Primary Outreach Services Team

- The DTES Primary Outreach Service model of care provides outreach primary health care that incorporates mental health and addiction services within community settings:

- - Non Residential Team: which will include Vancouver Community Shelters

  as a key points of contact with homeless for street entrenched individuals who are unconnected to health services

- - Residential Teams: which include service to VC funded SRO's and some BC Housing Supported Housing/SRO sites as part of the Ministry of Housing and Social Development (MHSD) Immediate Homeless Intervention Project (IHIP) in DTES.

What we do.....

The POS teams employ the pre-existing DTES Clinical Housing Team (CHT) Model of Care which provides primary health care outreach services to clients living in residential settings such as DTES SRO's. A full range of primary health care services are delivered by a team of nurses, nurse practitioner, physician, social workers/case managers and health care workers.

•Medical care includes assessment, wound care, diagnostics and lab work, immunizations, chronic disease management (self-care management strategies).

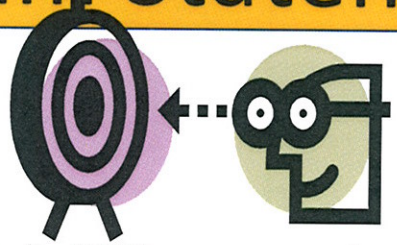
•Addiction care includes harm reduction information, appropriate referrals, and methadone maintenance (under development).

•Mental Health care includes assessment, supporting clients who are accessing the secondary system of care, advocacy, medication management, crisis management and referrals to appropriate and available mental health services.

Our Population of Focus....

Primary Outreach Services has delineated our POF(Population of Focus) into two Populations inclusive of an "OUT" population and an "IN" population. The "Out" population consists of individuals identified as HIV + who receive their HIV care from a Primary Care Provider other than Primary Outreach Services. The "IN" population consists of individuals identified as HIV+ who receive their HIV care from Primary Outreach Services.

Our Aim Statement.....



(1) To support the "engagement in care" of HIV+ co-managed patients with their "outside" HIV primary care provider. This will be measureed by the total number of "outside patients" who have seen their HIV primary care provider in the past 4 months divided by the total number of "outside patients."(Target=95% of outside patients have seen their HIV provider in the past 4 months.

(2) Improve overall quality of HIV care for "internally managed " patients, as measured by:

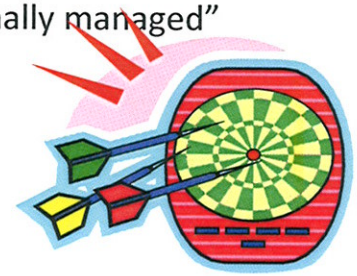
(a) HIV Primary Care Visits: the number of "internally" managed patients who have been seen by their POS HIV primary care provider in the past 4 months divide by the total number of "internally" managed patients(Target=95% with a visit in the past 4 months)

(b) HIV Viral Load: the number of "internally" managed patients who have had a Viral Load test in the past 4 months divided by the total number of internally managed patients(Target=95% with a VL test in the past 4 months)

(c) ART uptake among those unequivocally in need of ART: The number of internally managed patients with a CD4<200(ever or on last lab measure) currently receiving ART divide by the total number of internally managed patients with a CD4<200(ever or on last lab measure) (Target=>95% virologic suppression)

(d) Achieving maximal HIV virologic control if prescribed ART: The number of "internally managed"

(3) 50% of 1200 POS Clients to get an HIV screening by end of 2011.



Our progress so far……

Primary Outreach Services (Clinical Housing Team, Clinical Tenant Support Team, Clinical Outreach Team) have come together as one reporting body (team) for purposes of this collaborative. Our Change Team have been meeting bi-monthly to discuss progress/difficulties/obstacles to completing and reporting our progress. The following are PDSA's carried out to date:

- COT has carried out a Health Fair since the last collaborative and has decided to host additional Health Fairs every three months.
- CHT conducted a survey for the purpose of eliciting feedback from the tenants living at one of the SRO Hotels. Feedback was obtained and the team working in the SRO has attempted to follow-up with the suggestions put forward.
- Through bi-monthly Change Meetings, POS has shared information related to "data cleansing" as part of the process of moving forward with quality improvement.
- A letter is in process of being drafted, to distribute to our community partners, as a means of identifying out Services and how we envision collaborating in the delivery of care to their patients.

Baseline data so far….

Total number of HIV Positive clients in our “out “ population = 128

Total number of HIV Positive clients in our “in “ population = 19