

February 24, 2015

## DTES Second Generation Strategy Message from Laura Case and Dr. Rolando Barrios

It has been two years since we embarked on a planning process to address changing health needs in the Downtown Eastside (DTES). This journey has involved VCH leaders and staff, agency partners, and community-based service providers, as well as clients and residents in the DTES. Together we have identified opportunities to improve leadership, build partnerships and establish a shared vision for the future.

More than 65 ideas were submitted through our “Invitation to Innovate” process last year. This community input is reflected in the DTES Second Generation Strategy Design Paper. We are preparing to translate this input into action as we initiate a more detailed planning process.

There are more than 20 high level actions articulated in the Design Paper, based directly upon input and ideas provided by clients, community partners and service providers in the DTES. The community told us there are ways care in the DTES can be improved. Examples include better integration of clinic-based care and outreach services, better accessibility to methadone therapy and supervised injection services, and staff training to ensure competency and awareness around Aboriginal culture.

The DTES Second Generation Strategy Design Paper is the foundation for a strategy aimed at improving health outcomes in the DTES through a more integrated system that addresses evolving health needs. People are living longer and we are seeing fewer cases of HIV and Hepatitis C. While these results are positive, people are now living with new health challenges, such as multiple chronic diseases, acute mental illness and addiction challenges.

Consultation continues to be a key element in our planning process as we prepare to shift into implementation. The actions and priorities identified in the DTES Second Generation Strategy Paper will be shared with community partners, agencies, staff and clients for feedback before we move forward. Meetings with agency partners and dialogue sessions with clients will provide further opportunity for input. Feedback will also be received via our email: [dtes@vch.ca](mailto:dtes@vch.ca). All of this input will guide the development of a more detailed implementation plan that will rollout over the next three years.

It is important to note that this system transformation is not about cost cutting. VCH’s financial commitment to the DTES will not change as we use these resources more

effectively through a more coordinated system with better monitoring of client needs and outcomes.

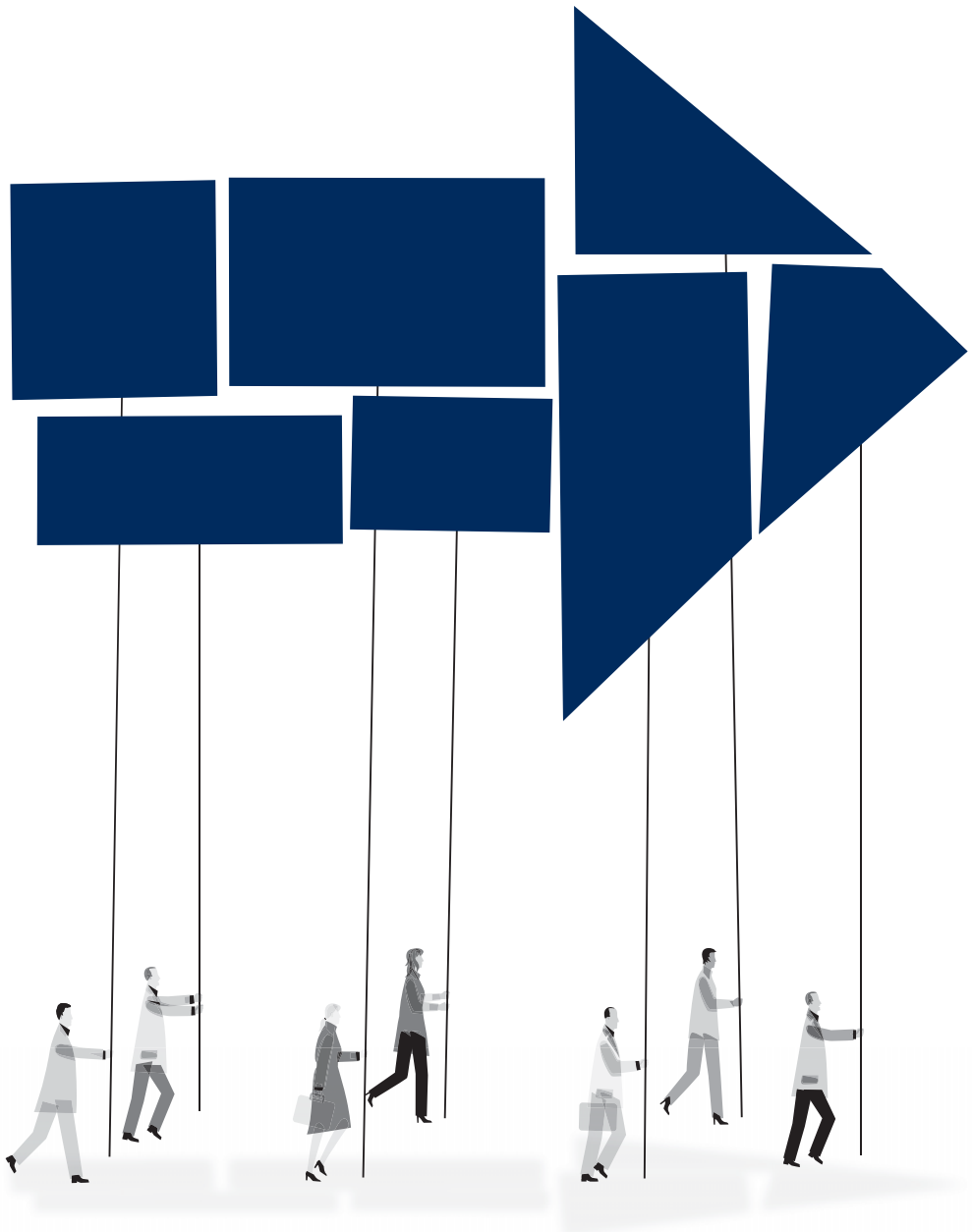
As we prepare to implement much-needed change and address emerging health challenges, we remain grateful for the ongoing commitment of those working in the DTES. A recurring message received throughout this consultation process is how important these service providers are to our clients and community.

Once we receive feedback on the Design Paper and confirm our vision for the future, we will develop a more detailed planning process and have a better understanding of how these changes will impact specific services, programs and people. We will continue to keep our community partners and staff informed and involved as this work progresses.

One thing is clear. We must continue to work together. From the start of this project our goal was to build a common purpose for DTES services, grounded in the needs and interests of the neighbourhood. The way forward is by moving through these changes together.

Laura Case, Chief Operating Officer, Vancouver Community

Dr. Rolando Barrios, Senior Medical Director, Community



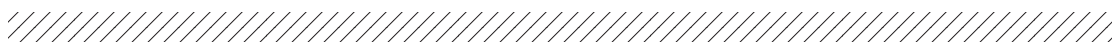
# Downtown Eastside Second Generation Health System Strategy

Coordinated partners, integrated  
care and performance excellence  
will lead to healthier clients





# VCH introduction



IT IS MY PLEASURE TO INTRODUCE YOU TO THE FINAL PAPER IN VANCOUVER COASTAL HEALTH'S *DOWNTOWN EASTSIDE SECOND GENERATION HEALTH SYSTEM STRATEGY DESIGN*.

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This paper builds on four previous papers and is the culmination of over two years of intensive work by VCH staff and physicians, our community partners, an outside expert review panel, and DTES clients. While building integration into the fabric of services that have traditionally operated in silos, this budget-neutral *Downtown Eastside Second Generation Health System Strategy* will better serve clients by improving and building on the many programs and services that are already working.

A central concept of this strategy has been to recognize the importance of including community knowledge and skills in the information gathering, decision-making and implementation process, and prioritizing improved relationships with our partners.

Towards this end, we have taken community, staff, outside expert, and client feedback very seriously, and have incorporated five new approaches into the Second Generation Health System Strategy that will improve services, access and delivery in the DTES. These five broad approaches include promoting coordinated partnerships, expanding care teams and staff competencies, integrating care, aligning services with client demand, and recommitting to the achievement of performance excellence.

Implementing these approaches will result in significant improvements in clients' lives through health expansions that include, but are not limited to, the creation of more extensive and intentional harm reduction services, increased training for peers, improved access to nutritious food, mobile health services for the most vulnerable populations, increased hours at Insite, and improved storefronts to assist with client navigation. Additionally, care will be better coordinated by moving away from stand-alone silo services, towards services that connect and support each other so clients can easily move from one needed service to another without encountering barriers.

We know that change is often a difficult process, and that is why VCH is only moving ahead with this strategy after extensive consultation. The *Downtown Eastside Second Generation Health System Strategy* will be rolled out incrementally, with care and attention paid to creating the least disruption to client care. We will provide transition support, and will keep our clients, community partners, and other stakeholders informed. Changes will be implemented slowly, on a small and manageable scale, with ongoing assessments to determine the health outcomes associated with each change. These assessments will inform future developments.

To foster further community engagement, VCH will convene discussion sessions in early 2015 about the actions described here, to inform the approach to implementation. Through increased partnership and collaboration we hope to create a system that is much more dynamic, as we discover together how to best meet the changing needs of the community. We are grateful to all who have participated in the process so far, and look forward to continuing to build positive partnerships, and to implementing innovative strategies that will provide our clients with the best care possible.

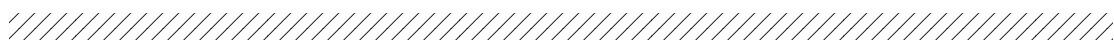
Laura Case  
Chief Operating Officer, Vancouver Community  
Vancouver Coastal Health

“Over the past two years, we’ve learned a lot about how to work together better as partners in service delivery. We’ve listened to the community’s wisdom about where there are opportunities for growth, innovation, and change. These lessons—not only about how to deliver service differently but also about how to be truly collaborative and consultative—will serve us well as we go forward on the journey of implementation.”

— Mary Ackenhusen, Chief Executive Officer, Vancouver Coastal Health



# Background of engagement and collaboration



THIS REPORT REPRESENTS THE CULMINATION OF THE SECOND GENERATION HEALTH SERVICES STRATEGY DEVELOPMENT BY VANCOUVER COASTAL HEALTH (VCH) TO BETTER SERVE CLIENTS IN THE DOWNTOWN EASTSIDE OF VANCOUVER (DTES).

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Since the summer of 2012, VCH has been engaging neighbourhood residents, service providers and other stakeholders in deliberations about how VCH can best respond to the community's changing needs.

