EVALUATION REPORT | OCTOBER 2020

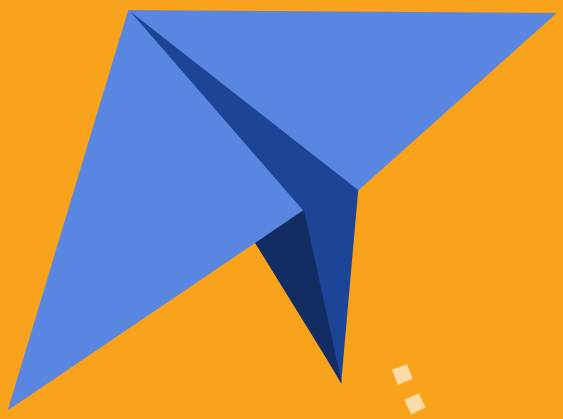
CAMICO Service Provision in Pandemic Housing and Outreach

wound-care HCV refer leg nausea X-ray foot edema swelling medications assess screen pain-management prenatal COVID-19 treat chest asthma cellulitis abscess HIV PWD pain case-manage OAT review mental health insomnia COPD care bloodwork check education dental Birth-control STI back detox PPRM

CoolAid
everyone deserves home

About The Cool Aid Society's Community Health Centre

Victoria Cool Aid Society's (VCAS) Community Health Centre (CACHC) provide low-barrier health services to inner-city populations that are economically vulnerable, have complex medical needs, and face multiple barriers to accessing care. Clients of CACHC experience homelessness, mental health issues, infectious disease, problematic substance use, and chronic illnesses.



"Health care goes hand in hand with supportive housing and emergency shelters."

Sandra Richardson, CEO
Victoria Foundation

About This Report

In March 2020, sheltering sites were created for people who were under-housed or homeless (*specifically those living in Topaz Park and on Pandora Avenue*), at risk of COVID-19, and deeply impacted by social program closures. These sheltering sites included locations at Howard Johnson, Travelodge, Save-On Foods Arena, Capital City Centre, and Comfort Inn. Island Health contracted with CACHC to provide medical care for people sheltered in these sites.

In response, the CACHC created the Cool Aid Mobile Inner-City Outreach (CAMICO) team. CAMICO consists of four clinics. Each clinic is staffed by two nurses. Nurses initially worked six hours a day, seven days a week. Due to changing needs and staffing availability, the nursing team reduced its hours to five days a week in later September. CAMICO also has four physicians, on-call and in person, serving the sheltering sites. Pharmacy services were also delivered at each site. This pharmacy program included pandemic prescribing. However, due to staffing capacity, CACHC pharmacy staff ceased delivery in early September. CACHC has appreciated the speed at which all service providers who have been involved with the COVID-19 response have managed to create new infrastructure, forge new relationships, and provide excellent care to Victoria's most vulnerable individuals.

This paper reports on CAMICO's activities and outcomes for the first five months of service (May-September 2020). The purpose of the report is to provide a deeper understanding of who were served through CAMICO services and what kinds of services were provided.

Acknowledgements

The CACHC is thankful for VIHA's continued support and partnership as we work to improve the health and well-being of the region's most vulnerable client populations.

The authors (*Marion Selfridge, Roz Milne, Kellie Guarasci, Tamara Barnett, Hanna Roy, Hana Mildenberger*) would like to thank the entire team at CAMICO and CACHC for their continued work and dedication and all of the clients for their contribution to the research. Special thanks to Taylor Kandler and Emily Lehre for their efforts in supporting this chart review and Kiffer Card for the graphic design, editing, and review of this report.

Methods

The report focuses on the major activities delivered by healthcare providers through CAMICO housing sites and outreach services. Data collection for this report involved several processes to best capture the activities of CAMICO and the reporting objectives.

Data Sources

Data Source	Description
1. Service Provision Data for Fiscal Year 2020/21	These data are collected and reported monthly and provide current and trend data on the main activities of the clinic.
2. EMR WOLF chart review	From August – October 2020 a chart review was conducted in the electronic medical record (WOLF) to determine prevalence and outcomes of health conditions within CAMICO client population
3. CACHC RMG (PPRM) Case Series	In May – October 2020 a chart review was conducted in the electronic medical record (WOLF) to identify patients that have been offered and taken up prescriptions of opiates, stimulants and benzodiazepines based on the March 2020 Risk Mitigation Guidelines (PPRM). This analysis is ongoing and preliminary information is provided.
4. Clinician Narratives	CAMICO clinicians were asked about the experiences of providing care in the novel CAMICO settings and provided oral and written feedback.

