

# BEYOND BLUE DOOR.

*Bridging Knowledge and Service Gaps  
for People Living with HIV with Precarious  
Health Insurance*

A Community-Based Research Report

August 2023

BEYOND  
BLUE DOOR





# ACKNOWLEDGEMENTS

*We acknowledge the land upon which this work was conducted as the traditional territory of the Mississaugas of the Credit, the Anishnabeg, the Chippewa, the Haudenosaunee and the Wendat peoples. As racialized researchers we stand in solidarity with Indigenous communities locally and globally, and are committed to challenging settler colonialism through continued critical reflection and action.*

We thank the participants, service providers, research partners, clinic staff and investigator team whose collective, dedicated efforts have driven this study forward. These include:

## Research participants

The knowledge generated in this study is made possible by the many research participants living with HIV with experiences of precarious health coverage and immigration status who shared their life stories. Their insights combined with those of service provider participants, including Blue Door Clinic staff, and those from varying health and social services were crucial in shaping the study's findings and recommendations.

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# TERMINOLOGY

**PLHIV:** People Living with HIV

**UPI:** Uninsured or Precariously Insured

**UPI PLHIV:** Uninsured or Precariously Insured People Living with HIV

**IFHP:** Interim Federal Health Insurance

**ASO:** AIDS Service Organization

**GIPA/MEPA:** The Greater Involvement of People Living with HIV and/or AIDS  
/ Meaningful Engagement of People living with HIV and/or AIDS

## ***What do we mean by the non-insured?***

### **With status but non-insured, precariously insured, or with limited coverage:**

- New immigrants or PR in 3 month OHIP waiting period
- Migrant workers
- International students

### **Status pending:**

- Applicants with pending inland sponsorship
- Humanitarian and compassionate applicants (H&C)
- Waiting to start application for status but not yet started

### **Between statuses or without status:**

- Visitor visa
- Temporary foreign workers between contracts
- Students graduated but waiting for work visas
- Rejected refugee claimants who are not deported
- Those who lost sponsorship due to relationship breakdown
- Those who lack ID to verify their status due to social situations (e.g. homelessness)

# 01 EXECUTIVE SUMMARY.

Beyond Blue Door is a community-based research study designed to reduce knowledge and service gaps for people living with HIV who are unable to access health care due to precarious or no health insurance.

People living with HIV who are uninsured or with precarious health insurance (UPI PLHIV) experience significant barriers in accessing HIV care. In response, a coalition of health and community service agencies developed the Blue Door Clinic (BDC). BDC has been providing HIV treatment, community support and assistance, and links to ongoing services for UPI PLHIV since September 2019.

Stemming from work at BDC, the Beyond Blue Door Research Study was initiated in 2020 by the Community Alliance for Accessible Treatment (CAAT; *formerly the Committee for Accessible AIDS Treatment renamed in 2022 after incorporation*) in collaboration with key service partners. The study aimed to build a knowledge base to better understand the health care needs and realities of UPI PLHIV, and support evidence-based interventions to reduce health inequities to promote equitable health care access.

## ***The goals of the study were to:***

01

**Generate** knowledge on the determinants of HIV related health disparities experienced by non insured or precariously insured PLHIV;

02

**Evaluate** the effectiveness and sustainability of the innovative Blue Door Clinic initiative to support linkage to stable, long-term primary care for PLHIV (UPI-PLHIV)

03

**Identify** evidence-based strategies to enhance service access to quality of care and support for PLHIV populations

## ***Research Design and Methods:***

The study was guided by the principles of social justice and equity. The team applied a mixed methods approach in two (2) phases to engage UPI PLHIV and service providers. In phase one qualitative narrative data was collected through focus groups and individual interviews with UPI PLHIV, service providers, and decision makers. Data collected at this stage aimed at understanding the social determinants and health disparities affecting UPI PLHIV.

In phase two both quantitative and qualitative data were collected to evaluate the effectiveness and impact of the Blue Door Clinic, and to identify wise practices and areas for improvement. Quantitative data included relevant health indicators, and service statistics related to linkages to care, retention, treatment access and referrals. Qualitative data was gathered through focus groups with PLHIV who had accessed services at the clinic, along with internal and external service providers.

Additionally, the RE-AIM framework was applied to track whether the intervention was able to reach the intended populations; the effectiveness of the Blue Door Clinic, the extent of adoption of the clinic by relevant stakeholders; the barriers and facilitators of clinic implementation, and maintenance or sustainability of practice changes and program integration at the organizational level among the partners in response to community needs, including needs before and during the COVID19- pandemic.

### ***What we Learned:***

Findings of the study are shared in two parts to detail what was learned through phase one and phase two of data gathering. These two sections highlight the realities of UPI PLHIV in accessing health care, and the evaluative results of the effectiveness of the Blue Door Clinic.

Insights on the realities of UPI PLHIV in accessing health care are based on data from 30 UPI PLHIV and 21 service providers and policy makers who discussed the challenges and resiliencies of their experiences. Their discussions covered four (4) broad areas that cross cut to affect both individual access to care as well as service provision by care providers including:

- Policies and structures that result in inequitable health care outcomes and access
- Health care services which are unclear to navigate for both UPI PLHIV and service providers leading to restrictive or inconsistent quality of provision
- Intersecting social determinants such as mental health stressors and precarious housing that compound access to care; and
- Community resiliencies and strategies for care that are adopted by individual UPI PLHIV and service providers such as building peer and service networks

Results of the service evaluation are shared in phase two of the findings. Service data of 159 UPI PLHIV who had accessed services at Blue Door Clinic, and discussions with 66 PLHIV and internal and external service providers clearly show the Blue Door Clinic is a highly valuable and innovative model filling significant gaps in health care provision for UPI PLHIV.

The key strengths of the clinic include a compassionate human-centred approach, multi-sectored partnerships pooled to link clients to care, language and interpretation supports offered by peers, and overall dedication to providing equitable care and treatment access. Challenges discussed were primarily connected to a lack of sustainable resources for the clinic which translates into limited capacities to meet growing service needs or outreach to relevant communities.

Additional findings are highlighted that stood out as critical for participants across both phases. These include the considerable impact of peer engagement and leadership, the adaptability and responsiveness of the clinic especially through considerable covid related challenges, and the use of integrated knowledge translation (iKTE) throughout the research project to continuously inform service optimization.

### ***Recommendations:***

The study's findings clearly highlighted the immense value of a dedicated program for precariously insured populations with HIV that provides holistic intersectional services through multi-sectored collaboration. Wise practices adopted in the work such as integrating GIPA/MEPA, allyship, an emphasized learning culture, intersectional service offering, and adaptive responsiveness are all that can be modeled in sectors looking to serve differently marginalized communities.

The report outlines 12 recommendations to enhance health equity and accessible healthcare for uninsured and precariously insured populations living with HIV in Ontario.