This process highlighted strengths and shortcomings of our approach to date, and has helped us in taking steps now to collaboratively improve service delivery and health outcomes in a neighbourhood with an evolving landscape and shifting health care needs. We've seen tremendous success over the past 15 years, particularly in regard to harm reduction and mortality for vulnerable residents, but we've seen new challenges emerge as well as long-standing issues that haven't been well addressed by existing service delivery models. VCH's community engagement and redesign process aimed to look at our service systems as a whole to address these unmet needs and systemic challenges, and to build on the success we've been able to achieve with our partners.

The redesign process has been guided by extensive consultation with our community partners, VCH staff and clients, as well as an Expert Review Panel. This consultation and subsequent analysis has resulted in the publication of three discussion papers and a directions paper, each of which has addressed an important piece of the service redesign process.

- In the first discussion paper, *Working with health agencies and partners in the Downtown Eastside*, published in October 2012, we invited feedback from agencies and partners regarding their perceptions of how VCH has succeeded or failed in aspects of our mandate to serve DTES residents, many of them with complex health care needs.

- The second discussion paper, *Staff perspectives on improving care and working with health partners and agencies in the Downtown Eastside*, was published in mid-2013, and asked for similar feedback from VCH staff.
- The final discussion paper, published in January of 2014, entitled *Client perspectives on improving health care in the Downtown Eastside*, requested feedback from DTES clients, with the goal of hearing directly from clients to gain a better understanding of their concerns and changing needs.
- The directions paper, *A Second Generation Health System Strategy for Vancouver's Downtown Eastside* put forth draft recommendations aimed at guiding the direction of future program and service adjustments (these recommendations have been updated below).
- An Expert Review Panel was convened to include the perspectives of organizations working with or adjacent to the health system in the DTES, in order to ensure that new VCH program ideas will be well aligned with the panel members' own efforts. The panel membership included BC Housing, City of Vancouver, Ministry of Children and Family Development, Ministry of Justice, Ministry of Social Development and Social Innovation, University of British Columbia, BC Centre for Disease Control, and the Vancouver Police Department. The panel held two meetings in late July and early August. The outcomes of these discussions have been used to inform some of the Actions, and a summary of the meetings can be found in Appendix 2.

- VCH also convened several workshops with over 50 representatives of DTES service providers, both external and internal to VCH, to identify the most crucial health outcomes for the DTES. This paper has been informed by the findings of those discussions, in combination with deliberations of operational and health measurement leaders within VCH. With each of the actions listed below, there are associated key outcomes that were identified through these processes.

Following the publication of these reports, VCH asked its health service partners and other community stakeholders to propose ideas for new services and service improvements to deliver on the recommendations outlined in the directions paper. 65 submissions were received and carefully reviewed. Many of these proposals have been incorporated in the development of this health system design paper and can be found in the **new approaches and actions** section.

To review these submissions as well as our prior reports, please visit [dtes.vch.ca](http://dtes.vch.ca).

In this report you'll find:

1. Refined recommendations from the first directions paper, *A Second Generation Strategy for Vancouver's Downtown Eastside*. These were updated with the knowledge gained through subsequent processes ("Invitation to Innovate" process, client perspectives discussion paper, etc.)
2. Funding and service priorities that support the recommendations and improve the DTES health system and outcomes for clients





The following list of priority actions is by no means complete. The actions you'll see highlighted below are those that we expect to be the most impactful and those we anticipate implementing early on. Implementation will result in service changes that range in scope from slight modifications, such as expanding hours at Insite, to an extensive redesign, like integrating primary care, mental health and addiction teams. These changes will impact both VCH direct services and VCH-funded services provided by external service providers. In all cases, implementation will require thoughtful, engaged operational planning and transparent, real-time monitoring of impacts to account for the complex and sensitive environment.

## Refined directions

The workshops that resulted in the *Directions Paper 1*, released last summer, included "Draft Recommendations" that outlined 19 important changes to improve health services for DTES clients. Since the draft recommendations were published there have been two engagement processes, the Client Perspective Paper and Invitation to Innovate. These processes gave additional insight and information that was used to refine the original Draft Recommendations outlined below. The refinements will be structured as amendments to existing recommendations, and the addition of recommendations #s 20–24, and can be found in Appendix #3.

## Amended recommendations (changes are underlined)

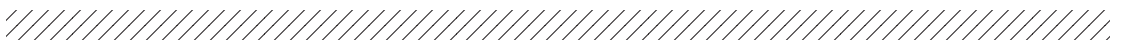
- **Draft recommendation #3 and #8 (combined):** "Invest in care models—including primary care, mental health, and addictions—that meet people where they are and can provide a range of services that are well integrated with other health and support services, for example integrated community clinics, low-barrier service environments, and housing facilities where appropriate."
- **Draft recommendation #14:** "Create a permanent housing coordination committee to work with key partners to improve accountability and equity, identify housing gaps, coordinate funding, repurpose housing to meet changing population needs, adapt mobile health services to ensure the necessary supports are in place, and share application and vacancy data."
- **Draft recommendation #19:** "Work with senior partners in government to coordinate services that impact health outcomes like the asynchronous distribution of welfare payments to DTES residents."

## Additional recommendations

- **Draft recommendation #20:**  
“Establish a care plan owner who is responsible for the coordination of care needs for clients requiring more complex care.”
- **Draft recommendation #21:**  
“Ensure clients who are aging and those who need end-of-life care have access to the support and care they require as their needs change.”
- **Draft recommendation #22:**  
“Explore the impact of nutrition as an upstream health intervention and incorporate nutritious meals as elements of VCH direct and funded services where this approach achieves key outcomes.”
- **Draft recommendation #23:**  
“Provide staff training and require all DTES staff to develop competencies that address specific needs within the DTES, including Aboriginal cultural safety, women’s needs in health care, trauma-informed care, youth, harm reduction fundamentals, the needs of aging clients, violence prevention and workplace safety for working with complex populations, and self-care for staff.”
- **Draft recommendation #24:**  
“Establish a continuum of care for major aspects of the DTES health service system, such as supported housing or addiction services, and communicate broadly about these continuums for easier and more transparent system navigation.”



# New approaches and actions



THE *DOWNTOWN EASTSIDE SECOND GENERATION HEALTH SYSTEM STRATEGY DESIGN* IS BUILT ON FIVE GENERAL APPROACHES AIMED AT ENHANCING CARE AND HEALTH, WITH SPECIFIC ACTIONS GROUPED UNDER EACH APPROACH.

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These approaches are:

1. Strengthen our relationships
2. Expand care teams and competencies
3. Integrate services to provide better-coordinated care
4. Align services with client demand
5. Achieve performance excellence

Two years of community collaboration and engagement have taken place to get to this point including the Invitation to Innovate, which garnered sixty-five submissions from community service providers, VCH physicians and staff. The ideas in the submissions significantly informed the new approaches and actions we plan to undertake and are described below. Some ideas are directly reflected while others have elements that have informed broader ideas, and have been woven into the fabric of the *Downtown Eastside Second Generation Health System Strategy Design*. Included in Table 1 (following page) is a brief outline of intended actions and their associated outcomes.

## **1. Strengthen our relationships**

We will develop and enhance partnerships that make services more complementary, coordinate systems better, and reduce silos.

### **1.1 Enhance Aboriginal cultural competencies and coordinate service planning with Aboriginal stakeholders<sup>1</sup>**

The First Nations Health Authority (FNHA) and VCH are partnering to provide health care services for Aboriginal people in the DTES, informed by the Urban Vancouver Aboriginal Health Strategy (UVAHS). The UVAHS development is in process and being jointly led by FNHA and VCH, and brings together stakeholders to build on the broad consultation work done over the past 10 years towards a coordinated service strategy. In addition, FNHA and VCH Public Health have established a framework for Aboriginal Cultural Competency, which will be embedded in all services across Vancouver, with the priority for early implementation and resourcing being in DTES services and teams.

Table 1: Client stages and associated outcomes

Stage	Client experience
Awareness	I understand the basics of health issues that are common in the neighbourhood, and also the basics about the available kinds of support that are relevant to me. It's easy to understand where and how I can get that support. I can get more information relatively easily at many places in the neighbourhood, even when I'm not feeling well.
Access	I can reach health services conveniently, by walking in, calling or emailing. I might be greeted by people working there who share experiences similar to mine. The environment and the people feel safe and welcoming, especially when I'm not doing very well. I find health services offered in places I go in the neighbourhood, like the drop-in centre or even my SRO hotel, so it's more manageable to access them. I can get help right away, without having to go all over the neighbourhood for it, and services are open at times that work best for me.
Engagement, assessment and planning	I see a clinician, and she helps me out. I can get to feel welcome and comfortable with her, even though it might take a while. We discuss my health concerns. To help figure out issues, we have the option to bring in a person who has experiences similar to mine. The clinician has connections to many different services, and together we figure out the best options for my treatment. She connects me to these services, and I have support from her team to follow through on our plan, get to those services, and check in with her again. She makes it clear that she is my main contact if anything changes or doesn't work in our plan.
Treatment	I see clinicians and other health services as planned. I can get most of my health care from just a few teams. Health workers are at my side along the way when I want support, and can help make sure I get to appointments. If I have a crisis, the health workers involved will connect me with my main contact clinician to address it. If I lose connection with that person, the health workers try to maintain that connection as long as I'm open to it. I start feeling better as the treatment takes effect.
Outcomes	With the support of my care team, I can keep up my treatment. As my health gets more manageable and has less negative impact on my life, I can do more. At times I have setbacks, and the team will be there to offer help. When I can manage my health pretty well, we can shift our plan to connecting with general health services on my own as I need.



