Systems Planning for Targeted Groups

2.2

SERVICE COORDINATION FOR HOMELESS PREGNANT WOMEN IN TORONTO

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INTRODUCTION

When pregnancy accompanies the precarious state of homelessness, a normal health condition presents unique challenges to the health and social service systems. Homeless women become pregnant for a number of different reasons including victimization, trading sex for safety or economic survival, lack of access to contraception, uncertain fertility, the need for closeness and intimacy, desire for a family and hope for the future (Killion, 1995; Killion, 1998; Little et al, 2007; Ovrebo et al, 1994; Tuten et al, 2003; Weinreb et al, 1995).

The health and social service needs of homeless pregnant women are unique and complex. The most pressing survival priorities for homeless women such as nutrition, safety, income, shelter and housing are often already competing with health needs such as primary and preventative health care, mental health care and substance use support services (Basrur, 1998; Beal & Redlener, 1995; Mayet et al, 2008). Adding pregnancy to the experience requires prenatal services such as medical care and parenting support. It requires particular attention to rest and good nutrition, and since homelessness and factors such as mental health and substance use can put a mother at risk of losing her baby to child protection agencies, bereavement support may also be required (Beal & Redlener, 1995; Little et al, 2007).

The barriers to accessing health and social services that homeless individuals face are numerous and documented elsewhere (Frankish et al, 2005; Greysen et al, 2012; Holton et al, 2010). There are also several specific barriers that homeless pregnant women face to accessing essential prenatal services. These include: denial of or ambivalence about pregnancy; unknown pregnancy due to irregular menses; developmental delay; history of trauma, social, sexual and physical abuse; mental illness (especially depression); substance use; lack of insight and awareness; past negative, stigmatizing or traumatic experiences with health care providers; lack of identification; precarious status; competing priorities for basic needs such as nutrition and shelter; transportation costs; lack of social support and accompaniment for appointments; previous history of having children apprehended or knowing someone who has; and the transient nature of their lives (Beal & Redlener, 1995; Bloom et al, 2004;

Little et al, 2007; Ovrebo et al, 1994; Paradis, 2012). As a result, babies born to homeless women suffer poor health outcomes including preterm birth and low birth-weight (Beal and Redlener, 1995; Killion, 1995; Little et al, 2005).

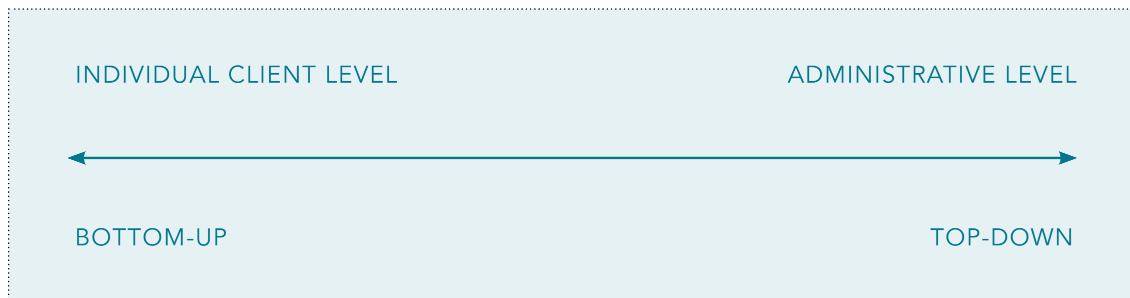
With appropriate access to care, these poor health outcomes can be prevented. In fact, pregnancy is frequently referred to as a window of opportunity for empowerment and change by engaging with homeless women who tend to be 'service-shy' (Killion, 1995; Killion, 1998; Mayet et al; 2008; Ovrebo et al, 1994). One important way to facilitate this is through service coordination efforts. A Canadian example of a service coordination program for homeless pregnant women is the Homeless At-Risk Prenatal (HARP) team in Toronto. This chapter presents the findings of a research study that explored service coordination for homeless pregnant women using HARP as a case study.

SERVICE COORDINATION

There is an extensive body of literature that explores the need for service coordination for homeless individuals and other populations whose complex needs span physical health, mental health, housing, disability benefits and other sectors (Fisher & Elnitsky, 2012). Sometimes called 'service integration,' this literature refers to a number of processes that range from coordinating services to restructuring services to consolidating systems (Austin, 1997; Fisher & Elnitskly, 2012; Gregory, 1996; Hassett & Austin, 1997). Terms like 'communication,' 'collaboration' or 'coordination' are often used to describe various activites related to service coordination (Fisher & Elnitsky, 2012).

For the purpose of this chapter, the term 'service coordination' is used to reflect the concept of engaging in different activites with the intention of ensuring that clients have access to the various health and social services that they need in an streamlined manner. Examples of such activities include case management linkages, outreach, providing parallel services, providing multiple services in one location, joint funding and interagency agreements (Austin & Prince, 2003; Hilton et al, 2003; Morrissey et al, 1997; Randolf et al, 1997).

FIGURE 1 *Service Coordination Continuum*



(Austin & Prince, 2003; Fisher & Elitskly, 2012; Hilton et al; 2003).

