Saskatoon Health Region
HIV Prevention, Treatment & Support Strategy

Developed by:
The Health Sector and Community within the Saskatoon Health Region
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Acknowledgements

This strategy could not have been realized without the participation of numerous experts within the health care sector and community. The Saskatoon Health Region would like to thank those who contributed to this document through their consultation or written feedback.

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- Emergency, Saskatoon Health Region
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- Home Care – Saskatoon Health Region
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Letter of Support

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September 30, 2010

Dr. Cordell (Cory) Neudorf
Chief Medical Officer
Saskatoon Health Region
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Saskatoon, SK.
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Dear Dr. Neudorf:

Re: Saskatoon Health Region HIV Strategy

On behalf of the Saskatoon Tribal Council (STC), we are writing to support the application from the Saskatoon Health Region (SHR) for the SHR HIV Strategy.

There is a demonstrated need for comprehensive services in the areas of prevention, treatment and palliation for HIV/AIDS clients in the region. In the past two years the STC Health Center has developed a very successful inter-agency collaboration in an attempt to reduce the incidence of HIV. The inter-agency collaborators provide a vital role for HIV/AIDS prevention by providing education and service delivery to individuals living in Saskatoon.

Please accept our letter of support for the SHR HIV Strategy. We would be pleased to address any questions that may arise. Thank you.

Sincerely,

Felix Thomas
Tribal Chief, Saskatoon Tribal Council

cc STC Chiefs
Ceał Tournier STC HFS Inc
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Executive Summary

Since 2005, Saskatchewan, including the Saskatoon Health Region (SHR) has been facing an alarming increase in the number of HIV cases. With Saskatchewan now leading the country with the highest infection rate at 19.2/100,000 population (2008) and SHR at 31.3/100,000 population (2009), SHR in collaboration with the province, is challenged to reduce the occurrence of new infections and improve the quality of life for those who are HIV positive. SHR is experiencing a concentrated epidemic where the majority of new infections are acquired through the sharing of injection drug equipment. Most clients are marginalized, aboriginal and often suffer from lack of housing, employment and transportation. In response to this concentrated epidemic the initiative has aligned the community’s needs with the HIV Provincial Strategy priorities and identified a three year implementation plan tailored to our community.

The critical components utilized in the development of this strategy include building care around the Expanded Chronic Care model, consulting with our community and health sector stakeholders, developing and expanding on partnerships; identifying best practices and learning from other provinces’ successes and challenges. The World Health Organization (WHO) April 2009 document Priority Interventions: HIV/AIDS prevention, treatment and care in the health sector served as a guide in the development of this strategy. The 5 priority interventions outlined in the WHO document provide the framework for the Saskatoon Health Region HIV Strategy. Priority initiatives were selected based on community consultations, promising practices and building supports into programs currently operating well.

The priority interventions for communities in SHR include:

1. Enabling people to know their HIV status
   a) Adopt or create standards of practice for pre and post test HIV voluntary counselling and testing to ensure consistency in practice.
   b) Increase access for HIV testing and counselling to most at risk populations, by providing testing opportunities where clients are currently engaged and through outreach.
   c) Participate in the expansion of Point of Care (POC) HIV testing to additional sites and outreach settings.
   d) Support efforts to obtain, locate, notify and provide voluntary counselling and testing to sexual, injection and social partners at risk of exposure to HIV.

2. Maximizing the health sector’s contribution to HIV prevention
   a) Expand locations providing free condoms and lubricant to most at risk populations.
   b) Increase access to prevention education and harm reduction supplies for injection drug use.
   c) Relocate current drop boxes and purchase smaller, discreet needle drop boxes to facilitate disposal of used needles.
d) Advocate for the provision of harm reduction strategies including prevention education and supplies in prisons.

e) Conduct applied research to better understand the context for needle sharing in our various communities. Involve community based researchers utilizing community sites such as AIDS Saskatoon. Implement leading practices to address prevention opportunities which may include, but is not limited to, innovative home or apartment-based interventions to mitigate sharing, and if there is street level sharing, consider integrating supervised safe injection as an element of medical clinical practice within services if and when warranted.

f) Provide satellite STI services in the core neighborhoods linked with other harm reduction services, outreach, surveillance, addictions services and tuberculosis programs.

g) Create supports and counseling to recalcitrant persons.

h) Train staff on recalcitrant behavior assessment, counseling, support and documentation.

i) Expand and strengthen working partnership by further integrating Mental Health and Addiction Services and Public Health Services together at multiple sites. Immerse addictions workers in needle exchange sites, implementing interventions based on the harm reduction hierarchy model supporting effortless movement into recovery programming.

j) Partner with community based organizations to provide Addictions Services and Mental Health support to clients within their home neighborhoods.

k) Cross train SHR health care workers to recognize, intervene and support persons who use injection drugs at all SHR sites.

l) Incorporate mental health, elder counseling and cultural supports into client care plans to address the root causes of injection drug use.

m) Enhance access to opiate substitution therapy through targeted recruitment of prescribers. Advocate for methadone access in appropriate rural sites within SHR.

n) Develop injection drug use peer to peer programs to support risk reduction behaviors. Include clients in the development of harm reduction and addictions programming.

o) Expand the services of the Methadone Assisted Recovery program to provide HIV and Hepatitis C testing through partnering with Public Health Services.

p) Implement targeted interventions to promote behavior change to prevent HIV and hepatitis C infections.

q) Build on the partnership between Methadone Assisted Recovery Program and Positive Living Program to integrate hepatitis C treatment with methadone programming.

r) Determine the need and capacity to provide an HIV and tuberculosis satellite service at the Methadone Assisted Recovery Program.

s) Develop and enhance partnerships between Obstetrics and Gynecology, WSCC, Public Health Services, Mental Health & Addiction Services, and Positive Living Program. Integrate HIV care with the obstetrical satellite clinic at Westside Community Clinic. Utilize cross training, outreach and consistent multidisciplinary team meetings to coordinate care, engage clients and ensure access to care at all points of contact.
t) Advocate for physicians to receive an optional fee structure to support their attendance at satellite clinics where at risk clients reside.

u) Provide targeted mental health and addictions support within the prenatal/postnatal care spectrum to support client success by:
   i) Coordinating HIV and methadone treatment regimes for clients initiating or continuing with methadone assisted recovery.
   ii) Providing pharmacy and addictions support to maintain antiretroviral therapy (ART) adherence, titrate methadone as required and intervene with methadone and ART interactions at all community, acute care and out patient venues.

v) Develop and integrate case management teams into the HIV care continuum to support the family unit and prevent perinatal transmission.

w) Utilize outreach and fixed site service to enhance client engagement.

x) Provide case management options by:
   i) Imbedding a case management team (case manager, Mental Health & Addictions outreach worker) to work with the Positive Living Program (PLP), WSCC and the Obstetrical satellite clinic at Westside Community Clinic (WSCC).
   ii) Integrating HIV clinical support into the Kid’s First case management program. Refer consenting clients to Kids First where appropriate.
   iii) Enhancing and expanding case management partnerships with AIDS Saskatoon, CUMFI, Healthy Mother Healthy Baby, Saskatoon Tribal Council Health Center, and the Ministry of Social Services/Child Protection Unit to support system navigation and widen access to specialized services including housing, nutritional supports, home visitation and cultural support.

y) Develop and implement a prenatal and postpartum case management care map to guide case management teams in the provision of best evidence care, supportive relationships and exceptional service. Deliver a standardized training and skill development package to address:
   i) Achievement of client goals and basic needs;
   ii) Antiretroviral therapy (ART) treatment adherence to prevent HIV perinatal transmission;
   iii) Education and skill development in support of HIV self-management;
   iv) Addictions treatment and recovery;
   v) Communication with social services/child protection unit to avoid child apprehensions where appropriate;
   vi) Implementation and coordination of strategies to engage mothers in long term planning to support or reunite family units.

z) Initiate a mother to mother peer mentorship pilot program within the Kids First program to support clients with parenting and life skills, healthy relationships, addictions treatment and recovery and management of health issues.

aa) Collaborate with the Ministry of Health to develop a provincial HIV testing guideline for HIV testing in pregnancy.

bb) In collaboration with the Department of Obstetrics and Gynecology, educate family physicians, obstetricians and nurse practitioners on current testing and counselling guidelines for HIV testing in pregnancy to minimize practice variations and enhance testing rates of pregnant women.
cc) Implement HIV Point of Care (POC) testing on labour and delivery.

dd) Revise pre-printed orders for utilization on labour and delivery and post-partum units to reflect best practice in the prevention of perinatal transmission for HIV positive women and their infants.

ee) Develop guidelines to support orders and to guide HIV testing on the units.

ff) Educate and train applicable staff to the harm reduction philosophy, the new processes and standards, and how to work with most at risk populations.

3. **Accelerating the scale up of HIV/AIDS treatment and care**

   a) In partnership with the HIV clinical care providers, develop and implement a single entry referral process to connect, engage and retain newly diagnosed clients to HIV treatment services by:

      i) Utilizing and revising the current Chronic Disease Management referral database to track incoming referrals and coordinate or triage access to care.

      ii) Integrating the referral system with case management / outreach support to enhance engagement and support transportation needs, ensuring outreach is utilized as an entry point to HIV treatment and care services.

      iii) Developing a monitoring and evaluation plan for the referral, triage and engagement system.

      iv) Initiating quality improvement processes to enhance retention and engagement to care.

      v) Building an incentive fund into the budget and reach out to community churches and organizations to assist with this incentive initiative.

   b) Redesign and expand the clinical HIV/Hepatitis C services to support the current RUH site, satellite clinics at WSCC and the Methadone Program by:

      i) Collaborating with the ID physicians to provide consistent scheduling of clinics.

      ii) Collaborating with sites of clinical care to design and provide same day appointments and drop in care for both program and/or physician staffed clinics.

   c) Build multi-disciplinary care teams at fixed and mobile venues by:

      i) Enhancing the team compliments through partnerships;

      ii) Redesigning and hiring additional staff to include clerical support; MH&A outreach workers; pharmacist; dietician; nurse practitioner; case managers; nurse clinicians; psychologist and community workers.

      iii) Situating team compliments within WSCC, RUH and outreach venues to provide consistent and skilled support in self-management, optimization of therapy, and follow up.

      iv) Ensuring clearly defined roles and collaboration within teams.

   d) Support the recruitment and training of family physicians and multi-disciplinary team members.

   e) Support access to services at WSCC by installing the Laboratory Information System (LIS) at WSCC.
Identify the need and opportunity for additional sites of care. Consider integration with other programming.

Develop and implement case management standards and key interventions aimed at timely access and retention to care, improved quality of life, addictions recovery, and prevention of perinatal transmission.

Imbed case management programming within the referral process.

Define clients who would benefit from case management support through assessment of their self management capacity.

Build case management teams through partnerships, redesign and hiring of additional staff at select venues with outreach capability utilizing:

- Social work prepared case managers, mental health & addictions and street health outreach workers and community based organizations to support this process;
- Current multidisciplinary staff specializing in HIV care and addictions nursing and pharmacists versed in addictions and antiretroviral therapy;
- Kids First and Healthy Mother Healthy Baby programming for HIV positive women and their infants;
- STC Health Center, AIDS Saskatoon and Central Urban Métis Foundation Inc (CUMFI) services.

Develop a consistent referral process to the HIV care teams for clients admitted to hospital. Initiate and coordinate treatment and discharge plans upon admission.

Support immunization coverage for all HIV and hepatitis C cases by:

- Including SHR nurses who work with HIV and hepatitis C cases in routine education and annual review of immunization competencies, anaphylaxis recertification and SIMS training.
- Advocating for SIMS access for all immunization providers.

Collaborate with community pharmacies, addictions and mental health services andWSCC to develop and implement direct observed therapy (DOT) programming at selected sites. Consult with the tuberculosis program on their successful DOT strategies. Evaluate outcomes.

Employ client goal setting within clinical care. Develop and implement targeted skill development and self-management supports.

Collaborate with psychology, psychiatry, elder services and mental health and addictions outreach to support timely access to mental health care.

Collaborate with Infectious Disease physicians, Positive Living Program and rural providers in the utilization of telehealth to deliver care.

Collaborate with AIDS Saskatoon, STC Health Center, Avenue Community Center, Live Well with Chronic Conditions (LWWCC) and Positive Living Program to explore the potential for a LWWCC peer led group.

Support collaboration between the Tuberculosis Control Program and Positive Living Program to prevent co-infection and enhance surveillance, prevention and treatment strategies by:

- Initiating a working group to monitor co-infection rates. Utilize data to guide program integration, intervention implementation and evaluation plans;
ii) Reviewing and implementing best evidence guidelines on initial and repeat Mantoux testing required for HIV positive clients. Developing and implementing guidelines;

iii) Developing a process to improve completion and reading on Mantoux tests. Offer alternative sites/care options through cross training and partnering;

iv) Offering cross training to Tuberculosis Control Program staff to support clients with harm reduction strategies (including distribution of condoms) to improve client access to harm reduction tools and skills.

v) Investigating the Tuberculosis Control Program’s ability to provide HIV testing with linkages to clinical care.

vi) Supporting collaboration between the Tuberculosis Control Program, PLP, PHS and Addictions and Mental Health Programs to consider optional tuberculosis sites of care at select venues.

s) Identify and partner with care home providers and Ministry of Social Services to ensure access to and financial support for those clients requiring transitional housing and home palliative care services. Provide addiction, home care, HIV clinical treatment and palliative supports to care homes.

t) Utilize the PLP nurse clinician and pharmacist to support Client Patient Access Services in discharge planning.

u) Investigate the home care and palliative care model and determine the revisions required to provide care for high risk clients.

v) Initiate conversation with the community and health sector to develop or create a transitional and palliative housing program for complex care clients.

4. **Strengthening and expanding health systems**

a) Identify a leadership structure involving Chronic Disease Management, Mental Health and Addictions Services, and Public Health Services to:

i) Develop a steering committee involving the community to guide the HIV strategy, implementation, funding and annual review. Ensure strong consideration of First Nations and Métis, municipal, police, client and community involvement.

ii) Advocate for and assist in the development of public policy to support employment, housing and availability of nutritious food.

iii) Ensure approval of HIV initiatives are based on pre-determined guiding principles and collaborative partnerships.

iv) Visibly support collaborative community and health sector initiatives such as community health fairs involving: police, education, First Nations and Métis, harm reduction programs, community initiatives and select health programs meaningful to this community.

v) Continue to support the IDU Continuum of Care Partnership B.R.I.D.G.E. that brings together agencies that work with persons who inject drugs.

b) Develop and deliver a standardized orientation and training program/certification in HIV care for all front line staff and community partners. Ensure core competencies are present to support interventions, skill development and consistent messaging tailored for addicted clients.
Incorporate cross-training between programs and task shifting to support cultural competencies as appropriate.

c) Incorporate cultural competency requirements in the hiring process for front line staff. Include Strengthening the Circle staff in the development of interview questions and include in the interview process.

d) Advocate for and collaborate with the Ministry of Health to develop an HIV Provincial Program accountable for:
   
   i) The adoption/development and implementation of provincial HIV prevention, treatment and care guidelines.
   
   ii) The development and support of a provincial registry for treating practitioners.
   
   iii) A repository for best practice and distribution.
   
   iv) The recruitment of family physicians and formal mentorship including training of family physicians and nurse practitioners.

e) In addition to the previously identified integration recommendations for treatment and care:
   
   i) Secure a location in the core community to provide low threshold multidisciplinary services to most at risk populations through a strong engagement model. Consider integration of services such as:
   
   - STI, tuberculosis and HIV/hepatitis testing and treatment, harm reduction services, Mental Health and Addictions, abscess care, home care and other supportive community services.
   
   ii) Utilize this fixed site location to support innovative service delivery such as outreach services.

f) Collaborate with Strengthening the Circle and bring aboriginal components to care through partnerships. Support First Nation and Métis communities to design and implement HIV prevention, treatment and support for First Nations and Métis.

g) Work with community based organizations such as AIDS Saskatoon to establish a strong peer to peer support program modeled to support a hierarchy of harm reduction.

h) Provide health care workers with the knowledge and skills to practice non-discriminatory behaviour through harm reduction training sessions on injection drug use and HIV in partnership with Peoples Strategies, B.R.I.D.G.E. Saskatoon’s Primary Prevention and Health Promotion Pillar and Strengthening the Circle.

i) Develop treatment and self-management guidelines to support health care staff in the delivery of abscess care, drug withdrawal and pain management.

5. Investing in strategic information to guide a more effective response

   a) Participate in enhanced surveillance activities to inform programming, monitor trends and track HIV cases, referrals and outcomes.

   b) Collaborate with the Ministry of Health to identify the data required to inform programming. Consider collaboration with the Health Quality Council to identify appropriate indicators and sources of data.

   c) Identify data management and research deficits and partner with Regional Health Authorities, the prairie province collaborative and the Ministry of Health to initiate development and integration of data systems and research opportunities.
d) Develop a partnership agreement between the Ministry of Health and SHR HIV programs to utilize current surveillance and treatment data to enhance prevention and treatment opportunities, prevent duplication, guide planning and evaluation.

The Cost of HIV Care

In Southern Alberta a study which included all HIV infected clients within their geographic area estimated costs of care stratified by CD4 cell count over a 9 year period (1997-2006). The mean cost per patient per month (pppm) was identified as $1,159 in 2005/06. The cost of care increased to $2,687 if the patient presented with advanced HIV status (CD4 cell count ≤75). A study in the United States estimated the cost of caring for an HIV positive patient who was also diagnosed with mental illness and substance abuse to be $3,880 (USD) per patient per month.(9)

We have not been afforded the resources or tools to calculate the costs pppm or per annum for HIV positive patients in Saskatchewan. We can however, safely estimate that without early diagnosis and appropriate interventions, health costs will increase for this population. By extrapolating on the costs as outlined above, the best we can estimate at this time are the strategy costs referenced below to prevent infections, manage and lower the costs for HIV care.

The departments that provide HIV care within SHR include Mental Health and Addictions, Chronic Disease Management, Pharmaceutical Services and Public Health Services. The cumulative annual budget these departments targeted for HIV care is $1,376,075. The budget particulars are as follows:

- Salaries $948,756 and Benefits $180,264
- Vehicle Operation/Transportation $ 22,712
- Harm Reduction Supplies $200,158
- Other Expenses $ 24,186

In addition, Saskatoon Tribal Council Health and Family Services Inc. have currently targeted $280,000 in salaries, transportation and programming expenses for HIV care.

In the face of this concentrated epidemic, these dedicated resources are not sufficient to prevent, treat and support HIV care in this region. This strategy includes an implementation plan, with an attached budget for the next 3 years (Appendix A)

Appendix B is a synopsis of the HIV Strategy budget for the region of Saskatoon. The essential start up costs and incremental funding is outlined. as follows:

**Year 1 Annualized Cost:**

<table>
<thead>
<tr>
<th>Quarter</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fall 2010:</td>
<td>$1,185,628</td>
</tr>
<tr>
<td>Winter 2010:</td>
<td>$881,741</td>
</tr>
</tbody>
</table>

Healthiest people ~ Healthiest communities ~ Exceptional service
Year 1 Total: $2,067,369

Year 2 Annualized Cost: $3,236,930
(Includes sustained funding for year 1 initiatives)

Year 3 Annualized Cost: $3,613,582
(Includes sustained funding for year 1 and 2 initiatives)

Total 3 year Cost: $8,917,881

Sustainable Cost: $3,611,782
(excludes inflation and wage increases)

If the interventions outlined in the document are not supported to a significant degree, we can expect costs to rise; care to increase in complexity and mortality to escalate.

To achieve a comprehensive response to HIV/AIDS the literature is clear that the above interventions must be enhanced together to prevent and overcome bottlenecks which inhibit care. In addition, this strategy has identified that collaboration between those who can influence the determinants of health and those who deliver health services is required to impact the health of this community. HIV has now challenged us to work together in a way we have not done before. A creative strategy is required to ensure a successful response that will stop the virus, save lives and properly utilize limited health care resources.
Introduction

Epidemiology

The Saskatoon Health Region (SHR), along with other health regions in Saskatchewan, has experienced a marked increase in new HIV infections (See figure 1). Saskatchewan presently leads the country in rates of positive HIV reports at 19.2/100,000 population. (38) Between 2005 and 2007, SHR was responsible for 53% of the new cases (See figure 2) compared to all health regions in Saskatchewan. In 2009, the HIV rate in SHR was 31.3/100,000. The large majority of new infections are acquired through the sharing of injection drug equipment. Persons affected by HIV are often marginalized, experience stigma and discrimination and suffer from lack of housing, employment and transportation.

Figure 1: HIV cases reported by gender, SHR 1997-2009

Figure 2: Proportion of HIV cases in SHR by RHA 2005 - 2007
The Development of the HIV Strategy Framework for Communities in Saskatoon Health Region (SHR)

In response to the marked increase of new HIV cases within SHR, the development of an HIV strategy was initiated. The intent was to identify the prevention, treatment and support needs of those in our community who are most at risk and are increasingly infected and affected by HIV. The critical components utilized in the development of this strategy include:

- Building the framework around the Expanded Chronic Care model.
- Consultations with our community and health sector partners, experts, and persons affected by HIV or injection drug use; hereafter known as stakeholders. Through their feedback, themes were compiled; strengths and gaps in care were identified.
- Identification of best and promising practices and learning from other provinces’ successes and challenges.

This information was organized utilizing the recommendations from The World Health Organization (WHO) April 2009 document *Priority Interventions: HIV/AIDS prevention, treatment and care in the health sector.* [47] This served as a guide to further determine the priority interventions for this strategy and is reflective of many priorities identified by the Saskatchewan Ministry of Health HIV Task Working Group. [37]

At the close of this document (Appendix A) is an attached implementation plan addressing timelines, work plan activities, deliverables and budgetary impact. The timelines are based on several factors which may include initiatives currently underway, strategies that require little to no additional financial resources, projects that have received provincial funding or ideas that require reorganization rather than additional resources.

