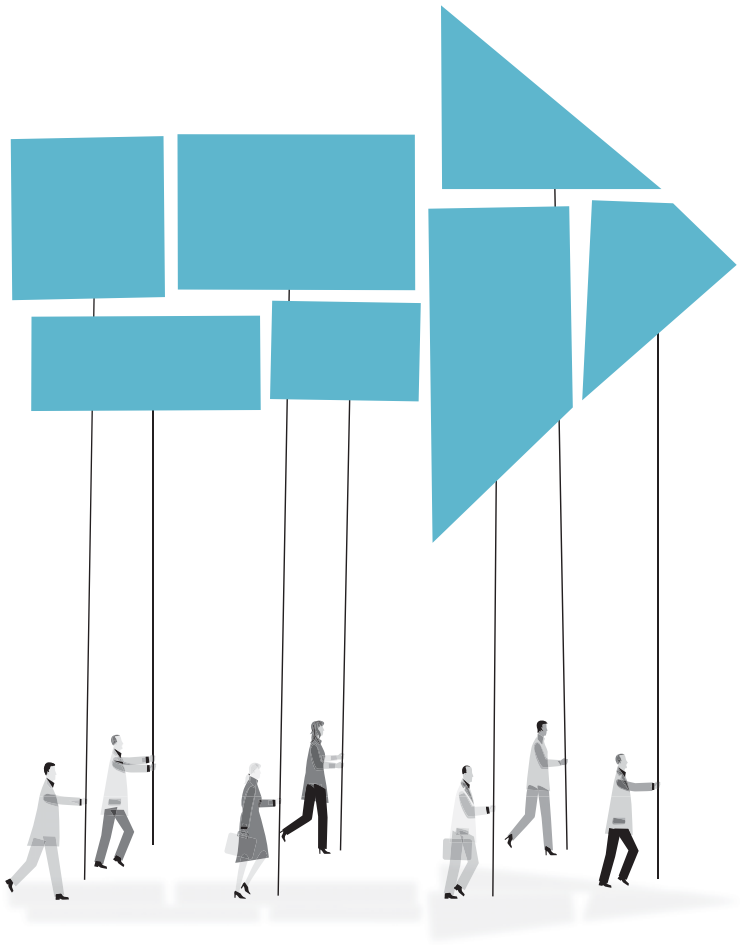
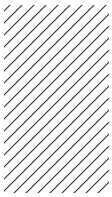
DIRECTIONS PAPER 1



A Second Generation

Health System Strategy for Vancouver's Downtown Eastside



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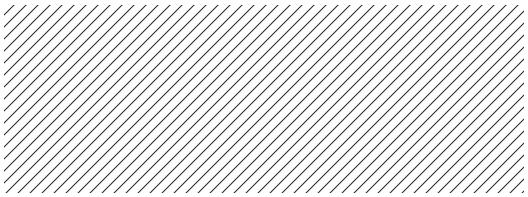


Introduction

THE VANCOUVER COASTAL HEALTH MISSION STATES THAT 'WE ARE COMMITTED TO SUPPORTING HEALTHY LIVES IN HEALTHY COMMUNITIES WITH OUR PARTNERS THROUGH CARE, EDUCATION AND RESEARCH'.

For some time now, our frontline staff and partners in the Downtown Eastside (DTES) have told us that we do not always live up to this commitment. A climate of mistrust has been allowed to set in. Too often, our communication and engagement with our staff and partners has been inconsistent.

As the regional health authority, we cannot solve all of the hardships experienced by some of our country's most vulnerable people. But we can certainly do a better job managing our part of the equation.

This year marks the fifteenth anniversary of the declaration of the public health emergency. It is an artificial marker, but one that has prompted us to more closely examine our role as the agency responsible for ensuring that residents in Vancouver's Downtown Eastside can access effective health care services.

Last autumn, VCH's board, CEO and senior executive team instructed staff to develop a new strategy to improve health outcomes and respond to the evolving needs of DTES residents. This strategy is intended to provide VCH and its partners with a renewed sense of urgency and focus, as well as to establish a more collaborative relationship.

Inevitably, any new strategy concerning health in the DTES will be compared to both the "Vancouver Model" and the Four Pillars Drug Strategy, which was adopted by the City of Vancouver three years after the public health emergency was first declared. These strategies had a powerful effect. They provided a clear course of action for health advocates, planners, and providers alike.