## Improvements

- Integrate a continuum of peer-based support into all DTES services
- Connect drop-ins to care
- Connect tenant support workers to outreach teams
- Integrate services to provide better-coordinated care
- Establish shared treatment continuums
- Address service gap for families and children

- Enhance Aboriginal cultural competencies and coordinate service planning with Aboriginal stakeholders
- Integrate a continuum of peer-based support into all DTES services
- Support neighbourhood-wide care competencies
- Connect drop-ins to care
- Connect tenant support workers to outreach teams
- Integrate services to provide better-coordinated care
- Expand mobile health services
- Low-threshold methadone clinic
- Food and nutrition coordination strategy
- Harm reduction strategic plan
- Enhance impact of Insite
- OD training

- Improve consultation and collaboration with government partners
- Integrate a continuum of peer-based support into all DTES services
- Support neighbourhood-wide care competencies
- Connect drop-ins to care
- Connect tenant support workers to outreach teams
- Integrate services to provide better-coordinated care
- Expand mobile health services
- Establish shared treatment continuums
- Address service gap for families and children

- Improve consultation and collaboration with government partners
- Integrate a continuum of peer-based support into all DTES services
- Support neighbourhood-wide care competencies
- Connect drop-ins to care
- Connect tenant support workers to outreach teams
- Integrate services to provide better-coordinated care
- Expand mobile health services
- Repurpose and design housing for specialized clients
- Managed alcohol

- Enhance partnerships with private clinics
- Develop service definitions with outcomes measures

## Key outcomes

- Better access to health services
- Increase in at-risk DTES residents engaging in services

- Better access to health services
- Reduction of stigma and discrimination
- Improvement in nutrition
- Increase in at-risk DTES residents engaging in services

- Improved client attachment to care provider
- Coordinating care provider established

- Client-reported quality of life
- Overall health improvement
- Improved client attachment to care provider
- Reduction in preventable ED visits and hospitalizations
- Improvement in housing
- Improved impact of treatment of chronic disease, mental health and addiction, HIV and Hepatitis C

- Overall health improvement
- Reduction of poverty and greater access to economic opportunity
- Improvement in housing
- Reduced care intensity required by client over time

**Expected outcomes:**

- Better access to health services
- Increase in at-risk DTES residents engaging in services
- Reduction of stigma and discrimination
- Improved client attachment to care provider
- Client-reported quality of life
- Overall health improvement

**1.2 Continue client and service provider dialogue and development<sup>2</sup>**

VCH will partner in Collective Impact processes that detail the current state of all services in the DTES using cross-sectoral data to monitor shared outcome measurements, and collaboratively respond to shared challenges. A Collective Impact process is not meant to redo the consultation work that has been done through the development of this plan and others, but to build on it, towards a service delivery culture of shared responsiveness and shared responsibility. The City of Vancouver's Mayor's Task Force on Mental Health and Addictions, of which VCH and Providence Health Care were members, recommended a Mental Health and Addiction Collective Impact group, which VCH will actively participate in and support. Additionally, VCH is supportive of exploring an End-of-Life Collective Impact process that brings together stakeholders to plan for responsive, accessible, and culturally appropriate end-of-life care in the DTES. Such service currently is available but inconsistently accessible to residents who need it.

In addition to Collective Impact structures, VCH will continue the dialogue that has been established through the process supporting the *Downtown Eastside Second Generation Health System Strategy Design* by way of workshops for focused and collaborative quality improvement.

**Expected outcomes:**

- Client-reported quality of life
- Overall health improvement

**1.3 Improve consultation and collaboration with government partners<sup>3</sup>**

Experience demonstrates that consultation and collaboration with government partners increases innovation and improves health outcomes for our clients. VCH will proactively and regularly consult with government partners to keep them informed of changing client needs and health services in the DTES. VCH will respond to other partners' changing services and policies. VCH will build on the success seen in recent years by partnering with the Vancouver Police Department on the ACT team service model in terms of case coordination. VCH will enhance our efforts in shared policy development between government organizations.

**Expected outcomes:**

- Client-reported quality of life
- Overall health improvement

**2. Expand care teams and competencies**

We will enhance care teams by drawing on peer-based support, tenant support workers and drop-in centres.

**2.1 Integrate a continuum of peer-based support into all DTES services<sup>4</sup>**

It is critical to the success and vision of the *Downtown Eastside Second Generation Health Strategy* that peer programs work as part of the system of DTES services. To best support clients' recovery journeys, peer programs must operate interdependently and collaboratively with health care services. As a central feature of the



continuum of non-clinical supports, peer services will link closely with navigation services to provide relationship-centered, accessible, and community-focused support. This vision is consistent with feedback from clients and staff, and came up as a central theme in the Mayor's Task Force for Mental Health and Addiction.

Peer-based services will be based on clear standards of responsibilities, including the expected relationships with other support providers, training, and support to ensure the role is sustainable and promotes health for the workers as well as the clients, according to best practices. These standards must support the diversity of different populations and needs, and they must also support a coordinated, coherent approach, which will involve a central coordinating role.

Peer-based services will be built as a continuum of positions that starts with the most low-barrier role and extends to positions with higher levels of responsibility. The most low-barrier role may involve basic harm reduction and health education, and the other end may extend to carrying out a client's care plan with a team of clinicians.

As with other service improvements, integration of this approach to peer-based support will be an incremental process, with continual monitoring of client outcomes. This gradual approach will maximize effectiveness while minimizing client and peer disruption.

**Expected outcomes:**

- Better access to health services
- Increase in at-risk DTES residents engaging in services
- Reduction of stigma and discrimination
- Improved client attachment to care provider
- Client-reported quality of life
- Overall health improvement

## 2.2 Support neighbourhood-wide care competencies <sup>5</sup>

A central theme of the engagement phase of the *Downtown Eastside Second Generation Health System Strategy* was the notion that the training opportunities and skill expectations of various agencies and care teams vary widely, and that more training in standardized competency areas is important to facilitating optimum health outcomes. In keeping with the vision of integrated service continuums and decreased silos, VCH will approach this issue as foundational competency development across all DTES services. From a service user perspective, this means that no matter what services you access, the staff person will have the basic skills to address your unique needs. Specialization within each of these areas will continue to be found in services specific to patient needs.

To address this need for standardized competency expectations, we will be developing and/or requiring competency training in a broad spectrum of areas identified as critical to successful client care, including Aboriginal cultural safety, harm reduction, the needs of aging clients, trauma informed care, women's care needs, youth needs and engagement, as well as workplace safety, self-care, burnout avoidance and recovery, and maintaining a respectful workplace. These competencies will be included in VCH job descriptions and Schedule A's for contracted service providers, but will also be developed and maintained through leadership culture across all DTES services.

Competency training will be offered by clinicians and community leaders who have demonstrated specializations and expertise in the competency area. Training will be both theoretical and hands-on, and

will have a strong practice component, but will also include online training programs for immediate needs such as qualifying casual staff.

***Expected outcomes:***

- Better access to health services
- Increase in at-risk DTES residents engaging in services
- Reduction of stigma and discrimination
- Improved client attachment to care provider
- Client-reported quality of life
- Overall health improvement

### **2.3 Connect drop-ins to care**

A central focus of the health service system design is maximizing accessibility of health care. Stigma, discrimination and marginalization are barriers for clients to access programs and services. Drop-in centres offer a remedy to this challenge and address the need for respite from isolation and the street. In the DTES, drop-ins offer an important connection to health care for marginalized people by building relationships with staff and awareness in a welcoming, low-barrier environment, in addition to providing basic necessities like showers and laundry. With this service model, we strive to meet clients where they are, with opportunities to engage with care providers. VCH will explore ways to integrate drop-in centres as an effective gateway to more intensive supports, according to clients' needs and interests.

Multi-agency coordination is vital to the success of drop-in services, in terms of both the range of drop-in centre services and programming, and coordination to support engagement of clients into other services. To this end, VCH-funded drop-in services in the DTES will be tailored to specific population needs, and work in a manner complementary to each other and to other services.

***Expected outcomes:***

- Better access to health services
- Increase in at-risk DTES residents engaging in services
- Improved client attachment to care provider
- Reduction in preventable ED visits and hospitalizations
- Improved impact of treatment of chronic disease, mental health and addiction, HIV and Hepatitis C
- Client-reported quality of life
- Overall health improvement

### **2.4 Connect tenant support workers to outreach teams**

To maximize residents' access to coordinated care, we will explore ways of incorporating tenant support workers into the provision of care. Where a person's supported housing is funded by either BC Housing or VCH, and only where a client consents to using this approach, we will connect the tenant support worker role to the health care team, to be involved in the development and supporting the sustainment of the care plan. To achieve this, engagement with clients and staff will be required to identify processes and relationships that support coordination of services and care, but maintain client privacy and organizational efficiency.

***Expected outcomes:***

- Better access to health services
- Increase in at-risk DTES residents engaging in services
- Improved client attachment to care provider
- Reduction in preventable ED visits and hospitalizations
- Improved impact of treatment of chronic disease, mental health and addiction, HIV and Hepatitis C
- Client-reported quality of life
- Overall health improvement





### 3. Integrate services to provide better-coordinated care

We will integrate partners and services so clients receive timely and coordinated care.

Throughout our discussions, we have heard the message that DTES services have developed organically and sporadically rather than as a coherent, integrated system. As a result, the services offered feel disjointed and uncoordinated despite the providers' best efforts to make them work together smoothly. With the five approaches introduced here, we aim to establish a more coherent, integrated system that supports service providers to work together in clearly established relationships to make the best possible outcomes and experience for a client.

Figure 2 shows the general structure of this system, where we focus on:

1. Awareness, engagement and enabling people to easily access care through gateway services, first-line care, and the acute care system. The goal is to minimize barriers and enable efficient client movement between services, according to need
2. Primary care that covers a broad spectrum and intensity of needs, particularly mental health and addiction, and coordinates care for complex needs rather than leaving clients to navigate the system on their own
3. Specialized services working with the primary care plan
4. Services staying engaged with clients to achieve lasting improvement and progression to less intensive treatment options