Appendix B is a synopsis of the HIV strategy budget for the region of Saskatoon. The essential start up costs and incremental funding is outlined.

Although we were able to consult with many stakeholders, we acknowledge that the consultations were limited in a number of areas. A significant proportion of those at risk within our community are of First Nations and Métis ancestry. To that end additional consultations and supportive plans to address these concerns, within the urban and rural areas of SHR are required. This is built into the strategic plan. We also acknowledge that the interventions within this strategy have a strong focus on those over-represented in our current HIV case numbers. This does not infer that the needs of those populations, who are not heavily represented in our new cases, are to be forgotten. The strategies that have been successful in decreasing those infections must be sustained and revisited to ensure the HIV prevention, treatment and support needs of these populations are met.

To achieve a comprehensive response to HIV/AIDS, the health sector and community must take responsibility for delivering interventions to prevent new infections, and to improve quality of life and avert premature death in adults and children living with HIV. The enclosed interventions will constitute an effective and equitable response to
HIV/AIDS if implemented together at sufficient scale and intensity. (47)

**Responding to HIV as a Chronic Disease**

Chronic conditions are increasingly a primary concern of health care systems world-wide. Chronic care is not, however, limited to non-communicable diseases. Health care specialists are acknowledging that HIV has now shifted from an acute to a chronic condition since the advent of highly active antiretroviral therapy (HAART) and improved prophylaxis against opportunistic infections. Use of HAART since 1996 has resulted in excellent client outcomes, reducing AIDS related morbidity and mortality. Auberg (2006) summarized studies showing that not only does HIV meet the criteria for a chronic illness when medication is available, but given the increased life span of people living with HIV; this means that they will develop similar chronic diseases to non-HIV populations. (1) A study conducted in New York City of the leading causes of death for those with HIV (1999-2004) identified that the percentage of deaths due to non-HIV related conditions increased from 19.8% to 26.3%. In addition, 76% of the deaths due to non-HIV related conditions were attributed to substance abuse, cardiovascular disease and age appropriate malignancies. (1, 36) Within Saskatoon Health Region (SHR), staff with the Positive Living Program (PLP) have increasingly found themselves dealing with non-HIV related conditions, such as hypertension, cancer, diabetes and cardiovascular disease due to advances in HIV management. Despite these advances, many of the clients continue to present in the late stages of the disease, primarily those struggling with substance abuse. This underlines the importance of HIV testing as part of routine care to identify HIV early and prevent the development of HIV related conditions.

This paradigm shift supports a need for comprehensive health care services developed around a self-management model, similar to those needed for diabetes, chronic obstructive pulmonary disease (COPD) and cardiovascular care. Self-management models support clients to assume an active and informed role in their health decisions. Clients are challenged to change behaviors and social relations to optimize health and proactively address the challenges of their chronic disease. Similar to diabetes and COPD; HIV requires lifetime changes in physical health, psychological functioning, social relationships and adoption of disease specific regimes.

To address the chronic care needs of those infected and affected with HIV/AIDS in SHR, this strategy supports the adoption of the Expanded Chronic Care Model (CCM), Wagner et. al (2001) currently utilized by Chronic Disease Management programs within SHR. (2)

This model was adopted based on:
- growing evidence that clients with chronic conditions do better when they receive treatment within an integrated system with self-management support and regular follow-up;
- evidence suggesting that organized systems of care, not just individual health workers are essential to produce positive outcomes;

Healthiest people ~ Healthiest communities ~ Exceptional service
The evidence that incorporation of the CCM principles into care has successfully changed health care practices and outcomes for chronic conditions in a number of American and Canadian settings including those within SHR.

The Expanded Chronic Care Model is a population-based, data driven, organizational approach to caring for people with chronic disease. The model is organized to enable care teams and their clients to deal proactively with chronic disease resulting in improved clinical outcomes and quality of life and reduced utilization of health care services long term. This system supports the development of informed activated clients and prepared proactive teams. It is the business of preventing acute complications in chronic disease.

The Expanded CCM (figure 3 next page) describes the influence of the health care system and the community, where a porous border between the two represents a flow of ideas, resources and people. Within this, the elements that encourage high quality chronic disease care are: self-management support, decision support, delivery system design, clinical information systems, and healthcare organization and leadership. In addition, this model takes into account the determinants of health such as poverty, nutrition, and housing which do not necessarily have a strong link to health care services or personal choice. Therefore a comprehensive approach to prevention is included through the elements of building healthy public policy, creating supportive environments, and strengthening community action. These elements include activities that the health sector can undertake themselves, some that require partnerships with community groups and governments, and others that require health care professionals and leadership to take an advocacy role. This integrated approach is aimed to assist the health care system to effectively “reduce[s] the burden of chronic disease, not just by reducing impact on those who have the disease but also by supporting people and communities to be healthy” (Barr et al., 2003, p.76).

A directional document by Kreindle et al (16) summarizing research evidence on how a system can be designed to better support chronic disease management and prevention suggested the following top priority areas to focus upon:

1. Delivery System Redesign – improving access through scheduling that supports same day appointments and provision of multidisciplinary teams through redesign and reorganization of health care roles.
2. Expansion of self-management support involving skill development targeted to clients with the least ability to manage their health.
3. Pursuing collaboration and opportunities with other sectors and community organizations to tackle the unmet non-health needs that are leading certain clients to over utilize health services.

This strategy has incorporated all of the CCM elements required for its success, with plans for ongoing evaluation and redesign where required. This has ensured that the HIV interventions identified in this document are appropriately integrated into both the health and community services within this region. Further to this, the intent is that this model will be implemented at all levels of programming developed to support this strategy.
Expanded Chronic Care Model:
Integrating Population Health Promotion


Community

Health System

Build Healthy Public Policy
Create Supportive Environment
Strengthen Community Action

Self-Management Develop Personal Skills
Delivery System Design/Re-orient Health Services
Decision Support
Information Systems

Activated Community
Informed Activated Patient
Prepared Proactive Practice Team
Prepared Proactive Community Partners

Productive Interactions & Relationships
Population Health Outcomes/Functional & Clinical Outcomes

Healthiest people ~ Healthiest communities ~ Exceptional service
Responding to HIV using the World Health Organization (WHO) Priority Interventions

The World Health Organization (WHO) promotes and supports initiatives in the health sector and in April 2009 released the document called Priority Interventions: HIV/AIDS prevention, treatment and care in the health sector. (47)

WHO has established five priority strategies for action where critical investment must occur to make significant progress towards the goal of universal access by 2010. Universal access is defined as “an environment in which HIV prevention, treatment, care and support interventions are available, accessible and affordable to all who need them. It covers a wide range of interventions that are aimed at individuals, households, communities and countries.” (WHO, 2009, p.1). (47)

These five strategies are:

1. Enabling people to know their HIV status;
2. Maximizing the health sector’s contribution to HIV prevention;
3. Accelerating the scale-up of HIV/AIDS treatment and care;
4. Strengthening and expanding health systems;
5. Investing in strategic information to guide a more effective response.

Additionally, WHO promotes a public health approach to the delivery of health services for HIV. Key principles include tailoring interventions to the type of epidemic and to the context of the epidemic.

Saskatoon Health Region (SHR) is situated in what the WHO defines as a concentrated HIV epidemic. In this scenario, “HIV has spread rapidly in a defined sub-population, but is not well-established in the general population. This epidemic state suggests active networks of risk within the sub-population. The future course of the epidemic is determined by the frequency and nature of links between highly infected sub-populations and the general population. Numerical proxy: HIV prevalence is consistently over 5% in at least one defined sub-population, but is below 1% in pregnant women in urban areas” (WHO, 2009, p.4). (47)

In 2008 a SHR needs assessment found that 23.8% of persons who accessed Street Health programming indicated that they knew they had HIV. (29)

The WHO also assists in selecting and prioritizing interventions and service delivery approaches. It is suggested when dealing with all epidemics to:

- Place top priority on enhancing prevention and select prevention strategies that match the pattern of transmission;
- Focus on geographical areas and populations where HIV is spreading most quickly;
- Select approaches to HIV testing and counselling that will increase entry to prevention, treatment and care;
- Plan for accessible treatment and care services by those affected, which may require redesign of services that are acceptable to persons who use injection drugs and sex trade workers;
- Select the most effective delivery of service: through households, communities, health centers, hospitals or outreach;
Ensure HIV testing, counselling, prevention, treatment and care services include outreach services to most-at-risk-populations (WHO, 2009, p. 5). (47)

In concentrated epidemics, the additional following interventions are suggested:
- Target interventions to most-at-risk populations, such as sex trade workers, persons who use injection drugs, men who have sex with men;
- Prioritize special interventions for injection drug use whenever the practice is identified;
- Ensure adequate coverage for prevention strategies;
- Use outreach by peers or people trusted by the affected population (WHO, 2009, p.5). (47)

It should be noted that in a concentrated HIV epidemic in a sub-population of injection drug use, such as SHR is experiencing, a comprehensive harm reduction package of HIV prevention, treatment and care for IDUs should include the following nine strategies:
1. Needle and syringe programs;
2. Drug dependence treatment – opioid substitution therapy;
3. Targeted information, education and communication for persons who use injection drugs;
4. Enabling people to know their status;
5. HIV treatment and care;
6. Promoting and supporting condom use;
7. Detection and management of sexually transmitted infections;
8. Prevention and treatment of viral hepatitis;

Guiding Principles*

- Introducing and basing all programming around a Harm Reduction philosophy – meet the person where they are at;
- Lowering threshold access to services such as: street level access, walk in, no appointments, multiple chances, multiple access sites;
- Providing a Patient First approach by being flexible with the clients; focusing on their needs;
- Sustaining ongoing care;
- Providing a continuum of care, interdisciplinary, holistic, with no fragmentation;
- Enhancing linkages and partnerships;
- Integrating the best and most promising practices through utilization of local research and quality monitoring;
- Integrating the vision, mission, values and the strategic directions of Saskatoon Health Region;
- Motivating and retaining health care workers;
- Engaging clients through self-management and peer based strategies;
- Engaging leaders and advocates to assist in creating new social norms and cultural respect.

*The principles above reflect a mix of community, expert and literature viewpoints.
1. Enabling people to know their HIV status

Current Practice

Ensuring there is every opportunity for people to be tested for HIV, especially those who practice high risk behaviors is a crucial first step in recognizing the extent of the epidemic.

In Saskatoon Health Region (SHR), nominal and non-nominal HIV testing is offered through family physicians, mediclins, Sexual Health Center (formally Planned Parenthood Saskatoon) and emergency rooms.

In addition to nominal and non-nominal testing, Public Health Services also offers anonymous HIV testing. Testing is offered at a variety of fixed sites such as the STI Clinic, Saskatoon Corrections Services and Brief and Social Detox (Larson House). Additionally, outreach services offer mobile HIV testing opportunities.

The ELISA screening test is performed via Saskatchewan Disease Control Laboratory (SDCL) in Regina on all venous samples followed by a confirmatory western blot on indeterminate and positive results. The turn around time for results is typically 7 - 14 days. Positive HIV results are the only reportable communicable disease that is mailed to testing practitioners and the medical health officer, resulting in delays when compared to other communicable diseases which are faxed.

It is known that the quality, breadth of topics and opportunity for informed consent varies widely in pre-test and post-test counselling among practitioners.

Currently, Public Health Services follows or offers assistance to testing practitioners of all new HIV positive case reports to ensure that the following issues are addressed:

- Timely notification of the result with opportunity to discuss HIV epidemiology, disease process and AIDS.
- A discussion on HIV transmission, risk reduction behaviours and the responsibility to prevent transmission through informing sexual and injection partners.
- HIV surveillance reporting requirements and elicitation of sexual, injection and social partner names.
- Identification and referral to social supports including case management support for pregnant or very ill clients.
- Discussing and offering publicly funded immunizations and additional STI / BBP testing followed by referral to medical supports for ongoing HIV medical care.

The Community Voice

- There are inconsistent standards of practice for pre-test and post-test counselling.
- There are limited locations offering HIV testing and outreach services.
- Point of care (POC) HIV testing is not available. This would reduce the waiting time for results and increase uptake.
Public Health has limited resources to support intensive partner notification, counselling and testing.

**Best and Promising Practices**

HIV testing and counselling services are the gateway to HIV prevention, treatment and support. The knowledge of HIV status has benefits at the individual, community and population level.\(^{(45)}\)

At the end of 2008, an estimated 26% of the 65,000 persons living with HIV in Canada were unaware of their infection. This hidden group cannot take advantage of appropriate care, treatment and counselling to prevent further spread of HIV until they are tested and diagnosed.\(^{(33)}\)

The Canadian HIV/AIDS Legal Network outlines the requirement for pre-test counselling that provides for informed and voluntary consent. Post-test counselling should provide opportunities for knowledge transfer, referral, support and counselling appropriate for HIV negative or positive results.\(^{(8)}\)

In low and concentrated epidemics, WHO recommends that programs focus on increasing access and uptake among most at risk populations. Furthermore, provider initiated testing should be considered in STI clinics, clinics who serve most at risk populations, where clients come for antenatal, childbirth and postpartum services and in tuberculosis and hepatitis related services.\(^{(47)}\)

The WHO states that when efforts to expand access to HIV testing are initiated that rapid HIV tests are recommended. Quality management systems should be established at all sites carrying out HIV testing.\(^{(47)}\)

HIV testing and counselling is recommended for sex and drug injecting partners or in children where vertical transmission is suspect.\(^{(47)}\)

Identification of exposed persons is contingent on the client and provider building a relationship of trust that ensures confidentiality is maintained. Partner name elicitation techniques are essential to assist with recall.\(^{(5)}\)

Additionally, adopting the social network approach allows clients a safe environment to disclose the names of persons who may be at risk without admitting to incriminating behaviors.\(^{(12)}\)
SHR Key Interventions

- Adopt or create standards of practice for pre and post-test HIV voluntary counselling and testing (VCT) such as the Ontario “Guidelines for HIV Counselling and Testing” to create consistent approaches to practice. (25)

- Increase access for HIV testing and counselling to most at risk populations through:
  - Securing a fixed core community site offering multidisciplinary services (e.g.: STI, HIV, hepatitis, tuberculosis testing and treatment, Addictions and Harm Reduction services) around an engagement model.
  - Increasing or initiating HIV testing at current locations offering services to most at risk populations (e.g.: Larson House, Saskatoon Corrections Center, AIDS Saskatoon, West Side Community Clinic, STC Health Center and the Methadone Program).
  - Scaling up efforts of outreach services to locate most at risk persons.

- Participate in the expansion of point of care (POC) HIV testing to additional sites and outreach settings. Advocate for consistent standards of practice such as pre and post-test counselling, selection of target population, laboratory requirements, test implementation and quality assurance measures.

- Support efforts to obtain, locate, notify and provide voluntary counseling and testing (VCT) to sexual, injection and social partners at risk of exposure to HIV. Provide training in partner name elicitation techniques.
2. Maximizing the Health Sector’s Contribution to HIV Prevention

HIV prevention in the Saskatoon Health Region (SHR) includes a wide range of services within and outside the health sector. These services include provision of education regarding harm reduction and distribution of supplies, treatment of sexually transmitted diseases, hepatitis C and substance abuse as well as prevention of HIV perinatal transmission.

Our community stakeholders and experts identified numerous strengths and challenges regarding prevention of HIV and the resulting client experience. Areas of discussion included the following categories:
- Enhancing access to harm reduction supplies;
- Increasing access to STI clinical services in the core community;
- Immersion of addictions recovery programming in needle exchange;
- Injection drug use - peer to peer programming;
- Hepatitis C counselling and treatment - preventing HIV and HIV/Hepatitis C co-infection;
- Prevention of perinatal transmission.

Enhancing Access to Prevention Education and Harm Reduction Supplies

Current Practice

It is commonly known that HIV is prevented through safer sex and safer injection. Services targeting the distribution of harm reduction supplies such as condoms, needles, biohazard containers, spoons, and filters are offered daily by Public Health Services (PHS), Saskatoon Tribal Council Health Center (STC Health Center) and AIDS Saskatoon. PHS and AIDS Saskatoon recently began offering sterile water in fall 2009. The needle exchange policy allows for persons who inject drugs to obtain as many new needles as they return and up to 20 new needles are provided to clients with no returns. In 2009, all three partners providing needles maintained an exchange rate of over 92%. [40]

SHR has 20 needle drop boxes located in the city limits with a few situated in the core neighborhoods. Disposal options are limited for homeless people who lack transportation. Access is also limited due to our cold winters.

The Community Voice

- The harm reduction philosophy is not universally supported or understood by all community members or professionals.
- The Harm Reduction Pillar of the B.R.I.D.G.E Injection Drug Use (IDU) Continuum of Care Partnership developed a Harm Reduction definition for all members in 2008, [32]
- The extent of harm reduction training is unknown for SHR sites or community partners.
- There is inconsistent distribution of condoms and lubricant in organizations working with most at risk populations.
- SHR is lacking a full range of harm reduction supplies for injecting and
smoking drugs; including ties, water, cookers, pipes and screens.

- A policy is required that supports persons who use injection drugs to obtain all the injecting equipment they require for themselves and others.
- There are insufficient numbers of needle drop boxes in areas where high risk needles are found.
- Advocacy for harm reduction in prisons is crucial.
- Supervised safe injection should be considered.
- An understanding of the use of preloaded syringes by dealers is crucial to understanding the role this issue may play in transmission.

**Best and Promising Practices**

- Promoting male and female condoms should be scaled up as part of a comprehensive HIV prevention program. [47]
- Community based interventions should include peer outreach to provide information on HIV/STIs, risk reduction counselling and the distribution of prevention supplies such as condoms and clean injection equipment. [47]
- During site visits to Vancouver’s downtown east side, it was observed that clean needles, condoms and other harm reduction supplies were available at most agencies, in back alleys and even staffed by peers.
- Evidence shows that counselling and condom provision in HIV serodiscordant couples is effective in preventing HIV transmission since most people living with HIV will remain sexually active. [47]
- “Stand alone interventions are known to have little impact, so policy makers should insist on a comprehensive package of interventions” (WHO, 2009, p. 24). [47]
- “A range of injecting equipment, paraphernalia and facilities for the safe disposal of used equipment should be available from a range of centre based specialist services, pharmacy needle exchanges, outreach (including peer delivered and secondary needle exchange)” (United Kingdom Harm Reduction Alliance, 2006, p. 3). [42]
- All needle exchange programs must:
  - allow injectors to take all the injecting equipment they need for themselves and the people they inject with;
  - not place limits on the amounts of injecting equipment people can take away; and
  - not routinely limiting distribution of equipment to those who do not bring back used equipment. [42]
- An assessment of harm reduction needs in the Saskatoon area [29] demonstrated that insufficient needles were available to clients, that weather and transportation were the largest barriers to bringing back used needles and that location and times were the largest barriers to obtaining enough new needles for each injection.
- During site visits to Vancouver’s downtown east side, it was observed that many needle distribution sites had adopted a needle distribution philosophy which allowed clients to take as many needles as required.
- WHO cites that it is critical that needle syringe programs cover the safe disposal of used equipment through education, needle exchange programs and placement of sharps containers in areas where drug use occurs. [47]
- A recommendation from the Saskatoon Health Region B.R.I.D.G.E.
IDU continuum of care partnership is to expand outreach services through existing organizations.\(^{[30]}\)

In June 2008, the Saskatchewan Provincial Government called for an independent review of needle exchange programs in Saskatchewan. The report, released in February 2009, states “Best practices in reducing the spread of HIV include integrating needle exchange with other services, outreach services, and peer distribution (all of which Saskatchewan has), and peer educators, and prison needle exchange (Saskatchewan uses peer educators on a limited basis, and does not do any prison needle exchange). Recent research also shows that aggressive contact testing, contact tracing, and education of HIV positive injection drug users can reduce spread of HIV” (Thompson, 2009, p. vi).\(^{[18]}\)

**SHR Key Interventions**

- Expand locations providing free condoms and lubricant to programs servicing most at risk populations.

- Increase access to prevention education and harm reduction supplies for injection drug use:
  - Provide persons who use injection drugs with all the equipment they need for themselves and others.
  - Provide a full range of harm reduction supplies: cookers, sterile water, ties, discreet biohazard containers.
  - Consider the implications for the provision of crack smoking kits as an alternative to injection drugs.
  - Purchase vending machines to dispense sterile injection equipment for when needle exchange programs are not open or are difficult to get to due to transportation or weather.
  - Enhance partnerships with reserves and rural areas within SHR to evaluate the need and resources required to expand needle exchange programming.

- Relocate current drop boxes and purchase smaller, discreet needle drop boxes to facilitate disposal of used needles.

- Advocate for the provision of harm reduction strategies including prevention education and supplies in prisons.

- Conduct applied research to better understand the context for needle sharing in our various communities. Involve community based researchers utilizing community sites such as AIDS Saskatoon. Implement leading practices to address prevention opportunities which, may include, but is not limited to, innovative home or apartment-based interventions to mitigate sharing, and if there is street level sharing, consider integrating supervised safe injection as an element of medical clinical practice within services if and when warranted.
Increasing access to STI clinical services

**Current Practice**

Similar behaviors place people at risk for both Sexually Transmitted Infections (STI) and HIV. The presence of an STI can enhance HIV transmission. Accessible STI clinical services contribute to HIV prevention through the provision of STI treatment, condom distribution and education. Currently, STI and HIV testing is offered through the Sexual Health Clinic (Public Health Services), the Sexual Health Center, the Health Bus and through primary care providers.