Most notably, the Four Pillars Drug Strategy led to the popularization of harm reduction as a key instrument of care for vulnerable and addicted residents. The opening of InSite, still the only safe injection site in North America, is a direct outcome of this strategy and an important achievement. Today, the Downtown Eastside has become a recognized leader in harm reduction. Its models of care are widely studied and replicated around the world, and significant reductions in the rate of HIV infection and overdose-related deaths have been achieved.

The 'second generation health system strategy' proposed in this directions paper builds on the success of the Four Pillars Drug Strategy and is well-aligned with the goals and achievements of the Vancouver Model. It replaces neither, but instead responds to changes within the DTES and provides an updated look at our priorities for the provision of community-based health services.

This strategy has been shaped directly by our senior team, staff and service partners. There is no single author — it is the result of intense collaboration over a period of six months. As a public document, this strategy allows VCH to mark its progress and will allow everyone, in the months ahead, to look back and assess how far VCH and its partners have come in reaching their goals.

Our work so far:

Our focus in this first year has been to re-engage with the concerns of VCH staff and health service partners by investing in an extensive dialogue.

First, we invited veteran journalist Charles Campbell to interview over 80 service partners and VCH staff, and prepare two discussion papers. These papers presented an independent and unvarnished account of how our partners and staff view VCH and its commitment to care in the Downtown Eastside.

These papers were the basis for a series of unprecedented dialogues between service partner leaders and members of the VCH senior executive and board. They were intended to send a signal that VCH is committed to acknowledging criticism and to moving forward constructively.

Next, we commissioned two strategists with deep experience in collaborative policy-making to host a series of five two-day workshops with 57 participants from more than 20 VCH-funded agencies operating in the DTES representing over 40 programs, as well as VCH managers and clinicians.

Though the division of services into five workshop segments was imperfect, it did allow participants to focus on their concerns related to specific program areas. These segments were:

1. Addictions and Mental Health Services;
2. Primary Care and Addictions Medicine;
3. Supported Housing;
4. Communicable Disease Prevention, Specialized Harm Reduction, and HIV Treatment Supports; and
5. Low Barrier Gateway, Navigation and Social Support Services.

Our focus in this first year has been to re-engage with the concerns of VCH staff and health service partners by investing in an extensive dialogue.

This directions paper is intended to clarify VCH's current understanding of the issues at hand, provide a sense of its vision and goals, and invite further conversation with residents, service providers, and government partners.

On the first day of each workshop, the participants discussed the changes they've observed in the local population and prioritized a list of issues to address. On the second day, the participants split into a series of working groups to draft recommendations that would resolve the issues they had identified. This work is the basis for this strategy and is documented in the five Workshop Directions Papers, which are included in the appendix to this report (separate document).

The participants of these workshops did not always reach complete consensus, but they were able to achieve significant agreement on many difficult issues and lay out a rough agenda for change.

The time invested by the participants during both the workshops and Campbell's interviews represent considerable commitment in terms of both time and energy on the part of our frontline providers and partners — time and energy they could have dedicated to providing direct services to clients. They are weary of talk for talk's sake. Their commitment to, and the tenor of their discussions are evidence that service partners see the untapped potential that can come from improved communication and coordination with VCH and with each other.

We are also committed to engaging DTES residents themselves in the development of this strategy. This spring, VCH invited Ann Livingston, the former executive director of the Vancouver Area Network of Drug Users (VANDU), to develop a new resident engagement initiative. This initiative is now in the midst of collecting input from DTES residents and will report back later this summer. Their priorities and commentary will be included in a supplement to this paper.

What this document is for:

This directions paper is the outcome of the work undertaken by VCH and its service partners. It is intended to clarify VCH's current understanding of the issues at hand, provide a sense of its vision and goals, and invite further conversation with residents, service providers, and government partners. Following input from our partners and stakeholders, its goals will influence future contract design and funding decisions.

The components of this strategy are summarized in a chart that can be viewed on page 10. In the pages that follow, the context for this strategy and its components are described.

The first section discusses twelve 'Key Observations' that summarize what VCH has learned from its discussions and explains its understanding of the service challenges facing health services in the DTES.

The second section, 'Transforming Care', describes the evolution VCH proposes for health services in the DTES.