***These recommendations target four key groups:***



***Affected  
Communities***



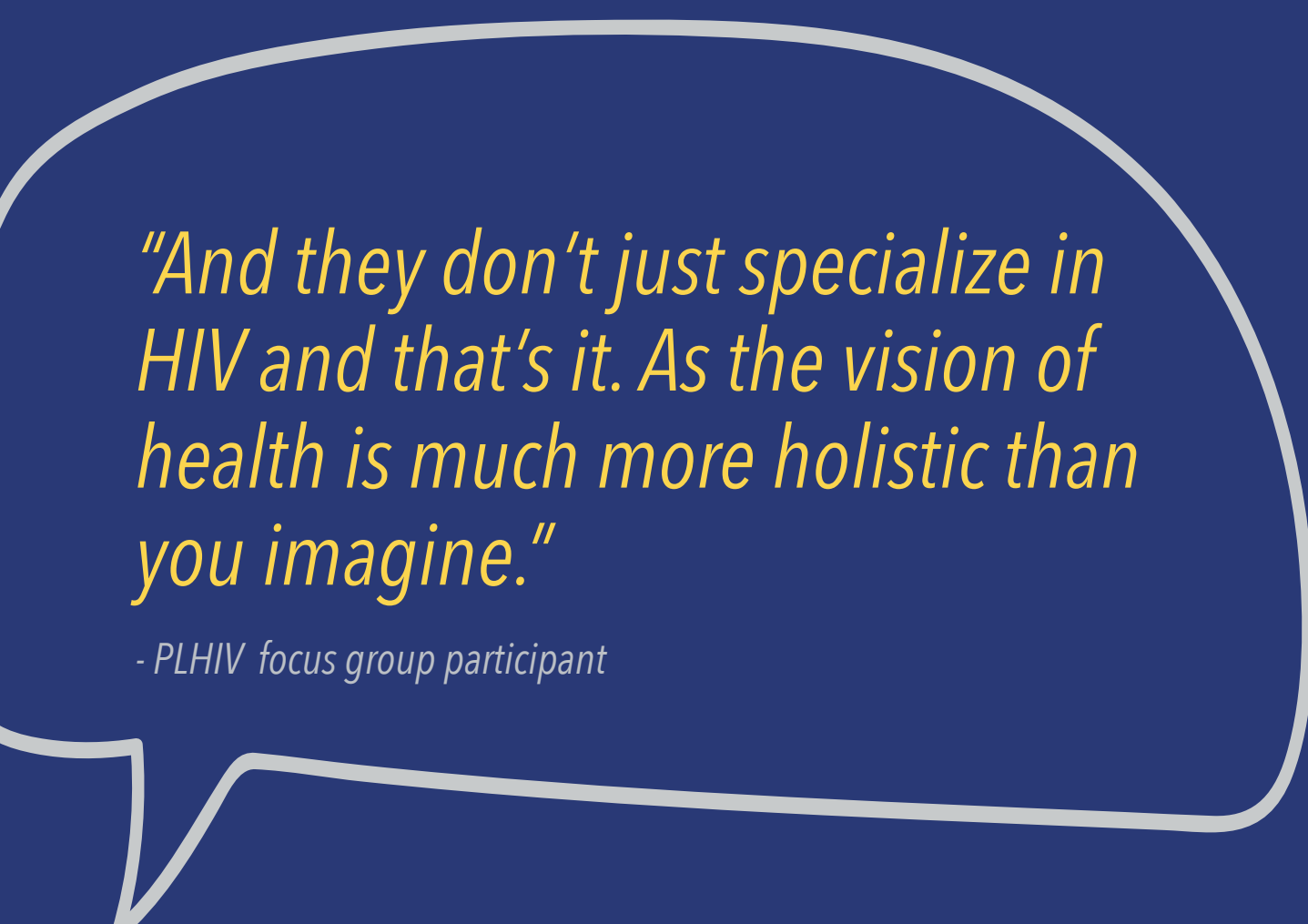
***Service  
Providers***



***Service  
Planners***



***Policymakers***



*"And they don't just specialize in HIV and that's it. As the vision of health is much more holistic than you imagine."*

*- PLHIV focus group participant*

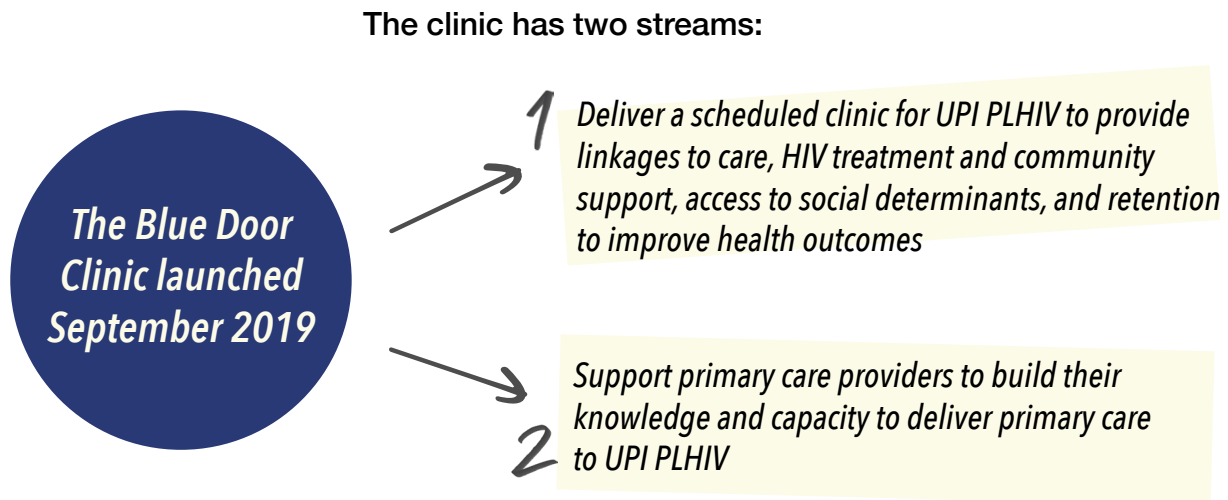


# 02 BACKGROUND.

People living with HIV who are uninsured or with precarious health insurance (UPI PLHIV) experience significant barriers in accessing HIV care. While the advances of ART and PrEP have made considerable progress in preventing HIV infections and improving the health outcomes of many people living with HIV, specific vulnerable and marginalized communities continue to be disproportionately impacted.<sup>1</sup> This affects individual health outcomes, and undermines the overall effectiveness of the public health response in curbing the HIV epidemic. In response, a coalition of health and community service agencies came together to develop the Blue Door Clinic, a unique health intervention that subsequently led to the Blue Door Research Project.

## 2.1 About the Blue Door Clinic

The Blue Door Clinic was first envisioned at the Ontario HIV Treatment Network (OHTN) ‘Pitching The Tent’ forum in 2018, and has since evolved into a ground-breaking, multidisciplinary coalition of service agencies providing HIV treatment, community support, and links to ongoing services for UPI PLHIV since September 2019.



The clinic is jointly operated by representatives of a service coalition who make up a Steering Committee (SC). The clinic service model was co-developed by community agencies, services providers and members of the PHA community, and based on careful consultation with affected communities. Service providers and peer navigators from collaborating agencies in the coalition work together to provide a full range of services including holistic primary health care, case management and connection to community and peer support.

1. Magalhaes L, Carrasco C, Gastaldo D. Undocumented migrants in Canada: a scope literature review on health, access to services, and working conditions. *J Immigr Minor Health*. 2010 Feb;12(1):132-51. doi: 10.1007/s10903-009-9280-5.



## Service Coalition Team

- Black Coalition for AIDS Prevention (SC)
- Community Alliance for Accessible Treatment (SC, Intake, CM)
- Casey House (SC, Intake, CM, RNs)
- Centre for Spanish Speaking Peoples (SC)
- Fife House (SC, Intake, CM)
- Hassle Free Clinic (SC, CM)
- Ontario HIV Treatment Network (Pilot staff (intake)/funding)
- Parkdale Queen West Community Health Centre (SC, MDs/NPs, RNs)
- Regent Park Community Health Centre (SC, MDs/NPs, RN, Admin)
- Sherbourne Health Centre (SC, RNs, Admin)
- Toronto People With AIDS Foundation/ Latinos Positivos (SC, Peer Navigators)

SC= Steering Committee | CM=Case Management |

MDs =Medical Doctors | NPs= Nurse Practitioners | RNs= Registered Nurses

## ***2.2 About the Beyond Blue Door Research Project***

The Beyond Blue Door Research Study was initiated in 2020 by the Committee for Accessible AIDS Treatment (CAAT) in collaboration with key partners. Stemming from work at the clinic, the study aimed to build a knowledge base of health care needs and realities of UPI PLHIV, and support evidence-based interventions to reduce health inequities to promote equitable health care access.

The study engaged PLHIV with precarious and no health insurance coverage and service providers working with them to learn about their experiences. It also evaluated the effectiveness and impact of the Blue Door Clinic, and identified long term strategies to improve the care and well-being of UPI PLHIV communities.

The research project was supported by the Endgame Research Funding from the Ontario HIV Treatment Network.



# RESEARCH DESIGN & METHODS

## ***3.1 Principles Guiding the Work:***

As a community-based implementation research Beyond Blue Door was guided by principles of social justice and equity, community accountability, collective empowerment and the Greater and Meaningful Involvement of People Living with HIV (GIPA/MIPA). The study was also informed by critical health promotion frameworks that recognize individual and collective health are intertwined; and, that health disparities are the outcomes of social determinants including access to economic and social resources, everyday encounters of discrimination, and social exclusion.

