Collaborative Approaches to Community Based Care for Homeless People: Toronto’s Inner City Health Associates

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Objectives

- Describe the health needs of homeless people in Toronto: the task.
- Introduce Toronto’s Inner City Health Associates Program (ICHA): the how and why.
- Discuss collaborative care strategies in use and lessons learned.
Homelessness in Toronto

- 28,000 individuals use shelters each year
  - 50% single men
  - 20% single women
  - 20% parents with children
  - 10% youth (age 15-24)

- Over 5,000 individuals on any given night
  - 78.5% in shelters
  - 7.9% outdoors
Homelessness and Health

- Homeless people are more likely to have chronic medical conditions, and die earlier than the general population.
- Their health risks include trauma, infestations, peripheral vascular disease, cellulitis, ulcers, dental problems, frostbite, Hep C, HIV and tuberculosis.
- 25-33% of homeless people have a serious mental illness.
- Among 300 Toronto shelter users:
  - 67% report a lifetime diagnosis of mental illness.

Hwang, 2000
Goering, 2002
Access to Health Services

- Majority have no regular source of medical care.
  - Patient factors, provider factors, health care system factors

- 75% of homeless individuals with mental illness did not receive psychiatric outpatient care in past year

- 27% of homeless individuals surveyed stated that receiving help with their health needs would help them achieve stable housing

Mental Health Policy Research Group, Mental Illness and Pathways Into Homelessness Conference, 1997
Toronto Shelter Support and Housing Administration, 2006 Street Needs Assessment: Results and Key Findings
Confronting Challenges

- Access to medical care poor
  - Dissatisfaction with health services
- Discharge planning from hospitals inadequate
- Coordination and collaboration among service providers missing
- Long term case management resources insufficient
- Inter-sectoral collaboration poor
ICHA-Who we are

- An association of 70 physicians – recently incorporated
  - 35 psychiatrists
  - 30 family physicians
  - 2 community medicine specialist
  - 2 internists
  - 1 pediatrician

- Most of the physicians are affiliated with the University of Toronto and one of its teaching hospitals.

- ICHA clinics in >40 frontline homeless agencies across Toronto.
ICHA - Mission

- To improve access to care.
- To improve health service coordination.
- To set the standard of excellence in homeless health provision
  - Hospital / community integration
  - Mental health and physical health
- To transform how communities view, access and influence academic institutions and levels of government.
ICHA – Removing Barriers to Care

- All physicians are funded by Alternate Payment Plan.
  - No ID/Health Card requirements.
- Access to MD to sign forms (e.g. disability, welfare)
  - Focus on determinants of health, recovery orientation
- Access to MD in frontline agencies / integration with agency work.
  - Direct and indirect consultations and community capacity building.
ICHA - Operations

- Administration / Program Development
  - Coordination / Integration

- Clinical Care
  - Access, quality, community capacity
  - Inter-professional, interagency and intersectoral collaboration

- Population level care
  - CAISI, pandemic planning

- Education
  - Medical student, resident electives, QI projects
ICHA Key Partners

- City of Toronto
  - SSHA
  - Social Services

- Toronto Drop In Network

- Toronto CCAC

- St. Michael’s Hospital

- Centre for Research on Inner City Health
Next Steps CATCH

- Grounded on inter-agency and inter-sectoral collaboration to address system fragmentation.

- Centralized access/intake to medical clinics in over 40 frontline agencies (shelters, drop-ins).

- Access to nursing and personal support in select agencies.
CATCH Discharge Planning Checklist

- A 10-12 item checklist to guide inpatient teams efforts in discharge planning (in progress)

- Facilitated access to income support while in hospital

- Transitional case management and peer support
Advantages of Collaboration

- Improved access to a continuum of health, housing and income supports.
  - Reduced waiting times for services
  - Improved care coordination
- Tertiary level expertise directly to the drop-in/ shelter / street.
- Community capacity building
- Richness of collaboration
  - Individual expertise (inter-professional)
  - Organizational resources (inter-agency)
  - System integration (inter-sectoral)
Next Steps - Confronting Challenges

*Improve*....
- Privacy and security of client PHI
- Clinical supervision of shelter staff delivering clinical services

*Build* ...
- Bridges to mainstream health service providers
- A client advisory board

*Avoid*...
- Fostering dependency on shelter system for health care
- Trans-institutionalization
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