Who is Accessing CAMICO Sites?

Indicator	N	%
Total number of clients accessing CAMICO services	**414**	
Total number of documented encounters with CAMICO physicians and nurses	**9823**	
Less than 5 encounters	104	25.1
6-20 encounters	130	31.4
21-40 encounters	94	22.7
41-60 encounters	55	13.2
61-80 encounters	23	5.6
81-105 encounters	8	1.9
Cool Aid Community Health Centre Client		
Yes – existing client	164	39.6
Yes – limited or not seen in +5 years	59	14.3
Yes – banned from CACHC	1	0.2
No	13	3.1
New	117	28.3
Homeless		
Yes	401	96.9
No	5	1.2
Unknown	8	1.9
Have spent time sheltering at		
Topaz	58	14.0
Pandora	8	1.9
Rock Bay Landing encampment	3	<1
Crystal Pool encampment	2	<1
Centennial Square	2	<1
Beacon Hill Park	7	1.6
Admitted to a temporary shelter		
Yes	376	90.8
No	39	9.4
Which Site		
Arena	47	11.4
Capital City	72	17.4
Comfort Inn	74	17.9
Howard Johnson	81	19.6
Paul's Motor Inn	4	1.0
Travel Lodge	98	23.7

During the reporting period (May-September 2020), 414 clients were identified as accessing care through CAMICO. A total of 9,823 client encounters were documented in the electronic medical record (EMR). These records capture in-person assessments, treatment episodes, case

management activities, room visits, and follow up on blood work, prescriptions, and critical health issues. While a quarter of clients had minimal contact with clinicians (25% had less than 5 encounters), **21% of clients had more than 40 documented encounters.** Eight clients had over 80 documented encounters. These numbers reflect the complex health conditions and needs of current CAMICO clients.

A significant number of clients (164 or 39.6%) were previously under the care of CACHC clinicians and 117 clients (28.3%) were new to CACHC. Clients also accessed services from other providers across Victoria. Approximately 28 (7%) clients had a current GP or NP; seven had GPs in other communities. However, at least 23 clients had a GP who they had not seen in many years, who was not comfortable prescribing narcotics, or who had retired. Over 30 (7%) clients had another prescriber for Opioid Agonist Treatment (OAT) such as suboxone, methadone, or kadian. Some clients have continued to see these providers at the Pandora Clinic. All pregnant clients accessed Her Way Home. At least seven clients had connections to GPs at the Foundry. For many, CAMICO has provided an opportunity to address significant medical issues that had been put off due to a variety of factors, including limited access to consistent medical care.

Over 95% of clients were homeless when first accessing CAMICO services or before entering the CAMICO sites. While many were not documented, it is clear that many campers at Topaz, Pandora and Beacon Hill Park have had contact with CAMICO clinicians. Over 90% of clients seen were offered temporary accommodations in the hotel sites and Arena. This population has been fluid. At least 18 have been evicted from sites. Clients who started at the Arena moved into the hotels when rooms became available. At least ten have moved to other places including other housing provided by Our Place, First Metropolitan, or BC Housing. Others have moved to Vancouver, up island, or have been incarcerated.

Resident lists provided by BC Housing in August 2020 were reviewed and all residents were identified as CAMICO patients in EMR, or not having had a documented interaction with CAMICO clinicians. A total of 380 residents were reviewed. Of these, 69 had not been seen by clinicians and have been flagged for check in by site nurses. **On September 15, across all sites, only 18% of residents had not had a documented clinician visit.**

Site	Total Residents Listed	CAMICO Status	Not Seen – Flagged for Check-In
Arena	38	35 (92%)	3 (8%)
Capital City Centre	96	64 (67%)	32 (33%)
Comfort Inn	60	53 (88%)	7 (12%)
Howard Johnson	89	74 (83%)	15 (17%)
Travelodge	97	85 (87%)	12 (12%)
TOTAL	**380**	**311 (82%)**	**69 (18%)**

The target population for CACHC is inner-city vulnerable populations with complex health needs and significant barriers to accessing care. CACHC was well positioned to support the client population at CAMICO and to provide services that appropriately reflect these complexities, namely, chronic infectious diseases including HIV and Hepatitis C (HCV), mental health and substance use issues, homelessness, and poverty. Similar to the most recent Victoria Homeless PIT count, the majority of the 414 CAMICO clients are aged 25-55 and 60% were identified as male in the EMR. At least 11% of clients had been incarcerated although this is likely underreported as it is not easily found within the EMR.

