

EVALUATION OF AN INNER CITY PUBLIC HEALTH CLINIC SERVING AN ABORIGINAL AND NON-ABORIGINAL POPULATION

LEANNE OWENS
ROBERT MCKIM, MSc¹
RESEARCH, EVALUATION AND QUALITY IMPROVEMENT,
PRIMARY CARE DIVISION

DIANE DOERING, RN, BScN
ANITA HANRAHAN, RN, MN
COMMUNICABLE DISEASE CONTROL, PUBLIC HEALTH DIVISION
CAPITAL HEALTH, EDMONTON, ALBERTA

Correspondence to: R. McKim, Director, Research, Evaluation and Quality Improvement,
Primary Care Division, 14007 - 50 Street, Edmonton, Alberta, T5A 5E4, bmckim@cha.ab.ca



Artwork by Lise Skidmore, NCSA

INTRODUCTION

For people struggling with poverty, addictions, mental illness, and homelessness, there are huge barriers to accessing health care services. Making and keeping appointments, finding transportation, and navigating unfamiliar surroundings often present insurmountable problems for this group. With the majority of new positive HIV and hepatitis C infections being reported from this area and recent syphilis and gonorrhea outbreaks added to the growing list of serious health risks, Capital Health Public Health Division decided to respond in new and innovative ways to these challenges.

The Capital Health Primary Care Research and Evaluation Team was engaged to evaluate Public Health's year-long pilot project — the Inner City Public Health Project (ICPHP). The project was funded by Alberta Lotteries, Capital Health Public Health Division, and in-kind by the Boyle McCauley Health Centre which provided space and utilities (such as power and phone) at no cost to the project. The project was initiated with clients on September 29, 2003 with the following goals established:

- Collect and disseminate information about demographics, health status and health risk of the inner city population.
- Test high-risk individuals who aren't regularly accessing these services.
- Promote and provide hepatitis A, hepatitis B and influenza immunization.
- Provide follow-up or access to follow-up services for those clients that test positive for HIV, hepatitis C and other sexually transmitted diseases.
- Increase continuity of care and access to public health services for high-risk inner city populations.

The two main strategies employed to meet the program outcomes were to:

- Set up mobile outreach clinics in environments that were familiar and accessible to the target population in order to reduce access barriers to a high-risk population.
- Employ a Community Health Representative to establish a recognizable presence in the community and build trust and relationships with potential clients and partner agencies.

OVERVIEW OF THE INNER CITY PUBLIC HEALTH PROJECT

In September of 2003, the Capital Region Public Health Division opened an office in the lower level of the Boyle McCauley Health Centre in the heart of Edmonton's inner city. The Public Health Office (PHO) was staffed with a full-time Public Health Manager, a full-time Community Health Representative (CHR), and three STD Nurse Specialists who provided a total of .4 FTE of service. Clients were able to drop into this office at any time. However, there were no scheduled office hours and staff were not always available. Most clients were seen through outreach clinics that were hosted at community agencies, shelters, and drop-in centres.

The Community Health Representative played a central role in building partnerships with external agencies, locating clients needed for follow-up and building trusting relationships with potential or current clients in order to support and encourage them in accessing health services. The CHR was responsible for approaching various agencies throughout the year to inform them of the services the public health team could provide and arranged times and space to set up the outreach clinics. Besides providing support to the nursing team and to individuals in the community, the CHR facilitated a weekly Women's Health Group and the Hepatitis C Peer Support Meetings at the Bissell Centre and occasionally worked on the Streetworks van assisting with needle exchange in the evenings. These strategies aimed to create a greater public health presence in the inner city and to establish a familiar and trusted individual within the community. Ideally this networking potential would lead to improved prevention efforts, harm reduction strategies, and follow-up with populations that have been historically hard to reach and difficult to track or engage.