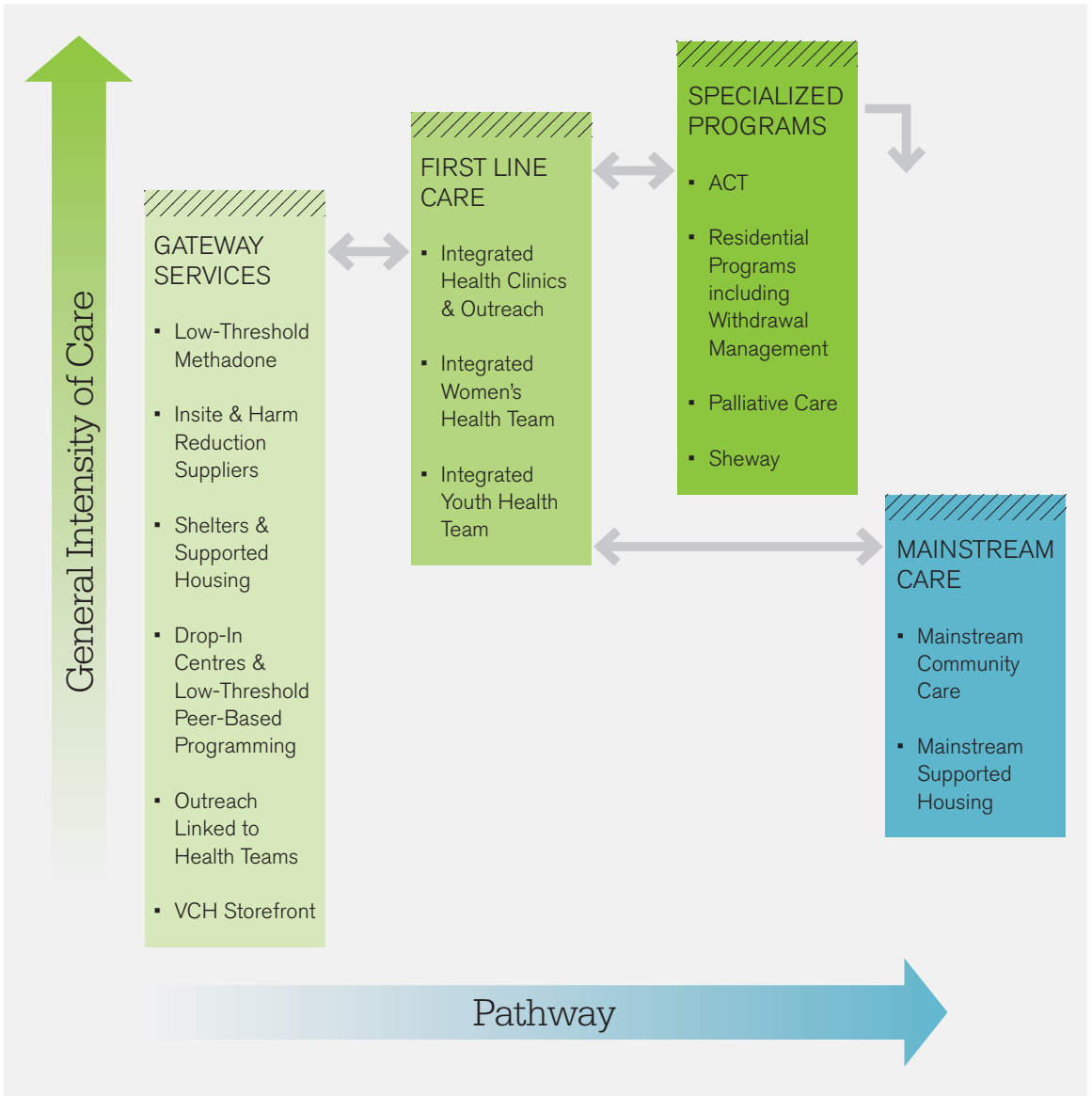
#### 3.1 Fund integrated health clinics<sup>6</sup>

The engagement phase of the *Downtown Eastside Second Generation Health Strategy* indicates that a move away from specialized clinics and services towards an integrated care model will be an important part of improving health service delivery and associated client outcomes. To increase collaboration and the ability to coordinate and share client information, VCH will be establishing an integrated care model that builds coordination and interdependence into services that have been structurally standalone—foundationally primary care, mental health, addiction, and home health, but extending to complementary services. Mobile health services and peer teams will work in tandem with the clinic-based team, as part of the overall care team for each individual client.

Care coordination will be a central feature of an integrated clinic model, including identifying a most responsible provider who is the lead person for coordinating a client's care. This person will be responsible for collaboratively creating a plan with the client that may involve coordinating multiple services to follow the care plan. The extent of coordination, which can vary from a one-issue care plan to intensive case management, requires a range of intensity depending on client needs. The level of intensity in each case will be determined by standardized assessment and clinical indicators.

The service delivery model for integrated clinics will be dependent on population and capacity needs. The draft service delivery model is outlined below.

Figure 2: DTES system design diagram



“...we aim to establish a more coherent, integrated system that supports service providers to work together in clearly established relationships to make the best possible outcomes and experience for a client.”



### **3.1a Women's community integrated health services**

VCH will work with partners to develop a full-time integrated women's health clinic with non-standard hours to meet the needs of women in the DTES. Though a final location hasn't yet been established, we recognize that choosing an appropriate location is critical to the success of the clinic, and we are currently examining options in the Oppenheimer Park area.

While a small scale fixed-address women's clinic is a vital piece of improving health care access and outcomes, community feedback and data indicates that there remains a significant demographic of women in the DTES who require a more proactive, creative and flexible approach. To this end, VCH will be establishing smaller, mobile clinics designed to meet women where they congregate. These temporary mobile "pop-up shops" will be agile enough to move as women move, allowing them to reach women who do not congregate in the same spaces as more mainstream, easily reached client populations. Pop-up health shops will have set hours, and will work with peers to ensure that vulnerable-client access is facilitated. The goal of these services will be to access an otherwise difficult to reach population, and, when possible, connect these clients to a fixed site.

Additionally, VCH will partner with BC Women's Hospital and the BC Centre for Disease Control to strategize service delivery and ensure no gaps or duplications exist between services. VCH will ensure staff and service partners have the appropriate expertise to meet the needs of the women served, including the unique needs of women working in the survival sex trade. To achieve this, we will continue formal and informal partnership dialogues

and service partnerships with women's service organizations and public agencies, building on the success of models like Living in Community out of the Renfrew Collingwood Neighbourhood House.

### **3.1b Integrated all-gender health centres**

Building on existing primary care locations as well as exploring the development of new facilities, integrated centres will provide primary and needs-specific health care in a comfortable neighbourhood environment. Hours will be expanded to meet capacity needs and the non-traditional schedule of many community members.

Services will include:

- Intensive case management and step-down services and lower intensity care coordination
- Primary care
- Communicable disease prevention and treatment
- Psychiatry and mental health clinicians
- Addiction medicine
- Home health teams hub
- Aboriginal cultural services
- Peer support
- After-hours care
- Mobile health services hub
- Medication management support

#### **Expected outcomes:**

- Better access to health services
- Improved client attachment to care provider
- Coordinating care provider established
- Reduction in preventable ED visits and hospitalizations
- Improved impact of treatment of chronic disease, mental health and addiction, HIV and Hepatitis C
- Client-reported quality of life
- Overall health improvement

### 3.2 Expand mobile health services<sup>7</sup>

VCH will expand the scope and scale of primary outreach services from the base of the new integrated health centres (as mentioned above) to care for clients who, for a variety of reasons, are not able to receive care at a fixed site. Mobile health services will also identify clients who would likely be successful moving to a fixed site, and will facilitate that transition. Mobile health services will be integrated into fixed site teams to support smooth transitions and flow, including primary care, mental health and addiction care. Mobile health services will work closely with peers and low-barrier services like drop-ins to identify client needs and facilitate strong relationships.

Attachment to primary care and mental health and addiction services is inconsistent across the neighbourhood, particularly for complex or vulnerable clients. This suggests that outreach must begin to play a significantly larger role in service delivery, when compared to embedded services. To facilitate this greater outreach capacity, we will extend mobile health services to clients who need this service regardless of which building they live in, with the necessary trade-off of de-embedding Primary Outreach Services programs (POS) from buildings they are currently attached. Increasing mobile health services will allow for the provision of health supports in a wider portion of the housing continuum—mobile supports have the capacity to access and improve health care access for clients living in BC Housing-funded units, in health-supported housing, as well as in private SROs. This will significantly decrease the number of DTES residents who are currently unattached or underserved by existing services, while maintaining service standards to clients who are attached to existing services.

#### *Expected outcomes:*

- Better access to health services
- Increase in at-risk DTES residents engaging in services
- Improved client attachment to care provider
- Reduction in preventable ED visits and hospitalizations
- Improved impact of treatment of chronic disease, mental health and addiction, HIV and Hepatitis C
- Client-reported quality of life
- Overall health improvement

### 3.3 Enhance partnership with private clinics<sup>8</sup>

There is a growing fee-for-service model being utilized by primary care and methadone clinics in the private and non-profit sector. To date VCH has worked inconsistently in partnership with fee-for-service clinics, resulting in entrenched service silos and uncoordinated care. These challenges to client care can be largely avoided by creating partnerships between VCH and fee-for-service clinics. Partnerships will be formed through the use of memorandums of understanding (MOUs) that will link private clinics and VCH services. The partnership model will be based on the successful and practical STOP HIV pilot program, the partnership between VCH Community Health Centres and private clinics in areas of Vancouver outside the DTES, and the recent VCH call for partnerships issued to pharmacies for medication management. VCH will work with clinics to articulate how fee-for-service partnerships fit with VCH's vision for primary care and other services, and how the two systems can work together to maintain a coordinated care plan for complex client needs.



**Expected outcomes:**

- Better access to health services
- Improved impact of treatment of chronic disease, mental health and addiction, HIV and Hepatitis C
- Reduced care intensity over time
- Client-reported quality of life
- Overall health improvement

**3.4 Establish shared treatment continuums<sup>9</sup>**

Mental illness, chronic disease, cognitive impairment, homelessness and aging are some of the conditions facing clients in the DTES. To provide better care across service providers and care teams, specific treatment continuums for these and other conditions must be developed and commonly understood. Each current service must be mapped along these continuums and shared with all providers to ensure appropriate care and client transitions. Three areas where this continuum development will begin are housing, addictions, and youth.

**Housing.** A critical step towards increasing access and equity in DTES housing is working with BC Housing, the City of Vancouver, and Streethome to establish a housing continuum that clusters clients according to need, and creates consistent criteria enabling service providers to match appropriate services with the needs of clients along this continuum. The development of well-defined and consistently applied housing continuum criteria will facilitate the creation of a more agile housing system that more equitably serves the needs of clients regardless of where they fall on the continuum. It will also better inform capacity challenges.

Using the LOCUS model for tiering VCH-funded units, we will transparently develop the continuum criteria based on the common understanding that the high-needs end of the housing continuum is health supported housing, and the lower-needs end of spectrum (independent living) is not functionally different from non-VCH-funded supported housing. For example, on the high needs end of the spectrum, a well-defined continuum will facilitate client moves into units with the appropriate levels of health services, while, on the lower needs end of spectrum, it will enable the adjustment of outreach services to match the changing needs of clients in their existing units.