Construct	N	%
Age (in years)	Mean = 40.5	
≤18	5	1.2
19 - 24	26	6.3
25 - 39	183	44.2
40 - 54	137	33.1
55 - 69	56	13.5
70+	4	1.0
Gender		
Female	164	39.6
Male	250	60.4
Comorbidities		
Asthma/COPD/Bronchitis	64	15.5
FASD/Traumatic Brain Injury/OBS/stroke	60	14.5
Chronic Pain	120	29.0
Dental Pain/issues	53	12.8
Cellulitis	140	33.8
HIV status		
Living with HIV	11	2.7
Newly engaged in care	3	
Adherent on ART	9	
Undetectable viral lodes	9	
Hepatitis C (HCV) status		
No HCV	206	48.9
Unknown	92	22.2
HCV antibody positive (AB+)	**116**	**28.0**
HCV Treatment status		/116
AB+ Unknown RNA	9	7.8
Cleared	18	15.5
On treatment	24	20.7
Treated - no Sustained Viral Load (SVR)	7	6.0
Treated SVR	21	18.1
Untreated	37	31.9

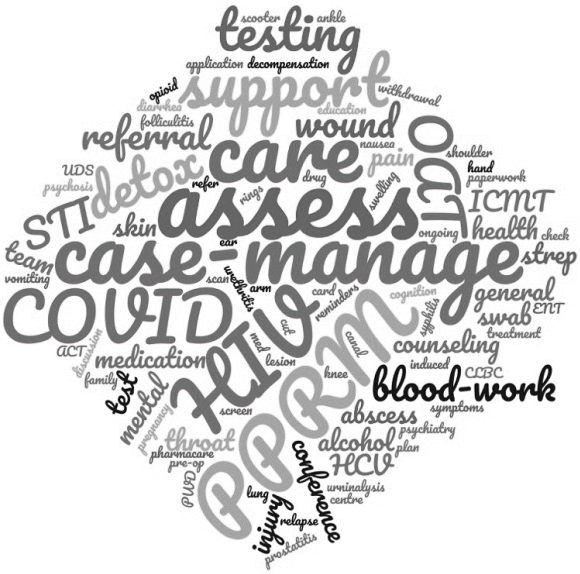
Many clients were living with chronic conditions that are exacerbated by homelessness such as asthma/COPD/bronchitis (15.5%) and soft tissue abscesses and cellulitis (33.8%). Many clients experience chronic pain (29.0%), including dental pain and pain from infections (12.8%). A total

of 14.5% had impaired cognition resulting from traumatic brain injuries, including those resulting from hypoxia related to overdose. At least 67 (16.2%) had recently overdosed in the past six months while many more had overdosed in the past.

People Living with HIV

Currently eleven CAMICO clients were identified as living with HIV: three clients were new to CACHC. CACHC plays a critical role in the Victoria STOP HIV/AIDS Collaborative which reports on two established testing and treatment indicators of efficacy in HIV treatment. Plasma viral load (PVL) testing is foundational to HIV disease management. Periodic monitoring of PVL is used as a predictor of disease progression, to help the client and provider decide when to begin antiretroviral drug therapy and is the standard to identify treatment failure. All eleven clients with HIV were reported to have had a PVL test within the past eight-month period; nine within the past six months. Most (82%) of those living with HIV were reportedly engaged in antiretroviral therapy (ART) and 82% had undetectable viral loads. Five clients have had HCV: one has cleared on their own, two have recently been treated, one has completed treated with SVR, and one remains to be treated. Ongoing case-management with this complex group includes efforts to prescribe single tablet regimen ART, support medication adherence, and provide other ongoing care (e.g., STI testing and treatment, OAT, PPRM, and psychiatric care).