**The Community Voice**

Satellite STI clinical services linked with other harm reduction services, outreach, surveillance, addictions services and tuberculosis is essential in the core neighborhoods.

- Support for working with recalcitrant persons is necessary.

**Best and Promising Practices**

- A range of models for delivering STI services is required to ensure access to most at risk populations. (47)
- The Canada Communicable Disease Report March 2005 outlines a public health approach to persons who fail to disclose their HIV status and should be used as a basis for policy development. (28)

**SHR Key Interventions**

- Provide satellite STI services in the core neighborhoods linked with other harm reduction services, outreach, surveillance, addictions services and tuberculosis programs.
- Create supports and counselling to recalcitrant persons.
- Train staff on recalcitrant behavior assessment, counselling, support and documentation.
Immersion of Addiction Recovery Programming into Needle Exchange Current Practice

SHR has identified a significant increase in opiate dependence within the general population. This has contributed to the transmission rate of HIV. There is a strong success rate in treatment of opiate addictions for approximately 600 individuals annually within our community. As the majority of clients who are vulnerable to HIV are struggling with substance abuse, the challenge for Addictions and Mental Health programs is to make this success a reality among injection drug users, sex trade workers and First Nations people within the core community. The ability to immediately respond with addictions support at the moment of opportunity will prevent HIV transmission and improve addictions treatment success rates.

- Currently, all needle exchange programs are staffed with outreach workers. Needle Exchange is provided through Public Health services (PHS), STC Health Center and AIDS Saskatoon. In the past, a trained addictions worker accompanied outreach staff in the PHS health works van.
- Presently there are no addictions staff engaged in needle exchange programs.
- Within SHR, the majority of persons who use injection drugs are opiate dependant.
- SHR has a Social Detox Unit with twelve male beds and six female beds. The Detox center is able to support opiate withdrawal and recovery services for individuals who can manage a detox from opiates.
- For clients unable to succeed with an opiate free lifestyle, Methadone Assisted Recovery is a viable option.
- SHR provides a Methadone Assisted Recovery Program in partnership with the College of Physicians and Surgeons. This program is staffed by three physicians and two Addictions counselors. In addition, there is one independent physician in the community. With these limited resources few high risk opiate users reach recovery.
- Many Mental Health and Addictions Programs are modeled with an appointment structure, limiting access.
- SHR continues to use old recovery models which embrace abstinence, resulting in limited support of the harm reduction hierarchy in the treatment process.

The Community Voice

- Access to Opiate Substitution Therapy (OST) or Methadone Assisted Recovery could be enhanced if there was a reduction in wait times.
- There is limited secondary prescribers for OST, therefore recruitment is required.
- There is no access to Opioid Substitution Treatment (OST) on reserves.
- It has been suggested to consider expansion of social detox to offer optional locations.
- It has been noted that the root causes of IDU have not been consistently addressed within the treatment process.
**Best and Promising Practices**

- “For individuals with opioid dependence, the most effective treatment is Opioid Substitution Therapy (OST). There is good evidence that OST leads to substantial reductions in illicit opioid use, criminal activity, deaths attributed to overdose, and risk behavior related to HIV transmission (including injection frequency and sharing of injection equipment). Studies have also demonstrated that OST improves retention rates in drug dependency treatment, adherence to antiretroviral therapy, and overall health and well being” (WHO, 2009, p. 25). [47]

- Messages on risk reduction should encourage persons who use injection drugs to adopt progressively less risky behaviors such as moving from indiscriminate sharing of equipment; to reducing the number of sharing partners and frequency; to cleaning used equipment; to using only sterile equipment; to adopting non-injection use and finally to abstinence. [47]

- WHO also addresses targeted interventions for persons who use injection drugs. Community-based outreach is identified as the most effective way to deliver HIV prevention, treatment and care to persons who use injection drugs, referring them to specific services for opioid substitution therapy and antiretroviral therapy. [47]

- It is recommended to have a comprehensive package of interventions, with key interventions scaled up until they cover all drug users. Stand alone interventions are known to have little impact. [47]

- “…abstinence-oriented treatment among program team members is associated with being an obstacle to providing effective treatment” (Jamieson et al., 2002, p. 53). [14]

**SHR Key Interventions**

Expand and strengthen working partnership by further integrating Mental Health and Addiction Services and Public Health Services together at multiple sites. Immerse addictions workers in needle exchange sites, implementing interventions based on the harm reduction hierarchy model supporting effortless movement into recovery programming.

Partner with community based organizations to provide Addictions Services and Mental Health support to clients within their home neighborhoods.

- Cross train Saskatoon Health Region health care workers to recognize, intervene and support persons who use injection drugs at all SHR sites. Incorporate mental health, elder counseling and cultural supports into client care plans to address the root causes of injection drug use.

- Enhance access to Opiate Substitution Therapy through targeted recruitment of prescribers. Advocate for methadone access in appropriate rural sites within SHR.
Injection Drug Use - Peer to Peer Programming

Current Practice

- Saskatoon Health Region (SHR) community agencies who work with persons affected by HIV and injection drug use (IDU) have limited to no peer to peer programming.
- Funds to support leadership and participation in peer to peer programming are not available.

The Community Voice

- The community feels that peer to peer programming for persons who use injection drugs would be beneficial.
- Incentives should be available to peers for participation and leadership in peer to peer programming.

Best and Promising Practices

- The World Health Organization (WHO) believes that meaningful involvement of people living with HIV is central to an effective HIV response. They should be involved in all aspects of the Health sector response to HIV. (47)
- “Include client / client education on reducing needle use and sharing and other HIV transmission risk behaviors” (Jamieson et al., 2002, p. 75). (14)

SHR Key Interventions

- Develop injection drug use peer to peer programs to support risk reduction behaviors. Include clients in the development of harm reduction and addictions programming.
Hepatitis C Counselling and Treatment – Preventing HIV and HIV/Hepatitis C Co-Infection

Current Practice

- Within Saskatoon Health Region (SHR) there were 227 new cases of hepatitis C in 2008 (76.1/100,000). Of note this does not include people who live on reserve and would be counted under First Nations Inuit Health data.\(^{(13)}\)
- The Positive Living Program (PLP) provides treatment, care and support for hepatitis C positive clients. There is limited funding for this initiative and HIV care will often take priority within the program increasing wait times for hepatitis C assessments.
- All clients with hepatitis C are tested for HIV in the PLP, through which new cases have been identified.

The Community Voice

- Hepatitis C is prevalent in this high risk community. It is often a precursor to HIV as it is transmitted in the same way. Services specifically targeting and engaging those who are Hepatitis C positive before they become co-infected with HIV is a logical avenue through which HIV transmission can be diminished.
- Community clinics situated in the core area have identified significant numbers of hepatitis C infected clients who are at high risk for HIV infection due to ongoing risky behaviours.
- Co-infection with hepatitis C and HIV makes HIV more difficult to treat.
- The PLP has developed a partnership with Methadone Assisted Recovery (MARS) to identify hepatitis C clients interested in treatment and provide hepatitis C treatment services on site.

Best and Promising Practices

- Within populations of persons who use injection drugs, effective HIV prevention programs focus on enhancing motivation to change behavioral patterns, teaching concrete strategies and behavioral skills to reduce risk, providing tools for risk reduction and reinforcing positive behaviour change.\(^{(35)}\)
- Reducing the risk of HIV in drug users is an achievable goal. Appropriately designed prevention programs can reduce transmission of not only HIV, but other blood borne diseases. This requires a comprehensive range of coordinated services in a wide range of settings including drug abuse treatment facilities.\(^{(23)}\)
- Participation in substitution maintenance therapy provides opportunity for early diagnosis of other health problems, counselling and testing, and referral for additional services. The best drug treatment programs provide counselling and testing for HIV and hepatitis C, immunizations for hepatitis A and B and counselling on the reduction of high risk behaviour. They are encouraged to be involved with HIV treatment, care and support as necessary to support their clients.\(^{(49)}\)
- HIV positive persons with chronic hepatitis C tend to experience more rapid liver disease progression than with hepatitis C alone and may benefit from earlier treatment.\(^{(26)}\)
### SHR Key Interventions

- Expand the services of the Methadone Assisted Recovery program to provide HIV/Hepatitis C testing through partnering with Public Health Services.

- Implement targeted interventions to promote behavior change to prevent HIV and hepatitis C infections.

- Build on the partnership between Methadone Assisted Recovery Program and the Positive Living Program to integrate hepatitis C treatment with methadone programming.

- Determine the need and capacity to provide an HIV and tuberculosis satellite service at the Methadone Assisted Recovery Program.
Prevention of Perinatal Transmission

Current Practice

Within our health region many HIV infected women and those within our most at risk population receive care in pregnancy through:

- The Westside Community Clinic (WSCC); including a monthly obstetrical satellite clinic provided by an obstetrician.
- Obstetrical specialists and family physicians.
- The acute care services which support women with their antenatal, labor and delivery and post partum care.
- Positive Living Program (PLP) providing preventative treatment for mom and baby; coordinating care between acute care and community before, during and after birth.
- Within the last 2 years, the PLP has followed 33 HIV positive mothers at various stages in their pregnancy and their infants up to the required 18 months of age. There have been 7 cases of perinatal transmission since 2005 where the mothers did not receive prenatal care or HIV testing.

As one stakeholder stated:
“Babies have been born HIV positive in Saskatchewan and that should be a never event”

Prevention of perinatal transmission is a crucial intervention within our region. The Positive Living Program, labor and delivery and post partum wards have combined their efforts to provide anti-retroviral therapy (ART) to prevent perinatal transmission. A combination of several interventions is required for those programs to achieve successful outcomes.

Following the birth of these infants, the family unit may become involved with:

- The Ministry of Social Services;
- Child Protection Services;
- PLP case manager (when pilot funding is available);
- Other health services such as STC Health Center, Kids First, Healthy Mother Healthy Baby.
- The Kids First Program provides programming to support the family unit including vulnerable children with their growth and development. They provide these services in collaboration with the Saskatoon Tribal Council and WSCC. Intensive home visits, child care, early learning supports, mental health and nursing services are delivered through this program.

The Community Voice

- Obstetrical and gynecological care in the core community is limited. Despite varied partnerships with associated services, this care is not fully integrated with testing, prevention, mental health and addictions, HIV treatment or community support services.
- The current funding structure available to our SHR family physicians and specialists does not support their consistent presence at satellite sites for most at risk persons.
- The majority of our clients struggle with addictions. We are missing the Mental Health and Addictions
service component in the prevention of HIV perinatal transmission.

- SHR does not have a standard process or position permanently funded to provide case management support for mothers and their infants to eliminate barriers to care and support treatment adherence through engagement.

- Many moms at risk are hesitant to or do not access prenatal care or plan for postnatal care. Barriers to accessing these services include stigmatization, fear of losing their children to social services; a fear of how they will be treated within the health care system. This has resulted in a number of women “going underground” to deliver their babies (home deliveries or on their reserves). This eliminates the opportunity to prevent perinatal transmission.

Stakeholder comments:
“**They know they should access prenatal care, but they are too scared of us.”**

“I have seen many moms go clean during their pregnancy, but their baby is apprehended anyway and then the mom falls off the wagon. That is distressing.”

- Although physicians working within SHR follow the Society of Obstetricians and Gynecologists of Canada (SOGC) recommendations, it appears the percentage of mothers admitted to labor and delivery who previously received antenatal HIV testing or subsequent testing is low.

- It appears that communication to physicians and nurse practitioners regarding the importance of antenatal HIV testing and skill development to support successful uptake is required.

- It was noted that Saskatchewan is missing a formal provincial guideline to guide HIV testing in pregnancy.

- The stat HIV testing process utilized by the labor and delivery ward and Royal University Hospital Laboratory is followed inconsistently resulting in missed opportunities.

- Offering point of care HIV Testing on antenatal and labor and delivery wards would support staff in the identification of HIV positive cases. This would provide the opportunity to prevent transmission where HIV testing results are not available or prenatal care did not occur.

- Policies and standard pre-printed orders for labor and delivery wards to prevent perinatal transmission requires further development. Processes to access and implement signed orders on labour and delivery and postpartum wards should be improved.

- Formal support and education of physicians and staff is required to ensure policies and orders are consistently followed once developed.

- Staff require skills and information to effectively work with this high risk population.

- First Nations involvement and peer to peer support in all areas of prenatal, post-partum and follow up care should be integrated to support this client population.

Stakeholder comment:
“**Pregnancy is an incredible motivator - not the time to be punitive. We must capitalize on this opportunity to engage women.”**
Best and Promising Practices

The Society of Obstetricians and Gynecologists of Canada (SOGC) Clinical Practice Guideline on HIV Screening in Pregnancy\(^{[15]}\) recommends:

1. All pregnant women should be offered HIV screening and appropriate counselling. Documentation should be on the chart.

2. Women should be offered HIV screening at their first prenatal visit; those who decline screening should have their concerns discussed.

3. Women who test negative for HIV and continue to engage in high-risk behaviour should be retested in each trimester.

4. Women with no prenatal care and unknown HIV status should be offered testing when admitted to hospital for labour and delivery. Women at high risk for HIV and unknown status should be offered HIV prophylaxis in labour and HIV prophylaxis should be given to the infant postpartum.

5. Women who test positive for HIV should be followed by practitioners who are knowledgeable in the care of HIV positive women.

All Canadian provinces currently recommend prenatal HIV screening in a variety of models. The recommendations vary from mandatory testing with a mandatory opt out approach to offering screening to all women; encouraging screening, or simply informing the woman that the test is available. Screening rates vary across the country, and national screening rates could be increased by consistent recommendations.\(^{[15]}\)

- The Ontario experience, where 90% of pregnant women agreed to an HIV test in 2004, without an opt-out policy indicates that very high testing rates are possible without compromising on counselling and informed consent.\(^{[8]}\)

- The Canadian consensus guidelines for the management of pregnant HIV positive women and their infants states that the benefits of optimal prenatal, intrapartum and post partum care of the woman and infant will result in significant reduction in perinatal transmission from 25% to less than 1%.\(^{[6]}\)

- HIV testing is currently recommended as part of routine pregnancy care in all Canadian provinces.\(^{[6]}\)

- The Canadian HIV/AIDS Legal Network recommends that Provincial and Territorial Governments in conjunction with health care professionals’ associations and regulatory bodies improve efforts to ensure that all women have access to HIV testing services, and all pregnant women be offered voluntary HIV testing with good pre and post- test counselling. Consent should be obtained when tested.\(^{[8]}\)

- In order to avoid loss to follow up of pregnant HIV positive clients, the WHO states that full integration of HIV intervention delivery within services for antenatal care, childbirth, newborn and postpartum care is a minimum requirement in any locality where HIV infection is common. The WHO defines integration as: “delivering multiple services or interventions to the same client by an individual health care worker or team of health care workers, and possibly workers from other fields” (WHO., 2009, p. 55).\(^{[47]}\)
“Expand current efforts to develop linkages and exchanges between people working in HIV/AIDS and providers of MMT” (Jamieson et al., 2002, p. 75).

**SHR Key Interventions**

**Clinical Support**
- Develop and enhance partnerships between Obstetrics and Gynecology, WSCC, Public Health Services, Mental Health & Addictions Services, and Positive Living Program. Integrate HIV care with the obstetric satellite clinic at Westside Community Clinic. Utilize cross training, outreach and consistent multidisciplinary team meetings to coordinate care, engage clients and ensure access to care at all points of contact.
- Advocate for physicians to receive an optional fee structure to support their attendance at satellite clinics where clients at risk reside.
- Provide targeted mental health and addictions support within the prenatal/postnatal care spectrum to support client success by:
  - Coordinating HIV and methadone treatment regimes for clients initiating or continuing with methadone assisted recovery.
  - Providing pharmacy and addictions support to maintain antiretroviral therapy (ART) adherence, titrate methadone as required and intervene with methadone and ART interactions at all community, acute care and outpatient venues.

**Case Management**
- Develop and integrate case management teams into the HIV care continuum to support the family unit and prevent perinatal transmission.
- Utilize outreach and fixed site service to enhance client engagement.
- Provide case management options by:
  - Imbedding a case management team (case manager, Mental Health & Addictions outreach worker) to work with the Positive Living Program (PLP), WSCC and the Obstetrical satellite clinic at Westside Community Clinic.
  - Integrating HIV clinical support into the Kid’s First case management program. Refer consenting clients to Kids First where appropriate.
  - Enhancing and expanding case management partnerships with AIDS Saskatoon, CUMRI, Healthy Mother Health Baby, STC Health Center, and the Ministry of Social Services/Child Protection Unit to support system navigation and widen access to specialized services including housing, nutritional supports, home visitation and cultural support.
Develop and implement a prenatal and postpartum case management care map to guide case management teams in the provision of best evidence care, supportive relationships and exceptional service. Deliver a standardized training and skill development package to address:
- Achievement of client goals and basic needs;
- Antiretroviral therapy (ART) treatment adherence to prevent HIV perinatal transmission;
- Education and skill development in support of HIV self-management;
- Addictions treatment and recovery;
- Communication with social services/child protection unit to avoid child apprehensions where appropriate;
- Implementation and coordination of strategies to engage mothers in long term planning to support or reunite family units.

Peer to Peer Programming
- Initiate a mother to mother peer mentorship pilot program within the Kids First program to support clients with parenting and life skills, healthy relationships, addictions treatment and recovery and management of health issues.

Prenatal Testing
- Collaborate with the Ministry of Health to develop a provincial HIV testing guideline for HIV testing in pregnancy.

- In collaboration with the Department of Obstetrics and Gynecology, educate family physicians, obstetricians and nurse practitioners on current testing and counselling guidelines for HIV testing in pregnancy to minimize practice variations and enhance testing rates of pregnant women.

- Implement HIV Point of Care (POC) testing on labor and delivery.

- Revise pre-printed orders for utilization on labor and delivery and post-partum units to reflect best practice in the prevention of perinatal transmission for HIV positive women and their infants.

- Develop guidelines to support orders and to guide HIV testing on the units.

- Educate and train applicable staff to the harm reduction philosophy, the new processes and standards, and how to work with most at risk populations.
3. **Accelerating the scale up of HIV / AIDS treatment and care.**

The Saskatoon Health Region (SHR) is experiencing an epidemic of HIV infection, particularly among persons who use injection drugs, sex trade workers, First Nations and incarcerated individuals. On one hand we have success in treating people with HIV and on the other; the challenge is making this success a reality for less privileged people in our community.

Our community stakeholders and experts identified numerous strengths and challenges regarding current treatment and care services and the resulting client experience. Areas of discussion included the following categories:
- Early referral and engagement - barriers to care after HIV diagnosis;
- Provision of care through accessible treatment sites and multidisciplinary teams;
- Treatment preparedness and adherence support through case management;
- Provision of clinical care- supporting the health of clients with HIV;
- Tuberculosis prevention, diagnosis and treatment;
- Transitional and palliative care challenges.

**Early Referral and Engagement - Barriers to Care after HIV Diagnosis**

**Current Practice**

- Public Health Services (PHS) consistently provides referrals to HIV care for newly diagnosed clients. These clients receive appointments with the positive living Program (PLP) nurse clinicians within 2 weeks at the Royal University Hospital (RUH) site; within 2-4 months with the Infectious Diseases Physician clinics at RUH; and within 2 weeks at the Westside Community Clinic (WSCC) satellite clinics. Pregnant or very ill clients are fast tracked into the clinic setting immediately. WSCC will see clients on a drop in basis or through appointment scheduling.
- PLP reported that 50% of newly referred clients do not attend their first appointment. In addition, a PHS and PLP case-management pilot (2006- 2007) project identified at least 75 HIV positive clients living in and around the core area of Saskatoon who had not accessed or had disengaged from care.
- The case management pilot which continued in 2008-2009 resulted in an increase in clinic attendance rates at West Side Community Clinic by 16% and a baseline measurement of ART uptake being 63% of clients.
- Saskatoon Health Region (SHR) does not have a referral tracking system to identify the number of new referrals; average time from referral to HIV appointment; percentage of clients engaged; percentage of clients lost to follow-up.

**The Community Voice**

- If clients are treated with highly active antiretroviral therapy (HAART),
rendering the virus undetectable, the risk of HIV transmission is diminished. If this is coupled with improving the ability to refer people to a treatment provider at the time of need, instead of being referred externally to a place they may never reach, progression of the disease can be prevented and ultimately diminish the rates of HIV in the community.

There is no standard process or dedicated positions to support entry and engagement to care and persons most at risk are frequently disengaging from care.

There are no quality improvement processes to support entry and engagement to care.

Clients will delay, refuse or disengage from care opportunities due to competing priorities including lack of food and clothing, homelessness, addictions, mistrust of health care personnel; limited ability to cope; lack of child care; an inability to manage or remember appointments or inaccessible clinic locations.

Incentives such as basic items for living such as food, help clients engage. We are not providing incentives or pleasant reasons for clients to want to attend.

The Manitoba HIV Program, which includes the Nine Circles Community Health Center and the Winnipeg Health Sciences Center, partnered with Public Health Services – Winnipeg Regional Health Authority to develop and implement a single entry referral process to ensure a consistent approach in the referral of newly diagnosed cases of HIV to the Manitoba HIV program. This program contained a strong outreach component attached to entry to care upon referral. The program strongly believed this was the reason for their engagement success. Nine Circles Community Health Center reported that prior to this process 30% of the clients referred to their program were not engaged. Now that rate is 10%. (Conversation with Carla Pindera, Manitoba HIV Program 2009).

In the downtown east side of Vancouver, all clinical and support sites provide food, clothing and additional incentives for their clients. Outreach and home care nursing personnel provided personalized incentives to engage and build trust. (Observed at the Vancouver site visit, January 2010).

