Models of collaboration with health care systems that improve care and reduce homelessness

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WHAT MAKES CANADIANS SICK?

50% YOUR LIFE

- INCOME
- EARLY CHILDHOOD DEVELOPMENT
- DISABILITY
- EDUCATION
- SOCIAL EXCLUSION
- SOCIAL SAFETY NET
- GENDER
- EMPLOYMENT/WORKING CONDITIONS
- RACE
- ABORIGINAL STATUS
- SAFE AND NUTRITIOUS FOOD
- HOUSING/HOMELESSNESS
- COMMUNITY BELONGING

25% YOUR HEALTH CARE

- ACCESS TO HEALTH CARE
- HEALTH CARE SYSTEM
- WAIT TIMES

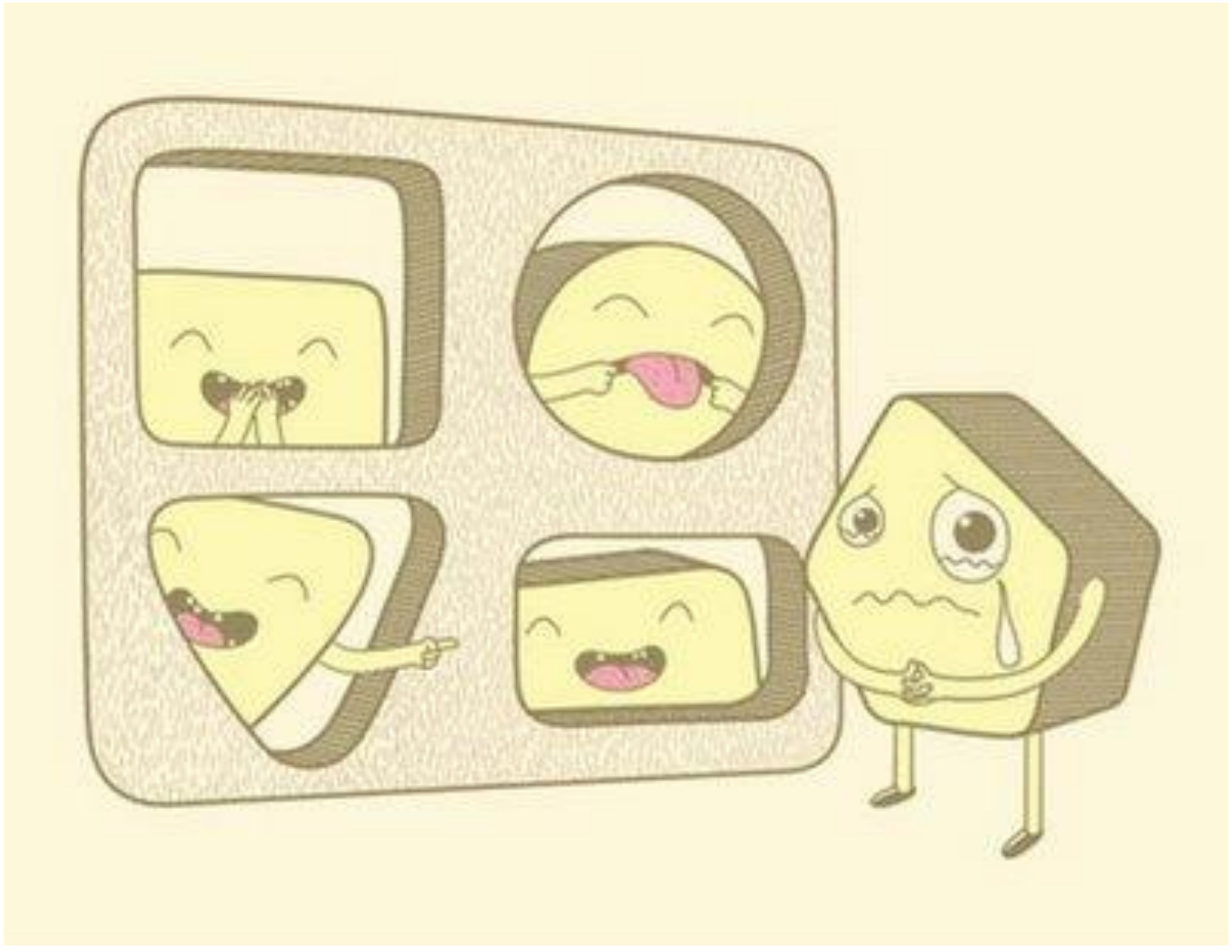
15% YOUR BIOLOGY

- BIOLOGY
- GENETICS

10% YOUR ENVIRONMENT

- AIR QUALITY
- CIVIC INFRASTRUCTURE

THESE ARE CANADA'S SOCIAL DETERMINANTS OF HEALTH #SDOH



ICHA | Inner City Health Associates

Vision:

To help end chronic homelessness in Toronto

Mission:

To improve access to care for the homeless population in Toronto

To improve collaboration and coordination amongst service providers working with the homeless in Toronto

To prevent additional chronic homelessness related to illness and disability in Toronto

To set the standard of excellence in the provision of homeless healthcare

What is ICHA?

- A group of more than 60 physicians working in over 40 shelters and drop-ins across the City of Toronto
- Primary, mental health and palliative care
- Street-involved, shelter & precariously housed
- Funded by the Ministry of Health and Long Term Care

More on ICHA

- Founded by a small group of physicians in 2005 advocating for the homeless
- Direct and indirect care
- Working closely with client, community workers and case managers
- Developing partnerships with community services & agencies
- Medical education (students, residents & fellows)
- Physician credentialing: St Michael's Hospital

ICHA By The Numbers In 2015/16

43
Sites

63
Physicians

2,978
New Patients

18, 811
Patient Visits

Number of Visits

Primary Care	Psychiatry	PEACH	Internal Medicine	Total
13,821	4,589	226	175	18,811

Psychiatry

Canadian Centre for Victims of Torture

Concurrent Disorders Support Services

Elizabeth Fry

Evangeline Residence

Evergreen Centre for Youth

Good Shepherd Non-Profit Homes

HOPE Ontario Works

HOPE Ontario Works Scarborough Site

Maxwell Meighen Centre

Multi-Disciplinary Access to Care and Housing (MATCH)

Multi-Disciplinary Outreach Team (MDOT)

Red Door

SMH Withdrawal Management Services

Street Haven

Streets to Homes

Toronto Community Addiction Team (TCAT)

TNSS At Home Intensive Case Management Team

Youth Without Shelter

Primary Care

Birchmount Residence

Cummer Avenue United Church

Downsview Dells

Fred Victor Centre

Gateway

Good Shepherd

Jessie's The June Callwood Centre

Robertson House

Sanctuary

Seventh Generation Midwives Toronto

St. Simons-the-Apostle

YWCA Toronto 1st Stop Woodlawn

Primary Care & Psychiatry

Agincourt Community Services

CATCH Good Shepherd

Christie Refugee Centre

CMHA Toronto Branch

Covenant House

Eva's Place

Eva's Satellite

FCJ Refugee Centre

Inner City Family Health Team (ICFHT)

NaMaRes

Seaton House

Sistering

Sound Times

St. Stephen's Community House

Women's Residence

CATCH Homeless (Coordinated Access to Care For The Homeless)

Thank you to all the staff of the CATCH-Homeless Program for their clinical work and their support in developing these slides, including Jason Kuhar, Charlene Crews, Ryan White, Taryl Bengershon, Michaela Beder, Dorian Deshauer, Gary Bloch and Good Shepherd RN Gelica Rongo

Collaboration

CATCH-Homeless is a collaboration between 3 main partners: **St. Michael's Hospital**, **Inner City Health Associates** and **Toronto North Support Services**.

Hospital partner sites include St Michael’s Hospital, CAMH and St Joseph’s Health Centre.

Community partnership with PARC Peer Support Program.

CATCH Homeless was created to reduce preventable hospital visits and improve and coordinate access to care for homeless populations who frequent the EDs and Inpatient Units of hospitals in downtown Toronto.

CATCH Overview

CATCH is a collaborative program which helps people who have unmet complex health care needs to access immediate health resources in the community.

CATCH Provides 3 services: 1) Access to a short-term family physician 2) Access to a short-term psychiatrist 3) Access to a short term intensive case manager. *Short term = 3-6 months

CATCH-Homeless – Serves clients who are experiencing homelessness and not already connected to services, with or without mental health or addiction problems. We do not accept referrals for clients who are housed or already connected to services in the community (to avoid duplication).