It is helpful to conceptualize the activities of service coordination along a continuum. This continuum combines concepts described by a number of different authors (Austin & Prince, 2003; Fisher & Elitskly, 2012; Hilton et al, 2003). Some activities fall closer to the individual client level on the left (e.g. case management linkages) and others are closer the administrative level on the right (e.g. interagency agreements) (Figure 1).

It is difficult to discern from the literature which aspects of service coordination are most effective under which circumstances. It can be assumed that this is particularly true for homeless pregnant women who have such unique needs, though this has not been well explored in the literature on homelessness and pregnancy. One exception is Little et al (2007), who outlined some aspects of service coordination and integration that were found to be successful for homeless pregnant youth. These included: networks, community advisory panels, case conferences, consistency of workers and strong cohesion between hospital and community agencies. The current study built upon these findings.

TORONTO PUBLIC HEALTH'S HOMELESS AT-RISK PRENATAL PROGRAM (HARP)

Approximately 300 babies are born to homeless mothers in Toronto each year, a number that has not decreased since 1998 and is likely to be greatly underestimated (Basrur, 1998; City of Toronto, 2012). Since 2007, Toronto Public Health (TPH) has been delivering HARP as part of the Healthy Babies Healthy Children Program to help address this complex public health issue. HARP is a team of specialized public health registered nurses and registered dietitians who work with high-risk homeless pregnant clients during their pregnancy and for a short time after. HARP clients are selected based on an acuity assessment that considers their health and social needs and stability, transiency and complexity (not all homeless pregnant women require such intensive case management; some low-risk homeless pregnant women fall into the 'usual care' Healthy Babies Healthy Children program at TPH). HARP providers meet with their clients on average once per week. HARP's primary goals are: one, improved access to prenatal care; two, connection to community services for health and social needs; and three, better health outcomes for baby and mom. Service coordination is a primary component of the work HARP does to achieve these goals, with HARP service providers acting as case managers to coordinate care for clients. HARP providers make referrals to other agencies to provide services for their clients and HARP providers also rely on other agencies referring homeless pregnant women to them as a way of case finding.

RESEARCH APPROACH

The primary research goal was to explore service coordination as conducted by HARP. Through a collaborative process between the investigator and the HARP team, the following research question was established: What aspects of service coordination serve the unique and complex needs of homeless pregnant women most effectively from the perspective of service providers?

METHODS

Semi-structured interviews were conducted with 27 individuals who were part of the service community for homeless pregnant women. The service community was defined as professionals who work with homeless pregnant women in the City of Toronto either in direct service provision or in agency leadership roles.

Participants were divided into internal and external groups. Seven internal participants represented public health nurses, registered dietitians and supervisors from HARP. Twenty external participants represented registered nurses, social workers, counsellors, outreach workers, parenting specialists, case managers, supervisors and coordinators working outside of HARP. The service sectors represented in the external participant sample included: shelter and housing, pre- and post-natal health, addictions, parenting, child protection, physical health and networking.

External participants were recruited initially through convenience sampling and recruitment continued in a snowball manner. Data were analyzed using an inductive analysis approach, as outlined by Thomas (2006), which facilitated establishing links between the research goals and findings and the development of a conceptual model.

FINDINGS

Two overarching themes emerged from this research that are described below: pregnancy creates a window of opportunity for change, but also a time pressure; and relationships are the key to successful service coordination. Ten activities that facilitate effective service coordination are then presented, followed by a discussion of how the findings demonstrate the value of a service coordination program for homeless pregnant women and the implications for research, policy and practice.

A WINDOW OF OPPORTUNITY FOR CHANGE, BUT ALSO A TIME PRESSURE

Several participants described pregnancy as a window that opens up an opportunity to engage homeless women and 'intervene about something.' It was generally felt that this window, as open or closed as it may be, creates some space to allow for progress toward stabilization and improvement in health for mom and baby.

In part, this window of opportunity is related to a sudden determination on behalf of the mother to achieve particular goals in order to provide for her child and herself, often described as hope for the future. Mayet et al (2008) and Ovrebo et al (2008) described this as well and TPH's prenatal care practice guidelines (2010) also reflect this concept.

After the baby is born the momentum created during the pregnancy was described as sometimes 'running dry' and the relationships between the client and her care providers change.

Another aspect of this window of opportunity is that there is an opening in the system of resource-intensive supports and services available to homeless pregnant women that are not necessarily available to other homeless women because a baby is involved (and many of these resources will again be unavailable to her shortly after the baby is born). Such services include but are not limited to service coordination through HARP, some shelter spaces and associated supports and some mental health and addiction services. This reflects a gap within the system of services for this population, one that several participants described as being problematic. It suggests that perhaps the system of care for homeless women places a higher value on care provision when there is a baby involved, and that pregnant women are more worthy of resource-intensive supports; or, alternatively, that this level of intensity of supports is provided because the system views the perinatal period as one of exceptionally high need, and this level of support is only possible because it is time limited.

Along with the window of opportunity that pregnancy creates, there is the 'pressure of the clock' that is guiding the relationship between the client and their service community. The baby is coming and the service community must do everything possible in a hurry to try to get mom stabilized, whatever this looks like for her. The time frame varies from case to case, as some clients are linked with HARP early in their pregnancy, while others are connected very late. Both internal and external participants described this urgency.