An additionally identified gap in the housing continuum that is a priority to address is transitions out of acute services. Clients being discharged from emergency departments, Burnaby Centre, and other treatment and residential health care facilities are at a pivotal transition point, and would benefit from additional support to complete the transition. We will work with partners to establish transitional beds that provide medically supported, short-term care for complex homeless patients upon discharge from acute health care services. Discharge plans will be created upon admission to ensure this service remains accessible and effective. Clients' time in these beds will continue the stabilization achieved earlier, and build relationships with next-stage community supports and service providers.

**Addictions.** VCH is currently bringing together physician and operations leads, as well as Providence Health Care medical leadership, to establish an addiction services continuum mapped to the Canadian and Provincial standards criteria. This will enable us to better connect harm reduction service users with treatment services, establish consistent clinical guidelines for appropriate care, support assessments prior to referrals being made in order to appropriately identify the right service, and direct future resources strategically.

A critical and missing component of the addiction services continuum is supervised injection capacity across the health service system. Given the success of supervised injection as a harm reduction measure, and given that a single centralized point of service for supervised injection creates barriers for many service users, VCH is interested in pursuing the development of supervised injection capacity in community health centres and other key service locations across the DTES and Vancouver.

The federal introduction of Bill C-2 has introduced additional requirements to successful Section 56 exemptions, which are required for operating a facility with supervised injection services. In light of the new requirements, we are working to obtain an exemption for the Dr. Peter Centre and upon success of this application will explore application for additional exemptions. We want to take this opportunity to thank our dedicated community members for being partners in this decades-long journey; we know there is more to do and we are grateful for the supportive partnership that will enable us to achieve future successes together.

An additional existing gap for addiction services is stimulant pharmacotherapy. VCH is committed to supporting and driving research and best practice implementation in this area, and to this end, local researchers are planning research into treatment options for stimulant addiction through the Canadian Institutes of Health Research's Canadian Research Initiative in Substance Misuse.

“If we want to attend to the DTES’s ongoing and emerging health needs, we will have to review the programs we designed several years ago, assess their currency, and realign them with the current needs. Increased accountability (for both VCH run and contracted services) through ongoing monitoring and reporting will help us to modify the course of our programs in a timely manner.”

— Rolando Barrios, MD



As we move forward with service mapping and future service planning, we want to demonstrate VCH's commitment to a strengths-based model of addictions services. Our services across the continuum are rooted in the belief that all people facing addiction challenges can and should have hope for healthy lives. Accordingly, the principle behind our service planning should be to support people to engage in treatment, rehabilitation, and/or community integration where ever possible, regardless of a client's current condition. This support needs to be balanced with a relationship-focused approach centered on trust and assertive engagement, as well as effective community and organizational partnerships to move clients easily to the right service for their needs.

**Youth.** VCH will continue to work with Providence Health Care (PHC) and the Ministry of Children and Family Development (MCFD) to identify our shared youth services continuum and collaboratively respond to shared gaps, as well as better coordinate services between organizations. Importantly, as a shared area of need we have identified support for youth transitions to adulthood, as a secondary consultative or short-term support to generalist services. Additionally, a critical intervention planned by VCH and PHC is framing the age parameters for youth services across our organizations as 12–24 wherever possible, in order to minimize mandate gaps for youth moving between services. Finally, this group will look to establish support and guidance for adult services coming into contact with youth, including harm reduction services, based on a shared philosophy and approach on how to support different groups of vulnerable youth.

**Expected outcomes:**

- Increase in at-risk DTES residents engaging in services
- Improvement in housing
- Reduction in preventable ED visits and hospitalizations
- Improved impact of treatment of chronic disease, mental health and addiction, HIV and Hepatitis C
- Reduced care intensity over time
- Client-reported quality of life
- Overall health improvement

**3.5 Pursue a client database<sup>10</sup>**

In the community consultation phase of the *Downtown Eastside Second Generation Health Strategy*, a common client database shared between VCH and contracted service providers was identified as a valuable component of a functional health service system. Considerable effort has been put towards this initiative, and privacy restrictions have led to roadblocks on many operational solutions. Although we have limited options for better connecting care providers through health information, we will work towards a database of health records compiled through academic partnerships and a research initiative to support quality improvement and demonstrate outcomes of service. This approach aligns with the Mayor's Task Force recommendation and action plan, and VCH will work with the City to maximize value of our collective efforts.

**Expected outcomes:**

- Client-reported quality of life
- Overall health improvement

## 4. Align services with client demand

There are several specialized service needs for specific clients in the DTES.

### 4.1 Repurpose and design housing for specialized clients<sup>11</sup>

A clearly defined housing continuum will lead to improved service delivery efficiency and effectiveness by enabling clients to be clustered according to specific health needs. We currently see an increased need for specialized housing for clients with acquired brain injury, cognitive impairments, and those who are facing health problems related to aging. Demand for specific needs will guide housing repurposing decisions, allowing incremental shifts and the gradual development of transition guidelines that incorporate lessons learned into opportunities for an evolving implementation strategy. An immediate priority for repurposing is to develop housing units to accommodate clients requiring wheelchair-accessible units and clustered home support.

#### ***Expected outcomes:***

- Better access to health services
- Increase in at-risk DTES residents engaging in services
- Reduction in preventable ED visits and hospitalizations
- Improvement in housing
- Improved impact of treatment of chronic disease, mental health and addiction, HIV and Hepatitis C
- Client-reported quality of life
- Overall health improvement

### 4.2 Low-threshold methadone clinic<sup>12</sup>

An area identified as a critical gap in recent years is low-threshold methadone. To this end, VCH will establish a care team in the DTES for people with untreated opioid addiction who have proven to be difficult to engage and retain in health services. A multi-disciplinary team will provide methadone maintenance and linkage to primary care, HIV, addiction and mental health services. With minimal requirements for low-dose methadone, chaotic clients will have an alternative to withdrawal and drug-related crime. This positive engagement creates the opening for more consistent methadone use, which can stabilize the chaos of addiction. With more stability, the opportunity increases for engaging in other care and support. In this way, the objectives of this service are to engage this population with a low-threshold approach; address obstacles to treatment initiation, adherence, and retention; and generate and enhance pathways and links for the client to other health services, particularly mental health, addiction, primary care and HIV care.

#### ***Expected outcomes:***

- Better access to health services
- Increase in at-risk DTES residents engaging in services
- Reduction in preventable ED visits and hospitalizations
- Improved impact of treatment of chronic disease, mental health and addiction, HIV and Hepatitis C
- Reduction of poverty and greater access to economic opportunity
- Reduced care intensity over time
- Client-reported quality of life
- Overall health improvement





### 4.3 Address service gap for families and children<sup>13</sup>

The most important aspects of providing health care to children and families in the DTES are raising community awareness and facilitating easier access to existing services, increasing service capacity to meet increasing demand, and coordinating VCH efforts with appropriate agencies.

While many services for vulnerable children and families exist in the DTES, our community engagement process demonstrated that potential service users don't have a sense of what the services are, or how to access them. This is partly because overall health programming is piecemeal and made up of part-time resource dedication embedded in place-based services, such as schools, drop-in hubs, and community centres. This approach is valuable to meeting people where they are, but can create access or visibility barriers for other potential service users who are not currently attached to services.

To raise community awareness and increase accessibility, we will be implementing two strategies. First, we will engage in a mapping exercise with the community and service provider partners in order to facilitate a better understanding of the full spectrum of services being offered, as well as where and when they're offered, and to identify opportunities for increased coordination, access, and visibility. Second, we will partner with key stakeholders to create and implement an easily accessible service network database reflecting the map content, and distribute online and print versions.

In addition, there are known service gaps for the changing demographics of the DTES neighbourhood, including new non-market units for families with children. VCH will work with BC Women's, the RICHER program, and existing community services to coordinate services to best meet the health care needs of vulnerable families.

An additional known gap is services for moms who have complex challenges but don't meet the entrance criteria for Sheway. For example, substance using adult mothers with children aged 1-6 have minimal support in this vulnerable time. Likewise, parents who have mental health or addiction challenges and who have school-aged children require supports and may not have the services to meet their needs. VCH will work with MCFD and VACFSS and other partners to understand these gaps and find creative solutions so families in the neighbourhood are set up for success.

Finally, community consultation has revealed some high-impact policy needs for this population that require strong partnership with MCFD/VACFSS and the VPD respectively. Through this collaboration we will develop a common approach to working with substance-using parents. Clinicians and social workers don't have a policy framework for how to best support the children and parents in a family-centered approach when a parent has problematic substance-use issues. This is an incredibly complex issue that too often causes harm to families because of the lack of common understanding between service agencies.

Further supporting strong shared policy, we will be implementing a shared educational initiative designed to inform health care and service providers working with pregnant women in the DTES about the appropriate application of the Mental Health Act. Instances have been reported where the application of ‘harm to other’ has been applied to the fetus while the law states in this context that a fetus is not a person until birth. An education initiative on this distinction will support consistent practice across service providers concerning the rights of vulnerable pregnant women.

***Expected outcomes:***

- Better access to health services
- Coordinating care provider established
- Client-reported quality of life
- Overall health improvement

#### **4.4 Managed alcohol<sup>14</sup>**

In our community consultation phase, we heard from service users in the DTES that alcoholism brings substantial and unmitigated harm, particularly for residents who drink non-potable alcohol. Although health services in the DTES have made significant strides in the field of harm reduction, service options for problematic alcohol and non-potable alcohol use have only recently emerged, and are primarily pilots. VCH is currently awaiting the results of a study on managed alcohol use, and pending the forthcoming results showing positive application for the DTES community, we will incorporate the appropriate services into low-barrier service environments.

“I have been serving the health care needs of the DTES population for over 20 years and I have observed the changes firsthand. The challenges and care needs are different to what they were back then. It is good to see the Health Authority adapt to the changing needs in a coherent strategic plan that partners with the community.”

— Ron Joe, MD, Associate Medical Director, Addiction Services



***Expected outcomes:***

- Better access to health services
- Increase in at-risk DTES residents engaging in services
- Reduction in preventable ED visits and hospitalizations
- Improved impact of treatment of chronic disease, mental health and addiction, HIV and Hepatitis C
- Client-reported quality of life
- Overall health improvement

**4.5 Food and nutrition coordination and strategy<sup>15</sup>**

VCH will work with all stakeholders, including the City of Vancouver food policy staff and the Vancouver Food Security Funders Table, towards the creation of a neighbourhood-wide strategic plan for food. The goals of this strategic plan for food are to increase food provision efficiency, improve and standardize nutrition, integrate with other VCH Community Food initiatives, and to provide vocational rehabilitation opportunities for VCH clients. Recognizing that many services provide small food programs to the extent they're able with limited resources, consulted stakeholders believe that by coordinating efforts and being strategic we can have a greater impact on the nutrition and health of the community. This action supports VCH's values for upstream intervention and the goals of Vancouver's Healthy City Strategy.