Improving Transitions of Care for People Who Are Homeless

The transition between hospital and community presents an opportunity to facilitate continuity of care and positive outcomes:

Reduced ED volumes

Decreased ED wait times

Reduced psychiatric ED/Inpatient readmission rates

Increased inpatient bed availability

Improved hospital/community resource utilization

Prevent fragmentation of care

Improved patient satisfaction and quality of life

Case Management Overview- TCM’s

CATCH Transitional Case Managers (TCMs) are now working from the St. Michael's Hospital, Centre for Addiction and Mental Health (CAMH), and St. Joseph's Health Centre ED and Inpatient departments.

If available, CATCH TCMs will meet with patients in the ED or the inpatient unit upon referral. If not on-site, CATCH-TCMs will make an appointment to connect with and meet referred clients in the community. (Average wait time 3-5 days).

CATCH Transitional Case Managers work with family physicians, psychiatrists, probation/parole officers, financial support case workers, social workers, counselors, shelter staff and other service providers to support patients’ access to medical care, mental health and addictions services, and other resources in the community.

Case managers help clients navigate the system, link clients to legal and health care supports, financial resources, provide referrals to external housing and treatment resources, provide counseling and support.

Progress to Date

1678 referrals in the first 5 years. As of early 2016, approx 1,300 client have been connected to a CATCH family physician, psychiatrist or case manger.

We have a dedicated clinic in the community at the Good Shepherd Ministries shelter, with a once/week clinic with 2 Psychiatrists & 1 Family Doctor.

Clinics are used to stabilize clients after discharge from hospital. Patients can be usually be seen within 1-3 weeks at Psych and GP clinics. Patients do not need a health card.

Challenges

Volume: High need for this service

Access to ordinary shelter beds, detox beds and safe-beds in Toronto used to bridge clients

Access to long term case management in the community.

Connection to any long term psychiatry.

Access to treatment facilities.

Affordable housing in Toronto. Supportive housing etc…

Serious and complex mental health needs for CATCH clients.

WHAT IS MDOT?

- A review of psychiatric outreach programs for homeless persons found only 3 (2 in USA, 1 in UK) that included psychiatrist, nurses, and allied health professionals.

- MDOT launched in 2005 after a Streets to Homes initiative to help the street homeless. Streets to Homes (municipal program) offers street level case management to assist with housing.

- Focuses on clients whose needs go beyond standard expertise and resources, especially street homeless individuals with severe mental illness and/or addictions who are unable to engage with other services

MDOT Services

- Mobile street outreach (two vans)
- Client-focused housing assistance. MDOT has its own housing specialist.
- Mental health and addictions assessment, treatment, and case management
- Services continue until clients are housed and able to access mainstream services. All clients connected to follow-up supports prior to discharge.
- Funded by the city of Toronto; parent agency is Toronto North Support Services, with staff also seconded from Fred Victor, South Riverdale Community Health Centre, CAMH, and LOFT.
- Current staff: 1 FTE nurse, 6 FTE case mangers (1 specializing in housing), 0.1 FTE concurrent disorders specialist, 0.6 FTE psychiatrists (via ICHA).
- Active caseload of about 60 clients

So does MDOT accomplish its goals?

- Retrospective chart review of all clients receiving a first psychiatric assessment between February 2012 and February 2014 for a new episode of treatment (clients seen by MDOT earlier were included if there had no clinical contact of any sort for prior 4 months) (Lettner et al, 2016).
- Open and closed cases were included, and data collection for open cases ended on April 30, 2014.
- Data extracted by MDOT case managers; data analysis was anonymous. Included demographics, diagnosis, housing status, initial GAF, MDOT service characteristics, hospital use, and the outcome measure of final housing status.

Who were these clients?

- 94 clients had first psychiatric assessments (by MDOT psychiatrist); 85 of these were homeless
- Mean age **45.7 years** (range 18-69); 19% ≥ 60 yrs
- **66% male**, 32% female, 1% transgendered
- **74% white**, 8% African-Canadian, 18% other
- **44%** seen to have moderate to severe **substance abuse / dependence**
- Mean initial GAF was 25; 19% had a GAF score ≤ 20.
- **68%** (58/85) were **street homeless**, sleeping rough. 54% continuously homeless for more than 36 months.
- **Psychotic disorder** not related to substance use was most impairing diagnosis in **78%**!

