Staff Pressures and Support**

Conversations among THN members and at the OAN have highlighted the growing stress on HIV service staff. The high turnover of staff in frontline agencies and strategies to better support resiliency are frequent topics of discussion in both networks. Anecdotal evidence suggests that the growing pressure on client's well-being in the increasingly expensive Toronto environment is only increasing these pressures. A 2013 environmental scan of HIV support workers across Ontario described a challenging reality for many support workers. *Support workers often felt frustrated and overwhelmed by the increasing demand for services, the continuing stigma, and the difficulty accessing allied services and supports in their communities such as housing and social assistance. Support workers said they struggle to meet complex client needs within available time and resources, and they feel ill equipped to respond to some particularly challenging problems, such as complex immigration issues, mental health needs and providing services for people within the prison system.[19]* While HIV service workers in Toronto have more allied services available to them, they also often have more clients.

On average, THN-member community-based agencies have an average of 4.9 staff funded to deliver HIV programs (as reported in OCHART.[3]) Over a third of these agencies have the equivalent of two HIV program staff or less. Placing the staff of multiple agencies together has the potential to help reduce staff isolation and burnout. Organizations with similar services may be able to provide backup in times of stress. Organizations will have more opportunity to share information about effective referrals and resources for clients. Just as important is the building of support relationships among employees of different agencies – a benefit observed[20] by co-location research. Organizations were also able to combine professional development opportunities for managers[20] and other pools of specialized workers.

In our sector, research[21] has shown that workers who themselves are living with HIV often feel isolated, and experience emotional triggers from client's narratives, as well as feelings of burnout from over-immersion in HIV at both personal and professional levels. Formal and informal peer support networks amongst service providers living with HIV has been reported as a successful strategy to address both personal and professional challenges.[21] Proximity would increase the potential formation of such networks. It may also increase opportunities for mentorship in a variety of roles, including supportive mentorships for workers living with HIV,[19] another proposed supportive strategy.

**Sustaining Dedicated Culturally-sensitive Supports for Vulnerable Clients**

THN member agencies are uniquely linked to their communities. Research shows that community-based agencies are trusted providers of culturally sensitive care.[22] Research also shows that community-based HIV programs are markedly more effective than most forms of community-based health promotion.[23]

Throughout the years, community based HIV organization in Toronto have adapted to the changing needs of the populations they serve, modifying programs to address specific needs within communities.[19] Today, as part Toronto to Zero, these organizations have begun to imagine a Toronto where the impact of HIV on our communities is reduced, surpassing the 90-90-90 goals (90% of all people living with HIV diagnosed; 90% of those are on treatment; and 90% of those virally suppressed) . THN members are part of work to achieve this outcome, but many organizations also worry about the most vulnerable 10-10-10 who will remain. As the overall impact of HIV is reduced, pressure will increase to fold HIV services into sexual health care and into broader social service agencies. The most vulnerable clients living with HIV will be faced with less dedicated support then ever before.

Creating a critical mass of agencies, who demonstrate their ability to share scarce resources and work together to create more streamlined services for those most in need, will help build a stronger case for the continued existence of dedicated HIV services. When, the need for HIV-specific services decreases, the co-located agencies will have established a collective resource, where needed services can be consolidated, as well as a unified voice for helping to shape the next generation of services.

## *The Vision*

Responding to these drivers, and prioritizing the needs of clients, THN member agencies wish to explore models of collaboration and integration that would enhance service access for our clients, reduce our operating costs, and provide more support for our staff. A step towards further integration could be co-location of one or more groups of HIV service organizations. Accordingly, the *Toronto HIV Sector Service Delivery & Co-location Models Working Group* was formed with co-chairs Janet Rowe (PASAN), and Suzanne Paddock (Toronto PWA Foundation).