People Living with HIV Hepatitis C



Temporary sheltering of Victoria's homeless population has created a unique opportunity to engage this marginalized population in hepatitis C (HCV) care. HCV is a curable infectious disease that is highly prevalent in the injection drug use population and shares a transmission pathway with HIV. In treating HCV we reduce the risk of transmission of HIV, increase immunization rates for all publicly funded immunizations, improve all-cause mortality rates, and engage patient in primary care and harm reduction. CACHC has an internationally recognized Nurse-led Hepatitis C Treatment Program with extensive experience working with vulnerable populations. This program enables us to effectively engage individuals in care. The nurse-led program has already targeted VCAS's 13 housing sites and the Rock Bay Landing Shelter in a micro-elimination test and treat program. By providing HCV treatment to clients who are homeless and accessing shelter services, the CACHC team has been able to treat clients who have experienced many barriers to accessing health care. These barriers include problematic substance use, significant history of mental illness, lack of primary care provider, stigma and shame around substance use, and the complexity of the healthcare system.

Clients lost to follow up from CACHC or Rock Bay Shelter testing or who were too unstable to treat are now having the opportunity to access 8-week (3 pill a day) or 12-week (1 pill a day) HCV treatments. Within CAMICO, a total of 116 clients have been identified as HCV antibody positive. Of these, 37 (31.9%) are currently living with HCV, 18 had spontaneously cleared HCV, and 21 had been previously treated successfully. On site primary care services include onsite phlebotomy, patient specific medication delivery, and comprehensive primary care. These efforts include intensive case management, which has helped 19 patients rapidly access HCV treatment.

Clinic nurses have also started 19 CAMICO clients on treatment. Currently, 31 clients are either on treatment or have finished and require SVR bloodwork to determine to treatment success. We are excited to work with AIDS Vancouver Island's HCV peer educators to increase HCV knowledge, reduce stigma and increase testing and treatment within the CAMICO sites.

People with Mental Health and Substance Use Needs

CAMICO clients experience extremely high levels of mental health and substance use challenges, as well as insecure housing and low-income levels. Within the EMR billing code 136 (32.9%) have a significant mental health diagnosis. Further investigation within chart review and consultations reveal that over 64% had mental health diagnoses and queries identified in their EMR with anxiety (27.0%), depression (28.2%), PTSD (21.7%), ADHD (12.1%) commonly documented. **Over a quarter of client's (117 or 28.3%) charts contain diagnoses or encounters related to complex mental health including psychosis (including drug-induced), Borderline Personality Disorder, Axis II, delusional and conduct disorder.** Many of the clients with these mental health challenges have required intense case management, medical and psychiatric care, including emergency services.

In total, 309 (74.6%) CAMICO clients have a billing code of a substance use disorder attached to their chart. More than three quarters (319 or 77.1%) of clients endorsed recent substance use (*opiates (62.1%), stimulants such as crystal meth (56.3%) or crack cocaine, GHB, or non-prescription benzodiazepines*), with many using multiple substances (49.5%). A larger percentage of clients use inhalation methods to ingest substances (53.6%). Comparatively, 38.2% reported injecting substances. In response to these hazards, CAMICO clinicians have made a concerted effort to assess client's functioning in order to assess and complete Person's with Disability (PWD) applications. To date, **48 PWD applications have been submitted** on behalf of clients, in order to increase their level of benefits, such as eye glasses, transportation, dental care, mobility devices, and medication coverage.

Construct	N	%
Mental Health (MH)		
Documented mental health issue	265	64.0
No	24	5.8
Unknown	128	30.9
Common MH issues		
ADD/ADHD	50	12.1
Anxiety	112	27.0
Depression	117	28.2
PTSD	90	21.7
Complex MH (Psychosis (including drug-induced), Borderline PD, Axis II, delusional, conduct disorder)	**117**	**28.3**
Psychiatric Medication		
Yes	99	23.9
No	247	60.1
Unknown	68	16.4
Number of CAMICO clients identified with following complexities in EMR (billing code)		
Substance Use Disorder	309	74.6
Significant Mental Health Diagnosis (depression, anxiety, bipolar and/or schizophrenia)	136	32.9
Recent Substance Use (excluding cannabis, alcohol, tobacco) last 6 months		
Yes	**319**	**77.1**
No	46	11.1
Unknown	49	11.8
History Injection Drug Use		
Yes	200	48.3
No	22	5.3
Unknown	192	46.4
Recent Substance Use		
Opiate	257	62.1
Crystal Meth	233	56.3
Multiple substance use	205	49.5
Injection Drug Use (IDU)	158	38.2
Inhalation	222	53.6
Recent Overdose (last 6 months)		
Yes	67	16.2
No	158	38.2
Unknown	189	45.7
PWD Status		
Has PWD	66	15.9
Application started	3	0.7
Applied while with CAMICO	48	11.6
Other (EI, CPP, Veteran's Affairs)	5	1.2
Unknown	247	59.7