After the baby is born the momentum created during the pregnancy was described as sometimes 'running dry' and the relationships between the client and her care providers change. This was especially true if the mother was not able to parent and the baby was taken into child protective services. Because of this, participants expressed how important it was to use this window of opportunity to get clients connected with as many resources as they may need. Ideally these connections would be with service providers who could continue to be involved after the baby was born wherever possible, because of mandate limitations on how long HARP can work with the mother after the baby is born. However, this was described as challenging given the structure of the system of services for this population.

Other authors have not described this concept of time urgency. It is very relevant to this discussion because it provides more context for why coordinating services for homeless pregnant women is unique compared to coordinating services for other homeless subpopulations. Relationships between service providers and service coordination activities are both highly impacted by this time pressure.

These themes demonstrate that within the context of the current system of services for homeless women, homeless pregnant women are in a unique position. While health and social systems are strained, HARP's model of service coordination works within these constraints and opportunities to improve access to services for homeless pregnant women not by addressing the number of services that exist within the system, but by acknowledging that these high-risk homeless pregnant women need some assistance to use them.

> *The system assumes that clients have the ability to go to appointments, HARP makes sure they get there… it's like a netting to capture people and ensure they get to existing services… It's not like we've created a new response, there was already prenatal care, but this population wasn't accessing it, now they are. (Internal participant)*

In a resource-constrained political and social context, high intensity case management and service coordination through programs like HARP may be the best option for ensuring homeless pregnant women have access to the health and social services they require. On the other hand, the time pressure could be relieved if such intensity of services were available for all high-acuity homeless individuals, creating the potential for the necessary services to already be in place when homeless women do become pregnant and allowing for more consistent care once they are no longer pregnant.

RELATIONSHIPS ARE KEY

Relationships Between Provider and Client

Strong therapeutic relationships between clients and providers were seen as the most important aspect of providing care to homeless pregnant women. In fact, it was seen as an intervention in itself. Building this trust was challenging: it involved a lot of effort in being flexible, persistent, answering phone calls and texts, listening, 'just being there,' taking baby steps and sometimes being 'fired and rehired,' which is consistent with findings in the literature (Little et al, 2007).

The ways in which HARP providers built trust with clients was guided by a number of standards of practice. Some examples include the TPH Prenatal Nursing Standards of Practice (TPH, 2010), Community Health Nurses Association of Canada (CHNC) Standards of Practice (CHNC, 2011) and Harm Reduction Principles (International Harm Reduction Association (IHRA), 2015).

The values from these frameworks that were particularly important for HARP providers to embody when developing trust with clients included a foundation of inclusive, equitable and client-centred care (TPH, 2010). The values and beliefs that all clients have strengths, clients are active partners in service delivery, the therapeutic nurse-client relationship is the centre of practice, harm reduction mitigates the consequences of high-risk behaviours and promotes better health, and that pregnancy provides a unique opportunity for empowerment and change were integral to how HARP providers conducted their work (TPH, 2010). Other important professional values included access and equity; professional responsibility and accountability (CHNC, 2011); dignity and compassion; universality and interdependence of rights; and transparency, accountability and participation (IHRA, 2015).

It doesn't matter how much you teach her about pregnancy, pharmacology, etc., if I can't build this relationship then none of this matters... if she won't see me, it doesn't matter what I know. (Internal participant)

A key facet of these relationships that is important to this discussion is that they are very fragile. Sometimes navigating therapeutic relationships was described as a 'dance,' where providers had to tread carefully because trust could be broken in an instant, and the window of opportunity to engage the client could close. This had to be finely balanced with helping the client get access to as many services as possible to become more healthy and stable in the pregnancy.

Knowing when to introduce topics or interventions depends on where you are on the continuum of the relationship with the client... asking them to do things or discuss certain topics when they are not willing or ready can put you at risk of losing the therapeutic relationship. (Internal participant)

Another commonly described part of this 'relationship dance' was the importance of deciding how to use the provider-client relationship effectively.

You have to use that bond effectively... If I have one shot at it, who do they really need to see? Do they need to see an obstetrician, or a psychiatrist? Sometimes you have to choose. (Internal participant)

This was described repeatedly by participants. It reflected a careful selection of providers that they were willing to introduce their clients to.

Relationships Between Service Providers

The relationships between providers were described as mostly being informal because they were not based on a partnership agreement between service agencies. In reality, while providers viewed these relationships as informal, they existed within an unwritten structure guided by both professional expectations of one another and agency-specific value systems. Internal participants sought relationships with service providers in the external service community who were like-minded, flexible and open to working with the complexities of homelessness and pregnancy compassionately. The external providers that internal providers preferred to work with practiced in a way that embodied the same value systems that guided their own practice (described in the previous section).

The careful selection of relationships with other providers in the service community was essential to the work that HARP providers did, as introducing clients to new service providers could be risky. Internal participants described many occasions when introducing their clients to practitioners who did not share the same value system led to a breakdown of their own therapeutic relationship with the client. In some cases HARP providers were able to slowly rebuild this trust and continue working together on goals; in others, clients went 'underground' and did not resurface in the health and social system until the birth of the baby.

