Taking Health Care to the Streets: Ottawa’s Inner City Health Project

Introduction

Life on the street is tough. Living conditions in shelters and on the streets constantly expose homeless individuals to extreme weather, infectious diseases and violence. Many individuals who are chronically homeless experience multiple mental and physical health problems, including mental illness and addictions. In general, the mainstream health care system is not set up to deal effectively with their health care needs. In Ottawa, Ontario, an innovative partnership is seeking to change this through the Inner City Health Project.

Needs not being met

Research has shown that diseases tend to appear at an earlier age among the chronically homeless population and are frequently more severe. In general, people who are homeless require more acute care than those who are housed, for a number of reasons. The physical environments in which homeless people reside often prevent effective delivery of services like home care. Many primary care services are based in clinics or facilities, with limited ability to provide continuous, mobile services to people who prefer to stay on the streets or who move frequently within the shelter system. Different service providers often assist the same homeless client without being aware of the duplication. Lack of follow-up and support results in repeat use of emergency care services for health problems that could be prevented or managed in a community setting.

Homeless people generally have poor success negotiating a health system that has limited flexibility. Chronically homeless individuals are transient, and often miss appointments; demand for specialists can mean long waiting times for rebooked appointments. Self-care strategies may be neglected, or impossible to carry out due to the lack of appropriate facilities or shelter. Most homeless individuals with chronic conditions do not fit into existing long-term and palliative care systems due to lifestyle and cultural issues. Palliative care facilities, for example, often prohibit substance use, rather than taking a harm reduction approach and allowing continued substance use within a hospice throughout the process of dying. Even when homeless individuals attempt to integrate into mainstream facilities, they often return to shelters and become long-term residents, as they know and prefer the shelter environment.

In many cities, the homeless shelter system has become the default care provider for individuals unable to access mainstream health care services. Shelter staff regularly are forced to meet
demands for which they are not adequately trained or funded. Although shelter workers and community health staff attempt to maintain contact with homeless individuals during hospital stays, coordination is often weak due to the lack of mechanisms for ongoing communication and dialogue between hospital staff and community service providers.

**Tackling the challenge**

Like other Canadian cities, Ottawa has been grappling with the issue of persistent homelessness. In 1999, the Regional Municipality of Ottawa-Carleton undertook a community consultation process that culminated in an action plan: *Creating Community Solutions.* This plan outlined the need to increase community capacity to provide addiction services, home care and convalescent, palliative and long-term care for people who are homeless or at risk of becoming homeless. It envisioned the development of an interagency network to improve access to health services for homeless people.

A number of organizations concerned with the health of homeless people formed an *ad hoc* group in June 1999 to explore ways to implement the health-related recommendations in *Creating Community Solutions.* A community consultation meeting was held in October 1999 to review the model with interested parties. Four working groups (convalescent care, palliative care, service providers and moderation of alcohol use/harm reduction) were formed to develop the different components of the model, and in November 1999 a process was begun to develop an appropriate governance structure for an Inner City Health Project.

The ‘founding partners’ of the Inner City Health Project included several shelters and service centres for homeless people (the Union Mission, the Salvation Army, Cornerstone Women’s Shelter, Shepherds of Good Hope, Youth Services Bureau), inner city primary health care facilities (Sandy Hill Community Health Centre, Centretown Community Health Centre), a home care organization (Community Care Access Centre), the Regional Municipality of Ottawa-Carleton, the University of Ottawa and the Ottawa Hospital. A Steering Committee of the partners was developed with terms of reference defining the roles, responsibilities and accountability of members of the committee. The terms of reference specified that the Steering Committee would meet a minimum of eight times a year, or as necessary, to guide the development, implementation and evaluation of the pilot project.

It was agreed that shelters and other agencies serving the homeless population would provide leadership in developing appropriate physical settings for the provision of health care services. The University of Ottawa, the Ottawa Hospital and the Regional Municipality of Ottawa-Carleton assumed responsibility for leading the development and delivery of enhanced health services to homeless individuals in these settings. The University of Ottawa agreed to be the sponsoring agency for the community consultation meeting as outlined in an October 1999 report, *Health for Individuals Who Are Homeless: A community response,* the vision of the Inner City Health Project is to provide health maintenance and health care services to homeless people in the region “commensurate with need and in a comprehensive, integrated fashion that is flexible, individualized, efficient and effective.” The project is based on 10 guiding principles:

- comprehensiveness of care: a balance between prevention and intervention
- innovation
- collaboration and communication among levels of government and different government departments, and between services providers, planners and people who are, or have been, homeless
- accessibility of health maintenance and health care services to all those in need, and flexibility to accommodate the unique circumstances of individuals
- a focus on long-term solutions
- community involvement
- outcomes-based programs and strategies
- harm reduction
- close integration with existing services
- inclusiveness: services that are sensitive to needs related to age, gender, race, language, culture, ability and sexual orientation.
purposes of the fiduciary, administrative and legal responsibilities of the partnership.