OAT and PPRM

The COVID-19 crisis has caused disruptions or changes in the drug supply for people who use drugs (CCENDU, 2020). These changes have made it harder for people to find reasonable quality drugs (Vancouver Island Drug Checking Project, 2020), forced people to use drugs alone and in isolation while physical distancing, or exposed this population to COVID-19 while they are seeking drugs out (Becker & Fiellin, 2020; Tyndall, 2020). Physicians, in collaboration with outreach nurses, working through CACHC have been prescribing Pandemic Prescribing for Risk Mitigation (PPRM) such as oral hydromorphone and dexedrine tablets, many times in conjunction with existing or new Opioid Agonist Therapies (OAT) such as methadone or kadian to patients at risk.

A quarter of clients (108 or 26.0%) were already on OAT when they began being served by CAMICO, while 118 (28.5%) were started on OAT, often in conjunction with PPRM. The most common OAT is Kadian (103, 45.6%), followed by methadone (93, 41.2%) with smaller numbers on suboxone (20 or 8.8%) or M-Eslon (10 or 4.4%). Of the 226 who were either already on OAT or recently started, just over half (119, 52.7%) have continued to regularly access (at least 5/7 days per week) OAT in the past 60 days.

Over half of the CAMICO cohort (229 or 55.3%) were provided a prescription for PPRM since the guidelines for Risk Mitigation (RMG) came into effect. The vast majority (201 or 97.8% of individuals) have been prescribed hydromorphone and a smaller group prescribed stimulants like Dexedrine (54 or 23.6%) or Ritalin (17 or 7.4%). Some clients have been prescribed both opiate and stimulant (26 or 11.3%). At least 72 clients were started on PPRM while they were staying at a homeless encampment, many in the first months of COVID-19 displacements to Topaz and Pandora. While analysis is ongoing within the larger group of clients offered PPRM through CACHC/CAMICO, preliminary work shows that 86 of the 229 CAMICO clients received PPRM (37.8%) without interruption and 124 (54.2%) are continuing to access PPRM.

Construct	N	%
Prescribed Opioid Agonist Therapy (OAT)		
Yes – already regularly prescribed	108	26.0
Started	118	28.5
No	183	44.2
Unknown	5	1.2
Current OAT		/226
Methadone	93	41.2
Buprenorphine/naloxone (suboxone)	20	8.8
Morphine (Kadian)	103	45.6
M-Eslon	10	4.4
Active OAT within past 60 days		/226
Yes	119	52.7
No	107	47.3
PPRM prescribed	229	55.3
PPRM Substances	201	48.6
Hydromorphone	194	46.9
Oxycodone	7	1.7
Dexedrine	54	13.0
Ritalin	17	4.1
Strattera	1	0.2
PPRM both Opiates and Stimulants	26	6.3
PPRM Other		
PPRM Benzodiazepines	2	0.5
PPRM Managed Alcohol Program	9	2.2
Started on PPRM in homeless encampment		
Yes	72	17.4
No	144	34.8
Unknown	12	2.9
PPRM dispensed without interruption		/229
Yes	88	38.4
No	138	60.3
Never started	4	1.7
PPRM Stopped		/229
Yes	101	45.0
No	124	54.2
Never started	4	1.7
Positive Outcomes		/229
Patient reported decreased illicit drug use	77	33.6
Urine Drug Screens since PPRM initiation		/229
Yes	88	38.4
No	125	54.6
Unknown (has other OAT/PPRM provider)	16	7.0

PPRM has already been linked to a variety of positive impacts both at an individual level as well as at a system's level. Indeed, at least one third of clients who accessed PPRM report a decrease in their illicit drug use. Additionally, PPRM-based interactions have facilitated the development of healthy relationships between clients and providers. Other positive outcomes included: decreased cravings, healed wounds through consistent wound care, reduced money spent on drugs, sleeping better, started HCV treatment, Increased emotional stability, PWD application, and Increased engagement in medical care, mental health support and dental care.

