July 2021

H.O.M.E

Health Outreach Mobile Engagement

H.O.M.E Program Initial Summary of Results: January 2021 – May 2021

About the H.O.M.E Program

The Health Outreach Mobile Engagement (H.O.M.E) Program provides a multi-disciplinary, multi-sectoral mobile response to improve the health outcomes and health equity of highly marginalized individuals in London, Ontario. The H.O.M.E Program was launched on January 11, 2021. It is a collaborative service approach between Addiction Services of Thames Valley, London Cares Homeless Response Services, London InterCommunity Health Centre, Middlesex-London Paramedic Service, and Regional HIV/AIDS Connection.[1]

The program provides primary care, harm reduction, support with substance use, basic needs, and wrap-around care services to highly marginalized individuals who face barriers to accessing traditional models of care where they are at, including emergency shelters, encampments, housing, and other community settings. Mobile services are offered from a Middlesex-London Paramedic Service Special Operations Bus two days a week and an urgent or non-urgent support SUV three days a week.

For more information about the H.O.M.E Program, visit www.homeprogram.ca.

[1] The H.O.M.E Program has received financial support from the Government of Canada's Substance Use and Addictions Program and from Ontario Health West.

A Snapshot of Initial Results

Results are inclusive of services provided between January 11, 2021 and May 31, 2021. A database was used to gather quantitative data. Qualitative results were derived from responses to a survey completed by program team members, site partners, and service partners.[2]

Service Access

66 **days of service** were provided by the H.O.M.E Program **between January and May 2021**

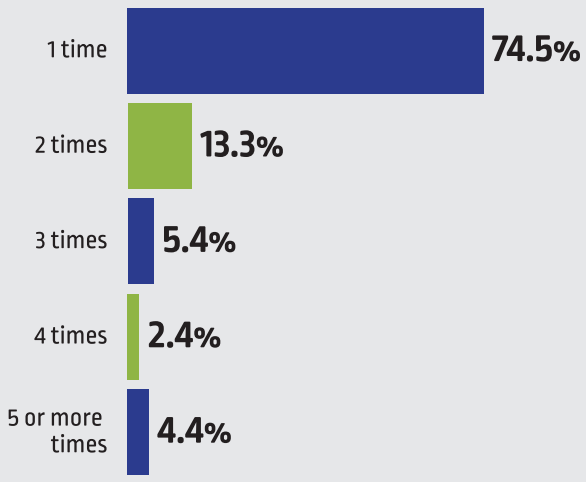
500 **unique people were served** by the H.O.M.E Program

817 **visits** were made to the H.O.M.E Program's mobile supports

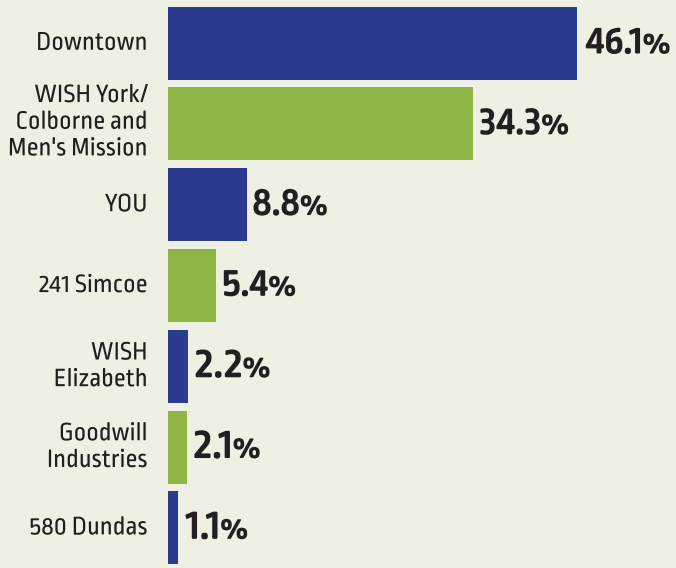
12 is the **average number of visits** made to the H.O.M.E Program each day service was provided

18 is the **highest number of visits made by one individual** to the H.O.M.E Program

Total Number of Times Unique Individuals Accessed the H.O.M.E Program (n=500)



Proportion of Visits at Each Program Site (n=817)



[2] At this time, a preliminary evaluation of initial results was conducted with program team members, site partners, and service partners. Further evaluation will be conducted to explore clients' experiences accessing the program and the impacts of the program on clients.