**Best and Promising Practices**

The World Health Organization (WHO) recommends regular monitoring and evaluation of indicators for inputs, processes, outputs and impacts. These are essential to guide programming, measure progress and ensure accountability. (47)
**SHR Key Interventions**

In partnership with the HIV clinical care providers, develop and implement a single entry referral process to connect, engage and retain newly diagnosed clients to HIV treatment services by:

- Utilizing and revising the current Chronic Disease Management referral database to track incoming referrals and coordinate or triage access to care.

- Integrating the referral system with case management/outreach support to enhance engagement and support transportation needs, ensuring outreach is utilized as an entry point to HIV treatment and care services.

- Developing a monitoring and evaluation plan for the referral, triage and engagement system.

- Initiating quality improvement processes to enhance retention and engagement to care.

- Build an incentive fund into the budget and reach out to community churches and organizations to assist with this incentive initiative.
Provision of Care through Accessible Treatment Sites and Multidisciplinary Teams

Current Practice

- Within SHR, HIV care and treatment is primarily provided by two entities. The Positive Living Program (PLP) initiates treatment and provides follow up care. The West Side Community Clinic (WSCC) provides both primary care and HIV management, and will initiate treatment with Infectious Disease (ID) Specialist support. Outside of the WSCC, there is limited support from family physicians where HIV follow-up care is required. This reality has placed a significant strain on these two systems as the HIV diagnoses increase and case complexity heightens.
- Although the Positive Living Program (PLP) provides out patient services at Royal University Hospital (RUH), satellite clinics are not supported by the Infectious Diseases (ID) physicians at Westside Community Clinic (WSCC) on a consistent basis. The PLP nurse clinician and pharmacist are available once per week at this site with the intent to provide a more reliable presence. The WSCC continues to be overwhelmed with the increase in HIV cases and their complex needs.
- There is a high rate of clients not attending their appointments. A redesign of appointment scheduling processes should be considered as appointments appear to be a barrier to care.
- Within HIV clinical care there are varied expectations and roles for the ID physicians and nurse clinicians due to the heightened workload, inadequate family physician support, limited pharmacy and lack of clerical, social work, outreach and case management support. Together with the changing nature of the epidemic, these elements have challenged the efficacy and functioning of these teams.

The Community Voice

- The fluctuating course of HIV and addictions management requires regular interactions between care givers and clients.
- An enhancement of the number and type of staff to support a team approach is required to engage and improve the health of HIV positive clients challenged by social pressures.
- There are limited sites of care for HIV services. RUH is outside the core community which is a draw for some clients and a barrier for others. Sites of care may need to be developed or expanded to enhance HIV care services in the core community to include both mobile and fixed sites.
- Clients like the PLP and Obstetrical services at WSCC.
- Approachable sites of care within SHR include SWITCH, WSCC, Street Health Program Health Works Van, STC Health Center needle exchange, AIDS Saskatoon and the Health Bus.

Best and Promising Practices

- With a concentrated epidemic, the World Health Organization (WHO) recommends that service delivery be made available through outreach workers and outlets in venues accessible and acceptable
to the target population. Suitable service delivery models to secure entry into care and treatment include:

- Outreach approach which involves peers and people who are trusted by the client;
- Self-help or community groups partnering with care services;
- Provision of HIV services within existing health, social or welfare services already targeting this client group. Locate clinical services for this high risk population in their own neighborhoods.\(^{(47)}\)

The delivery system element within the Chronic Disease Management Model calls for a design that encourages and enables productive interactions. The benefits of ready access to a nurse, case manager and other professionals for optimal self-management and assistance with disease control have been demonstrated. Program re-design requiring ready access requires strong leadership, appropriate incentives and effective improvement strategies by the health organization.\(^{(43)}\)

The Directional Document “Lifting the Burden of Chronic Disease ♦ What’s worked ♦ What Hasn’t ♦ What Next” \(^{(14)}\) stated that, of all the Chronic Care Model (CCM) elements to improve chronic disease management delivery system redesign has the most solid evidence. Changing the system is more efficient than trying to change the individual provider’s behaviour.

Identified projects to be considered for redesign include:

- Improving scheduling and organization of care – through advanced access (enabling clinics to offer same day appointments); as well as other initiatives such as changing locations of care to accessible venues; providing telephone based care where appropriate.
- Identification and revision of roles within multi-disciplinary teams to ensure optimal use of skills and prevent service gaps and duplication.\(^{(16)}\)
- “A large multidisciplinary network of people who work in different capacities and locations. All of these individuals could have contact with clients/clients that may, in turn have significant impact on treatment outcomes” (Jamieson et al., 2002. p. 52).\(^{(14)}\)
**SHR Key Interventions**

Redesign and expand the clinical HIV/Hepatitis C services to support the current RUH site, satellite clinics at WSCC and the Methadone Program by:
- Collaborating with the ID physicians to provide consistent scheduling of clinics.
- Collaborating with sites of clinical care to design and provide same day appointments and drop in care for both program and/or physician staffed clinics.

Build multi-disciplinary care teams at fixed and mobile venues by:
- Enhancing the team compliments through partnerships;
- Redesigning and hiring additional staff to include clerical support; MH&A outreach workers; pharmacist; dietician, nurse practitioner; case managers; nurse clinicians; psychologist and community workers.
- Situating team compliments within WSCC, RUH and outreach venues to provide consistent and skilled support in self-management, optimization of therapy, and follow up.
- Ensuring clearly defined roles and collaboration within teams.

Support the recruitment and training of family physicians and multi-disciplinary team members.

Support access to services at WSCC by installing the Laboratory Information System at WSCC.

Identify the need and opportunity for additional sites of care. Consider integration with other programming.
Treatment Preparedness and Adherence Support through Case Management

Current Practice

- Limited funding has allowed for a pilot project to provide case management for HIV positive pregnant women and their infants. Successful outcomes were realized when the combined services of addictions and mental health, HIV care (WSCC and PLP) and social supports provided by STC Health Center. Women engaged in treatment; infants tested negative for HIV and women were supported to provide safe care for their infants.

The Community Voice

- SHR is missing an integrated approach for support of complex care clients. There is no one who sees the “whole picture” of the client and their goals.
- Each program is limited in their collaboration as they do not know who is involved with the client.
- Programs are isolated from each other.
- The addiction dominates the clients and their behaviour, therefore medical care is often not their priority.
- There is no social work position available or funded to support clients.
- Basic needs are not being met making engagement in treatment for HIV a low priority.

- Strong partnerships across programs and care groups are required within the community to support the needs of the clients which are often outside the ability of the health sector.

Best and Promising Practices

Case management should only be considered for carefully targeted clients least able to manage their own conditions. Best outcomes here appear to be for clients with poorly controlled conditions, difficult living situations, lack of knowledge about their illness, lifestyle risk factors, depression, and lack of motivation to change their behaviour, lack of prior linkages to health and community services. [16]

Stakeholder comment

“Disengagement of clients may be due to another priority at hand. They need to know there is a soft place to land when they return to us - no questions asked.”

Healthiest people ~ Healthiest communities ~ Exceptional service
SHR Key Interventions

- Develop and implement case management standards and key interventions aimed at timely access and retention to care, improved quality of life, addictions recovery, and prevention of perinatal transmission.

- Embed case management programming within the referral process.

- Define clients who would benefit from case management support through assessment of their self-management capacity.

- Build case management teams through partnerships, redesign and hiring of additional staff at select venues with outreach capability utilizing:
  - Social work prepared case managers, mental health & addictions and street health outreach workers and community-based organizations to support this process;
  - Current multidisciplinary staff specializing in HIV care and addictions nursing and pharmacists versed in addictions and antiretroviral therapy;
  - Kids First and Healthy Mother Healthy Baby programming for HIV positive women and their infants;
  - STC Health Center, AIDS Saskatoon and Central Urban Métis Foundation Inc (CUMFI) services.

- Develop a consistent referral process to the HIV care teams for clients admitted to hospital. Initiate and coordinate treatment and discharge plans upon admission.
Provision of Clinical Care -
Supporting the Health of Clients with HIV

Current Practice

- Public Health Services trains public health nurses in immunization and authorizes access to the Saskatchewan Immunization Management System (SIMS) for its users. Physicians, primary care nurses and RNs who provide immunization in the health region are required to phone or fax Public Health for verification of previous immunization and subsequently report immunizations administered back to PHS for back entry into SIMS. The PHS site that provides for verification is open 8 am to 4:30 pm Monday to Friday.
- Vaccinations to support the health of HIV positive clients is provided by Public Health Services (PHS), Westside Community Clinic (WSCC) and Positive Living Program (PLP) (by physician order). Verification of past immunizations prior to administration of additional immunizations have caused delays in immunizing and clients leaving care before authorization and immunizations are received.
- There has been opportunity to collaborate with community methadone prescribing pharmacies to provide Directly Observed Therapy (DOT) in select cases with successful outcomes.
- Brief Detox has provided DOT for clients utilizing their services.
- The PLP pharmacist plays an effective role in connecting and educating retail pharmacies, setting up DOT opportunities, navigating and supporting clients through the various federal and provincial drug plans for medication coverage, expediting federal immigration reimbursements, supporting clients with medication interactions and side effects and supporting family physicians and specialists to provide best evidence treatment and care. This role has minimal funding (0.3 FTE), limiting these interventions substantially.
- Infectious Diseases (ID) physicians are traveling to rural areas providing clinics within the Prince Albert Federal Penitentiary, and also within Prince Albert.
- The Live Well with Chronic Conditions (LWWCC) Program provides a structured community based program, licensed by the Stanford Chronic Disease Management Program. The program is delivered by trained lay leaders. The program delivered in SHR is a general program relating to all chronic diseases. Stanford also carries a curriculum targeted for HIV.

The Community Voice

- PHS has lone access to SIMS. Access to SIMS by all staff vaccinating HIV positive clients would improve immunization rates.
- Access to phlebotomy and test center services is limited to 1 day per week at WSCC due to limited lab technology personnel and associated funding. Without test results, it is difficult to move forward on a treatment regime.
- Multiple agencies are working with these complex clients leading to divergent and conflicting goals. Client goals are not consistently
identified throughout the system or within the clinical care.

- There is no maternal child clinic at any site of care.
- Psychology and psychiatry services are not readily available to deal with the root issues of their addiction, behavioral issues, self loathing or for serious depression or suicidal behaviour. Referring clients to emergency departments results in clients disengaging from care.

**Best and Promising Practices**

- Recommendations on immunizations for childhood and adults living with HIV are under review by the World Health Organization.\(^{(47)}\)
- Saskatchewan Ministry of Health provides publicly funds Hepatitis A, B, Influenza and Pneumococcal vaccines to HIV positive persons.
- With a concentrated epidemic, the WHO recommends that service delivery be made available through outreach workers and outlets in venues accessible and acceptable to the target population.
- Within Canada, Tuberculosis Control Programs utilize Directly Observed Therapy (DOT) to ensure adherence to tuberculosis treatment. The following circumstances are given priority for DOT in resource limited settings:
  - Suspected or proven drug resistant organisms;
  - Treatment failure;
  - Injection drug-users/homelessness;
  - Suspected nonadherence or previous nonadherence;
  - Psychopathology;
  - HIV infection;
  - Children.\(^{(31)}\)
- Current evidence in the delivery of chronic disease management services supports a greater role for non-physician practitioners. This involves the transfer of function from one health care provider to another; typically from a physician to a nurse or pharmacist or employment of a nurse practitioner.\(^{(16)}\)
- Research has confirmed self – management support is a highly successful element of the Chronic care Model. Of note, not all interventions were found to be effective. The findings indicated one should:
  1. Avoid programs that solely provide information or education. Programs should address something the clients lack and cannot easily acquire (such as a skill).
  2. Ensure initiatives are integrated into regular care.
  3. Target interventions to those with the greatest need including underserved populations; monitor who participates.
  4. Monitor and evaluate lay led programs before expanding further due to unclear evidentiary support.
- The Stanford Chronic Disease Management Program has been a leader in the development of peer led self-management programs to help participants improve health and quality of life. Evaluations have shown that the program improves health behaviours and health status and also resulted in fewer hospitalizations and days of hospital admission.\(^{(21)}\)
**SHR Key Interventions**

- **Support immunization coverage for all HIV and hepatitis C cases by:**
  - Including SHR nurses who work with HIV and hepatitis C cases in routine education and annual review of immunization competencies, anaphylaxis recertification and SIMS training.
  - Advocating for SIMS access for all immunization providers.

- Collaborate with community pharmacies, addictions and mental health services and WSCC to develop and implement DOT programming at selected sites. Consult with the tuberculosis program on their successful DOT strategies. Evaluate outcomes.

- Employ client goal setting within clinical care. Develop and implement targeted skill development and self-management supports.

- Collaborate with psychology, psychiatry, elder services and mental health and addictions outreach to support timely access to mental health care.

- Collaborate with Infectious Disease physicians, Positive Living Program and rural providers in the utilization of telehealth to deliver care.

- Collaborate with AIDS Saskatoon, STC Health Center, Avenue Community Center Live Well with Chronic Conditions (LWWCC) and Positive Living Program to explore the potential for a LWWCC peer led group.
Tuberculosis Prevention, Diagnosis and Treatment

Current Practice

- The Tuberculosis Control Program provides preventative tuberculosis treatment for HIV positive clients. They have a strong DOT program for tuberculosis control fuelled by incentives and transportation supports for clients to attend their clinical appointments.
- The Tuberculosis Control Program does not order HIV tests but refers clients to a physician.
- The Positive Living Program (PLP) has partnered with the Tuberculosis Control Program to support a quality improvement initiative on the completion and reading of mantoux tests in the Positive Living Program (PLP). The first stage of quality improvement actions increased the Mantoux reading rate from <1% to 49% (2008-2009).
- The PLP collaborates with the Tuberculosis Control Program to identify the tuberculosis status and mantoux testing results of all new HIV positive clients.
- The Tuberculosis Control Program supports the PLP to provide their clients with options for follow up of mantoux testing.

The Community Voice

- Whether a client was tested for HIV is rarely known. If the client was tested, the results are not consistently communicated to the Tuberculosis Control Program. There is a need to either provide HIV tests through the program or have an appropriate referral process.
- Clients may benefit from a “one stop shop” with services in the same building, where they can be tested and receive care and counseling.
- Staff would benefit from cross training, merging resources and educating each other.
- Partnerships with Public Health Services, PLP, Mental Health and Addictions, Ministry of Social Services, and Health Bus would be beneficial.
- Clients feel frustrated due to lack of service, falling between services and navigating the system.
- There is a lack of communication between programs regarding clients and barriers are often within services.
- Clients are often homeless and struggle with addictions. They have many social challenges.
- Data between programs is not consistently shared. Sharing would improve client care and reduce duplicate work and information.

Best and Promising Practices

- HIV has a significant impact on tuberculosis rates. Globally, tuberculosis is the most common cause of death in HIV infected people. HIV dramatically increases the progression to tuberculosis disease. People who have tuberculosis infection without HIV co-infection have a 5-10% lifetime risk of developing tuberculosis disease, whereas those with HIV have a 5-10% annual risk of developing tuberculosis disease. Although tuberculosis can occur at any stage in the course of HIV, the risk increases with advanced immunosuppression and the risk decreases for those receiving HIV treatment. Active
tuberculosis may also enhance the progression of HIV.\(^{(31)}\)

- The WHO Policy Guidelines for Collaborative Tuberculosis /HIV Services for Injecting and Other Drug Users \(^{(46)}\) recommends the following collaborative activities:

  1. Establish the mechanisms for collaboration
     - Set up a coordinating body for tuberculosis / HIV activities effective at all levels;
     - Conduct surveillance of HIV prevalence among people with tuberculosis;
     - Carry out joint tuberculosis / HIV planning;
     - Conduct monitoring and evaluation;

  2. Decrease the burden of tuberculosis among people living with HIV
     - Establish intensified tuberculosis case-finding;
     - Introduce Isoniazid prevention therapy;
     - Ensure tuberculosis infection control in health care and congregate settings.

  3. Decrease the Burden of HIV among people with tuberculosis
     - Provide HIV testing and counseling;
     - Introduce HIV prevention methods;
     - Introduce co-trimoxazole preventative therapy;
     - Ensure HIV care and support;
     - Introduce antiretroviral therapy;

- The Maximum Assisted Treatment (MAT) Center provides HIV direct observed therapy (DOT) for clients and partners with the Tuberculosis Program. They coordinate a blitz of all MAT clients requiring screening or X-rays 1-2 times per year. (Site visit in downtown east side in Vancouver, January 2010)

- The Canadian Recommendations for the screening and prevention of tuberculosis in clients with HIV and Screening for HIV in tuberculosis clients and their contacts are: \(^{(31)}\)

  1. Every client with newly diagnosed HIV should be assessed for the presence of active tuberculosis at time of diagnosis of HIV.

  2. All clients with newly diagnosed tuberculosis should be strongly encouraged to undergo HIV testing according to guidelines.

  3. HIV testing of contacts of infectious tuberculosis cases should be considered if they are at risk for HIV.

- Health care providers, administrators and tuberculosis controllers should strive to promote coordinated care for clients with tuberculosis and HIV, and to improve information sharing between tuberculosis control programs and HIV/AIDS programs.\(^{(34)}\)
**SHR Key Interventions**

Support collaboration between the Tuberculosis Control Program and Positive Living Program to prevent co-infection and enhance surveillance, prevention and treatment strategies by:

- Initiating a working group to monitor co-infection rates. Utilize data to guide program integration, intervention implementation and evaluation plans;

- Reviewing and implementing best evidence guidelines on initial and repeat Mantoux testing required for HIV positive clients. Develop and implement guidelines;

- Developing a process to improve completion and reading of Mantoux tests. Offer alternate sites/care options through cross training and partnering;

- Offering cross training to Tuberculosis Control Program staff to support clients with harm reduction strategies (including distribution of condoms) to improve client access to harm reduction tools and skills.

- Investigating the Tuberculosis Control Program’s ability to provide HIV testing with linkages to clinical care.

- Supporting collaboration between the Tuberculosis Control Program, PLP, PHS and Addictions and Mental Health Programs to consider optional tuberculosis sites of care at select venues.
Transitional and Palliative Care Challenges

Current Practice

- There is limited to no home care nursing support provided in the core neighborhood of Saskatoon. These workers are often bound by risk assessment red flags.
- Very few clients access palliative care and if they do, leave prematurely as the Saskatoon Health Region (SHR) palliative care model does not accommodate alternative lifestyles. Some clients request to die at Brief & Social Detox (Larson House) rather than palliative care.
- Private care homes do not take HIV positive or addicted clients for various reasons including that the Ministry of Social Services provides $1026/month to cover costs and the average home charges $1800/month.
- Brief & Social Detox (Larson House) has advocated for clients to stay in care homes and support the care homes with addictions services for successful placement.
- The Health Bus provides excellent abscess care, condom distribution and links to care.

The Community Voice

- Clients have requested optional sites other than emergency rooms to receive general health care that they are currently accessing emergency departments for.
- Consider care provided by key HIV team members or partners at other sites who are friendly and oriented to this high risk population for such things as abscess care, IV therapy.
- HIV positive clients are frequently discharged from hospital on treatment regimes that they do not know how to manage, or prescriptions are not filled as they require assistance to work through the payment process.
- The Positive Living Program (PLP) nurse clinician and pharmacist could play a key role in working with the acute care system to support clients with discharge planning.
- Many clients do not have a home upon discharge and do not have a place that will accept them. Many access Brief & Social Detox (Larson House) for help.
- Addicted clients do not fit the home care model as “they don’t follow the rules.”
- Special care aides will not enter homes of people with addictions, however some nurses may. No one is trained to work with HIV or addictions.
- Collaboration is needed with First Nations groups, Social Services and housing groups.
- Consider delivering care in an alternative environment, through outreach and as a team.

Best and Promising Practices

- The Community Transitional Care Team (CTCT) located in east side downtown Vancouver is a community based program that provides medical care for injection drug users who require in hospital antibiotic treatment for acute bacterial infections, endocarditis, osteomyelitis and septic arthritis. In traditional hospital care many clients do not complete their 4-6 week treatment regime and leave against medical advise prematurely. This...
nine bed program cares for 50-60 persons who use injection drugs per annum with an annual budget of 2.2 million. In their first year, 44% of clients were HIV positive. They partnered with the Portland Hotel Society- Community Services Society (who operate the hotel the program is situated in) and the Transitional Service Teams (who manage client flow in local hospitals). Goals were to increase retention and antibiotic adherence; decrease repetitive hospital stays and to facilitate transition from acute in hospital treatment to long term out of hospital medical care. Their first year evaluation found that after caring for 16 clients (between May 2005-Jan 2006) 94% completed treatment. 81% of these clients had a previous against medical advice discharge. Their analysis indicated that CTCT produced better results and cost less. [22]

Home Care Nurses in east side downtown Vancouver travel in pairs to provide DOT with Methadone and ART and clinical care supported by an outreach physician. (Site Visit Vancouver, January 2010)

SHR Key Interventions

- Identify and partner with care home providers and Ministry of Social Services to ensure access to and financial support for those clients requiring transitional housing and home palliative care services. Provide addiction, home care, HIV clinical treatment and palliative supports to care homes.

- Utilize the Positive Living Program nurse clinician and pharmacist to support Client Patient Access Services in discharge planning.

- Investigate the home care and palliative care model and determine the revisions required to provide care for high risk clients.