Co-located organizations would share a rental space, but would maintain distinct identities and governance of their program activities. It may make sense to establish newly co-fflocated services in thematic groupings, which may be located in more than one space. This approach might also make it easier to find appropriate spaces. Strategically situating complementary services together would provide opportunities for these agencies to examine their services, potentially strengthening and expanding some services while reducing duplication. A common reception area could reduce costs for the partner agencies, but it might also be used to create more streamlined service access for clients.

The working group has already begun discussion of the common values that might guide any integration of services, including co-location. At a co-located site, commitments to clients at the site would need to be spelled out and agreed to in terms of equity, social justice, anti-racist practice, reconciliation and sex positivity.

**The Structure of a Co-located Site**

Co-location arrangements are typically structured through a series of agreements between the partners. Three possible models for multi-partner co-location are cited by the US-based Nonprofit Centers Network:[24]

- Independent Providers - An independent non-profit organization provides services to other independent organizations via service agreements or contracts.
- Joint Venture – Multiple, but not necessarily all, of the participating organizations share governance of the co-location site, with appropriate collective structures created to oversee the facility.
- Fiscal Sponsorship - One organization acts as a legal and fiscal umbrella for other, often smaller entities.

Whatever structure is decided, a series of agreements would need to be in place describing the ways that leasing and other costs are shared, how the physical space is governed and tenants approved, and how site security is arranged (see the Edmonton Non-profit Shared Space Feasibility Toolkit for a useful list of agreements).[25] There would need to be processes for scheduling the use of common facilities. Participating organizations would need to have agreed on how the space is branded, how the confidentiality of clients is protected.

To co-locate HIV service organizations, a broad array of programmatic challenges will need to be discussed and addressed. Examples include hours of service, client banning practices or the facilitation of low barrier access to harm reduction supplies. Some organizations also have unique physical needs around particular services such as food bank operations. Consideration of these options along with power imbalances between agencies will be part of the development of recommendations.

At this point in the process, the THN working group wishes to leave potential participation in any service integration and co-located space open to consideration by all THN community-based partners. Other organizations associated with HIV services and our priority populations will be considered as service integration and co-location participants.

THN has contracted with *Strategisense Consulting* to develop and lead a stakeholder engagement framework, conduct key discussion meetings and ultimately, present options, requirements and recommendations for moving forward. It is anticipated that this work will be completed by the fall of 2020.

**Evidence for Shared Service Sites**

There is no significant body of literature on the co-location of HIV support services. Some research has been done looking at the co-location of clinical and support services, and a 2019 systematic review[26] analyzed 36 co-location initiatives of this type, in terms of HIV care outcomes. Positive associations were seen with regard to linkage to care and antiretroviral uptake, with more mixed outcomes around retention in care and viral suppression. However, at this point in the THN co-location initiative, no clinical partners are foreseen.

A body of literature exists on the co-location of general non-profit services, including non-academic publications[27] by coalitions of agencies exploring and/or evaluating co-location. This literature was reviewed with a focus on co-locating agencies providing human and social services to diverse low-income populations.

Three large evaluations were reviewed in detail: one of government service agency co-locating in British Columbia,[28] a second of social and settlement service agencies co-locating in Indianapolis (USA),[20] and a third of multi-dimension service agencies (family services, housing, sexual assault services, support for aging populations) co-locating in Queensland, Australia.[29] A number of **factors contributing to the successful development of co-location initiatives** were identified in all three evaluations:

- Identify and co-locate partners that provide complementary services and serve overlapping populations.
- Have a common vision and guiding principles for the initiative – undertake visioning meetings. Carefully manage the scale and scope of the initiative.
- Have leaders committed to the vision, who will work to reconcile inevitable differences between partner interests and strategic directions. (One study suggested that a lead coordinating individual or organization is critical to success.[20])
- Recognize that creating a great co-located space will take large amount of time and energy, place a significant burden on those engaged in the initiative, and require effort to maintain momentum. (The Australia evaluation documented that establishing the three co-location spaces involved in that study took longer than initially envisioned. [29])

Not surprisingly, the largest barriers to success were conflict between the parties, lack of financial resources and leadership as well as the absence of an appropriate building for co-locating.