MDOT service characteristics

- Mean **length of MDOT service for closed** cases was **34 weeks** (range 1-100, SD 24).
- Mean length of service for **open cases** was **46 weeks**.
- 10 (11.8%) clients were admitted to hospital due to medical illness.
- 36 clients (**42%**) had completed **56 psychiatric admissions**, with a mean of about **8 weeks *in total* as a psychiatric inpatient** during MDOT involvement. Clients with a psychotic illness were much more likely to be hospitalized; only 2/19 clients without psychosis were ever hospitalized
- MDOT was involved with subsequently hospitalized clients for a mean 14 weeks before first psychiatric hospitalization.
- Overall, MDOT initiated involuntary presentation to hospital for 22/85 clients and voluntary presentation for 3 clients

So did they find housing?

- 6 were in hospital (3 on psychiatric wards) at end of MDOT involvement or data collection.
- For the remaining, **52%** of discharged clients and **46%** of all clients (active & closed cases) had a permanent address by the end of MDOT involvement or data collection
- For initially street homeless clients, these proportions were 46% and 39%, respectively
- **70%** of clients who were housed at the end of MDOT involvement (n=30) were in **apartments**; the rest were transitional housing or boarding homes
- For **initially street homeless** and no longer in treatment

MDOT (n=38), **58% were indoors**

...(and not in jail!) at the end of MDOT involvement

But who found housing?

- Using logistic regression models, **psychosis, increasing age, longer duration of homelessness, and substance use significantly decreased** the probability of being housed:
- Psychosis — OR 0.29 (0.06-1.32)
- Increasing age — OR 0.94 (0.89-0.99)
- Homelessness > 36 months — OR 0.10 (0.02-0.50)
- Moderate to severe substance abuse — OR 0.23 (0.05-0.97)
- But **hospitalization greatly increased the chance of being housed**. Only 4/30 (13%) of psychotic clients who were not hospitalized found housing, compared to 23/31 (74%) of psychotic clients who were hospitalized. The odds ratio (logistic regression model) was 23.4 (1.86-27.33) for clients with psychosis.
- Hospitalization always preceded the obtainment of permanent address, but 3 clients were re-hospitalized after being housed.
- Two of these returned home while one remained in hospital awaiting long-term care

The bottom line

- Mobile street outreach with nursing and psychiatric support can house about half of clients who are homeless, including those who have been on the street and homeless for years.
- Adverse influences of prolonged homelessness and substance abuse reported previously in literature and are not surprising.
- Being psychotic, generally speaking, doesn't help one navigate life's challenges.
- Hospitalization can really help homeless people with psychosis find housing!
- LOS in hospital was not significant because average LOS of longest individual stay was quite long (7.5 weeks).
- Our hypothesis is that hospital treatment should continue until there is enough improvement to allow housing efforts.

A Snapshot: Toronto's Homeless

homeless: 5200

in streets: 450

1+ chronic disease: 75%

HCV: 28x | Heart Disease: 5x | Cancer: 4x

severe depression: 30%

elderly: 10%

Homeless at EOL

Life expectancy: 34-47 yo

Mortality rates: 2.3-4x

Location of death:

transitional spaces

residential dwellings

ED & hospital [+++vast majority]

VANCOUVER NEWS

Homeless deaths preventable with homes: report

by Canadian Press - BC Local News
posted Nov 6, 2014 *at* 5:34 PM — *updated* Nov 10, 2014 *at* 2:13 PM

By Tamsyn Burgmann, The Canadian Press

VANCOUVER - He was a wily character with a bright personality, known for philosophical musings as he sold flowers from the streets of downtown Vancouver where he also lived for 15 years.

But there would be no storybook ending for Tom Sawyer, a homeless man who died of blunt force trauma in an alleyway, believed to be the victim of unknown assailants.

A report released Thursday highlighting the risks of vagrancy found that homelessness cuts a person's life span in half in British Columbia, with the majority of deaths by accident, suicide or homicide.