I know [the other practitioner's] views, philosophy, how she works. I know she'll be really good for this client. I know she and I can communicate with this client. I'll tell the client: 'we're going to refer you to [X], I'll get you this [provider] that I really like, you'll like her too.' I'm going to feel good, client's going to feel good, and... all the trust I've built with the client won't be washed away with that one introduction. (Internal participant)

Interestingly, the relationships between service providers were described by a number of participants as being very similar to their relationship with a client: they take time and energy to build; they require persistence, flexibility and trust; and they can be fragile.

> *If you give up too easily, or if you get defensive when they don't give as much as you do, the relationship won't happen. And it's a constant negotiation that requires a lot of work.*
> *(Internal participant)*

Once built, the relationships between service providers were guarded very closely. Internal participants described wanting to 'stick with' these service providers when they found them, preferring to spend their energy strengthening these relationships rather than finding new ones. This was because it was generally felt that some service providers did not share the same values and "you just can't budge them" (internal participant).

When HARP providers selected external service providers in this way, the most important values they looked for in individual providers were underpinned by many of the same principles that guide HARP providers' practice that have already been mentioned. Harm reduction principles were particularly important, including: dignity and compassion, demonstrated by accepting people where they are at without judgment; incremental change, demonstrated by acknowledging the significance of any positive change that individuals make; universality and interdependence of rights, by demonstrating that all individuals have the right to health and social services; and transparency, accountability, and participation, by valuing open dialogues and the input of a wide range of stakeholders (most importantly including clients) in decision making (IHRA, 2015). Trust, flexibility, mutual respect, understanding each other's roles and mandates, and supporting each other were also described as essential to these relationships.

In addition to the time commitment required to maintain provider-provider relationships and differences in personal clinical practice values, other challenges to building strong relationships included conflicting value systems at the agency level, or agency mandates.

The value systems that HARP providers embodied and hoped to see from the service providers and agencies they chose to work with reflected an ideology that assumes that what is right for the mother is right for the baby. This emphasis on placing the mother's needs at the centre of care decisions was a primary feature of service coordination within this service community for high-risk homeless pregnant women. When this clashed with the ideologies of service providers or agencies that HARP clients needed to work with challenges arose and the relationship between service providers was described as less effective for the client. The inefficiencies included more time being spent trying to coordinate services for HARP clients, longer wait times for clients to access services, and less communication between service providers. This resulted in an overall less streamlined approach to care and more barriers for the client meeting their goals.

Strategies used within the service community to deal with these challenges included taking the time to learn about each other's agency, being respectful, pointing out the strengths of each partners' contribution to the service community, acknowledging the limitations of what each agency can offer and reaching a common ground.

Informal Relationships

Throughout the interviews it became very apparent that almost all participants valued the informality of their relationships with other service providers. Formal partnership agreements between HARP and the agencies that external providers work for did not exist, with the exception of one agency. The only formal process that was discussed was obtaining consent from clients to allow providers to discuss case details with one another.

Informal relationships between practitioners allowed them to facilitate access to services in a more seamless and timely manner. These processes were described as being important because they allowed agencies to just 'pick up and run' without paperwork or time-consuming referral processes getting in the way. When a client is willing to meet with a particular service provider, the sooner it happens the better.

Overall the majority of both internal and external participants considered the current informal methods to be effective. Myrtle et al (1997) support this; they describe the value of informal partnerships in service coordination for marginalized groups in general, stating that tightly integrated systems may not be as desirable as some argue, and that alternatives to formal arrangements or 'loosely coupled' integration strategies might allow for adaptation to meet clients' needs more effectively.

It is worth noting, however, that although practitioners viewed these relationships at informal, they were guided by a set of values and professional expectations that are described in the previous section. This created an unwritten set of guidelines within the service community.

One challenge to the value placed on informal relationships in the service community that was often described by both internal and external participants is the fact that even once relationships between providers were well established, staff turnover presented an enormous risk to the system of service coordination for clients. When providers in the service community left their position (e.g. they moved on to other jobs, took holidays or got sick), the relationship between care providers was over, and the other party in the relationship was left with a 'gap to fill.' For example, if a HARP provider had one or two contacts in the mental health sector that she knew to be an excellent fit for HARP clients, and one of these providers moved on to a different role, the HARP provider then needed to establish a new relationship within the mental health sector. This was also the case for external providers when a HARP nurse with whom they had a relationship left their position, as sometimes external participants were left not knowing who to refer their homeless pregnant clients to for service coordination. Even if this gap was just temporary, this greatly impacted the client's access to services because of the 'window of opportunity' and 'time pressure' concepts previously described.

It is important to mention that participants were well aware of the risks of building these types of informal working relationships. "We don't do it this way because we're stupid and we don't want things to be sustainable. It's because we are so cautious of who we introduce our patient to" (internal participant), and this was seen as more valuable because the client's needs were always first. This was so important because in the experience of HARP staff, without the trust between them and the client many of these women disappeared altogether and did not access *any* services.

Strategies to ease the transition into the service community for new service providers were noted by some participants, but it was clear that there was no easy answer. Some expressed that it was helpful to have new HARP providers introduce themselves to external service providers. Doing this introduction face-to-face worked far better than over the phone. While introducing new staff to partners did not mean the new relationship picked up where the old one left off, it created space for the development of mutual trust without having to start from a clean slate. Others felt that building the new relationship just happened

organically over time as clients were shared through talking on the phone and eventually meeting in person.