The third section presents a second generation health system strategy for the DTES. It lays out a direction for health care in the DTES through an overarching 'Concept', three high-level 'Goals', and nine 'Strategic Enablers'. It concludes by listing nineteen 'Recommendations', which are tangible steps VCH intends to pursue.

This proposed strategy is not intended to be comprehensive. Detailed strategic plans often fail to predict change or adapt to lessons learned along the way. Instead, this strategy describes what VCH believes are the essential components for moving forward over the next 6-18 months in order to put VCH in a stronger position to learn, collaborate, and respond to changing needs in the DTES.

Key Observations

THE FOLLOWING TWELVE KEY OBSERVATIONS SUMMARIZE MANY OF THE THEMES THAT WERE RAISED OVER THE COURSE OF THE FIVE DTES SEGMENT WORKSHOPS, OR WHICH APPEAR IN CHARLES CAMPBELL'S TWO PAPERS.

The observation is summarized in italics and is followed by a brief discussion. The proposed components of the second generation strategy which follow this section are intended to respond to these 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 empathic 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.

For too long we have not been clear, even internally, about our vision and goals for the provision of health services in the DTES. Without clearly articulated goals, better integration and service alignment along the continuum of care becomes difficult to achieve. Too often we find ourselves working at cross-purposes.

VCH endorses the concept of subsidiarity — that community-based and community-managed services have an important role in providing more responsive and culturally appropriate care.

Our contracting process should work to preserve and enhance the ability of our funded partners to focus on what they do best while still operating within a strengthened common framework concerning best practice, public accountability and a commitment to improving health outcomes.

Weak or episodic leadership also undercuts our relationships with other government partners operating in the DTES. The health community needs a consistent and vocal representative at the table to help define a shared agenda and advocate on behalf of DTES residents and the clinical community.

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.

For too long we have not been clear, even internally, about our vision and goals for the provision of health services in the DTES.

Clear goals are only helpful if we can work with our frontline providers to achieve them. Our managers will need to be the conduit for that work. VCH staff are already stretched — we will need to find ways to use our managers more effectively.

VCH managers have been tasked mainly with enforcing contracts and handling crises. We believe there is a better way that focuses their attention on addressing system challenges and enabling service coordination. We want to see our managers enabled to use their expertise to work more strategically.

If VCH managers are empowered and supported, we believe they can become better stewards of VCH resources, pursue frontline and system innovation, focus on outcomes, and build stronger relationships with our service partners.

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.

For one of the most researched neighbourhoods in Canada, we have surprisingly little comprehensive data on the health status of the resident population. Frustratingly, raw data exists but in incompatible formats. With better community-level health data we can identify priorities, assess collective impact, and reallocate limited resources to their maximum effect.

Complex DTES clients need coordinated care from multiple providers, yet the providers we work with are using different, unconnected client record systems. It is important for VCH to maintain the security of patient and client information, and we acknowledge that PARIS was designed for a health system that for the most part looks very different from a DTES health service environment. But client confidentiality policies, secure access portals, and usability issues can and must be addressed so that providers can put their interaction with clients in a broader care context.

Finally, we need to make it so that case conferencing amongst multiple providers in different organizations is straightforward and hassle-free. Sometimes the best innovations are simple, and what's needed to improve care is simply a conversation with the right people.

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 always living better.

The health needs of the DTES population are changing and the structure of health services must respond.

Some of the most vulnerable DTES residents with serious brain injuries and cognitive impairments cannot be humanely or responsibly served in the DTES. A new model of residential care is required, and the cooperation of our provincial partners

will be necessary to secure placement for some residents in future tertiary mental health facilities.

For other chronic conditions, such as COPD, untreated Hepatitis C, or age-related disease, we believe clients are best served when they have consistent and coordinated contact with health providers grounded in relationships of mutual understanding and trust. In part, this can be achieved if care providers have more opportunities to meet clients outside of a clinical setting.

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 additional 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.

Crack cocaine, crystal meth, non-beverage alcohol, polyuse, and dangerous drug additives will have significant long-term consequences on the health of users. But creating and expanding new harm reduction programs, though required, threatens to dilute already limited resources. Research, including the NAOMI and SALOME trials, suggests many drug users would be safer and healthier if they had controlled, managed, and supervised access to medically-prescribed heroin.