The Inner City Public Health Project became a flexible resource within the community that provided a variety of services as the need emerged. These services included:

- serology testing for syphilis, HIV, hepatitis A, B and C;
- vaccination against influenza, pneumonia, hepatitis A and B and Td Booster;
- assessment, testing, and treatment for sexually transmitted infections such as gonorrhoea, chlamydia, herpes, trichomoniasis and bacterial vaginosis;

- pregnancy testing;
- assistance with treatment for conditions such as lice and scabies;
- referrals for follow-up for a variety of health issues;
- assisting clients with accessing other services by providing transportation (bus tickets) and accompanying clients to appointments;
- one-on-one education between clients and STD nurses;
- facilitation of the Women's Health Group and Hepatitis C Peer Support Group meetings at the Bissell Centre;
- provision of health information to the community by hosting the Urban Health Seminar Series, a series of presentations that present information on critical health issues to staff of agencies working with the inner city population.

EVALUATION

PURPOSE

In the first stage of this evaluation a framework was created that identified program outcomes and linked them to strategies and indicators. Because this was a pilot project it was of particular importance to provide ongoing evaluation that would inform current practice. A report was provided at 3 and 6 months and a variety of processes were modified throughout the year. For example, in the initial 3 months several different drafts of the Health Status Questionnaire were administered at point of first visit with the client. We report here on the final evaluation of the pilot project after one year of operation.

DATA COLLECTION

Four key data sources were used for this evaluation.

- **The Health Status Questionnaire:** A questionnaire that was usually administered by the Community Health Representative to the client at their first visit. Questions were asked about demographics, health history, and health risk behaviours.
- **Database:** The main database stored all of the information from the health status questionnaire as well as test results and immunizations received for each client. The database storing this information was stripped of any information that could identify the client.

- **Daily log sheets:** At the beginning of each clinic a new log sheet was started and a list of all clients and their reason for visiting was logged.
- **Face-to-face interviews:** Interviews were conducted with the three STD nurses and the Community Health Representative that worked with the Inner City Public Health Project, as well as with 8 staff members from the following partner agencies: Boyle McCauley Health Centre, Bissell, George Spady, Urban Manor, Kindred House, and Streetworks. Interviews lasted from 15 to 30 minutes. Respondents read an information letter and signed a consent form prior to the interview.

FINDINGS

UTILIZATION OF SERVICES

The Inner City Public Health Project operated out of an office in the basement of the Boyle McCauley Health Centre. Clients were able to drop into this office at any time. However, there were no scheduled office hours and staff were not always available. Approximately 15% of client visits were at this Public Health Office (PHO). The rest of the clients were seen at mobile outreach clinics that were set up at various community agencies around the inner city. Each clinic usually lasted from 2.5 to 3 hours. During the first year of this project there were:

- 305 Unique Clients (number of unique charts started according to the database).
- 754 Visits (according to the daily logs). On top of these visits there were 101 flu vaccinations administered for the 2003 flu season.
- 170 Clinics (according to the daily log sheets).
- 12 different clinic locations that changed throughout the year.

Utilization patterns were analyzed by month (Table 1) and by location of outreach clinic (Table 2). There were no apparent trends based on month. This may be partially due to the fluctuation in clinic location and availability of the STD nurses from month to month. Excluding the clinic held in September 2003 (not full month), there were an average of 53 visits per month at the outreach clinics (range is 23–76, median 57) and an additional 9 per month at the Public Health Office (range is 3–14, median 9.5). When considering utilization by location it is also difficult to identify any trends. The Bissell Centre had the highest number of client visits (242), second highest number of clinics run (40) and the highest average number of visits per clinic (6.1).