A group of community service agencies in Sudbury conducted an Equity-Focused Health Impact Assessment,[30] looking for advice from the literature about how to co-locate in a way that would minimize stigma for service users and maximize their impact in the low-income communities they served. Their report emphasized:

- The need for a common guiding framework and goals for all participating agencies, with multiple recommendations about establishing common standards and procedures to respect the emotional, cultural, and physical safety needs of diverse service users and to shape a physical space that creates safe environments for all.
- Establishing a shared intake and reception to protect confidentiality and anonymity, as well as shared processes for user feedback. Multiple studies show that maintaining privacy is critical to ensure that HIV services are accessible to all.[31,32]
- The establishment of clear processes and supports for interagency human resource collaboration including the development of shared positions between participating agencies and internal postings for all employees at the centre.

The Indianapolis study[20] interviewed 30 individuals involved in the delivery of social and settlement services at different co-located sites. Over 75% of these sites had been established for 10 years or more. This unique group of informants provided data about what they felt did and did not happen at established co-located sites.

| Perception of Co-location Benefits from Established Sites (Indianapolis Key Informant Interviews[20]) | |
|---|---|
| Majority Agree | – cost-effective<br>– allows sharing of resources and ideas<br>– increases clients served<br>– improves client outcomes |
| Approximately 50% Agree | – reduces service duplication<br>– leads to effective communication between organizations |
| Disagree | – increase the number of services that each family/individual accesses<br>– reduces competition between organizations |

These reflections on the long-term outcomes of co-location demonstrate the benefits, but they also reveal that collaboration and integration is not inevitable. If partners at a shared site wish to collaborate in ways that create a seamless resource for clients, this will need to be an intentional part of the planning process.

**A Shared Space as a Platform for Shared Services**

The THN working group hopes to approach any co-location as an opportunity to explore synergies that would ultimately create better support and resources for our clients. This will likely include clearer, potentially expedited referral pathways between co-located organizations and may evolve towards shared programming. The Edmonton Non-profit Shared Space Feasibility Toolkit[25] includes discussion of co-location and governance models, but it also notes that *non-profits who undertake shared space discussions soon find their discussions expanding well beyond the sharing of physical space.* This toolkit offers some important considerations:

- Organizations have cultures. When considering shared services the fit between these cultures is as important as the fit between services.
- Sharing physical assets (meeting space, a photocopier) is relatively straightforward; sharing people will take more planning and effort.
- Clear partnership agreements and well-defined reporting structures are key to any shared services; put partnership agreements in place as soon as possible (this can be a good way to focus negotiations.)
- Start small with projects that can be more easily agreed to; build collaboration and trust over time.
- Be realistic and mindful about where you invest your time and energy. What will create benefit for clients and for partner organizations?

## *Conclusions*

Community based HIV service organizations are a vital resource that allow the HIV sector to direct prevention and support services to specific communities from within. Their client populations have complex needs, which are currently served through a complicated web of referrals. Service integration and co-location of organizations serving these clients has the potential to:

- Simplify service access
- Promote service innovation
- Contain organizational operating costs
- Increase support and resiliency for staff
- Sustain dedicated culturally-sensitive support for vulnerable clients

A co-located grouping of one or more HIV service organization in Toronto could be a platform for more integrated and effective services for people living with and affected by HIV and those at risk of infection.

## References


[1] Toronto HIV/AIDS Network. Mission Statement. At http://www.torontohivaidsnetwork.org/about-us/

[2] CBC. Census 2016: More than half of Torontonians identify as visible minorities. Oct 26, 2017. https://www.cbc.ca/news/canada/toronto/census-visible-minorities-1.4371018

[3] OHTN. The Ontario Community HIV/AIDS Reporting Tool (OCHART). Unpublished data extracted December 2019.

[4] Choi SK, Holtgrave DR, Bacon J, et al. Economic Evaluation of Community-Based HIV Prevention Programs in Ontario: Evidence of Effectiveness in Reducing HIV Infections and Health Care Costs. AIDS Behav. 2016 Jun;20(6):1143-56.