A multidisciplinary research team made up of people with lived experiences, clinicians, researchers, community service providers, health system managers, analysts and policy makers identified study objectives to:

- Generate knowledge on the determinants of HIV related health disparities experienced by non insured or precariously insured PLHIV;
- Evaluate the effectiveness and sustainability of the innovative Blue Door Clinic initiative to support linkage to stable, long-term primary care for PLHIV (UPI-PLHIV); and
- Identify evidence-based strategies to enhance service access to quality of care and support for PLHIV populations

## ***3.2 How Data was Collected:***

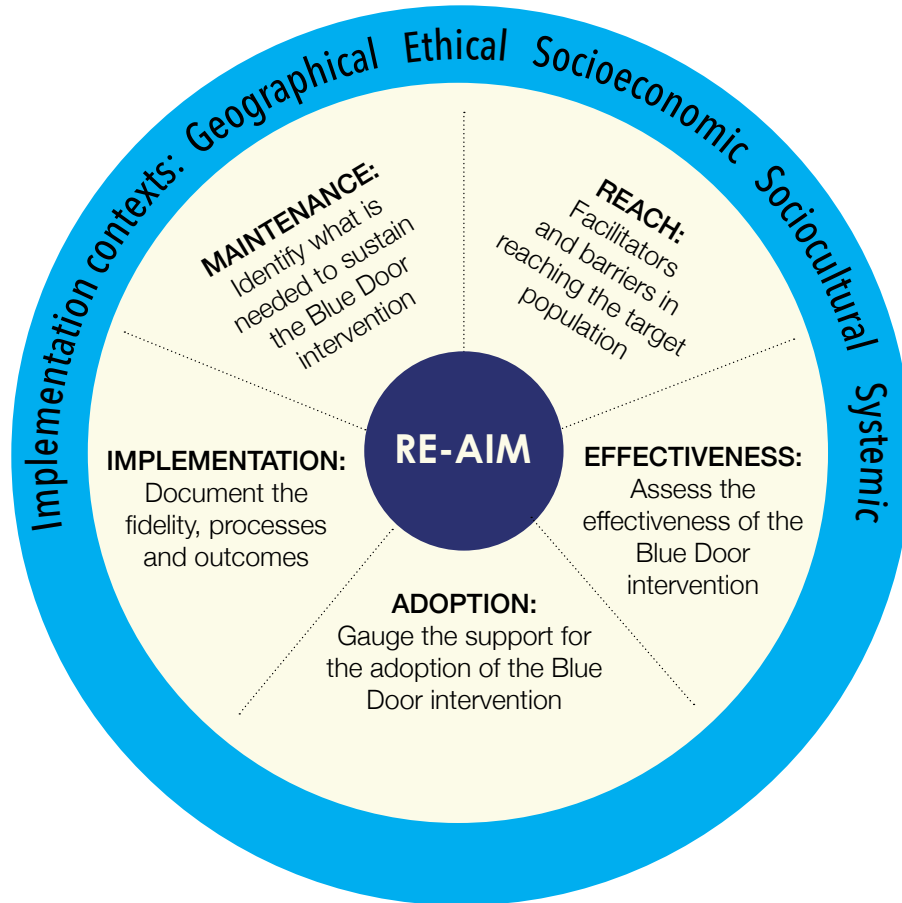
The team applied a mixed methods approach, which included the use of focus groups, individual interviews, questionnaires and Blue Door Clinic service statistics. Data collection took place over two (2) phases and engaged individual UPI PLHIV and service providers from diverse social care sectors.

Phase one generated qualitative narrative data through focus groups and individual interviews with UPI PLHIV, service providers and decision makers. Participants included UPI PLHIV who have had direct personal experiences of having partial or no health insurance coverage within two (2) years prior to study recruitment (regardless of immigration status). Discussion questions centred on experiences of migration, navigating health care and treatment access in home countries and Canada, strategies of care and resilience, and ideas for changes in the health system. Overall data collected at this stage aimed at understanding the social determinants and health disparities affecting UPI PLHIV.

Phase two included both quantitative and qualitative data collection aimed at evaluating the effectiveness and impact of the Blue Door Clinic. Quantitative data included cumulative service statistics of clients at the clinic related to linkage to and retention in primary care, and referral to access social determinants. Qualitative data in phase 02 was gathered through focus groups with UPI PLHIV who had accessed services at the clinic, along with internal and external service providers. Discussion questions in this stage centered on experiences of service access at the clinic, strengths, challenges and ideas for growth and enhancement.

The RE-AIM framework,<sup>2</sup>(see *diagram*) emphasizing ‘Reach, Effectiveness, Adoption, Implementation, and Maintenance/ Sustainability’ was used in the phase 02 service evaluation to review additional qualitative and process data. This included data related to sustained partnership engagement and adaptive measures in response to community needs, before and during the COVID-19 pandemic.

**RE-AIM Framework and Contexts:**



**3.3 Analyzing the Data**

Qualitative focus group discussions and interviews from phase 01 and 02 were transcribed verbatim and analyzed using an interpretive thematic approach. Transcripts were repeatedly read by members of the research team to develop a strong familiarity and understanding of the data. A summary of each transcript was also developed to capture the dynamics, contexts and nuances in each focus group or interview. Coding of key themes took place based on narratives of the participants and research questions. Codes of each transcript were discussed by team members to ensure agreement on the interpretation of data.

Inductive analysis was applied to the ideas and stories articulated by the participants, and deductive analysis was used based on pre-existing concepts and frameworks. Analysis was strengthened through engagement of all team members in critical discussion and interpretation of the data results.

<sup>2</sup> Holtrop, J. S., Rabin, B. A., & Glasgow, R. E. (2018). Qualitative approaches to use of the RE-AIM framework: rationale and methods. *BMC health services research*, 18, 1-10.



# ***FINDINGS***



# 04 FINDINGS.

Findings of the study are shared in two parts to detail what was learned through phase one and phase two of data gathering. These two sections highlight the realities of UPI PLHIV in accessing health care, and the evaluative results of the effectiveness of the Blue Door Clinic respectively.

## 4.1 Realities of Health Care Access for Uninsured and Precariously Insured People Living with HIV

Insights on the realities of UPI PLHIV in accessing health care are based on data from 51 participants described below. PLHIV participants had direct personal experiences of having partial or no health insurance coverage within the 2 years prior to study recruitment (regardless of immigration status).

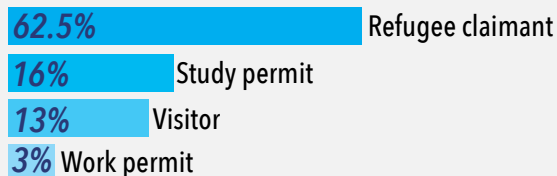
### WHO DID WE ENAGE: (phase 01)