Table 1: Client Utilization by Month

<i>Date</i>	<i># of clinics held</i>	<i># of new clients seen</i>	<i>Average # of new clients per clinic</i>	<i># of visits at outreach clinics</i>	<i>Average # of visits per clinic</i>	<i># of drop-in visits at PHO</i>	<i>Total Visits</i>
<i>Sept. 2003</i>	1	7	7.0	7	7.0	0	7
<i>Oct. 2003</i>	13	33	2.1	62	4.8	3	65
<i>Nov. 2003</i>	10	20	1.8	39	3.9	8	47
<i>Dec. 2003</i>	11	29	2.6	64	5.8	14	78
<i>Jan. 2004</i>	19	40	2.1	76	4.0	6	82
<i>Feb. 2004</i>	18	40	2.2	75	4.2	6	81
<i>Mar. 2004</i>	23	28	1.2	54	2.3	10	64
<i>Apr. 2004</i>	19	26	1.4	58	3.1	14	72
<i>May 2004</i>	13	21	1.6	56	4.3	10	66
<i>June 2004</i>	20	20	1.0	70	3.5	11	81
<i>July 2004</i>	6	10	1.7	23	3.8	9	32
<i>Aug. 2004</i>	6	14	2.3	24	4.0	14	38
<i>Sept. 2004</i>	11	17	1.5	36	3.3	5	41
TOTALS	170	305	1.8	644	3.8	110	754

The Boyle McCauley Health Centre (42 clinics) and Boyle St. Co-op (26 clinics) had the second and third highest number of visits respectively (138 and 68 visits) but were ranked 5th and 10th in the average number of visits per clinic. Kindred House was the only other location where more than 10 clinics were held with the remainder of sites hosting anywhere between 2 and 10 clinics. The average visits per clinic were 3.8.

HEALTH STATUS QUESTIONNAIRE DATA

The Community Health Representative (CHR) collected client information at the initial intake using the Health Status Questionnaire. Most questions were answered with at least a 90% rate of completion with the exception of the questions regarding previous testing and immunization. Clients were frequently unable to recall whether or not they had been tested or immunized, what the results of those tests were or when they were tested (Table 3).

CLIENT DEMOGRAPHICS

Forty-nine percent of the population was male, with 70% of clients between the ages of 25 and 54. There were differences in gender and origin with women being younger than men and Aboriginal younger than non-

Table 2: Client Utilization by Location

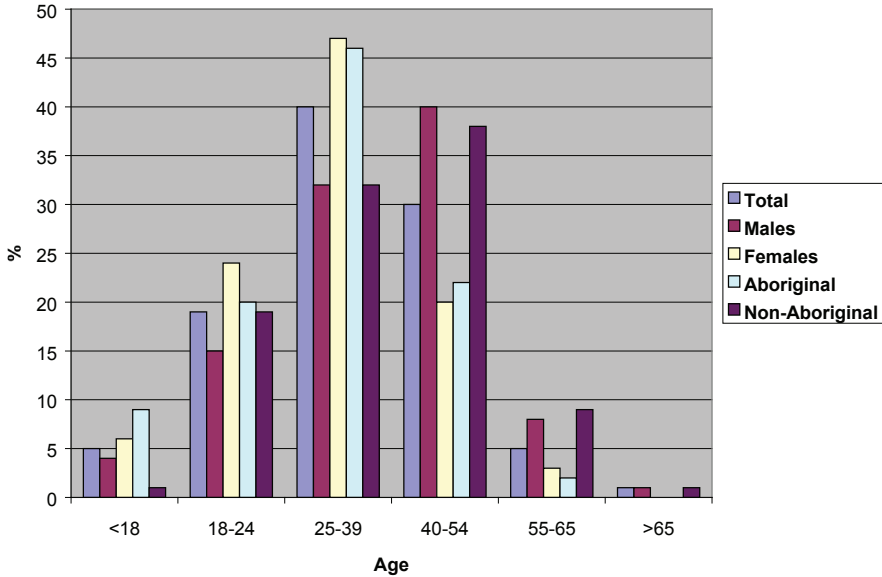
<i>Clinic Location</i>	<i># of clinics held</i>	<i># new clients seen</i>	<i>Average # of new clients per clinic</i>	<i># of visits</i>	<i>Average # visits per clinic</i>
<i>Bissell Centre</i>	40	89	2.2	242	6.1
<i>Salvation Army</i>	8	23	2.9	37	4.6
<i>People in Need (Bridgeway)</i>	4	6	1.5	18	4.5
<i>Inner City High School</i>	10	15	1.5	41	4.1
<i>Boyle McCauley Health Centre</i>	42	59	1.4	138	3.3
<i>Hope Mission</i>	6	10	1.7	18	3.0
<i>Urban Manor</i>	5	6	1.2	15	3.0
<i>Boyle St. School</i>	3	7	2.3	9	3.0
<i>Kindred House</i>	14	18	1.3	39	2.8
<i>Boyle St. Co-op</i>	26	40	1.5	68	2.6
<i>George Spady Shelter</i>	2	2	1.0	5	2.5
<i>Women's Emergency Accommodation Centre</i>	10	9	0.9	14	1.4
<i>Public Health Office</i>	n/a	21	n/a	110	n/a
TOTALS	170	305	1.8	754	