- Initiate conversation with the community and health sector to develop or create a transitional and palliative housing program for complex care clients.
4. **Strengthening and expanding health systems**

There are certain components within our health sector that require strengthening to support the scale up of HIV/AIDS interventions. These include collaboration between those who work to influence the determinants of health and those who deliver health services. Although this includes mobilization of partners from many sectors, the health sector does have a significant role and responsibility to provide leadership and coordination given the many opportunities to impact HIV-related services.[47]

Our community stakeholders identified a number of components that should be addressed:

- Leadership and Governance;
- Human resource development;
- The integration and linkage of health services;
- The mobilization of partnerships including those living with HIV and the community surrounding them;
- Stigma and discrimination.

**Leadership and Governance**

**Current Practice**

- The current funding structure supports individual programs rather than collaborative and integrated funding structures that support clients.
- There is no leadership structure in place that pulls all programs together to implement an HIV plan within SHR.

**The Community Voice**

- HIV needs to be a priority within SHR.
- HIV is a chronic disease. Chronic disease management has a role to play in leading HIV care implementation and outcomes.
- Mental Health and Addictions and Public Health Services should be included in leading HIV care.
- Leadership from the First Nation and Métis Communities, police, the education systems and our municipal and provincial governments is required.
- Staff within the community and health agencies are feeling ineffective, not connecting with each other with no mutual understanding of what the goals are.

**Best and Promising Practices**

- Strengthening health care systems requires leadership. This is crucial for effective implementation of any improvement initiative, not only in the leaderships' clear voice of support, but to show that the identified changes are a priority, and that there are adequate resources and time for implementation. [16]
- “Leaders with consistent messages are needed to: counter stigma and discrimination; support the involvement of people living with HIV; ensure equity in access to services; deal with the gender dimensions of the epidemic; speed progress towards reducing the gap between resources available and resources required to scale up the response” (WHO et al., 2009, p. 63).[47]
WHO defines effective leadership as that which creates an environment that not only accelerates the scale-up of the HIV response, but defines the values and principles that underlie the process, holds different stakeholders accountable, and supports innovation to maximize the impact of the interventions. \(^{(47)}\)

Accelerating the response to HIV also requires leadership from business, industry, academic and research institutions. It will require leadership within neighborhoods and communities. This must come from community councils, faith based and other community organizations, people living with HIV and people vulnerable or at high risk of infection.\(^{(47)}\)

**SHR Key Interventions**

**Identify a leadership structure involving Chronic Disease Management, Mental Health and Addictions Services, and Public Health Services to:**

- Develop a steering committee involving the community to guide the HIV strategy, implementation, funding and annual review. Ensure strong consideration of First Nations and Métis, municipal, police, client and community involvement.

- Advocate for and assist in the development of public policy to support employment, housing and availability of nutritious food.

- Ensure approval of HIV initiatives are based on pre-determined guiding principles and collaborative partnerships.

- Visibly support collaborative community and health sector initiatives such as community health fairs involving: police, education, First Nations and Métis, harm reduction programs, community initiatives and select health programs meaningful to this community.

- Continue to support the IDU Continuum of Care Partnership B.R.I.D.G.E. that brings together agencies that work with persons who inject drugs.
Human Resource Development

Current Practice

- Saskatchewan does not have a formal training program for physicians or associated team members in HIV care. When they are able, support of training requests has been assumed by the Positive Living Program (PLP). No formal accountability or funding support has been appointed.

The Community Voice

- Health sector and community staffs’ knowledge on HIV and Mental health and Addictions is lacking, impacting their ability to engage clients and provide skilled interventions, basic knowledge and consistent messaging.
- SHR staff need help to overcome their misunderstandings and improve their communication with those who have a different ethnicity, culture, economic status, lifestyle or sexual orientation.
- There are no province wide best practices for clinical care developed or adopted.

Best and Promising Practices

WHO recommends ensuring quality of training through the use of experienced facilitators, establishing supervision and a clinical mentoring system and deploying mentors for post training and on the job supervision.[47]
SHR Key Interventions

- Develop and deliver a standardized orientation and training program/certification in HIV care for all front line staff and community partners. Ensure core competencies are present to support interventions, skill development and consistent messaging tailored for addicted clients. Incorporate cross-training between programs and task shifting to support cultural competencies as appropriate.

- Incorporate cultural competency requirements in the hiring process for front line staff. Include Strengthening the Circle staff in the development of interview questions and include in the interview process.

- Advocate for and collaborate with the Ministry of Health to develop an HIV Provincial Program accountable for:
  - The adoption/development and implementation of provincial HIV prevention, treatment and care guidelines.
  - The development and support of a provincial registry for treating practitioners.
  - A repository for best practice and distribution.
  - The recruitment of family physicians and formal mentorship including training of family physicians and nurse practitioners.
The Integration and Linkage of Health Services

Current Practice

- Agencies providing services to at risk populations in the core communities include: Westside Community Clinic (WSCC) (a low threshold engagement model that invites the attendance of most at risk populations); STC Health Center provides needle exchange services and harm reduction supplies in a van stationed behind WSCC with office space on Avenue P South where case management and nursing support is delivered; Public Health Services provides mobile services, harm reduction supplies and STI / BBP testing in the evenings at fixed stops on Avenue H and 20th, Avenue R and 20th and Avenue P and 20th, plus roaming services. Daytime outreach provides services to those who have been newly diagnosed with HIV or who are named as having had contact with HIV.
- Mental Health and Addictions (MH&A) collaborates with STC Health Center, WSCC and the Positive Living Program to provide case management for pregnant HIV positive women and the very sick.
- MH&A provides brief and social detox services in the community.
- AIDS Saskatoon provides education and support services.
- Clients access prevention, treatment and support services from multiple points within SHR as depicted in Appendix C “HIV Prevention Treatment and Support Services Continuum.”

The Community Voice

- Many services appear to be designed for the benefit of the programs, not the client. Low threshold, flexible programming supporting clients where they are at should be the approach that is valued.
- Move care away from institutions, supporting fixed and mobile models of care within the high risk community.

Stakeholder comment:
“Lack of communication between agencies leads to no referrals between them”

Best and Promising Practices

- WHO recommends that services should be delivered across a continuum of care. This requires integrated and linked service provision at all levels of the health system, from primary to secondary to tertiary (specialist) care, embracing all elements of the health system, including home-based and community-based outreach care.[47]
- During site visits to Vancouver’s downtown eastside, organizations such as the Vancouver Downtown Native Health Society were observed to have a service delivery model focused on engaging most at risk persons through food and social supports. Many programs offering prevention treatment and support were integrated at one site or situated next to each other.
**SHR Key Interventions**

In addition to the previously identified integration recommendations for treatment and care:

- Secure a location in the core community to provide low threshold multidisciplinary services to most at risk populations through a strong engagement model. Consider integration of services such as:
  - STI, tuberculosis and HIV / hepatitis testing and treatment, harm reduction services, Mental Health and Addictions, abscess care, home care and other supportive community services.

- Utilize this fixed site location to support innovative service delivery such as outreach services.
The Mobilization of Partnerships

Current Practice

There have been a number of partnerships formed throughout the health region to support HIV care. Examples of such partnerships include Public Health Services and AIDS Saskatoon; West Side Community Clinic and Mental Health and Addictions (MH&A) and Positive Living Program (PLP); STC Health Center, PLP and MH&A; TB Control Program and PLP.

The Community Voice

- Encourage partnerships between community and health sector organizations. Support integration of programming and encourage visibility of same.
- Lack of housing, child care, transportation, food, clothing and employment has limited our ability to provide education and care that will have positive outcomes. The right partnerships could break this barrier down.
- Aboriginal health services are limited within Saskatoon Health Region (SHR) in comparison to other provinces. This should be enhanced.
- Strengthening the Circle has a mandate to cover First Nations Métis, Urban/Rural issues within SHR & have developed partnerships.
- Presently there is not a good peer to peer network functioning in SHR.
- We should initiate a “peer to peer leader model.” Peer support creates a non-judgmental atmosphere.
- Peer leaders require support with their ongoing challenges to succeed.
- Clients who have HIV have also peer-led as volunteers and at times have received financial reimbursement.
- Persons who access service (PWAS) were “very proud to be part of the hepatitis C project”.
- Clients are excited about participating in a peer led initiative.

Best and Promising Practices

- There is considerable data proving poverty predicts morbidity and mortality. As noted in the discussion paper ‘Lifting the Burden of Chronic Disease”, simply providing education or information has limited impact on this population. Although the health care sectors work is important, it alone cannot relieve the burden of chronic disease. Evidence supports the crucial need for policy and structural interventions that address the social determinants of health. We are advised to actively pursue advocacy and advisory roles to ensure the evidence addressing the determinants of health is reflected in public policy; tackle the social factors that promote illness in our community through intersectoral collaboration; and use information about health disparities to design and target health services.(16)
- People living with HIV (PLHIV) are a vital resource in the response to the epidemic. The involvement of PLHIV in advocacy efforts, in policy dialogue, in service delivery, and in the effort to reduce stigma and discrimination has already been documented extensively. Innovative mechanisms have been developed to involve them in HIV-related services.e.g. On clinical teams, as links with communities and as community health workers. People
living with HIV can also serve as expert clients and trainers.\(^{[14]}\)

- Outreach is an area in which peer based strategies, linkages and partnerships with agencies working at the front line or street level are particularly important.\(^{[14]}\) There is a need for support for peer based advocacy groups (at local, provincial, national levels).\(^{[14]}\)

- “Peer based groups can provide services - a portion of treatment funding could be allocated to these groups to provide socialization (a place to go), advocacy, education, job-finding services, etc” (Jamieson et al., 2002, p. 32).\(^{[14]}\)

**SHR Key Interventions**

- **Collaborate with Strengthening the Circle and bring aboriginal components to care through partnerships. Support First Nation and Métis communities to design and implement HIV prevention, treatment and support for First Nations and Métis.**

- **Work with community based organizations such as AIDS Saskatoon to establish a strong peer to peer support program modeled to support a hierarchy of harm reduction.**
Stigma and Discrimination

Current Practice

The Community Voice

- Stigma and discrimination are very real in SHR.
- Clients fear accessing particular health care services due to stigma and discrimination of injection drug users, ethnicity and HIV status. One such place is known as “Death Valley” or as explained during client consultations, “you wait till you die”.
- Clients have stated that Saskatoon Health Region caregivers lack in compassion and understanding. Through “word of mouth” certain doctors and nurses are avoided.
- When accessing care for pain management, clients face staff who make assumptions and no clinical assessment is conducted. Clients would prefer to go to the street for drugs rather than face a negative reaction.
- Persons who use injection drugs have been known to avoid particular health care services due to stigma and discrimination.

Best and Promising Practices

- WHO states that stigma and discrimination within the health system can be easily confronted through simple measures that provide workers with accurate information that allays fears and dispels misconceptions about HIV and transmission. (47)

Stakeholder comment

“I have a dream . . . if we have to hold the record for having the highest number of new HIV infections per capita in Canada; we should be leading in HIV care.”

SHR Key Interventions

- Provide health care workers with the knowledge and skills to practice non-discriminatory behaviour through harm reduction training sessions on injection drug use and HIV in partnership with Peoples Strategies, B.R.I.D.G.E. Saskatoon’s Primary Prevention and Health Promotion Pillar and Strengthening the Circle.
- Develop treatment and self-management guidelines to support health care staff in the delivery of abscess care, drug withdrawal and pain management.
5. **Investing in strategic information to guide a more effective response**

A well functioning health information system generates reliable and timely strategic health information from which programming decisions are based. To be effective, planning and programming of the HIV strategy should be linked to a regular review of all data as there is considerable overlap of the initiatives for HIV prevention, treatment and support within our community. This will provide the evidence from which to inform the development of policies, strategies and program development.

**Current Practice**

- Public Health Services (PHS) has limited resources to implement the provincial HIV enhanced surveillance questionnaire. There is an inconsistent process in prioritizing client needs over perceived health provider questionnaire requirements. Responding to multiple questions, often very personal, is not the priority for this population. (As of April 2010, increased resources have allowed for the implementation of the advance surveillance questionnaire).
- SIMS is available and utilized for immunization coordination.
- The Street Health data base is available to communicate client coordination plans, however requires refinement.
- The Positive Living Program has a data base that is difficult to use, requires data input and analysis resources that are not funded.
- The Tuberculosis Control Program data base collects data that is accessed solely by the Tuberculosis Control Program.
- Programs work within the confines of the privacy legislation which is challenging to coordinate care or share data.
- Provincial and regional data is either inaccessible or incomplete, hindering the development of evidence based programming.

**The Community Voice**

- SHR is lacking capacity to support research initiatives both formal and practical.
- Data between programs is not consistently shared. Sharing would improve client care and reduce duplicate work and information.

**Best and Promising Practices**

- The WHO recommends that in order to remain effective, planning and programming of the HIV response must be linked to regular reviews of the epidemiological situation and program performance. Programs should regularly track, analyze and use data from multiple sources including:
  - HIV and AIDS case reporting;
  - Patient monitoring from testing and counselling services, HIV care and treatment services;
  - STI clinics;
  - Tuberculosis and maternal and child services;
  - Surveys to assess and monitor HIV resistance.\(^\text{[47]}\)
WHO recommends HIV surveillance systems be capable of adaptation and modification to address the specific needs of the epidemic.\textsuperscript{(47)}

**SHR Key Interventions**

- Participate in enhanced surveillance activities to inform programming, monitor trends and track HIV cases, referrals and outcomes.

- Collaborate with the Ministry of Health to identify the data required to inform programming. Consider collaboration with the Health Quality Council to identify appropriate indicators and sources of data.

- Identify data management and research deficits and partner with Regional Health Authorities, the prairie province collaborative and the Ministry of Health to initiate development and integration of data systems and research opportunities.

- Develop a partnership agreement between the Ministry of Health and SHR HIV programs to utilize current surveillance and treatment data to enhance prevention and treatment opportunities, prevent duplication, guide planning and evaluation.
The Cost of HIV Care

Estimating the cost of enhancing HIV prevention, care and support services is challenging due to the changing treatment and prevention modalities over the last number of years. We can, however, look to a number of studies that have estimated the cost of caring for clients when HIV infected.

In southern Alberta, a study which included all HIV infected clients within their geographic area estimated costs of care stratified by CD4 Cell count over a 9 year period (1997-2006). The study examined the effect of reporting costs of HIV care only and in antiretroviral therapy (ART) experienced clients. For the purposes of this strategy the general outcome of the study concluded that:

- The mean cost per patient per month (pppm) increased slightly from $1,082 in 1997/98 to $1,159 in 2005/06.
- The mean cost pppm when the client’s CD4 is <75 increased from $1,595 to $2,687.
- Costs for the following CD4 ranges remained quite stable over time:
  - CD4 >500 cost pppm was $979;
  - CD4 range of 201-500 the cost pppm was $1,057;
  - CD4 range of 76-200 the cost pppm was $1,294.

The in hospital costs accounted for most of the cost increases. If the costs were reported only using ART experienced clients the costs would be overestimated by 2-9%. Costs for only HIV care were 10-24% lower than total care costs.

Where clients presented with a CD4 range <75, they were more likely to have been unaware of their HIV status until they were hospitalized for AIDS; were disconnected from health care; or had failed ART causing serious decline of health. These clients require intense monitoring, with frequent clinic visits, lab tests and more complex ART regimes.

The study noted that late presenters had increased significantly in their newly diagnosed clients, contributing to higher overall costs and higher in hospital care costs. The study concluded that enhanced testing to achieve earlier diagnosis and initiation of ART could potentially reduce costs of late presentation and in hospital care.[17]

The above statistics had not identified costing stratification related to co-morbidities such as mental health diagnoses or the added challenge of substance abuse. An American study[9] analyzed baseline utilization and cost data on these triply diagnosed clients from the HIV/AIDS Treatment Adherence health outcomes and Cost Study. Baseline interviews were conducted on 1,138 triply diagnosed clients. They identified utilization of in hospital and out of hospital services and medications over the preceding 3 months. Nationally representative unit costs were then applied to identify the average monthly expenditures. A baseline mean expenditure was identified to be $3,880 USD per client per month. This was found to be nearly twice as high as expenditures for HIV/AIDS in general ($1,957 / month in 2002 USD).

Within Saskatoon Health Region, late presenters appear to have increased, contributing to higher overall costs and
higher in-patient care costs. A review of clients admitted to St. Paul's Hospital and Saskatoon City Hospital between Jan 1, 2008-Dec 31, 2009 was completed retrospectively. The preliminary results showed that there were 30 clients admitted for a total of 39 admissions. The total client days were 1,171 with an average stay of 30 days.

The most common reasons were AIDS defining illnesses at 33% (13/39); Endocarditis 31%(12/39) and pneumonia 15%(6/39).

The average CD4 on admission was 136 with 82% (31 clients) admitted with counts below 200. 23% (7/31) of the clients were diagnosed with HIV on admission. Death occurred in 5/31 (16%).

It is reasonable to assume that the cost of HIV care in Saskatchewan will be reflective of the referenced statistics.

The departments that provide HIV care within SHR include Mental Health and Addictions, Chronic Disease Management, Pharmaceutical Services and Public Health Services. The cumulative annual budget these departments targeted for HIV care is $1,376,075. The budget particulars are as follows:

Salaries $948,756
Benefits $180,264
Vehicle Operation/Transportation $22,712
Harm Reduction Supplies $200,158
Other Expenses $24,186

In the face of this concentrated epidemic, these dedicated resources are not sufficient to prevent, treat and support HIV care in this region. If the interventions outlined in the document are not supported to a significant degree, we can expect costs to rise, care to increase in complexity, and mortality to escalate.

This strategy includes an implementation plan, with an attached budget for the next 3 years (Appendix A).

An amended budget (Appendix B) was submitted to the Ministry of Health to include the essential resources needed for SHR and partners. The essential start up costs for the second quarter of 2010-2011 and remaining quarters were estimated as follows:

Year 1 Annualized Cost:
Fall 2010: $1,185,628
Winter 2010: $881,741
Year 1 Total: $2,067,369

Year 2 Annualized Costs: $3,236,930
(Includes sustained funding for year 1 initiatives)

Year 3 Annualized Costs: $3,613,582
(Includes sustained funding for year 1 and 2 initiatives)

Total 3 year Cost: $8,917,881

Sustainable costs beyond 3 years: (excludes inflation and wage increases)
$3,613,582

Stakeholder comment:
“What is the cost of not dealing with HIV?”
Operationalizing the Response

The Saskatoon Health Region HIV Prevention, Treatment and Support three year implementation plan is attached. This plan includes timelines, work plan activities, deliverables and budgetary impact. As funding limitations are often a reality, the interventions that are essential to move the strategy forward are bolded in Appendix A.

To achieve a comprehensive response to HIV/AIDS, the literature is clear that we require the right people to do the right job. The basic interventions must be scaled up together to prevent and overcome bottlenecks which inhibit care. Interventions must be targeted to the people most at risk. The essential interventions have been identified accordingly.
Conclusion

The Saskatoon Health Region along with Saskatchewan is now facing a significant increase in HIV infection rates. Saskatchewan now leads the country with the highest infection rate at 17/100,000 population.[38] In 2003, we were one of the lowest in Canada at 5.0/100,000. Currently, the Saskatchewan Ministry of Health is finalizing the Provincial HIV Strategy and its release is expected by the summer of 2010. We acknowledge this work, and have identified how these priorities could be implemented within our own community. As no community is alike, the input of our stakeholders was key in identifying those interventions required to achieve success.

Saskatoon Health Region’s HIV Prevention, Treatment and Support Strategy has identified that preventative and testing programs, cultural supports, clinical care, mental health and addictions and those who influence the determinants of health all have significant impact on the success of this strategy. HIV has now challenged us to work together in a different way. Collaboration between these entities is required to support a more effective response that will stop the virus, save lives and properly utilize limited health care resources.

Picture 1: Client comment regarding 09/10 Positive Living Program and Mental Health & Addictions Case Management Pilot
References


(IDUs) in Saskatoon, Saskatchewan. Saskatoon: Saskatoon Health Region, Public Health Services, Healthy Lifestyles Department; 2006.

(13) iPHIS: integrated public health information system [computer program]. Ottawa: PHAC; 2005.


(29) Plamondon K, de Bruin P. Bridging services with community voices around injection drug use: results and recommendations from an assessment of harm reduction needs in the Saskatoon area. Saskatoon: Saskatoon Health Region; 2009.


(32) Public Health Services, Saskatoon Health Region. A working definition of harm reduction for the Saskatoon & Area Community. 2008.


Street Outreach Database: needle exchange rates [computer program]. Saskatoon: 2006.


