HIV/AIDS Prevention, Care, Treatment and Support

Best Practices for Community Health Centres

Association of Ontario Health Centres, December 2005

HIV/AIDS Prevention, Care, Treatment and Support:
Best Practices in Community Health Centres

December 2005, Association of Ontario Health Centres

Project Manager, Loralee Gillis
Project Coordinator, Cheryl Woodman
Report Editor, Lea Narciso

For more information, contact:

Association of Ontario Health Centres
1 Eva Road, Suite 220, Toronto, ON M9C 4Z5
Tel: 416-236-2539
Fax: 416-236-0431
Website: www.aohc.org

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Canadian AIDS Society (CAS)	Kim Thomas

N.B.: Contact information for all participating CHCs is available on the AOHC website. Go to: **www.aohc.org** and click on "Contact Us" and then "Member List."

List of Acronyms

ACT	AIDS Committee of Toronto
AHAC	Aboriginal Health Access Centre
AOHC	Association of Ontario Health Centres
ASO	AIDS Service Organization
BHO	Building Healthier Organizations
BlackCAP	Black Coalition for AIDS Prevention
CAAT	Committee for Accessible AIDS Treatment
CACHCA	Canadian Association of Community Health Centre Associations
CATIE	Canadian AIDS Treatment Information Exchange
CHC	Community Health Centre
CTCHC	Central Toronto Community Health Centres
HETF	HIV Endemic Task Force
HR	Harm Reduction
IDU	Injection Drug User
LGBT	Lesbian/Gay/Bisexual/Transgendered/Transexual
OAN	Ontario AIDS Network
OHIP	Ontario Health Insurance Plan
PACD	Person of African Caribbean Descent
PASAN	Prisoners HIV/AIDS Support Action Network
PHA	People Living with HIV/AIDS
TEACH	Teens Educating and Confronting Homophobia
WHIWH	Women's Health In Women's Hands

Executive Summary

Ontario's Community Health Centres (CHCs) play a strategic role in addressing the AIDS epidemic in Ontario and Canada. CHCs provide clinical care, treatment and support to people living with HIV/AIDS (PHAs) as well as health promotion and prevention services for individuals and communities at risk of becoming infected with the virus. One of the goals of CHCs and AHACs is to serve people in Ontario who face significant barriers in accessing health and social services. Because of this mandate, CHCs serve many vulnerable populations disproportionately affected by HIV/AIDS.

At the 2002 Association of Ontario Health Centres (AOHC) Annual General Meeting, a motion was passed that the AOHC, in association with member health centres, make a commitment to develop best practices for HIV/AIDS care and support that addresses the disparities in health status, healthcare access and modes of health treatment based on the determinants of health including race, gender, immigration status and socio-economic condition. A proposal was submitted in response to this directive and, in April 2003, the AOHC received funding from the AIDS Division of Health Canada to implement the *HIV/AIDS Best Practices in Community Health Centres Project*.

The goal of the project was to support CHCs by developing resources and information to assist in the planning and implementation of HIV/AIDS best practices at their centres. The project was intended to support the work of CHCs that are currently providing HIV/AIDS services, as well as those centres that were interested in implementing HIV/AIDS programs or services.

The project was supported by AOHC staff and guided by a steering committee consisting of representatives from twelve CHCs in Ontario who work in HIV/AIDS prevention, treatment and/or care. Data were collected from CHC frontline service providers and service users as well as AIDS service organizations (ASOs) across the province. Important themes that emerged from the data included:

Programs and Services

CHCs across Ontario offer a variety of programs and services to PHAs and to those at risk of becoming infected with the virus. Empowering individuals, families and communities to have increased control over their health is one of the principles of the CHC/AHAC model of care. This principle is reflected across the continuum of care, treatment and support that CHCs provide, both by supporting individuals to take responsibilty for their health and supporting communities to maintain and improve their health. Both of these principles are key to providing effective HIV/AIDS services.

Supporting Individuals and Families

The most highly utilized services in CHCs include counselling, general primary care, prevention education, safer drug use supplies, safer sex supplies, transportation and referrals to other specialists. Many service users commented that accessing programs and services at CHCs has had a significant impact on their lives, particularly due to the empathy of service providers that enabled them to build trusting relationships. Several clients indicated that their CHC was the only place they had disclosed their HIV status.

CHCs create spaces where service providers connect with hard-to-reach clients and provide health promotion and educational information. Clients use CHC HIV/AIDS services because they offer safe, trusted and integrated services where clients feel comfortable discussing HIV/AIDS issues and accessing programs that are not available elsewhere. Service providers highlighted a number of services and programs that are vital to their clients including anonymous testing, harm reduction, clinical care and drop-in centres.

Building Community Capacity

In Ontario CHCs, utilizing and investing in community capacity has enhanced HIV/AIDS care, treatment and prevention services. CHCs are community-based organizations with established relationships with the communities they serve. Affected and vulnerable communities are involved in decision-making and program development.

The participation of PHAs is a key element which helps organizations shift from just service delivery to both service delivery and advocacy. Ensuring the meaningful participation of PHAs, however, is not a seamless process for many organizations. Major obstacles to involving PHAs include lack of access to sufficient HIV/AIDS education and training. Further, disclosure of HIV status, health concerns, transportation and child care may act as barriers to people becoming involved in HIV/AIDS related programs. CHCs can bridge these gaps by providing access to training, information sessions and peer programs.

Access and the Social Determinants of Health

CHCs serve people in Ontario who face significant barriers in accessing health and social services. CHCs also address the social determinants of health within a framework of social justice. These goals are consistent with the policy directions of Ontario's current HIV/AIDS Strategy and provide clear direction for the strategic role that CHCs play in addressing Ontario's AIDS epidemic.

Serving Vulnerable Populations

Service providers indicated that housing, employment, lack of stable income and poverty were of concern to their clients' health. CHCs design their programs to meet the needs of specific populations and communities which individual centres identify as priority populations. Many of the populations that CHCs specialize in serving are the same populations that have been identified as underserved or hard-to-serve in HIV/AIDS literature and/or the Ontario HIV/AIDS Strategy.

Addressing Barriers to Access

CHCs aim to increase the accessibility of programs and services for individuals and for the community as a whole. They approach this goal by, for example, organizing activities that are relevant to the needs identified by the community and by providing an accessible, convenient and comfortable space in which to access services. Further, many centres have found ways to facilitate more accessible HIV/AIDS prevention, treatment and care for their clients.

The development of best practices in HIV/AIDS services in CHCs includes ensuring access and equity in health care. CHCs address a broad range of barriers to accessing services faced by a variety of vulnerable populations. The work of CHCs helps to address the impact of the social determinants of health in the lives of the individuals, families and communities. As a sector we can learn from our successes and provide a template for other models of care that are struggling to address issues of access.

Coordinated Care

Coordinated care is one of the principles of the CHC model of care. Coordinated care includes two strategies: first, within centres, services and programs are delivered and shared by an interdisciplinary team of providers and second, that the CHC team coordinates services for their clients in the community and with other parts of the health and social services sectors. Coordinating care is often invisible work that can be overlooked. Respect for the interrelatedness of practices is an important value within CHCs that grounds our work as we strive to integrate treatment, care and prevention of HIV/AIDS. Although CHCs have extensive experience in care coordination, the process is seldom seamless. While participants in the study identified this integration as a strength of our model of care, they also emphasized that integration does not happen without great effort.

Coordinating Programs and Services

HIV/AIDS care is often integrated into CHC programs and services. Several centres indicated that this approach works well and makes clients feel more comfortable about using CHCs for their HIV/AIDS care. Some centres have developed specific HIV/AIDS services and programs.

CHCs that have clinical staff who are knowledgeable in the area of HIV/AIDS are able to provide integrated HIV/AIDS prevention, treatment and care services to clients. This valuable resource enables education exchanges amongst service providers and assists clients in receiving comprehensive clinical services. Most CHCs, however, have lengthy waiting lists and are in need of more clinical staff. Increasing staff resources and mentorship opportunities for all clinical staff would allow more CHCs to offer HIV/AIDS services in their communities.

Many service users that we interviewed felt that their service providers were working together as a team. Service providers have mixed impressions of the coordination at their centres: some feel their coordination is excellent, communication is open and staff are accessible while others feel a definite separation between clinical staff and health promotion, harm reduction and outreach teams. Placing an emphasis on coordination of services is an essential component in the prevention, treatment and care of populations affected by HIV. Such care requires the exchange of information and close coordination among all participants in the care process.

Partnerships

The CHC philosophy of care encourages partnerships with health and social service organizations in catchment communities and beyond. This strategy helps to leverage resources and ensures excellence in care coordination. HIV service providers have developed partnerships to ensure broad access to comprehensive care, to increase centres' capacity to serve diverse populations and to expand staff skills and knowledge.

Across the province, many CHCs partner with local ASOs to provide HIV/AIDS services. ASOs are non-profit, community-based organizations that offer HIV/AIDS-related services to communities. Many ASOs believe that ASOs and CHCs have much to learn from one another and expressed interest in working more collaboratively with CHCs in the future.

CHCs aim to coordinate activities so that CHC and community resources are used effectively and efficiently. Lack of coordination can be a barrier to access, particularly for vulnerable and/or marginalized populations. As such, there are a variety of effective approaches for integrating HIV care into the work of CHCs and for creating a team that can provide this care. CHCs can provide leadership and mentorship for other models of care. Staff at many CHCs would benefit from training and skill development related to working effectively in an interdisciplinary team. While CHCs have developed many effective partnerships across the province, there are opportunities to work more closely with ASOs to provide better care for PHAs or those at risk of HIV.

Evidence and Evaluation

CHCs practice one of the most accountable models of delivering primary health care. Mechanisms for accountability include governance through community boards, the Building Healthier Organizations accreditation process and the CHC Program Evaluation Framework.

CHCs use evidence-based practice and evaluation to improve and support their programming and services. Collecting evidence and research and regularly evaluating programs and services provides models of best practices and documentation of their unique and valuable work. Further, CHCs integrate research and evaluation into their practices to ensure clients receive the best care possible. Regular evaluation of programs ensures constant improvement and innovation and documents the value of CHCs in addressing Ontario's AIDS epidemic.

Showcasing CHC Best Practices

Research has demonstrated that the most effective HIV/AIDS prevention and treatment services are those that are responsive to the needs of the communities and populations that they serve. Now in the third decade of the epidemic, we know that effective services are seldom generic; they need to be tailored to the expressed needs of service users. A strength of the CHC model of care is that they are founded on the principle of providing services that meet the needs of local communities. CHCs have developed a wide variety of innovative programs and services in response to the needs of the communities we serve.

Adapting services to diverse communities is a challenge. Service providers struggle with designing services and supports that are responsive to the needs of clients and communities. This project has been the first step in sharing our models of excellence across the province and learn-

ing from each other's successes and challenges. To identify best practices, this project asked CHCs about their innovative work in HIV/AIDS services.

Recommendations

This project was the first step in documenting the work of CHCs in Ontario and providing a forum for service providers in our organizations to communicate with each other and to plan collective action. The ***HIV/AIDS Best Practices in Community Health Centres Summit*** held in Toronto in January 2004 was the first time that service providers from across the province came together to discuss their HIV/AIDS work in CHCs. The Summit was intended to provide participants with an opportunity to network, share models of excellence and to look ahead to next steps for CHCs in the development of HIV/AIDS care.

Recommendations from the Summit are based on our research and the experience of the seventy-nine participants who attended the event. These recommendations are directed at various groups including CHCs, ASOs, the AOHC and various funding bodies including the Ontario Ministry of Health and Long-Term Care. Recommendations are organized in three sections based on the workshop groups that met during the Summit:

1. CHCs' Unique Contribution: Integrating Care, Treatment and Support with Prevention, Outreach and Health Promotion

- — Develop more effective systems of internal and external referral.
- — Develop formal HIV/AIDS testing and follow-up protocols within CHCs.
- — Develop strategies to address stigma within CHCs for clients who are at risk of HIV or who have HIV/AIDS.
- — Encourage and provide resources for peer teaching and peer review.

2. Building Coalitions: The Foundation for Building Capacity for HIV Work in CHCs

- — Secure resources to support the development of internal CHC coalitions through mentoring and peer training.

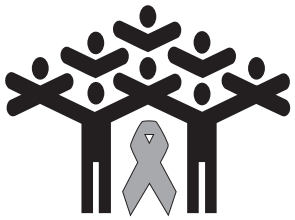
3. CHCs' Strategic Role in the Ontario AIDS Epidemic: Funding, Research and Public Policy

- — CHCs become strategic partners in the implementation of the *HIV/AIDS Strategy for Ontario to 2008* through the development and delivery of HIV/AIDS programs.
- — CHCs be considered for additional HIV/AIDS research funding and resources.
- — Ensure and solidify CHCs' contribution to HIV/AIDS policy through provision of the necessary supports and resources to increase participation across Ontario.

Conclusion

CHCs are responding to Ontario's AIDS epidemic by providing accessible primary care and health promotion services to diverse populations. The CHC model of care provides an ideal platform upon which HIV/AIDS services can be delivered. This model allows for the integration of the determinants of health into service delivery; calls for evidence-based programming and policymaking; and possesses inbuilt mechanisms for monitoring and evaluation to determine the effectiveness of the services delivered.

Because few CHCs have published accounts of their work, this report is a first step in sharing the HIV/AIDS work of CHCs with a broader audience. Our research has documented the HIV/AIDS services that Ontario CHCs are providing to their communities; identified the successes and challenges of that work; and clarified the role that the CHC sector plays in HIV/AIDS care in Ontario. The project has demonstrated the strategic role of CHCs in addressing the HIV/AIDS epidemic in Ontario and has provided clear recommendations for improving the integration of CHCs into the *HIV/AIDS Strategy for Ontario to 2008*. It is our hope that this document can be used to guide the next steps in provincial collective action towards the development of HIV/AIDS programs in local centres.



Introduction

Ontario's Community Health Centres (CHCs) play a strategic role in addressing the AIDS epidemic in Ontario and Canada. CHCs provide clinical care, treatment and support to people living with HIV/AIDS (PHAs) as well as health promotion and prevention services for individuals and communities at risk of becoming infected with the virus. One of the goals of CHCs is to serve people in Ontario who face significant barriers in accessing health and social services. Because of this mandate, CHCs serve many vulnerable populations disproportionately affected by HIV/AIDS.

It is well documented that the social determinants of health contribute to new infections and affect the ability of PHAs to maintain their health. CHCs work to decrease the impact of the social determinants of health and to increase access to prevention, care, treatment and support. CHCs are also leaders in providing an integrated approach to HIV prevention, care, treatment and support based on the determinants of health. Essentially, CHCs provide a model for a one-stop-shop through which clients conveniently access HIV/AIDS health and social services. These approaches are consistent with the policy directions of Ontario's *HIV/AIDS Strategy to 2008*.[1]

The findings of this study provide a snapshot of HIV/AIDS programs and services in CHCs across Ontario. We hope this work will be informative for frontline service providers and managers in CHCs as well as policy makers.

Project Background

At the 2002 Association of Ontario Health Centres (AOHC) Annual General Meeting, a motion was passed that the AOHC, in association with member health centres, make a commitment to develop best practices for HIV/AIDS care and support that addresses the disparities in health status, healthcare access and modes of health treatment based on the determinants of health including race, gender, immigration status and socio-economic condition. A proposal was submitted in response to this directive and, in April 2003, the AOHC received funding from the AIDS Division of Health Canada to implement the *HIV/AIDS Best Practices in Community Health Centres Project*.

The goal of the project was to support CHCs by developing resources and information to assist in the planning and implementation of HIV/AIDS best practices at their centres. The project was intended to support the work of CHCs that are currently providing HIV/AIDS services, as well as those centres that were interested in implementing HIV/AIDS programs or services.

Key objectives of the project included:

- Developing a sustainable network of HIV/AIDS service providers in Ontario CHCs;
- Identifying current research and guidelines that support the integration of HIV prevention, treatment and care;
- Documenting successful adaptations to evidence developed by CHCs;
- Documenting and disseminating existing best practice models for HIV prevention, treatment and care in CHCs;
- Developing and recognizing skills and abilities of frontline CHC service providers across Ontario in HIV/AIDS best practices; and
- Identifying areas for collaboration and research in the CHC sector in HIV/AIDS services.

Defining Best Practices

Best practices are an important tool for addressing HIV/AIDS issues in our communities and are also important from a systems perspective. CHCs engage in best practices development:

- To ensure we are providing quality care that is evidence-based and designed to address the needs of our communities;
- To demonstrate the validity of alternative approaches to practice;
- To gather information and data which can help us demonstrate resource needs for our client groups;
- To support the "Building Healthier Organizations" accreditation process;
- To provide a means of accountability to our communities, our CHC boards and funders; and
- To provide a framework for sharing models of excellence and pooling our collective knowledge and resources.

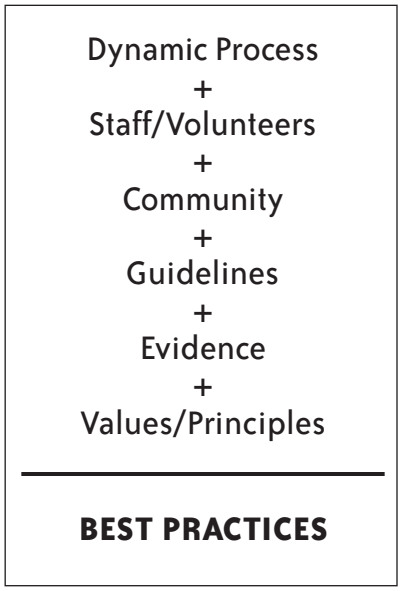
The CHC definition of best practices is based on the knowledge that communities have different needs that must be taken into account when providing services. CHCs do not simply standardize practice but rather develop practices that are based on evidence and which respect the unique needs of their respective communities. This model includes the communities we serve as partners in the best practices development process.

Best practices in CHCs are dynamic and change in response to learning through practice, program evaluations and new evidence. In CHCs, the knowledge and expertise of practitioners is an essential element in the development of best practices. The CHC concept of best practices includes developing tools and strategies that enable practitioners to share knowledge and skills to build on one another's expertise and innovation.

The CHC movement is based on values and principles that include, but are not limited to, addressing the social determinants of health and advocating for social justice. Best practices in CHCs are based on our collective values as a movement and the values and principles of the local communities in which they are implemented. Concepts that characterize the CHC definition of best practices are summarized in **Figure 1**.

Best practices in CHCs also incorporate guidelines for practice based on evidence, indicators of positive intervention and processes to ensure staff, volunteer and community involvement. More information about this model can be found in the resource binder *From Evidence to Outcome: Integrating Best Practice and Program Development: A Guide for Interdisciplinary Teams* which is available from the Association of Ontario Health Centres.[2]

Figure 1 Definition of Best Practices



Strategic Goals of the CHC Program

The Ontario CHC program is founded on five strategic goals:

Accessibility — To increase the accessibility of CHC activities for individuals and for the community as a whole in terms of: activities that are relevant to the needs identified by the community; physical access/convenience; a welcoming/safe/comfortable environment; and timeliness and availability of activities.

Wellness and Prevention — To establish and maintain prevention activities that contribute to health and well-being of individuals in the community.

Coordination — To establish and maintain co-ordination between activities internal and external to CHCs, so that CHC resources are used efficiently.

Provision of Holistic Activities — To establish and maintain activities that reflect due consideration of the broad determinants of health that affect the whole person, family and community.

Individual and Community Responsibility — To increase individual and community ownership/responsibility for their lives and the life of the community in terms of: access to useful information and resources; perceptions of control; ability to make decisions; ability to take action; decreased reliance on professionals; political influence; and representation in decision-making bodies.

All CHC programs and services, including our HIV/AIDS services, are developed and delivered in accordance with these goals. Throughout this report we will highlight how these features of our model of care uniquely position CHCs to serve people who are vulnerable to or affected by HIV/AIDS.

