

SUPPORT SERVICES for  
PEOPLE LIVING with  
HIV IN ONTARIO:  
PROVINCIAL HIV  
SUPPORT SERVICES  
PROGRAM  
DESCRIPTION

For AIDS Bureau funded  
AIDS Service Organizations

*Revision Date:*  
*April 2015*

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# Support Services for People Living with HIV in Ontario: Provincial HIV Support Services Program Description (April 2015)

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## I. Introduction

In 2012, the AIDS Bureau funded an environmental scan of support services provided by twenty-eight AIDS service organizations (ASOs) across the province. The scan included a survey and focus groups with support workers, interviews with Executive Directors (EDs) and a survey of HIV outpatient clinics. The findings from the environmental scan outlined a number of challenges associated with providing support services to people living with HIV across Ontario: variation in how support services are defined and delivered, concerns about recruitment and retention, operationalizing GIPA and MIPA and the need to enhance communication between both ASOs and HIV clinics and among ASOs and other community partners.

In the Community Advisory Committee's view (i.e., the ASO representatives who guided the environmental scan), many of the challenges identified in the findings may be addressed, in the absence of additional funding, by clarifying the role of ASOs in providing support. This includes establishing realistic expectations of ASOs and their support workers and actively sharing and promoting best practices for delivering support services.

To address the Committee's suggestions, the AIDS Bureau, in partnership with the OHTN Evidence-based Practice Unit (EBPU) established the Support Services' Guidelines Working Group, which is comprised of executive directors, program managers and support workers. Through a series of meetings and community consultations, the working group identified the minimum set of core support services that all ASOs should provide. To promote consistency across the province, the working group developed standard definitions for these core support services, as well as provincial guidelines to support their delivery. Many ASOs currently provide and will likely continue to provide additional support services.

This document presents the overall provincial support services program framework that includes these core services. The purpose of the document is to assist ASO support workers and managers to implement the recommended best practices for delivering core support services and required documentation of these services.

## II. Our Provincial Strategy

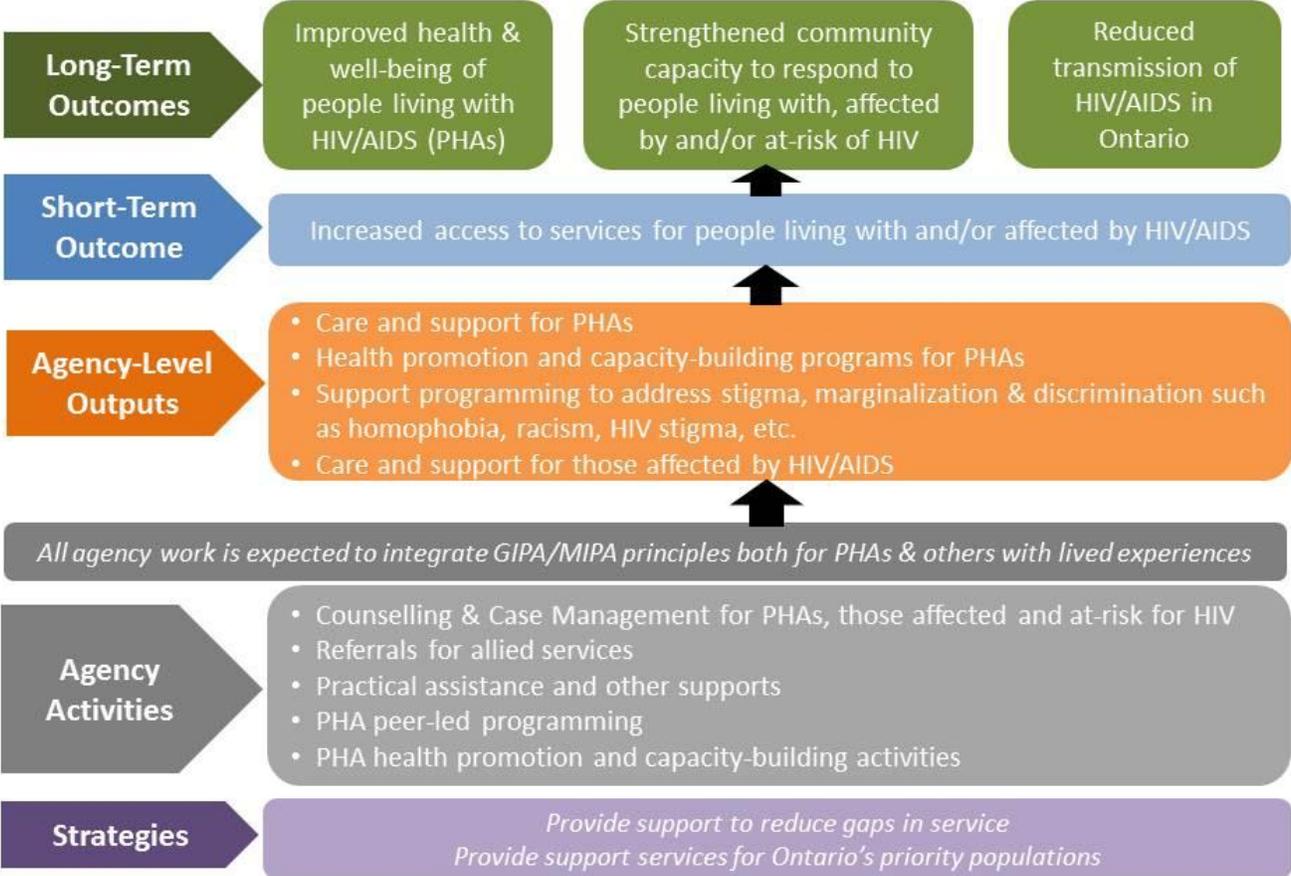
Support services are an integral part of the AIDS Bureau's overall strategy to support an evidence-informed, community-based response to HIV/AIDS in Ontario. The long term health outcomes resulting from this strategy are: i) Improved health and well-being of people living with HIV/AIDS (PHAs); ii) Strengthened community capacity to respond to people living with, affected by and/or at-risk of HIV; iii) Reduced transmission of HIV/AIDS in Ontario .