Some of the challenges to service coordination related to relationships described above are consistent with some of the general barriers to service coordination described in the literature (Christian & Gilvarry, 1999; Eisen et al, 1999; Fischer & Elnitsky, 2012).

Significant additions from this study include the exploration of how value systems in this service community at the individual and agency level impact service coordination and the risk that staff turnover presents in the context of a system that values such informal relationships.

ACTIVITIES THAT FACILITATE EFFECTIVE SERVICE COORDINATION

Ten activities were identified during the interviews that made coordinating services for homeless pregnant women effective in the context of this service community. They are listed according to their position on the partnership continuum (Figure 1), starting from individual case level activities on the left, towards more administrative level activities on the right. This is demonstrated more clearly in the Framework for Effective Service Coordination (Figure 2), which is described in more detail in the following section.

Activity 1:
Seamless Pathways for Referrals

Referring a client from one agency to another was usually the first entry to service coordination. Much like informal relationships, informal referral pathways were highly valued. This was mainly described as being able to call a particular service provider directly and get the referral process started right away without having to struggle with navigating formal referral channels such as application forms or general intake telephone lines.

Referring a client from one agency to another was usually the first entry to service coordination. Much like informal relationships, informal referral pathways were highly valued.

As mentioned previously, pregnancy creates a window of opportunity and the need for connection to services is almost always time sensitive. Such streamlined processes for referral allowed for more timely access to services for clients, and were described as resulting in faster, more efficient care. When service providers did not have strong relationships with a provider in a service sector they needed to refer a client to, they had to use the formal referral processes and this was often viewed as a barrier to accessing services for their clients.

Activity 2: Working Together Regularly

When two service providers who shared clients worked together frequently the working relationship was stronger. Sharing clients regularly created more opportunities for providers to interact with each other and work on important aspects of building relationships.

Working together frequently was something that was facilitated more easily for providers who work in the service sectors that homeless pregnant clients use most often (e.g. HARP, prenatal medical care services and child and family social services). On the other hand, when providers referred clients to services that clients use less often, more time would go by without having a mutual client and the relationship between providers was less likely to be maintained (e.g. housing services).

Activity 3: Regular Communication Related to Clients

When service providers shared a common client, communicating with each other regularly was generally considered to be critical to service coordination because the lives and needs of these clients can change so quickly. When clients gave service providers consent to communicate with each other about the details of their care, providers could give each other updates on progress, discuss goals and challenges, and strategize about how to address barriers as the client's circumstances changed. This communication took place mainly over the phone and in person. This was viewed by participants as a way of creating a more transparent and effective environment of care for clients.

The frequency of communication required for effective service coordination was identified as being individual to the specific needs of the client. Participants described that these discussions mostly happened on an as-needed basis and when relationships between providers were strong, facilitating these conversations was relatively easy.

Activity 4: Case Meetings

Case meetings are meetings where two or more service providers and the client are present. These meetings had all the benefits described above with the added benefit of the client being present. During such meetings service providers worked together with the client to establish goals, brainstorm, problem solve, make a plan of action, divide the work and make sure services provided by each agency did not overlap. These meetings were seen as particularly important for agencies that were regularly involved in the client's care provision including HARP, child protection services, prenatal medical services and in some cases shelter and housing services.

As the primary service coordinator, HARP was viewed as being in the unique and important position of having more intimate knowledge of the client, and therefore having more ability than other care providers to advocate for her and identify areas of strength and limitations. External agencies really valued this because it helped them make more informed decisions about care provision.

Another positive outcome of these meetings was that they ensured that the client and all providers involved were on the same page and hearing the same messages. This provided clarity for realistic goal setting. Once goals were established, HARP could continue to reinforce these messages for the client throughout her pregnancy. Some participants described that some homeless pregnant clients fragment their services by using multiple services and sharing different information with each. Participants described that while this is a coping mechanism, fragmentation creates barriers to coordination and it can result in either service duplication or gaps. Case meetings created a safe place where clients could start to build trust with all of their providers and reduce fragmenting behaviours.

The frequency of case meetings to make service coordination most effective depended on the needs of the client and the type of service being provided. In some cases it could be once during the pregnancy (for example, a meeting to establish an appropriate shelter option). In other instances, case meetings might be necessary once every three weeks (for example, case meetings related to parenting where the HARP worker, Children's Aid worker and the client meet regularly to assess achievement of goals that impact the client's ability to parent such as mental health and addiction stability). As was the case with communication between service providers, both internal and external participants indicated if they had a good relationship with the service providers involved, arranging case meetings was fairly easy.

Notably, not all service providers felt that case meetings worked well for them. As with all service coordination activities, the use of case conferences needed to be tailored to the needs of the particular client and the goals the service providers were working towards.

When providers in the service community did not know about each other and the services provided at their various agencies, they could not work together.

Activity 5:
Outreach Activities

When providers in the service community did not know about each other and the services provided at their various agencies, they could not work together. Engaging in outreach activities on an ongoing basis enhanced service coordination by creating opportunities for providers to introduce themselves, engage with one another outside of client care and discuss organizational mandates and values.