Services Provided

Number of Times Each Type of Service Was Provided

Type of Service	Number of Times Provided
Medical care	545
Healthcare system navigation	497
Social service system navigation	254
Harm reduction equipment	247
Harm reduction education	209
Basic needs – food and drink	104
Infectious disease testing	71
Basic needs – personal needs items	71
Identification services	68
Harm reduction case management	64
Referral to another community resource	40

> *The H.O.M.E Program extends our reach, especially during COVID. It aligns addiction [and harm reduction] work with healthcare services and is building/strengthening a continuum of care. Deaths and serious health impacts can be prevented or minimized, and [the program] can build trust for those who avoided care due to feeling unwelcome or poorly treated."*
>
> *– Program Team Member*

> *The presence of the H.O.M.E Program has given us a very helpful option in responding to participants who may otherwise be reluctant to attend at a traditional clinic or hospital."*
> *– Site Partner*

Type of Service	Number of Times Provided
Basic needs – clothing	39
Referral to London InterCommunity Health Centre	35
Transportation assistance	34
Addiction services education	27
Housing support	18
Referral to Regional HIV/AIDS Connection	17
Addiction services screening/assessment	14
Referral to Addiction Services of Thames Valley	9
Other type of service	9
Addiction services case management	2

Initial Program Impact[3]

The 5 Most Significant Impacts of the H.O.M.E Program on Clients

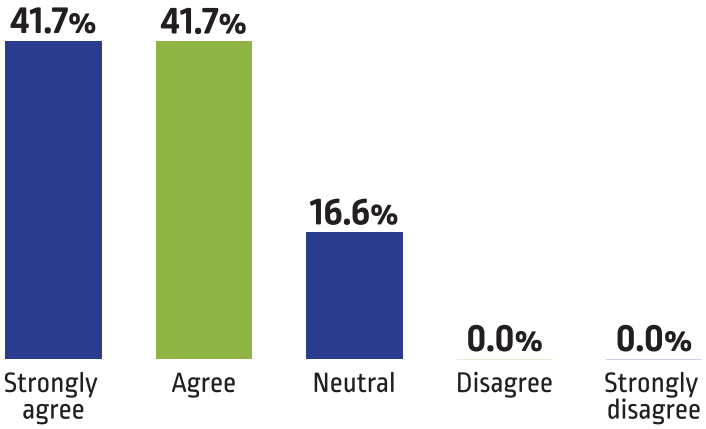
1. **Improved Access and Decreased Barriers to Needed Services** – By providing a new, flexible service option that meets individuals where they are, partners reported clients face fewer barriers to accessing the health and social services they require (e.g. transportation, wait times, discrimination) and are better able to receive assistance and care.
2. **Development of Greater Trust in Care Services and Reduced Stigma** – Partners highlighted the program is building trust and rapport with the community and is creating a safe place for clients to access services in a way that promotes respect and reduces experiences of stigma.
3. **Access to Multiple Supports in One Location** – According to partners, providing a variety of health and social services and supporting system navigation has created an opportunity for clients to better address multiple determinants of health.
4. **Timely Access to Care** – Partners reported the H.O.M.E Program has made it easier for clients to get help in the moment when they need service and access more routine care.
5. **Improved Health Outcomes** – Based on the experience of partners, the H.O.M.E Program has been able to provide care to individuals who otherwise would have experienced life threatening illness had they not accessed the program.

5 Benefits of H.O.M.E Program Partner Collaboration

1. **Sharing of Knowledge and Experience Between Partners** – According to partners, benefits of the collaborative program model have included increased sharing of knowledge and experience, hearing different perspectives, gaining a better understanding of partner organizations and their capacity and resources, and better understanding pathways of service.
2. **Increased Capacity for Service Coordination and System Navigation** – Partners highlighted the collaborative partnership has "opened doors" for communication and direct links to partner services, partner engagement in case consultation and planning, and wraparound care, as well as an ability to identify opportunities for system level change or application.
3. **Improved Reach and Accessibility of Services** – By leveraging existing relationships between a partner and client, other program partners are better able to develop connections and trust with marginalized individuals, ensuring "no door is the wrong door" to service.
4. **Creating a Shared Culture of Service** – Partners reported that working collaboratively is fostering a shared culture of service centred around common goals and a mechanism to maintain accountability for reducing barriers to service and meeting client needs.
5. **Development of Collaborative and Supportive Working Relationships** – The program partnership has also helped to promote collaborative relationships between staff from different organizations and create a network of professional and personal support for staff.