As a social determinant of health, food is rivaled only by housing in terms of its impact as a form of preventative care. With this in mind, and seeking to tie food delivery to desired program outcomes, we will develop public health nutrition standards for existing funded food services, and expand our community kitchens to promote skill development and capacity building for residents.

Additionally, VCH will conduct a research pilot that examines a targeted food strategy's overall health impact on complex service users. Specifically, the research will be used to determine what the impact of a nutritious diet is on chronic disease, wound care, and symptom management for service users who are unable to provide food for themselves and would therefore not benefit from a community kitchen approach.

To offset increased food program costs, we will create a service provider resource network, which will develop and share best practices with respect to food programming and nutrition. The network will also champion partnerships with the private sector to support multi-party investments in quality food to leverage food as nutrition, and support a food recovery program that will work with grocery stores and restaurants to distribute food to low-income residents. We will look to extend this network, including food recovery, to other Vancouver neighbourhoods outside the DTES to ensure success for residents transitioning to housing across the city.

***Expected outcomes:***

- Improvement in nutrition
- Increase in at-risk DTES residents engaging in services
- Client-reported quality of life
- Overall health improvement

#### 4.6 Harm reduction strategic plan<sup>16</sup>

Harm reduction philosophy and practices should be embedded in all DTES services. We will work towards having harm reduction be a core competency across VCH-operated or contracted services. Additionally, we will ensure harm reduction is a critical component of the addiction services continuum and an opportunity to assertively engage appropriate clients in addiction treatment, as well as other indicated health services. We will incorporate the lessons we have learned about engagement through the successes achieved by our Assertive Community Treatment and Assertive Outreach teams, and will develop evaluation frameworks to ensure continuous quality improvement and consistency across services.

To keep pace with this evolving field, we will identify and build standard practices. This development will take place in collaboration with the BC Centre for Disease Control, through a strategic plan for harm reduction in the DTES, based on common philosophy and strengths-based, engagement-centered values.

***Expected outcomes:***

- Reduction in preventable ED visits and hospitalizations
- Better access to health services
- Increase in at-risk DTES residents engaging in services

#### 4.7 Enhance impact of Insite<sup>17</sup>

We've seen tremendous success from the service Insite offers, and VCH is enormously supportive and proud of the work happening there. Two improvements would enhance its impact: 1) change Insite's hours to open earlier in the day for this high-demand period, and 2) install a TV screen at Insite and other high visibility

areas to show drug alerts for IDUs. The screen will be updated centrally in real time to ensure clients have immediate access to information about drug contaminations or potency.

***Expected outcomes:***

- Reduction in preventable ED visits and hospitalizations
- Better access to health services
- Increase in at-risk DTES residents engaging in services
- Client-reported quality of life
- Overall health improvement

#### 4.8 Overdose training<sup>18</sup>

We've seen success in the naloxone and overdose prevention training programs, both in terms of outcomes and service efficiency. VCH intends to expand our existing naloxone and OD prevention training to ensure training happens at each service location, and use the "train the trainer" model to build capacity for peers and colleagues.

Additionally, in recognition that we still have a long way to go in overdose prevention and treatment of stimulants, VCH will remain committed to supporting new research and pilots in stimulant pharmacotherapy overall, including in the area of harm reduction and overdose prevention.

***Expected outcomes:***

- Reduction in preventable ED visits and hospitalizations
- Better access to health services
- Increase in at-risk DTES residents engaging in services
- Client-reported quality of life
- Overall health improvement



#### 4.9 Pain management best practices<sup>19</sup>

We heard in the Client Paper that establishing better practice around pain management would have a large positive impact on the lives of many DTES residents. VGH and St. Paul's have existing council structures on pain management best practices, which VCH will extend to the DTES through a quality improvement collective made up of clinicians, operations leaders, and consultation with client groups. The aim of the collective will be to develop a practice model of pain management specific to client needs in the DTES. VCH is invested in taking a leadership role on best practice pain management for DTES service users as part of our commitment to client-centered care and harm reduction.

##### ***Expected outcomes:***

- Reduction in preventable ED visits and hospitalizations
- Improved impact of treatment of chronic disease, mental health and addiction, HIV and Hepatitis C
- Reduced care intensity over time
- Client-reported quality of life
- Overall health improvement

### 5. Achieve performance excellence

#### 5.1 Learn with clients

VCH will convene regular client focus groups and interviews to stay connected to clients' changing health needs. VCH will create opportunities and forums where clients feel comfortable to learn about services and voice concerns about their health and/or health services. We will partner with peer services to ensure accessibility and a low-barrier environment for feedback.

The Collective Impact processes also offer a mechanism for incorporating client voices in service assessment and planning.

##### ***Expected outcomes:***

- Increase in at-risk DTES residents engaging in services
- Reduction of stigma and discrimination
- Improved impact of treatment of chronic disease, mental health and addiction, HIV and Hepatitis C
- Client-reported quality of life
- Overall health improvement

#### 5.2 Develop services definitions and outcomes measures

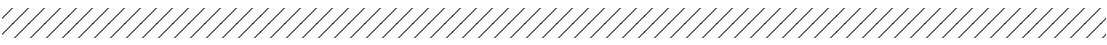
VCH will continue the collaborative momentum to develop service definitions and outcomes measures consistent across contracted services and VCH direct services. For service agreement language, we will create and update standards to define services such as target population, program purpose and deliverables, as well as creating cost benchmarks relative to service complexity.

Additionally, VCH will include in all contract language the expectation that service providers ensure their facility is a safe space for more vulnerable populations, including women, youth, children, LGBTQ2S people, and Aboriginal people. We will work with community members and service providers to develop language that reflects the intent of this inclusion.

##### ***Expected outcomes:***

- Client-reported quality of life
- Overall health improvement

# Conclusion



## VCH SUPPORTS SERVICES OUTSIDE OF THE DTES

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VCH recognizes that the DTES is an unprecedentedly inclusive community and virtually the only Vancouver neighbourhood with housing that is both low-barrier and affordable at income assistance rates. Accordingly, VCH remains dedicated to fully supporting clients who wish to remain in the DTES.

However, many clients with complex health challenges, including mental health and addiction issues, prefer to live in communities outside the DTES. A common barrier that prevents mentally ill and addicted people from living outside of the DTES is a lack of appropriate services and supports, and too often clients who do secure housing outside the neighbourhood return to the DTES regularly because of the lack of supports found in other communities. To address this, VCH supports housing and associated service options being created in other Vancouver neighbourhoods, and across the province, to enable choice and facilitate success for residents who wish to leave the DTES.

Similarly, people facing complex social and health issues, including mental health and addictions, frequently end up in the DTES from other communities across British Columbia and Canada. This is often due to either a lack of services in their home community, or the absence of a welcoming, supportive social and medical environment for complex people. VCH seeks to work with governments in other communities to develop the capacity to welcome, support, and treat people with complex challenges so they have the choice to remain in their home community where their natural support systems exist.



## **Second Generation Health System Strategy implementation**

With the publication of this design paper, the Second Generation Health Systems Strategy enters its next phase. It is important to restate that these directions will be implemented incrementally. Outcomes will be monitored in real time and will guide future decisions in the development of both contracted and VCH services. This will lead to important changes in the provision of health services—services that will become more tightly focused on the objectives that have been identified in collaboration with our clients, health system partners, and VCH staff.

As we move ahead and implement this strategy, we will continue to work to strengthen our relationship with the community and with our partners.

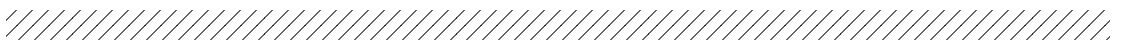
Specifically, we will:

- Hold a series of forums to answer questions regarding the *Downtown Eastside Second Generation Health System Strategy Paper*
- Share the first phase of service changes to be implemented, the implementation approach and the timeline
- Conduct related service redesign and procurement processes to implement the service changes

The Second Generation Health Systems Strategy was initiated because of our recognition that new energy and perspectives are required. Our commitment to becoming a more responsive organization remains, and we look forward to collaborating with DTES residents and our partners as we begin to implement this shared strategy. Through consistent dialogue on improving client care and a focus on performance excellence, we will achieve positive outcomes for our clients.

“It is important to restate that these directions will be implemented incrementally. Outcomes will be monitored in real time and will guide future decisions in the development of both contracted and VCH services.”

# Appendix



- 1 Discussion Paper #1 — *Working with health agencies and partners in the Downtown Eastside*, page 22  
Discussion Paper #2 — *Staff perspectives on improving care and working with health partners and agencies in the Downtown Eastside*, page 25  
Discussion Paper #3 — *Client perspectives on improving health care in the Downtown Eastside*, pages 14, 21, 24, 25, 33  
Directions Paper 1 — *A Second Generation Health System Strategy for Vancouver's Downtown Eastside*, key observation #10, recommendation #5

**Related ideas:**

- ICM Team
- Women's Treatment Centre
- Youth Knowledge Transfer
- Women's Resource Centre and Shelter
- DTES Stabilization Centre

- 2 Discussion Paper #1 — *Working with health agencies and partners in the Downtown Eastside*, pages 21, 31, 36, 37  
Discussion Paper #2 — *Staff perspectives on improving care and working with health partners and agencies in the Downtown Eastside*, pages 16, 23, 24  
Discussion Paper #3 — *Client perspectives on improving health care in the Downtown Eastside*, page 32

**Related ideas:**

- Optimizing Methadone Proposal
- DTES Dialogue Project
- EOL Care Coll Impact
- MH&A Coll Impact
- Community Dialogue to VCH Leadership

- 3 Discussion Paper #1 — *Working with health agencies and partners in the Downtown Eastside*, page 15  
Discussion Paper #2 — *Staff perspectives on improving care and working with health partners and agencies in the Downtown Eastside*, pages 7, 10, 19  
Discussion Paper #3 — *Client perspectives on improving health care in the Downtown Eastside*, pages 4, 29, 30  
Directions Paper 1 — *A Second Generation Health System Strategy for Vancouver's Downtown Eastside*, recommendation #19