Outreach activities that were valued in the service community included care providers in care coordination roles (e.g. HARP) going to agencies and sharing information about their services and how to access them, establishing contacts with providers who work at the client level and ensuring both parties are clear about how to communicate with one another. In some of the external agencies that often work with homeless pregnant clients (e.g. a prenatal clinic), assigning one HARP provider to act as a contact point and representative was described as extremely helpful. Other outreach activities included sending out staff contact updates by email and providing flyers of program and service details during networking events. Participants also described that it is important for all agencies to engage in such outreach activities, not just HARP.

The frequency of such activities required was not clear from the responses. In general, however, participants felt that these outreach activities were not being done often enough. The most commonly discussed challenge to outreach was time, as balancing outreach activities with client activities and other work responsibilities was challenging. Many internal participants expressed having to prioritize their client-related work over outreach activities, and this had an impact on how well care was coordinated for clients.

Activity 6:
Establishing Mutual Goals and Values

It was clear from the interviews that the service providers that had the best relationships and the most effective service coordination were those who shared mutual values because it made working together with clients to establish goals and a plan of care easier.

As previously identified, differences in values occurred on two levels: at the individual level and at the agency level. When differences in values occurred at both levels, relationships and service coordination were particularly difficult. The important value systems for working with high-risk pregnant clients in this service community have been previously discussed. Other factors that influenced these value systems in the context of services for homeless pregnant women include power dynamics, political will, agency priorities and funding structures.

"It makes it hard for HARP… because our [mandate] can be challenging for them at times… We make exceptions sometimes, but our mandate is limiting. We've [had to] work through many frustrations." (External participant)

The most effective service coordination occurred when, despite differences in values and mandates, providers were able meet on a common ground and acknowledge that although they may not offer the same service in the same way, they all have the clients' needs at the core of their work.

"Even though we don't all offer the same service and can't do it in the exact same way, there is a meeting on a common ground." (External participant)

Activity 7:
Communication Outside of Clients

In addition to regular communication about clients, the participants that had the most collaborative relationships had some element of communication outside of client care. This refers to interactions that were not directly discussing a case. An example is discussing aspects of the work at a systems level rather than client-based level. Much of this communication took place during other service coordination activities including outreach, participating in networks and sharing resources.

In addition, a handful of participants discussed how their relationships with a particular contact were so strong that they communicated even outside of these activities. An example is using personal email or text to provide an update on something that was 'heard through the grapevine' that impacted how the service community might provide care to homeless pregnant women such as a bed opening in a supportive housing unit, or impromptu discussions that occurred after case meetings or networking events that help service providers get to know one another on a more personal level.

These interactions, for those who experienced them, were said to improve the relationship and therefore service coordination. Rationale provided was similar to many of the other activities: it helped service providers learn more about each others' values, expertise, styles of work, perspectives and created a working relationship with more mutual respect. While not all participants experienced this type of communication, those who did stated that they thought these working relationships should serve as a model for the 'ideal relationship.'

Activity 8:
Sharing Resources

A handful of the external participants described HARP providers as being 'a part of our team,' meaning that when they came to another agency to see mutual clients they were treated as if they worked there. External providers that experienced this sharing of resources said that the HARP providers knew the staff at their agencies, used shared office and clinical spaces, and were familiar and comfortable with the culture of practice in that setting. Both internal and external participants who experienced this viewed it as positively impacting service coordination, as it helped build mutual trust and goals and facilitated collaboration.

External providers that experienced this sharing of resources said that the HARP providers knew the staff at their agencies, used shared office and clinical spaces, and were familiar and comfortable with the culture of practice in that setting.

Activity 9:
Participation in Networks, Communities of Practice and Educational Events

One specific way that participants were able to communicate outside of client interactions was through participating in networks, communities of practice and educational events.

The two primary examples of these available within this services community were the Young Parents No Fixed Address network which met monthly and the Community Advisory Panel at St. Michael's Hospital, which met quarterly. These networks have been integral to the service community in many ways. Such events provided an opportunity for members of the service community from different sectors and professional backgrounds to come together and discuss issues related to providing care for homeless pregnant women. Participants described them as an opportunity to: interact with colleagues outside of clients, meet service providers they had only interacted with over the phone, learn more about the services offered at other agencies, meet and introduce new staff, work through conflicts, establish shared goals and common ground, share resources and updates on what is happening 'on the ground,' brainstorm and problem solve about challenging client situations and generally strengthen relationships.

Some participants also described a supportive aspect to these events. This was seen as important because of how difficult this type of work can be, particularly because many service providers work in isolation.

Another critical aspect of networking opportunities is that events that were supported by management but led by front line staff were felt to be the most successful. This was because the front line staff lived the experience of working with clients, and therefore they knew the issues best.

The frequency of such networking meetings that was ideal for service coordination could not be determined based on the interviews. However, most participants expressed satisfaction with the frequency of the meetings they attended.

Barriers to service providers attending such meetings were also identified, and these included workload and lack of management support. Having the meeting minutes circulated by email was something that was valued when participants could not attend.