Table 3: Percentage of Clients Who did not Know the Answers to or were Missing Data for Questions Regarding Previous Testing and Immunization History

	<i>Have you ever had a(n)</i>	<i>What were the results of your most recent...</i>	<i>What was the date of your most recent test for...</i>
<i>HIV test</i>	6%	10%	36%
<i>Hepatitis C test</i>	11%	15%	48%
<i>Hepatitis B test</i>	42%	44%	85%
<i>TB test</i>	24%	28%	67%
<i>Hepatitis A Immunization</i>	26%	n/a	n/a
<i>Hepatitis B Immunization</i>	39%	n/a	n/a
<i>Flu Immunization</i>	12%	n/a	n/a
<i>Pneumococcal Immunization</i>	22%	n/a	n/a

Aboriginal. The majority of the population were Aboriginal (52%). This compares to 9.8% of the population in Edmonton central region being of Aboriginal origin (Fig. 1).

Figure 1: Self-Reported Age based on Origin and Gender



The majority of clients had less than a grade 12 education (60%) with 81% of Aboriginal clients reporting they had not completed high school. Only 15% of the clients reported full employment and 9% reported casual employment while 52% reported some source of government assistance. Table 5 shows self-reported primary sources of income for the population broken down by non-Aboriginal/Aboriginal and gender differences.

Sixty-one percent of the population reported being single with 21% indicating they were married or in common law relationships. Sixty-four percent indicated they had lived in Edmonton for more than 5 years with 27% indicating they had lived outside Edmonton in the last year.

The majority (58%) of clients reported having no telephone number and 35% reported no permanent residence with 59% of these being Aboriginal.

Sixty percent of persons with a permanent address reported they were at least partially self-sufficient in obtaining food compared to only 19% of those that reported no permanent address. Forty-three percent of clients report-

ed that they relied on agencies (soup lines, overnight shelters that provided food) at least part of the time for food.

HEALTH STATUS

Clients were asked about their history of testing for HIV, hepatitis C, hepatitis B and tuberculosis. One quarter of the population self-reported having been told they were positive for hepatitis C, 5% positive for TB, 4% for hepatitis B and 2% for HIV. They were also asked for their immunization history. Thirty percent reported that their hepatitis B immunization was fully completed and 6% reported that it was partially completed. Eight percent reported full completion and 4% partial completion of hepatitis A immunization. In addition, 31% received the influenza vaccination and 6% the pneumococcal vaccination during the most recent flu season.

Forty percent of clients (122 clients) report having been told by a professional that they have depression, anxiety or some other mental illness. Of these clients, 54 reported depression, 16 reported anxiety, 27 reported other mental illness, 22 reported at least two of the three and 3 clients reported all three mental health issues.

Table 4: Self-Reported Origin of Clients

<i>Origin</i>	<i># of clients</i>	<i>Percent of clients</i>
<i>First Nations</i>	101	33
<i>Metis</i>	51	17
<i>Inuit</i>	5	2
<i>Canadian Born/Non Aboriginal</i>	134	44
<i>Foreign Born</i>	11	4

HIGH RISK HEALTH BEHAVIOUR

The majority of clients reported participating in unprotected sex (84%) and using alcohol (69%), drugs (57%), and tobacco (85%).