50%

Naheed Dosani
@NaheedD

Should #Homelessness itself be considered a 'palliative' diagnosis? I'd say so | vicnews.com/national/vanco… | #cdnhealth

RETWEETS 3 FAVORITES 2

7:28 PM - 9 Nov 2014

PEACH

PEACH: Palliative Education and Care for the Homeless

Introducing PEACH

Mobile

Street & Shelter-based service

Early Supportive & Palliative Care

Healthcare navigation

PEACH Findings

No ED/acute hospitalizations: 64%

EOL in location of preference: 78.3%

Reconnected to family/friends: 82.6%

Opioids:

- Prescribed: 58.5%
- Substance use risk assessments: 90.2%

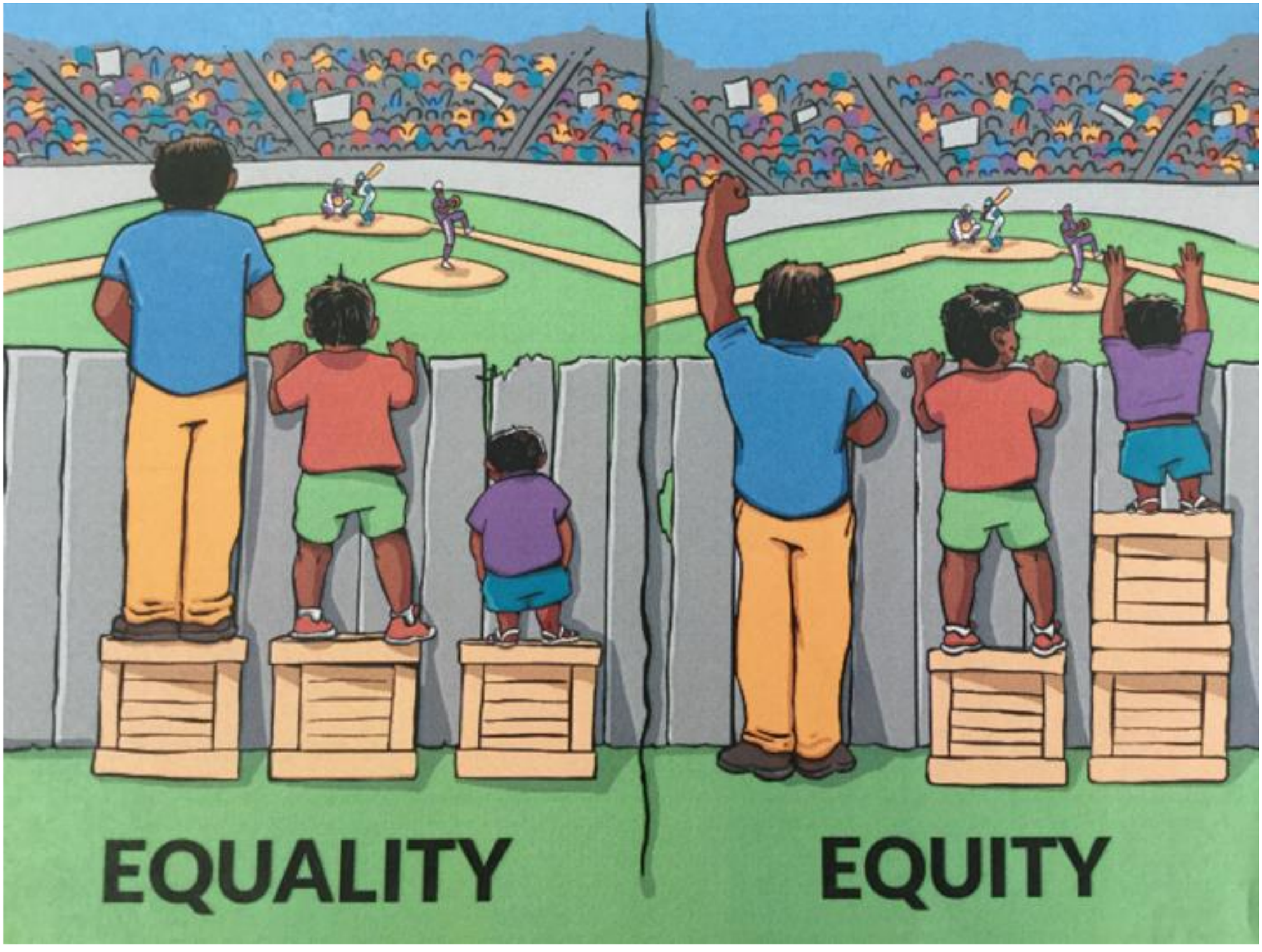
Shared care: 82.9%

Wednesday April 01, 2015

"What's a life worth?"