Methods

The methods used to collect information for this project were based on the principles of community-based research. Community-based research draws on the knowledge and skills of the community to understand health and to identify activities that can improve health services. This project brought together a steering committee of twelve representatives from the CHC sector to work with AOHC staff, including a project coordinator. The committee was involved at the earliest stages of the project. They developed a Terms of Reference (**Appendix A**) and helped define the research objectives of the project. The committee also was part of the analysis and interpretation of data and provided input into how results would be disseminated.

Data was collected from CHC frontline service providers, service users and ASOs across the province. The selection criteria and recruitment strategies were developed in consultation with the project coordinator and steering committee. The project identified five groups from whom it was important to collect information:

Group 1: Service providers in CHCs

This group included service providers working in HIV/AIDS prevention, treatment, care and/or support that were selected from twelve CHCs in Ontario. The steering committee identified and recruited participants at each of their centres. A follow-up email was sent by the project coordinator to provide project information and encourage participation from service providers. The project coordinator contacted additional centres for interviews. One to three service providers were interviewed at each centre. In total, eighteen face-to face or telephone interviews were conducted, with the purpose of determining service provider perspectives on current HIV/AIDS clinical and health promotion best practices and to identify challenges and successes in delivering these services. Prior to the interviews, participants were given a project information sheet and consent form. Two steering committee members participated in a pilot exercise to test the initial interview. Service providers were not compensated for their time with the understanding that the project work would positively impact their work and their clients. All interview documents for this group, including the project information sheet, consent form and interview questions are located in **Appendix B**.

Group 2: Service users

Service users were recruited through CHC service providers at their centres. One staff member from each partner centre volunteered to do interviews with two service users. Participants were identified through their use of HIV/AIDS related services at the CHC. These services could be clinical services and/or health promotion and prevention services. Participants were compensated $25.00 and two transportation vouchers. Interviews with service users were one-on-one interviews conducted by a service provider who was working at the service user's CHC. Interviewers went through an interviewer training process before conducting the interviews (**Appendix C**). Twelve service users from six CHCs were interviewed for no more than thirty minutes. The purpose of the interviews was to illustrate why clients come to CHCs for HIV/AIDS services and what services clients felt were important and useful. Service users were able to provide a first-hand look at the effects of CHC HIV/AIDS services in Ontario communities. Prior to the interviews, participants received a project information sheet and completed an informed consent form. Study participants understood involvement was voluntary and were given the option to withdraw from the study at any time. All documents for this group can be viewed in **Appendix B**.

Group 3: Service providers in ASOs

ASOs in the same community as a CHC were selected and mailed a brief survey with the purpose of determining ASO service provider perspectives about the services that CHCs bring to their communities. The surveys also sought to determine what sorts of partnerships or collaborations, if any, existed between CHCs and ASOs in the same community. Twelve surveys were returned. The survey tool is included in **Appendix D**.

Group 4: Ontario CHCs which do not have a formalized HIV/AIDS program in place

A brief survey was mailed to the executive directors of all CHCs which do not currently have HIV/AIDS programming in place. The executive directors or staff at fifteen centres completed the survey. The purpose of this survey was to determine what services these centres are providing and what support they would like to have in terms of HIV/AIDS-related services. The survey tool is included in **Appendix E**.

Group 5: HIV/AIDS service providers in CHCs outside of Ontario

To create interest among HIV/AIDS service providers outside of Ontario, a flyer and a letter about the project were created and distributed at a Canadian Association of Community Health Centre Associations (CACHCA) meeting. Follow-up phone calls were made to nine centres outside of Ontario and phone interviews were conducted with only two centres. Due to the insufficient sample size, this information was not integrated into the report.

Overview of Project Report

CHCs are actively responding to Ontario's AIDS epidemic by providing accessible primary care and health promotion services to diverse and marginalized populations. Few CHCs have published accounts of the work they do. While most centres document their work and complete program evaluations, this information is produced primarily for use by the local CHC. This report is a first step in sharing the HIV/AIDS work of CHCs with a broader audience.

Due to the lack of published literature about the work of CHCs, our literature review aims to consolidate and enhance the evidence base on which the work of CHCs is built. It provides examples of how other models of care and service providers have adapted research and evidence to design practices that are responsive to and respectful of the needs of the communities they serve. Information from our literature review is integrated throughout the report.

Chapter 1: Programs and Services

In this section, the range of HIV/AIDS services offered at CHCs are outlined. Service users of HIV/AIDS-related services discussed the impact that CHC programs and services have had on their lives and service providers highlight a number of services and programs of which they are particularly proud.

Chapter 2: Access and the Social Determinants of Health

One of the main goals of CHCs is to increase the accessibility of programs and services for individuals and for the community as a whole. This section documents both the barriers that clients experience in maintaining good health and the challenges that CHCs face in providing accessible services. It also discusses methods CHCs use to facilitate more accessible HIV/AIDS prevention, treatment and care for their clients.

Chapter 3: Coordinated Care

CHCs aim to establish and maintain coordination between activities internal and external to CHCs, so that CHC resources are used efficiently. Our research indicates that there are some structural and organizational characteristics that support coordination of care. This section considers service coordination within individual CHCs and amongst external organizations.

Chapter 4: Evidence and Evaluation

CHCs represent one of the most accountable models for delivering primary health care. Mechanisms for accountability are identified and the various types of evidence used in CHC practice are documented in this chapter.

Chapter 5: Showcasing CHC Best Practices

We asked CHCs about unique and innovative work they are doing and what they are most proud of at their centres in terms of HIV/AIDS services. From these stories, best practice approaches were identified. This section highlights some of the successes of Ontario CHCs in HIV/AIDS work.

Chapter 6: Recommendations and Conclusion

This chapter presents next steps and recommendations for the CHC sector in HIV/AIDS services. These recommendations were generated through project interviews and surveys and from discussions and action planning that occurred at the Summit.

CHAPTER 1
Programs and Services

This chapter provides an overview of the programs and services offered in CHCs for individuals, families and communities, and provides an overview of the literature that supports this work. CHCs across Ontario offer a variety of programs and services to PHAs and to those at risk of becoming infected with the virus. The chapter is divided into two sections: the first section describes programs and services that focus on the health of the individual and family while the second section focuses on programs and services that address the health of communities as a whole.

Empowering individuals, families and communities to have increased control over their health is one of the key principles of the CHC model of care. This principle is reflected in the care CHCs provide, both by supporting individuals to take responsibility for their health and supporting communities to maintain and improve their health. Both of these principles are key to providing effective HIV/AIDS services.

Table 1 Prevention Programs and Services Offered by CHCs

PROGRAM/SERVICE	NUMBER OF CHCs OFFERING SERVICE OR PROGRAM (n=18)
Testing:	
HIV testing	18
Anonymous testing	8
Nominal testing	6
Prevention Programs:	
Peer prevention programs	18
Pamphlets and written info	18
Prevention education for people at risk	16
Health promotion programs geared towards people with HIV	6
Safer Sex Materials:	
Safer sex supplies	18
Condoms	18
Lube	8
Dams	2
Female Condom	1
Harm Reduction Materials:	
Safer drug use supplies	12
Needle exchange	12
Crack pipes	7
Outdoor needle bins	4

1.1 SUPPORTING INDIVIDUALS AND FAMILIES

The range of HIV/AIDS services offered at CHCs is outlined in **Tables 1 to 3** and includes prevention, treatment, and care and support programs and services.

When asked about their use of CHC services and programs, service users indicated that they were accessing the majority of services and programs. The most utilized services included counselling, general primary care, prevention education, safer drug use supplies, safer sex supplies, transportation and referrals to other specialists. Clients receiving HIV prevention, care and/or treatment from CHCs tended to learn about the services through word-of-mouth or referrals from hospitals, outreach workers, social services or community groups.

Table 2 Treatment Programs and Services Offered by CHCs

PROGRAM/SERVICE	NUMBER OF CHCs OFFERING SERVICE OR PROGRAM (N=18)
General primary care	18
HIV primary care	8
Access to pharmaceutical drugs (antiretrovirals)	2
Complementary therapy	2

Table 3 Care and Support Programs and Services Offered by CHCs

PROGRAM/SERVICE	NUMBER OF CHCs OFFERING SERVICE OR PROGRAM (N=18)
Referrals to community services	18
Counselling	18
Referrals to other specialists	11
Referrals to HIV primary care	7
Social work	3
Drop-in centre	3
Food bank/food vouchers	3
Access to vitamins/supplements	3
Psychiatry	3
Transportation	2
Laundry service	2
Case management	1
Computer centre	1
Voicemail program	1
Support groups	0

Table 4 provides an overview of services that clients would like to receive that are not currently provided at their local centres. CHC service providers echoed many of the needs identified by service users.

Table 4 Services Requested by Clients

CLIENT REQUESTED SERVICES
Harm Reduction:
Safe injection sites
Crack pipes
Methadone maintenance programs
Support group for drug users
Clinical:
More doctors
On-site lab/X-ray technician
More information about living without HIV/AIDS medication
Testing:
Increased hours for anonymous HIV testing
Anonymous Hep C and STI testing
More direct person-to-person education
Other:
Access to vitamins and supplements
Meals
Pamphlet outlining all programs and services offered by centre

A. Client-Focused Care

A cornerstone of the CHC model of care is to provide care that focuses on client needs. Client-focused care was identified as a key feature of best care practices in a report on HIV/AIDS ambulatory care in Ontario. The report suggests that all other elements comprising best care flow from this fundamental goal. Client-focused care sees patients involved in the decision-making process of care, collaborating with health care providers to determine their care, and thus empowering them in their own wellness.[3]

Many service users commented that accessing programs and services at CHCs has had a significant impact on their lives, particularly due to the empathy of service providers that enabled them to build trusting relationships. Several clients indicated that their CHC was the only place they had disclosed their HIV status:

> *By talking to the staff, it lifts my spirits. I am comfortable talking about my health status here. I do not disclose to anyone else.*
>
> CHC client

CHCs create spaces where service providers can connect with hard-to-reach clients and provide health promotion and educational information. Clients use CHC HIV/AIDS services because they offer safe, trusted and integrated services where clients feel comfortable discussing HIV/AIDS issues and accessing programs that are not available elsewhere.

The service providers we interviewed highlighted a number of services and programs of which they were particularly proud including anonymous testing, harm reduction, clinical care and drop-in centres. The following section provides an overview of some challenges and successes CHCs face in delivering these programs and services.

B. Anonymous Testing

Many CHC staff indicated that anonymous testing is an important service that should be available at CHCs. Currently many CHCs provide nominal or non-nominal testing but have to refer clients to another testing site for anonymous testing. Several centres pointed out difficulties in negotiating their own anonymous testing sites due to financial barriers and difficulties in establishing partnerships with outside testing agencies.

Somerset West CHC, a centre that houses anonymous testing in Ottawa, has been successful in offering testing to some hard-to-reach populations. However, they have found that many of the homeless and drug using populations are still not accessing anonymous testing in the clinic. To address this issue, they began an anonymous street-testing clinic in January 2004. Staff also felt that anonymous Hepatitis C testing would be a great benefit to their clients although this is not currently available.

C. Harm Reduction Programs

One of the unique successes of CHCs has been their use of harm reduction programs in HIV-related services. Harm reduction is a set of practical strategies that reduce negative consequences of drug use, incorporating a spectrum of strategies from safer use to managed use to abstinence. Harm reduction strategies meet drug users "where they're at," addressing conditions of use along with the use itself.[4]

These programs require the development of trust between staff and clients. The service users we interviewed indicated that compassion, non-judgmental attitudes about client situations and building trust played a large role in enabling them to access HIV/AIDS services. Service providers also emphasized the importance of trust building in harm reduction programs:

> *When we go to the satellite sites to distribute the stuff (needles, condoms, vein cream) we are building trust over time. People start to ask us questions about HIV, Hep B and Hep C.*
>
> CHC service provider

All harm reduction programs provided needle exchange. Many centres also attempted to reach people who were using crack because this population is at increased risk for HIV and other

infections. Every program indicated the need to distribute crack pipes as a harm reduction strategy. The distribution of crack pipes and associated devices is not funded. There has been great controversy about funding crack kits for distribution. As such, service providers are often faced with the dilemma of how to serve crack users, without providing safer crack kits. All service providers interviewed at CHCs felt that safer crack kits are an important resource in addressing the HIV/AIDS epidemic:

> *Pipes are the 'gateway' to the drug world. The more crack kits we distributed the more needles we gave out.*
>
> CHC service provider

> *We would like to be able to give out crack kits, but we can't afford that. People are using asthma inhalers as pipes. Clients take a lot of non-lubed condoms then use the ring part of the condom to hold the tinfoil on their homemade pipes.*
>
> CHC service provider

Investment in CHCs' harm reduction programs for drug users has proven an effective prevention measure, with the numbers of new infections in IDUs decreasing since the year 2000[1]. Continuing to support and resource these programs in CHCs will ensure that lives will be saved through prevention of infections.

D. Clinical Care

General clinical services for clients with or at risk of HIV are offered at all centres, but HIV specific care and treatment is offered only at those centres with a clinician who has a strong interest in and knowledge of HIV. Many physicians worry that the new generation of doctors may not have an interest in HIV treatment and care and they want to encourage more clinicians in this direction. There are mentorship programs available specifically for physicians, but these types of mentorship programs are not available for other clinical staff.

> *I consider myself an HIV primary care specialist. HIV is integrated into our regular clinical practice. A number of the physicians here have done a mentorship program and additional training for HIV/AIDS. There is a 5-day training for doctors, which includes a series of lectures by other primary care physicians and HIV specialists.*
>
> Physician, Regent Park CHC

North Hamilton CHC has developed a unique model of clinical care, with one physician focusing on staying up-to-date with HIV treatments and issues. Another physician may act as the primary family doctor but the client would see the CHC HIV doctor several times a year. Formal

assessment and intake forms have been developed so that all providers are aware of the HIV/AIDS care provided.

> *We have over 100 people with HIV coming to our clinic. Half of these see no other specialists and half are shared with other infectious disease specialists. We have a system of internal shared care, meaning I stay up-to-date on HIV care issues and other doctors may be the general family doctor for a client. If a client doesn't go to another HIV specialist, they will see me at least four times per year. Patients have access to all services. We organize four regional rounds per year and providers of all types come to this. We have developed assessment and intake sheets for people with HIV so that all providers are on the same page for HIV/AIDS care. This is a guideline for best practice. It triggers the provider to do certain blood tests and procedures at certain times.*
>
> Physician, N. Hamilton CHC

E. Drop-In Centres

Drop-in centres provide a welcoming space for clients where learning can occur and trust can be built. Centres that have drop-in programs have suggested that drop-ins are a place where communities can meet with each other and with service providers. Drop-ins provide a space to access hard-to-reach clients and to do some health promotion and education.

> *Our drop-in centre is always open to the community. The focus is on high-risk populations: youth, homeless and substance users. There is a hot meal program and we do some health promotion and education. We have this session on Friday evenings from 4-7pm. We chose Friday so people can get stocked up on supplies for the weekend.*
>
> Harm Reduction Worker,
> Lawrence Heights CHC

> *We started a drop-in centre just for aboriginal people who are homeless. It is called "Bendagin," which is an Ojibwa word, meaning "Come in." We have lunch, crafts and addictions counselling.*
>
> Health Promoter, Wabano AHAC

Drop-in centres are a space where services are provided to individuals and families, and they are a space where communities can begin to come together to organize, mobilize and look at broader issues that affect the health of the whole community.

1.2 BUILDING COMMUNITY CAPACITY

Community involvement and activism have played a central role in combating HIV/AIDS since the beginning of the epidemic by generating individual and social change.[5, 6] Examination of community capacity (a community's resources, skills, networks, leadership, values, history and challenges) can help in the understanding of community dynamics and create ways to mobilize a particular community for action.[7]

In CHCs across Ontario, utilizing and investing in community capacity has enhanced HIV/AIDS prevention, treatment and care services. CHCs are community-based organizations with established relationships with the communities they serve. Affected and vulnerable communities are involved in decision-making and program development.[8]

The participation of HIV-positive individuals is a key element which helps organizations to shift from just service delivery to both service delivery and advocacy. However, ensuring the meaningful participation of PHAs is not a seamless process for many organizations. Major obstacles to involving PHAs include lack of access to sufficient HIV/AIDS education and training.[9, 10] Additionally, disclosure of one's HIV status, health concerns, transportation and child care may act as barriers to people becoming involved in HIV/AIDS related programs.[5, 8] CHCs can bridge these gaps by providing services including access to training, information sessions and peer programs.

A. Peer Programming

PHAs often bring a high degree of personal investment, motivation, dedication, compassion and commitment to their work. PHAs can relate to service users and offer peer support.[8] In a study addressing care and support challenges conducted by the Canadian AIDS Society (May 2002), care recipients reported a strong desire for increased peer support.[11] The positive effects of trained community peers whose life circumstances and characteristics closely resembled those of the target population is one of the most important factors influencing the delivery of health information.[12]

Many CHCs in Ontario are exceptionally proud of the peer programs that exist at their centres. Several CHCs operate programs on peer-based models. The goals of these programs vary, but will often include:

- assisting clients to develop skills, increase self-esteem and control over their lives;
- providing a friendly and welcoming environment for clients; and
- fostering community development and community awareness around HIV/AIDS prevention.[13]

Clients and service providers often describe peer programming as one of CHCs' greatest successes. CHCs interested in developing a peer model at their centre can learn from other centres working with similar populations such as those indicated in **Table 5**.

Table 5 Sample Peer Programming in CHCs

CHC	TYPE OF PEER PROGRAM	POPULATION OF PEERS
Queen Street West, Lawrence Heights South Riverdale, Parkdale	Harm Reduction	Drug Users
Planned Parenthood Toronto	Youth Sexual Health	Lesbian/Gay/Bisexual/ Transgendered/Transexual Youth
Regent Park	Service User Access Training Program	Immigrants and Refugees without health insurance (now or in the past) and service providers for this population.

B. Train-the-Trainer Approach

An element of peer programs is often a train-the-trainer approach to providing education. The ability of the learner to become the teacher and feel empowered to bring their knowledge to others is described by Ramos et al. (2002) using a model based on a cooperative training approach. This approach uses community-based expertise as catalyst in the formation of self-sustaining networks of trainers in HIV organizations.[14]

Poindexter et al (2002) developed a model to address community training and put empowerment into practice. The following elements of the model can be adapted into other programs wanting to shift power from providers to the learners:[15]

— **Participatory development** — The relevance of sessions for participants can be maximized if participants and/or community stakeholders determine the topics or workshops.

— **Self-selection of goals** — Rather than telling the learners what was important to learn, invite the learner to choose their own individual goals.

— **Learner-centred evaluation** — Have the learners evaluate themselves three months after the workshop, rather than being judged by someone else's criteria.

— **Collaboration between systems** — Teach learners how to develop partnerships with government, university and community-based organizations.

DeMarco & Johnsen (2003) describe a community collaboration which resulted in a series of educational programs for women living with HIV/AIDS, their family, friends and caregivers. Two nutritious meals, childcare and transportation were offered at every program. Updated information on current treatment strategies was available at every session and topics focused on self-care and empowerment. The goal of the program was to support women to take control of their wellness and health care while remaining in their community. The program also provided the opportunity to network with other clients of HIV/AIDS programs and to meet and collaborate with peer leaders and activists. The women involved in the project used the knowledge they gained not only for their own health and development, but in developing a research project to

create a prevention program for adolescent women of colour in their community.[16] CHCs often provide similar educational programs for their clients.

CHC peer programs provide community members with an opportunity to learn skills and share knowledge with the community. Peer programs weave in a number of services including skills building, employment, housing referrals and prevention education. In HIV education and services, some peers are trained to distribute safer sex and/or safer drug supplies and educate on these topics within a framework of harm reduction. Further, populations who may not otherwise access CHC services may trust peer workers.

> *Our peer program is a big component of the IDU outreach project. We recruit former and current drug users, drug trade workers and sex trade workers. They provide peer support, do training and distribute materials within a sub-cultural context. They are educating and informing us about the needs in the community.*
>
> Outreach Worker,
> Lawrence Heights CHC

Clients and peers benefit from contacts with social services and their knowledge of safer drug use practices is shared with other members of the community.