Thirteen percent reported current use of intravenous drugs and 27% reported previous intravenous drug use. Sixteen percent reported currently sharing needles or paraphernalia such as straws, pipes, spoons, and other drug-related equipment. An additional 17% reported previous sharing of drug related paraphernalia. Sixteen percent were currently involved in the sex trade and 5% were previously involved. Approximately one third of clients reported tattoos and/or piercings. The Aboriginal clients were more likely than

Table 5: Self-Reported Source of Income: Percentage by Origin, Gender and Overall

	<i>Employed</i>	<i>Casually Employed</i>	<i>EI</i>	<i>SFI</i>	<i>AISH</i>	<i>Student Financing</i>	<i>No Income</i>	<i>Other*</i>
<i>Total</i>	15	9	2	26	16	8	10	13
<i>Aboriginal</i>	10	11	1	26	14	9	14	15
<i>Non-Aboriginal</i>	20	8	3	26	17	8	7	12
<i>Male</i>	18	17	2	23	16	6	11	7
<i>Female</i>	11	2	2	28	15	11	11	19

non-Aboriginal clients to report participating in unprotected sex (84% vs. 70%) and were more likely to report use of alcohol (81% vs. 57%) and drugs (67% vs. 46%). They were more than twice as likely (23% vs. 10%) to report involvement in sex trade (Table 6).

Table 6: Self-Reported Health Risk Behaviours: Percentage participating by Origin

	<i>Alcohol</i>	<i>Drugs</i>	<i>IDU</i>	<i>Share Drug Paraphernalia</i>	<i>Involvement in Sex Trade</i>	<i>Unprotected Sex</i>	<i>Use of Tobacco</i>
<i>Aboriginal</i>	81	67	14	16	23	84	86
<i>Non-Aboriginal</i>	57	46	11	18	10	70	84
<i>Total</i>	46	57	13	17	16	77	85

TESTING

There were a total of 1570 tests given for various communicable diseases (Table 7). Only 13% of clients (39 of 305) did not receive any testing. There were no new cases of HIV or syphilis found. Twelve percent of those tested for hepatitis C were positive and an additional 9% had a previously positive test result on file at the Provincial Laboratory. Almost half of all hepatitis A antibody tests and 29% of anti-hepatitis B surface antigen tests were positive. Only 3% of chlamydia, 2% of gonorrhoea, and 2% of hepatitis B surface antigen tests were positive.

IMMUNIZATIONS

A total of 33 clients started the hepatitis A immunization series, which consisted of two vaccinations; one given initially and another 6 months later.

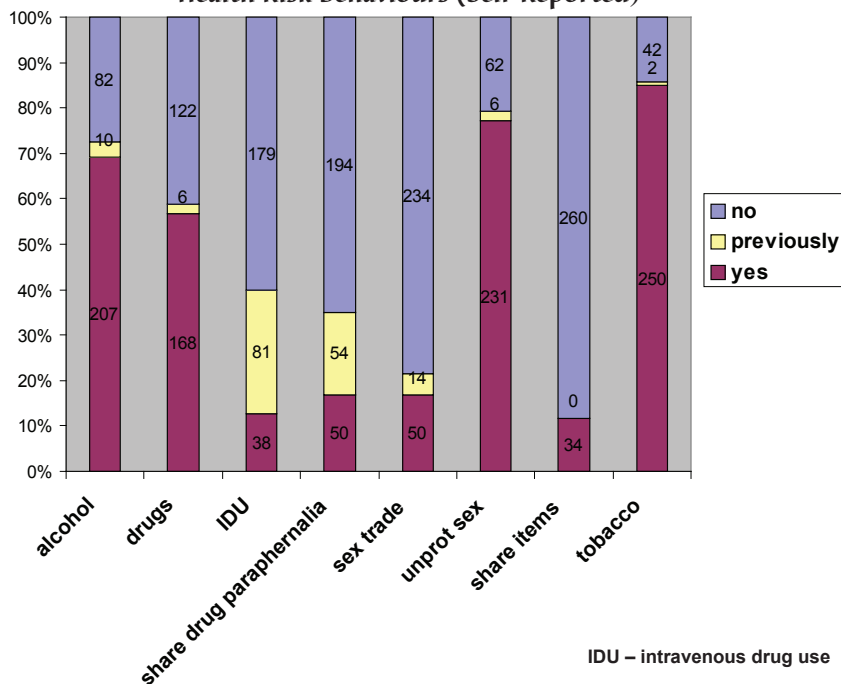
Table 7: Number of Tests Performed and Test Results