**30** PLHIV with lived experiences of precarious health coverage status

#### IMMIGRATION STATUS

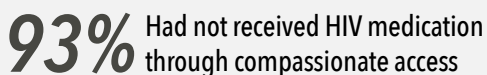
when moved to Canada



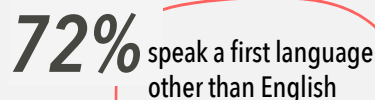
#### EMPLOYMENT



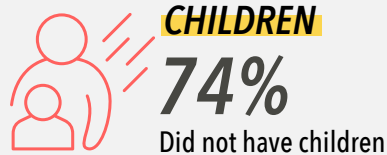
#### TREATMENT



#### LANGUAGE



#### CHILDREN



**21** Service providers from diverse disciplines serving precariously insured PLHIV

#### TYPE OF SERVICE PROVIDER



#### CLIENT BASE

% of PLHIV clients six (6) months prior to the study

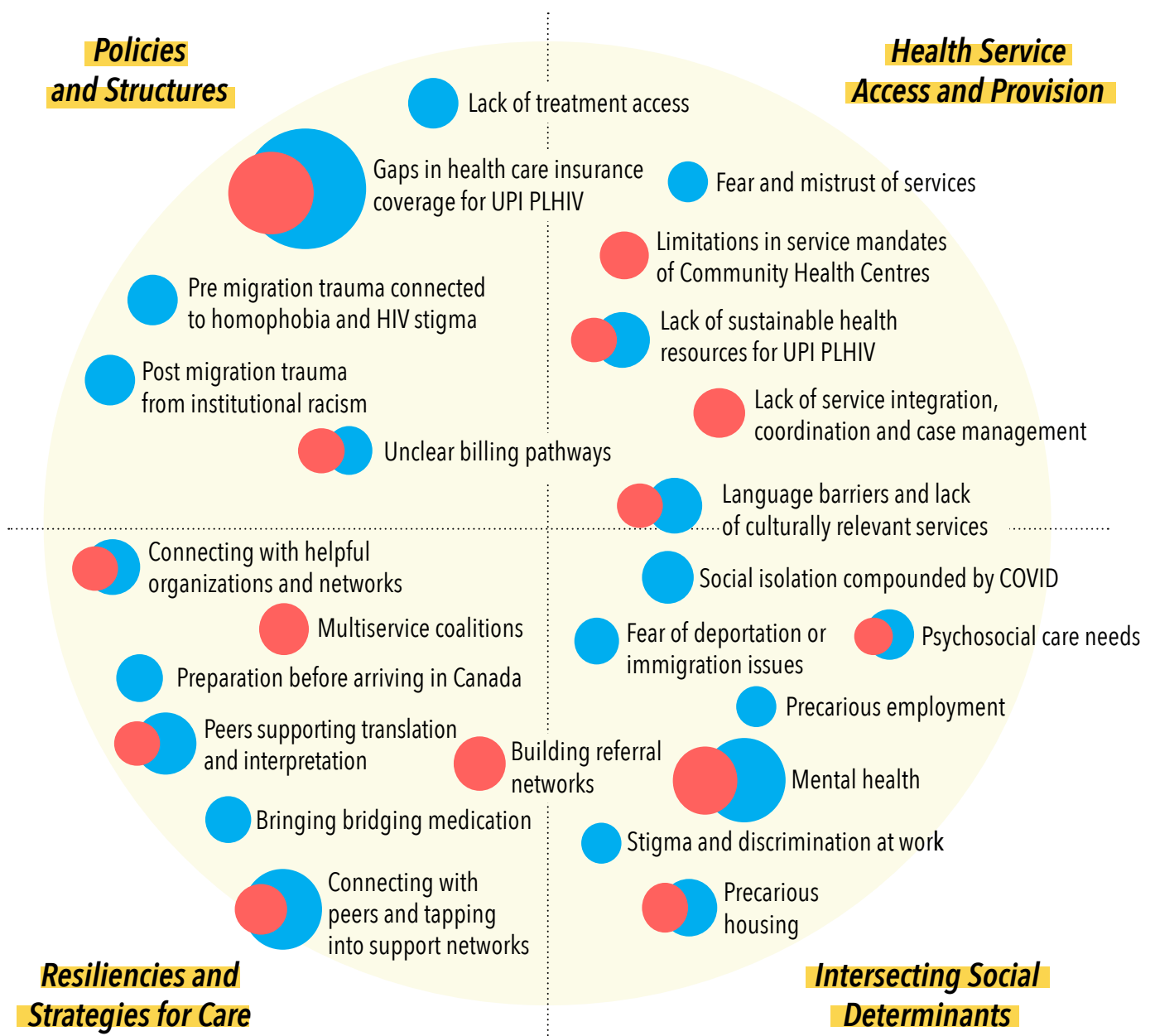
**78% - 32%**



## WHAT DID WE LEARN:

Participant discussions covered four (4) broad areas that cross cut to affect both individual access to care as well as service provision by care providers.

- **Policies and structures** that result in inequitable health care outcomes and access
- **Health service access and provision** which are unclear to navigate for both UPI PLHIV and service providers leading to restrictive or inconsistent quality of service
- **Intersecting social determinants** such as mental health stressors and precarious housing that compound access to care; and
- **Community resiliencies and strategies for care** that are adopted by individual UPI PLHIV and service providers such as building peer and service networks



● Factors discussed by Individuals ● Factors discussed by service providers ● Discussed by both

## a. Policies, Systems and Structures

UPI PLHIV participants spoke at length about how inequitable policies and systems impacted their lives, first in their home countries, and then in Canada. Pre and post migration related stressors and trauma were cited as dealing with significant structural violence such as homophobia, gender-based violence, HIV stigma, internalized shame, HIV disclosure and issues of mental health. Global inequities that drive a lack of, or limited access to HIV treatment and care were also referenced.

“*I have had a lot of struggle to hide myself because they are very homophobic there and my status, HIV status, I could not say out loud because everybody has a stigma... it's a kind of toxic environment, you have to hide yourself all the time and have to create your character. I am not able to live like myself as I'm living here.*”  
- PLHIV Participant

Structural challenges related to post-migration experiences to Canada were also discussed. Primary concerns were cited as gaps in health care insurance coverage for students, migrant workers, temporary residents and new immigrants. A lack of dedicated and sustainably resourced health services was discussed as a major barrier leading to unclear service and/or billing pathways

*“...I had to look for help because the hospital is charged me \$2,000 a night and they were trying to get me out... and there weren't helping me find medication before I leave so, I had to-- my friend has to ask people to help, to get help for me.”*

- PLHIV Participant

”

Service providers raised similar issues related to structural barriers of health insurance coverage. The limitations in service mandates or catchment areas of Community Health Centres (CHCs) was also raised as CHCs are funded to service uninsured clients. Delays or reduced government services or immigration processing due to the COVID19- pandemic was also discussed by both individual UPI PLHIVs and service providers.

*“... I would say the first one is access to healthcare, I find a lot of people, especially people with no status don't have OHIP or they don't have insurance coverage or employment benefits or even things like Trillium or ODSP or OW, so often their paying for their treatment or paying for their healthcare out of pocket or going to walk-in clinics paying out of pocket...”*

- Service Provider Participant

”



## b. Health Service Access and Provision

Structural challenges cited above translated into issues related to health service access and provision for both groups of participants. A general lack of knowledge and /or misinformation about the associated health coverage for UPI-PLHIV was frequently discussed. Participants recalled experiencing hesitancy from care providers to work with precariously insured populations, either due to limited knowledge, awareness of costs, complexity of care needs, language, or coverage and billing issues.

Lack of service navigation and case management support to help clients access components of care such as lab costs or drugs for students was also referenced. Service providers cited limited capacities in service coordination and integration resulting in unclear referral pathways or knowledge of available support.

“ *“...when [international] students are diagnosed with HIV they, - turns out they sort of discover they do not have medical coverage for um, to cover medical care and once we sort of outside of the GTA, the number of medical providers who have experience with, and expertise in dealing with uninsured people drops significantly....students end up traveling long distances to get care or paying a lot of money to get care or not getting care at all but certainly, the kinds of pressures that they placed on community health clinics and other organizations in smaller communities that um, are sort of -they have the sole mandate in that area to provide those services but have historically not provided services”*

- Service Provider Participant

Participants also identified language and cultural barriers when accessing HIV information and health care. These challenges were experienced in tandem with barriers of mobility, communications and time constraints. For example, limited data plan for communication, precarious/multiple employment situations preventing time to seek care, and lack of privacy preventing access and adherence to medication.

“ *“...when I was diagnosed in the hospital, the case worker did not know any places, any agencies to help me figure out my HIV or get information about my HIV. I had to do research, had to get my friends or someone outside to get information, to be able to connect to programmes for people to help me.”*

- PLHIV Participant

”

*"...mentally you see, like because already we have this condition the last thing you want is stress not knowing where your next meds will come from. You are trying to apply, and push through the immigration process, that can be very stressful. I can't even explain it but I spent a lot of sleepless nights."*

- PLHIV Participant

### **c. Intersecting Social Determinants**

Structural barriers and limited access to health service was compounded by essential needs and social determinants such as integrated support for housing, income support, immigration issues, and more. Participants stressed mental health challenges related to HIV disclosure; fear of deportation; stigma and discrimination at work; and experiences of racism in Canada. This led to a strong fear and distrust of government and healthcare systems by UPI PLHIV. Social isolation was also discussed as compounded by COVID19- related lockdowns and closures.

Service providers cited the struggle of meeting complex psychosocial care needs and social determinants. They particularly referenced how these intersect to create impediments to care, and impact UPI PLHIVs experiences of, and decisions to access services.

“

*"...a big (issue) is housing. If a client doesn't have a fixed address, it's difficult for me to get them treatment, medication, things like that because these pharmaceutical companies of these compassionate act - they require you to have a fixed address - so often if a client doesn't have a fixed address, if they are precariously housed, homeless, living in a shelter what not, it has to be sent to our clinic or to a friend that has an address but those who don't have that then it's difficult, they can't get the medication."*

- Service Provider Participant

*"Many that I work with come from different countries that are refugees in political asylum, so they're coming with a lot of fear, and trauma, and grief. So that is something that challenges me a lot because those come up intermittently at different points that you take four steps ahead with the client and then two steps back... so I think just focusing on, oh get the medication, get the income, get the stable housing, I think that's not enough. There has to be a holistic approach with mental health and well being of the individual"*

- Service Provider Participant

”

#### d. Community Resiliency and Strategies for Care

While the realities of how UPI PLHIV access health care are complex and strife with challenges for both individuals and service providers, the resiliencies that both groups demonstrated should also be recognized. These strategies for care were deeply effective and hopeful.

Participants discussed the benefits and importance of pre-migration planning. This enabled them to tap into community connections and prepare by bringing a bridging supply of medication. Prior to arrival in Canada some had reached out to peers to build a network and participate in information sharing and psychosocial support. These community service connections also acted as an important starting point for service referrals to culturally & linguistically specific HIV, sexual health, and mental health services.

Seeking and investing in peer networks were a clear strategy for UPI PLHIV but service providers also talked about the importance of service referral networks. Strategies for care are driven by dedicated and capable service providers as well.