**Related ideas:**

- Harm Reduction Strategic Plan — SY1
- EOL Care Coll Impact
- MH&A Coll Impact
- OD Interventions — SY1
- Medication Adherence Collaborative





- 4 Discussion Paper #1 — *Working with health agencies and partners in the Downtown Eastside*, pages 26, 38  
Discussion Paper #2 — *Staff perspectives on improving care and working with health partners and agencies in the Downtown Eastside*, page 30  
Discussion Paper #3 — *Client perspectives on improving health care in the Downtown Eastside*, page 26

**Related ideas:**

- Coordinated Continuum of Care
- Nurse Care & Peer Navigator
- ICM Team
- ICM Step Down Team from ACT
- HIV-AIDS Treatment Support Program
- Housing for HCV Clients
- Counseling Services
- Youth Addiction and Outreach Integration
- Strathcona ACT
- Women's Resource Centre and Shelter
- Treatment Continuum
- Primary Care Outreach

- 5 Discussion Paper #1 — *Working with health agencies and partners in the Downtown Eastside*, pages 21, 28  
Directions Paper 1 — *A Second Generation Health System Strategy for Vancouver's Downtown Eastside*, enabler A, recommendation #7

**Related ideas:**

- Coordinated Continuum of Care
- HIV-AIDS Treatment Support Program
- ICM Team
- ICM Step Down Team from ACT
- Women's Treatment Centre
- Strathcona ACT
- Harm Reduction Housing Centre for Older Adults in the DTES

- Women's Resource Centre and Shelter
- Treatment Continuum
- DTES Stabilization Centre
- Integrated Addiction Specialists

- 6 Discussion Paper #1 — *Working with health agencies and partners in the Downtown Eastside*, pages 21, 28  
Discussion Paper #2 — *Staff perspectives on improving care and working with health partners and agencies in the Downtown Eastside*, pages 18, 22, 26  
Discussion Paper #3 — *Client perspectives on improving health care in the Downtown Eastside*, pages 8, 29  
Directions Paper 1 — *A Second Generation Health System Strategy for Vancouver's Downtown Eastside*, recommendation #3

**Related ideas:**

- Treatment Continuum
- Supervised injection in primary care clinics
- Integrated Addiction Specialists
- Women's Resource Centre and Shelter
- Primary Care Outreach

- 7 Discussion Paper #1 — *Working with health agencies and partners in the Downtown Eastside*, page 38  
Discussion Paper #2 — *Staff perspectives on improving care and working with health partners and agencies in the Downtown Eastside*, pages 13, 18, 27, 28  
Directions Paper 1 — *A Second Generation Health System Strategy for Vancouver's Downtown Eastside*, recommendations #s 3, 8

**Related ideas:**

- Coordinated Continuum of Care
- Primary Care Outreach
- Nurse Care & Peer Navigator
- Medication Adherence Collaborative
- Youth Addiction and Outreach Integration
- Strathcona ACT
- Integrated Addiction Specialists

- 8 Discussion Paper #2 — *Staff perspectives on improving care and working with health partners and agencies in the Downtown Eastside*, page 20  
 Discussion Paper #3 — *Client perspectives on improving health care in the Downtown Eastside*, pages 9, 33

**Related ideas:**

- Methadone +
- Integrated Disease Management

- 9 Discussion Paper #1 — *Working with health agencies and partners in the Downtown Eastside*, pages 17, 21  
 Discussion Paper #2 — *Staff perspectives on improving care and working with health partners and agencies in the Downtown Eastside*, pages 8, 11, 24, 26, 29  
 Discussion Paper #3 — *Client perspectives on improving health care in the Downtown Eastside*, page 19  
 Directions Paper 1 — *A Second Generation Health System Strategy for Vancouver's Downtown Eastside*, recommendations #s 14, 16, 17

**Related ideas:**

- Youth Addiction and Outreach Integration
- Youth Knowledge Transfer
- Treatment Continuum
- Addiction and Cognitive Disorder Service

- 10 Discussion Paper #1 — *Working with health agencies and partners in the Downtown Eastside*, page 21  
 Discussion Paper #2 — *Staff perspectives on improving care and working with health partners and agencies in the Downtown Eastside*, pages 3, 7, 11, 16

**Related ideas:**

- Optimizing Methadone Proposal
- Client Care Plan Outcomes

- 11 Discussion Paper #1 — *Working with health agencies and partners in the Downtown Eastside*, pages 1, 5, 8, 13, 14, 17, 25, 26  
 Discussion Paper #2 — *Staff perspectives on improving care and working with health partners and agencies in the Downtown Eastside*, pages 14, 29, 38  
 Discussion Paper #3 — *Client perspectives on improving health care in the Downtown Eastside*, pages 18, 19  
 Directions Paper 1 — *A Second Generation Health System Strategy for Vancouver's Downtown Eastside*, recommendations #s 14, 16, 17

**Related ideas:**

- Coordinated Continuum of Care
- Housing for HCV Clients
- Harm Reduction Housing Centre for Older Adults in the DTES
- Treatment Continuum
- Long-Term Beds
- DTES Stabilization Centre
- Complex Care and Addictions
- EOL Care Coll Impact
- Addiction and Cognitive Disorder Service

12 Discussion Paper #1 — *Working with health agencies and partners in the Downtown Eastside*, pages 35, 37  
Discussion Paper #2 — *Staff perspectives on improving care and working with health partners and agencies in the Downtown Eastside*, pages 7, 11, 13, 14, 23, 24  
Discussion Paper #3 — *Client perspectives on improving health care in the Downtown Eastside*, pages 5, 8, 25  
Directions Paper 1 — *A Second Generation Health System Strategy for Vancouver's Downtown Eastside*, recommendation #9

**Related ideas:**

- LT Methadone Proposal — [Short Form]
- DTES Stabilization Centre

13 Discussion Paper #1 — *Working with health agencies and partners in the Downtown Eastside*, pages 36, 39  
Discussion Paper #3 — *Client perspectives on improving health care in the Downtown Eastside*, page 30  
Directions Paper 1 — *A Second Generation Health System Strategy for Vancouver's Downtown Eastside*, recommendation #5

**Related ideas:**

- Youth Addiction and Outreach Integration
- Youth Knowledge Transfer

14 Discussion Paper #1 — *Working with health agencies and partners in the Downtown Eastside*, pages 20, 31, 34, 35  
Discussion Paper #2 — *Staff perspectives on improving care and working with health partners and agencies in the Downtown Eastside*, page 6  
Discussion Paper #3 — *Client*

*perspectives on improving health care in the Downtown Eastside*, page 22  
Directions Paper 1 — *A Second Generation Health System Strategy for Vancouver's Downtown Eastside*, recommendation #12

**Related ideas:**

- Coordinated Continuum of Care
- Managed Alcohol Distribution Program
- Harm Reduction Housing Centre for Older Adults in the DTES
- Non-residential MAP
- DTES Stabilization Centre

15 Discussion Paper #1 — *Working with health agencies and partners in the Downtown Eastside*, pages 23, 25  
Discussion Paper #3 — *Client perspectives on improving health care in the Downtown Eastside*, pages 6, 26

**Related ideas:**

- N/A

16 Discussion Paper #1 — *Working with health agencies and partners in the Downtown Eastside*, page 5  
Directions Paper 1 — *A Second Generation Health System Strategy for Vancouver's Downtown Eastside*, enabler G, recommendation #10

**Related ideas:**

- Harm Reduction Strategic Plan — SY1

17 Discussion Paper #3 — *Client perspectives on improving health care in the Downtown Eastside*, page 8  
Directions Paper 1 — *A Second Generation Health System Strategy for Vancouver's Downtown Eastside*, recommendation #12

**Related ideas:**

- Injection Services — SY2
- OD Interventions — SY1

18 Discussion Paper #1 — *Working with health agencies and partners in the Downtown Eastside*, pages 18, 21

Discussion Paper #2 — *Staff perspectives on improving care and working with health partners and agencies in the Downtown Eastside*, page 28

Directions Paper 1 — *A Second Generation Health System Strategy for Vancouver's Downtown Eastside*, recommendation #10

**Related ideas:**

- OD Interventions — SY1

19 Discussion Paper #3 — *Client perspectives on improving health care in the Downtown Eastside*, page 20

**Related ideas:**

- pain mgmt physio\_march 2014\_final



# Appendix II

## **External review Panel Summary**

Part of the Second Generation Health System Strategy

Late in the summer of 2014, the Second Generation Strategy (SGS) working group invited 20 external guests and stakeholders to attend one of two sessions to review the proposals submitted to VCH during its “Invitation to Innovate” process. These submissions were broadly based on the directions recommended in the draft *Second Generation Strategy*, which was published following extensive collaboration with VCH staff and Downtown Eastside health service partners in spring 2013.

The purpose of the external review panel was to introduce the SGS process, its findings, and the results of the “Invitation to Innovate” to representatives of other public bodies working within the DTES but outside of the health system, including the Vancouver Police Department, the justice system and BC Housing.

During each three-hour session, a brief overview of the strategy and process was presented, and a discussion was facilitated allowing each reviewer to share their perspectives concerning the merits of the submissions.

## *Perspectives from the reviewers*

The reviewers unanimously endorsed the need for further dialogue among all health and non-health public agencies working to alleviate poverty and illness in the DTES. At a minimum this should include more frequent meetings among service partners, but could also include a new council or informal body that would have a mandate to promote information sharing and exchange. Specifically, several reviewers urged the creation of a special representative in the DTES for children and youth. This representative would be charged with advocating on behalf of the needs of vulnerable young DTES residents, and could play an important role in focusing efforts to interrupt the generational cycle of violence, addiction and abuse. Similarly, the reviewers also urged more focused resources to assist or intervene to address the mental health issues of parents with young children.

The reviewers expressed concern that proposals recommending new funding for abstinence-based programs were often inconsistent with recognized best practices, and believe that prospective clients would be better served by low-barrier programs that address addiction but do not require complete abstinence. Two noted exceptions to this were the perceived demand for abstinence programs for women recently discharged from corrections facilities who are looking “to get or stay clean” and the importance of abstinent housing options for clients already part way through their recovery from addiction.