	Total # of Tests	Positive	Negative	Previously Positive*
Hepatitis A Ab	97	48	49	n/a
Anti-Hepatitis B Surface Ag	178	52	126	n/a
Hepatitis B Surface Ag	177	3	174	n/a
Hepatitis C virus	156	17	125	14
HIV	247	0	245	2
Syphilis	255	0	224	31
Gonorrhoea	183	3	180	n/a
Chlamydia	184	10	174	n/a
Other**	93	26	67	n/a

* Previously Positive indicates that the client has a previously positive test result on file at the Provincial Laboratory. In the case of HIV and Hep C the client is not re-tested.

** "Other" includes tests for herpes, trichomoniasis, bacterial vaginosis, and yeast infection.

Figure 2: Percentage (and Number of Clients) Participating in Various Health Risk Behaviours (Self-Reported)



Eight individuals had completed their series by the end of Sept. 2004. Twenty clients self-reported previously completing the hepatitis A series and 53 were confirmed to already have hepatitis A antibodies. Six clients declined hepatitis A immunization.

Eighty-eight clients had begun the hepatitis B immunization series, which consisted of three shots to be given at 0, 1, and 6 months. Approximately one-third (28) completed the 3 shot series, another third (33) had received their second vaccination and the final third (27) had only received the first vaccination. Seventy-three clients self-reported previously completing the hepatitis B series and an additional 57 were confirmed as already having antibodies for hepatitis B. Nine clients were on record as declining hepatitis B immunization.

One hundred and one influenza vaccinations were given during the 2003 flu season.

FOLLOW-UP

Fifty-four percent of those that were tested received their results. Individuals that did not test positive or that tested positive but were already given treatment (e.g., antibiotics for gonorrhea or chlamydia) were not tracked down. Those that were positive, required follow-up, and did not return to receive results were sent a letter (if there was an address on record), contacted through one of the partner agencies or through the Community Health Representative when possible. Seven of the eight partner agency staff that were interviewed said that their agency had helped to track down clients on at least one occasion.

A positive hepatitis C result requires extensive follow-up. The primary role of the Inner City Public Health Project was to inform clients of their results, link hepatitis C positive clients to follow-up services, and to provide immunization for hepatitis A and B. It is important to note that some clients received a result of previously positive when tested for hepatitis C. This indicated that the client already had a positive result on file at the provincial lab. Due to the predominantly incurable nature of the disease the lab does not re-test these individuals and instead indicates "previously positive" on the results.

In the first year of this project there were a total of 95 clients who were positive for hepatitis C. There were 17 clients with positive hepatitis C tests (5 of which had also self-reported being hepatitis C positive at intake), 14 clients with previously positive hepatitis C tests (8 had self-reported being positive at intake and 6 reported that they were negative or did not know

their current status) and an additional 64 clients that self-reported having hepatitis C at intake that were not re-tested. Thirty-three percent of these 95 clients reported current intravenous drug use (IDU) and 50% reported previous IDU. Twenty-four percent reported currently sharing drug paraphernalia and 36% reported previous sharing. Thirty-three percent had body piercings and/or tattoos.