*"I have connected with a lot of women who have become like sisters, friends, so you know I'm so connected to the community. I'm talking about a community of PHAs, and so much that if there is something, if I'm having anything, any problems or challenges that I'm not able to figure out on my own, I can get help. I can easily call... you know and say I'm stuck here, how can I navigate this? They are able to assist. So, that has really helped me a lot -especially um that I left my extended family back home and I did not have anybody here. So, it's like I have another family now"*

-PLHIV Participant

*"...the way that you can you know resist this just to move on and try to get in touch with people in your community and be more social and more open and not isolate yourself... so, I just tried to you know get away from, from isolation and be more social and you know get more um help you know in touch with, with other people in my situation"*

-PLHIV Participant

*"...just having a point person in those pharmaceutical companies that I can speak to regarding compassionate access and just having that one person, it gets through a lot of the red tape..."*

-Service Provider Participant



*"I was happy, happy like I am volunteering, I am doing something. So anytime they text me like 'will you be able to volunteer with us next week' I am always like I can't wait because I am going to meet new people. So that has really been helping me a lot."*

-PLHIV Participant

*"After what I have been through, I was thinking that I need to volunteer in helping people, because I know I won't be last. There will be others who will be going through the same thing that I went through and I would put myself out there to help anybody that is going through the same thing"*

-PLHIV Participant



## WISE PRACTICES

### PEER POWER



The role of peers in resilient strategies for care cannot be highlighted enough. Participants engaged in all stages of the research stressed the critical importance of peers as they navigate complex health systems and services. UPI PLHIV clients and community members became volunteers at the Blue Door Clinic and overall, approach opportunities to connect and support their peers with passion, enthusiasm, and dedication.

At Blue Door Clinic Peer Navigators play a unique dual role in both providing language interpretation support during clinic visits as well as connecting clients to community peer networks and service agencies where they volunteer. But whether or not they were connected to Blue Door Clinic, participants were intent on giving back, volunteering, and supporting their community.

For many, the act of volunteering and supporting their community was deeply connected to their own wellbeing and sense of connectedness.

## 4.2 Effectiveness of the Blue Door Clinic Intervention

The following section outlines the results gathered from phase 02 of data gathering that evaluated the effectiveness of the Blue Door Clinic in supporting UPI PLHIV linkages to stable, long-term primary care.

### WHO DID WE ENGAGE: (phase 02)

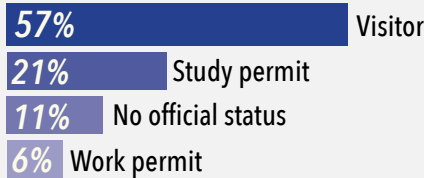


Focus Group Participants

159

**Clients of Blue Door Clinic** whose quantitative service data was analysed

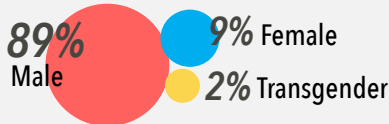
#### IMMIGRATION STATUS



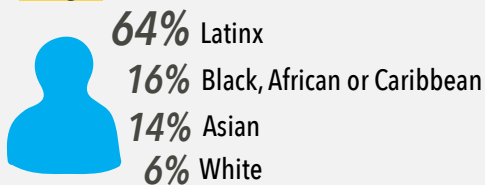
#### LANGUAGE

65% prefer service in languages other than English

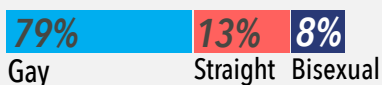
#### GENDER



#### RACE



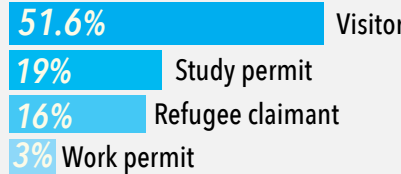
#### SEXUAL ORIENTATION



31

**PLHIV** who utilized clinic services within the study period

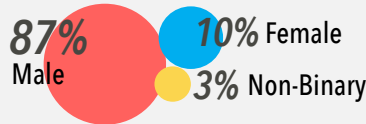
#### IMMIGRATION STATUS



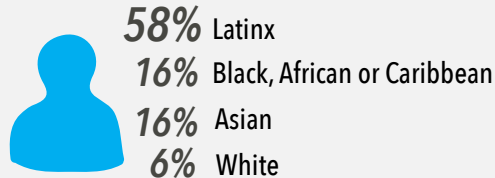
#### LANGUAGE

77% speak a first language other than English

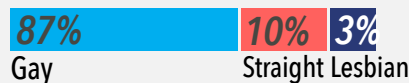
#### GENDER



#### RACE



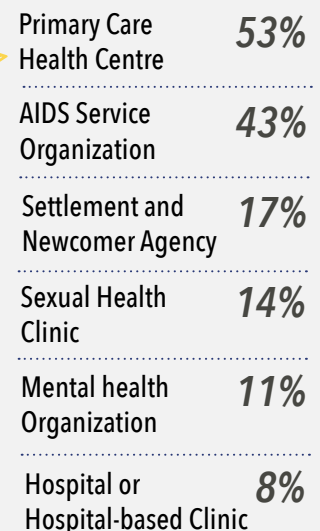
#### SEXUAL ORIENTATION



35

**Service providers** from the clinic and service partners

#### TYPE OF SERVICE PROVIDER



#### CLIENT BASE

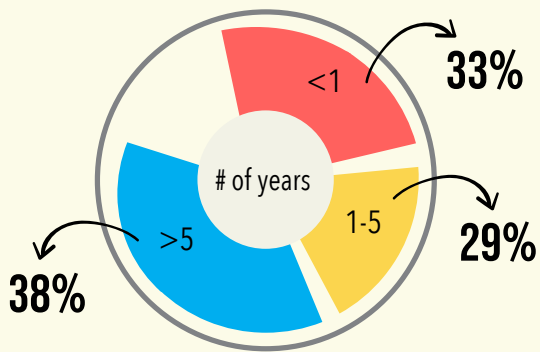
% of PLHIV clients six (6) months prior to the study

38%

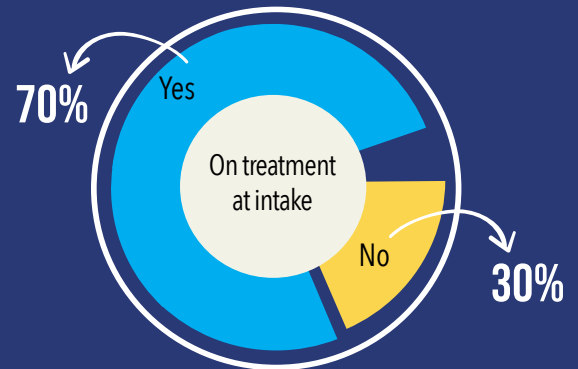
**Client Service Data**

Cumulative service statistics of 159 clients at the clinic related to linkage to and retention in primary care, and referral to access social determinants are presented here.

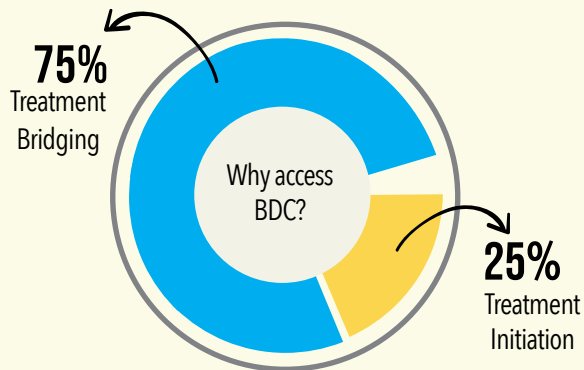
**LENGTH OF TIME SINCE HIV DAIGNOSIS:**



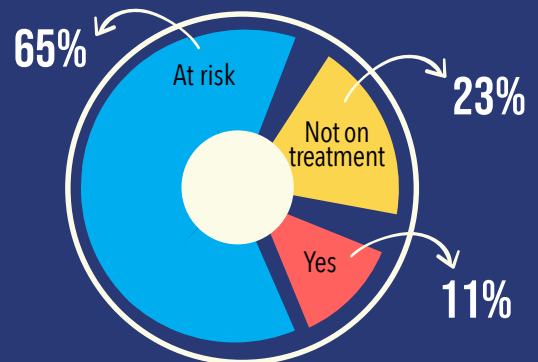
**HIV TREATMENT AT INTAKE:**



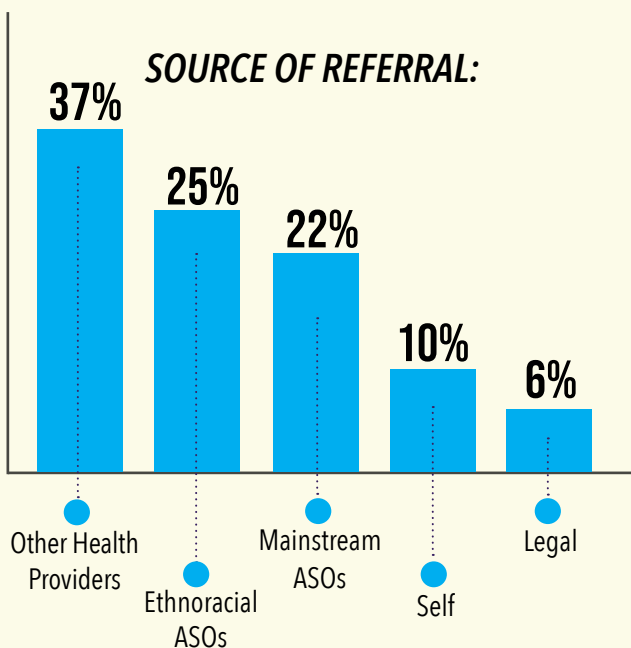
**PURPOSE OF ACCESSING BLUE DOOR CLINIC:**