The reviewers were also skeptical that a proposal to equip DTES residents with mobile phones would produce lasting benefit, and instead could make recipients a target for theft.

When ranking the potential benefits of competing proposals, the reviewers were also disinclined to support additional resources for physiotherapy, citing the need for services directed more explicitly at addressing mental health and addiction issues.

The reviewers did express support for enhanced funding to support more intensive case management, believing that closer coordination between clinicians and service providers would yield improved health outcomes for clients while also reducing costs to the system as a consequence of lower intervention or hospital readmission rates.

They also endorsed the need for expanded and dedicated housing options for aging DTES residents, especially those who are cognitively impaired as a result of severe addiction or brain trauma.

When addressing several proposals for enhanced harm reduction services, the reviewers were strong proponents for placing integrated addiction specialists within care teams and at more sites throughout the DTES. They also agreed with calls to better coordinate the provision of methadone treatment when clients are involved with the justice and prison system, noting that missed or poorly timed treatments can cause extreme pain and other consequences caused by sudden withdrawal.

The reviewers also endorsed the merits of a dedicated harm reduction strategy for the DTES. This strategy would seek to further normalize harm reduction practices within the health system, and specifically to build on the important precedent of Insite by embedding similar services in health clinics within and beyond the DTES. The reviewers were persuaded that a new low occupancy stabilization centre, operated with support from the VPD, could augment this strategy. Such a facility would be especially useful for clients involved in gang-related activities and violence.

Most especially, the reviewers were unanimous in their support for more resources and services being directed to meet the needs of women in the DTES. As is often recognized, women continue to bear the brunt of sexual and physical abuse as a consequence of ill health, addiction and a culture of gender-based violence. The need for increased space at women’s shelters, particularly secular shelters that provide additional support for young mothers, was apparent to the review group.



Equally, a dedicated women's treatment and resource centre integrating the full range of health and psycho-social services could provide significantly enhanced and better coordinated services to vulnerable DTES women. While not a health mandate, the reviewers also recognized the difficulty DTES residents have obtaining childcare, making it harder for women to pursue employment or training opportunities.

The reviewers also noted that a unified directory or 24/7 referral hub that could maintain up-to-date information concerning available services, beds and other resources could go a long way to reducing administration costs and expediting access to services within the DTES.

Finally, the reviewers stressed the importance of accelerating access to services for youth — especially those who are at risk of developing serious addictions and/or are vulnerable due to pre-existing mental illness. In these cases, the reviewers agreed with proponents recommending the provision of these targeted services outside of the DTES to reduce the risk of unnecessary exposure to cultures of violence and addiction.

When invited to speculate on the future of health services in the DTES, the reviewers believe that the role of peer support will grow as harm reduction practices continue to enter the mainstream. Ultimately, they expect supervised injection and consumption facilities to be located in health facilities throughout the province, possibly reducing the concentration of drug users in the DTES. Similarly, they expect that gentrification will continue to accelerate in the DTES, displacing traditional residents and leaving smaller "islands" of health services available to remaining residents.

The reviewers cautioned that major interventions are still required to disrupt the uptake of illegal drugs by at-risk youth, and they expressed alarm that narcotics like crystal meth are much more damaging than heroin and other more conventional intoxicants. They warn that the potency and affordability of crystal meth threatens to create a new health crisis among the current and future generations of drug users in Vancouver.

Lastly, the reviewers expressed their concern that no new provincial resources are available to address these longstanding health challenges, and that many organizations feel trapped in a cycle of constant cutbacks, threatening the sustainability of their services.

# Appendix III

Table 1: Client stages and associated outcomes

## Second Generation Health System Strategy Overview

### Key Observations

1. The DTES remains a crucible for our society's most intractable challenges. Its residents—as well as VCH and contracted staff—can only benefit from empathetic and engaged VCH leadership. VCH is uniquely positioned to speak for the health community, and to use both its mandate and convening power to build durable alliances that can best meet the needs of vulnerable DTES residents.
2. VCH managers are stretched across too many services, and there is too little consistent leadership; active communication, effective contract management and most critically the ability to pursue opportunities for greater collaboration and service optimization are neglected.
3. The lack of robust community-level data, shared client-information files, and case conferencing practices for DTES health services has become a critical impediment to improving care for what is a diverse, complex, and changing client population.
4. The emergence of chronic conditions and underlying concurrent mental health disorders is placing added strain on many health service providers; vulnerable DTES residents are living longer but they are not living well.
5. Having fought to establish and preserve Insite, proponents of harm reduction have yet to build consensus around new goals. Changing drug use patterns and risks related to drug purity have not been adequately addressed; an interim and achievable step towards the medicalization of opiates needs to be identified to maintain momentum.
6. Emotional and physical trauma contributes to the vulnerability of local residents; too few VCH funded health services—as well as police and emergency response—incorporate trauma-informed practice or an awareness of the effects of trauma in their interaction with residents.
7. Supportive housing remains a foundation of care, providing stability and respite; housing options remain too few and are too often tied to services that are neither portable nor respond to the changing intensity of client need.
8. The absence of appropriate addiction and mental health services beyond the Downtown Eastside can limit the choice and movement of vulnerable DTES residents; a de facto policy of containment exists which is unsupported by medical or other evidence. For some, this policy creates a tolerant and supportive community that provides stability and leads to improved health. For others it may exacerbate a cycle of addiction, violence, mental distress and poverty. At a minimum, greater choice should be available for those wishing to seek treatment or establish themselves outside of the community.
9. Gentrification in the DTES is a source of conflict, further destabilizing the community; development pressures may be inevitable, but the history of groundbreaking initiatives, a tolerant community, and a concentration of low-income housing and health service providers equips the DTES to be a unique community of care.
10. Aboriginal people remain over-represented in the DTES. As the First Nations Health Authority begins to develop an urban Aboriginal health strategy with VCH and other partners, it remains essential for VCH to support Aboriginal service providers and promote greater cultural competency across all VCH-funded health services.
11. Women remain acutely vulnerable and have trouble accessing appropriate gender-specific services; protecting, serving and empowering women should be a special focus for DTES investment.
12. There are insufficient interventions—either adequate housing or treatment—available to intercept homeless or drug-involved youth who are new to the DTES; this is, in part, contributing to a cycle of long-term addiction and poverty.

### Concept

To support the evolution of local health services towards the provision of cost-effective, evidence-based care within a cohesive network of community-based health services.

### Goals for DTES health system improvement

- Operational excellence
- Improved health outcomes
- Synergistic partners

### Conditions

### Recommendations

1. Work with partners to develop a robust care coordination system for clinical and other service providers and assertively promote case conferencing between providers
2. Build on the success of the ACT teams and other intensive care coordination models
3. Invest care models—including primary care, mental health and addictions—that meet people where they are and can provide a range of services that are well-integrated with other health and support services, for example integrated community clinics, low-barrier service environments, and housing facilities where appropriate
4. Require all VCH and contracted services to put in place gender equity and gendered violence policies, and set goals for utilization of services by women
5. Designate dedicated VCH leads for women, youth and aboriginal services in the DTES, and host dedicated working groups to improve services for these populations
6. Develop a DTES staff wellness strategy with contracted service providers to address workplace stress and fatigue
7. Create a trauma taskforce that de-stigmatizes the behavioral consequences of trauma and encourages services and frontline providers to adjust their practices accordingly
8. Shift funding for mental health services towards mental health counseling that embeds itself where people already are, in housing facilities and low-barrier service environments.
9. Require all physicians at VCH-funded or managed services to hold a methadone license, and work with relevant partners to provide 24-hour access to low-cost, low-barrier methadone treatment at multiple sites in the DTES



## Enablers

- A. A commitment to trauma-informed care across VCH-funded and managed services
- B. Improved care coordination and patient data-sharing among providers
- C. Dedicated, consistent and collaborative VCH leadership within the DTES and with external partners
- D. A focus on outcomes and improved reporting supported by robust community health data
- E. A culture of active communication and community-based, patient-centred care
- F. A commitment to harm reduction services appropriate for the diversity of drug users present in the DTES
- G. Appropriate mental health services and facilities operating locally and provincially
- H. A commitment to providing freedom of choice and movement for vulnerable residents, particularly for youth and women
- I. Better integrated and appropriate IT services available and employed by VCH-funded and managed services

## Stable funding and improved contracting

- 10. Work with clinicians and researchers to refresh or create delineated addiction treatment and harm reduction strategies concerning specific drugs of abuse, including opioids, cocaine and alcohol
- 11. Continue to support research and work with academic and government partners to build the case for medicalized opiates in addition to opiate replacement and other addiction treatment programs
- 12. Develop a business case for providing expanded access to Insite, and identify additional partner sites to host and support new safe consumption programs, including managed alcohol, throughout the DTES
- 13. Create a task force on harm reduction and youth to provide clear guidelines concerning access to harm reduction programs for minors
- 14. Create a permanent housing coordinating committee with key partners to improve accountability and equity, identify housing gaps, coordinate funding, repurpose housing to meet changing population needs, adapt mobile health services to ensure necessary supports are in place, and share application and vacancy data
- 15. Work with research partners to develop and track a focused set of community-level health outcome indicators for the DTES, and publish yearly reports that update partners on health system progress.
- 16. Pursue models for clinical care in supported housing that move with and can respond to the changing needs of individual residents
- 17. Create and maintain a supported housing directory for the DTES that describes the purpose and features of all supported housing facilities and programs available to DTES residents
- 18. Advocate for new tertiary mental health facilities for the city's most vulnerable residents living with severe brain injury and cognitive impairments
- 19. Work with senior partners in government to coordinate services that impact health outcomes like the asynchronous distribution of welfare payments to DTES residents
- 20. Establish a care plan owner who is responsible for the coordination of care needs for clients requiring more complex care
- 21. Ensure clients who are aging and those who need end of life care have access to the support and care they require as their needs change
- 22. Explore the impact of nutrition as an upstream health intervention and incorporate nutritious meals as elements of VCH direct and funded services where this approach achieves key outcomes
- 23. Provide staff training and require all DTES staff to develop competencies that address specific needs within the DTES, including Aboriginal cultural safety, women's needs in health care, trauma-informed care, youth, harm reduction fundamentals, the needs of aging clients, violence prevention and workplace safety for working with complex populations, and self-care for staff
- 24. Establish a continuum of care for major aspects of the DTES health service system, such as supported housing or addiction services, and communicate broadly about these continuums for easier and more transparent system navigation