Ideally, most users will gradually make the transition to opiate replacement therapies — which in the DTES are already oversubscribed. For others, this transition may be impossible, raising important policy questions concerning the long-term role of heroin-assisted therapy in harm reduction and promoting health and stability.

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.

It's likely that a strong majority of vulnerable DTES residents are affected by past and recurring trauma. Some have developed disruptive coping mechanisms, or as a consequence engage in chaotic behaviours.

Too often these symptoms create barriers that make it difficult for trauma-affected residents to access care. When these symptoms lead to conflict, care is denied, making it more likely that these residents will end up in emergency departments or jail.

Adapting services to meet the needs of these residents is an important challenge. Exhausted frontline staff struggle to provide these clients with the patient and responsive care they require. And when frontline workers engage more directly, they risk internalizing their client's trauma. Frontline staff need the support of mental health services capable of providing therapeutic counseling to these clients. Since mental health services are already managing significant case-loads focused on psychotic mental disorders that are more amenable to medication, new approaches will be required to expand access to trauma-informed counseling.

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.

(continues on page 12)

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.

Second Generation Health System Strategy Overview

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

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

Conditions Stable funding and improved contracting

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 in primary care models that meet people where they are and can provide a range of services that are well-integrated with other health and support services
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 behavioural 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
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, identify housing gaps, coordinate funding, 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 advocate for the asynchronous distribution of welfare payments to DTES residents

Vancouver CoastalHealth

The provision of VCH-funded supported housing is a key enabler of health for some residents but also falls to the edge of our mandate. Stable housing is an important component of treatment, and is closely correlated with improved health outcomes. Nevertheless, VCH needs to review and clarify its role in housing, in conversation with other government partners.

Certainly there is a strong case for change: too often health services that are linked to housing are inflexible and are unable to respond to a client's changing needs. When housing alternatives are unavailable, this leads to the sub-optimal use of health services as the focus shifts to preserving the client's tenancy. Creating a standard for more flexible and responsive services in different residential settings would help to improve the allocation of health resources and create greater stability for clients.

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.

VCH recognizes the importance of client choice in accessing community-based services. Ultimately, a mature community-based health system that is fully responsive to the needs of those requiring mental health and addiction services would provide care in a range of appropriate, supportive environments. The success of our service partners demonstrates that there is no single model of care, and that equally there is no single model of community. VCH needs to work with its service partners to clarify and strengthen existing pathways to care both within and beyond the DTES so that any resident can pursue a healthy, stable and supportive life in their community of choice.

9. Gentrification in the DTES is a source of conflict, further destabilizing the community; development pressures may be inevitable, but a history of groundbreaking anti-poverty and health initiatives, a tolerant community, as well as the supply of low-income housing and availability of health services makes the DTES a unique community of care.

VCH recognizes that the DTES is a community in flux. Development pressures are reshaping its streets and in many instances, dislocating long-time residents. Despite these changes, we believe it's important to maintain a concentration of community-based mental health, addiction and primary care services in the DTES. We look forward to participating with our health service partners in the development of the new Community Area Plan, currently being

VCH needs to work with its service partners to clarify and strengthen existing pathways to care both within and beyond the DTES.

We believe it's important to maintain a concentration of community-based mental health, addiction and primary care services in the DTES.

led by the City of Vancouver, that is mindful of the important legacy and continued relevance of low-barrier and specialized community-based services in the DTES.

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.

The health status of Aboriginal residents in the DTES should remain an urgent concern for local VCH-managed and funded services. Aboriginal residents continue to be over-represented among vulnerable residents living in the DTES. VCH needs to be a strong advocate for its First Nations health service partners, and take greater care to ensure that culturally-appropriate services are more readily accessible at all service sites in the DTES.

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.

Too many women in the DTES are the victims of abuse, and endure sustained and repeated acts of violence. The effects of this trauma are often compounded by infection, addiction and mental illness. The vulnerability of women in the DTES and the inadequacy of police and health services contributed to one of the most horrifying chapters in the life of this community.

This culture of violence and exploitation is unacceptable, and VCH must redouble its efforts with other government agencies and its service partners to provide women with the dedicated services and safety they need. As recently documented in *The Report of the Missing Women Commission of Inquiry,* we must also work to address the underlying causes of gender violence. For VCH, this means taking responsibility for providing women with appropriate, safe, gender-specific health services within the DTES and throughout the region.