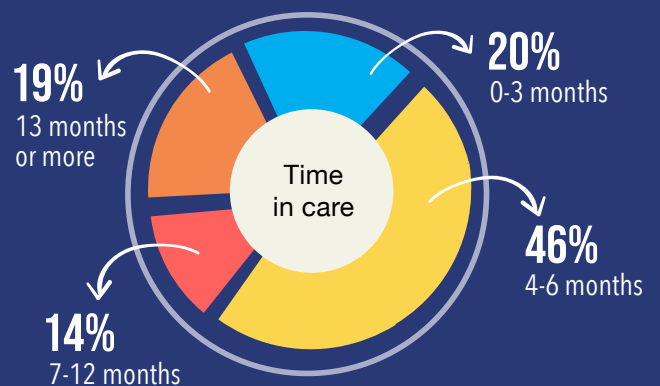
**HIV TREATMENT INTERRUPTIONS AT INTAKE:**



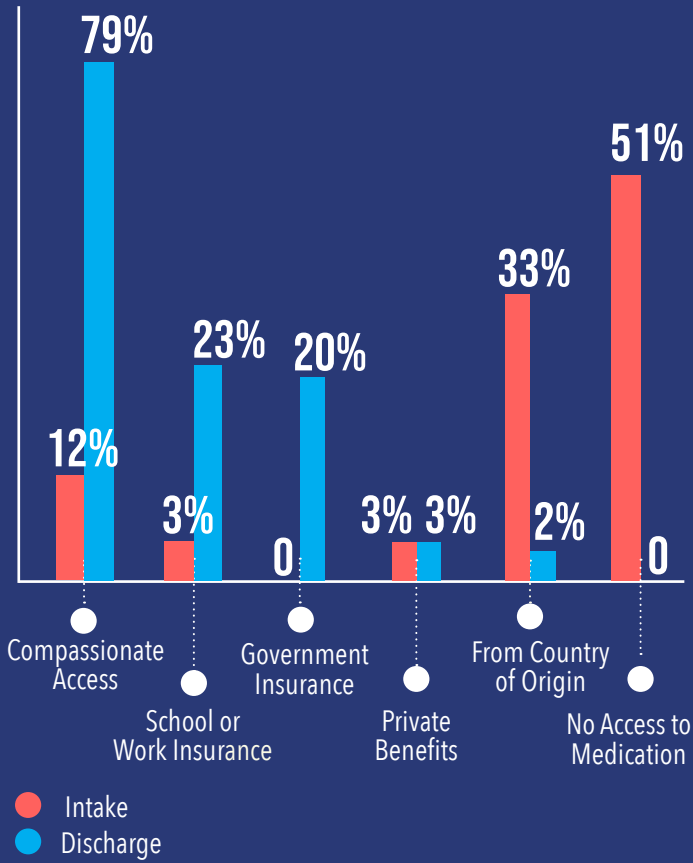
**SOURCE OF REFERRAL:**



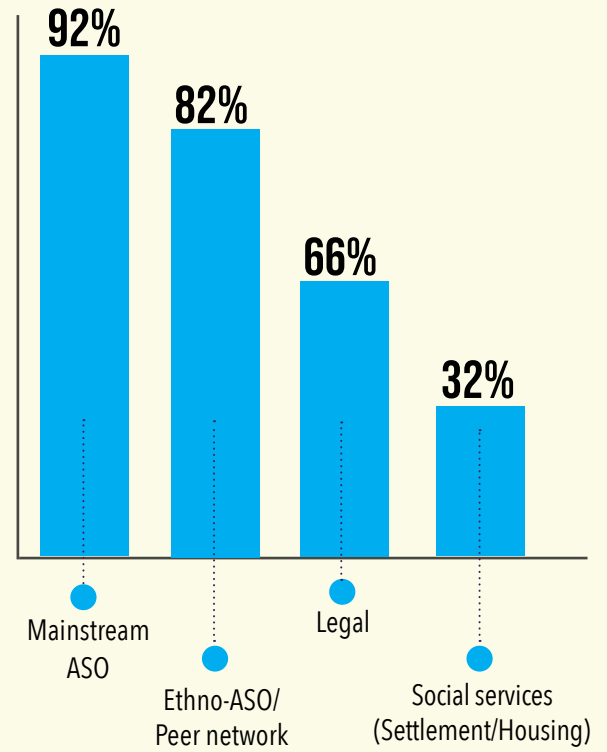
**LENGTH OF TIME IN CARE AT BLUE DOOR CLINIC:**



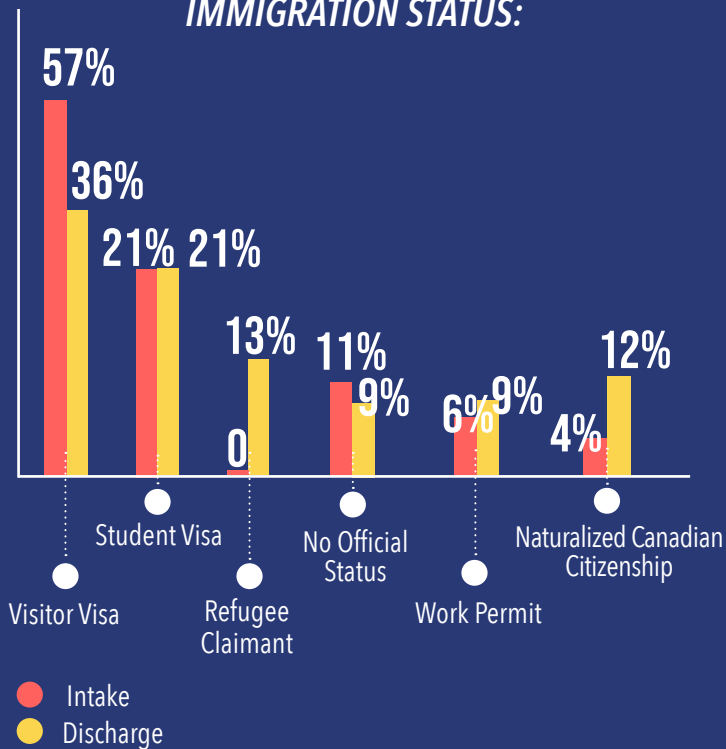
### SOURCE OF MEDICATION:



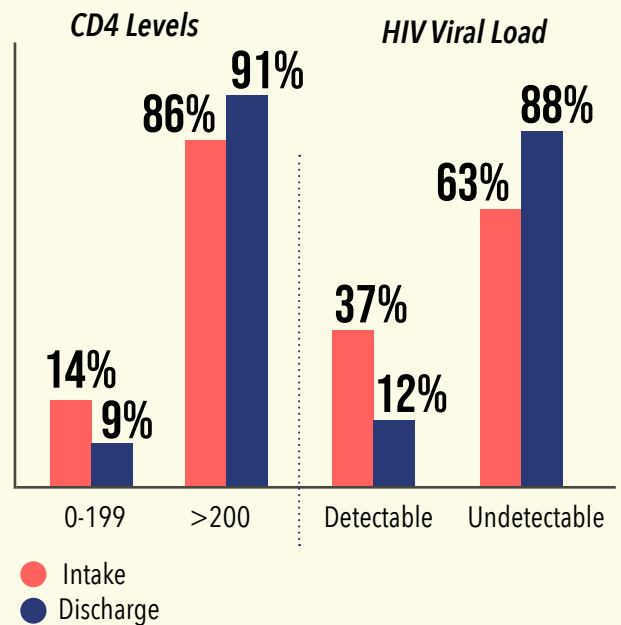
### OUTWARD REFFERALS:



### IMMIGRATION STATUS:



### HEALTH INDICATOR CHANGES AT DISCHARGE:



## WHAT DID WE LEARN:

In focus groups both client and service provider participants discussed the following strengths and challenges for Blue Door Clinic as part of the service evaluation:

### *Strengths of the Blue Door Clinic*

#### **a. Humane, Person-centered, Affirming Care**

A majority of participants recalled the care and service received at Blue Door Clinic as humane, compassionate and affirming. They referenced the benefits of services provided with a holistic approach where clients talked about being integrated into a support network as opposed to being served as an individual client. UPI PLHIV participants referred to service providers as committed, compassionate, flexible and professional.