In the short-term, all HIV support services provided in Ontario directly link to the outcome of "Increased access to services for people living with and/or affected by HIV/AIDS". ASOs meet this outcome through the delivery of support services for PHAs, those affected and at-risk for HIV, referrals to allied services, practical assistance and other supports, peer led activities, health promotion and capacity building activities for PHAs. For more details

about the intended outcomes for support services, refer to the condensed version of the AIDS Bureau Funding Program – Logic Model below and the complete logic model at the end of this document.

### AIDS Bureau Funding Program – Logic Model

[Condensed version - Short-Term Outcome: Increase access to services]



### III. Our approach to providing support services

#### The people we support<sup>1</sup>

In 2012-13, programs reported serving, on average, 12,918 people in each half of the year (across 61 programs that report in OCHART), including 4,410 new clients<sup>2</sup>. (Note: some clients may be counted more than once as they may access services at more than one agency). Most new clients (where their age is known<sup>3</sup>) are over age 25 (70%) and a significant proportion (30%) are over age 40. Increasingly, there is a trend towards agencies seeing older clients for support services. All regions reported an increase in the number of clients who are over the age of 55 compared to the 2011-12. This likely represents an aging population that is living with HIV as well as the number of new clients who are older when they first access support services.

Most clients of support services are people living with HIV (74%, H2<sup>4</sup>). In 2012-13, the next highest proportion of clients (13%) were people affected (i.e., partners, family, friends of people with HIV), followed by people at risk (i.e., people who engage in unsafe sexual and/or drug use behaviours) (7%). Programs reported 6% of clients of support services as “other”, which include mainly people with blood disorders, people with hepatitis C and sex workers.

Overall, the majority of clients accessing support services are male (62%), approximately one-third are female (35% in 2012-13) and 2% are trans. The number of trans people accessing services has been increasing over the years. There was a 150% increase in trans people accessing community-based HIV programs between the years 2008/09 and 2012/13.

Clients are also accessing support for an increasingly complex array of issues. Agencies provide services to help address the multiple social determinants of health that affect the lives of people living with and at-risk for HIV. In 2012-13, programs supported clients who were experiencing issues of stigma/discrimination, poverty, food insecurity, unemployment, mental health concerns, as well as substance use issues. In addition, almost half of the agencies reporting in OCHART (41%-44% in 2012-13) identified that unstable housing, violence and sexual abuse continue to be areas of concern for their clients. In order to meet these needs, agencies continue to monitor and adapt their programs and services as well as develop strong referral networks for their clients.

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<sup>1</sup> Unless otherwise indicated, all data is from The View From the Front Lines (2013) representing the 2012-2013 reporting period.

<sup>2</sup> We recognize that there are different names used across the sector (for different reasons at different times) to refer to individuals who access services at ASOs. For ease of understanding, we have chosen to use the term ‘client’ however this refers to the broader spectrum of clients, participants, members and service users.

<sup>3</sup> The large number of clients whose age is unknown (82%) is due to one agency that provides legal services that does not collect data on client age.