[5] Williams P, Narciso L, Browne G, Roberts J, Weir R, Gafni A. Characteristics of People Living With HIV Who Use Community-Based Services in Ontario, Canada: Implications for Service Providers. JANAC: Journal of the Association of Nurses in AIDS Care 2005;16(4):50- 63.

[6] Toronto to Zero. A Call to Action to End HIV in Our City, May 2019. At https://torontotozero.ca/resources/

[7] Ontario HIV Epidemiology and Surveillance Initiative (OHESI). New HIV diagnoses in Ontario, 2017.Toronto, Ontario, July 30,2019. At: http://www.ohesi.ca/wp-content/uploads/2019/07/OHESI-2017-new-diagnoses.pdf

[8] OHESI. HIV Diagnoses in Ontario: Refinements to Surveillance Data in the 2018 reports. December 16, 2019. At: http://www.ohesi.ca/hiv-diagnoses-in-ontario-refinements-to-surveillance-data-in-the-2018-reports/

[9] Ontario HIV Professional Specialty Group. Eleventh Annual HIV Pharmacy Education Day Report, December 12, 2019.

[10] Fife House. Annual Report 2018-19. At: https://www.fifehouse.org/wp-content/uploads/AR-web-final.pdf

[11] Toronto HIV/AIDS Network. Strategic Plan, April 1st 2016 to March 31st 2020. At www.torontohivaidsnetwork.org/wp-content/uploads/2018/09/THN-Strategic-Plan-2016-to-2020.pdf

[12] Committee for Accessible AIDS Treatment. PHA Capacity Building & Mentorship. At: www.hivimmigration.ca/index.php/programs/pha-capacity-building/

[13] Toronto HIV/AIDS Network. Volunteer HIV Core Training. At: http://www.torontohivaidsnetwork.org/volunteer-hiv-core-training/

[14] Ontario Ministry of Children, Community and Social Services. Ontario's Special Needs Strategy. At: http://www.children.gov.on.ca/htdocs/English/professionals/specialneeds/strategy.aspx

[15] Ontario Ministry of Health and Long-term Care. Ontario Health Teams: Guidance for Health Care Providers and Organizations. At: http://health.gov.on.ca/en/pro/programs/connectedcare/oht/docs/guidance_doc_en.pdf

[16] Toronto Real Estate Board. Commercial Realty Watch, Third Quarter 2019. At: http://www.trebhome.com/files/market-stats/commercial-reports/cw19Q3.pdf

[17] Statista. Asking rent per square foot of office space in Toronto in the 4th quarter of 2019, by submarket. At: https://www.statista.com/statistics/802500/asking-rent-per-sf-office-space-toronto-by-submarket/

[18] Charity Village. Friendship, Courtship, Partnership: Why Canadian Nonprofits need to think about working together differently. 2011. At https://charityvillage.com/cms/Portals/0/charityvillage/Downloads/Shared_Services_Report.pdf

[19] Collins E., Cain R., Bereket T., Chen Y.Y., Cleverly S., George C., Hayes P., Jackson R., Layman-Pleet D., Li A., Prentice T., Taylor D., Travers R., (2007) Living & Serving II: 0 Years Later - The Involvement of People Living with HIV/AIDS in the Community AIDS Movement in Ontario. Toronto: The Ontario HIV Treatment Network.

[20] Bradbury S, Laca G et al. Building Co-Location: A Report Prepared for Marion County Coalition On Youth and the Early Intervention and Prevention Initiative, April 2011. At: https://bit.ly/38R8PUI

[21] Li A, Wales J et al. Changing access to mental health care & social support when people living with HIV/AIDS become service providers. AIDS Care 2014;27:1.

[22] Rapid Response Service. Impact of Community-Based Organizations for People Living with HIV. Toronto, ON: Ontario HIV Treatment Network; Oct 2015.