Activity 10:
Management Support

Feeling supported by management is something that was critical to frontline providers working with homeless pregnant women. In particular, feeling supported to engage in the activities of services coordination that did not involve clients such as relationship building activities with other providers and attending networking events and communities of practice. Lastly, it was also considered highly valuable to have the management of different agencies working together on systemic process-related activities such as advocacy or policy work.

THE VALUE OF SERVICE COORDINATION FOR HOMELESS PREGNANT WOMEN

A final important theme that emerged from the interviews is that a specific service that provides flexible service coordination (such as HARP) is extremely valuable. Internal and external participants alike indicated that HARP made unique and essential contributions to the service community for these clients.

"As a result [of HARP], I think these young women have more support, more opportunities to parent, fewer apprehensions, more opportunities for young parents to get some stability in their lives."
(External participant)

HARP providers were seen as essential to the service community for homeless pregnant women in Toronto because: they were specialized in providing care exclusively to high-risk homeless pregnant women; they followed their clients anywhere in the city regardless of catchment area; they had frequent contact and therefore intimate knowledge of their client; and they had a unique ability to engage with this complex population. HARP providers were specifically valued for their expertise in the following areas: building and maintaining therapeutic relationships with clients who are typically difficult to engage; medical prenatal needs, because this allowed other care providers to focus on their own specialties; health literacy and education, because they were able to translate and continuously reinforce messages from other service providers for clients; and mental health care, specifically referring to their skills in crisis intervention which was something that many service providers expressed feeling uncomfortable with.

HARP providers were seen as essential to the service community for homeless pregnant women in Toronto because: they were specialized in providing care exclusively to high-risk homeless pregnant women.

SUMMARY OF FINDINGS

This section has clearly demonstrated that relationships were the most important aspect of service coordination, and that while informal processes for communication were highly valued, this can sometimes be risky and needed to be integrated with activities that facilitate effective service coordination. These concepts are summarized in Table 1, and are further explored in the following section using the Framework for Effective Service Coordination in Figure 2.

TABLE 1 *Effective Relationships Between Providers: Challenges and Strategies*

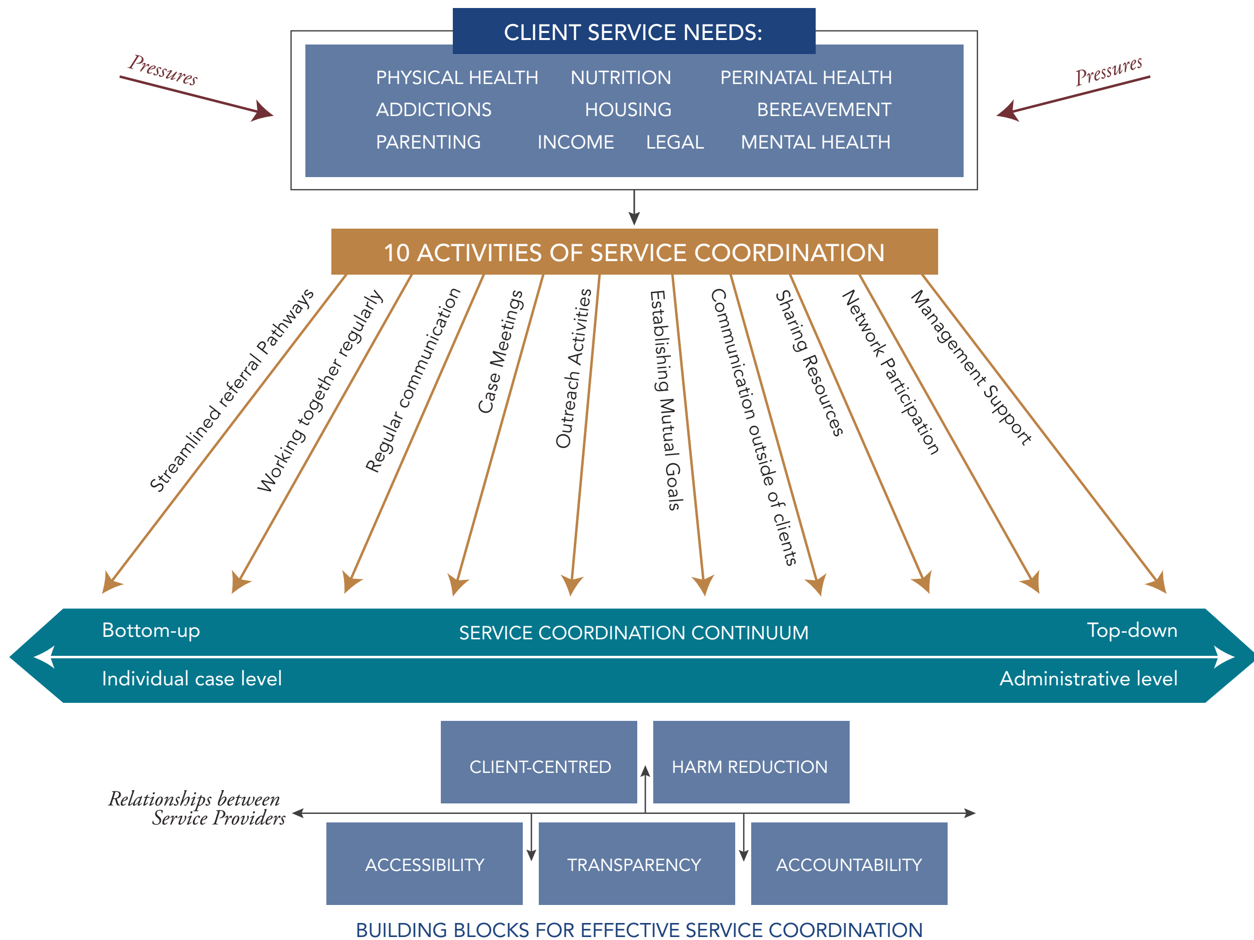
CHALLENGES	STRATEGIES
Conflicting mandates, goals and values	Taking the time to learn about each other's agency and value systems
Inconsistent understanding of roles	Being respectful
Infrequent mutual clients	Acknowledging the strengths and limitations of each partner and agency
Time consuming	Reaching a common ground
Workload and clinical priorities	Management support
Staff turnover	Outreach activities
	Participating in networking, communities of practice, and education events