Eighteen of the 95 clients did not self-report being hepatitis C positive and were presumably being told for the first time of their positive hepatitis C status. Of these 18 clients 83% had received their test results. Of those that had received results (n=15) 74% had at least begun hepatitis A immunization or were already immune and 91% had at least begun hepatitis B immunization or were already immune.

Of the 64 clients that self-reported having hepatitis C that were not re-tested, 78% had at least begun hepatitis A immunization or were already immune and 91% had at least begun hepatitis B immunization or were already immune. Approximately one quarter of these 64 clients began hepatitis A and B immunizations with this initiative even though they were diagnosed with hepatitis C prior to their initial contact.

There were no new cases of HIV or syphilis. However, some clients were having the follow-up syphilis testing done through the Inner City Public Health Project.

Forty-seven clients had received STD treatment. Nine clients of the 11 (82%) that tested positive for gonorrhea or chlamydia either received treatment or at least received results. Fifteen clients of the 20 (75%) that tested positive for "other STDs," including herpes, trichomoniasis, bacterial vaginosis, and yeast infections, either received treatment or at least received results.

STAFF INTERVIEWS

Staff of inner-city agencies and at Boyle McCauley were asked through formal interviews about their experience with the program being run in the inner city. Two major themes emerged.

1. Many of the clients were not proactive regarding health care issues. The outreach clinics provided an opportune way of reaching those that would not otherwise seek out the services provided through the initiative. The following were a few typical answers:

- *"Then there's the whole having to actually plan and go and take care of and be proactive about taking care of their health, which is not a priority of most of*

the people we work with. So if we have it here people are more likely to access it and be proactive about taking care of their health."

- *"A lot of the people we work with are very crisis based ... [with the outreach clinics] here they can be more proactive."*
 - *"[The clients] need specialized attention because they ... are not terribly well organized and they're not out there accessing the services on their own."*
2. Many of their clients were uncomfortable or unable to access public health services in more traditional settings. The outreach clinics were in locations and environments that clients have already established as being familiar and comfortable. Therefore, the clients are more likely to access services. The following were some of the statements supporting this theme:
- *"Often they forget about appointments or they don't feel comfortable going to appointments or their esteem levels are so varied that they tend not to use the services outside of the inner city."*
 - *"It can be intimidating to go to the STD clinic at the General [Hospital]... it's a great environment there but it can still be intimidating for some people to leave this area. There is this invisible boundary that's around the inner city and it can be difficult for some people to leave that boundary — it's about safety and this is where they are comfortable."*
 - *"The sheer location ... and that they actively solicited that client group is really important. It provides a really important point of entry for them."*

CONTINUITY OF CARE AND ACCESS TO PUBLIC HEALTH SERVICES

There were three strategies identified to reach the program outcome of continuity of care and increased access to public health services:

1. Establish partnerships with internal and external agencies.
2. Client Advocacy and assistance in following through on health care plans.
3. Encourage repeat visits and follow-up.

During the first 2 months there were only 4 agencies participating: The Boyle McCauley Health Centre, Bissell Centre, Women's Emergency Accommodation Centre, and Urban Manor. At year's end there were 12 different partner agencies that had hosted clinics. Through the interviews, it was found that the partner agencies' staff were familiar with the Inner City Public Health Project (ICPHP), valued the services provided, and were satisfied with their partnership with the Public Health Unit at Boyle McCauley.

