



OICH – Our History

Sheila Burnett (Shepherds of Good Hope), Rob Cushman and Bonnie Dinning (Health Department), Diane Morrison (The Mission), Connie Woloschuk (Salvation Army) Wendy Muckle (Sandy Hill CHC) and Jeff Turnbull (University of Ottawa) had similar concerns about a sub-group within the population of chronically homeless shelter users who, despite complex health needs and frequent use of health services were not well cared for. An informal count among the attendee's easily identified 70 individuals who had complex health problems and, who were also high users of emergency medical care and shelter services. It appeared that the failure to adequately address their needs was a complex mix of serious health problems, mental illness, addictions and challenging behaviours. It was not apparent whether the homelessness was the cause of ill health or the ill health prevented the person from being housed.

Although there was no clear solution at hand; there was a strong sense that, as a community, our care could be more effective if we knew more about this population, communicated better and worked together. This was the beginning of what eventually became Ottawa Inner City Health, Inc.

The Homeless are Entitled to Health Care

The interest and concern about the chronically homeless had two dimensions. The priority was a desire to provide services which are similar in terms of quality of care to those received by housed citizens while recognizing the unique needs of the chronically homeless population. This objective was balanced with the need to prevent unnecessary or inappropriate use of scarce resources and to promote the rights of the homeless to access mainstream services. The resulting model of service includes aspects of program development which are uniquely adapted to the needs of the populations while focusing on integration with mainstream services to the greatest extent possible.

Health and Homelessness in Ottawa

The simple fact is that homelessness is bad for your health. Life on the streets or in shelters, expose individuals to extreme weather, infectious diseases and violence. The age adjusted death rate for homeless individuals is 4X that of a housed population. Many of those who consistently experience difficulty in finding or retaining housing have multiple mental and physical health problems including substance abuse and generally poor coping skills. Mainstream systems for providing health care, social service benefits and housing are not well equipped to address the complex interrelated needs and challenging behaviours which characterize this population. Services which are intended to address a specific short term crisis (i.e. loss of housing) are not attuned to providing ongoing support services which are essential for this population.

Research shows that illness among the homeless tends to appear at a younger age than a housed population. A complex mix of acute and chronic conditions is the result of a lack of preventative care, difficulties in accessing appropriate care, the challenges in obtaining appropriate and effective



treatment and the challenges of monitoring the condition of a population which is mobile, economically and socially impoverished.

In 1998 in Ottawa, the shelter system had become the default care provider system for those unable to access mainstream health care services. Despite the lack of resources, mandate or supports, frequently those who were the sickest and most difficult to care for were found in local shelters. On one hand it was apparent that shelters were not resourced nor mandated to shelter people who were so sick and yet, other alternatives did not exist. Frequently, long time shelter users had a strongly stated preference for remaining within “their community” which pointed to the need to strengthen the capacity within the homeless community to care for our members.

Action Plan to End Homelessness

In 1999, the municipal government in Ottawa undertook a planning process which culminated in the first action plan to end homelessness. The plan outlined the need to increase community capacity to provide addictions services, home care and convalescent, palliative and long term care for people who are homeless and proposed an interagency network to improve access to health services for the homeless. What was envisaged was a unique model of service which would bring expertise and resources from the emergency shelter system matched with high quality health care services. The model would rely heavily on communication, coordination and collaboration in order to operate. Accordingly, a model of governance was developed which engaged organizations from the health, social, housing and legal sectors in a collaborative relationship at the corporate and service delivery level.

There were many unique aspects to this proposed model all of which needed to be tested out and evaluated. The idea of implementing a pilot project was proposed since it seemed too risky to commit permanent resources to a model which had never been tried before. For example, although providing primary health services in shelters was not new in Ottawa; the concept of setting aside areas of the shelter exclusively for the use of those who were ill and layering on specialized health services was. The rationale for this new model of health care was to try to replicate the equivalent of a “home and family” to the homeless person for the duration of their illness. Although elements of this model existed elsewhere in Canada, the idea of providing integrated services which would include all cohorts of homeless persons and engage all programs and services across shelters and service sectors was unique. The University of Ottawa agreed not only to assist the community with aspects of research and program evaluation required for the pilot project but, accepted the challenge of being the project sponsor. The University of Ottawa provided financial, administrative, IT and corporate support during the pilot project phase. As a result, the project incorporated teaching and research as core activities since its inception.

Cross Sector Communication and Collaboration

The planning process had identified that the biggest barrier to effective care was the lack of effective communication between health care providers and the shelters, community workers and other sectors. The concept of establishing an organization with a mandate to promote effective communication,



collaboration and coordination of efforts between sectors and providers was appealing but, there was little to predict the likelihood of success. The concept that homeless persons would experience “seamless” health care between hospitals, home care and community health services was appealing but, there were serious doubts that the homeless patients would even access an organized service of this kind.