<sup>4</sup> For each reporting period: H1 = April – September; H2 = October – March

## The people who provide this support: Ontario's support workers

According to the support services environmental scan, in 2012 there were approximately 200 support workers across the province. The Environmental Scan background survey identified a wide variety of professional experience and diverse employment history of those delivering support services to PHAs in Ontario. Thirty-six percent (36%) of support workers who participated in the scan disclosed they have lived experience with HIV, two thirds (62%) identified they had been in their current position for 3 years or less and 79% reported having some post-secondary training. In addition, 48% of executive directors who participated in the scan disclosed they were living with HIV.

Furthermore, consistent with a strong commitment to GIPA/MIPA (the Greater and Meaningful Involvement of People Living With HIV/AIDS) all agencies identified that they actively recruit people living with HIV to paid and volunteer positions within their organizations. Many agencies also encourage clients to participate actively in the planning and delivery of support services. Active **peer involvement** is becoming one of the key overarching principles of the Support Services program. In many agencies **peer involvement** ranges from volunteering at support sessions/specific activities to being employed by ASOs in the capacity of support workers or other staff positions.

Each support worker has their own story, which has brought them to an AIDS service organization. Support workers attributed their unique combination of lived experience, education and work experience as enabling them to connect with clients and provide support. Some workers received education in social services, psychology, social sciences or education and chose HIV as their primary field of interest. Other workers initially began contributing as volunteers, received "on-the-job" training and later filled a staff position. Yet other workers utilized skills and knowledge they gained through education and professional development in other fields and professions to bring them to the HIV sector. This diverse group delivers support services utilizing a wide range of approaches, practices and service models. However, all of these people share a common dedication to the work they do - serving their clients with their "whole heart".

## How we provide support services: Our values

A thirty-year history within the HIV/AIDS movement in Ontario has allowed community members and ASOs to develop and promote a unique approach to their work. Our approach is guided by our commitment to the GIPA/MIPA Principles ([www.ontarioaidsnetwork.on.ca](http://www.ontarioaidsnetwork.on.ca)) which provide a framework for all work within the HIV/AIDS sector. We believe in, promote and support the greater and meaningful involvement of people living with HIV in all aspects of ASO programming. For support services, many agencies now invite and provide opportunities for involvement to PHAs who access services and serve the community as volunteers, peer workers, or staff members. Many sites have also implemented programming with a focus on striving to build the capacity of all people who access our support. We work to ensure that all people have access to the information they need to make informed choices about their lives. In addition, we provide opportunities to empower people living with HIV through skills development and leadership activities.

The following values and principles guide the delivery of Ontario's ASO support services:

**Anti-oppression framework** – we provide support within a framework that recognizes how “race, gender, sexual orientation and identity, ability, age, class, occupation and use of social services can result in systemic inequalities for particular groups” and works to promote inclusiveness, accessibility, equity and social justice across our agencies.<sup>5</sup>

**Client-centred approach** – we believe that clients are the experts about their own lives and provide support with the understanding that clients have autonomy over their lives and the choices they make.

**Community based** – working from a grassroots response that is rooted in creating partnerships and referral networks, we provide portable services – this means we reach out to people and provide support in the places where they naturally gather and at other community sites where people access services.

**Creating safe spaces**– we create work and social environments where clients, staff and community members feel safe to express themselves, share their values/beliefs, disclose sensitive information and ask for help.

**Harm reduction approach** – working from a harm reduction philosophy we accept people where they are at and work to reduce harms associated with behaviours but do not insist upon abstinence from these behaviours.

**Independence** – we provide support to clients and community members when they request services and we believe that each individual can and should live independently, making informed choices and decisions about their life, their health and their future.

**Non-stigmatizing/Non-judgmental** - we accept our clients for who they are, the choices they make and provide services in a non-judgmental manner so as not to attach shame to people's behaviour or life circumstance.

**Peer based** – where possible we offer community members services and supports provided by someone with lived experience; this is not specifically limited by lived experience of HIV.

**People-first** – we treat each person holistically and recognize that each individual is a person first rather than a set of conditions that need to be addressed.

**Service improvement**– we review and evaluate our programs/services on a regular basis and adapt them to meet clients' changing needs and feedback.

**Social justice** – we believe that all individuals who are living with HIV should have equal access to the services they require. We strive to remove barriers to accessing our services and to ensure that all people can access our services without discrimination; including but not limited to discrimination based on age, gender identity, religion, class, sexual orientation, race, national or ethnic origin, colour and mental or physical ability.

**Solution-focused** – we provide clients with resources, allowing them to focus on finding the solutions they are looking for to maintain independence and improve their quality of life.

**Strength-based** – we help clients identify their strengths and build on what they have and can do rather than focusing on “what is missing”.