[3] Qualitative results represent feedback provided by program team members and partners. The most common themes presented in numbered lists represent the frequency of responses provided to an open-ended question.

Number of Partners Who Report They Feel Better Able to Support Highly Marginalized Individuals in London as a Result of the H.O.M.E Program (n=12)[4]

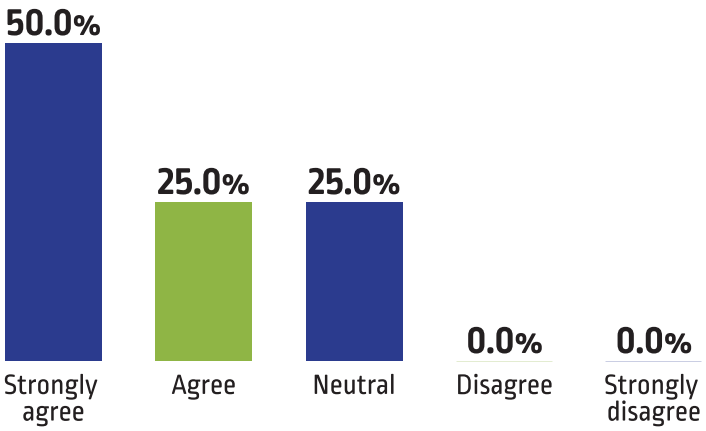


> *We are building rapport with the community and building trust with folks to seek medical care without stigma."*
>
> *– Program Team Member*

Most Common Ways Partners Are Better Able to Support Clients

1. **Increased Awareness of Needs, Trends, and Other Services** – Partners reported that as a result of participating in the H.O.M.E Program, they are more aware of current trends and issues, have a better understanding of the population being served and their needs, and have learned about other available services.
2. **Ability to Connect With People Partners May Not See Otherwise** – Through the H.O.M.E Program, partners identified they are better able to provide care to individuals who may not seek out assistance, making their services more accessible in the community.

Number of Partners Who Report Their Organization Is Better Able to Support Highly Marginalized Individuals in London as a Result of the H.O.M.E Program (n=12)



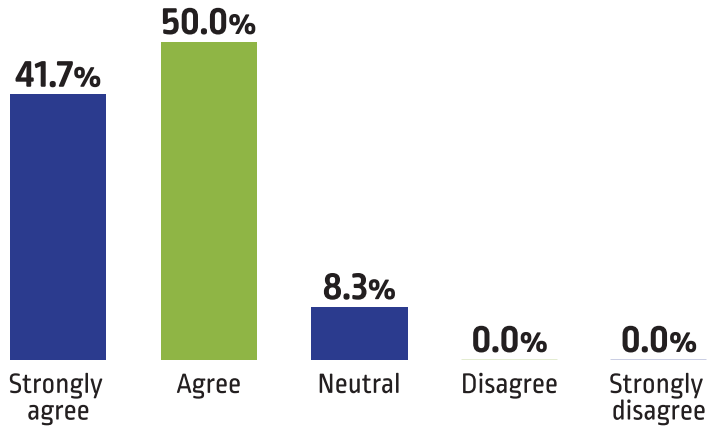
> *Having a safe place for our clients to access health care if they have had poor experiences at hospitals or other healthcare clinics helps clients to feel respected and allows them to get health care they would otherwise avoid."*
>
> *– Program Team Member*

[4] It is important to note that the program team members who responded to this question already have a high level of knowledge of the population being served, which highlights the significance of respondents reporting the program has improved their ability to provide better service to highly marginalized individuals.