Dr Naheed Dosani and his patient Archie (Frank Faulk - CBC)

Listen 15:39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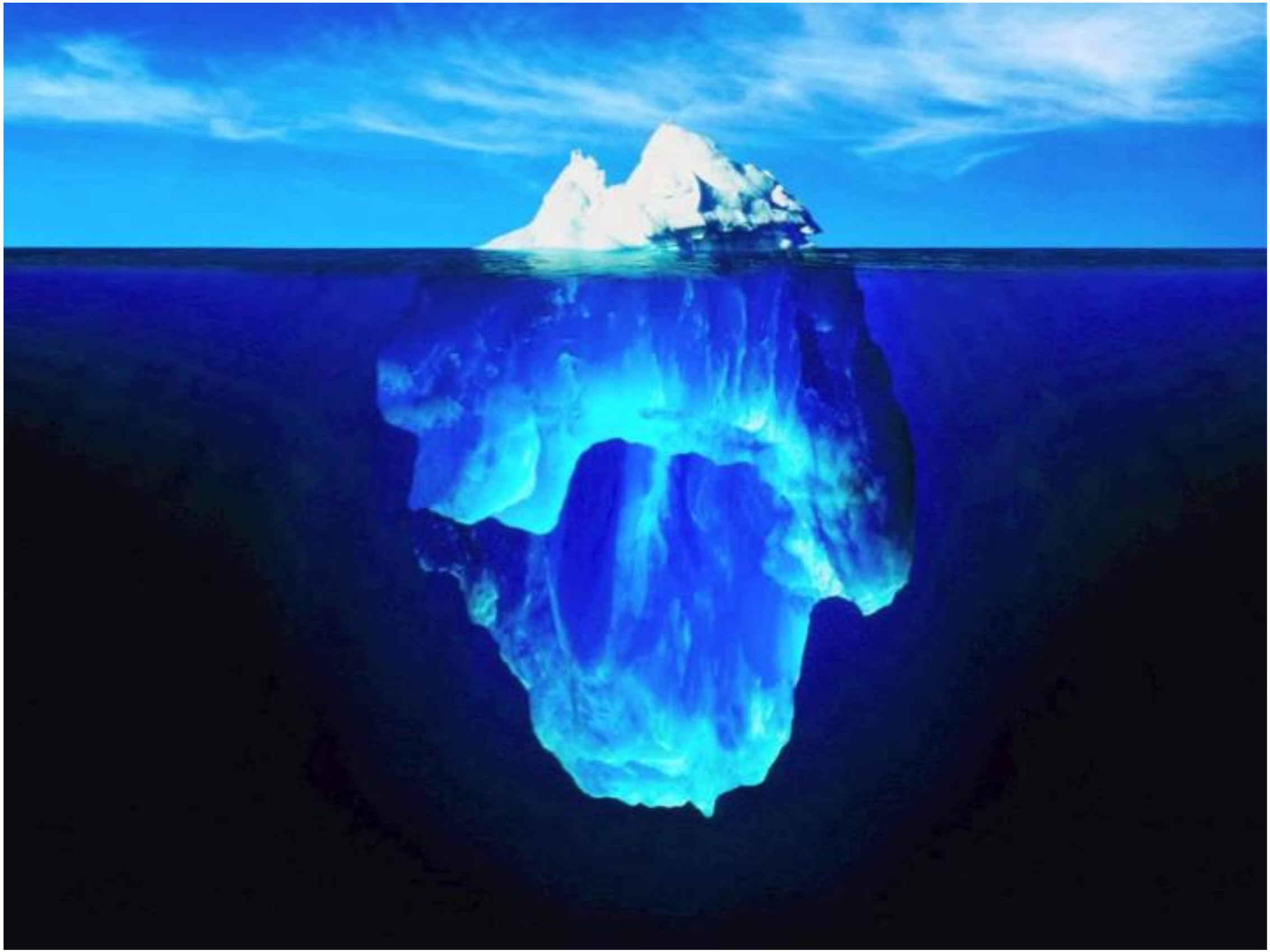


KEEP YOUR COINS.
I WANT
CHANGE
BANKSY