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<sup>5</sup> Taken from; Ontario Child Welfare Anti-Oppression Roundtable (AOR) (2008) “Anti-Oppression in Child Welfare: Laying the Foundation for Change Discussion Paper”, Ontario, Canada.

## Why we provide support services: History of Ontario's Response to HIV <sup>6</sup>

"In the early days of HIV, prevention and support programs were largely volunteer-driven, formed by communities to fill an obvious gap in services. When traditional health care services (i.e., physicians, hospitals) were reluctant to respond to the needs of HIV, community activists used a range of strategies (volunteerism, community development, public protest, media, lobbying) to draw attention to the issue and obtain funding for independent, community-driven, AIDS programs.

Even when the government moved to establish more formal, care-focused services – such as community-based AIDS organizations, the HIV out-patient clinics, anonymous testing programs, needle and syringe exchange programs, dedicated AIDS hospices – these programs were distinct and AIDS-specific, rather than being integrated into larger health organizations or into broader health issues, such as sexual health. For example, separate HIV clinics were established rather than integrating them with existing infectious disease clinics. They also funded community-based organizations to provide AIDS prevention and education, rather than existing public health/health promotion programs.

This was due to a number of factors, including:

- the stigma associated with AIDS
- the unwillingness or inability of the established health care system to deal with a new, frightening, contagious disease
- the unwillingness or inability of government to talk openly about sexual practices that put people at risk
- the distrust (often justified) of government, public health and the health care system by the population most affected: gay men
- the ability of community-driven organizations to reach the target audience" [p.59]

"In the mid-1980s, when little was known about HIV and people died within months of diagnosis, Ontario's response to HIV focused on stopping the spread of HIV and caring for those who were infected. Its strategy was to:

- target the behaviours that put people at risk of acquiring HIV (i.e., unprotected sex and needle sharing)
- identify and provide treatments that would slow the progress from HIV infection to AIDS and keep people alive (i.e., treating opportunistic infections, developing anti-retroviral therapies)

For a time that strategy was effective. Between 1990 and 1997, the number of new cases of HIV infection diagnosed each year in Ontario dropped by more than 50% (Remis et al., *Report on HIV/AIDS in Ontario 2000*. Ontario Ministry of Health and Long-Term Care. December 2001). Over the same period, our ability to treat HIV infection also improved dramatically. The number of deaths from AIDS dropped significantly during the mid to late 1990s and the number of people living with HIV has grown." [p5]

"In order to continue making progress, to keep reducing the number of new case and prolonging lives, Ontario's strategy evolved to its current focus – to address the inequities that put people at-risk and the broader health and social problems that affect health." [p9]

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<sup>6</sup> Retrieved from *Ontario's Strategy to Address HIV/AIDS to 2008* (June 2002), p59 on November 6, 2013  
[http://www.health.gov.on.ca/en/public/programs/hiv aids/oach\\_strategy.aspx](http://www.health.gov.on.ca/en/public/programs/hiv aids/oach_strategy.aspx)

## IV. The Support Services We Provide

Currently ASOs provide, collect and report information about twenty-three activities related to support services to the funder using OCHART (Ontario Community HIV/AIDS Reporting Tool). Historically, the agencies and the Funder collaboratively developed this list of support services allowing ASOs to collect data about and highlight the unique activities and services they deliver. Over time, differences in program delivery models resulted in each ASO having a different understanding of the scope and outcomes of support services, the expectations for what services are to be delivered and how to record this work. Furthermore, the Environmental Scan revealed a number of sector-wide issues related to definitions and the scope of support services.

In order to address this variation in the scope and intended outcomes for support services in Ontario, the Support Services' Guidelines Working Group recommended clustering existing support services under five **Program Areas**. The concept of Program Areas allows agencies to better categorize, record, analyze existing services and develop new support services.

**The Provincial HIV Support Services Program includes the following core support services within these five Program Areas:**

### 1. Intake/Service Initiation

Intake typically begins with the process of engagement. This is the process of reaching out and accepting new clients coming to the agency for support. Intake begins when a new client comes through the door and ends when this client is **linked** with and **enrolled** into one or more programs/services provided by the ASO.

The purpose of intake process is **building relationships** with new service users, **gathering information** (demographic/medical/social/other) about the client to help **determine the client's eligibility for services**, **identify the client's needs** and **make appropriate referrals** (internal and external).

Intake procedures are specific to each ASO and depend on the programs offered at each agency and their individual requirements. In 2012-13, agencies reported (in OCHART) that 2,555 clients<sup>7</sup> accessed services in the Intake Program Area.

Intake is a process, which can include providing orientation to the agency, **information about rights and responsibilities** of service users, developing relationships and building rapport, explaining the confidentiality procedures, limitations to confidentiality and client consent process (implied and informed) for the agency.