There have also been a variety of challenges that CAMICO staff have had to overcome in providing PPRM services at CAMICO sites. For example, CAMICO staff are mindful that CAMICO hotel rooms are clients' homes and that knocking on their door with health care requests can feel intrusive. This issue is reinforced by clients' responses to nurses, "*call me on my phone, don't bother me at home, don't knock on my door*." At CAMICO, nurses have been asked to initiate, locate, and connect with clients for a wide variety of pressing health concerns, including follow up to OAT and PPRM prescribing. By healthcare providers assuming responsibility and initiating contact with clients, CAMICO clinicians are trying to find a balance between providing adequate care and the loss of the clients' autonomy to take action of their own healthcare needs. While the preferred outcome would have clients presenting their health care needs to the 'in-house' clinic, many clients live chaotic lifestyles with concurrent disorders which cause unintended barriers for them to access the clinic on their own. Furthermore, some clients are not home during clinic hours – particularly if they are engaged in other activities aiming to supplement their income.

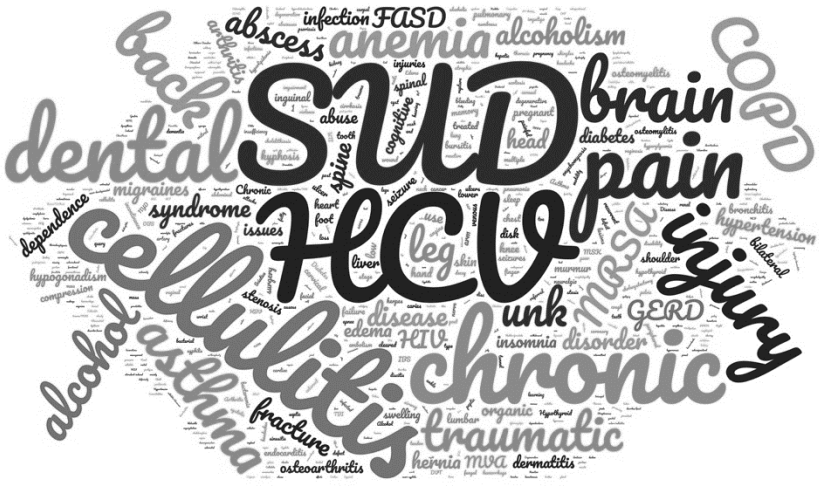
Consistent nurse presence at the CAMICO sites has meant that they are responsible for the monitoring and follow up of clients accessing PPRM and OAT. One of the main challenges nurses encounter is the ever-evolving guidelines and policies which direct nurses on what types of monitoring is best practice. This changing momentum surrounding the requirements for accessing PPRM can potentially create some confusion and mistrust between clients and health care providers. An example of this problematic situation can be seen in meeting the required frequency of a urine drug screen (UDS) to confirm the ingestion of OAT or PPRM (rather than diverting the prescriptions offered) and to assess if they have been able to move away from illicit drug use. To date, 88 (38.4%) of PPRM clients are known to have provided a UDS. Many CAMICO clients have experienced some form of trauma related to the non-voluntary use of UDS such as needing to complete UDS to have visitation with children through Ministry of Children and Family Development (MCFD) or to be in a treatment program. Communicating and engaging with clients with honesty and integrity regarding the monitoring requirements for accessing PPRM has been vital, letting them know that everyone who is receiving PPRM is required to provide a UDS periodically.