*“Here it is completely different, here it is much friendlier, much more accessible. Blue Door Clinic’s principle is the human being, regardless of where you come from, regardless of what race you are, whether you have resources or not, the most important thing is your life, your health...the service is super good, it’s excellent.”*

-PLHIV participant

*“And they don’t just specialize in HIV and that’s it. As the topic of the vision of health is much more holistic than you imagine. The nurses, very empathic, very human, very helpful, very sensitive.”*

-PLHIV participant

#### **b. Multi-Sector and Intersectional Approach**

Both client and service provider focus group participants pointed to the network of partners and multi-sectored nature of the service as a significant strength linking clients to crucial care.

Partnerships with diverse agencies such as AIDS Service Organizations (ASOs), legal and immigration services, community services, and settlement agencies, resulted in meaningful external referrals and follow-ups. Combined with allied health providers such as MDs and pharmacists at CHCs and Sexual Health Clinics, the overall spectrum of partnerships reflected an intersectional and holistic approach to care.





The clinic's wraparound model linking clients to relevant care addressing clinical and psychosocial needs was highlighted by both client and service provider participants. Internal service providers at the clinic spoke of positive client feedback on the wraparound model while external service providers particularly appreciated the efficient referral and follow-up process.

*"I've worked in a lot of places, I don't know a lot of other clinics or places that do wraparound care like that, where you have a nurse, you have a systems navigator, or you have a doctor or nurse practitioner, all of those things available at the same time. I think um, common feedback I get from clients, positive feedback I get is that they're really impressed with how much we're able to do with one visit. So, you can get connected to treatment, you can get connected to a doctor, immigration services, a lawyer, so many things with just one visit. And that's really incredible to me, because I don't know a lot of other places where you can do that."*

-Service Provider Participant

*"our organization receives direct referrals from Blue Door, and those referrals are not warm referrals, they're hot referrals. So, everything's done before it gets to us and it's pretty seamless linking people into care. It's one of the better systems that we've experienced in receiving referrals and, and we receive referrals from \*\*, immigration panel physicians, walk-ins, etc, but at Blue Door, it's a very seamless process and we find it very helpful and, useful for us."*

-Service Provider Participant

Efficient and timely access to starting and/or bridging treatment access was cited by participants as a key strength at the clinic. Participants spoke of how staff at the clinic leveraged service partnerships to coordinate access to treatment and medication.

*"the same day that I had my appointment at Blue Door, that same day they gave me the medicine, and on that same day they linked me to my pharmacy, since it is the same pharmacy as always. It was very fast"*

-PLHIV participant

“

*"The first time I asked for help, Peer \*\*, was the one who helped me. He channeled me directly to \*\*. Immediately, he gave me the attention, they sent me to the pharmacy for medication. It was good, very good why, because it is something very compassionate, it is something very good for people we do not know, who are new, or who do not have the idea of how to get medicine elsewhere"*

-PLHIV participant

”

### c. Peer Driven Linguistic and Culturally Relevant Care

The provision of linguistic and culturally competent holistic care was well recognized as a valuable part of Blue Door Clinic's service offering. Language specific services with support from Peer Navigators and Case Managers were specifically cited along with the network that peer connection offers UPI PLHIV clients.

*"Some of the things I think that Blue Door has done really well is like the integration of community supports, like other agencies and partners, either through peers that have been able to be on site or be present to support clients, outside of the clinic..."*

-Service Provider Participant

*"Peers translate for the different community members that speak multiple different languages. And these peers also support this new community member... so that they can gain access to not only our agency, but other multiple agencies that are in the city, we also can then follow up with a person and help them through the immigration process all the way up to finding them doctors, medication access, getting them onto OW, ODSP, financial assistance, food programs and anything else that's offered at the agency."*

-Service Provider Participant

*"As a person living with HIV... especially when you're new to a country and you meet a client they introduce themselves 'so I'm also a PHA'... you will be okay you know, that sense of assurance, it really means a lot. Peers contribute a lot especially in the first stages of someone settling in Canada. When you don't know the language and then you hear somebody speaking a language and you know they're also positive like you, it changes how you look at things and it helps you in your settlement process..."*

-PLHIV participant



# WISE PRACTICES

## ADAPTABILITY AND RESPONSIVENESS



The COVID 19 pandemic exacerbated health risks and mental distress amongst service populations. It also posed extraordinary stress on the service system as a result of health provider sickness, staff redeployment, inter-institutional staff travel restriction, space restriction due to physical distancing needs.

Participants talked appreciatively about Blue Door Clinic's responsiveness, and the proactive and flexible ways in which they worked to connect with clients. Well implemented practice changes included:

- Changing the client intake and peer navigation services from in-person to online and via phone and using whatsapp or text when necessary;
- Drop-in change to appointment; and,
- Expand recruitment and training for new providers to address staff shortage



*"Meeting people where they're at, having different ways of connecting, contacting people working in different geographies across the province, I think we can be really, really proud of that work."*

-Service Provider Participant



## ***Challenges of the Blue Door Clinic***

### **a. Operational Capacities at due to lack of sustainable funding:**

The most significant challenge cited was in relation to the absence of core funding and how this is not only unsustainable, but also prevents assurance of optimal service provision. Resource restraints were said to present challenges to coordinating clinical case management and follow up needs. Additionally, space limitation was cited as another key factor impacting options for clinic scheduling and service delivery.

Staff turnover, onboarding limitations and rotational staffing inconsistencies were identified as factors affecting continuity of care. Additionally, Blue Door Clinic is not set up for long term primary care and staff face service mandate restrictions such as being unable to care for non-Poz partners of PLHIV.

### **b. Outreach, Resource Material and Clinic Promotion**

UPI PLHIV clients specifically talked about the need to make people more aware of Blue Door Clinic and to increase its accessibility to communities who need these services. Both clients and service providers also highlighted the insufficient online, social media and print resource materials in different languages available for their communities.



*“So, as someone who’s trying to immigrate into the country, if I could just search Google and be able to know more information on oh, there is actually a service where I can assess without needing the healthcare here and that would actually give a piece of mind for me before I had to get panic about”*

-PLHIV participant

*“We have language, huge language challenges you know, and so we provide peers who help with translation and who help with accompaniment. And that just goes beyond having a service, but that individual who is also living with HIV who can help, I would say to just make the whole experience real, and located in lived experience. Then to be able to have persons who are fluent in these languages, and there are so many, there are so many languages that we have to try to provide for.”*

-Service Provider Participant



### c. Systems and Structures:

Service providers cited specific structural challenges related to linkages to care such as lack of access to non-HIV specialists or external references to primary care. Beyond reduced intake from other providers during the pandemic, they pointed to a shortage of MDs available and willing to take on precariously insured clients. This was in part due to a lack of HIV experienced providers especially outside GTA.

Participants also spoke of limitations in CHC service population mandates that have led to negative experiences for clients referred - for example, they “*never see the doctor in-person*”, or “*got externally referred for HIV care again (from another CHC)*”

In terms of treatment access, barriers to HIV drugs due to changing or limited time for compassionate access on certain meds (especially impacting people who are multidrug resistant) was noted.

*“I think that the health system is already sort of confusing enough for newcomers. And so being able to say, like, you can see me, but you can't go to emergency or like we can get you your HIV medications, but can't get you maybe prophylactic antibiotics or mental health medications, I think it becomes sort of quite difficult for people to navigate.”*

-Service Provider Participant

*“one of the challenges that for me, kind of as the person consulting from the outside is access to medications and how that shapes decision-making around antiretroviral therapy choices. I find it quite challenging because often we're making choices that are not ideal for this patient, right? We're making them based on 'this is what we have access to', or 'this is what we, we know we can give them in an uninterrupted way.’”*

-Service Provider Participant

As discussed earlier, client challenges around mental health, precarious housing and employment, and other social determinants greatly impact service access. Service providers reiterated the need for trauma-informed and culturally relevant mental health care along with support around other determinants.