As part of the Intake Program Area support workers carry out and record the following six services:

- Assess the priorities for the client
- Set up the client's file (this includes baseline data collection)
- Determine a client's eligibility for agency services
- Provide orientation to the agency
- Engage with the client (building rapport)
- Conduct program specific intake (if required)

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<sup>7</sup> Note: Clients can be counted in more than one Program Area and may have accessed services in each Program Area more than once.

## 2. HIV Case Management

Case management is a **time-limited process** that involves understanding the client's complex needs, helping to coordinate services to meet those needs, referring clients to other appropriate services and advocating on behalf of clients for the services they need. The process begins with an assessment that aims to identify the client's health goals, works with the client to develop a plan to achieve those goals and then follows the case management cycle.

*Note: Only clients who are formally enrolled in the HIV Supportive Case Management Program Area receive this service. Otherwise, clients receive a combination of the support activities that make up the other Program Areas.*

For each case management session, workers need to identify what element of the case management cycle this particular meeting is addressing:

- Assessment
- Planning
- Implementation
- Evaluation
- Transition

HIV supportive case management services are provided to support clients with connecting to HIV care, staying in care and managing HIV. Workers must document the focus of each case management session they provide by choosing one of the following four options:

- Connection to HIV care
- Retention in HIV care
- HIV management
- Other (please specify)

Please refer to HIV Supportive Case Management service model (currently under development) for more details.

In 2012-13, agencies reported (in OCHART) that 7,514 clients<sup>8</sup> accessed services within the Case Management Program Area. This includes the number of clients receiving individual advocacy and referrals.

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<sup>8</sup> Note: Clients can be counted in more than one Program Area and may have accessed services in each Program Area more than once.

### 3. Practical assistance

This Program Area includes three (3) services that provide clients with access to materials, basic needs items and services for which they face challenges in accessing (i.e. they would not be able to or would have difficulty paying for/accessing at their own expense).

In 2012-13, agencies reported (in OCHART) that 8,812 clients<sup>9</sup> accessed services with the Practical Assistance Program Area.

As part of the Practical Assistance Program Area support workers deliver and record these services:

**Complementary Therapies** – Includes the following treatments, which may reduce stress, boost the immune system, or have other beneficial effects:

- acupuncture
- chiropractic
- homeopathy/naturopathy
- nutritionist services,
- massage (Reiki, Shiatsu, Reflexology)
- meditation/yoga
- art and dance

#### **Food Programs -**

- food voucher/gift cards
- food banks
- food hampers/holiday food gift basket
- community kitchen/meal programs (a location where clients access nutritious meals, cooking classes)
- meal replacement and supplements (like Ensure and Vitamins)
- groceries
- infant formula/baby food/diapers

#### **Practical Assistance Distribution –**

- financial assistance (application fees, tuition)
- assistance with Trillium premiums
- child care subsidy, clothing (includes bedding, toiletries)
- free service/event (e.g., haircuts, dental, event tickets)
- gift cards (non-food)
- holiday/general gift basket (e.g., “Holiday Bag” (non-food)
- household items (e.g., bedding, kitchen supplies, pet food)
- help with transportation (rides provided or taxis) or bus tickets
- assistance with wills, other insurance and tax and legal information

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<sup>9</sup> Ibid.

## 4. Counselling and Support Services

This Program Area includes activities where a client receives specific services directly from a certified professional, non-professional, volunteer, or peer. In 2012-13, agencies reported (in OCHART) that 7,755 clients<sup>10</sup> accessed services within this Program Area.

As part of the Counselling & Support Services Program Area support workers carry out and record the following:

**Bereavement Services** – These services are provided on a wide range of grief and loss issues including counselling and assistance with memorial/funeral arrangements.

**Clinical Counselling** - Includes a one-on-one session with a client to talk about specific issues or concerns for which the individual is seeking assistance. A trained and certified professional delivers these sessions using a structured form of therapy (e.g., cognitive behavioural therapy, etc.). The sessions can be delivered in person, over the phone or using videoconferencing technology.

**General Support Session** - A general support session does not involve treatment for a mental health issue (i.e. thought, cognition, mood, emotional regulation, perception or memory that may seriously impair the individual's judgment, insight, behaviour, communication or social functioning). Examples include vocational/career counselling, financial/money management counselling, life skills counselling/coaching and emotional support. Usually non-clinical counselling is practical, short-term and often guided or directed by the counsellor.