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.

Reducing the availability of dedicated youth services in the DTES does not discourage young people from settling in the community. When vulnerable youth seek services in adult-oriented environments, providers are forced to navigate between effective harm reduction techniques and responsible child protection. It's a situation with no easy answers. VCH needs to provide guidance about how to serve youth in adult environments, as well as how to provide more dedicated youth services both in the DTES and the wider community.

Transforming Care

The twelve key observations describe our understanding of what needs to change. The draft strategy that follows describes what we think should be done. It is meant to:

- Provide greater clarity concerning our vision and goals for the provision and improvement of health services in the DTES;
- Reorient VCH and its collaborators towards the health issues that have recently emerged or have remained inadequately addressed in the DTES;
- Serve as a point of departure for further conversation with residents, service providers, and government partners; and
- Establish the priorities that will serve as the basis for contract design and funding decisions.

From the first to second generation of care:

The first era of active engagement with the health needs of the Downtown Eastside has produced important health gains for the DTES community. Arguably, this first era had three distinctive features:

- The effort to introduce and popularize the Four Pillars strategy — particularly harm reduction;
- The provision of crisis-focused services, the creation of basic supports and improved access to care;
- The proliferation of new agencies, models and services made possible by significant new public investment.

As we look ahead, we anticipate that the next era of health service provision will be defined by the maturation of harm reduction services, an emphasis on comprehensive addiction treatment and a greater appreciation for the role of trauma in the lives of vulnerable DTES residents.

We also anticipate a shift towards more mature, better-integrated, evidence-based health services that are suited not only to addressing crises, but also longstanding, complex chronic health conditions.

Ultimately, we believe care can be delivered more efficiently and effectively in the DTES. We know this will require, at a minimum, new partnerships as well as more extensive collaboration between our health service partners. It may also require new management models and potentially the consolidation of some agencies. It will certainly involve better coordination with other service providers working throughout the city, and the creation of pathways to care that provide opportunities for those seeking to leave the DTES to do so.

We must acknowledge that we are operating in a constrained funding environment. Currently, VCH spends more than $60 million each year to provide community-based addiction, primary care and mental health services to vulnerable DTES residents. Through this transition and beyond, we intend to manage this investment more actively in collaboration with our local partners, while also improving our ability to demonstrate the impact of this investment on the health and wellbeing of DTES residents.

The Strategy

A SECOND GENERATION HEALTH SYSTEM STRATEGY FOR VANCOUVER'S DOWNTOWN EASTSIDE.

The health services which VCH provides and funds within the DTES are a part of a region-wide network of care, and are shaped by advances in clinical practice, management culture, community expectations and available resources.

As the regional health authority, we seek to support the evolution of all local health services towards the provision of cost-effective, evidence-based care within a cohesive network of community-based health services.

Our goals are to support operational excellence at every level of VCH and among our contracted health service partners; to work deliberately and measurably towards improved health outcomes for vulnerable residents living in the DTES; and to foster more open and synergistic partnerships among our health service partners as well as with other agencies, organizations and orders of government active in the DTES.

In order to achieve these goals, we are committed to advancing nine strategic enablers. Together they describe what we believe are among the necessary pre-conditions to achieving significantly improved health outcomes for vulnerable residents in the DTES in the years ahead.

First, VCH will recognize the significance of principle and recurring trauma in the lives of many DTES residents, and ensure that the provision of trauma-informed care become a standard of practice across all VCH-funded and managed services in the DTES.

Second, VCH will work to improve care coordination and patient data-sharing among providers to enhance the responsiveness of services to the needs of clients, and reduce inefficiencies and delays in obtaining effective care.

Third, understanding the importance of sustained and effective leadership, and that our commitment to the DTES must be long-term and consistent, VCH will redouble its efforts to provide dedicated, attentive and collaborative leadership within the DTES and with external partners.

Fourth, we will invest in improved reporting of health outcomes supported by more robust community health data. We believe that better data will strengthen performance and accountability. It is essential that VCH have access to the health outcome and population data that

We want to underscore the importance of both stable funding and improved contracting as conditions that are critical to the success of this strategy.

helps us ensure our priorities align with the needs of the community, and that this data is shared with our health service partners so it can help them improve their services.