The partners developed a proposal for a multi-stage pilot project to support, monitor and evaluate innovative strategies and partnerships to improve the delivery of health services to homeless people in Ottawa-Carleton. They expressed the vision of the project as a “community in which individuals who are chronically homeless have equitable access to the supports and services they require to maintain or improve their health.”

To achieve this vision, the partners foresaw enhanced coordination of primary care services and community care planning, and collaborative efforts to improve accessibility to secondary and tertiary care services. The project also was designed to include enhancement of respite and convalescent care programs for homeless individuals and development of chronic, long-term and palliative care programs. Another element was a harm-reduction residential ‘managed alcohol’ facility (where controlled drinking would be allowed) for homeless people with alcohol addictions. Ongoing coordination, monitoring, evaluation and better integration of health programs with other services for homeless people in the region (such as addiction and mental health services) were other important elements of the project proposal.

With funding from the federal government, a consultant was hired to research the existing computer and information management systems of the various organizations and assess the feasibility of creating an integrated health information system. To fund the central administrative costs of coordinating and managing the pilot project, the University of Ottawa, on behalf of the Steering Committee, submitted a proposal to the Supporting Community Partnerships Initiative of Human Resources Development Canada (HRDC) in October 2000.

Funding awarded for a two-year pilot project provided salaries for a project director, a medical director, an administrative officer, a medical records assistant and 10 client care workers. Partner organizations committed the time of their health care and shelter staff to the project. However, the HRDC funding committee felt strongly that the salaries of physicians and nurses for the project should be covered by the provincial Ministry of Health, and removed that portion of the budget from the final funding awarded. The partnership has been negotiating with the provincial ministry, but at the time of writing had not received provincial funding.
In the interim, the partners have struggled to try to make up the shortfall. The City of Ottawa has been paying for one nursing position and the Victorian Order of Nurses (VON) for another. According to Bonnie Dinning of the City of Ottawa Homelessness Initiatives Team, who chairs the Inner City Health Steering Committee: “The University of Ottawa has developed a patchwork to provide physician services through the support of several private physicians.” These arrangements have enabled the Inner City Health Project to get started, but the shortage of physician and nursing resources has necessarily limited the reach of the project.

A new model of care

The Inner City Health Project began providing services in June 2001. In its first four months, more than 150 people were admitted to the project; at the end of September 2001, 55 people were participating.

Project administration is overseen by the project director, Wendy Muckle. Two physicians from the Ottawa Hospital share the function of medical director and other physicians provide medical services. At three project ‘sites’ (shelters of the Union Mission, Salvation Army and Shepherds of Good Hope), a registered nurse has responsibility for coordinating services: This staffing amounts to the equivalent of the two full-time positions contributed by the City of Ottawa and the VON. Client care workers, whose salaries are paid from the project budget, assist individuals with personal care needs. At the shelter sites, shelter workers assist with referrals and various aspects of care. “Volunteers are another valued group,” notes Katharine Robertson-Palmer, coordinator of the Homelessness Initiatives Team for the City of Ottawa, “especially in the palliative care program.”

There are four broad components to the project: case coordination and ambulatory care, palliative care, special care and a management of alcohol program.

Case coordination and ambulatory care includes intake and assessment, ongoing assessment, case management, primary care treatment, and coordination of care with other services such as hospitals, shelters, community centres and community-based mental health services. Front-line shelter staff, outreach workers, public health and community health care nurses, hospital social workers and discharge coordinators, doctors and clients themselves identify homeless persons in need of health care interventions. These individuals must consent to the initial referrals and to providing information for a determination to be made that they might be in need of service.

To be eligible for entry to the project, an individual must be chronically homeless, have complex health problems, lack other supports or resources and not have the financial or social means to obtain such supports or resources. Once someone is admitted to the project, the medical director and nurses assess health needs and determine the services required as well as the appropriate delivery mechanism (respite care, palliative care or primary care, for example). The project nurses work with the homeless individual, shelters and primary care providers to ensure that an appropriate care plan is in place.

“In many instances,” says Wendy Muckle, “family doctors, nurses or outreach workers have relationships with the person that are very important and need to be supported. We negotiate with these care providers about their continued involvement and who will provide what. In other instances, the individual has not had any access to health care providers and we need to create a team to provide care. We also negotiate with our clients about where they will receive services and what they want to receive. Individuals may have a strong preference for one location over another and we will try to accommodate their wishes, provided it can be done safely.”

At all the project sites and in the community, care workers help with bathing, dressing, mobility, feeding, administration of medications, travel to appointments, shopping and keeping rooms in order. “The care workers basically substitute for what family members would do,” says Wendy.
“We’re trying to recreate the conditions that people would have had at home with their families.”