Appendix A

SHR HIV Strategy Prevention, Treatment & Support Implementation Plan

Priority Strategies & Budget
<table>
<thead>
<tr>
<th>Priority Strategy</th>
<th>Work Plan Activity</th>
<th>Deliverables</th>
<th>Timeline</th>
<th>Outcome Measures</th>
<th>Budget</th>
</tr>
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<tbody>
<tr>
<td>1. Implement standards of practice for HIV pre and post test voluntary counselling and testing (VCT).</td>
<td>Adopt or create standards of practice for pre and post test HIV counselling and testing such as the Ontario “Guidelines for HIV Counselling and Testing”.</td>
<td>Standards of practice are identified. Training module is developed. Training is provided to front line HIV testing providers.</td>
<td>Year 1</td>
<td>↑ # of staff who receive consistent HIV pre and post test voluntary counselling and testing (VCT) training.</td>
<td>Core educator/developer funding Refer to costing under Priority # 23(a) Alternative: PHS Nurse Clinician Priority assignment</td>
</tr>
<tr>
<td></td>
<td>Create and implement an evaluation based on staff and client satisfaction.</td>
<td>Survey is created and implemented.</td>
<td>Year 2</td>
<td></td>
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<tr>
<td></td>
<td>Revisions are recommended.</td>
<td>Revisions for training are incorporated.</td>
<td>Year 3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Increase locations that serve most at risk populations to offer HIV voluntary counselling and testing (VCT), including outreach services.</td>
<td>Expand and increase HIV VCT at sites providing services to most at-risk populations</td>
<td>HIV VCT is initiated or expanded at Larson House, Saskatoon Correctional Center, Methadone Program, AIDS Saskatoon and through STC HEALTH CENTER. WSCC is supported to provide HIV VCT.</td>
<td>Year 1</td>
<td>↑ # of HIV tests preformed Individual Level: ↑ # of persons aware of their HIV status ↑ knowledge to reduce the risk of acquiring or transmitting HIV ↓ transmission of HIV ↑ access to HIV care, treatment and support ↑ protection to unborn infants</td>
<td>PHN (Funded SUN partnership) PLP Nurse (Funded SUN partnership) to support WSCC</td>
</tr>
<tr>
<td></td>
<td>Scale up outreach services to most at risk populations to provide HIV VCT.</td>
<td>Outreach services provide HIV VCT blitzes 2 – 3 times per year. Enhance STC’s partnership with reserves &amp; rural areas within SHR to evaluate the need &amp;locations for HIV testing sites</td>
<td>Year 1 Year 2 - 3</td>
<td></td>
<td>PHN (Funded SUN partnership) 1.0 FTE STC Health Center Nurse Refer to costing under Priority #3</td>
</tr>
<tr>
<td>Priority Strategy</td>
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<tr>
<td>Identify a location in the core community to provide multidisciplinary services to most at risk populations, implement HIV VCT in the new location.</td>
<td>HIV VCT is initiated or expanded at the fixed multidisciplinary site in the core community.</td>
<td>Year 2 - 3</td>
<td></td>
<td>1.0 PHN FTE (with swing support from STI Clinic) $103,315 Refer to fixed site costing Priority # 24</td>
<td></td>
</tr>
</tbody>
</table>

3. **Provide point of care (POC) HIV VCT.**

Identify pilot sites to participate in the Ministry of Health implementation of point of care (POC) HIV VCT.

Pilot sites are selected that adhere to consistent standards of practice. Potential sites include: Sexual Health Clinic, Westside Community Clinic (WSCC), STC Health Center, Labour & Delivery

<table>
<thead>
<tr>
<th>Work Plan Activity</th>
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<th>Outcome Measures</th>
<th>Budget</th>
</tr>
</thead>
<tbody>
<tr>
<td>Participate in training for POC.</td>
<td>Pilot sites attend training.</td>
<td>March 8, 2010</td>
<td>† confidence and competence of POC providers.</td>
<td>Year 1 Training and test kits are funded by Ministry of Health. Persons attending training may be ‘train the trainers’ for additional staff.</td>
</tr>
<tr>
<td>Adhere to consistent standards of practice for pre and post test counselling, selection of target population, laboratory requirements, test implementation and quality assurance measures.</td>
<td>Pilot sites adhere to standards of practice.</td>
<td>Year 1</td>
<td>† consistency in standards of practice.</td>
<td>1.0 FTE STC Nurse $80,000</td>
</tr>
<tr>
<td>Evaluate competence, confidence and quality of POC providers.</td>
<td>Providers are evaluated.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Expand sites offering POC HIV VCT.</td>
<td>Additional sites provide HIV POC VCT.</td>
<td>Year 2</td>
<td>† # of sites providing POC VCT.</td>
<td>Year 2 Core educator / developer funding may be required to support expansion of sites.</td>
</tr>
<tr>
<td>Priority Strategy</td>
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<tr>
<td>4. Support intensive efforts for partner notification and VCT.</td>
<td>Enhance efforts to obtain, locate, notify and test sexual, injection and social partners exposed to HIV. Develop a process between PHS and STC to support partner notification through STC</td>
<td>Increased staff time is dedicated to outreach efforts to obtain, locate, notify and test HIV partners.</td>
<td>Year 1</td>
<td>↑ in number of HIV partners obtained. ↑ in number of HIV partners successfully notified. ↑ in number of HIV partners successfully offered VCT. ↓ HIV transmission through early diagnosis.</td>
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<tr>
<td></td>
<td></td>
<td>Training in elicitation techniques is provided.</td>
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<tr>
<td></td>
<td>Provide training in partner name elicitation techniques.</td>
<td>Training in elicitation techniques is provided.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Evaluate partner notification strategies.</td>
<td>New or sustained strategies are supported.</td>
<td>Year 2</td>
<td></td>
</tr>
</tbody>
</table>

5. Expand locations providing free condoms and lubricant to most at risk populations.

| | Determine sites providing services to most at risk populations. Prioritize sites to distribute lubricated condoms to most at risk populations. Determine if funds are required to support prioritized sites. Purchase lubricated condoms. Distribute to sites. | Lubricated condoms provided at sites who serve most at risk populations. | Year 1 | ↑ # of lubricated condoms distributed ↓ transmission of STIs and HIV | Annual costs: $90 / 1000 condoms $2,000 |
| | | | | | |
| 6. Increase access to harm reduction supplies for injection drug use. | Provide persons who use injection drugs with prevention education and harm reduction supplies | Adoption of a needle distribution policy. | Year 1 | ↓ transmission of HIV ↓ transmission of HCV ↓ endocarditis ↓ abscess | Annual costs: $65,000 to expand # of needles for distribution $50,000 for biohazard containers $190,000 for stericups |
| | Provide a full range of harm reduction supplies: cookers, sterile water, ties, discreet | Provision of a full range of harm reduction supplies. | | | |

Maximizing the health sector’s contribution to HIV Prevention
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<tr>
<th>Priority Strategy</th>
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<tr>
<td>biohazard containers</td>
<td>Purchase vending machines to dispense sterile injection equipment for when needle exchange programs are not open or are difficult to get to due to weather or transportation Enhance STC’s partnership with reserves and rural areas within SHR to evaluate the need and resources required to expand needle exchange programming</td>
<td>Increases access to sterile injection equipment.</td>
<td>Year 1-2</td>
<td>↓ in ER visits</td>
<td>$190,000 for sterile water $1,200 for tens</td>
</tr>
<tr>
<td>Advocate for the development of a provincial harm reduction supplies toolkit to standardize and support the implementation of distribution and collection of used needles.</td>
<td>Increase support for implementation of a harm reduction program for persons who use injection drugs on reserves and rural areas.</td>
<td>↑ access to harm reduction supplies on reserves and rural areas. ↑ standardization of harm reduction supplies distribution and collection. ↑ range of harm reduction supplies provided.</td>
<td></td>
<td></td>
<td>$10,000 for vending machines 1.0 Nurse Coordinator (STC Health Center in Kind)</td>
</tr>
<tr>
<td>7 (a). Purchase smaller needle drop boxes to facilitate disposal for persons without easy access to their own disposal container.</td>
<td>Connect with epidemiologist for needles found in the community report 2008. Determine placement of drop boxes that make disposal the easy choice. Contact Vancouver downtown eastside for the manufacturer’s contact information of their small needle drop boxes.</td>
<td>Placement of needle drop boxes that make disposal the easy choice.</td>
<td>Year 1</td>
<td>↓ in needles found in the community.</td>
<td>~ $15,000 for purchase and installation Ongoing disposal costs TBD</td>
</tr>
<tr>
<td>Priority Strategy</td>
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<tr>
<td>Place smaller drop boxes in areas that allow safe disposal the easy choice.</td>
<td>Contact the manufacturer on the cost of this box and the production timeline. Request info on how the box is emptied – is there another box inside? Investigate cost of the steel pole for mounting. Determine cost of installation. Contact Biomed and determine ongoing cost of cleaning out the boxes. Enhance relationship with the community association to support drop box placement.</td>
<td>A location is secured offering multidisciplinary services (e.g.: STI, HIV, HCV, TB testing and treatment, Addictions and Harm Reduction Services, abscess care and support services) around an engagement model.</td>
<td>Year 1 – 3</td>
<td>↑ # of STI tests performed to most at risk population.</td>
<td>In Kind</td>
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<tr>
<td>8. Provide satellite STI services in the core neighbourhoods linked with other harm reduction services, outreach surveillance, addictions services and TB.</td>
<td>Identify a multi service site. Identify the need/location to provide a satellite STI clinic. Determine complementary staff providing services. Consider the new STC Health Clinic site.</td>
<td>A location is secured offering multidisciplinary services (e.g.: STI, HIV, HCV, TB testing and treatment, Addictions and Harm Reduction Services, abscess care and support services) around an engagement model.</td>
<td>Year 1 – 3</td>
<td>↑ # of HCV tests performed. ↑ early diagnosis and treatment of STIs and HCV. ↓ transmission of HIV due to early treatment of STIs. ↑ needle exchange rate. Also see #2 previous section.</td>
<td>Contingent on funds for infrastructure.</td>
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<tr>
<td>9. Create a policy to provide support and counselling to recalcitrant persons.</td>
<td>Review the CCDR statement on recalcitrant behaviour. Compare practice with larger centres. Determine best practice for recalcitrant behaviour.</td>
<td>A policy is developed to provide support, counselling and documentation of recalcitrant behaviour.</td>
<td>Year 1 – 3</td>
<td>↑ in HIV positive persons disclosing their HIV status to sexual and drug injection partners. ↓ transmission of HIV</td>
<td>In Kind</td>
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</table>
### SHR HIV Prevention, Treatment & Support Priority Strategies and Budget

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<tr>
<td>Support, counselling and documentation for recalcitrant behaviour.</td>
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<td>Train staff on recalcitrant behaviour assessment, counselling support and documentation.</td>
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<tr>
<td>Develop a partnership between PHS, Mental Health &amp; Addiction Services, AIDS Saskatoon and STC Health Center</td>
<td>Needle exchange immersed into the addictions treatment and recovery plan.</td>
<td>Year 1</td>
<td>† # of clients referred successfully to treatment.</td>
<td>1.5 FTE Addictions Counsellor/Outreach positions  ($28.55 x 1950 hours x 1.19 = $66,250.28 + $28.55 x 975 x 1.19 = $33,125.00) Total = $99,375.28</td>
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<tr>
<td>Adopt a model based on a harm reduction addictions recovery process utilizing motivational interviewing.</td>
<td>Clear consistent targeted interventions and motivational interviewing based on harm reduction hierarchy.</td>
<td></td>
<td>† # of clients with negative HIV test who remain negative after one year.</td>
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<tr>
<td>Train addictions and needle exchange outreach workers to utilize targeted interventions to move clients toward / link with an addictions recovery plan / program.</td>
<td>Immediate access to treatment and a recovery plan at needle exchange sites.</td>
<td></td>
<td>† in clients within sub-population evaluation groups that move one step within the harm reduction hierarchy.</td>
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<tr>
<td>Identify one sub-population of like users (opiate or non-opiate); develop an evaluation process to measure risk reduction and addictions recovery outcomes within needle exchange programming.</td>
<td>An evaluation report is created annually and the program is revised as required.</td>
<td>Year 2</td>
<td></td>
<td>2.5 FTE Addictions outreach positions STC Health Center ($40,000x2 = $80,000 + $20,000x1 Total = $100,000</td>
<td></td>
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<tr>
<td>Identify an additional sub-population of like users and develop an evaluation process to measure risk reduction and addictions recovery outcomes. Incorporate evaluation</td>
<td>An evaluation report is created annually and the program is revised as required.</td>
<td>Year 3</td>
<td></td>
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<tr>
<td>1.5 FTE Addictions outreach position AIDS Saskatoon NE site $17,700</td>
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<tr>
<td>10 (b). Immerse mental health and elder counselling into recovery programming to address the root causes of substance abuse.</td>
<td>outcomes and revisions into ongoing services</td>
<td>Mental Health Counselling services are provided at time of need.</td>
<td>Year 1</td>
<td>↑ # of clients accessing elder and cultural services to support their recovery plan. ↑ # of clients accessing counselling services to support their recovery plan.</td>
<td>Fund Elders to support counseling and cultural services ($125/day x 244 days=$30,500.) IRS Counsellor in Kind STC MH&amp;A Position funding 1.0 FTE $40,000 STC Health Center – Equipment, supplies, training and maintenance of center $25,800 Determine need for Psychology Position refer to costing under Priority # 17 (b)</td>
</tr>
<tr>
<td>10 (c) Enhance access to OST</td>
<td>Collaborate with counselling and psychiatry services to implement access to care at time of client need. Collaborate with Strengthening the Circle and STC Health Center to support client access to elder and counseling services.</td>
<td>Elder services are available to clients at time of need. Utilize Indian Residential School Counselor through STC Provide Life skills counseling/programming through STC Health Center</td>
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<tr>
<td>11. Identify and implement a peer program for persons who use injection drugs</td>
<td>Recruit physicians as OST prescribers</td>
<td>OST access at time of need</td>
<td>Year 1-2</td>
<td>↑ # of clients on OST</td>
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<td></td>
<td>Advocate for methadone access in targeted rural sites within SHR Utilize lean process to streamline addictions treatment programming</td>
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<td></td>
<td>Research successful peer to peer programs utilizing community based researcher at AIDS Saskatoon in partnership with SHR Hire a 0.5 FTE Peer to Peer Mentoring Coordinator at AIDS Saskatoon to implement and evaluate program Support program</td>
<td>A peer to peer program is implemented in SHR. Revisions are made on evaluation outcomes.</td>
<td>Year 1 – 2</td>
<td>↑ engagement of persons who use injection drugs. ↑ client supports. ↑ clients seeking addictions counselling and treatment. ↓ HIV / HCV transmission. ↓ in needles found in the community.</td>
<td>$15,000 Peer Program research and development $17,700 Peer Mentoring Coordinator $15,000 to hire peers</td>
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## SHR HIV Prevention, Treatment & Support Priority Strategies and Budget

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| 12 (a). Expand the services of the Methadone Assisted Recovery Program to provide HIV HCV testing and harm reduction skill development. | Partner with PHS to provide and coordinate HIV and HCV testing and counselling opportunities; harm reduction skill development as part of programming. | HIV VCT provided at the Methadone Program. | Year 1 | ↑ HIV testing  
↑ HIV infection  
↑ HCV testing  
↑ # of HCV clients treated  
↑ clients engaged in harm reduction practices  
↑ co-infection rates | PHN funded as per SUN partnership  
Refer to Priority # 2  
PLP Nurse Clinician - In Kind. |
| 12 (b) Integrate HIV and Hep C treatment on site through program partnerships. | Develop a satellite HCV treatment site at MARS integrating HCV/HIV awareness and testing and HCV treatment. | HCV satellite treatment site at MARS.  
Nurse clinician providing group education on HIV/Hep C, HIV testing and follow up and Hepatitis C treatment. | Year 2 | ↓ HIV infections  
↓ HCV infection  
↑ clients engaged in harm reduction practices  
↓ co-infection rates | 1.0 FTE HIV / Hep C Nurse Clinician $103,315 may be required if workload increases to support expansion of treatment. |
| 13 (a) Enhance programs and integrate services to support HIV+ women and their infants in the prevention of Perinatal Transmission. | Develop and enhance partnerships between Obstetrics and Gynecology, Infectious Diseases, PHS, MH&A Services, WSCC and PLP. | Pre and post natal care immersed into addictions, HIV preventative and treatment plan in a high risk community. | Year 1 | ↑ clients accessing care  
↑ # of clients engaged in care  
All pregnant women high risk or infected clients and their infants are offered testing, preventative treatment and supports pre and post partum  
↑ # of pregnant high risk HIV negative women engaged in testing and harm reduction counseling | |
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<tr>
<td>13(b) Develop and integrate case management teams into the HIV care continuum to prevent perinatal transmission and support the family unit.</td>
<td>Health, advocating for an optional physician funding structure to support new service delivery model.</td>
<td>satellite clinics supported by family physicians and specialists in a high risk community.</td>
<td>† # of pregnant HIV positive women engaged in testing and harm reduction counseling</td>
<td>Advocate for Ministry funding for physician optional fee structure.</td>
<td>Refer to pharmacist costing under Priority #17(b)</td>
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<td></td>
<td>Develop and implement a model of care to coordinate HIV and methadone treatment within community, outpatient and acute care sites.</td>
<td>Targeted treatment and support plans utilizing pharmacy, addictions and treatment staff in the management of ART and methadone interactions, and prevention of methadone withdrawal due to impact of pregnancy and ART.</td>
<td>Elimination of mother to child transmission (MTCT) ↓ incidence of methadone withdrawals due to impact of pregnancy and ART ↑ adherence to methadone and ART regimes ↑ # of clients achieving their goals and meeting their basic needs ↑ # of clients in addictions treatment and recovery ↑ # of clients adhering to ART Treatment</td>
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<td></td>
<td>Mental Health and Addictions support offered throughout the HIV care continuum for all mothers in the antenatal, delivery and post-partum period.</td>
<td>↑ # of pregnant HIV positive women engaged in testing and harm reduction counseling</td>
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<td></td>
<td>Develop a dedicated pre / post natal HIV CM model and care map guiding case management teams in best evidence and targeted interventions. Train staff accordingly.</td>
<td>Skilled CM teams delivering clear consistent best evidence care.</td>
<td>↑ # of clients achieving their goals and meeting their basic needs</td>
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<td></td>
<td>Collaborate with the Kids First program to integrate HIV clinical support into their CM programming, integrate the HIV care map and clinical care to support clients</td>
<td>Engaged HIV+ women and their infants receiving HIV centered case management support through the Kids First program.</td>
<td>Year 1 Increased number of mothers caring for their infants in a safe and secure environment. Preventative HIV treatment regimes for infants consistently adhered to by the biological or custodial parents.</td>
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<td></td>
<td>Hire a dedicated case manager and outreach worker implement as outreach and fixed site service delivery models with strong referral processes.</td>
<td>Dedicated CM and outreach worker within WSCC, PLP and obstetrical teams supporting HIV+ pregnant clients and their NB who choose not to</td>
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Refer to 1.0 FTE CM / outreach funding under Priority # 18 (b)
### SHR HIV Prevention, Treatment & Support Priority Strategies and Budget

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<tr>
<td><strong>13 (c)</strong></td>
<td><strong>Increase HIV testing in pregnancy rates</strong></td>
<td>Access Kids First.</td>
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<td></td>
<td>Integrate an expand case management partnerships with STC Health Center, HMHB, Quint, CUMFI and Ministry of Social Services.</td>
<td>Client access and easy navigation to support options including housing, financial support, nutritional supplies and counselling, cultural and peer supports.</td>
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<td></td>
<td>Collaborate with the Ministry of Health to develop a formal guideline for HIV testing in pregnancy.</td>
<td>Formal guideline for HIV testing in pregnancy for Saskatchewan developed.</td>
<td>Year 1 - 2</td>
<td>As above</td>
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<td></td>
<td>Collaborate with the Department of Obstetrics and Gynecology to educate family physicians, obstetricians and nurse practitioners on guidelines for HIV testing in pregnancy.</td>
<td>HIV testing in pregnancy guidelines adhered to by physicians and nurse practitioners when completing antenatal screens.</td>
<td>Year 1 - 2</td>
<td>Increased HIV testing rates of pregnant women within SHR and Saskatchewan.</td>
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<td></td>
<td>Identify unit supports required to deliver POC testing on the labour and delivery ward. Train staff and implement according to standard guideline.</td>
<td>POC testing is provided following standardized guidelines on labour and delivery.</td>
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<td><strong>14.</strong></td>
<td><strong>Develop pre-printed orders with supporting guidelines to support the Labour and Delivery / Postpartum wards to prevent HIV perinatal transmission.</strong></td>
<td>Best evidence care consistently provided to prevent HIV perinatal transmission to newborns delivered on the wards.</td>
<td>Year 1 - 2</td>
<td>As above</td>
<td>In Kind</td>
</tr>
<tr>
<td></td>
<td>Collaborate with Labour and Delivery / Postpartum, ID, PLP, pharmacy, Obstetrics and Gynecology to develop pre-printed orders for Antiretroviral therapy and preventative care in labour and birth and for infants following birth.</td>
<td>Skilled staff delivering preventative medications during delivery and following birth of the newborn.</td>
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<tr>
<td></td>
<td>Develop guidelines to support best evidence practice. Educate and train staff.</td>
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*Funding to support POC training and implementation on Labour and Delivery to be determined*
### SHR HIV Prevention, Treatment & Support Priority Strategies and Budget

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<tr>
<td>15. Identify and implement a peer program pilot for new mothers at risk for, or infected with, HIV.</td>
<td>Research successful peer to peer programs for new mothers faced with parenting responsibilities and challenged with high risk behaviours for HIV. Consider implementing through Kids First Programming.</td>
<td>Peer support of HIV+ mothers during the pregnancy and post partum course.</td>
<td>Year 2 – 3</td>
<td>↑ engagement of new mothers at high risk for, or infected with, HIV.</td>
<td>Training and development $15,000, Implementation $20,000</td>
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<td>↑ client supports</td>
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<td></td>
<td>↑ clients seeking and maintaining addictions counselling and treatment.</td>
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<td></td>
<td>↑ # of mothers caring for their infants in a safe and secure environment.</td>
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### Accelerating the Scale Up of HIV / AIDS Treatment and Care