Fifth, VCH will work with its partners to provide better integrated and appropriate IT services for VCH-funded and managed services. Inadequate IT systems are a major barrier to effective case management, information sharing, health outcome reporting, and community health data compilation. The quality and sophistication of IT services in the DTES should be equal to the IT supports available across the VCH network of care.

Sixth, understanding that improved client outcomes for vulnerable individuals can be achieved through more mobile, embedded and responsive health services, VCH will work to create a culture of active communication and community-based, patient-centred care in the DTES.

Seventh, recognizing that harm reduction services should respond to changing drug use patterns, VCH will commit to the provision of harm reduction services appropriate for the diversity of drug users present in the DTES.

Eighth, major improvements in DTES health outcomes can only be achieved with access to appropriate mental health services and facilities operating locally and provincially. As a first step, VCH will seek to work with the provincial government and other health authorities to consider the role of tertiary and residential mental health facilities in supporting the health system to meet the needs of patients.

Ninth, while maintaining a strong commitment to community-based care in the DTES that reflects the special health needs of the neighbourhood, VCH will work with its partners to expand the freedom of choice and movement for vulnerable residents, particularly for youth and women. We believe it is important that residents can access different service providers according to their needs, and that pathways to service outside of the DTES exist for those wishing to exit the community.

These nine strategic enablers will form a basis for more responsive and effective health care in the DTES. They will only have impact through sustained effort from VCH along with many of the other organizations active in the DTES.

Similarly, we want to underscore the importance of both stable funding and improved contracting as conditions that are critical to the success of this strategy. Our goals and recommendations assume a relatively stable funding environment over the short and mid-term — while also anticipating increasing demand for services and changes to the complexity and intensity of the services required. Improved contracting — both competitive tendering and ongoing contract management — will be an important area of focus for VCH and its managers.

Proposed Recommendations

Like every aspect of this strategy, the following recommendations are drawn from the extensive conversations that took place with representatives of VCH-funded or managed services. They set out a course of action that will guide VCH's efforts to achieve its goals and objectives over the course of the next 6-18 months. They do not appear in order of priority.

VCH intends to:

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 Assertive Community Treatment (ACT) teams and other intensive care coordination models;

3. Invest in primary care models that meet people where they are and can provide a range of services that are well-integrated with other health and support services;

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 multidisciplinary trauma taskforce that campaigns to de-stigmatize the behavioural consequences of trauma and that 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;

10. Work with clinicians and researchers to refresh or create delineated 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 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, identify housing gaps, coordinate funding, 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; and

19. Work with senior partners in government to create a new system for the asynchronous distribution of welfare payments to DTES residents.

VCH is operating in a period of prolonged fiscal constraint. This context is important because it underscores how, in the face of this pressure, we are determined to maintain at or near our current level of investment in the Downtown Eastside.

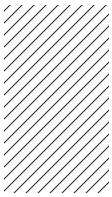
Next Steps

The backdrop for this strategy should come as no surprise. VCH is operating in a period of prolonged fiscal constraint. Services provided across the region are being reduced and in some cases eliminated. We are currently taking steps to reduce our administrative costs, with the consequence of job losses throughout our organization. This context is important because it underscores how, in the face of this pressure, we are determined to maintain at or near our current level of investment in the Downtown Eastside.

Later this summer, we will host a meeting between our partners in BC Housing, the City of Vancouver and various government ministries. This meeting will be the first of several aimed at soliciting their input to this strategy and creating greater alignment across our organizations. VCH intends to use this forum to advocate for the goals outlined in this strategy as well as for continued and enhanced investment in the DTES.

We will also share this strategy with residents and health service partners through a series of 'open houses'. These sessions will continue the conversation that has begun and solicit input on this proposed strategy. We also look forward to the input of a series of interviews and workshops with local residents led by Anne Livingston as part of a new resident engagement program. The perspective of local residents and clients is essential to informing the evolution of this strategy.

Lastly, we realize that no strategy can be effective unless it is implemented, and that effective implementation will require the determination and insight of all of our partners working in the DTES. To this end, this autumn VCH will issue an "Invitation to Innovate" to our health service partners active in the Downtown Eastside. This invitation will be an open, public process that invites submissions indicating how the goals, enablers and recommendations set out in this strategy could be achieved within existing health budgets. Future Requests for Proposals and service contracts beginning in 2014 will seek to incorporate the best ideas described in these submissions.



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