[23] Merzel C, D'Affilitti J et al. Reconsidering Community-Based Health Promotion: Promise, Performance, and Potential. Am J Public Health. 2003 Apr;93(4):557-74.

[24] Cefola J, Brotsky C, Hanson R. Shared Services: A Guide to Creating Collaborative Solutions for Nonprofits. The Nonprofit Centers Network, 2010. At: https://www.nonprofitcenters.org/publications/ [For purchase access.]

[25] Bubel A, Cabaj P, Soots L. Edmonton Nonprofit Shared Spaces Feasibility Toolkit. At: https://www.edmonton.ca/programs_services/documents/PDF/Non-profit-SharedSpace-Toolkit.pdf

[26] Mizuno Y et al. Is co-location of services with HIV care associated with improved HIV care outcomes? AIDS Care. 2019 Nov;31(11):1323-1331.

[27] Charity Village. Collaboration 101. June 2012. At: https://charityvillage.com/Content/92041/Collaboration_101.pdf

[28] Ryser L, Patterson D et al. Learning from Smart Services and Infrastructure Projects in Rural BC: Final Report 2016. At: http://rplc-capr.ca/wp-content/uploads/2016/06/Smart-Services-CASE-STUDIES.pdf

[29] Lennie J. Learnings, case studies and guidelines for establishing shared and collaborative service delivery in the non-government sector, Feb 2010. At: https://communitydoor.org.au/collabcasestudies

[30] Sudbury & District Health Unit. Equity-Focused Health Impact Assessment – A Community Pilot: An Assessment of a Shared Space Model for Sudbury Community Service Agencies, December 2012. At: https://www.phsd.ca/wp-content/uploads/2015/03/EfHIA_Pilot_Shared_Space_Full_EN.pdf

[31] Rapid Response Service. The impact of location on implementation of HIV/STI prevention interventions among LGBTQ communities. Toronto, ON: Ontario HIV Treatment Network; April 2019.

[32] Cooper V, Clatworthy J, Youssef E, et al. Which aspects of health care are most valued by people living with HIV in high-income countries? A systematic review. BMC Health Services Research 2016; 16(1): 677.

## Appendix 1: Toronto HIV Network Membership 2019

| Community-based Agencies with HIV programming | Community-facing HIV programs at Toronto Hospitals |
|---|---|
| 2-Spirited People of the First Nations | 410 Sherbourne, St. Michael's Hospital |
| Action Positive VIH/SIDA | Casey House |
| Africans In Partnership Against AIDS | Clinic for HIV-related Concerns, Mt Sinai |
| AIDS Committee of Toronto | Immunodeficiency Clinic, University Health Network |
| Alliance for South Asian AIDS Prevention | Positive Care Program, St. Michael's Hospital |
| Asian Community AIDS Services | Rachlis Clinic, Sunnybrook Hospital |
| Barrett House/ Good Shepard | Women's College Hospital |
| Black Coalition for AIDS Prevention | Public Health, Housing, Hospice and Counselling Orgs |
| Centre for Spanish-Speaking Peoples | David Kelly Services |
| Centre francophone de Toronto | Fred Victor House |
| Committee for Accessible AIDS Treatment (CAAT) | Philip Aziz Centre |
| Deaf Outreach Program, ON Association of the Deaf | Planned Parenthood Toronto |
| Fife House | Toronto Public Health |
| HALCO | The 519 |
| Hemophilia Ontario | |
| Hospice Toronto | Community Health Centres/ Population-focused Clinics |
| Latino Positivos | |
| LetsStopAIDS | Anishnawbe Health |
| LOFT | Central Toronto CHCs (Parkdale, Queen West) |
| Maggie's: Toronto Sex Workers Action Project | Hassle Free Clinic |
| PASAN | Regent Park CHC |
| St. Stephens Community House | Sherbourne Health |
| Teresa Group Child and Family Aid | South Riverdale CHC |
| Toronto People With AIDS Foundation | Women's Health in Women's Hands |
| | |