**When providing general support sessions workers record the main focus of the session, choosing from:**

- |                                    |                           |                                  |
|------------------------------------|---------------------------|----------------------------------|
| ▪ Disclosure                       | ▪ Harm reduction          | ▪ PEP/PrEP                       |
| ▪ Emotional well-being             | (substance use)           | ▪ Physical Health                |
| ▪ Employment services              | ▪ Hepatitis               | ▪ Relationships/Social supports  |
| (interview skills, resume writing) | ▪ HIV symptoms management | ▪ Risk reduction (safer sex)     |
| ▪ Financial counselling            | ▪ Housing                 | ▪ Smoking cessation intervention |
| (debt management, budgeting)       | ▪ Mental health           | ▪ Stigma/Discrimination          |

*Note: Both clinical and non-clinical counselling can involve personal growth, relationship support for individuals or couples, help with human relationships, assertiveness and communication training, relaxation and stress management, problem-solving, goal-setting, career planning and support with workplace issues, etc.*

**HIV Pre/Post -Test Counselling** - Counselling that is provided to individuals/couples who are considering HIV testing or have taken the test.

**Interpretation/Translation** – This includes both written and spoken services provided in the client's mother tongue (e.g., accompany clients to appointments and provide interpretation)

**ODSP Employment Support (ES) Services** – This agency-specific service is an employment support program, specifically funded by ODSP.

**Settlement Services** – These services are targeted towards new immigrants. Services may be provided in the areas of health, mental health, housing, legal, employment, English as a Second Language, childcare, assisting clients with the immigration system, etc.

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<sup>10</sup> Note: Clients can be counted in more than one Program Area and may have accessed services in each Program Area more than once.

**Treatment /Medication Adherence** – This is focused on teaching the client strategies to increase their level of adherence to their medication or to discuss treatment options and decide upon the best choice for them.

**Wellness Check** – This is a quick check-in over the telephone or an in-person friendly visit (by a peer or staff person) to the client’s home to reduce isolation and identify if further scheduled support sessions are needed.

## 5. Agency specific services –Support within Housing and Hepatitis C

This Program Area includes two agency specific services: Support within Housing and Hepatitis C Services.

### *Support within Housing*

This section pertains to those agencies that provide supportive housing to their clients. Each supportive housing agency will provide training to the appropriate staff members to ensure accurate data entry for the recording of these activities. Agencies that do not provide supportive housing will not use this section.

As part of the Support within Housing Section (in the Agency Specific Services Program Area) staff members that provide direct support to clients living in supportive housing will record the following activities:

- Medication Management
  - Directly observed treatment/therapy (DOT)
  - Medication reminders
  - Medications refused
- Housekeeping
- Personal Care
- Cooking
- Palliative Care

### *Hepatitis C Services*

This section pertains to agencies that provide a specific set of support services to people living with or affected by Hepatitis C. Members of provincial Hep C teams provide these services. Each Hep C team will provide training to the appropriate staff members to ensure accurate data entry for the recording of these activities. Agencies that do not receive funding from the Hepatitis C Secretariat and do not have Hep C teams will not use this section.

As part of the Hepatitis C Section (in the Agency Specific Services Program Area) Hep C team members that provide support to clients living with or affected by Hep C will record the following sets of activities:

- HCV Clinical Services
- HCV Case Management Services
- Testing

## Services Recorded Across all Program Areas

All services delivered within the five Program Areas include providing **Indirect Services/Third Party Contacts**, **Simple client contacts**, **Session outcomes (i.e., Referrals)**, which are an integral part of the Provincial HIV Support Services Program. In addition, workers will record **Appointment Characteristics (includes Peer involvement)** and **Case Notes** for all services delivered.

### Appointment Characteristics

This section involves recording information about the funding stream for this service, whether the appointment was scheduled or the client dropped in, the type of contact held with the client (in-person, phone call, etc.), whether the client used emergency healthcare services since their last appointment and either signed or withdrew a release of personal information to a third party. Lastly, workers will indicate if a peer was involved in delivering this service and will also indicate whether other case members or workers attended the appointment.

### Indirect Services/Third Party Contacts

This section involves activities that workers routinely conduct on behalf of their client in the general course of providing support. They include contacting other service providers for the client and discussing the client's case with other service providers (internal and external) in order to ensure a more holistic approach is taken to support the client. In addition, support workers provide support in filling out forms and search for information required to better support their client. Furthermore, workers may also travel to and from appointments with their clients. Lastly, support workers may advocate and intervene on behalf of clients to make sure they can access the services they need and the benefits to which they are entitled. In addition, workers may also focus on the empowerment of clients, through training and support, to act as advocates for themselves and others.

### Referrals

Referrals involve connecting individuals with appropriate agencies and services both internally and externally. Note: Internal referrals are for agency use only. They are not reported to the funder.