Through a partnership with Desjardins Pharmacy, the project has received donations of wheelchairs, canes, bath chairs and basic medications. “The medication system is key to successful health outcomes,” says Wendy. “Our clients are all quite ill and most are on many medications (up to 25 different medications a day.) Most participants have never taken their medications as prescribed before, and we achieve huge health benefits from simply giving the medications properly. We keep all medications locked up and they are offered at the appropriate time by the care workers. This eliminates theft, selling of medications on the street and improper use and allows us to closely monitor patients’ responses to their medications.”

The palliative care component provides residential care beds in a new hospice at the Union Mission with 24-hour, 7-days-a-week care. The Mission has dedicated staff to this facility, which officially opened in May 2001. It is expected that about 50 individuals could be served by the palliative unit in any given year. The hospice is open to both men and women; women who prefer to receive palliative care at a women’s shelter have the option to do so at the Cornerstone shelter.

According to Diane Morrison, executive director of the Mission and co-chair of the Inner City Health Steering Committee, the hospice “has evolved in this short time into a two-part project. We have eight beds for terminally ill people and four to five beds for chronically ill people who have a terminal disease but with a longer prognosis. There have been some interesting discoveries: Some people have arrived from the hospital with a very short-term prognosis (less than a week), and two months later they are still with us. At this time, we are attributing this to the fact that they are back among friends, there is more personal care, a better monitoring of medication and we understand them better. We have known most of these people for years.”

“This project was not set up as a ‘hospital model’ hospice,” she notes. “There would be too many restrictions and residents would leave – if they could. It has to be like their home, where they can come and go when they need to. Their friends are allowed to visit – in fact, their friends are encouraged to be part of their care.”

Like other aspects of the project, the hospice works on a harm reduction model. “Most or all of our patients are substance users/abusers,” notes Diane. “Until we opened the hospice, they either died in the hospital or in a rooming house, on the streets or in the shelter. We have done two things: provided adequate pain medication and prescribed alcohol for those who need it.”
The special care part of the project makes available beds and support for those who need care for convalescence or short-term treatment. Twelve beds at the Salvation Army are reserved for this purpose, and more will be added as needed to a maximum of 20. The convalescent time should speed recovery following discharge from hospital and, in some cases, prevent the need for admission to hospital.

Individuals have stayed for as little as four days and as many as 40. Lynn Wingert, director of the Salvation Army shelter, notes that: “These are not new clients. These are the same clients that we would have anyway. The difference is that, without this project, they would be dispersed throughout the shelters and they wouldn’t be receiving adequate care. They would be neglected and at risk for further complications.”

As part of the Inner City Health Project, the Salvation Army facility embraces the harm reduction philosophy. However, the organization itself espouses sobriety and the shelter is ‘dry.’ “That’s taken into consideration when choosing a location for clients,” Lynn notes. “For example, someone who has really cut down on his drug or alcohol use might want to come here. On the other hand, someone who wants to use and is going to be very intoxicated will probably stay at another shelter if he can’t control his use.” She notes that it can be upsetting for other shelter residents – who may have chosen to stay at the Salvation Army shelter because it is dry – if special care residents are intoxicated. The harm reduction compromise has been that if these individuals “go out and use outside the premises, they would have to sober up considerably before coming back.”

The Hope Recovery Stage II management of alcohol program is the other component of the Inner City Health Project. It reserves 10 spaces at the Shepherds of Good Hope shelter for people who are chronic alcoholics and have been homeless for many years. “The program involves providing the basic needs of the individuals,” says Mary Ann Glazer, executive director of the shelter. “One of the basic needs is alcohol. The people assessed and chosen for the program are long-term chronically homeless individuals who are seriously addicted to alcohol. We call them the ‘urban legends.’ Everybody knows them – and nobody knows what to do to help.”

The management of alcohol program appears to be doing something to help. Managed doses of alcohol are made available to the program’s clients at intervals throughout a 16-hour day in a drop-in setting, and these individuals sleep in a designated area of the shelter each night. The intent of the program is to reduce harm to individuals and the community by minimizing or eliminating the use of harmful substances, preventing binge drinking, reducing injuries and use of crisis services, and lessening incidents of community disruption. Participants have access to social services, counselling, alcohol-related services and clinical services.

Not all addicted shelter clients choose to participate. “It takes a relationship,” says Mary Ann. “It is not always a self-motivated choice. They do it because they recognize that you can help them or they’re safer doing this.”
Clients are valued partners

The Inner City Health Project is committed to involving its clients in the management of the project. Wendy Muckle visits the project locations most days to see how things are going. Homeless individuals participating in the project were involved in the development of information materials and have contributed poetry and songs to be featured on the project’s website. Participants in the management of alcohol program have been consulted on program development, and client input is being sought for performance reviews of Inner City Health Project staff.