FRAMEWORK FOR EFFECTIVE SERVICE COORDINATION

The Framework for Effective Service Coordination in Figure 2 brings together the findings of the research. The Framework is applicable to all service providers working in the service community for homeless pregnant women, their leadership teams and other health service delivery decision makers.

At the top of the Framework, the Client Needs Arch presents the unique and complex service needs of homeless pregnant women as described by participants. These are integral to the conceptualization of service coordination for homeless pregnant women because their needs are different than those of other homeless and marginalized populations (Basrur, 1998; Beal & Redlener, 1995; Mayet et al, 2008).

FIGURE 2 *Framework for Effective Service Coordination*



Service coordination is at the centre, and the 10 Activities of Service Coordination are presented as arrows to indicate their position along the Service Coordination Continuum (presented in Figure 1). In general, the more activities partners engage in the better the relationships are and service coordination is more effective for clients.

Below the Service Coordination Continuum are the Building Blocks of Service Coordination, which reflect the values that service providers need to embody to effectively work with this population. Most important is the glue that holds the Building Blocks together: the relationships between service providers. The Activities of Service Coordination help strengthen the relationships between providers in the service community, which in turn holds the whole system together.

There are also External Pressures on service coordination, depicted as flashes over the Client Needs Arch. These pressures include the time crunch due to the pregnancy window of opportunity being open for only a short period of time, limited resources that are sensitive to this population's unique needs, the transiency of this population, staff turnover, and the fragility of relationships between clients and providers and between providers.

IMPLICATIONS

The Framework for Service Coordination for Homeless Pregnant Women ties the themes of this research together, and can be applied in at least three important ways. First, individual service providers can use it to guide their practice. Second, it can be used at the organizational level as a guide when designing service models or reallocating resources in order to better serve the clients. Staffing models should allow client caseloads to be light enough so providers have enough time to engage in service coordination activities. Third, it can be used to validate the efforts already being made within organizations to engage in service coordination by demonstrating that each effort providers make for building relationships and coordinating services has an impact on the client (e.g. in program evaluation or quality control endeavors).

Thinking more broadly, this research highlighted some opportunities for system responses to the way care is currently provided to homeless pregnant women. The primary themes that informal, carefully selected, one-on-one relationships are 'the key' to service coordination efforts is really challenged by the fact that these relationships can fall apart if a service provider leaves an organization or gets sick. This presents an imperative for agencies to engage in more outreach activities across the service community and create some contingency plans for when this occurs in the hopes of creating a more streamlined process for service coordination in the sector as a whole.

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The higher availability of resources available to homeless women during pregnancy compared to other times has an important implication for services to homeless pregnant women. The discussion highlights an opportunity to consider the questions: Would making intensive service coordination services available to all homeless women improve overall outcomes and reduce the time pressure that exists when pregnancy is involved? What would it take for the system to demonstrate that all homeless women deserve the level of high-intensity resources that homeless pregnant women have access to?

This study contributes to the body of evidence that exists to support HARP's service coordination intervention as a promising practice for high-risk homeless pregnant women by providing an understanding of the contextual factors that influence the intervention in the Toronto service community (Canadian Homelessness Research Network, 2013). It also initiates the work for creating a promising practice in service coordination in general that could potentially be implemented more broadly across the system of homelessness services. Further research such as a realist evaluation would strengthen the case for the activities of service coordination as a promising practice.

CONCLUSIONS

This research has explored the specific aspects of service coordination that are most effective for homeless pregnant women. The experience of being homeless complicates a normal health condition into a precarious event in a woman's life. Without the appropriate support, a woman who is homeless and pregnant, who is already experiencing an incredible amount of barriers to accessing appropriate health and social services, faces the possibility of having a baby with poor health outcomes and the potential for being unable to parent her child. HARP provides a unique service that uses a number of strategies to effectively coordinate services for this population in Toronto, creating an example of an effective response to a complex health issue that could serve as a model for other Canadian cities.

The key features of effective service coordination for homeless pregnant women are: relationships between clients and providers, the relationships between providers, informal relationships, seamless pathways for referrals, working together regularly, case meetings, mutual goals and trust, communication outside of clients, sharing resources, participating in networks and communities of practice and management support.

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