Pregnant Women

There have been eight confirmed pregnancies at CAMICO-serviced sites: seven clients living in COVID hotel sites and one with no-fixed address (NFA). Two clients obtained medical termination services via referral from CAMICO doctors. Five clients continued with pregnancy and delivered with support of CAMICO nurses, Her Way Home (HWH), and the Perinatal Addictions team, some with the added support of other outreach teams. Weekly pre-natal clinics were set up at the CAMICO sites during this time to provide intensive care and case management. There is one ongoing pregnancy; this client is living at a CAMICO hotel site and is connected to CAMICO nurses/doctors, HWH, and Access Midwifery services. Of the eight confirmed pregnancies, five clients remain housed at CAMICO sites (hotels), one client has been NFA throughout, and two clients who were housed at CAMICO sites are now living in market rent or other housing arrangements, as of last contact. While it is unclear in the EMR exactly when each client first discovered they were pregnant or first received care related to their pregnancy, three clients' first CAMICO encounters regarding their pregnancy did not occur until week 24, 26, and 28. On becoming attached to CAMICO clinics six (75%) clients received OAT/PPRM treatment, seven (87.5%) were screened for Hep C/HIV, and five (62.5%) were screened for STIs. Four (50%) clients were found to be positive for Hep C and the appropriate bloodwork and pre-treatment applications/approvals were sought by CAMICO clinicians. Of the five pregnancies which were carried to delivery, two were discharged from hospital to foster care, two were discharged from hospital into the care of the client's family member(s), and one was discharged from hospital under the care of the client. In addition to the above confirmed pregnancies, two clients have attended one of the CAMICO clinics expressing their intention to become pregnant. Both of these clients have previous children who are currently in the care of others, and both clients have engaged independently and spontaneously with CAMICO clinicians around their intent to become pregnant.

Patients with Complex Health Conditions

The individuals who are receiving temporary shelter in the hotel sites have highlighted the ongoing gaps in our health and social services. The individuals seen through CAMICO have had multiple encounters with the emergency, acute care, criminal justice and social welfare systems over their lifetimes. It is common for individuals to have been released/discharged from these services to inadequate follow up care or no supports at all which negatively impacts their overall health. In regards to health specifically, we see a pattern of people accessing ER in



acute crisis repeatedly for the same and/or progressive issues without resolution. This pattern negatively impacts an individual's ability to access care appropriately and causes further harms. With the establishment of onsite primary care clinics, CAMICO clinicians have been better able to connect clients to care, assessment and treatment for multiple health and social issues.

For example, a client with untreated degenerative musculoskeletal disorder, polysubstance use and multiple chronic illnesses including psychiatric was able to engage with primary care clinicians and start receiving care for their multiple comorbidities. Within the first 4 weeks of the CAMICO clinic opening this resident had:

- laboratory diagnostics collected onsite for evaluation of chronic health issues;
- initiated pharmacological treatments for substance use, chronic medical and psychiatric disorders, with daily delivery from community pharmacy;
- transportation to and from diagnostic imaging;
- onsite assessment by an occupational therapist for determining appropriate mobility aids and room modifications;
- received safety and mobility aids; and
- completed a PWD application for financial support and access to associated services.

When this patient did become acutely ill, the care team was able to assess the need for hospital care and liaise with acute and emergency services to improve the transition to hospitalization. When the client left hospital early against medical advice, again, the onsite primary care team was able to coordinate continued medical treatment and assessment in the community to reduce the risk of further decompensation.

In another example, a client with multiple co-morbidities including HIV, cognitive impairment, chronic bronchitis, sinusitis and osteoarthritis has had over 90 encounters with CAMICO clinicians documented since moving into CAMICO site. While this has been challenging to manage the client's concerns, especially around worries of contracting COVID-19, an ER note from March 26 2020 states: "I did note that the patient had **25 emergency room visits in the last 12 months** and also approximately **19 chest x-rays in the last 12 months** for respiratory symptoms: all have been negative for pneumonia to my knowledge. She also had a CT, which did not demonstrate a PE." After this note the client had five more ER visits – one in March, and four in April – before moving into CAMICO site. **Since May she has only had 2 ER visits:** One in late May and one in mid-August. These visits were for symptoms of sore throat, joint pain, and a non-productive cough. This is a considerable decrease in ER visits, saving the Health Authority thousands of dollars and unnecessary diagnostic testing.

An assessment of ER visits of the first 20 clients in chart review showed a total of 61 ER visits in the year previous to CAMICO and 19 ER visits since staying at CAMICO sites. This represents a reduction from 5.1 visits per month to 3.8 visits per month. These results suggest that providing medical care to the sheltering sites may help address many issues faced by vulnerable people.