### Missing Appointments and Simple Client Contacts

This section allows support workers to record when clients miss or need to cancel and reschedule their appointment. Simple client contacts involves workers recording instances of when they call clients to book an appointment, leave a message or send them a letter or email. This section also allows workers to record whether or not these attempts at contacting the client were successful or not successful (e.g., phone not in service, email bounced back, etc.). These administrative functions are not reported to the funder but are important for agency program planning.

### Case Notes

The Service Contact document contains a section for worker's case notes. As part of the overall policies governing support work, each agency needs to have a specific policy for case noting. This policy should outline the timeframe for recording case notes and explain the type of information they should contain.

## V. How we record and report support services

The Support Services Guidelines working group has developed the following documentation requirements for the delivery of core support services across the five Program Areas: Intake, HIV Supportive Case Management, Practical Assistance, Counselling and other Support Services and Agency-Specific Services.

- 1) The peer-driven and peer-developed documentation procedure is tailored to the way that support workers deliver services across the five Program Areas. It follows the current HIV support service delivery model that begins with an intake process of connecting new clients with the appropriate programs and services to meet their needs.
- 2) The OCASE case management system is to be used by support workers to collect baseline information

Use the following OCASE e- documents to record baseline information:

- a. Intake Form/Baseline Information
- b. Demographic Information Update

*Note: the baseline information collected is similar to the nine areas identified below in the Presenting Issues Update*

- 3) The OCASE case management system is to be used by support workers to record all interactions and services delivered to clients

Use the following OCASE e-documents to record all interactions and services:

- a. Service Record
- b. No Show/Simple Client Contact

- 4) Support workers will record changes in client outcomes over time across the following nine social determinants of health service areas as identified by each client:
  - Current safety concerns
  - Housing
  - Food security
  - Education/Employment
  - Family Status and Social support
  - Immigration
  - Income and Benefits
  - Well-being
  - Living with HIV

Use the following OCASE e-document to record changes in client outcomes:

- Presenting Issues Update OCASE e-document

## 1. Mapping Services to Program Areas<sup>11</sup>

Each support service contact with a client is viewed as a unique and specific count of service delivery that falls within one of the five Program Areas.

- If a client receives more than one service during the same meeting/interaction, all of these services (delivered by the same worker) can be recorded at the same time in one entry.
- A new or separate meeting/visit/interaction between a worker and a client (even on the same day) requires creating a new Support Service Client Contact Document.
- To ensure consistent data entry, ASOs will need to look at the whole spectrum of support services they deliver and attribute each service to a specific Program Area (e.g., Practical assistance) and category (e.g., food program) by looking at the definitions above and matching them with the work they do and clearly recording them.
- These instructions must be consistent across the agency, documented and shared with all staff members (i.e., new staff member(s) orientation and existing staff members during team meetings).

### For example:

- Meeting with a client to update their resume and improve interview skills should be recorded as a *General support session* with *employment services* as the focus. General support sessions fall under the *Counselling and Support Services Program Area*.
- Going to a client's home for a 'friendly visit' to check-in and see how they are doing should be recorded as a *Wellness Check*. Wellness checks fall under the *Counselling and Support Services Program Area*. If a peer conducted the visit, indicate 'yes' a peer delivered this service.

### a. Collecting and updating Baseline and Demographic Information

Baseline data is collected from all clients accessing support services and recorded in the Baseline document (completed only once). This data collection is part of the Intake process and should be completed within the first 2 – 4 weeks (~ 1 month) of the client's interaction with the agency or 2 – 3 contacts with the agency (as per agency protocol). This data is collected and recorded once to track the client's initial presenting issues. Further changes in the client's life are recorded as "Status change" within the nine service areas described above in the Support Services Client Contact Document.

The following information is recorded in the Baseline Document:

- Client demographics
- Baseline information
- Presenting issues for the client
- Client contact information

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<sup>11</sup> Mapping identifies how activities delivered by staff are linked to the appropriate categories for reports to the Funder. Provincial HIV Support Services – Program Description (April 2015)

## Updating Client Demographic Information

Client demographic information that may change over time along with changes in HIV or HCV status, employment, income and housing status need to be kept up to date in the client's file. These changes are recorded in the Demographic Information Update document. . Workers are required to check the accuracy of client's demographic and status information at least once every six months before using this information to complete the mandatory semi-annual OCHART report to the AIDS Bureau.

### b. Recording Intake Services

During the intake process workers record the following types of services in the Service Contact document:

- Assessment of priorities
- Set up client file
- Determine eligibility of agency services
- Orientation to the agency
- Engagement (building rapport)
- Program specific intake(s)

### c. Recording HIV Case Management Services

Support workers record case management services **only** for those clients who are enrolled in the case management program according to the agency eligibility requirements and intake process. Recording case management services requires linking the service activity with specific service goals. Workers identify session focus and stage of the case management support cycle.