> *I'm now housed because of a referral from a harm education worker and I have some employment through the harm reduction peer program. I'm now practicing harm reduction and promoting it to others where I live.*
>
> Client, S. Riverdale CHC

Some peer programs are volunteer-based, while others are paid positions. Depending on the community served, each method has its benefits. At Planned Parenthood, Toronto, a volunteer peer program has worked well for its youth programs:

> *We have a volunteer program that does peer education on sexual health topics and HIV. Volunteers go through twelve weeks of training in sexual health and then do peer education on their own. We can't take as many people as want to volunteer and we have some volunteers who have been with us for ten years. It's a very unique program.*
>
> Health Promoter,
> Planned Parenthood

Parkdale CHC pays peers for the positions they hold and they see this as an important method of valuing the contribution that peers make at their centres.

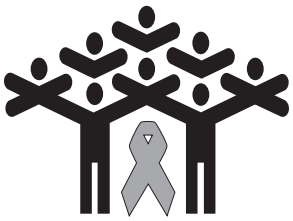
> *Our peer program is a paid position. The peers do street outreach and some needle exchange. They learn basic counselling skills and can go to various courses. They are paid for improving their skills. They use*

their connections to contact people and if a peer is showing a lot of initiative they may get to work other part-time/contract positions at the centre. They grow into their jobs and then there is a wider variety of things they may be able to do.

Outreach Worker, Parkdale CHC

Chapter Summary

CHCs provide a broad range of programs and services to PHAs and to individuals and communities who are at risk of contracting the virus. Programs and services are developed based on identified needs of individuals and communities. Our philosophy of care puts the client at the centre of the care process. CHCs work actively to support clients to be partners in their own care and in the process of creating healthy communities. Our approach to care enables us to serve some of Ontario's most vulnerable communities.



CHAPTER 2

Access and the Social Determinants of Health

This chapter provides an overview of some of the populations most vulnerable to HIV that are served by CHCs, the barriers they face in accessing services and staying healthy and the role that CHCs play in addressing these barriers.

One of the goals of the CHC program is to serve people in Ontario who face significant barriers in accessing health and social services. Another goal of CHCs is to address the social determinants of health within a framework of social justice. These goals are consistent with the policy directions of the current provincial *HIV/AIDS Strategy for Ontario to 2008* and provide clear direction for the strategic role that CHCs play in addressing Ontario's AIDS epidemic.

Ethnicity, sexual orientation, gender, drug use, immigration status and primary language are among the most significant characteristics that can impede access to services.[17] Other documented barriers include lack of access to affordable housing, drug treatments, employment and lack of services for families with affected and/or infected children.[18, 19, 20] These issues impede efforts to prevent infection and affect people's ability to cope with the disease if they are infected.[8]

The literature on HIV/AIDS services stresses the central importance of addressing access issues and the social determinants of health as the foundation for providing quality services. For example, in a recent best practices document reviewing HIV ambulatory care in Ontario, service users identified accessibility and availability of care as the most important features of client care, and the ones that were the least satisfactory. The study suggests that standards of care should address access issues, such as location of HIV clinics, hours of clinic operation, gender, poverty, access to medications, clinic and staffing resources and coordination of care.[3]

Another recent study from Ottawa conducted by Anne Wright and Associates[21] documented the challenges of providing HIV/AIDS services and recommended the following strategies for improving access to services:

- Increasing initiatives around prevention, harm reduction and wellness;
- Adapting programs and services to be cultural affinity-appropriate; and
- Expanding support resources in key areas where there are gaps such as: increasing availability of case management and mutual support for PHAs (specifically drug users, gay men, immigrants and refugees, women and families); expanding harm reduction resources available; and expanding affordable housing.

A recent study conducted at Casey House, a well-known palliative-care hospice in Toronto for PHAs, identified similar strategies to address barriers to access for their services.[18] These included:

— Implementing interpretation services;
— Implementing childcare services;
— Providing of on-going education and training opportunities in culturally competent service delivery;
— Maintaining of a community advisory committee;
— Ensuring that staff, volunteers and board members reflect populations living with HIV/AIDS; and
— Continuing harm reduction education.

These studies document barriers that are common for both ASOs and CHCs. CHCs are well positioned to help address some of these barriers and to increase access to AIDS services generally.

2.1 SERVING VULNERABLE POPULATIONS

Service providers indicated that housing, employment and lack of stable income and poverty were of greatest concern to their clients' health. **Table 6** shows some barriers to good health for CHC clients who are living with or at risk for HIV/AIDS.

Table 6 Barriers to Good Health of CHC Clients

BARRIERS TO GOOD HEALTH (N = 18)	
BARRIER	**# RESPONSES**
Lack of employment/stable income	14
Lack of housing	10
Poverty	5
Lack of legal immigration status	4
Poor nutrition	4
Addictions	2
Language barriers	2
Lack of access to pharmaceuticals	1
Systemic racism/discrimination	1

These and other social determinants of health are considered barriers to the good health for the populations served by CHCs. Table 7 outlines the populations that service providers tend to see for HIV/AIDS related services. This data illustrates that CHCs see clients from marginalized populations that face varying degrees of difficulty in accessing health care and/or HIV/AIDS services.

Table 7 Primary Populations Served in HIV/AIDS Related Services

PRIMARY POPULATIONS SERVED IN HIV/AIDS-RELATED SERVICES ACCORDING TO SERVICE PROVIDERS (N=18)	
POPULATION	**# RESPONSES**
Drug users	11
Homeless people	10
Women	9
Non-insured/non-status persons	6
New immigrants and refugees	6
Sex trade workers	6
Gay men	4
People with mental illness	4
People from HIV-endemic regions	3
Dual diagnoses	2
Aboriginal peoples	2
Street youth	2
Youth	1
Children	1
Recent prison release/parolees	1

CHCs play a strategic role in ensuring accessible services for populations vulnerable to HIV/AIDS in our province.

> *As the HIV/AIDS epidemic in Ontario continues to expand, CHCs have started to strategically position themselves to better address the HIV/AIDS issues affecting the populations they serve. CHCs in Ontario are funded to work with populations which experience multiple barriers accessing health and social services. These are also some of the groups most highly affected by HIV/AIDS.*
>
> Health Promoter, WHIWH

CHCs design their programs to meet the needs of specific populations and communities which individual centres identify as priority populations. Many of the populations that CHCs specialize in serving are the same populations that have been identified as underserved or hard-to-serve in HIV/AIDS literature and/or the *Ontario HIV/AIDS Strategy to 2008*.

One of the strengths of the CHC model of care is our ability to serve marginalized populations who face the most daunting barriers in accessing services. Individual CHCs develop strategies to address specific barriers depending on their location and the clients they serve. The following paragraphs outline the literature documenting populations that are disproportionately affected by HIV/AIDS that CHCs are well positioned to serve. This overview is not comprehensive but serves as an introduction to the needs and issues of the communities and populations served by CHCs. Chapter 5 provides more detailed information about the programs and services that CHCs have developed to meet the needs of these populations.

A. Immigrants and Refugees

Legal immigration status affects access to HIV/AIDS services. Improving access to HIV/AIDS healthcare for people who are immigrants, refugees or without status is an important role of CHCs:

> *A high percentage of immigrant and refugee clients are surviving in fragments of their family. There are a lot of gaps there that in a different context might not be present within the family. There are settlement issues. They are too busy making ends meet to go out and get information about good health.*
>
> Health Promoter, WHIWH

PHAs in Canada who do not have official immigrant or refugee status are not eligible for Medicare. Immigrants who have been granted landed status must wait three months to receive OHIP. Many PHAs do not access care even when they are able to obtain OHIP because they are afraid the immigration department will access their health records and reject their application for immigration due to their HIV status.

CHCs are a link between many uninsured PHAs and networks of support. Health care providers serve uninsured clients through informal networks with others willing to provide services. However, CHC resources are severely stretched and many CHCs are unable to accept new clients due to limited resources. This may mean arranging services outside the CHCs, which can be difficult for clients who aren't covered by OHIP. Often this is made possible through informal arrangements with other organizations but health centres may have to pick up the costs:

> *Say a client is diagnosed. She has no health coverage. She will see a person who takes care of her assessment. If the client doesn't have money, the health centre will pay for this. If she has to go to a specialist, the centre negotiates payment.*
>
> Service Provider, Regent Park CHC

Several CHCs are members of the Committee for Accessible AIDS Treatment (CAAT) which has developed recommendations to improve the care and support for clients without OHIP coverage. These recommendations include:

— The development of local health care networks including:

- Compiling a list of HIV specialists and primary care physicians who are willing to serve immigrants, refugees or undocumented PHAs;
- Developing a linguistically and culturally appropriate referral list of services available to PHAs in Ontario without legal status, health insurance or drug coverage;
- Developing fact sheets that outline health benefits and drug coverage eligibility for people at various stages of the immigration process;
- Enhancing existing recycling mechanisms for HIV antiretroviral drugs in which unused drugs are collected and redistributed to those who need them. Funding and drug sup-

plies could come from recycled drugs, drug companies and individual donations. This project is being piloted and is housed at the Toronto People with AIDS Foundation. Compassionate access to pharmaceutical drugs will be available to those who have short-term barriers to access.

— A role for local hospitals in championing the issue of immigrant and refugee PHAs including developing formal arrangements between CHCs and hospitals to facilitate access to care for PHAs with no coverage. Currently several CHCs have informal access on a case-by-case basis.

— Enhancing funding to enable CHCs to meet the increasing needs of the immigrant population.

— Developing a national network to advocate for changes to policies by the provincial and federal governments.[22]

B. People from HIV-Endemic Areas

HIV-endemic refers to countries or populations where there is a high prevalence of HIV infection in the general population (generally greater than 0.8%) and the most important mode of transmission is heterosexual contact. A number of countries in the Caribbean and Sub-Saharan Africa are classified as HIV-endemic.[1] Cultural taboos, fear of racism, fear of deportation and fear of disclosure often leave people from HIV-endemic regions reluctant to seek medical attention or be tested for the virus. In African and Caribbean populations living in Ontario, stigma and concerns about confidentiality are prevalent and, in some cases, having people of African or Caribbean descent (PACD) as service providers can be a barrier to service because of fear of being ostracized by the community.

Educational workshops to decrease stigma in local communities and dissemination of information in mediums other than in written form were recommended as strategies by the HIV Endemic Task Force (HETF) to address the rising incidence of HIV/AIDS among PACD. The HETF which is comprised of Toronto-area CHCs, HIV/AIDS groups and researchers recommended the development of anonymous HIV testing sites in locations where men and women of African and Caribbean descent are currently accessing other services.[23] Other studies suggest that empowering clients to disclose their status, integrating HIV care into the community and decreasing the stigma associated with the condition will further enhance access to HIV care for these populations.[24, 25]

C. Women

Women account for about 20% of new HIV diagnoses in Ontario. Of the 2 339 women diagnosed in Ontario, almost 25% are from countries where HIV is endemic and 25% are injection drug users.[26] It is not a homogeneous group and services for women affected by HIV/AIDS must take into account a broad range of factors. Health service care needs for HIV-positive women are often complicated and include social and family issues that may not be seen in their male coun-

terparts. Lack of transportation, child rearing and other family responsibilities may be related to women's lower use of care.[27] Unmet client needs can have a profound effect on treatment adherence.[28] Having resources in place to be able to offer transportation support or childcare can help to decrease these barriers.[29] Providing support services that address the specific needs of women and children can help to increase clients' access to HIV/AIDS services.

D. Aboriginal People

Health Canada estimated that Aboriginal people, who make up only 2.8% of Canada's population, accounted for 17.7% of new HIV infections in 2000. Gay and two-spirited men continue to be the largest group of Aboriginal people affected by HIV/AIDS. In general, Aboriginal people with HIV tend to be younger and a larger proportion are women and IDUs than in the general population. The primary barriers that impede the effective delivery of HIV/AIDS services to Aboriginal people in Ontario are the prevalent belief that HIV is a gay, urban disease and the lack of availability of culturally appropriate counselling and support services.[1]

The *Ontario Aboriginal HIV/AIDS Strategy* indicates that many Aboriginal programs and services addressing substance use are based exclusively on an abstinence model and that most harm reduction programs are not culturally appropriate for Aboriginal people. The report suggests that the development of culturally appropriate harm reduction programs would be a helpful approach in this community.

The majority of Aboriginal people in Ontario do not have access to HIV anonymous testing. Mobile HIV testing for Aboriginal people may be a useful strategy for providing this service and for simultaneously overcoming barriers such as remoteness, concerns about confidentiality and issues related to cultural difference.[30]

Aboriginal Health Access Centres (AHACs) offer culturally appropriate primary care to Aboriginal people and attempt to address barriers to health services. Many CHCs across Ontario also serve Aboriginal people and communities. Goals of the *Ontario Aboriginal HIV/AIDS Strategy* can be used by CHCs and AHACs to guide service delivery for Aboriginal people affected by HIV/AIDS. The following is an overview of the *Ontario Aboriginal HIV/AIDS Strategy*'s goals:

Promotion — Increase awareness of healthy sexuality, understanding of Aboriginal traditional teachings within the Aboriginal community and awareness and sensitivity in the non-Aboriginal community regarding Aboriginal culture, beliefs and values.

Prevention — Develop HIV/AIDS awareness and prevention programs for presentation in educational facilities attended by Aboriginal people.

Treatment — Develop and promote culture/community-based traditional treatment and rehabilitation programs and services while ensuring improved access to western medical approaches.

Training — Increase access and support for Aboriginal people living with HIV/AIDS who wish to pursue education, employment and training opportunities, including opportunities for program management and leadership development.

Supportive Housing – Create opportunities for safe, accessible, affordable and supportive housing for Aboriginal people living with HIV/AIDS and their families/partners.

E. Injection Drug Users (IDUs)

The prevention of HIV/AIDS with the drug-using population must continue to be a priority in Ontario. Increasing and enhancing prevention and harm reduction programs and treatment services for this population is effective and maintaining this approach will likely contribute to the decrease in the number of new infections in IDUs in Ontario.[1] Harm reduction programs typically include needle and syringe exchange, outreach and non-judgemental client-centred counselling, whereas abstinence models focus on a zero-tolerance for the use of substances. There are many examples of harm reduction programs housed in Ontario CHCs that have developed innovative practices that respond to the needs of drug-using service users.

Wright's assessment of HIV/AIDS services in Ottawa emphasizes that there must be more effective campaigns to develop public support and understanding for harm reduction. She suggests that options for addictions treatment such as methadone maintenance treatment should be more readily available. Her report highlights some of the work that CHCs have been doing in HIV/AIDS intervention in the past ten years, such as the establishment of Oasis, a program of Sandy Hill CHC specializing in serving clients who are infected or affected by HIV.[21]

Safe injection facilities have been part of successful harm reduction strategies in Vancouver, Australia and many European countries. Research on a pilot safe injection site in Vancouver is establishing whether the site improves the health of injection drug users, reduces overdoses, increases drug users appropriate use of health and social services and decreases health, social, legal and incarceration costs associated with injection drug use in the city.[31] Integrating these methods requires considerable time and resources.

A 2001 national action plan report on HIV/AIDS and injection drug use suggests that to ensure service needs are met, needle exchange and disposal services and access to methadone treatment must be improved and discriminatory attitudes towards drug users living with HIV/AIDS must be addressed.[32] CHCs could be a strategic place to expand harm reduction services such as methadone clinics because of our skill and experience in reaching out and providing services to drug-using populations.

2.2 ADDRESSING BARRIERS TO ACCESS

CHCs aim to increase access to programs and services for individuals and for the community as a whole. CHCs approach this goal by organizing activities that are relevant to the needs identified by the community and by providing accessible, convenient and comfortable spaces in which to access services. Many centres have found ways to facilitate more accessible HIV/AIDS prevention, treatment and care for their clients.

Our interviews indicated that staff at CHCs face different situations each day and must think innovatively to ensure clients are getting the services they need at CHCs and beyond. Interviews with service users indicated that they are generally able to access care and services in a timely manner. Service providers and service users identified what they consider the main barriers to accessing HIV/AIDS services and the strategies they use to address them. These barriers are summarized in **Table 8**.

Table 8 Overview of Barriers and Facilitators to Accessing HIV/AIDS Services in CHCs

BARRIERS

Stigma regarding:
- HIV
- Sexuality
- Drug use
- Sexual orientation

Organizational Barriers
- Hours of operation
- Location
- Transportation to centre
- Reception not able to do sharps exchange
- Long waiting lists
- Language
- Overworked staff

Budget Restrictions
- Under-resourced
- Not enough $ for someone to have a CT-scan/in-depth services
- Not enough for interpreters
- Lack of funding for programs like HIV nutrition
- Doesn't allow for free counselling services for youth
- Limited hours
- Not enough physicians

Staff
- Lack of cultural awareness
- Resistance to harm reduction from clinical staff
- Working in silos; isolated from other staff
- Lack of commitment to involve difficult clients
- Distrust of service providers

FACILITATORS

Approaches
- Harm reduction
- Multidisciplinary/interdisciplinary teams
- Empowering individuals and communities
- Commitment to providing culturally-appropriate services

Organizational Facilitators
- Central location
- Building is not identifiable as HIV centre
- Varied operation hours
- Visibility in community
- HIV as a stated priority
- External connections create resources with other services
- Respectful, empowering centre
- Partnerships with outside agencies
- Clear mission and strong identity
- Visible cues of acceptance at centre

Resourced Services
- Peer program
- Childcare
- Transportation
- Drop-in centre
- Walk-in clinic
- Legal advice
- Outreach social support
- Food bank

Staff
- Trust of service providers
- Positive, open-minded attitudes
- Diversity
- Staff that speak languages other than French/English
- Internal champions in HIV
- Knowledgeable staff/staff trained in HIV/AIDS
- Welcoming main reception
- Supportive Executive Directors

A. Stigma

Stigma exists about HIV, sexuality, drug use, sexual orientation and lifestyle choices. Stigma may present in many forms including stigma from within the community itself, stigma from service providers at a CHC or stigma from other clients. Since HIV infection is often associated with particular sexual or drug-related activities, stigmatization is common. Disclosure of HIV/AIDS status can expose clients directly or indirectly to discrimination or rejection by family, friends and com-

munity. CHCs attempt to address stigma and create an environment in which clients can feel comfortable and safe including ensuring that clients have control over disclosure of their HIV status.

The CHC approach helps to address the stigma experienced by clients. CHCs provide an empowering, culturally appropriate environment that increases use of programs and services and ensures healthier individuals and communities. CHCs approach HIV/AIDS in a unique and innovative manner, providing an interdisciplinary approach to service. Integration of prevention, treatment and care at some CHCs creates accessible and comprehensive HIV/AIDS services.

B. Staff Attitudes

Staff attitudes such as respect and acceptance were cited as important facilitators to increasing access to HIV/AIDS services. Service users and service providers commented that multi-lingual and culturally diverse staff encouraged clients to access HIV/AIDS services that they may not have otherwise utilized.

Service providers indicated that there is still room for training and education of CHC staff. Amongst staff, resistance to the harm reduction model and lack of commitment to be involved with difficult clients still occurs. Providers often felt that they are isolated because they work in the area of HIV/AIDS. Some felt that these divisions existed even between those who worked in HIV services with those who work with drug users or in the field of mental health.

Several service users commented that when using services outside of the harm reduction programs they encountered staff that were not comfortable providing service to people who were drug users or homeless. They found centre services outside the harm reduction program inaccessible due to staff attitudes:

> *People's perceptions of my clients are a real barrier. It can take years to get someone to walk into a health centre and then if a professional treats them poorly, it's all undone.*
>
> CHC Service Provider

C. Organizational Barriers and Facilitators

Organizational barriers and facilitators have a significant impact on the accessibility of services. Accessibility is increased by the visible cues of acceptance that many CHCs create through informative posters and welcoming and inclusive staff. CHCs encourage input and feedback from clients on service provision that gives valuable information regarding accessibility of services. The visibility of CHCs in the community, combined with the unidentifiable nature of many HIV/AIDS programs and clinics, encourages clients to access CHC HIV/AIDS services.