Client	At CAMICO (May-Sept 2020)		Previous Year (May 2019-April 2020)	
	Cause of Visit(s)	No. of Visits	Cause of Visit(s)	No. of Visits
1	None	0	Respiratory Distress	3
2	Bike accident hand injury	1	Dog-bite and resulting osteomyelitis; drug contamination	7
3	None	0	None	0
4	Mental health, HIV PEP, abdominal pain, nausea vomiting post drug use, ingrown hair	8	Mental Health	1
5	Abscess	1	Glass, hand swelling, skin problems	6
6	None	0	Dental pain, STI testing	2
7	None	0	Detox, cellulitis	5
8	Ankle pain	1	Neck abscess	2
9	Nausea and vomiting	1	Withdrawal, chest pain	2
10	Swollen finger	1	None	0
11	None	0	Overdose, mental health, infections	10
12	None	0	Opiate withdrawal	1
13	Tooth pain	1	Head sore	1
14	None	0	None	0
15	Pain after falls	3	Falls, mental health, bloody stool	13
16	Chest hematoma	1	Fall, end stage liver disease	6
17	None	0	Angiodema	1
18	None	0	Foot Swelling	1
19	Withdrawal, shortness of breath	1	None	0
20	None	0	None	0
	N = 19		N = 61	

Youth and Young People

Youth who have 'aged out' of the system and are engaged in survival strategies are a key group within CAMICO. Indeed, in each of the hotels there are youth with development disabilities, complex psychiatric and/or concurrent substance use issues. Some of the youth are connected to Community Living BC or are under care agreements through MCFD as they are identified as having extreme needs for supports and/or protection. While it is essential that these youths have housing, it is our recommendation that the hotels are not appropriate for them. Youth at CAMICO sites are at high risk of continued exploitation and require a higher level of specialized support, intervention, safety/security and care. Currently, this level of support is more than what is available or feasible to offer at the hotels. It is unreasonable to expect housing and support staff to protect vulnerable youth within a housing site that is predominantly inhabited by street involved adults.

People with Aggressive or Violent Tendencies

The risk of violence at the CAMICO sheltering sites presents significant challenges for the entire medical and peer support staff. The placement of people into the sheltered housing sites was done quickly, with little consultation with the service providers who were tasked to provide on-site support and without a thorough assessment around appropriate cohorts. This process, albeit impressive in getting people housed, has placed staff and residents at risk of violence, victimization and exploitation. This has led to the co-habitation of vulnerable and predatory/anti-social sections of the population which has further negatively impacted the most vulnerable within this group. As a result, there have been many 911 calls for domestic violence, gang presence and reports of weapons at each of the CAMICO sites. There have also been reports of sexual assault and sexual exploitation of (underage) girls. The level of support required for clients experiencing severe mental health and substance use disorder is lacking in temporary sheltering sites. In turn, the safety and wellbeing of these clients, their neighbors, and the staff are negatively impacted. For example, one long-term CACHC client was recently evicted due to their violent and antisocial behaviour. This individual had previously been banned from the Johnson Street clinic in 2018 due to aggressive and anti-social behavior. In May 2020, the CAMICO staff recorded their first interaction with the client and at that time identified him as a "risk for violence." A care plan was developed to manage this individual's unique needs. From May to September, there were 11 chart entries documenting aggression towards CAMICO staff. On September 1st the client was sectioned after threatening to kill a CAMICO physician and nurse. He subsequently spent one week in hospital, but was discharged back to the sheltering site against the recommendations of CAMICO staff, who felt that the supports required to address his mental illness, brain injury, and substance use disorders were not available. The patient was referred to the ACT team but before he was picked up he assaulted an on-site security guard. As a result, the police were called and he was evicted.

Conclusion

CAMICO services have been rapidly deployed in response to the unprecedented dual public health crises arising from the overdose epidemic and COVID-19 pandemic. Multiple agencies have come together to provide housing, social support, and healthcare to some of the most vulnerable members of our community.

Indeed, CAMICO has provided low barrier access to primary health care services (*over 9,823 visits with 414 clients including 117 new clients*) for a complex population (*75% with substance use disorder, 64% with chronic mental illness*) while supporting the health and wellness of diverse clients in need of personalized care (e.g., HCV/HIV care, reproductive care, substance use care). Clients by CAMICO include people living with HIV, people living with hepatitis C, people with substance use or mental health needs, pregnant women, youth, and people with aggressive or violent tendencies.

The intensity of care provided at CAMICO sites and through outreach to unsheltered clients in parks demonstrates ongoing challenges of the overdose crisis, the lack of affordable housing, and COVID-19. Based on existing evidence, it is clear that providing medical and other care within low barrier housing sites provides many opportunities to reduce ER visits and support the health and well-being of people with complex substance use and mental health needs.

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