Most Common Ways Partner Organizations Are Better Able to Support Clients

1. **Extended Reach and Connecting With People Where They Are** – According to partners, the H.O.M.E Program has extended the reach of their organizations by enabling partners to be more mobile and meet people where they are, which has been particularly valuable during the COVID-19 pandemic when building capacity restrictions have been in place.
2. **Building a Stronger Continuum of Care** – Partners noted the H.O.M.E Program has helped their organizations better align services to build a stronger continuum of care and provide clients with wraparound supports.
3. **Increased Ability to Prevent or Minimize Serious Health Impacts** – Being able to prevent and minimize serious health impacts for clients and save lives as a result was one of the key benefits of engaging in the H.O.M.E Program for partner organizations.
4. **Developing Trust With Individuals** – It was noted that as a result of the H.O.M.E Program, partner organizations are building trusting relationships with marginalized individuals.

Number of Partners Who Report They Feel Better Able to Work With Other Service Providers to Support Highly Marginalized Individuals in London as a Result of the H.O.M.E Program (n=12)



> *When a complex case is brought forward, medical and outreach [teams] can plan together to solve issues or troubleshoot scenarios."*
>
> *– Program Team Member*

Most Common Ways Partners Are Working Better With Other Service Providers to Support Clients

1. **Developing Intentional Ways of Working Together** – Partners highlighted that through the H.O.M.E Program, they have developed more formalized, intentional ways of working together to address a specific need, which has allowed them to engage in crucial conversations, share resources, and learn more about other organizations and what they can do for clients.
2. **Addressing Client Needs More Quickly** – It was noted that having organizations work collaboratively in a formal way has created a sense of urgency in addressing identified issues. Further, with multiple organizations working on site at the same time, the H.O.M.E Program has enabled partners to connect clients more directly and rapidly to the type of care they need.

Experience With Program Implementation

The 5 Most Common Things That Have Gone Well With Implementing the H.O.M.E Program

1. **Providing More Flexible, Accessible, in the Moment Service** – Bringing service into the community and being able to connect with clients in a more flexible and nimble way has increased service accessibility for highly marginalized individuals. Further, partners noted the H.O.M.E Program has developed a low barrier, supportive service by creating a safe space for in the moment care and connections to assistance and providing immediate intervention in emergency or critical situations.
2. **Reaching Clients That May Not Otherwise Access Service** – According to partners, one of the successes of the H.O.M.E Program has been the ability to connect with clients who may be difficult to reach, may not often seek assistance, experience barriers accessing services, or would not access medical care and social assistance through other means.
3. **Developing a Collaborative Service Model** – Partners reported the H.O.M.E Program has fostered the development of a collaborative service model that brings together staff with different knowledge and skill sets, strengthens communication and professional connections between partners, and helps partners develop an improved understanding of how to work together to better serve clients.
4. **Building Rapport With the Community** – Developing meaningful connections and rapport with clients and community members was noted by partners as being a key success of the program, which is helping clients to build trust in partners and greater comfort accessing services.
5. **Problem Solving and Planning Together to Coordinate Care** – Partners also highlighted that working together through the H.O.M.E Program has fostered collaborative problem solving and engagement of partners in case consultation and planning.

> *[Clients] expressed extreme gratitude about us being able to come to them directly or indirectly to provide for their healthcare needs. We have helped people avoid developing sepsis due to multiple infections, more severe illness due to proper wound care, and improved well-being due to sincere concern for their overall health. Safer Opioid Supply [a service provided as part of the H.O.M.E Program] has been instrumental in helping to prevent [overdose] death and severe illness from the contaminated street drug supply."*
>
> *– Program Team Member*

Opportunities for Ongoing Improvement

1. **Greater Consistency of Services Offered and Service Hours** – Partners identified that moving forward, it is important to ensure increased consistency in the program start time and the types of services available each day.
2. **Increased Mobility and Ability to Change Locations** – In order to further increase client uptake and reach highly marginalized community members where they are, it was suggested that it would be helpful to assess program locations and be even more mobile in the future.
3. **Continued Improvement of Partner Communication and Coordination** – Partners also suggested efforts be continued to improve communication within the program team to support strong working relationships and coordination of program services.
4. **Revising the Program Name** – It was noted that there may be some misunderstanding of the program name amongst those accessing the program, with the name being associated with receiving primarily housing related services, and that consideration should be given to revising the program name.
5. **Improved Management of Program Supplies** – Partners reported a challenge experienced during initial program implementation has been inconsistent stock of supplies available in the mobile unit for outreach activities and that moving forward, it is important to ensure appropriate stock of supplies and equipment is regularly maintained.