Organizational barriers such as location and resource limitations all affect clients' abilities to access services. Clients have felt the resource limitations and frozen budgets of CHCs in the form of lack of interpreters, absence of HIV nutrition classes, long waiting lists and overworked service providers. All participating centres reported that the demand for services exceeded the resources available.

Another concern of service users was limited hours and not enough medical doctors. Service users would like more evening and weekend hours available at CHCs and they would like to see a decrease in the extremely long waiting lists to see a family physician at CHCs. Service providers confirmed that the barriers to accessing clinical care posed significant problems for their clients.

Service users also indicated that there is a lack of harm reduction supplies and services to meet individual and community needs. Participants identified the lack of funding for crack kits and insufficient staff to do needle exchange as particular problems. Service users felt that CHCs should have needle exchange programs and that the hours for needle exchanges should be less limited.

> *This population tends to not be good at appointment based practice. We try to find a balance to give them some responsibility for their appointments and balance this with accessibility. But we have a 2-year waiting list to see a physician, so people tend to just use the walk-in. The walk-in is for acute care, but it is being used for long-term, complex problems. It's like a band-aid and people have to use the walk-in as their family doctors. We need more resources.*
>
> Outreach Worker,
> Queen West CHC

When CHCs have adequate resources and funding for specific programming, more community members are able to participate in HIV/AIDS programs. Resources for peer programs, food banks, transportation, childcare, legal advice, walk-in clinics, outreach and social support were all identified as facilitators to accessibility of services.

Chapter Summary

The development of best practices in HIV/AIDS services in CHCs includes ensuring access and equity in health care. CHCs address a broad range of barriers to access faced by vulnerable populations. The work of CHCs helps to reduce the impact of the social determinants of health in the lives of the individuals, families and communities we serve. As a sector we can learn from each others' successes and we can provide a template for other models of care that are struggling to address issues of access.

CHAPTER 3

Coordinated Care

Coordinated care is one of the foundational principles of the CHC model of care. Coordinated service includes two strategies: first, within centres, services and programs are delivered and shared by an interdisciplinary team of providers and second, the CHC team coordinates services for their clients in the community and with other parts of the health and social services sectors. Coordinating care is often invisible work that is overlooked. Respect for the interrelatedness of practices is an important value within CHCs that grounds our work as we strive to integrate treatment, care and prevention of HIV/AIDS. Although CHCs have extensive experience in care coordination, the process is seldom without considerable challenges. In this chapter we discuss models of coordinated or shared care documented in the literature, and highlight some of the successes and challenges of implementing coordinated care in CHCs.

3.1 COORDINATING PROGRAMS AND SERVICES

One of the unique features of the CHC model of care is the combination of clinical care, social services and community development. Many of the CHCs we interviewed in our research are providing a combination of treatment services for PHAs as well as a variety of prevention services. While participants in the study identified this integration as a strength of our model of care, they also emphasized that integration does not happen without great effort.

Many health care providers believe that coordinating care reduces the energy patients expend to obtain services and assists in reducing patient burnout. Coordinated services includes a more seamless transition of patient care information and easier access to services. Ultimately, a model of smooth coordination in a centre can reduce both service user and service provider burnout.[20] According to Tsasis, continuity, comprehensiveness and compassion are essential components in the treatment and care populations affected by HIV.[33]

Providing quality comprehensive HIV/AIDS services requires integrated delivery networks in which infrastructure such as health information systems, flexible staffing models and financial alignment are in place. One documented model of such practice is Mercy Health Services (MHS) in Detroit. MHS attributes several factors to the success of their clinical integration network in HIV care:

Shared vision and common values — Establishing a common vision of clinical integration and basing all activities on the goal of improving the care delivered to patients and their families. This relates directly to the professional values of clinicians and energizes their efforts.

Clinical leadership development — Clinical integration requires acquisition of a new skill set for clinicians and administrators.

Relationship building — Including formal opportunities for individuals to establish relationships with peers from their own and other disciplines across care settings.

MHS appointed a clinical integration priority team to lead the clinical integration efforts and to develop a work plan to focus its activities. By adopting a framework, rather than a specific model, local case and care management programs could be tailored to the needs of the community. Clinical integration forums allowed service providers to network, share learning and begin to identify key elements in the care of these patient groups that could be addressed together.[34]

The proposed *HIV/AIDS Strategy for Ontario to 2008* emphasizes the importance of fostering leadership for an integrated approach to HIV prevention, support, care and treatment based on the determinants of health. The ideal model would include:

- Locating HIV services on one site
- Testing
- Using a case management approach
- Primary care
- Establishing outreach clinics
- Access to social services
- Integrating HIV treatment into settings that already provide culturally sensitive services for people from countries with high rates of HIV infection

CHCs provide HIV prevention, treatment, health counselling and primary care services to high risk and vulnerable populations and already integrate the key features of the model outlined in the provincial *HIV/AIDS Strategy*.

A. Integrating HIV Care in a CHC

HIV/AIDS care is often integrated into CHC programs and services. Several centres indicated that this approach works well and makes clients feel more comfortable about using CHCs for their HIV/AIDS care.

> *There are no specific programs for HIV. We have counselling and psychiatry services and this fits in with all the rest. Specific HIV programs are done more through partnerships i.e. with the Ontario AIDS Network. Some clients like fitting into the background so not everyone knows they have HIV. This can be a strength.*
>
> Physician, N. Hamilton CHC

Other centres have developed specific HIV/AIDS services and programs. Oasis, a project of Sandy Hill CHC, in Ottawa, encourages clients to utilize their services to stabilize their health and provide support. Clients most often have regular treatment and care provided outside of Oasis, but are able to access clinical services at Oasis when needed.

Some people come for clinical services only. We know they're getting other services elsewhere and that's great. Maybe they came to see the doctor here today because they felt ashamed or embarrassed to see their other primary care physician. They can re-stabilize here and then go back to their regular physician.

Nurse, Oasis, Sandy Hill CHC

CHCs with clinical staff that are knowledgeable in the area of HIV/AIDS are able to provide integrated HIV/AIDS prevention, treatment and care services to clients. This valuable resource enables education exchanges amongst service providers and assists clients in receiving comprehensive clinical services. Most CHCs have lengthy waiting lists and are in need of more clinical staff. Increasing staff resources and mentorship opportunities for all clinical staff would allow more CHCs to offer HIV/AIDS services in their communities.

B. Working as a Team

Many service users that we interviewed felt that their service providers were working together as a team. Service providers have mixed impressions of the coordination at their centres. Some service providers felt that coordination at their CHC is excellent, that communication is open and all staff is accessible. Others feel a definite separation between clinical staff and health promotion, harm reduction and outreach teams.

Staff at Oasis felt they had developed an excellent communication model. Part of their success in coordination has been the debriefing session at the end of each day for all clinical staff.

The coordination at our centre is excellent. We have team meetings and the first issues discussed are always safety and client concerns. There is also a lot of informal consultation throughout the clinic. There is a half hour debriefing at the end of clinic for everyone working that day. This means we hear from the greeter outside, medical reception, the drop-in worker, doctors and nurses. This debriefing started because the drop-in staff and greeter would group up and discuss their days around the table. The nurse and doctor began getting into the discussions and we decided to formalize it. Sometimes we plan it around our partnerships so we'll have it at a time when the psychiatrist can join us, for example. We always celebrate something great that happened during the day. It's a great time for info exchange and care decisions and connecting.

Nurse, Oasis, Sandy Hill CHC

Parkdale CHC uses a shared care model in which a nurse practitioner works alongside a member of the outreach team. This facilitates more communication amongst service providers of different disciplines. All team members at Parkdale CHC meet monthly to discuss services.

We are able to get clients into the clinic quickly. There's really seamless coordination. We meet once a month. Even the psychiatrist communicates well and we find common ground between the street level and medical teams. It's very practical.

Outreach worker, Parkdale CHC

Other individuals feel there are challenges in coordinating services among harm reduction teams and the clinical staff. This was a common concern amongst harm reduction workers who struggle to have clients accepted at their centres and who may be working with staff that are not supportive of a harm reduction model of care.

There are some "friends" at the medical clinic, but I shouldn't have to do it this way. It should be more professional and without judgment. We know not to refer certain clients to certain practitioners. They don't all believe in the harm reduction model. Coordination isn't really working, but there are a couple of great docs who agree to see my clients.

Street Outreach Worker

The centre has hired someone to look at coordinated care. Most suggestions had to do with the service delivery of the harm reduction model. Some of the doctors are questioning their own beliefs and we have no meetings with the clinic. Since our evaluation report, cooperation with the other programs has increased.

Harm Reduction Worker

Other centres address coordination among staff by having a formal HIV/AIDS service delivery protocol that is followed by all service providers.

We have an elaborate protocol for HIV service delivery starting at pretest through treatment and care.

Health Promoter, WHIWH

Placing an emphasis on coordination of services is an essential component in the prevention, treatment and care of populations affected by HIV. Such care requires the exchange of information and close coordination among all participants in the care process.

C. Case Management Approach

CHCs are often faced with busy schedules that make efficient communication amongst service providers challenging. When healthcare professionals share responsibility for a single patient across organizational boundaries, a high degree of communication between providers is necessary. There is considerable evidence that new technology, such as systems for sharing electronic

health records, supports effective delivery of coordinated care.[35] The possibility of integrated case management, using a computerized networking system which could keep track of results, consults, lab records and identify trends, was a key solution offered in the literature.

The case management approach to providing coordinated HIV services is suggested in the proposed *HIV/AIDS Strategy for Ontario*. Case management has been proposed as a solution to system fragmentation and for facilitating best delivery of services. Case management creates interdisciplinary communication that can be positive for clients who need service coordination. Provan et al. suggest that it is the way managed care is implemented that will determine if enhanced collaboration among providers occurs. For example, if managed care is simply imposed on providers, client services may suffer and enhanced collaboration amongst provider agencies is unlikely. If providers are partners in creating integrated services, the benefits can be very positive and contribute to the health of those clients whose services need coordinating.[36]

Our research suggests that there are some clearly identifiable structural and organizational characteristics that support coordination of care. Some of the strengths and challenges identified in terms of HIV/AIDS prevention, treatment and care service coordination are summarized in **Table 9**.

Table 9 CHC Service Coordination Successes and Challenges

SUCCESSES

Team building:
- Team meetings and meetings that have all staff at the table
- Good relationship development amongst all staff
- Open communication
- Debriefing sessions
- Everyone on the team being considered an equal contributor

Referrals:
- Case coordinators and use of computerized system to track referrals
- Formalized internal referral system

Formalized Protocol:
- Formalized and elaborate protocol for HIV service delivery starting at pre-test through to treatment and care
- Using an outside consultant to look at coordination of care
- Ongoing program evaluation to identify strengths and areas for growth

Case Conferencing and Case Coordinators:
- Case conferencing on clients
- Ensuring all staff have experience working with all types of clients
- Having a case coordinator who acts as an interface between clients and clinic

CHALLENGES

Staff Challenges:
- High turnover of staff
- Discriminatory attitudes of some staff towards clients
- Hierarchy of services in which some people feel less valued than clinical staff
- Some staff not supporting the harm reduction model

Disclosure Issues:
- Disclosure issues may impact on coordination of care

D. Coordination Amongst CHCs

HIV services are not evenly distributed across the province. The majority of centres who participated in interviews are located in Toronto and Ottawa. The inter-centre coordination is quite different in these two regions. In both Toronto and Ottawa staff at CHCs often use personal contacts with staff at another centre to share information and resources. At this level, it is very informal communication. Ottawa has implemented a more formal system of coordination; in Ottawa, CHC service providers meet at sessions called "Interclinics." The Interclinic is a chance to share training and learning opportunities. Once every three months a centre in Ottawa is designated to plan an Interclinic Day, which may be a half or full day session. This is a combination of small and large group discussions, guest speakers and caucusing. This allows CHCs in the region to stay connected and to connect with other individuals who are working in a similar area. The staff that attend these meetings, which cover all health issues, including HIV/AIDS, describe them as useful and rejuvenating.

E. Strategies for Rural Settings

Many CHCs serve rural, northern and isolated communities. The North Carolina Services Integration Project (NCSIP) created a model of integrated care for HIV-positive, geographically dispersed residents. Integration resulted in enhanced care coordination and helped service providers develop new skills and create support systems amongst their colleagues. They were able to rely on a larger community for care management advice, and to reduce their isolation by sharing experiences. The NCSIP was a five-year federally funded project in which staff facilitated coordination between HIV clinicians and case managers through multiple modes of enhanced communication, such as the development of a computer network to enable confidential and consensual information sharing for the purpose of enhanced provider decision-making. Medical and social service providers developed care-maps for HIV clinical care, case management and hospital services. The teams also created practice guidelines for HIV services. The care-map provided both a model of integration and a tool for clinical and psychosocial care and management. Providers came together to decide on practice guidelines and discovered each other as a resource and support. The care-maps helped providers in rural areas to understand basic guidelines to follow and what to expect of care by other specialties.[36]

Minore and Boone discuss possibilities for improving interdisciplinary teams and filling service gaps in rural Canada, specifically in Ontario's north-western Aboriginal communities where adequate service in HIV/AIDS prevention and care is a concern and coordination can be difficult. Interdisciplinary teams practicing in these northern communities include a number of paraprofessionals working with professionals to meet the needs of otherwise underserved HIV client populations. The term paraprofessional refers to community members who are hired to utilize their cultural and community awareness to deliver culturally appropriate health services. Enhancing the utility of paraprofessionals in rural health care teams can offset the lack of professionals working in remote areas and addresses cross-cultural barriers that exist between non-Aboriginal professionals and Aboriginal clients.[37] Best care and team functioning occurs when members are clear about their own and each others' roles, respect an equal, but different knowledge base and have confidence in one another's competence.[38]

3.2 PARTNERSHIPS

The CHC philosophy of care encourages partnerships with health and social service organizations in their respective catchment community and beyond. This strategy helps to leverage resources and ensure excellence in care coordination. HIV service providers have developed partnerships to ensure broad access to comprehensive care, to increase centres' capacity to serve diverse populations and to expand staff skills and knowledge. **Table 10** provides a summary of partnerships in which CHCs participate.

Table 10 Sample Partnerships in CHCs

CHC/AHAC	PARTNERSHIP	BENEFIT
All Toronto CHCs Interviewed	Toronto Public Health	Sharing information and referrals Receiving harm reduction supplies
Wabano	Assembly of First Nations	Use of website to get out information Collaboration for World AIDS Day
Oasis	Ottawa Public Health Royal Ottawa Hospital University of Ottawa, Law School Bruce House Hospice	Sharing information and referrals Communicating to ensure clients will be prepared if there is a positive test result. The law school sends a legal aid student once/week to work with HIV+ clients. Intake worker comes once/month to help people fill out intake forms to be admitted to the hospice/apartments Send an addiction/mental health worker once/week
Queen West, Parkdale Lawrence Heights South Riverdale	Safer Crack Use Coalition (SCUC)	CHCs connect and support each other in working with crack users Share information and advocacy work
Queen West	TRIP (Toronto Ravers Information Program)	Initiates CHC work for youth/raver population at risk of HIV/AIDS
Parkdale	Parkdale Activity and Recreation Centre (PARC)	Staff provide outreach services to clients at PARC and provide a healing centre clinic Clients receive shared care from service providers at both organizations
Planned Parenthood	Hassle Free Clinic	Pipeline for information and training in anonymous testing and pre- and post-test counselling
Regent Park	St. Michaels Hospital Committee for Accessible AIDS Treatment (CAAT) Casey House	Informal relationship in which Regent Park assists in resolving issues and arranging care for clients at the hospital on a case-by-case basis.
	20 different organizations involved in programs such as the Service Access Training Program and Compassionate Pharmaceutical Access Project	Access to services when a client is extremely ill

CHCs also refer clients to other ASOs. The chart below provides a sample list of the types of HIV/AIDS services that clients are using outside of CHCs. It is important for CHCs to know where clients are getting other services so that services are not being duplicated and service user/service provider time is being used efficiently. Column two of **Table 11** outlines the most common organizations to which CHCs refer their clients.

Table 11 HIV/AIDS Services Outside of CHCs

HIV/AIDS SERVICES USED BY CLIENTS OUTSIDE OF CHCs (REPORTED BY SERVICE USERS)	ORGANIZATIONS TO WHICH CHCs REFER CLIENTS (REPORTED BY SERVICE PROVIDERS)
Anonymous HIV testing	Anonymous HIV testing
ASOs	ASOs
Legal Aid	Legal Aid
HIV/AIDS specialty clinics	HIV/AIDS specialty clinics
or HIV/AIDS Hospital Care	or HIV/AIDS Hospital Care
Support group	Family doctor
Women's centres	Drop-ins
Alcoholics Anonymous	Methadone doctor

A. ASO Service Providers

Across the province many CHCs partner with local ASOs to provide HIV/AIDS services. ASOs are non-profit, community-based organizations that offer HIV/AIDS-related services to communities. ASOs work to improve the quality and length of life of those infected and affected by HIV and to prevent the spread of HIV. The Ontario AIDS Network (OAN) is a province-wide coalition of community-based ASOs that provides a wide range of services. There are currently fifty member ASOs in Ontario. A list of Ontario ASOs is included in **Appendix F**. Contact information for OAN member ASOs can be found at **http://www.ontarioaidsnetwork.on.ca/**. Many CHCs see the value of linkages with ASOs in their community to address the needs of the diverse range of PHAs they see.

The twelve ASOs that responded to our survey were asked to describe collaborations and/or partnerships they currently had with CHCs, or ones they would be interested in forming. Most respondents were interested in collaborating with a CHC in the areas of primary care, needle exchange, Hep C programs and community development. Three of the twelve respondents were interested in learning more about what types of collaboration might be possible. Only one respondent was not aware that CHCs offered HIV/AIDS services.

ASOs were familiar with some of the unique HIV/AIDS services that CHCs provide to clients including: primary care services (n=5), counselling (n=1), targeted programs for populations such as babies, moms, and seniors (n=1), testing and in particular anonymous testing (n=2) and medication access (n=1).

Overall, the ASOs who responded to the survey were interested in building relationships with CHCs in their communities and some respondents were interested in building relationships

with other CHCs outside their local community. In one case, a geographically isolated ASO expressed great interest in the possibility of exploring partnership opportunities with CHCs. In another case, an ASO service provider noted that some of the clients he works with are ex-prisoners and that it can be difficult to find service providers who are friendly and open to these clients. He felt that his clients might be better served in the CHC environment because of their familiarity in serving diverse clientele. Many ASOs believe that ASOs and CHCs have much to learn from one another and many expressed interest in working more closely with CHCs in the future.

Chapter Summary

CHCs aim to establish and maintain coordination between activities internal and external to CHCs so that CHC and community resources are used effectively and efficiently. This is a strength of our model of care that can be a benefit to clients who are seeking HIV/AIDS services. Lack of coordination can be a barrier to access, particularly for vulnerable and/or marginalized populations. There is a variety of effective approaches for integrating HIV care into the work of a CHC, and for creating a team that can provide this care. CHCs can provide leadership and mentorship for other models of care about how to effectively coordinate care. It is also clear that staff at many CHCs would benefit from training and skill development related to working effectively in an interdisciplinary team. While CHCs have developed many effective partnerships across the province, there are clearly many unexplored opportunities to work more closely with ASOs to provide better care for people living with or at risk of HIV/AIDS.

CHAPTER 4

Evidence and Evaluation

CHCs are one of the most accountable models for delivering primary health care. Mechanisms for accountability include governance through community boards, the Building Healthier Organizations (BHO) accreditation process and the CHC Program Evaluation Framework. This report includes a list of online resources in **Appendix I**. Some of the sites include information and documents that could be used as evidence to support the development of evaluation of HIV/AIDS programming in CHCs.