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<tr>
<td>16. Develop and implement a single entry referral process connecting new diagnosis to HIV treatment services to manage wait times; track and retain clients to care. Integrate this system with outreach support to enhance engagement.</td>
<td>Work with HIV clinical care partners to develop a single entry referral process within SHR to manage wait times, track and retain clients in care and ensure care is accessible. Revise the CDM referral data base to track incoming referrals and coordinate / triage access to care. Integrate referral system with case management / outreach support to enhance engagement and support transportation needs. Develop a monitoring and evaluation plan for the current system. Initiate QI process to Revised entry to care</td>
<td>All testing physicians / staff within SHR are aware of the referral process. A single entry process is consistently followed utilizing the CDM referral data base; supported by a strong triage process. Prevention outreach is utilized as an entry point to HIV treatment and care services. Case managers and outreach workers remove barriers to accessing treatment for new clients. Wait times for new referrals and engagement in care is evaluated upon first year of implementation.</td>
<td>Year 1 - 2</td>
<td>Process for referral followed by all testing physicians and staff within SHR and those outside of SHR who utilize the treatment facilities with SHR.</td>
<td>Referral tracking and monitoring data base. Funded through the Positive Living Program ($3,000) In Kind</td>
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<td>The referral data base monitors the appointment process and engagement of all HIV referrals to SHR.</td>
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<td>Outreach is integrated into care and support services. Clients are connected to a clinical team member within 3 days of referral and attend clinical appointments within 2 weeks with minimal effort.</td>
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<td>A baseline of the number of clients engaged and retained in care and wait times are identified from which to plan future.</td>
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<td></td>
<td>enhance retention and engagement.</td>
<td>processes implemented and targets identified.</td>
<td></td>
<td>interventions, targets and redesign measures.</td>
<td>SHR base incentive fund $1,000</td>
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<td></td>
<td>Work with community agencies, churches and industry to support HIV care treatment and support programs with incentives of food and other basic needs.</td>
<td>A consistent flow of incentive products utilized by all HIV prevention, care and treatment programs / venues coordinated through a central depot.</td>
<td>Year 1 - 2</td>
<td>Targets to ↑ # of clients engaged and retained in care are realized.</td>
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<td></td>
<td>Implement an annual evaluation of clients engaged and retained in care; initiate QI processes as required.</td>
<td>Revised entry to care processes implemented.</td>
<td>Year 3</td>
<td>↓ # of new HIV cases.</td>
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<td></td>
<td>Collaborate with the ID physicians to provide consistent scheduling of clinics.</td>
<td>Positive Living Program (PLP) clinics for HIV care provided weekly at WSCC.</td>
<td>Year 1</td>
<td>Weekly HIV clinics supported by ID at WSCC.</td>
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<tr>
<td>17 (a) Re-design and expand the clinical HIV / Hep C services to support the current RUH site, satellite clinics at WSCC and the MARS program</td>
<td>Collaborating with sites of clinical care to design and provide same day appointments / drop-in care for both program and/or physician staffed clinics.</td>
<td>Drop-in and same day appointments available to clients.</td>
<td>Year 1</td>
<td>↑ # of clients accessing care</td>
<td>Sessional pay for ID physicians and GPs for mentorship / clinical care in clinics (provincial funding).</td>
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<td></td>
<td>Situate PLP team compliments within WSCC – through lease of WSCC space for PLP RN; case manager and outreach workers.</td>
<td>Multidisciplinary team support available to clients accessing RUH and WSCC sites of providing consistent and skilled support in self-management, optimization of therapy and follow-up.</td>
<td>Year 1</td>
<td>↑ # of clients taking ART</td>
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<td>Ensure access to the Laboratory Information System (LIS) at all sites of care (WSCC).</td>
<td>Treatment and care provided to clients based on accurate and most current lab data.</td>
<td>Year 1</td>
<td>↓ viral load in treated clients</td>
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<tr>
<td></td>
<td>Ensure access to the Laboratory Information System (LIS) at all sites of care (WSCC).</td>
<td>Treatment and care provided to clients based on accurate and most current lab data.</td>
<td>Year 1</td>
<td>Improved CD4s in treated clients</td>
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<tr>
<td></td>
<td>Ensure access to the Laboratory Information System (LIS) at all sites of care (WSCC).</td>
<td>Treatment and care provided to clients based on accurate and most current lab data.</td>
<td>Year 1</td>
<td>Team support accessible to clients.</td>
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</tr>
<tr>
<td></td>
<td>Ensure access to the Laboratory Information System (LIS) at all sites of care (WSCC).</td>
<td>Treatment and care provided to clients based on accurate and most current lab data.</td>
<td>Year 1</td>
<td>Treatment decisions based on current data and best evidence.</td>
<td>$6,000 LIS at WSCC lab (data access &amp; Lab processing/ Community net installation to support</td>
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<td>17 (b) Develop and build multidisciplinary teams to support fixed and mobile venues.</td>
<td>Hire clerical support for the RUH site and enhance current clerical support at WSCC.</td>
<td>Clerical support provides reception duties, referral process support, data entry for evaluation processes and client file support.</td>
<td>Year 1</td>
<td>Program data is compiled and outcomes available for evaluation. Team members are freed up to provide client care. Client requests and care is streamlined quickly and efficiently. Referral process is supported by clerical. Improved treatment adherence. Community pharmacies advocating for clients and dispensing appropriately. HIV treatment provided according to best evidence guidelines. Client access to medications in a timely manner. Community pharmacists, GP and teams receive consistent continuing education opportunities.</td>
<td>1.0 Medical Office Asst. - RUH site $46,630</td>
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<td></td>
<td>Hire a pharmacist to support clinics, clients, community pharmacies, incipient care, discharges and family physicians.</td>
<td>Pharmacy support leads and provides direction on effective medication, treatment, adherence options and payment support for ID physicians, PLP team, GPs community pharmacies and clients.</td>
<td></td>
<td></td>
<td>0.3 FTE clerical support WSCC 11 hrs/wk- 600/yr at $17.30/hr x 600 x 1.19 = $12,352 Additional 1 FTE pharmacist $111,900 (.3 FTE funded)</td>
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<td></td>
<td>Hire an HIV / Hep C nurse clinician to support WSCC site and community.</td>
<td>PLP RN available in the core area providing HIV clinical care and self-management support at WSCC full time as well as incipient support at SPH to coordinate care and discharges to the community.</td>
<td></td>
<td>Continuity of care from incipients through to discharge to community. Informed and activated clients. ↑ # of clients retained in care. ↓ transmission of HIV</td>
<td>1.0 FTE HIV / Hep C nurse clinician - funded</td>
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<tr>
<td>Hire a psychologist to support clients and team.</td>
<td>Clients supported to deal with root issues of addiction, behavioural issues and depression.</td>
<td>Year 2</td>
<td>Root issues leading to risk behaviours are addressed with clients. Internal link and referrals between mental health and addictions are strengthened, improving continuity of care.</td>
<td>1.0 FTE Psychologist $52,459 x 1950 x 1.19 = $121,731.11 (Potential for re-direction)</td>
<td></td>
</tr>
<tr>
<td>Hire a dietician to support clients and team members.</td>
<td>Clients receiving counselling and self-management skills to meet nutritional requirements. Dieticians supporting HIV+ clients at HMHB, Kids First, and FFF receive support in the provision of best evidence care.</td>
<td>Year 2</td>
<td>Best evidence practiced by all nutritionists supporting HIV+ clients. Access and advice on nutritional products to support nutritional deficits. Counselling guidance on meal plans based on social services income and homeless situations. Improved BMI.</td>
<td>Consider utilization of STC nutritionist In Kind 0.5 FTE nutritionist $33.30 x 988 x 1.19 = $39,151.00 if support not possible with current STC resources In addition current programming for nutritional support could be utilized through HMHB, Kids First, FFF.</td>
<td></td>
</tr>
<tr>
<td>Collaborate with MH&amp;A to provide addictions support in partnership with HIV clinical care. Provide a strong presence at WSCC with expansion to the hospital environment for methadone titration/ART interactions.</td>
<td>Timely addictions support available to clients and HCP within the hospital and community environments as part of the HIV treatment and adherence plan and self-management programming.</td>
<td>Year 2</td>
<td>↑ # of clients successful in Methadone assisted recovery and ART adherence. ↑ # of clients who move one step within the harm reduction hierarchy.</td>
<td>Addictions Nurse Clinician (funded)</td>
<td></td>
</tr>
<tr>
<td>Explore current nurse practitioner positions in Primary Care and potential role within HIV care.</td>
<td>Identify NP role within HIV care.</td>
<td>Year 1</td>
<td>Enhanced NP position requirements identified as well as role and outcome parameters in support of HIV care.</td>
<td>To be determined. 0.5 FTE Nurse Practitioner (STC in Kind)</td>
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17 (c) Initiate a needs
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<tr>
<td><strong>Identify the need and opportunities for additional sites of care or enhancement of current services.</strong>&lt;br&gt; Expand services through hiring and redesign to sites of need supported by appropriate team.</td>
<td>Enhance lab tech support at WSCC lab.</td>
<td>Client access to phlebotomy Monday to Friday.</td>
<td>Year 2</td>
<td>Plan developed for additional access points or enhancements supported by date on the needs of the community. Informed and activated clients. ↑ # clients retained in care. ↓ transmission of HIV. ↑ adherence to ART regimes.</td>
<td>0.5 FTE CLXT lab position at WSCC $26,000 $70</td>
</tr>
<tr>
<td><strong>Develop a partnership between PLP, STC Health Center, MH&amp;A, and Kids First to identify a case management model to support HIV care. Develop a process to coordinate communication and services.</strong>&lt;br&gt; Develop a guideline to identify clients who would most benefit from case management support. Hire MH&amp;A outreach workers</td>
<td>Needs assessment and outcome report completed. Required positions incorporated into programming.</td>
<td>↑ # of clients receiving blood work to monitor disease process and treatment plan.</td>
<td></td>
<td></td>
<td>1.0 FTE HIV / Hep C nurse clinician $103,315 1.0 FTE pharmacists $111,900</td>
</tr>
<tr>
<td><strong>Support treatment preparedness and adherence through case management (CM)</strong>&lt;br&gt;(a) Build, develop and implement a case management team with standards and key interventions aimed at timely access and retention to care, improved quality of life, addictions recovery, and</td>
<td>Develop a training manual for case-managers, outreach workers and community workers. Orient and mentor case management staff.</td>
<td>CM programming tailored to HIV+ clients meeting their food, transportation, skills, health and cultural needs. CM support for clients with limited self-management capability. CM orientation and training program tailored to support IDUs and achieve positive outcomes. Case management staff</td>
<td>Year 1</td>
<td>Prepared proactive multidisciplinary teams Clearly defined HCP roles. ↑ # of clients with stable HIV conditions. ↑ # of client engaged in care. ↑ # of clients attending health maintenance appointments. Improved quality of life.</td>
<td>2.0 FTE Diploma Senior Addictions CMs ($30.83 x 1950 hours x 1.19 = $71,542.00) x 2 FTE = $143,084.03 4.0 FTE Diploma Addictions Outreach Workers ($28.55 x 1950 hours x 1.19 = $66,250.28)</td>
</tr>
<tr>
<td><strong>Refer to Priority # 23(a) Core Educator / Developer Funding.</strong></td>
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<th>Priority Strategy</th>
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<tr>
<td>prevention of perinatal transmission.</td>
<td>and case managers to support the case management process.</td>
<td>with expertise in addictions and mental health support available to link clients to care.</td>
<td>↑ # of clients engaged in addictions recovery. &lt;br&gt; Informed and activated clients.</td>
<td>x4 = $265,001.12</td>
<td></td>
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<tr>
<td>(b) Imbed case management programming within the team and community.</td>
<td>Imbed case management programming within the referral process.</td>
<td>Referral system which automatically triages clients to care based on self-management capacity.</td>
<td>↓ transmission of HIV.</td>
<td>Transportation allowance &lt;br&gt; <strong>CVA costs x 2 (1 car per team)</strong> &lt;br&gt; $4,738.68 x2 &lt;br&gt; = $9,477.36</td>
<td></td>
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<tr>
<td>(c) Enhance CM teams to support growing cases of HIV clients.</td>
<td>Utilize the PLP nurse Clinician and Case management team to support HIV+ clients admitted as inpatients</td>
<td>Consistent inpatient referrals to HIV care teams &lt;br&gt; Treatment and discharge plans initiated and coordinated upon admission</td>
<td>Continuity of care from inpatients through to discharge into community.</td>
<td>See STC and AIDS Saskatoon positions priority #10 (a)</td>
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<td>Identify and partner with community and health sector partners to support case management. &lt;br&gt; Develop client transportation guidelines /protocols to appropriately utilize transport services to health and supportive services; ensure client skill development for own transportation needs</td>
<td>Community agencies identified and integrated into case management programming to enhance supports In transportation and engagement in care</td>
<td>↑ # of clients have housing needs met. &lt;br&gt; ↑ client access to transportation supports &lt;br&gt; ↑ client skill development to negotiate own transportation &lt;br&gt; ↑ # of clients receiving elder and other traditional supports.</td>
<td>Refer to Priority #17 (b) &lt;br&gt; Nurse Clinician and #18 (b)CM funding</td>
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0.25 FTE AIDS Saskatoon community worker for transport support <br>$12,000 <br>Mileage funding $2,000 <br>STC Health Center mileage funding $2,000
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<td>Hire additional case managers and outreach workers to support clients.</td>
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<td>Year 2</td>
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<td>See additional transport supports Priority#18 (a)</td>
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<td>1.0 FTE Diploma Senior Addictions CMs ($30.83 x 1950 hours x 1.19 = $71,542.</td>
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<td>2.0 FTE Diploma Addictions Outreach Workers ($28.55 x 1950 hours x 1.19 = $66,250.28) x2 = $132,500.56</td>
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<td>Transportation allowance **CVA costs x 2 (1 car per team) $4,738.68 x2= $9,477.36</td>
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<td>Space $$</td>
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<td>19 (a). Support the health of clients through</td>
<td>Orient nurses who provide care to most at risk populations to complete</td>
<td>HIV and Hepatitis C clients will be vaccinated at every opportunity as</td>
<td>Year 1</td>
<td>$ of completed series for Hepatitis A and B immunization in HIV and</td>
<td>In Kind.</td>
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<td>redesign of immunization processes and support of staff certification.</td>
<td>their inoculist certification.</td>
<td>appropriate</td>
<td></td>
<td>HCV clients.</td>
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<td></td>
<td>Advocate for SIMS access for all immunization providers.</td>
<td>Nurses will have access to vaccination history to ensure adequate and safe vaccination coverage.</td>
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<td></td>
<td>Advocate for provincial funding for Gardasil vaccinations for women at risk.</td>
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<td>↑ # of HIV clients receiving pneumococcal immunization.</td>
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<td>Consult with the TB program on their successful DOT strategies.</td>
<td>Review of TB DOT program successes and challenges with implications incorporated into DOT programming plan.</td>
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<td>Partner with select community pharmacists.</td>
<td>Select Methadone dispensing pharmacies involved in DOT program development implementation and evaluation.</td>
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<td></td>
<td>Delivery of DOT programming pilot.</td>
<td>DOT programming implemented with select community pharmacies and clients.</td>
<td></td>
<td>DOT Pilot Program implemented.</td>
<td>Education support for community pharmacies partnering with DOT initiatives. $5,000</td>
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<td></td>
<td>Evaluation of pilot outcomes.</td>
<td>Report outlining evaluation results.</td>
<td></td>
<td>↑ # of methadone treated clients adherent to ART.</td>
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<td></td>
<td>Develop standardized client education and self-management modules on HIV and harm reduction with targeted messaging for IDU / high risk population.</td>
<td>Standardized targeted education packages delivered by all staff to support an activated client and proactive teams.</td>
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<td>Year 1</td>
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<td>↑ # of clients with increased CD4s.</td>
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<td>Year 1</td>
<td></td>
<td>↑ # of clients with ↓ VL.</td>
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<td>↑ 3 of clients with ↓ VL</td>
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<td>Core Educator /Developer Funding Refer to costing under Priority #23(a)</td>
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| **19 (d)** Provide timely access to psychiatry, psychology and elder counselling. | Collaborate with psychology, elder services to support client access to services at time of need. | Accessible counselling services dealing with the root causes of substance abuse. | Year 1 | ↓ HIV transmission  
↓ hospitalizations and ER visits | Refer to costing under Priority # 10 (b) & #17(b) for psychology services (1.0 FTE) |
| **19 (e)** Collaborate with ID physicians, PLP and rural providers in the utilization of Telehealth to deliver care. | Identify knowledge and assessment needs of the rural physicians.  
Plan and deliver through Telehealth information support.  
Provide clinical support by Telehealth as indicated. | Information sessions on HIV care and treatment delivered to support rural physicians.  
Clinics supported by ID physicians and PLP team (via Telehealth) provided in rural areas. | Year 1 | ↑ # of clients accessing HIV care in rural areas.  
↑ adherence to ART.  
↑ # of clients with increased CD4s.  
↓ HIV transmission  
↓ hospitalization and ER visits. | Provincial education support |
| **19 (f)** Collaborate with AIDS Saskatoon, STC Health Center, Avenue Community Center, LWWCC and PLP to explore the potential for a LWWCC peer led group supported through AIDS Saskatoon. | Develop a partnership between LWWCC, AIDS Saskatoon, STC Health Center, Avenue Community Center and PLP.  
Explore peer led programming and adapt to fit environment.  
Provide training and support for leaders utilizing the Peer mentoring Coordinator position and initiate plans for sustainability. | LWWCC peer led program situated at AIDS Saskatoon supporting the health and quality of life for clients living with HIV. | Year 1 | Improved quality of life for clients.  
↑ # of client managing symptoms.  
Expanded support structure for clients.  
↑ adherence to ART.  
↑ # of clients with increased CD4s.  
↓ HIV transmission  
↓ hospitalization and ER visits. | AIDS Saskatoon Peer Mentoring Coordinator see funding priority #11. |
## SHR HIV Prevention, Treatment & Support Priority Strategies and Budget

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<tr>
<td>20. Support collaboration between the TB and PLP programs to prevent co-infection and enhance surveillance, prevention and treatment strategies.</td>
<td>Initiate a working group to monitor co-infection rates. Utilize data to guide program integration, intervention implementation and evaluation plans.</td>
<td>Surveillance guides HIV / TB program planning, monitoring and evaluation in the prevention and treatment of co-infection.</td>
<td>Year 1</td>
<td>Programming decisions re: co-infection based on strong surveillance.</td>
<td>No funding required – resources through partnerships and cross training.</td>
</tr>
<tr>
<td></td>
<td>Review and implement best evidence guidelines on initial and repeat Mantoux testing required for HIV+ clients. Develop and implement guidelines.</td>
<td>HIV+ clients are offered Mantoux testing following best evidence guidelines.</td>
<td></td>
<td>↑ # of clients tested for TB.</td>
<td></td>
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<tr>
<td></td>
<td>Develop a process to improve completion and reading of Mantoux tests. Offer alternate sites/care options through cross training and partnering.</td>
<td>TB testing of all HIV clients according to best evidence by offering alternate sites/options to read results.</td>
<td></td>
<td>↑ # of clients with Mantoux s planted, read and counseled.</td>
<td></td>
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<tr>
<td></td>
<td>Develop TB and HIV program guidelines to support consistent testing and identification of active and preventative treatment of TB in HIV+ clients.</td>
<td>Identification and engagement of clients who require active and preventative counselling and treatment of TB.</td>
<td></td>
<td>↓ # of clients with active TB.</td>
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<td></td>
<td>Cross train TB staff to support clients with harm reduction strategies (including distribution of condoms) to improve client access to harm reduction tools and skills.</td>
<td>All clients accessing the TB program with risk behaviours will receive harm reduction information and tools to prevent co-infection.</td>
<td></td>
<td>↑ # of clients receiving preventative TB treatment.</td>
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<tr>
<td></td>
<td>Investigate the TB program’s ability to provide HIV counselling and testing with linkages to clinical care. Provide cross training as appropriate.</td>
<td>TB clients will receive HIV testing information and counselling as part of their care.</td>
<td></td>
<td>↑ use of harm reduction tools.</td>
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<td></td>
<td></td>
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<td></td>
<td>↓ HIV infections/co-infection with TB</td>
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<td></td>
<td></td>
<td></td>
<td>↓ # of clients at risk for HIV are tested for HIV</td>
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No funding required – resources through partnerships and cross training.
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<tr>
<td>Support collaboration between the TB program, STC Health Center, PLP, PHS and addictions and Mental Health programs to consider optional TB sites of care at select venues.</td>
<td>HIV clients will receive TB care and education as part of their care.</td>
<td>Year 1</td>
<td>Plan for funding / structure and role out secured.</td>
<td>Addictions and PLP RN funded.</td>
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**21. Palliative, Transitional and Home Care provided for clients with complex care needs.**

Partner with Ministry of Social Services to ensure access to and financial support for those clients requiring transitional housing and home palliative care services. Partner with PLP, MH&A, Palliative home care and home care to support this delivery of services. Initiate conversation with the community, SHR and Provincial Health to develop / create transitional housing site. Complex care clients with HIV and associated challenges receive care in LT and private care homes with care home staff and clients receiving strong supports through MH&A, PLP, palliative and home care service. SHR, provincial and community support plans for palliative transitional housing for addicted clients. Year 2 - 3 Plan for funding / structure and role out secured. Consider fundraising or partnership with the hospital foundation. Addiction RN/PLP RN $103,315 x 2 (nurse B) = $206,630 dependent on workload. To be determined.
### SHR HIV Prevention, Treatment & Support Priority Strategies and Budget