> *The energy, enthusiasm, and commitment to collaborate in a spirit of generosity, understanding that combining workers with different skill sets and work cultures is a challenge. I think we are collectively growing in terms of understanding how to serve the clients and to create appropriate supports for staff and healthy teams."*
>
> *– Program Team Member*

Stories of Impact

Sandra Feels Cared For by the Program Team [5]

Sandra has a history of substance use, was engaged in survival sex work, and experienced intermittent homelessness, but has been living in a new place for almost nine months. Sandra also has cancer and has experienced ongoing challenges accessing care at home and in the hospital due to stigma, poor experiences accessing care, lack of transportation, and reduced mobility. To ensure she gets the care she needs, the H.O.M.E Program outreach team visits Sandra three times a week to provide medical care and cancer treatment follow-up, emotional support, and basic needs. The team also coordinates care with Sandra's health care providers and helps her engage with the Safer Opioid Supply program. When talking about the H.O.M.E Program, Sandra shared the following: "That team is my lifeline. They treat me like a queen, which isn't something I'm used to. They make every day better. I'll be sitting here feeling sorry for myself, and thinking about all of the terrible things that have happened, and then they show up and everything feels so much better. I hope they know how much I appreciate them and all of the work and effort they put into me, even though I don't always feel like I deserve it."

Rupert Is Receiving Regular Wound Care and Is Seeking Further Supports in the Community

Rupert had an infection in both legs due to cellulitis for over a year, but was reluctant to seek care due to long hospital wait times and fear of withdrawal. Rupert was accessing the Carepoint Consumption and Treatment Service provided by Regional HIV/AIDS Connection (RHAC), one of the H.O.M.E Program collaborative partners, and was encouraged to seek medical support when the H.O.M.E Program started. Through ongoing engagement with Carepoint staff and H.O.M.E Program outreach team members from RHAC, rapport and trust building, and support from a "familiar face" from RHAC to help him access the program, Rupert decided to attend the H.O.M.E Program's mobile clinic where he was provided antibiotics and was successfully connected to the London InterCommunity Health Centre for the first time. Rupert has continued to access wound care on a weekly basis, has kept his legs wrapped with clean dressings, and is seeking further supports in the community. Rupert shared that he has had positive interactions with the program team and expressed his gratitude for the H.O.M.E Program.

Theo Made a Positive, Meaningful Connection With Supports Where He Was At

Theo was previously a client with Addiction Services of Thames Valley (ADSTV), but recently lost his housing and has been unable to access service since. While the H.O.M.E Program outreach team (which consists of ADSTV staff who have built a connection with Theo) was in the community, they saw Theo and learned his motorized wheelchair battery was dead, leaving him stranded. The team also learned Theo had been in and out of hospital that day and he had given his bag with the wheelchair charger to a friend for safe keeping, due to not having a place to store his belongings. The outreach team was able to find Theo's friend, get the charger and personal belongings back to Theo, and get the wheelchair re-charged. Further, the team reached out to a paramedic on the program team who brought Theo a hat and shirt for sun protection. When Theo received these items, he was speechless and had tears in his eyes. By meeting Theo where he was at, the outreach team was able to address his immediate needs, make a meaningful and positive connection, and help Theo feel cared for.

[5] Please note that names have been changed to maintain anonymity.

Request for Support

Initial program results indicate the H.O.M.E Program is improving access to health, harm reduction, addiction, and social services for highly marginalized community members – services many would not otherwise access. In order to continue offering comprehensive wraparound care services using a collaborative, mobile approach, the H.O.M.E Program is seeking continued financial support. Through continued operation five days a week, the H.O.M.E Program can build on its initial successes, continue to increase program reach and mobility, and ultimately create positive impacts on the social determinants of health for highly marginalized individuals in London.

Next Steps

Moving forward, the H.O.M.E Program will continue providing mobile service in order to provide care to individuals where they are and reduce barriers to needed healthcare and social services. Further evaluation will also be conducted to explore clients' experiences accessing the program and the impacts of the program on clients, partners, and collaborative service delivery.

H.O.M.E

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January 2021 – May 2021

London InterCommunity Health Centre

Regional HIV/AIDS Connection

Addiction Services of Thames Valley | Services de toxicomanie de Thames Valley

Middlesex-London Paramedic Service

London CARES Homeless Response Services