In our survey of CHCs we asked service providers to identify the sources of evidence they use for the development of their programs and to evaluate the ongoing effectiveness of their programs and services. **Table 12** documents the various types of evidence used in CHC practice. Many centres use formal program evaluations as a basis for their practices suggesting that there is a strong commitment to using formalized methods of program development and evaluation in the sector. CHCs also rely on anecdotal information that involves informally gathering stories and information from staff, clients and the community. For service providers needing to maximize their time providing support to clients, anecdotal evidence is often a less time-consuming gauge of successes and challenges in practice.

Table 12 Evidence Used in Practice

EVIDENCE USED IN PRACTICE (n = 18)	
EVIDENCE	**# RESPONSES**
Anecdotal information from staff, community and/or clients	8
Program evaluation reports	7
BHO	3
Observation	2
Clinical Practice Guidelines	2
Purkinje data	2
Needs assessments	2
Key informant interviews	1

Table 13 summarizes the tools used in CHCs to evaluate programs and services. Regular staff evaluations and use of outside consultants are the most common methods indicated for evaluation of HIV/AIDS services.

Table 13 Evaluation Tools Used in Practice

EVALUATION OF SERVICE (n = 18)	
TOOL USED	**# RESPONSES**
Staff evaluations	10
Outside consultants	6
Anecdotal evidence	5
Client feedback forms	5
Client focus groups	3
Purkinje data	2
Client interviews	1
Client surveys	1
No formal evaluation	1
Other: Peer chart review; evaluation sheet at reception counter; community consultation	

Overall, the largest barriers to integrating evidence and evaluation in practice are time and resources. Service providers are busy providing prevention, treatment and care services and this often creates challenges in documenting evidence:

> *We are so busy providing resources that it is hard to document everything. There is a lack of resource support. We get no extra resources for doing this work from our core funders. There is a lack of recognition that this takes extra effort…I have to do a form for Public Health and one for my program, among others. This is all done manually and is time consuming. We track advocacy, referrals, counselling, needle exchange, meetings, street outreach all on paper and then a peer worker inputs the data. My evidence gives me all the information I need for my programs. We're reluctant to apply for more funding because that's one more report to write and with no administrative assistance, this is a challenge.*
>
> Outreach Worker,
> South Riverdale CHC

Evidence collected from program evaluations can support the growth and improvement of programs and be positive experiences for both clients and staff involved. The COUNTERfit Harm Reduction Program at South Riverdale CHC recently did a program evaluation that outlined the successes and challenges faced by staff and clients. The evaluation provided evidence that the CHC is an ideal location for harm reduction programs due to the accessibility of its location, the high level of confidentiality and the wide range of services offered. The evaluation recommended a drop-in, on-site methadone program and additional training for health centre staff about addiction, drug use, harm reduction, the sex trade and health effects of addiction.

Harm reduction staff at the centre feel that the evaluation has had benefits in educating other CHC staff and has improved communication with the clinical team:

Since our (COUNTERfit) evaluation report, cooperation with the other programs has increased.

Outreach Worker,
South Riverdale CHC

Evaluating the prevention work done at CHCs poses particular challenges. The work is not always easy to document. Some service providers feel that prevention efforts are sometimes under-evaluated, and consequently under-valued.

Prevention is hard to evaluate. It seems we only recognize the value in prevention when we don't do enough of it and it fails. Is it success when we keep someone HIV-negative for 4 years?

Health Promoter, WHIWH

HIV/AIDS services are also tracked through Purkinje software, a data collection and information management system shared by all CHCs in Ontario. There are many frustrations with this system including:

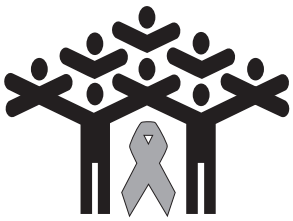
- Time consuming data entry;
- Difficulty getting feedback and reports;
- No training model to learn from;
- The system does not track relevant information for harm reduction models and social services; and
- It is not comprehensive for services outside the clinical realm.

Some service providers did comment on the benefits of Purkinje. They felt it was useful in:

- Showing accountability;
- Documenting the demographic composition of a community or population served;
- New version of system allows centres to look at volume of clients and why they are being seen;
- Charting; and
- Collecting statistics, which can help provide evidence for funding proposals by validating services.

Chapter Summary

CHCs use evidence-based practice and evaluation to improve and support their programming and services. Collecting evidence and research, and regularly evaluating programs and services provides models of best practices and documentation of the unique and valuable work of CHCs. CHCs integrate research and evidence into their practices to ensure clients receive the best care possible. Regular evaluation of programs ensures constant improvement and innovation and provides documentation of the value of CHCs contribution to addressing Ontario's AIDS epidemic.



CHAPTER 5

Showcasing CHC Best Practices

Research has demonstrated that the most effective HIV/AIDS prevention and treatment services are those that are responsive to the needs of the communities and populations that they serve. In the third decade of the epidemic, we know that effective services need to be tailored to the expressed needs of service users. One of the strengths of the CHC model of care is that our organizations are founded on the principle of providing services that meet the needs of our local communities. CHCs have developed a wide variety of innovative programs and services in response to the needs of their local communities.

CHCs were asked about innovative work they are doing and what they are most proud of at their centres in terms of HIV/AIDS services. From these stories, many best practices approaches were identified. The following section highlights some of the successes of Ontario CHCs in HIV/AIDS work.

A. CMSC: Train-the-Trainer and *Souper Africain*

The Centre médico-social communautaire in Toronto serves French-speaking people and clients from HIV-endemic regions. The HIV/AIDS services they provide are primarily prevention programming and testing. One of their great successes has been the development of a train-the trainer guide. It is a French-language binder combining valuable information and models with paintings about HIV by a painter from Senegal. The binder provides comprehensive steps to train volunteers and interested people in HIV prevention. The train-the-trainer program itself is called "VIH/Sida Vous et les vôtres." One of the program's successes was the unexpected involvement of six African men in the program that was initially targeted to women. The men's interest is important in a culture in which HIV/AIDS is very stigmatized.

Another successful program is "Souper Africain," a health promotion activity where African food is served and health topics are discussed. The facilitator tries to include HIV in most discussions and people often ask questions about HIV after the presentation. In the beginning, few people attended the program. The project coordinator, who is a member of the community, began visiting African food and music stores to recruit participants and now between twenty-five and thirty people attend on the last Friday of every month.

Some of the resources available from CMSC include:

- French-language train-the-trainer binder;
- French-language HIV binder for service providers; and
- *Messages d'espoir* — a book of stories and poems about living with HIV.

B. Lawrence Heights CHC: Addressing Stigma and Internal Referrals

Lawrence Heights Community Health Centre is proud of making strides forward in educating themselves and others on HIV and IDU work in their community. They have faced difficulties when serving varied populations of clients in their community. Lawrence Heights has focused on reducing stigma around HIV, Hepatitis C, drug users and the homeless population by including them at the centre and through workshops addressing stigma and challenging people to think about themselves and others and the impact that HIV has in all our lives. Staff have attempted to connect with the communities they serve. The result has been that more volunteers from the Lawrence Heights community have been recruited in their harm reduction programming.

The internal system of referrals at Lawrence Heights is an example of an innovation in service coordination. It uses a computer program system called the Advanced Access System and it allows streamlining of services in intake and booking clients. If a client is in need, the system ensures that they can see a case coordinator who will book the client to see a physician within twenty-four hours, making the whole clinic accessible to all clients. Further information about this program is available from Lawrence Heights Community Centre.

C. North Hamilton CHC: Leaders in Education

North Hamilton CHC provides more than just HIV care. North Hamilton coordinates the rounds for the region on HIV care and prevention. They are leaders in teaching and creating a new generation of medical care providers who are knowledgeable about HIV. Twelve residents from McMaster work at the centre and are encouraged to carry caseloads with HIV-positive clients as they try to "invent" a family doctor who has an understanding of HIV care.

The centre has been active in creating resources and tools for HIV/AIDS services including:

- *The Positive Living Guide 3rd Edition*, which is a resource for people in Hamilton and surrounding areas living with or affected by HIV/AIDS;
- *HIV and Pain – what YOU can do* and *HIV and Fatigue – what YOU can do.* Student occupational and physical therapists have written these rehabilitation booklets that support clients in coping with HIV/AIDS; and
- An HIV First Assessment Intake Form and HIV Progress Checklist, which enable all providers to access information for HIV care and triggers providers to do certain blood tests at certain times.

In the early years of the HIV epidemic, the centre began the practice of having a memorial service for clients who had died of HIV. All staff and other clients with HIV attend. It helps build an understanding and respect for all clients using services at the centre. North Hamilton has demonstrated innovation in services and a commitment to their clients.

D. Sandy Hill CHC: Oasis Victories and the Cheque-Buddy Program

Oasis is a project of Sandy Hill CHC and it is for people at risk, infected or affected by HIV/AIDS. It is a health centre for marginalized populations that specializes in HIV/AIDS. As health is stabilized and barriers to accessing health care are addressed, clients are able to access other healthcare. Oasis is well known for treating people well and teaching people to treat themselves well. Because they are only open four hours a day, they see their role as empowering people to take care of themselves.

At Oasis, the staff celebrates "Oasis Victories," which are small, day-to day events that make a difference in the lives of their clients. A victory may be a client calling to say they won't be at an appointment or a client taking responsibility for unacceptable behaviour at the clinic. These victories are celebrated at the daily debriefing sessions that Oasis has implemented.

One of many unique programs at Oasis was the cheque-buddy program. The cheque-buddy program, called "HHH" (for health, HIV and homelessness), was a program where an outreach worker would go with a client when they received their monthly benefits cheque. Clients would voluntarily sign up for the program and set goals they wanted to achieve such as paying rent or buying food with the money. The worker would then support the client to meets these goals.

E. Parkdale CHC: Prevention Education Workshops

In 2003 Parkdale CHC developed a prevention workshop. The workshop was tailored to target groups in the community including IDUs, people involved with the prison system, homeless people, Afro-Caribbean men and women, elderly male sex trade consumers, sex workers, marginalized youth and the lesbian-gay-bisexual-transgendered-queer community. Parkdale CHC recruited participants in partnership with Toronto Public Health, Community Outreach Programs in Addictions (COPA), Prisoner AIDS Support Action Network (PASAN), New Hope Drop-in, St. Christopher's House and Savard Women's Hostel. They also partnered with the AIDS Committee of Toronto (ACT), BlackCAP, WHIWH, and Good For Her (a women's sex shop) for resources and optimal information delivery.

The workshops were a success according to an evaluation report. Through the process of hosting the workshops, a manual of information and resources was developed for service providers. The resource manual is a self-directed teaching guide for service providers, so that knowledge is not lost with staff turnover. The centre hopes to train peers to be the trainers themselves in some of the workshops. The HIV/AIDS Resource Manual is available at Parkdale CHC and provides an excellent source of information for other centres who may be interested in the workshop models which are geared to a number of specific communities.

F. Planned Parenthood: Volunteer Program

Planned Parenthood, "The House" CHC offers services to clients who are between the ages of thirteen and twenty-five years. They have established a volunteer program for peer education in sexual health which includes twelve weeks of training in sexual health. Peer educators then do face-to-face sexual health education with clients. There is an observation period for three months

during which new volunteers shadow more experienced peer trainers before they work on their own. Volunteers receive a comprehensive information binder and many volunteers stay with the program for years. Planned Parenthood works in partnership with the Hassle Free Clinic for anonymous testing and they are working towards partnering in HIV/AIDS 101 training for volunteers, which would cover issues like testing and risk reduction. Volunteers contribute to the chart information of a client and the coordinator signs off on this. Additionally, Planned Parenthood offers a Teen Info Line staffed by teen volunteers and hosts TEACH (Teens Educating and Confronting Homophobia).

G. Queen West CHC: Peer Street Outreach Program

Queen West CHC is a site of Central Toronto CHC (CTCHC). CTCHC is a leader in the development of inner city health services focusing on the needs of homeless and street involved youth and local area adults, youth and families. The peer street outreach program involves community peers who have personal experience of drug use or being homeless in the CTCHC catchment area. Peers are paid to provide street outreach, to act as members of the harm reduction team and to help plan new program activities. Peers attend monthly meetings and on-going skills building workshops. Training sessions include HIV/AIDS 101, harm reduction, train-the-trainer, Hepatitis A, B and C and counselling skills. According to the staff this is the longest running peer outreach program in Toronto. Queen West has also developed a Voicemail Program through which clients can sign up for voicemail at a rate of $10.00 for three months. The program will cover this fee for peer workers.

Further, CTCHC has developed many resources that may be of use to other centres including: ongoing training programs, concrete job performance expectations and workplace policies for peers.

H. Regent Park CHC: HIV Medication Access Pilot Project and Service Access Trainer Program

Regent Park CHC has been a leader in pioneering services for PHAs and has engaged in groundbreaking work in the area of improving access to health, social and legal services for immigrants and refugees and people without immigration status who are living with HIV/AIDS. In 1995-96, they launched the CHC Accessibility Project that provided a series of training workshops and mentorship opportunities to support CHCs, ASOs and other health and service organizations to provide services to this population.

Recently, Regent Park CHC provided a key coordinating role in supporting the work of the Committee for Accessible AIDS Treatment (CAAT). CAAT is a community network of frontline health and community service providers working together to promote access to services for marginalized and vulnerable PHA populations. Working with CAAT, RPCHC coordinated an action research project, Improving Access to Health Care for People Living with HIV/AIDS Who Are Immigrants, Refugees, or Without Status. The findings identified strategic interventions to address the determinants of health affecting social, legal, health, and treatment access for these populations. Three community-driven project initiatives have since been developed and implemented, based on the findings of the original project:

1. The Service Access Training Program, housed at Regent Park CHC, provides training for service providers and immigrant/refugees PHAs to develop skills to effectively negotiate service access in the immigration and health care systems. To date, nine PHAs and over thirty service providers from different communities have been trained through the program.
2. The HIV Medication Access Project, now housed at the Toronto People with AIDS Foundation, provides case management support and coordination for getting compassionate access to pharmaceutical drugs for HIV positive clients.
3. The Legal Information Project, coordinated by the HIV/AIDS Legal Clinic of Ontario (HALCO), developed easy to understand fact sheets on HIV and immigration policies, service eligibility and coverage for people at various stages of the immigration/refugee application process as well as training materials for legal service providers.

Other CHCs involved in CAAT include Shout Clinic (site of CTCHC), Parkdale, Davenport-Perth and Women's Health in Women's Hands. Two resource documents, "Resource Listing of Services for Newcomers Living With HIV/AIDS" and "HIV and Immigration Service Advocate Training Manual" have been developed by CAAT and are available through Regent Park CHC.

I. Somerset West CHC: Anonymous Testing

Somerset West CHC coordinates anonymous testing for the city of Ottawa and offers all levels of HIV testing and support. Beginning in January 2004, Somerset West will offer anonymous HIV testing on the street. The health centre has an excellent harm reduction program and provides extensive street outreach. Adding anonymous HIV testing to their services will increase accessibility to clients who might otherwise never be tested. Street outreach workers do the testing on the street for the clients, meeting the clients 'where they are at.' In an informal survey, clients on the street said they would be willing to do an HIV/AIDS test right on the spot. Outreach workers have been trained to draw blood from a vein and to provide HIV pre- and post-test counselling. There had been many concerns about starting this program including liability issues and obtaining informed consent from people who are under the influence of drugs or alcohol but the program is now underway. A medical directive that allows anonymous HIV testing on the street has been established along with policies and procedures. Service providers at Somerset West are proud that this unique service will be available in their community. Clients at Somerset West are also able to access computers, the Internet and phones free of charge at the centre.

On a more social side of programming, outreach workers at Somerset West have been offering clients some events that allow them to get out of their regular environments. The goal is to show people that they can still participate in life and to provide a time to relax and gather in a safe space. For instance, a spa night for sex trade workers offers socializing, make-up and manicures allowing participants to pamper themselves and feel healthy.

J. South Riverdale: COUNTERfit Harm Reduction Program

The COUNTERfit Harm Reduction program operates from South Riverdale CHC. The program has become a model for harm reduction programs within and beyond Ontario. Through needle

exchange, one-on-one education sessions, peer programming and a wide variety of resources, the COUNTERfit program is an accessible, well-used program contributing to HIV prevention and community wellness in South Riverdale. South Riverdale CHC has supported the program with strong administrative leadership and a willingness of the staff at the centre to learn about harm reduction. At the community level, the program attempts to work with other service providers to create a more accepting environment for drug users. The project coordinator and peer assistants connect with the community and provide HIV/AIDS education. The program is particularly proud of its satellite volunteer sites. Prominent drug users in the community may host a satellite site where needle exchange, vein creams and safer drug use information is provided. There are incentives to be involved with the program including harm reduction program satellite cards (which are recognized by police officers), resources and involvement and ownership of the program.

K. Wabano AHAC: Innovative Prevention

Wabano AHAC in Ottawa has an HIV/AIDS health promotion program that incorporates prevention education and storytelling. One of the biggest barriers to HIV services in the Aboriginal community is stigma around HIV/AIDS. "The Stories Are My Teachers" is a community development health promotion plan that uses theatre in various forms to tell stories and educate the community about HIV-related issues. Puppetry, playback theatre and video have all been successful strategies for communicating HIV/AIDS information. The HIV/AIDS program staff at Wabano view their job as one of repairing broken trust and creating positive space to showcase talents. They focus on creating a safe space where people are valued and lessons are learned. Centre staff have learned that they often have to speak indirectly about HIV because people will avoid programs that are labelled as an HIV/AIDS program. For instance, an educational video or play may contain no HIV information but the follow-up might be a discussion with an Elder where safer sex information and HIV is brought into a discussion of living life in balance. Peer models are often used to connect with community members.

Some of the innovative HIV/AIDS programs and activities at Wabano include:

- "Our Lives Would be Changed Forever," a play written by a client at Wabano. The title is based on a quote from an old shaman and the play is about the journey of the Aboriginal people going through challenges and finding solutions, health and support;
- *Keep The Circle Strong* consists of two games and a manual that focus on HIV/AIDS prevention;
- Traditional doll making, comforter-making, woodcarving and twig furniture act as vehicles for promoting discussion about health and HIV/AIDS; and
- World AIDS Day Camp-out where staff met people in the reception area and had a 10-question anonymous quiz about HIV/AIDS. If clients did the quiz and then checked their answers they could enter a draw to win $50.00.

L. Women's Health In Women's Hands (WHIWH): Integrating and Building Services

WHIWH CHC serves women, specifically women from African, Caribbean, Latin American and South Asian communities including immigrants, refugees and non-insured/non-status individuals. Most of their HIV work has been targeted to African and Caribbean women and service providers working with them. At WHIWH, HIV prevention, treatment and care is integrated with all services. The centre has undertaken several research studies including "The Silent Voices of the HIV/AIDS Epidemic: African and Caribbean Women." This project documented the factors that influence black women's responses to HIV/AIDS and the experiences of black women and women of colour with HIV testing during pregnancy including their understanding of informed consent and reasons for testing or not testing for HIV during pregnancy. This research addressed a gap in knowledge of HIV/AIDS about a group that is disproportionately affected by the epidemic in Ontario. Further, it has allowed the centre to partner with the community and utilize the expertise and experiences of women to build more effective programs.

Recently, WHIWH has undertaken a health promotion project that helps women better understand technical health information around HIV. HIV specialists and other guest speakers come in to explain and simplify technical medical information for clients. Clients, in turn, have the opportunity to discuss issues arising from service provision such as disclosure to children and family, cultural perspectives and the importance of dealing with their HIV status in their own time and manner. Together with women, WHIWH hopes to build an HIV/AIDS disclosure model that will be shared with service providers working with black women living with HIV/AIDS. The advocacy work at WHIWH occurs not only at an individual level but also at a systemic level and through policy work. At WHIWH, HIV prevention, treatment and care is integrated with all services, making it a successful, holistic core program.

Chapter Summary

This chapter documented some of the successes and challenges that CHCs experienced in the process of adapting the care they provide to respond to the particular needs of local communities.