*“...the significant things that are going on in their life are outside of the clinical pieces, the things that affect their ability to continue taking medication or even being on treatment or making it through those clinic doors. Which is sometimes mental health, sometimes it's immigration, settlement, sometimes it's housing, sometimes it's you know, do I have enough, if they're working cash jobs...”*

-Service Provider Participant



# WISE PRACTICES

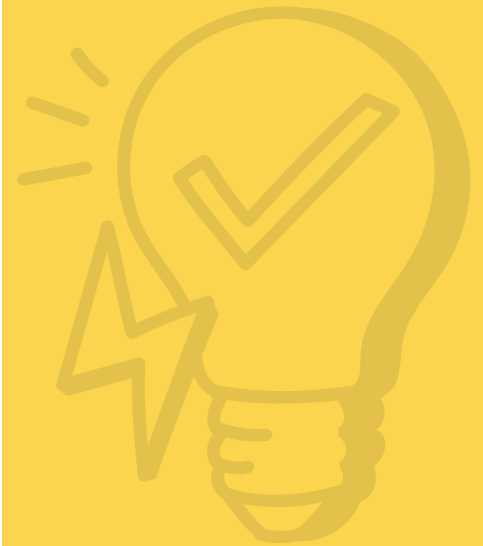
## INTEGRATED KNOWLEDGE TRANSLATION AND EXCHANGE



Findings from the focus group fed back to the Steering Committee to support Integrated Knowledge Translation and Exchange (iKTE). In this way research results informed real-time practice adjustment and quality improvements in bolstering operations at Blue Door Clinic.

Specifically, research focus groups identified gaps in continuity of care and follow up in between clinics. These informed the establishment of:

- Nursing coordinator position to support clinical case management and follow up
- EMR tools on clinical summary and care planning developed to improve client care
- ‘Blue Door Clinic Capacity Building Project’ to engage clinical, community, and peer service providers to develop needed knowledge and skills to service UPI PLHIV communities



*"...Despite being small, [BDC] cares for so many people and despite the fact that it is transitory, its response times, its attention, it is extremely valuable as we have not seen any other, and I would love that many hospitals and clinics take up Blue Door Clinic as an example of service"*

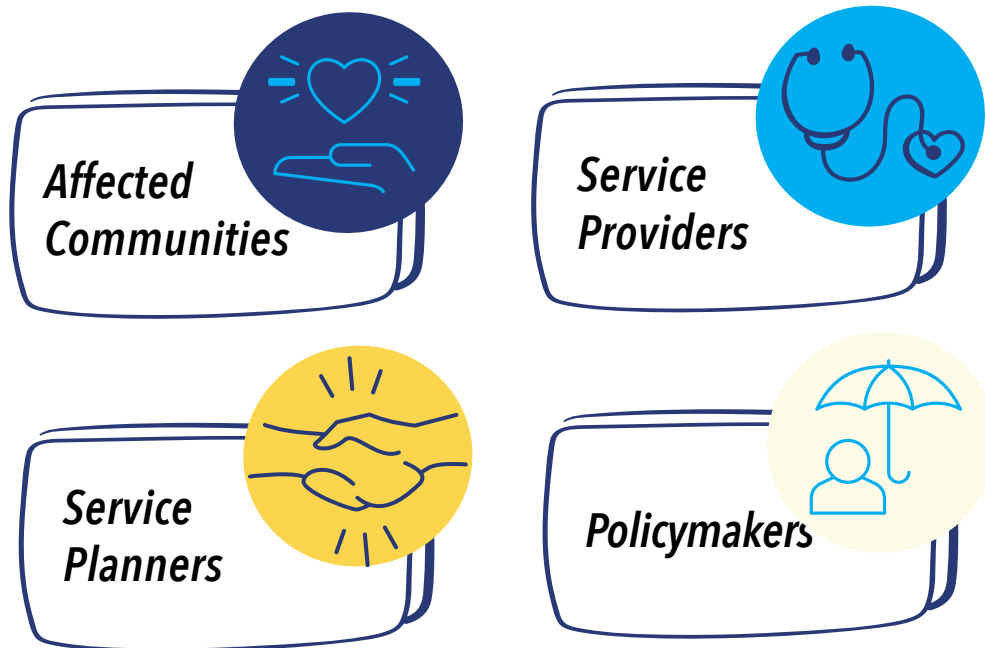
*-PLHIV focus group participant*

# 05 RECOMMENDATIONS

The study's findings clearly highlighted the immense value of the model of a dedicated program for precariously insured populations with HIV that provides holistic intersectional services through multi-sectored collaboration. Wise practices adopted in the work such as integrating GIPA/MEPA, allyship, an emphasized learning culture, intersectional service offering, and adaptive responsiveness are all that can be modeled in sectors looking to serve differently marginalized communities.

This report outlines 12 recommendations to enhance health equity and accessible healthcare for uninsured and precariously insured populations living with HIV in Ontario.

*These recommendations target four key groups:*







## **Affected Communities**

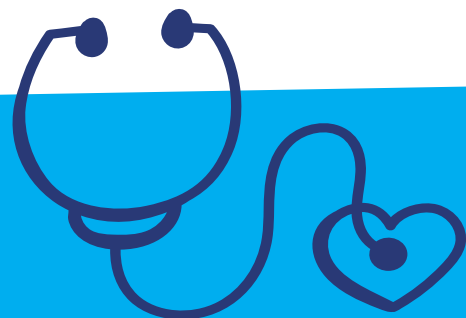
Affected communities need to maximize their leadership roles to co-create health services that are culturally relevant and accessible:

01. Leaders and advocates from affected communities need to mobilize and engage in co-designing, guiding and evaluating the development of linguistically inclusive, culturally safe and community responsive resources and services for UPI PLHIVs.
02. Secure resources to maximize peer roles in promoting and delivering services to affected communities, through roles including but not limited to program ambassadors, service navigators, and providing individual and group-based peer support to promote self-agency.

## **Service Providers**

Service providers need to invest in holistic healthcare approaches focusing on trauma-informed care and mental health competency:

03. Practice affirming and compassionate holistic primary health services that addresses the complex intersectional needs of UPI PLHIV populations, through collaborative partnerships with multi-sector service providers from health clinics, pharmacies, settlement, legal, housing and HIV service agencies.
04. Develop awareness and critical understanding of the unique mental health needs of this community.
05. Build capacities and practice competence specific to the realities of UPI PLHIV communities to promote and deliver trauma-informed, culturally safe services.





## **Service Planners**

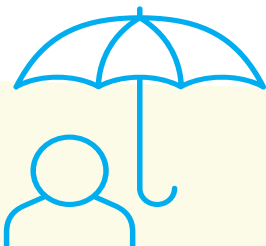
Service planners need to ensure the sustainability and scalability of successful models like the Blue Door Clinic by securing core funding and incorporating proven wise practices of GIPA/MEPA and community-responsive practices.

06. Secure core funding for Blue Door Clinic to ensure sustainable provision of services, including staffing to meet the clinical, case management, peer navigation and interpretation needs, core supplies as well as administrative support.
07. Secure resources to strengthen equitable and inclusive GIPA/MEPA practices to maximize opportunities for UPI PLHIV in co-designing and co-delivering services at the Blue Door Clinic
08. Develop user-friendly online service resource listing, navigation tools and digital initiatives to strengthen information access for people with various immigration statuses.
09. Replicate and scale up the Blue Door Clinic model to deliver services at different regions in Ontario to serve UPI PLHIVs and similarly marginalized populations.
10. Promote the integration of wise practices related to GIPA/MEPA, allyship, intersectional approaches, community responsive and evidence-informed practice changes, to other service frameworks across health sectors.

## **Policymakers**

Policymakers and funding partners need to develop responsive policies and equitable funding initiatives to resource and promote innovative and inclusive practices and ensure universal health care access.

11. Increase resource support for innovative models of supporting care, including:
  - Core funding for Blue Door Clinic
  - Multi-lingual service provision in all partner agencies by using trained peer interpreter and web-based translation technology
  - Peer navigator services and other peer-led programming, and
  - Expanding the service mandate of Community Health Centres to include precariously insured populations such as international students, temporary workers and visitors.
12. Establish a publicly funded pharmacare program to ensure universal treatment access for all Ontario residents in need of life-saving and life-sustaining treatments regardless of insurance coverage or immigration status.



***For more information about Blue Door Clinic:***

[www.bluedoorclinic.org](http://www.bluedoorclinic.org)

***For more information about this study or the Community Alliance for Accessible Treatment (CAAT):***

CAAT

526 Richmond St. E.,

Toronto ON M5A 1R3

Tel: 1-844-720-2772 (Toll-free)

Tel: 647-249-8869 (Local)

Website: [caat.link](http://caat.link)



**PARTNERS:**



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