### d. Recording Practical Assistance

ASOs must decide where the practical assistance services they provide to clients fall within the three main categories: Food program, Complementary therapy, and Practical Assistance Distribution. In addition, ASOs must further categorize the inventory of items they distribute to clients within practical assistance distribution, food programs and activities provided within complementary therapies (see page 9). These instructions should be recorded and communicated to all staff.

### e. Recording Counselling & Other Support Services

ASOs provide a range of counselling and other support services including clinical and non-clinical sessions. Each counselling and support service must be linked to the appropriate category within this Program Area (e.g., Bereavement services, Counselling session (clinical), General support session; for full list see page 10). In addition, the focus of each general support session (see page 9) must be recorded. Lastly, if peers deliver these services, peer involvement should be indicated within the Service Contact document.

## 2. Recording client outcomes/changes in a client's life

Each agency will record changes in client outcomes/changes in a client's life across the same nine social determinants of health service areas identified used for the baseline demographic information<sup>12</sup>:

- Current safety concerns
- Housing
- Food security
- Education/Employment
- Family Status and Social support
- Immigration
- Income and Benefits
- Well-being
- Living with HIV

Each worker will record these changes when their client reports a change in one of these determinants of health during their session. Changes are recorded in the Presenting Issues Update document

We recognize that these changes may or may not be the direct result of the support services provided by the agency, however, the supports provided by the agency have contributed to the client's outcomes/changes in the client's life and/or impact the type of support provided and focus of each session. Furthermore, tracking changes on the agency and sector level allows us (the funder) to identify new and emerging trends in demand for services and the outcomes of different support services.

## 3. Minimum reporting requirements

It is expected that each interaction with a client receiving support services is recorded within the OCASE Service Contact document within 24 – 72 hours of the visit/session (as per agency protocol and a case-by-case basis for each interaction). For example, this data entry process might look different for an emergency situation or for organizations with part-time staff. It is recommended that each agency develop practices that protect and formalize time for worker's to record their support service client interactions to meet these timelines.

It is suggested that agencies/staff take 5 – 10 minutes after each appointment to record the services provided. If this is not possible, some agencies close the office specifically for staff administrative work. It is expected that all staff complete documentation tasks during this period (e.g., 2hrs, 1 morning during the week, etc.). It is not a recommended best practice for workers to sit in front of the computer doing data entry when speaking with their clients.

For each support service contact recorded, the following information is required:

- Contact date, type, duration and type of service
- At least one Program Area must be selected
- At least one service item within each selected Program Area
- A change in the client's life within one of the nine social determinants of health (if disclosed)
- Use of emergency medical services since the last contact (if disclosed)
- Whether or not other case members and/or other workers were present

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<sup>12</sup> These nine service areas are based on a scan of indicators used in other similar sectors, literature on health outcomes and the experience and collective knowledge of working group members.

#### **4. Core training for support workers:**

Each agency should ensure that all support workers:

- All support workers receive mandatory training to use OCASE in general and specifically, the Support Service Client Contact Documents (Intake form, Service record, etc.) to meet the minimum reporting requirements.
- All support workers who provide HIV Case Management receive the training in this service delivery model, how to conduct the client needs assessment (in the context of HIV Case Management) and training in how to record their work in OCASE.
- All support workers receive training in writing case notes, according to the agency policy and practices.
- All support workers receive regular program supervision.

#### **5. Accountability to the Funder (reporting and evaluation)**

Support workers should routinely record the services they provide to clients. Documentation is an integral part of service provision that informs client care planning, support program development and demonstrates accountability to the Funder.

To achieve a high level of service for clients and meet accountability requirements to the funder, support workers and their program managers are expected to:

- Record activities in a timely fashion and perform regular reviews of service reports according to the agency's record keeping policies
- Maintain sufficient data to complete reports required by funders (e.g., OCHART semi-annual reporting, etc.)
- Evaluate their program services on a regular basis to identify areas for program improvement, measure client satisfaction and determine achievement of program outcomes

All support workers should receive formal, in-house training on documentation and the agency's established record keeping policies, within the first month of hiring. Agencies can follow training checklists to ensure all support workers are properly trained to record their work.

The EBPU can provide support with tools for documentation/record keeping, best practices for data administration procedures, reporting to the funder and developing evaluations for your support program.

#### **VI) Closing remarks**

This program description is a living document that reflects the adaptive and responsive nature of Ontario's HIV Support Services Program. It will be revised and updated as required.