Service providers struggle with designing services and supports that are responsive to the needs of clients and communities. This project is a first step in sharing our models of excellence across the province and learning from each other's successes and challenges.

CHAPTER 6

Recommendations

This project was a first step in documenting the work of CHCs in Ontario and providing a forum for service providers in our organizations to communicate with each other and to plan collective action. The HIV/AIDS Best Practices in Community Health Centres Summit held on January 30th 2004 at Ryerson University in Toronto was the first time that service providers from across the province came together to discuss their HIV/AIDS work in CHCs. The Summit materials and report are found in **Appendices G and H**. The Summit was intended to provide participants an opportunity to network, share models of excellence and to look ahead to next steps for CHCs in the development of HIV/AIDS care.

The recommendations that emerged from the Summit are based on both the findings of our research and on the experience of the seventy-nine participants who attended the event. Recommendations are presented in the format developed by the working groups at the Summit and they are directed at various groups including CHCs, ASOs, the AOHC and various funding bodies including the Ontario Ministry of Health. These recommendations are not the end of the conversation but are meant to provide a guide for the next steps in collaborative action for our sector. Recommendations are organized in three sections based on the three workshop groups that met during the summit:

Workshop Group 1: Integrating Care, Treatment and Support with Prevention, Outreach and Health Promotion: CHCs' Unique Contribution

Workshop Description

One of the unique features of the CHC model of care is the integration of clinical care, social services and community development. Many of the CHCs we interviewed in our research are providing treatment services for PHAs as well as a variety of prevention services. While participants in the study identified this integration as a strength of our model of care, they also emphasized that integration does not happen without great effort. The goals of the session included identifying ways that centres may support each other in this work and identifying resources or supports that will facilitate this work across the sector as a whole.

Recommendation 1: Develop more effective systems of internal and external referral.
Rationale: Service providers would like to see systems of internal and external referrals in place. Currently, several CHCs have informal access to hospitals on a case-by-case basis. CHC service providers would like to see formal arrangements developed between CHCs and hospitals so that

CHC clients who, for example, have no OHIP coverage, can access hospital services when necessary. Service providers also recommended that individual centres develop systems of internal referral. One method of achieving this is through computerized referral systems and/or the use of case coordinators who can facilitate the streamlining of services in intake and booking clients.

Recommendation 2: Develop formal HIV/AIDS testing and follow-up protocols within CHCs.
Rationale: CHCs that have directed time and resources into developing protocols for HIV/AIDS testing and follow-up have been successful in maintaining high standards of service for clients affected by HIV/AIDS. These protocols ensure that CHC are on the same page when considering HIV/AIDS services. While clinical guidelines exist, there are many different situations in CHCs that could be addressed in individualized centre protocols. Such protocols could also include confidentiality standards specific to the CHC interdisciplinary approach.

Recommendation 3: Develop strategies to address stigma within CHCs about clients who are either living with or at risk for HIV/AIDS.
Rationale: In order to provide integrated HIV services within CHCs, service providers must work effectively with one another and with their clients. Both service users and service providers feel that many CHC staff are not comfortable providing services to clients who are HIV-positive, homeless or drug users. Staff attitudes have an important role in optimal service delivery. Service providers recommended a mandate to address this issue and to ensure that programs and services at CHCs are accessible to all clients. Peer education, community education and training in the area of HIV/AIDS and stigma may be appropriate strategies to address these issues.

Recommendation 4: Encourage and provide resources for peer teaching and peer review.
Rationale: There is potential for growth in CHCs in the areas of peer teaching and peer review. Two CHCs have mentorship programs for physicians in the area of HIV/AIDS care and Regent Park CHC provides a Service Access Training Program to educate service providers on HIV and immigration issues. These programs could be used as models for education and skills building amongst all service providers in CHCs. Peer review can be used to improve accountability and as a learning tool amongst staff. Sharing experiences through peer models is an effective and important method of information transfer within and amongst CHCs.

Workshop Group 2: Building Coalitions: the Foundation for Building Capacity for HIV Work in CHCs

Workshop Description

CHCs are founded on two principles: first, that communities should make their own decisions about the distribution of health care resources; and second, that collective action can lead to both individual empowerment and systemic change. These principles strongly influence the kind of HIV/AIDS work that we do in our communities. A common theme in our research findings was that building coalitions and working with partners who are interested in HIV/AIDS work is an important strategy for CHCs that are new to HIV/AIDS work. The goals of this session included

identifying strategies or best practices for developing coalitions that may be of use to centres that are just beginning this work, and identifying partnerships or coalitions that the sector as a whole should pursue.

It is important to recognize the benefits of coalitions and to identify best practices for coalition building in CHCs.

Benefits of coalitions include:

- Sharing resources
- Learning gaps and trends in services
- Mutual support and protection
- Speak with a unified voice
- Ongoing support

Keys strategies for building coalitions include:

- Find your allies
- Make it broad based
- Make it tangible
- Keep it open to new ideas
- Involve and pay people most affected
- Make sure the agency, not just front-line service providers, is supportive
- Develop structure and talk about this up front
- Remember: the process is the outcome
- Tailoring processes to facilitate participation from all
- Consider the work you do and the research capacity

Challenges to building coalitions include:

- Not getting too ambitious; don't start things you can't complete.
- Consider if the meeting process is still effective.

Recommendation 5: Secure resources to support the development of internal CHC coalitions through mentoring and peer training.

Rationale: Internal coalition building would be a good place to begin for CHCs. Internal coalition building would involve CHCs working together through mentoring and peer training. They would be building capacity to build coalitions and leveraging the resources that CHCs do have. Ottawa's "Interclinics" are a model of CHCs in one region working and learning together. CHC service providers having great experience in working within coalitions suggested that CHCs do not start external coalition building until we have more resources. Coalitions require significant time, energy and resources and without these, a coalition group may not survive. Partner coalition work must be resourced and recognized. To support this effort, AOHC could:

— Look at resources around community-based research (CBR);
— Link with CBR resources and develop CBR capacity and evaluation;
— Partner with the OAN and McMaster's Community-Linked Evaluation AIDS Resource (CLEAR) Unit;
— Share skills, lessons learned, models and tools, but don't assume one size fits all; and
— Lobby for resources and recognition.

Workshop Group 3: CHCs' Strategic Role in the Ontario AIDS Epidemic

Workshop Description

One of the goals of the CHC program is to serve people in Ontario who face significant barriers in accessing health and social services. CHCs serve many marginalized populations that are disproportionately affected by HIV/AIDS. Another goal of CHCs is to address social justice issues and determinants of health. This is consistent with the policy directions of Ontario's current HIV/AIDS Strategy. Clearly, CHCs have a strategic role to play in addressing Ontario's AIDS epidemic. Panellists in this workshop discussed CHCs' role in funding, research and public policy in relation to Ontario's HIV/AIDS Strategy. Participants were invited to share ideas and strategies to enhance the role of CHCs in our provincial response to the HIV/AIDS epidemic.

Esther Tharao, a health promoter at WHIWH, was one of the panellists. She presented several recommendations for solidifying and expanding the strategic role of CHCs in HIV/AIDS care in Ontario. Key points from that presentation include:

— CHCs' model of service delivery provides an excellent platform on which HIV/AIDS services can be delivered. Features of this model include:
— Integration of the determinants of health into service delivery;
— Evidence-based programming and policy making; and
— Built-in mechanisms for monitoring and evaluation to determine effectiveness of services delivered.

CHCs have a well-established infrastructure on which to effectively:

— Develop and deliver HIV/AIDS programs and services;
— Conduct HIV/AIDS research; and
— Contribute to the development of effective HIV/AIDS policy.

Recommendation 6: CHCs become strategic partners in the implementation of the Proposed HIV/AIDS Strategy for Ontario to 2008 through the development and delivery of HIV/AIDS programs.
Rationale: As previously showcased, many CHCs have already positioned themselves as key players in service delivery for various populations affected by HIV/AIDS. These CHCs have

developed models of HIV/AIDS service delivery that can be easily modified and used elsewhere. These models illustrate that with necessary human and financial resources, interested CHCs can become involved in HIV/AIDS service delivery. Using CHCs' history of working in partnerships with different stakeholders to leverage resources and CHCs' networks to disseminate information, skills, training and advocacy we can see how HIV/AIDS education, prevention, support, treatment and care services can be integrated, convenient and crucial community resources.

Recommendation 7: CHCs be considered for additional HIV/AIDS research funding and resources.

Rationale: Building knowledge and evidence to support the development of effective services and policies is very important to ensure the success of CHC work in HIV/AIDS. Needs assessments, community action and/or research done in various partnerships and evaluations and monitoring of programs are necessary components of effective programs and policies as indicated by CHCs that have done research to support their programs. Some CHC research has influenced programs and policies outside of CHCs reaching ASOs, policy makers and other HIV/AIDS researchers. This is an indication that with necessary support systems CHCs can play a role in building knowledge and evidence to fulfill some of the goals and objectives of the HIV/AIDS Strategy for Ontario. CHCs also have an internal data tracking system that can provide valuable data and information on communities and individuals affected by HIV/AIDS. It is recommended that CHCs be considered for further HIV/AIDS research funding and resources. Service providers want to raise the profile of HIV/AIDS without compromising other resources.

Recommendation 8: Ensure CHCs' contribution to HIV/AIDS policy through provision of necessary supports and resources to increase participation across Ontario.

Rationale: Research done within CHCs has been used to influence policies and programming to facilitate effective HIV/AIDS services. Many CHCs have made great contributions in establishing HIV policies and planning committees to address the HIV/AIDS epidemic in Ontario. Influence on HIV-related policies by CHCs needs to be improved by providing the supports and resources needed to increase participation across Ontario. Ensuring full participation of CHCs as partners in the implementation of the HIV/AIDS Strategy for Ontario requires financial resources and involvement in strategy implementation planning activities, capacity building/strengthening, support of programs, service delivery and research needs to be adequately resourced. This requirement for resources can be met if the AIDS Bureau and Community Health Branch work in partnership with CHCs to ensure their strategic involvement in HIV/AIDS service delivery in Ontario. Service providers discussed the importance of inviting the AIDS Bureau and Community Health Branch to the table so that we can work together.

Conclusion

CHCs are actively responding to Ontario's AIDS epidemic by providing accessible primary care and health promotion services to a diverse population base. Ontario's CHCs have a key role to play in Ontario's HIV/AIDS Strategy. The proposed HIV/AIDS Strategy for Ontario advocates two key strategies for addressing the HIV epidemic in Ontario: innovation in practice and looking beyond the virus to the other factors that affect people's health and well-being. CHCs have extensive experience in implementing innovative practices such as using a determinants-of-health approach, addressing social justice issues and providing integrated HIV/AIDS services to communities.

We are leaders in an integrated approach to HIV prevention, support, care and treatment based on the determinants of health. The CHC model of care provides an excellent platform on which HIV/AIDS services can be delivered. This model integrates the determinants of health into service delivery, calls for evidence-based programming and policymaking and has inbuilt mechanisms for monitoring and evaluation to determine the effectiveness of the services delivered.

In this project, we have:

- Identified current research and guidelines that support the integration of HIV prevention, treatment and care;
- Documented successful adaptations to evidence developed by CHCs;
- Documented and disseminated existing best practice models for HIV prevention, treatment and care in CHCs;
- Developed and recognized skills and abilities of frontline CHC service providers across Ontario in HIV/AIDS best practices;
- Developed a network of HIV/AIDS service providers in Ontario CHCs;
- Identified areas for collaboration and research in the CHC sector in HIV/AIDS services; and
- Provided recommendations for next steps for the CHC sector in developing their strategic role in HIV/AIDS service provision in Ontario.

The work of the project has helped illustrate the strategic role that CHCs play in addressing Ontario's AIDS epidemic. This document can be used to guide the next steps in collective action on a provincial level and for the development of HIV/AIDS programs in local centres.

APPENDIX A

Terms of Reference for Advisory Committee

Purpose

To ensure that the deliverables from the HIV/AIDS Best Practices (HABP) Project meet the requirements of the funder and support the work of CHCs in the sector.

Accountability

The Advisory Committee (AC) is directly accountable to the Executive Director of AOHC (Gary O'Connor). The chair of the AC will be the AOHC staff representative on the AC (Loralee Gillis).

The project coordinator will be directly accountable to AOHC staff (Loralee Gillis), and will meet regularly with the AC.

The AC will develop a process for communicating project milestones to the sector.

Functions

To bring the voice of the sector to the Project.

To provide contextual information about HIV/AIDS work in the sector and to ensure the needs of the sector are reflected in the Project.

To review all project deliverables to ensure fit within the sector and applicability in diverse communities.

To support communication efforts about the Project within the sector.

Membership

All deliverables from the Project will be developed with the guidance of the AC. For the purposes of this Project, membership of the AC will include:

A representative from AOHC

Representatives from CHCs doing HIV work in the sector

Other HIV/AIDS organizations with an interest in and/or commitment to the Project.

An effort will be made to ensure service-user participation in the committee and the Project as a whole.

Meetings

Meetings will be held as needed. It is anticipated that the AC will meet monthly for the duration of the Project.

Most meetings will be convened at AOHC. When face-to-face meetings are not possible, meetings will occur via conference call.

Quorum

Every effort will be made to ensure a quorum of 50% of active members.

If quorum is not reached at a meeting absent members will be give a time-limited period to respond to decisions.

The AC will make an effort work to on a model of consensus-based decision-making. If consensus cannot be reached, a vote will be taken and dissenting views will be documented.

Evaluation

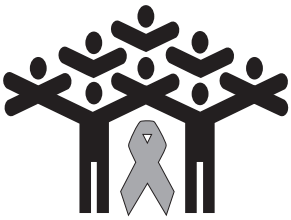
Regular and ongoing informal meeting evaluations will be arranged by the chair to ensure continuous improvement.

Term

The AC will stand for the duration of the Project – from mid-April 2003 to mid-March 2004.

Costs

Costs associated with participation on the AC will be covered by AOHC; however, all expenditures must be pre-approved by the chair of the AC.



APPENDIX B

Information Sheet, Consent Form and Interview Guide for Interview Participants: Service Providers and Service Users

Information Sheet for Interview Participants – Service Providers

What is the HIV/AIDS Best Practices Project?

The HIV/AIDS Best Practices Project is a project of the Association of Ontario Health Centres (AOHC) - an umbrella organization for 65 Community Health Centres across the province. At the AOHC 2002 AGM, members identified HIV/AIDS as a priority issue. The Project Advisory Committee consists of 12 representatives from Community Health Centres that are leaders in the sector at providing HIV care. Best practices in CHCs mean excellent and innovative care, prevention, treatment and support. Best practices create quality care for our communities and a model that can be shared amongst HIV/AIDS service providers. The Project objectives are:

1. To develop a sustainable network of HIV/AIDS care providers from CHCs across the province
2. To identify current research and guidelines that supports the integration of HIV care, prevention and treatment in CHCs
3. To document successful adaptations to evidence developed by CHCs
4. To document and disseminate existing best practice models for HIV care, prevention and treatment among CHCs across the province
5. To develop the skills and abilities of front line service providers across the province to develop best practices in HIV care, prevention and treatment
6. To identify areas for collaboration in HIV care, prevention and treatment among CHCs in Ontario
7. To identify research priorities in the CHC sector on HIV care, prevention and treatment

What are Best Practices?

Best practices in Community Health Centres are a dynamic process sensitive to each CHC community and their unique circumstances. They involve people, community, guidelines for

practice, evidence of positive intervention and values and principles. Best practices allow us to share models of excellence, pool our resources across and beyond the sector, provide quality care for our communities and accountability to our communities and funders.

What will the interviews be like?

Service providers that work in Community Health Centres providing HIV/AIDS services will be interviewed for no more than one hour. Interviews will be arranged at locations that are convenient for the person being interviewed. Notes will be taken during the interview with the consent of the participant. To facilitate connections among service providers, the roles and centres of all interviewees and descriptions of the centres' programs will be included in the final report.

How will I find out results of the HIV/AIDS Best Practices Project?

An HIV/AIDS Best Practices Summit will be held on January 30, 2004. During the Summit, results of the Project will be shared and skill-building sessions will occur. At the end of the Project in February/March 2004, a final report will be written and sent to all participants and CHC executive directors.

Who do I contact if I have any further questions?

If you have any further questions about the Project, please contact either the Project Coordinator, Cheryl Woodman at (416) 236-2539 Ext. 237 or the Project Supervisor and Manager of Research and Evaluation at the Ontario Association of Health Centres, Loralee Gillis at (416) 236-2539 Ext. 227.

On January 30th, 2004 members of the Advisory Committee invite representatives from CHCs across the province to gather for a Summit on Best Practices in HIV/AIDS Services. Major activities at the Summit will include information sharing and networking, skill development, and priority identification and goal setting for best practices in HIV/AIDS care, prevention and treatment. This is an excellent opportunity to hear the results of the project interviews.

Consent Form for Interview Participants - Service Providers

Name: _____

Centre:_____

Position:_____

Phone: _____

Email:_____

I understand and consent to the following terms of participation in the Best Practices Project interview. YES ☐ NO ☐

I have received and read the HIV/AIDS Best Practices Project Information Form for Interview Participant. YES ☐ NO ☐

I understand that during the interview notes will be taken. YES ☐ NO ☐

I understand that I may discontinue the interview at any time and/or I may refuse to answer any questions. YES ☐ NO ☐

Please feel free to contact the Project Coordinator, Cheryl Woodman, at the Association of Ontario Health Centres, (416) 236-2539 ext. 237 email: **cheryl@aohc.org** or Project Supervisor, Loralee Gillis at 416-236-2539 ext. 227 if you have any questions or concerns before, during or after the interview.

By signing below, I agree to participate in the interview:

_____ _____

Signature of the Interview Participant Date

Questions for Interview Participants – Service Providers

Name(s): _____

Centre:_____

Part I: Programs and Services

1. What programs and services does your CHC include in HIV/AIDS?

Prevention

☐ HIV testing ☐ HIV anonymous testing

☐ Health promotion programs geared for people with HIV (example)

☐ Prevention education for people at risk (example)

☐ Safer sex supplies: ☐ Lube ☐ Condoms ☐ Female Condom ☐ Dams ☐ Other

☐ Safer Drug use ☐ Supplies ☐ Needle Exchange ☐ Crack pipes ☐ Other

☐ Other (describe) _____

Treatment

☐ HIV primary care ☐ Access to pharmaceutical drugs (i.e. antiretrovirals)

☐ Other (describe) _____

Care and Support

☐ Referrals to HIV primary care ☐ Referral to specialists ☐ Referral to Social Work

☐ Referral to Case Management ☐ Drop-in centre

☐ Support group (describe)_____

☐ Food bank ☐ Food vouchers ☐ Transportation ☐ Access to vitamins/supplements

☐ Laundry service ☐ Other (describe) _____

2. Identify the populations that you work with who use HIV/AIDS services.

- ☐ women
- ☐ pregnant women
- ☐ children
- ☐ homeless people
- ☐ drug users
- ☐ street youth
- ☐ youth not living on the street
- ☐ persons from HIV-endemic regions
- ☐ persons with mental health challenges
- ☐ men who have sex with men
- ☐ new immigrants and refugees
- ☐ non-insured/non-status persons
- ☐ people whose 1st language is not English/French
- ☐ other_____

3. Are there any tools or resources you have developed that we could share with other CHCs?
4. What does your centre do that you are most proud of?
5. What do you do that is unique and innovative?
6. Where do you get your funding for HIV/AIDS services? And what other resources do you use?

Part II: Barriers to Access

7. What are the greatest barriers to good health of the populations you work with who have or are at risk of having HIV/AIDS?

- ☐ Housing
- ☐ Employment
- ☐ Stable income
- ☐ Legal immigration status
- ☐ Poor nutrition
- ☐ Access to pharmaceutical drugs
- ☐ Other _____

8. What are the most significant barriers to accessing HIV/AIDS services for the populations with whom you work? Are there any particular barriers at your CHC that make services less accessible? What facilitates delivery of good service/how does your centre help meet these needs?