“The clients have been very pleased to be included,” notes Wendy. “The use of a harm reduction approach is probably one of the best tools for truly involving people in their own care planning and decisions. When you align yourself with people and look at their substance use together, the relationship is quite different from when you are trying to make them not use. At first, many don’t really believe that they will not be kicked out if they admit to using, but they quickly catch on that we are serious. We stress that as long as they are benefiting medically from being in the program and are not posing a risk to others, the substance use is not a reason to exclude them.” Diane Morrison underscores that: “We have consulted with the street people about this model, we have listened and we will continue to evolve. They have shown great respect for what we are trying to do. We have to be partners, if this is going to work.”

A promising beginning

Sophisticated information technology is another key to achieving the project’s goal of providing integrated, seamless care for homeless individuals. Software is being created to record information and create electronic health records for all project clients. The software is being developed and implemented through a partnership between Dinmar Consulting, the City of Ottawa and the Inner City Health Project.

The information technology system will include an electronic health record and a system to allow service providers to record daily care and services. The technology is similar to that employed in online banking. Service providers will be able to log onto a secure, password-controlled section of the Inner City Health Project’s website to view records and enter care information.

The Inner City Health Project is still in its early stages, and it is too soon to predict the results. So far, according to Wendy Muckle, participants are “very happy with the care they are getting, and the community response has been very positive.” Results from the first few months suggest that homeless individuals participating in the project spend less time in hospital and in emergency rooms than previously.

An evaluation plan is being developed that includes a cost analysis of health care for the homeless, a ‘social autopsy’ (which will seek to uncover the social factors that have contributed to the often premature deaths of homeless people), and a broader panel study of the health status of individuals who are homeless. “In the long term, we are hoping that the evaluation and research will allow us to provide a business case to support obtaining long-term funding of the Inner City Health Project,” says Bonnie Dinning.

Careful preparation and early involvement of key stakeholders have been vital to the successful rollout of the Inner City Health Project. Wendy Muckle notes that: “One of the things that worked really well was that all the agencies involved had some identifiable area of expertise or skill, and what the project did was ask them to build on that skill – to do something different, with a different population, but basically to build on that skill. Sometimes agencies try to do it all themselves. This seems easier because you have control, but it actually takes a lot longer.”

Bonnie Dinning notes that: “The one thing that we were able to establish early on was a trust factor. That allowed us to think beyond just being
a partnership or coordinating services, and to start thinking of this as an entity – to think about what we want to achieve, who could put what into the pot, how our agencies would interact with each other.” She notes that “there were a few rough spots” in the first few weeks of operation – due mainly to lack of clarity around the respective roles of the project director, shelter directors and shelter staff. “The reason we’ve been able to keep moving forward is that trust factor.” The drawing up of detailed individual agreements between each partner organization and the project is helping to sort out any residual confusion and clarify exactly who does what.

According to Bonnie, the early community consultation “helped bring clarity to the project goals and fostered commitment. It also allowed for a broader range of stakeholders to advise the existing steering committee on who should be at the table, and legitimized the group in the eyes of the community. The ability to have decision-makers at the table expedited planning. Senior managers were able to commit resources to cover shortfalls.” Participating agencies have contributed significant resources of their own to the project.

Like everyone else, the project is struggling to cope with the strains and cuts in the health care system. Still, for many homeless people, even receiving limited care is an improvement. Prior to participating in the Inner City Health Project, for example, homeless individuals often could not get on waiting lists for services like physiotherapy. Now, those participating in the project are on waiting lists – sometimes with hundreds of others, but they are on the lists. As Wendy notes: “This project is about entitlement: It’s about getting these people the same access as everyone else. Now their needs are being acknowledged and they’re in the queue with everyone else. It may not be ideal, but it’s fair.”

Ann Simpson


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Endnotes

1. Harm reduction is a public health approach to dealing with substance abuse issues that places first priority on reducing the negative consequences of drug or alcohol use rather than on eliminating use or ensuring abstinence.

2. The various municipalities of the Region amalgamated to form the City of Ottawa on January 1, 2001.

3. Additional partners have since joined the initiative, including the Wabano Centre for Aboriginal Health, the Royal Ottawa Hospital, the Canadian Mental Health Association (Ottawa branch), the Champlain District Health Council and the Victorian Order of Nurses (VON).

4. Primary care includes basic services to prevent disease, detect illness at an early stage and treat routine, uncomplicated conditions. Secondary care includes medical interventions to prevent deterioration or the development of complications in a case of illness or injury; such care is often rendered by a specialist. Tertiary care includes health care services that tend to be complex and sophisticated, usually more invasive and more reliant on technology.