It was not very common for agencies to send their clients to outreach clinics that were not at their site. A possible reason for this was confusion

about how or where to refer. The following comments were made about referrals:

- *"We don't always know where they [the outreach clinics] are ... if they had some sort of printout they could send so if I do refer people I know when and where."*
- *"Oh yeah they're down in the basement of Boyle McCauley but I don't know what days they're there and what days they're not."*
- *"[Our agency could act] potentially as a referral source ... I think that we've got a little bit of work to do still around making sure staff are aware of it."*

Respondents were also asked about their satisfaction with the overall partnership with the ICPHP. Six respondents replied very satisfied and two responded somewhat satisfied. The main concern appeared to be related to lack of communication:

- *"As far as we're concerned those clinics that came on site — I'm not sure why it just sort of fizzled out if that was our fault or theirs... I don't know why that happened. If we're just not going to be able to use it enough?... [S]ome more consistency around that kind of thing would've been nice."*
- *"I'm not sure that we're working as integrated as we could... We could communicate more. I take responsibility for that."*

A couple of individuals took this time to reiterate how pleased they were with their clients' response to the clinics:

- *"We were surprised about how the clients responded. They seemed to be really open to going over and chatting with the nurses.... I think that the staff liked to see that kind of thing happening."*
- *"I would like to see it keep going ... sometimes they would come and what looks like nothing's happening is [actually] that they come and because they're here they are building relationships. So even though a client this time may not see them, as they keep coming, more and more clients will go.... I was shocked actually at how they mostly saw somebody every time they were here."*

CONCLUSIONS

The Inner City Public Health Project was designed to demonstrate the feasibility of providing an outreach clinic within the inner city to clients who don't normally use or sporadically use primary health care services. In theory, this is a population that is transient and doesn't access health service until they become severely ill. In so doing they provide a source of medical risk for the population as a whole especially in the area of communicable disease. This project targeted this group and defined the risk populations as individuals involved in the sex trade, those using intravenous drugs, and so-called

marginalized inner city groups who had limited access to primary health care services. Our results show that 16% of the group seen were currently involved in the sex trade; 13% were intravenous drug users; 21% reported they had a previous history of sex trade involvement and/or intravenous drug use.

Forty percent reported having been diagnosed with a mental illness, the majority lived in poverty, 58% reported not having a phone, and only 24% reported being employed. The majority (52%) were Aboriginal. When asked what their main health care resource was, 30% indicated they had no resource, while a further 21% indicated they used walk-in clinics. This data supports the need for outreach service for this group.

Testing for communicable disease was the major activity of the clinic with 74% percent being tested for HIV. Forty-nine percent were tested for hepatitis C, 56% of whom reported no previous hepatitis C testing. Approximately 50% of all clients were tested for chlamydia and gonorrhea and 76% were tested for syphilis.

Partner agencies indicated that the targeted group was being reached and the role of the outreach services was most effective because the clinic partnered with agencies that already had established trusting relationships with many of the key populations being addressed. The outreach clinic was also able to reach those who tested positive more readily because of the relationships with the partner agencies.

The results reflect a positive influence on the health and well being of clients seen through this initiative. The number of new agencies added to the service post initiation suggests there is unmet capacity in the inner city. Further improvements though are indicated: two suggestions were role clarification between the staff of the initiative and partner agencies, and better coordination with these agencies regarding service provision. For example, a standardized referral process for community agencies to have their clients seen would facilitate success in this area.

The results also indicate a need to better understand the population that lives in the inner city and to address the fact that better than 50% use only episodic or no primary health care. For example, what are the current barriers to receiving care for this group? Furthermore, the Aboriginal population is significantly over represented in this area. This group made up 52% of the clients using this service in an area of Edmonton that has an Aboriginal population of 9.8%. This poses the question of why this is happening and what can be done to improve the service for this group.

There were limiting factors in this evaluation that are important to address. First, there were adjustments made to what and how data was collected throughout the year. The Health Status Questionnaire changed several times with additions, deletions, and minor changes made in how a question was asked. Another factor with unknown implications was the fluctuation of staff availability during the summer months. There were fewer clinics run in fewer locations. This may have affected relationships that were beginning to form or general accessibility for some clients. Finally, much of the data received was self-reported. There were no means to cross-reference most of this information which led to an unknown error factor. The population of clients that provided the information included individuals with mental health, cognitive, and psychosocial (i.e., addictions) issues, further complicating the validity of self-reported data.