Barriers	Facilitators
ORGANIZATIONAL	
☐ Difficulty recruiting staff who reflect the populations served	☐ Clear mission and strong identity
☐ Lack of resources (describe)	☐ Peer programs
☐ Lack of programs	☐ Legal advice
☐ Housing support	☐ Social support
☐ Transportation	☐ Available transportation
☐ Safer sex info and supplies	☐ Varied operation hours
☐ Safer drug use info and supplies	☐ Available child care
☐ Location of centre	☐ Other _____
☐ Operation hours	
☐ Child-care	
☐ Other _____	
SOCIOCULTURAL	
☐ Stigma about HIV	☐ Knowledge of cultural norms
☐ Stigma about drug-use	☐ History of activism
☐ Stigma about sexuality	☐ Other _____
☐ Distrust of service providers	
☐ Other _____	
INTERNAL	
☐ Staff attitudes	☐ Staff training in HIV/AIDS
☐ Political environment	☐ Internal "champions"
☐ HIV not perceived as a priority	☐ HIV stated priority
☐ Other _____	☐ Active PHA participation
	☐ Other _____

Part III: Coordinated Care

9. What staff work in HIV/AIDS services at your centre and what are their roles?

   Physicians ☐ Primary care ☐ Counselling ☐ Prevention ☐ Treatment ☐ Harm reduction

   Nurse Practitioner ☐ Primary care ☐ Counselling ☐ Prevention ☐ Treatment ☐ Harm reduction

   Nurses ☐ Primary care ☐ Counselling ☐ Prevention ☐ Treatment ☐ Harm reduction

   Social Workers ☐ Primary care ☐ Counselling ☐ Prevention ☐ Treatment ☐ Harm reduction

   Outreach Workers ☐ Primary care ☐ Counselling ☐ Prevention ☐ Treatment ☐ Harm reduction

   Health Promoters ☐ Primary care ☐ Counselling ☐ Prevention ☐ Treatment ☐ Harm reduction ☐ Nutritional Counselling ☐ Other

   Harm Reduction Workers ☐ Primary care ☐ Counselling ☐ Prevention ☐ Treatment ☐ Harm reduction (describe) ☐ Educational Programs (describe) ☐ Other

   ☐ Other_____

   ☐ Peer Workers

10. What's working for you in terms of coordinated care? What do the clients like about it? What are the advantages of coordinated care?
11. What are the challenges of coordinated care?
12. How do you ensure coordinated care at your centre?

Part IV: Partnerships

13. Do you have contact with other CHC HIV/AIDS service providers? Who and how so?
14. Do you work with public health? ASOs? How so? What have been the successes and challenges?

Part V: Evidence and Evaluation

Evidence is the information used in making a decision or judgement, or in solving a problem. We use different pieces of information as (1) evidence for making program decisions, and (2) evidence of the effectiveness of a program

15. What kind of evidence do you use in your practice?

Knowledge of Community Context

- ☐ Anecdotal information from staff, community residents, clients
- ☐ Observation
- ☐ Key informant interviews
- ☐ Community stories
- ☐ Census data
- ☐ Other_____

Literature

- ☐ Literature reviews, models, theory
- ☐ Clinical practice guidelines
- ☐ Other _____

Indicators

- ☐ Program Evaluation reports
- ☐ Diary (i.e. barrier diary)
- ☐ Purkinje data
- ☐ Needs assessments
- ☐ Other _____

16. What are the barriers to finding/integrating evidence?

- ☐ Time
- ☐ Lack of resources
- ☐ Lack of training
- ☐ Other _____

17. Is Purkinje useful in terms of HIV/AIDS services?

1	2	3	4	5
Not at all	Slightly	Somewhat	Useful	Extremely useful

18. What is useful about Purkinje?

19. How do you evaluate your services?

- ☐ Outside consultants
- ☐ Client interviews
- ☐ Purkinje data
- ☐ Anecdotal evidence
- ☐ Client feedback forms
- ☐ Changes in client health status/outcomes
- ☐ Staff evaluations
- ☐ No formal evaluation (explain)
- ☐ Client focus groups
- ☐ Other _____

Part VI: Training and Resources

20. How did your centre start doing HIV/AIDS work?
21. What kinds of training could you/or your centre use to improve the HIV/AIDS services you provide?
22. What kinds of resources could you/or your centre use to improve the HIV/AIDS services you provide?

Information Form for Interview Participants - Service Users

What is the HIV/AIDS Best Practices Project?

The HIV/AIDS Best Practices Project is made up of representatives from 12 Community Health Centres in Ontario who provide HIV care and prevention. The Project aims to develop best practices skills and abilities for HIV/AIDS service providers. Best practices mean excellent and innovative care, prevention, treatment and support. Best practices create quality care for our communities and a model that can be shared amongst HIV/AIDS service providers.

Why do you want to interview me?

We are interviewing people who use HIV/AIDS related services at their Community Health Centres. We want to know what you think works well at your community health and how these services might be even better.

What will the interviews be like?

You will be interviewed for no more than 45 minutes. Interviews will occur at your Community Health Centre and your interviewer will be someone from your centre that you know and have received services from in relation to HIV/AIDS care, treatment or prevention. Notes will be taken during the interview.

Will my name/identity be shared?

No. You will sign a consent form at the beginning of the interview and confidentiality will be maintained. Individuals will not be identified in any Best Practices documents.

Is there an honorarium?

Yes. You will be given 2 TTC tokens and paid $25.00 for participating in the interview.

How will I find out results of the HIV/AIDS Best Practices Project?

An HIV/AIDS Best Practices Summit will be held on January 30, 2004. During the Summit, results of the project will be shared. At the end of the Project in February/March 2004, a final report will be written. All service providers/interviewers will be given a copy of the report to distribute to clients.

Who do I contact if I have any further questions?

If you have any further questions about the Project, please contact the Project Coordinator, Cheryl Woodman at (416) 236-2539 Ext. 237 or Project Supervisor, Loralee Gillis at (416) 236-2539 Ext. 227

Consent Form for Interview Participants - Service Users

I, _____(Name or Pseudonym), understand and consent to the following terms of participation in the Best Practices Project interview:

I have received and read the HIV/AIDS Best Practices Project Information Form for Interview Participants.	YES ☐ NO ☐
I understand that during the interview notes will be taken.	YES ☐ NO ☐
I understand that I may discontinue the interview at any time and/or I may refuse to answer any questions.	YES ☐ NO ☐
I understand that the information I provide will remain confidential and that I will not be identified in the interim or final reports nor will any identifiable characteristics be included in the interim or final reports.	YES ☐ NO ☐

Please feel free to contact the Project Coordinator, Cheryl Woodman, at (416) 236-2539 ext. 237 or Project Supervisor, Loralee Gillis, at (416) 236-2539 ext. 227 if you have any questions or concerns before, during, or after the interview.

By signing below, I agree to participate in the interview:

_____ _____

Signature of the Interview Participant Date

_____ _____

Signature of Witness/Interview Date

Interview Questions Interview Participants – Service Users

Name of INTERVIEWER :_____

Centre:_____

Part I: Programs and Services

1. What services do you use at your CHC?

2. How did you find out about your CHC and their services?
   - ☐ Word of mouth
   - ☐ Referral from an AIDS Service Organization
   - ☐ Referral from hospital
   - ☐ HIV Specialist
   - ☐ Social service provider
   - ☐ Other (please describe) _____

3. What do you like best about this CHC?

Part II: Barriers to Access

4. What made you decide to use this CHC?
   - ☐ Location
   - ☐ Transportation
   - ☐ Harm reduction program
   - ☐ Childcare services
   - ☐ Like the staff
   - ☐ Social Support
   - ☐ Language
   - ☐ Couldn't get services elsewhere
   - ☐ Special programs (such as)
   - ☐ Peer programs
   - ☐ Other (describe) _____

5. How long have you received services at this CHC?
   - ☐ Less than 1 month
   - ☐ 1-6 months
   - ☐ 6-12 months
   - ☐ 1-2 years
   - ☐ 2-5 years
   - ☐ Longer than 5 years

6. Why do you keep coming back?
7. Are there services you get here that you can't get anywhere else? Such as?
8. Are there any difficulties that you have experienced when trying to access HIV/AIDS services at this CHC?
9. What other HIV/AIDS-related services would you like to receive here that currently are not provided?

Part III: Coordinated Care

10. What staff at the centre do you see for care and services?

- ☐ Physician
- ☐ Nurses
- ☐ Nurse Practitioner
- ☐ Outreach worker
- ☐ Other _____
- ☐ Social worker
- ☐ Counsellor
- ☐ Health promoter
- ☐ Harm Reduction worker

11. Do your service providers here talk to each other/work together? If yes, in what ways?

Part IV: Partnerships

12. What other HIV/AIDS services do you use?

- ☐ HIV specialist
- ☐ AIDS Service Organizations
- ☐ Other (describe) _____
- ☐ Support groups outside of the CHC
- ☐ Anonymous testing

13. Has your CHC referred you to other HIV/AIDS-related services? Such as?

14. Do your service providers at other health facilities talk to/work with your service providers at this CHC? If yes, in what ways?

Part V: Evidence and Evaluation

15. Do you have the opportunity to provide feedback to your CHC about what you think of their services? If so, were they responsive?

Part VI: Training and Resources

16. What resources/information have you received from your CHC that you found particularly useful?

- ☐ Pamphlets/brochures
- ☐ Tokens
- ☐ Safer sex counselling
- ☐ Other _____
- ☐ Food
- ☐ Needle exchange
- ☐ Safer drug use counselling

Part VII: Concluding Comments

17. What impact does this CHC have in your life? Has it changed or improved your life? How?

18. Do you have any other comments you would like to make about the services you receive at this Community Health Centre?

APPENDIX C

Information for Interviewers

Project Overview

The HIV/AIDS Best Practices Project is looking for service providers to conduct interviews with users of their Community Health Centre having or at risk of HIV/AIDS.

The Project

The HIV/AIDS Best Practices Project is a project of the Association of Ontario Health Centres (AOHC) - an umbrella organization for 65 Community Health Centres across the province. The Project Advisory Committee consists of 12 representatives from Community Health Centres (CHCs) that are leaders in the sector at providing HIV care. The Project aims to develop the skills and abilities of front line service providers in CHCs across Ontario to develop best practices in HIV care, prevention and treatment; to build on existing best practice models for HIV services; and to develop a sustainable network of HIV/AIDS care providers from CHCs across the province.

Role of Service Providers

Many clients using HIV/AIDS related services at CHCs would feel more at ease talking with a service provider with whom they have already established a trust relationship. We are recruiting 10 to 12 service providers to do interviews with 2 clients each. Surveys may be conducted in languages other than English.

Responsibilities

Service providers will attend a brief training where they will be introduced to the survey and have an opportunity to practice administering the survey. If interviewers are unable to attend the Advisory Committee where this is occurring, an individual training session is possible. Service providers will be asked to recruit participants from among their clients. Each survey will take about 30 minutes to administer. They can be done in person or over the phone. Service providers will be responsible for distributing a $25.00 honorarium to each client and obtaining an informed consent form from each client. Service providers will be asked to return all surveys and informed consent forms to the Project Coordinator by November 17.

For more information please contact Cheryl Woodman at 416-236-2539 X 237 or cheryl@aohc.org.

Interview Information

Surveys and Recruitment

Each service provider will be asked to do two interviews only. Please do not hand the surveys to participants and have them fill them out. People will have different interpretations of what the questions mean. It is important that you administer the survey yourself.

All surveys must be returned to Cheryl by Monday, November 17th.

Please bring the surveys in a sealed package to South Riverdale CHC. If you cannot come to South Riverdale, please make arrangements with Cheryl or mail the surveys back to:
Cheryl Woodman, AOHC, 1 Eva Road, # 220, Toronto, ON, M9C 4Z5

Dissemination of results

The Project Coordinator will compile survey information in a report. The report will be disseminated by January 30th, 2004. The project staff will never know the name of the service user participants. If participants have concerns about confidentiality, they can contact the project coordinator or project supervisor.

The Package

In your package you will find:
2 copies of the survey
2 consent forms for interview participants
2 receipt of honorarium forms (Signed receipts MUST be returned to Cheryl)
2 service provider comments sheet
2 self-addressed, stamped envelopes
Information sheet and tips for interviewing
1 pen
4 of Cheryl's business cards

You will also receive and sign for $50.00 that you will use to pay the participants a $25.00 honorarium and 2 TTC tokens.

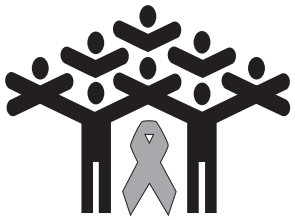
Interviewing Tips

- Reassure people that whether or not they decide to participate, it will not affect your relationship with them as a service provider.
- No identifying information, including names of service providers, doctors, or organizations will be used.
- Remember that you can ask probing questions if you feel that someone is not telling you everything. However, be respectful and cautious of people's hesitation - there may be good reasons they are not telling you everything.

- You may have information that you think the participant should be including, but isn't. You can probe for this information, but remember that this is the participant's interview, not yours. The survey is an opportunity for them to say what's important to them and not necessarily what you expect them to say. There is an opportunity to add your comments after the interview.
- Interviews should take 30-45 minutes. It is possible to complete them in this time. Try to schedule time-limited appointments with people.
- Before you start interviewing, think of ways to help participants conclude their responses and ways to bring the interview to a close.
- Sometimes it is difficult to respond to a participant's questions or requests for information while you are trying to elicit information. Suggesting that you schedule a time to meet in the future may help alleviate time pressure.
- If people have questions that you can't answer, they may call/email Cheryl.

The relationship of research and service provision: questions to consider

- What are your clients' perceptions about research? Do they see it as empowering or marginalizing? As something that affects their lives or something that has no effect?
- (How) Does a researcher/interviewer relate to participants differently than service providers relate to clients?
- (How) Will doing this interview change your clients' perceptions of you?
- As a service provider, how do you engage emotionally with clients? How might this be different in an interview situation?
- (Why) Is research better funded than direct services?
- How do our own social, racial, ethnic, gender and class identities impact on the interactions that we have with clients? With research participants?



APPENDIX D

ASO Survey

Background

The Association of Ontario Health Centres (AOHC) is the not-for-profit umbrella organization of Community Health Centres, aboriginal health access centres and community health service organizations across Ontario. Many of our centres provide primary health care, support and prevention services for people living with HIV and/or those who are at high risk of contracting the infection.

We are currently developing a best practices model for HIV work in CHCs. One of the goals of our Project is to support and facilitate closer working relationships between CHCs and ASOs. As a first step, we would like to get feedback about your relationship and/or knowledge of your local CHCs. Below you will find a very **brief survey** – it should only take about 10-15 minutes to complete. This information will be used to help us identify ways that we can work more effectively with ASOs in the province.

Instructions

Please respond to all questions as fully and clearly as you are able. If you have any questions/concerns about the Project or the survey, please contact Cheryl Woodman at 416-236-2539 ext 237, or Loralee Gillis at 416-236-2539 ext 227. Mail/Fax/Email responses by December 1st, 2003.

Name: _____

Position:_____

Organization:_____

Phone: _____

1. Are you aware of any CHCs in your ASO community? If yes, please list. YES ☐ NO ☐

2. Do you collaborate with a CHC in any of your HIV/AIDS services? YES ☐ NO ☐

3. If yes, how so?

4. If no, would you be interested in collaborating/forming partnerships with a CHC? How so?

5. Do you know of clients who use a CHC in your community for primary care? YES ☐ NO ☐
   What is their feedback, if any?

6. Are there any unique HIV/AIDS services that CHCs provide to clients that you currently do not provide?

7. Please add any other comments you may have regarding HIV/AIDS services and Community Health Centres.

Thank you for completing this survey!
Please FAX or MAIL back by December 1st, 2003.
Cheryl Woodman, The Association of Ontario Health Centres,
1 Eva Road, Suite 220, Toronto, Ontario, M9C 4Z5
Fax# 416-236-0431 Email: **cheryl@aohc.org**

APPENDIX E

CHC Survey

Background

Many of our centres provide primary health care, support and prevention services for people living with HIV, and/or those who are at high risk of contracting the infection. In 2002 our membership passed a resolution at our AGM that AOHC should develop best practices in HIV/AIDS care for the sector. We received funding from Health Canada to develop a best practices model for HIV work in CHCs and currently an HIV/AIDS Best Practices Project is underway.

Below you will find a very brief survey - it should only take about 10-15 minutes to complete. This information will be used to help us learn about the HIV/AIDS service provision in centres that don't have formalized HIV/AIDS programs and to identify ways that we can effectively support these centres.

Instructions

Please respond to all questions as fully and clearly as you are able. If you have any questions/concerns about the Project or the survey, please contact Cheryl Woodman at 416-236-2539 ext 237, or Loralee Gillis at 416-236-2539 ext 227. Mail/Fax/Email responses by December 1st, 2003.

Name: _____

Position:_____

Organization:_____

Phone:_____

1. Do you have any HIV+ clients that you are aware of? YES ☐ NO ☐

2. Do you provide HIV/AIDS Prevention services? YES ☐ NO ☐
   Treatment services? YES ☐ NO ☐

3. Please describe the resources you use to provide these services (i.e.: funding, staff, booklets/pamphlets, resource binders, other)?