Defining Program and Services

The health needs of the chronically homeless are complex and numerous. In the face of limited resources, the community was challenged to identify what the priorities should be. Primary care was not seen as a priority because a team of nurses from the community health centres and health department were already providing access to primary health care in shelters. There was interest in palliative care due to the increasing numbers of people suffering from HIV and Hepatitis. At the time, many homeless persons simply refused to access palliative services or, were refused access. Unless they died in hospital, basic palliative support services like home care were not accessible. There was an identified need not only to provide access to care but, to change the culture of the homeless community to provide greater capacity to deal with death and dying. The Mission identified an interest in developing an expertise in palliative care on behalf of the community. Their interest in palliative care eventually leads to a major fund raising effort to build a Hospice for the homeless.

There was also an identified need for a “safe” place for homeless people who were ill or leaving hospital to be cared for. During the planning period, it was identified that homeless persons stayed an average of four days longer in hospital than housed individuals. The Salvation Army Booth Centre had set aside 10 beds for people who were frail or vulnerable in the shelter where they could receive extra support. The Booth Centre was enthusiastic about the opportunity to add nursing, physician, personal care and home care services. Eventually, this became the Special Care Unit program. There was tremendous support in developing this program from the hospital and home care sectors that saw an opportunity to facilitate timely discharge from hospital and the provision of home care services.

The sub-population among the homeless who was consistently identified as the most difficult to care for was the chronic street alcoholic. The Shepherds of Good Hope had an interest in developing programming to better serve their needs through a structured harm reduction program where controlled drinking would be allowed. A relationship was struck with a similar program at the Seaton House Annex in Toronto who provided support advice and staff training. Development of the Managed Alcohol Program challenged the entire community to consider a new approach to caring for addicts. The planning committee included representatives of from police, addictions, mental health and the health care services.

Pilot Project

In April 2001, funding from the federal Supporting Community Partnerships Initiative (SCIP) was secured for the pilot project. The pilot included many challenges. The available funding was sufficient to pay for



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the central administration of the project but, did not include funding for doctors or nurses. The prospect of having a health care project without health care providers forced the founding partners to allocate existing or fundraised dollars to pay the salaries of health professionals. Renovation of the office space for the central administration staff ran into difficulties which left the project “homeless” before it had even opened. The lag time between the submission and approval of a three year pilot project actually left only two years to implement and evaluate the entire program.

The project plan also included development, implementation and evaluation of an electronic health record which would be shared by multiple service providers at different service location. Web based software was developed through a partnership with Dinmar Consulting, the City of Ottawa and Inner City Health which allows service providers to record daily care and communicate with each other. The technology is similar to that employed in online banking.

Despite the challenges, the pilot project was hugely successful. The program was running at 100% capacity within six weeks of opening. Founding partners not only honoured their contribution agreements but, in most cases far exceeded original promises of resources, staff and supports. Within a year of opening, the original 35 beds had expanded to 55 beds. By the end of the third year of operation, the capacity of the program had expanded to 75 beds without any additional funding in the budget.

Harm Reduction

One of the most important guiding principles of the program is harm reduction. All aspects of the programs and services incorporate this approach into the work. Almost all patients in Ottawa Inner City Health have a substance abuse problem, most have mental illness and many have both. The decision to adopt a harm reduction approach for the pilot project was based on recognition that current approaches were not working and, that many of those who were excluded from receiving care because of their behaviours were among the sickest and most vulnerable of the homeless. The process of incorporating a harm reduction project into existing organizations presented interesting challenges. Staff had to learn to cope with having different sets of “rules” and expectations for different clients within the facility. The harm reduction approach which does not rely on applying “consequences” to undesirable behaviours was initially difficult for staff to understand and apply. There was an understandable reluctance to reward “bad behaviour/substance use” and fear that patients would be harmed in the process. Implementing a harm reduction approach has required a “leap of faith” on the part of Boards, Managers and the front line staff in each of the service partners.

Although the process of implementing a harm reduction approach for the Inner City Health services in each service location was slightly different, the outcome has resulted in the capacity to provide a consistent approach across all service sites.



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The Search for Stable Funding

Despite an extremely positive program evaluation and demonstrated cost savings, the pilot project funding ended in March 2003 without a commitment of ongoing funding from the Ontario Ministry of Health and Long Term Care. Despite the lack of enthusiasm on the part of funders, service partners refused to accept defeat. Between March 2003-2005, the Ottawa Inner City Health project operated on a combination of donations from partner organizations and bits of one time funding from the Ministry of Health and Long Term Care. The Ottawa Hospital played a lead role both in advancing funding to resolve funding shortfalls and, working with the Ministry of Health to identify suitable funding.

In February 2005 Ottawa Inner City Health Project incorporated as a non-profit organization becoming Ottawa Inner City Health, Inc. Charitable status was received in June 2005. The Ontario Ministry of Health and Long Term Care has committed funding on an ongoing basis.