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| 22. Develop a leadership and governance structure to support the HIV strategy utilizing a chronic disease management approach. | Develop a partnership and collaboration between CDM Addiction and Mental Health and PHS. Develop a leadership structure supporting roles, accountability, governance, and budget. Establish a steering committee with consideration to include community members and client representation. Hire a project manager responsible to coordinate strategy implementation, active collaboration of partners, evaluation, review and course correcting. | Governance structure accountable for the implementation, evaluation and support of the HIV strategy. A client first funding model and management of same. Communication and implementation of values and principles that underlie the strategy process including the reduction of stigma and discrimination. Regional Policy development regarding HIV care and service. Strong partnerships between health sector, community and provincial stakeholders that contribute to effective interventions and outcomes. Innovative and collaborative programming. Participation and integration with the provincial HIV committee. | Year 1   | HIV strategy implemented and coordinated within and outside the health sector. Identification of bottlenecks and opportunities and interventions implemented re: same. Outcome monitoring and reporting. Deceased stigma and discrimination within SHR. Program delivery and revisions to approaches based on evaluation outcomes /readjustment of targets. Integration and collaboration of SHR programming with provincial HIV strategy. Proactive strategies with emerging issues. Improved quality of care. Joint health sector and community accountability for HIV care, treatment and support. | Medical Director Stipend $20,000  
1 FTE project Manager $118,048  
Committee Travel costs to support provincial meetings $250.00  
0.5 FTE Medical office assistant $23,315 |
## SHR HIV Prevention, Treatment & Support Priority Strategies and Budget

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<tr>
<td><strong>23 (a).</strong> Develop and deliver standardized orientation and training program / certification for all front line staff and community partners to ensure core competencies are present to support delivery of interventions, skill development and consistent messaging are tailored for addicted clients.</td>
<td>Advocate for provincial leadership in training content/Develop a general orientation program for all front line staff addressing HIV / Addictions, CDM, harm reduction. Incorporate cross-training between programs and task shifting as appropriate. Coordinate education updates / lunch and learn sessions. Deliver orientation sessions to all front line HIV related staff involved in HIV programming.</td>
<td>Standardized orientation package delivered to all front line HIV staff. All HIV related staff demonstrate and implement core competencies and skills in all client care provided.</td>
<td>Year 1</td>
<td>Clients are engaged across all programming and hearing same messaging; staff speaking the same language. ↓ VL in treated clients. ↑ clients enrolled in addictions treatment and recovery. ↑ clients receiving timely care in an accepting environment. ↑ client satisfaction with health care providers and services accessed.</td>
<td>2.0 FTE Core Educator/Program development Positions $44,44 x 1950 x 1.19= $103,123.02 X2 FTE= $206,246.04</td>
</tr>
<tr>
<td><strong>23 (b) Incorporate cultural competence requirements in the hiring process for front line staff working in HIV programming.</strong></td>
<td>Include Strengthening the Circle staff in the development of interview questions and include in the interview process. Participate in the development and distribution of HIV clinical care guidelines. Support and play an active role in the recruitment and training of family physicians.</td>
<td>Hiring process that measure and require cultural competence. HIV clinical care guidelines consistently implemented throughout Saskatchewan. An HIV curriculum for GPs implemented through the College of Medicine / Division of Infectious</td>
<td>Year 2</td>
<td>↑ in most at risk populations engaging in care. ↑ in # of staff who demonstrate cultural competence.</td>
<td>In Kind.</td>
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<tr>
<td><strong>23 (c) Advocate for and</strong></td>
<td>Advocate for and</td>
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(POCT coordination; Pre/Post test training; Harm reduction training; Needle exchange/addictions training; general orientation; peer training development; HIV education modules; case management /outreach development training and mentorship; policy development)
### SHR HIV Prevention, Treatment & Support Priority Strategies and Budget

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<td><strong>collaborate with the Ministry of Health to develop a HIV Provincial Program leading HIV care in Saskatchewan.</strong></td>
<td>Provide mentorship and training opportunities. Participate in the development of a central registry for treating physicians. Develop a network of HIV clinician mentors to enhance the number of family physicians / other professionals to deliver HIV care within SHR and rural settings. Develop a list of family physicians receptive to mentorship opportunities. Pilot program at selected sites.</td>
<td>Family physicians utilizing best evidence guidelines supporting HIV clients as a chronic disease. ID physicians and HIV care teams supporting family physicians in the care of HIV+ clients.</td>
<td>Year 2 - 3</td>
<td>HIV clinical guidelines distributed provincially. HIV curriculum and mentorship program implemented. ID physicians supported by GPs/NPs. GPs supported by ID physicians. Mentorship practicum’s at RUH, WSCC and rural sites. Client access to GP and ID care in a timely manner. ↓ VL in treated clients. ↑ CD4s in treated clients. ↑ # of clients accessing care. ↑ # of clients taking ART. ↓ wait times to receive care.</td>
<td>mentor/train GP’s per year Total $50,000 in 3 years</td>
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<tr>
<td><strong>Advocate for Provincial Support.</strong></td>
<td>(Estimated cost: $16,666.00 for year 2 curriculum/program development to mentor/train GP’s per year –Total $50,000 in 3 years)</td>
<td>(Estimated cost: $16,666.00 for Year 3 curriculum/program development to mentor/train GP’s per year -Total $50,000 in 3 years)</td>
<td><strong>Strengthening and Expanding Health Care Systems</strong></td>
<td>Secure a location in the core community. Determine complementary staff providing services. Consider new STC Health Center site</td>
<td>A location is secured offering multidisciplinary services (e.g.: STI, HIV, HCV, TB testing and treatment, Addictions and Harm Reduction services, abscess care and support</td>
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<td>services to most at risk populations through a strong engagement model.</td>
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<td>services) around an engagement model.</td>
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<td>↑ in engagement of most at risk population.</td>
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<td>↓ in ER attendance for abscess care.</td>
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<td>↑ engagement in pregnant females who are most at risk.</td>
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<td>↑ # of most at risk persons referred to addictions treatment, including OST.</td>
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<td>↑ # of HIV cases referred to HIV treatment.</td>
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<td>↓ in needles found in the community.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>↓ in HIV / HCV transmission due to better access to harm reduction services (e.g.: injection equipment and condoms)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>↑ in immunizations</td>
<td></td>
</tr>
<tr>
<td>25. Support and partner with Aboriginal and First Nation communities to bring cultural components to care.</td>
<td>In collaboration with Strengthening the Circle and STC Health Center support the design and implementation of FN and Metis HIV prevention, support and a treatment programming within SHR.</td>
<td>Linkages and referrals from SHR agencies to FN and Metis health and community programming. Support of opportunities to mentor and be mentored by FN and Metis program staff. Support of elder care in programming.</td>
<td>Year 1</td>
<td>↑ in most at risk populations engaging in care.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>↑ in # of staff who demonstrate cultural competence.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Operational costs TBD</td>
<td>In Kind</td>
</tr>
</tbody>
</table>
## SHR HIV Prevention, Treatment & Support Priority Strategies and Budget

<table>
<thead>
<tr>
<th>Priority Strategy</th>
<th>Work Plan Activity</th>
<th>Deliverables</th>
<th>Timeline</th>
<th>Outcome Measures</th>
<th>Budget</th>
</tr>
</thead>
</table>
| 26. **Provide health care workers with the knowledge and skills to practice non-discriminatory behaviour and cultural competence through harm reduction training, sessions on injection drug use and HIV.** | Develop a training program for health care workers specific to non-discrimination behaviours, harm reduction, IDU and HIV. Incorporate cultural competence programming through People’s Strategies | Health care workers display non-discriminatory behaviour. | Year 1 | ↓ in discriminatory behaviour displayed by health care workers who work with most at risk populations.  
↑ in most at risk populations engaging in care.  
↑ in staff who understand harm reduction theory, IDU and HIV.  
Post test scores reveal a measurable difference in knowledge and attitudes concerning stigma and discrimination, harm reduction, IDU and HIV. | Refer to Priority #23 (a) Core Educator/Developer Funding. |
| | Identify sites that work with persons most at risk of IDU and HIV (e.g. ERs)  
Provide training in non-discrimination, harm reduction, IDU and HIV. | Staff to have access to training in harm reduction, IDU and HIV. | | | |
| | Provide a pre and post test evaluation to measure increase in knowledge and attitudes.  
Revise training program relevant to post test results. | Clients are comfortable and feel safe at all sites of care within SHR. | Year 2 | | |

---

### Investing in Strategic Information to Guide a More Effective Response
<table>
<thead>
<tr>
<th>Priority Strategy</th>
<th>Work Plan Activity</th>
<th>Deliverables</th>
<th>Timeline</th>
<th>Outcome Measures</th>
<th>Budget</th>
</tr>
</thead>
<tbody>
<tr>
<td>27. Redesign Hepatitis C Surveillance and Public Health Case Management activities to inform programming and effectively monitor trends.</td>
<td>Participate in the Enhanced Hepatitis Surveillance System (EHSS) project with PHAC.  Allocate Hepatitis C Surveillance within Street Health Program.  Determine best use of PHAC funding to participate in the EHSS.  Prioritize immunization, education, risk reduction and partner notification to prevent HIV.  Advocate that laboratory services perform HCV PCR on all positive HCV antibody tests.</td>
<td>Enhanced hepatitis surveillance is undertaken with funding to support it. Street Health Program manages Hepatitis surveillance activities. PHAC funds are best allocated. New HCV cases have complete immunization of publicly funded vaccines. New HCV antibody results are processed for PCR immediately.</td>
<td>Year 1</td>
<td>↑ in immunizations for HCV cases.  ↑ in number of HCV partners obtained.  ↑ in number of HCV partners successfully notified.  ↑ in number of HCV partners successfully offered HIV VCT and HCV testing.  ↓ HIV transmission through HCV risk reduction counseling.</td>
<td>PHAC funding.</td>
</tr>
<tr>
<td>28. Redesign HIV Surveillance and Public Health Case Management activities to inform all programming and effectively monitor trends.</td>
<td>Participate in the Ministry of Health’s routine and enhanced HIV surveillance surveys. Implement the redesigned surveillance information data collection tool. Hire an enhanced surveillance officer to oversee the collection, monitoring and reports of the outcome parameters required.</td>
<td>Feedback on surveillance information collected is given. A redesigned surveillance data collection tool is available that balances information collection with service provision priorities.</td>
<td>Year 1</td>
<td>↑ in value in data collected to monitor epidemiological trends and inform decisions.</td>
<td>PHN funded - SUN partnership.</td>
</tr>
</tbody>
</table>

PHN funded – SUN partnership.

1.0 FTE enhanced surveillance & research officer $51,500
**SHR HIV Prevention, Treatment & Support Priority Strategies and Budget**

<table>
<thead>
<tr>
<th>Priority Strategy</th>
<th>Work Plan Activity</th>
<th>Deliverables</th>
<th>Timeline</th>
<th>Outcome Measures</th>
<th>Budget</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>29.</strong> Collaborate with the Ministry of Health to identify the data collection required. Implement, design and strengthen data management to monitor and evaluate programming.</td>
<td>Determine data to be collected, at what program level and by whom. Consider collaboration with HQC to ID appropriate indicators and sources of data. Determine data systems currently available and systems to be developed.</td>
<td>Coordinated and standardized data collection and analysis. Partnerships with Health Authorities, the Ministry of Health and Research to collect, develop and integrate data systems and research opportunities.</td>
<td>Year 1 - 3</td>
<td>Central repository of data utilized by programs to enhance care and inform programming. ↓ HIV transmission. ↑ quality of life. ↓ system utilization.</td>
<td>Provincial funding for data management</td>
</tr>
<tr>
<td><strong>30.</strong> Promote and support research opportunities.</td>
<td>Develop partnerships between the prairie provinces collaborative and Ministry of Health, PLP and PHS to identify research questions and data requirements.</td>
<td>Research questions and data management requirements identified.</td>
<td>Year 1 - 3</td>
<td>Research findings supporting practice.</td>
<td>To be determined.</td>
</tr>
</tbody>
</table>

### Budget for New Initiatives - Year 1

<table>
<thead>
<tr>
<th>Comments:</th>
<th>Year 1</th>
</tr>
</thead>
<tbody>
<tr>
<td>• biomed disposal costs not included in budget</td>
<td>Baseline costs: $1,185,628</td>
</tr>
<tr>
<td>Incremental costs $881,741</td>
<td>Year 1 Total: $2,067,369</td>
</tr>
</tbody>
</table>

### Budget for New Initiatives - Year 2

<table>
<thead>
<tr>
<th>Comments:</th>
<th>Year 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Operational costs for a fixed site for Needle exchange/STI and supportive services are not included • Curriculum/Program Development for GP’s/HCP’s not included</td>
<td>Incremental costs: $1,169,561</td>
</tr>
<tr>
<td>Sustained funding Yr1: $2,067,369</td>
<td>Year 2 Total: $3,236,930</td>
</tr>
</tbody>
</table>

### Budget for New Initiatives - Year 3

| Year 3 |
| Incremental costs: $376,652 |
**Based on a monthly fixed cost of $210.89 the fixed cost for a year for one CVA = $2,530.68. CVA cost estimates are based on the year/make model of the unit, this will be higher on newer vehicles. The mileage rate is 0.18/km. Cost is based on an estimated usage of 1000 km per month, the cost per month = $184.00. Total cost for 1 year = $4,738.68.

Annual and sustained funding does not include inflation and increases as per collective agreements.

**

| Year 1: | April 1, 2010- March 31, 2011 |
| Year 2: | April 1, 2011- March 31, 2012 |
| Year 3: | April 1, 2012 – March 31, 2013 |

<table>
<thead>
<tr>
<th>Sustained funding</th>
<th>$3,236,930</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yr1/Yr2:</td>
<td></td>
</tr>
<tr>
<td>Year 3 Total:</td>
<td>$3,613,582</td>
</tr>
</tbody>
</table>

| Sustainable annual costs beyond 3 years: | $3,613,582 |
## Addendum B

### HIV Strategy Budget for the Region of Saskatoon
#### 2010-2011

### Essential Start up Costs

<table>
<thead>
<tr>
<th>Timeline</th>
<th>Initiative</th>
<th>Description</th>
<th>Costing</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initiate Fall 2010</td>
<td>Coordination &amp; Community Engagement</td>
<td>Project Manager/ Coordinator (1.0 FTE)</td>
<td>118,545</td>
<td>118,545</td>
</tr>
<tr>
<td></td>
<td>Clinical Management</td>
<td>Multidisciplinary Team Enhancements</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>1.0 Clerical PLP</td>
<td>46,630</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>0.3 Clerical WSCC</td>
<td>12,352</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>1.0 Pharmacist</td>
<td>111,900</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>0.5 Lab Tech WSCC</td>
<td>26,000</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>1.0 RN STC Health Center</td>
<td>80,000</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>1.0 HIV Social Case Manager/ Outreach (pre/postpartum CM/</td>
<td>71,542</td>
<td>168,561</td>
</tr>
<tr>
<td></td>
<td></td>
<td>general CM/Funding received fall 2010)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>CVA costs (SHR)</td>
<td>9,477</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Client Transport costs (STC)</td>
<td>12,000(0.25 FTE)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>0.25 Community worker for transport support (AIDS Saskatoon)</td>
<td>2,000</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Situate clinical services in core area</td>
<td>7165</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>PLP nursing/pharmacy/CM office lease costs at WSCC</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>STC Health Center -Equipment, supplies, training and maintenance to support services</td>
<td>25,800</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>4.5 Addictions outreach placed in</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>Needle exchange</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>(1.5) Street Health Van</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>(2.5) STC Van</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>(0.5) AIDS Saskatoon</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>1.0 MH &amp; A Worker (STC)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Elder Consultation and support (STC Health Center)</td>
<td>30,500</td>
<td>30,500</td>
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<tr>
<td></td>
<td></td>
<td>Client engagement incentive fund</td>
<td>1,000</td>
<td>1,000</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Laboratory Information System at WSCC Lab (data access to support treatment decisions)</td>
<td>6,000</td>
<td>8,000</td>
</tr>
<tr>
<td></td>
<td></td>
<td>LIS Printer</td>
<td>2,000</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Prevention &amp; Harm Reduction</td>
<td>Prevention &amp; Harm Reduction</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Needles, containers, stericups, water, ties (STC; AIDS Saskatoon; SHR)</td>
<td>240,600</td>
<td>240,600</td>
</tr>
<tr>
<td></td>
<td>Enhanced Surveillance &amp; Research</td>
<td>Enhanced Surveillance Officer</td>
<td>51,500</td>
<td>51,500</td>
</tr>
</tbody>
</table>

### Annualized Costs (prorated as required)

$1,185,628
<table>
<thead>
<tr>
<th>Timeline</th>
<th>Initiative</th>
<th>Description</th>
<th>Costing</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Winter 2010</td>
<td>Prevention &amp; Harm Reduction</td>
<td>Condoms, needles vending machine, Needles containers, sterile cups, water, ties (STC; AIDS Saskatoon; SHR)</td>
<td>27,000</td>
<td>267,600</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Needle drop box purchase and placement</td>
<td>15,000</td>
<td>15,000</td>
</tr>
<tr>
<td></td>
<td>Clinical Management</td>
<td>Case Management</td>
<td>265,000</td>
<td>265,000</td>
</tr>
<tr>
<td></td>
<td>Community Engagement and Education</td>
<td>Research development support for Peer to Peer Model development (expansion of current use Community based researcher in partnership with SHR)</td>
<td>15,000</td>
<td>32,700</td>
</tr>
<tr>
<td></td>
<td></td>
<td>0.5 Peer to Peer Mentoring Coordinator (AIDS Saskatoon) for implementation of peer to peer programming</td>
<td>17,700</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Community Engagement and Education</td>
<td>Human Resource Training policy, orientation development</td>
<td></td>
<td>252,876</td>
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<tr>
<td></td>
<td></td>
<td>2.0 Core Educators</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>1.0 clerical assistant</td>
<td>206,246</td>
<td></td>
</tr>
<tr>
<td></td>
<td>DOT pharmacy partners - Education funding</td>
<td></td>
<td>46,630</td>
<td></td>
</tr>
<tr>
<td></td>
<td>DOT pharmacy partners - Education funding</td>
<td></td>
<td>5,000</td>
<td>5,000</td>
</tr>
<tr>
<td></td>
<td>Clinical Management &amp; Community Engagement</td>
<td>0.5 Clerical Support Committee Travel costs Physician Stipend</td>
<td>23,315</td>
<td>43,565</td>
</tr>
<tr>
<td>Total Winter Additional Annualized Costs</td>
<td></td>
<td></td>
<td></td>
<td>881,741</td>
</tr>
<tr>
<td>Year 1 Annualized Total Costs</td>
<td></td>
<td></td>
<td></td>
<td>2,067,369</td>
</tr>
<tr>
<td>Initiative</td>
<td>Description</td>
<td>Costing</td>
<td>Total</td>
<td></td>
</tr>
<tr>
<td>----------------------------------------</td>
<td>-----------------------------------------------------------------------------</td>
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<td></td>
</tr>
<tr>
<td>Sustained funding for year 1 initiatives</td>
<td></td>
<td>2,067,369</td>
<td>2,067,369</td>
<td></td>
</tr>
<tr>
<td>Clinical Management</td>
<td>Contact tracing enhancements</td>
<td>103,315</td>
<td>206,630</td>
<td></td>
</tr>
<tr>
<td></td>
<td>PHN 1.0 FTE</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>1.0 PHN multi service site</td>
<td></td>
<td></td>
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</tr>
<tr>
<td></td>
<td>Multidisciplinary team enhancements</td>
<td>479,412</td>
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</tr>
<tr>
<td></td>
<td>PLP Nurse Clinician 1.0 FTE (additional site)</td>
<td>103,315</td>
<td></td>
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</tr>
<tr>
<td></td>
<td>PLP nurse clinician HCV Treatment @ MARS</td>
<td>103,315</td>
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<tr>
<td></td>
<td>1.0 Pharmacist</td>
<td>111,900</td>
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<td></td>
<td>1.0 Psychologist</td>
<td>121,731</td>
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<tr>
<td></td>
<td>0.5 Dietician</td>
<td>39,151</td>
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<tr>
<td>Case Management</td>
<td>1.0 Senior addictions CM</td>
<td></td>
<td>213,519</td>
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<tr>
<td></td>
<td>2.0 Addictions Outreach</td>
<td>71,542</td>
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</tr>
<tr>
<td></td>
<td>CVA costs</td>
<td>132,500</td>
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</tr>
<tr>
<td></td>
<td></td>
<td>9,477</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fixed site for multidisciplinary services</td>
<td>Infrastructure lease costs</td>
<td></td>
<td>220,000</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Tenant improvement costs (one time)</td>
<td>80,000</td>
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<tr>
<td></td>
<td></td>
<td>140,000</td>
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</tr>
<tr>
<td>Community Engagement and Education</td>
<td>Financial incentive for peer contribution for IDU</td>
<td>15,000</td>
<td>50,000</td>
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</tr>
<tr>
<td></td>
<td>Peer to peer group/programming</td>
<td></td>
<td></td>
<td></td>
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<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Peer to Peer Mothers at Risk</td>
<td>35,000</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Research development and implementation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Year 2 Annualized Total Costs</td>
<td></td>
<td></td>
<td>3,236,930</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Plus inflation and increases as per collective agreements</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## Budget Forecast Year 3  
2012-2013

<table>
<thead>
<tr>
<th>Initiative</th>
<th>Description</th>
<th>Costing</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sustained funding for Year 2 and 3 initiatives</td>
<td></td>
<td>3,236,930</td>
<td>3,236,930</td>
</tr>
</tbody>
</table>
| Clinical Management | Case Management  
2.0 Community worker CM  
1.0 Addictions outreach CM  
CVA costs | 99,034  
66,250  
4,738 | 170,022 |
| Transitional Housing/private care home supports  
2.0 FTE Addictions/PLP nurses | | 206,630 | 206,630 |

**Year 3 Annualized Total Costs**  
**3,613,582**  
Plus inflation and increases as per collective agreements

**Sustainable Costs Beyond 3 years**  
**3,613,582**  
Plus inflation and increases as per collective agreements
Appendix 3
HIV Prevention, Treatment and Support Service Continuum (as of April 2010)