_____

_____

4. Would you be interested in a mentoring program/staff training to support your staff in HIV/AIDS related service provision? YES ☐ NO ☐

5. If yes, what sort of information would you be interested in acquiring in relation to HIV/AIDS services?

- ☐ HIV/AIDS literature
- ☐ Prevention education
- ☐ HIV/AIDS outreach program
- ☐ Resource lists for HIV/AIDS services in your area
- ☐ Anonymous HIV testing
- ☐ Harm reduction program
- ☐ Other (please describe) _____

6. Please add any other comments/information you may have regarding HIV/AIDS services at your centre.

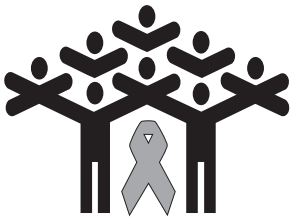
Thank you for completing this survey!
Please FAX or MAIL back by December 1st, 2003
Cheryl Woodman, AOHC,
1 Eva Road, Suite 220, Toronto, Ontario, M9C 4Z5
Fax# 416-236-0431 Email: **cheryl@aohc.org**

APPENDIX F

List of ASOs in Ontario

AIDS Service Organization	Website Address
127 Isabella Non-Profit Residence	http://www.icomm.ca/isabella/
2-Spirited People of the 1st Nations	http://www.linkup-connexion.ca/Members/ON/2Spirited.html
AIDS Committee of Cambridge, Kitchener Waterloo and Area	http://www.acckwa.com/
African Community Health Services (ACHES)	e-mail: aches2002@aol.com
Africans in Partnership Against AIDS (APAA)	http://www.apaa.ca/Home/Home.htm
AIDS Action Now!	http://www.volnetmmp.net/aids_action_now.htm
AIDS Action Perth	e-mail: julie@aidsperth.ca
AIDS Committee of Durham	http://www.aidsdurham.com/
AIDS Committee of Guelph & Wellington	http://www.aids.guelph.org/
AIDS Committee of London	http://www.aidslondon.com/
AIDS Committee of North Bay & Area	http://www.aidsnorthbay.com/
AIDS Committee of Ottawa	http://www.aco-cso.ca/about.htm
AIDS Committee of Simcoe County	http://www.acsc.ca/
AIDS Committee of Sudbury (ACCESS)	http://www.accessaidsnetwork.com/
AIDS Committee of Timmins & District	e-mail: aids_timmins@ntl.sympatico.ca
AIDS Committee of Toronto (ACT)	http://www.actoronto.ca/
AIDS Committee of Windsor	http://www.mnsi.net/~aidscw/
AIDS Committee of York Region	http://www.acyr.org/app_forms.html
AIDS Niagara	http://www.aidsniagara.com/
AIDS Support Committee of Sarnia Lambton Inc.	http://www.aidsarnia.org/
AIDS Thunder Bay	http://my.tbaytel.net/actb/
Algoma AIDS Network	http://www.algomaaids.com/
Alliance for South Asian AIDS Prevention (ASAP)	http://www.mybindi.com/community/socialserv/asap.cfm
Asian Community AIDS Services (ACAS)	http://www.acas.org/800index.html

Association of Iroquois and Allied Indians	http://www.aiai.on.ca/
Black Coalition for AIDS Prevention (BlackCAP)	http://www.black-cap.com/
Bruce House	http://www.brucehouse.org/ie.htm
Casey House Hospice	http://www.caseyhouse.ca/
Canadian AIDS Treatment Information Exchange (CATIE)	http://www.catie.ca/
Centre for Spanish Speaking Peoples–AIDS Program	http://www.spanishservices.org/home.html
David Kelley HIV/AIDS Counselling Program	http://www.fsatoronto.com/programs/dksHIV.html
Deaf Outreach Project	http://deafontario.ca/DOP.htm
Fife House Foundation	www.fifehouse.org
The AIDS Network (Hamilton)	http://www.aidsnetwork.ca/
Haemophilia Ontario	http://www.hemophilia.on.ca/
HIV/AIDS Legal Clinic of Ontario (HALCO)	http://www.halco.org/
HIV/AIDS Regional Services (Kingston)	www1.kingston.net/~hars/
HIV-T Group	e-mail: tgroup@gosympatico.ca
Huron County HIV/AIDS Network	e-mail: tdavison@ttc.on.ca
John Gordon Home (London)	e-mail: johngordon@wwdc.com
Maison La Paix (Sudbury)	e-mail: mlapaix@vianet.ca
Miriam Child & Family Support Services	e-mail: miriamgp@idirect.com
Ontario Aboriginal HIV/AIDS Strategy	e-mail: strategy@2spirits.com
Peel HIV/AIDS Network	http://www.phan.ca/
Peterborough AIDS Resource Network (PARN)	http://www.parn.ca/
Positive Youth Outreach	http://www.positiveyouth.com/static/positive.html
Prisoners HIV/AIDS Support Action	http://pasan.org/PASAN.htm
Teresa Group Child and Family Aid	http://www.teresagroup.ca/
Toronto Prostitutes Community Service Project	http://www.walnet.org/csis/groups/maggies/
Toronto People with AIDS (PWA) Foundation	http://www.pwatoronto.org
Union of Ontario Indians (NVM)	http://www.anishinabek.ca/uoi/
Voices of Positive Women	http://www.vopw.org/voicesweb/index.htm



APPENDIX G

HIV/AIDS Best Practices in CHCs Summit Package

Agenda

8:15 - 9:00 am	Registration
9:00 - 9:30 am	Welcome and Project History Loralee Gillis, Manager of Research and Evaluation, AOHC
9:30 - 9:45 am	Ontario Minister of Health Honourable George Smitherman
9:45 - 10:00 am	Project Overview Cheryl Woodman, HIV/AIDS Best Practices Project Coordinator, AOHC
10:00 - 10:15 am	Client Perspective
10:15 - 10:45 am	*Break/ Networking/ Displays*
10:45 – 12:30 pm	Workshop Series One: Showcasing Best Practices in CHCs
12:30 - 2:00 pm	*Lunch/Guest Speakers* Dr. Robert Remis Department of Public Health Sciences, University of Toronto Frank McGee Coordinator, AIDS Bureau, Ministry of Health and Long Term Care
2:00 - 3:45 pm	Workshop Series Two: Action Planning
3:45 - 4:00 pm	*Break*
4:00 - 4:30 pm	Sharing Action Plans
4:30 - 4:45 pm	Next Steps
4:45 - 5:00pm	Evaluation and Thank you

Speakers

Raffi Balian is the project coordinator of the COUNTERfit Harm Reduction Program which is housed at South Riverdale CHC. Raffi is an active drug user and has used methadone since 1998. He is the co-founder of the Illicit Drug User Union of Toronto (IDUUT) and has worked in Harm Reduction programs since 1993.

Bonnie Barter is the HIV/AIDS Coordinator at Parkdale Community Health Centre. She has a twenty year history of activism and 7 years experience in the area of Harm Reduction. She attended George Brown in the Human Services Counselling course and has worked in several shelters, in street outreach and adult education. Bonnie has researched and authored dozens of articles and pamphlets on poverty issues, activism, and social services, as well as told the stories of the voiceless. She spent almost a year in Tent City, Toronto, advocating for squatters' rights.

Hannah Cowan has 32 years of nursing experience all over North America. In 1988 she approached the AIDS Committee of Ottawa to gain knowledge about HIV/AIDS. She became a volunteer there and hasn't left the field since. Hannah began working as a nurse at Oasis, a program of Sandy Hill CHC, at the program's inception and continues to be an integral member of the Oasis team.

Dr. Alan Li has been working at Regent Park Community Health Centre since 1987. He has been an active HIV primary care physician for the last 12 years. Alan has been involved on many community based HIV/AIDS related health promotion initiatives including the previous CHC AIDS Accessibility Project (94-96), Asian Community AIDS Services and the HIV/AIDS Cultural Network of Metro Toronto amongst others. Alan also worked at Casey House Hospice from 1992-2000 and was the medical director at Casey House from 1997-2000. Alan has been on the Ontario Ministry Advisory Committee on HIV/AIDS since 1990. Alan is the research supervisor that oversaw the action research on "Improving Treatment Access for Immigrant, Refugee and Non-documented PHAs."

Raymond Macaraeg is a nurse practitioner who joined the Parkdale CHC Homeless Initiatives team in 2003 and works in a partnership with Parkdale Activity and Recreation Centre (PARC) serving hard-to-reach populations. Raymond works in a shared care model with the community health outreach worker at Parkdale.

Frank McGee has been the Coordinator of the AIDS Bureau since February 1997. The AIDS Bureau provides funding for community-based AIDS support and education programs, outreach to injection drug users, the CLEAR Unit and the OHTN, monitors Anonymous HIV Testing in Ontario and provides secretariat for the Ontario Advisory Committee on HIV/AIDS. Frank has had diverse experience with HIV/AIDS issues including research, community and government. He has presented at numerous international, national and provincial conferences on HIV/AIDS.

In his role as AIDS Coordinator, Frank participates on a range of HIV/AIDS research projects and teams. Frank is currently the Co-chair of the Federal/Provincial/Territorial Advisory Committee on HIV/AIDS and is an ex-officio member of the federal Minister of Health's Advisory

Committee on HIV/AIDS. Prior to becoming Coordinator of the AIDS Bureau, Frank held a number of AIDS-related government positions starting in 1988 in the Public Health Branch and the AIDS Bureau.

Barb Panter is the HIV/AIDS Outreach Educator at Queen West Community Health Centre. She has worked in the field of HIV Prevention and Harm Reduction for over 8 years in Toronto and the Downtown Eastside of Vancouver.

Matthew Perry is a Community Legal Worker at the HIV & AIDS Legal Clinic (Ontario) HALCO. He has been with HALCO for over 6 years. Prior to his work at HALCO, Matthew completed a Masters of Arts degree in Sociology in Education, examining how HIV prevention messages targeted at gay men are interpreted. HALCO is a community legal clinic funded to provide free legal services to low-income people with HIV/AIDS across the province of Ontario. At HALCO, Matthew works with all the staff to provide summary advice, legal representation, law reform and public legal education to as many PHAs and affected individuals and support workers across the province as possible.

Patrick Saunders is a Community Health Outreach Worker at Parkdale CHC. He has worked at Parkdale CHC since 1998, initially doing needle exchange as a Street Outreach worker. The work Patrick does is in partnership with PARC and he works in a shared care model with a nurse practitioner. Patrick was involved in developing the Parkdale CHC HIV/AIDS workshop models.

Esther Tharao is currently a Health Promoter at Women's Health in Women's Hands. She has been involved in the AIDS movement locally and nationally for 11 years, working primarily with ethno-cultural communities. Esther has been a member of the Ministerial Council of the Canadian Strategy on HIV/AIDS for three years, ending September 2003. She also sits on the Ontario Advisory Committee on HIV/AIDS (OACHA), the Ontario HIV Endemic Task Force/African and Caribbean Council on HIV/AIDS in Ontario and the Scientific Review Committee of the Ontario HIV Treatment Network. She has a strong interest in both academic and community-based research and the transfer of scientific research into practice at the community level. She is a graduate student at the University of Toronto, Department of Public Health Sciences, Social Science and Health Program and is currently involved in three research projects.

At the time of printing, not all bios were available. Other speakers include:

Dean, Queen West CHC

Paulos Gebreyesus, Community Health Worker, Lawrence Heights CHC

Mary Lemke, Program Director, Queen West Site/Central Toronto CHC

Beatrice Mbayo, HIV Project Coordinator, Centro medico-social communautaire (CMSC)

Wayne Oake, Community Health Branch

Dr. Robert Remis, University of Toronto, Department of Public Health Sciences

Anutha Samgam, Regent Park Community Health Centre

Stella, Regent Park Community Health Centre

Facilitators

Glen Brown is the lead consultant of Glen Brown & Associates Consulting, which provides organizational development, policy, communication and facilitation services to the not-for-profit sector. He has provided services to many HIV/AIDS organizations and Community Health Centres. Prior to establishing the consulting business, he worked in a variety of management, leadership and communications roles. His most recent career, from 1996 to 1999, was as a senior manager at the Canadian AIDS Treatment Information Exchange (CATIE). His prior position (1988 to 1995) was the Communications Officer of the Ontario Confederation of University Faculty Associations (OCUFA).

Gail Flintoft is a social worker. She has been at Casey House Hospice for 14 years and has been involved, as a volunteer, at the Board level in local mental health services. Gail is also involved on a national and provincial level in the AIDS field and is currently chair of the Board of the Canadian AIDS Society.

Lynne Raskin is the Executive Director of the South Riverdale Community Health Centre. In this role, she has been involved in the development and delivery of many partnership projects with a goal to building healthier communities. Lynne has worked in community health/mental health for over 20 years at local, municipal and provincial levels. Throughout her career she has challenged systemic barriers, which prevent every person's right to appropriate, accessible and timely health care despite their individual circumstances.

SUMMIT WORKSHOP SERIES ONE

Showcasing Best Practices from Across Ontario

This series of presentations will be showcasing best practices in a variety of HIV/AIDS Community Health Centres in Ontario. All presenters are from CHCs in Ontario. Each presenter will spend 20 minutes giving an overview of a unique and/or innovative program, service or project at their centre. There will be 10 minutes for questions and discussion at the end of each presentation. This is an opportunity to learn about the work of centres from across the province, and to share the successes and struggles CHCs encounter in providing HIV/AIDS services.

Participants will select one presentation from each time slot that they wish to attend. You are free to change from room to room, or to stay in one location for the duration. There will only be a brief break between sessions, so if you are switching rooms to see another presentation, please go directly to that room and quickly find a seat so that all sessions can start and end on time.

Workshop Schedule

10:45am- 11:15am	**ROOM A: Oakham Lounge** (2nd Floor) A1 — Parkdale CHC, Toronto *Patrick Saunders and Raymond Macaraeg* **ROOM B: AB Room** (2nd Floor) B1 — Women's Health in Women's Hands CHC, Toronto *Esther Tharao* **ROOM C: Thomas Room** (Ground Floor) C1 — Queen West CHC, Toronto *Barb Panter & Client/Peer worker*
11:20am- 11:50am	**ROOM A: Oakham Lounge** (2nd Floor) A2 South Riverdale CHC, Toronto *Raffi Balian* **ROOM B: AB Room** (2nd Floor) B2 - Oasis, Sandy Hill CHC, Ottawa *Hannah Cowen* **ROOM C: Thomas Room** (Ground Floor) C2 — Centre médico social communautaire, Toronto *Beatrice Mbayo*
11:55am- 12:25pm	**ROOM A: Oakham Lounge** (2nd Floor) A3 — Regent Park CHC, Toronto *Alan Li* **ROOM B: AB Room** (2nd Floor) B3 — Lawrence Heights, Toronto *Paulos Gebreyesus*

Workshop Descriptions

Series One: Showcasing Best Practices from Across Ontario

Time 1: **10:45-11:15 am**

A1 — Parkdale CHC has developed a resource binder of HIV/AIDS Prevention Education Workshop Models that they have delivered in their community. **Patrick Saunders**, an outreach worker and **Raymond Macaraeg**, a Nurse Practitioner will provide an overview of the project and some reflections on the street outreach that they do together.

B1 — Women's Health in Women's Hands CHC has developed an integrated HIV/AIDS services model to meet the needs of the women they serve. Women at the centre emphasized that HIV/AIDS services needed to be integrated with regular health care in order to ensure access and to prevent clients feeling stigmatized. **Esther Tharao**, a Health Promoter at the centre, will describe the development of this model of care.

C1 — Queen West CHC has developed a unique and very successful Peer Program. **Barb Panter**, an outreach worker at the centre along with a **Client and Peer Worker**, will provide an overview of the Peer Program and the Centre's Homelessness Initiative.

Time 2: **11:20-11:50 am**

A2 — The COUNTERfit Program at **South Riverdale CHC** has provided support and harm reduction services to many drug users in South East Toronto. The project's coordinator, **Raffi Balian** has developed many unique approaches to harm reduction. He will be sharing some methods of developing a harm reduction program and successes and challenges of the COUNTERfit Program.

B2 — Oasis is located in Ottawa and is part of Sandy Hill CHC. Oasis is a unique model for providing care to people who are living with or at risk of HIV/AIDS. Oasis has worked to build partnerships and coalitions in order to strengthen the work it does in the community. **Hannah Cowen**, a nurse at Oasis, has worked to develop these partnerships and the innovative programs and services of Oasis.

C2 - Le Centre Médico-Social Communautaire (CMSC) est un des cinq centres francophones medicaux-sociaux en Ontario. **Beatrice Mbayo**, coordinatrice du projet VIH/SIDA: "VOUS ET LES VOTRES" du CMSC, qui est un projet de prevention dans la communautie qui sert les clients francophones provenant des regions ou le VIH / Sida est endemique. Beatrice discutera des methodes qu'elle utilise dans l' education de prevention de VIH au CMSC. Cette presentation sera en français.

Time 3: **11:55 am-12:25pm**

A3 — Alan Li is an HIV/AIDS Primary Care Physician who works at **Regent Park CHC**. Alan has worked with the Committee for Accessible AIDS Treatment to improve access to health and social services for immigrant and refugee PHAs living without health coverage in Ontario. Alan will provide an overview of the history of the project with a particular focus on the

Compassionate Access Pilot Program which will soon be providing HIV drugs for people who do not have drug coverage in Ontario.

B3 — Paulos Gebreyesus is a community health worker at **Lawrence Heights CHC**. One of the community health program activities has included educational training for staff and community members to reduce stigma associated with HIV, homelessness, and harm reduction work. Paulos will discuss the impact of stigma-reducing education in the Lawrence Heights community.

Summit Workshop Series Two: Action Planning

This workshop series focuses on planning next steps for both individual CHCs and for the CHC sector as a whole. Each session features 3 to 4 panellists who will speak briefly about the topic. The remainder of the session will be devoted to discussion and planning among participants. Each group will bring recommendations back to the large group for next steps or future action. All recommendations will be forwarded to the Advisory Committee for the project and to AOHC for consideration. Notes will be taken at each session and integrated into our final project report.

Participants can choose one session to attend for the afternoon.

Workshop Schedule

(Descriptions included in Chapter 6)

Oakham Lounge (2nd Floor)

A: CHCs Unique Contribution - Integrating care, treatment and support with prevention, outreach and health promotion.

Panellists: Hannah Cowan, Oasis; Boni Barter, Parkdale CHC;
Mary Lemke, Queen West CHC
Facilitator: Gail Flintoft, Casey House Hospice

AB Room (2nd Floor)

B: Building Coalitions - the foundation for building capacity for HIV work in CHCs

Panellists: Raffi Balian, South Riverdale; Dr. Alan Li & Matthew Perry, Regent Park/CAAT;
Barb Panter, Safer Crack Use Coalition
Facilitator: Glen Brown, consultant
Thomas Room (Ground Floor)

C: CHCs' Strategic Role in Ontario AIDS Epidemic-Funding, Research and Public Policy

Panellists: Esther Tharao, Women's Health in Women's Hands; Frank McGee, AIDS
Bureau MOHLTC; Wayne Oake Community Health Branch, MOHLTC
Facilitator: Lynne Raskin, South Riverdale CHC

APPENDIX H

HIV/AIDS Best Practices in CHCs Summit Report

On January 30, 2004 the AOHC and the HIV/AIDS Best Practices Steering Committee hosted the HIV/AIDS Best Practices in Community Health Centres Summit at Ryerson University in Toronto. The Summit was intended to provide participants an opportunity to network, share models of excellence and to look ahead to next steps for CHCs in developing best practices in HIV/AIDS services. It marked the first time that service providers from across the province have come together to discuss their HIV/AIDS work.

Seventy-nine people attended the event, including:

- 51 representatives from 22 CHCs across Ontario
- 12 representatives from AIDS Service Organizations
- 4 AOHC staff
- 2 representatives from the Ministry of Health (AIDS Bureau, Community Health)
- 2 representatives from Toronto Public Health
- 1 representative from Health Canada
- Ontario Minister of Health, Honourable George Smitherman
- 6 CHC service users

The single-day event began with an opening welcome by Ontario Minister of Health, George Smitherman. Mr. Smitherman announced the McGuinty government's commitment to disease prevention, HIV/AIDS education, support, research and treatment and to working with all partners in the HIV/AIDS community. He acknowledged that in order to succeed in fighting HIV/AIDS we must strengthen our ability to address the social determinants of health for people at greatest risk of HIV infection and those living with HIV/AIDS. Mr Smitherman went on to say that integration of HIV/AIDS services into Community Health Centres is an important step in this process and concluded that: "Community Health Centres, with their history of being rooted in community and their range of diverse services, are well positioned to be part of the response to HIV."

The day continued with a project overview by AOHC staff and client perspectives on the HIV/AIDS services they have received at their CHCs. The morning workshop series was an opportunity for CHC service providers to showcase best practices, share information, network with colleagues and create potential partnerships.

Lunch hour speakers were Dr. Robert Remis from the Department of Public Health Sciences, University of Toronto and Frank McGee, Coordinator, AIDS Bureau, Ministry of Health and Long-Term Care. Dr. Remis reviewed the epidemiological trends in HIV for many of the populations served in Ontario CHCs and Frank McGee discussed AIDS Bureau initiatives and funding.

APPENDIX I

Online Resource Listing

Canadian Aboriginal AIDS Network (CAAN)	www.caan.ca
Canadian AIDS Society (CAS)	www.cdnaids.ca
Canadian HIV/AIDS Information Centre	www.aidssida.cpha.ca
Canadian AIDS Treatment Exchange (CATIE)	www.catie.ca
Canadian Association for HIV Research (CAHR)	www.cahr-acrv.ca
Canadian Foundation for AIDS Research (CANFAR)	www.canfar.com
Canadian HIV/AIDS Legal Network	www.aidslaw.ca
Canadian HIV Trials Network	www.hivnet.ubc.ca
Canadian Treatment Action Council (CTAC)	www.ctac.ca
Interagency Coalition on AIDS and Development (ICAD)	www.icad-cisd.com
International Coalition of AIDS Service Organizations (ICASO)	www.icaso.org
Ontario AIDS Network (OAN)	www.ontarioaidsnetwork.on.ca
UNAIDS	www.unaids.org
CATIE Electronic Library	www.catie.ca/library.html
AIDS Committee of Toronto (ACT) Library Catalogue	www.actoronto.org/library
Canadian HIV/AIDS Legal Network Resource Centre	www.aidslaw.ca/maincontent.htm#rc
World Health Organization (WHO) Publications on HIV/AIDS	www.who.int/pub/en
HIV/AIDS Clearinghouse	www.clearinghouse.cpha.ca
HIV Community-Based Research Network	www.hiv-cbr.net
The Sexual Health Network	www.sexualhealth.com
Canadian Harm Reduction Network	www.canadianharmreduction.com

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