March 2022

H.O.M.E

Health Outreach Mobile Engagement

H.O.M.E Program Evaluation Report

Year 1

January 11, 2021 - January 10, 2022

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The evaluation of the H.O.M.E Program would also not have been possible without the rigorous data collection efforts conducted by the H.O.M.E Program team and collaborative partners. Thank you for your thoughtful and candid reflections regarding the implementation of the program, which have been incorporated throughout this evaluation report.

We would also like to extend our gratitude to H.O.M.E Program clients for their contributions and candor in providing feedback about their experiences accessing the H.O.M.E Program and the insights they shared about how the program can continue to improve its services and supports.

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INTRODUCTION

ABOUT THE H.O.M.E PROGRAM

The Purpose of the H.O.M.E Program

The 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 who face barriers to accessing traditional models of care.

Who the H.O.M.E Program Serves

The H.O.M.E Program serves individuals who are experiencing homelessness, or are insecurely housed, or are clients rostered with the London InterCommunity Health Centre.

The H.O.M.E Program Approach

The H.O.M.E Program model was developed using a flexible, low-barrier, community-based approach. Through an integrated mobile team, the H.O.M.E Program aims to bring service to clients where they are at, including encampments, emergency shelters, housing, and other community settings, re-connect with clients, build relationships with those who may not be accessing services, and ensure the delivery and continuity of comprehensive primary care and wraparound supports. 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.

Services the H.O.M.E Program Offers

Through the mobile clinic, the program provides a full scope of primary and acute medical care services, including follow-up care and referrals to other services and providers. The H.O.M.E Program also provides harm reduction education and supplies, addiction services, basic needs supports, and wraparound services to clients.

How the H.O.M.E Program Came About

The H.O.M.E Program was launched on January 11, 2021 in response to three critical issues facing London's highly marginalized community members: opioid poisoning and overdose, COVID-19, and precarious housing. The H.O.M.E Program is a collaborative, multi-agency service approach implemented by CMHA Thames Valley Addiction and Mental Health Services, London Cares Homeless Response Services, London InterCommunity Health Centre, Middlesex-London Paramedic Service, and Regional HIV/AIDS Connection.

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

PURPOSE OF THE EVALUATION

An evaluation of H.O.M.E Program was conducted to:

- Determine the reach of the program and opportunities to optimize reach;
- Assess the impacts of using a collaborative, multi-disciplinary, mobile outreach model on access to primary care and wraparound services;
- Understand the experiences of clients accessing the program; and
- Identify lessons learned from implementing the program, including successes, challenges, and opportunities for improvement or change.

PURPOSE OF THE REPORT

The purpose of this report is to share the results from the evaluation of the first year of H.O.M.E Program implementation from January 11, 2021 to January 10, 2022.

The results presented in this report will be used to support evidence-informed decision-making regarding the provision of mobile primary care and wraparound services and will be used to guide ongoing implementation of the H.O.M.E Program.

METHODOLOGY

The following sources of data were used to prepare the results presented in this report:

- **H.O.M.E Program Database** – Information from each engagement by the H.O.M.E Program team with clients was recorded in the database, including a unique ID code for the individual, the date and location of the engagement, and the types of services provided.
- **Client Survey** – Clients who received support from the H.O.M.E Program were asked to complete a survey to share their feedback about their experience with the program and what difference it made for them. Surveys were provided in a paper and online format. In total, 25 individuals completed a survey between December 13, 2021 and January 28, 2022.
- **Collaborative Partner Survey** – Members of the H.O.M.E Program team and site partners completed an online survey between January 10, 2022 and January 23, 2022 to provide information about what has gone well with the program, what could be done differently, and what difference the program has made on how partners work together to serve highly marginalized individuals in London. A total of 21 collaborative partners completed the survey.
- **Collaborative Partner Focus Group** – On January 20, 2022, a focus group was held with members of the H.O.M.E Program team to explore the impacts of the H.O.M.E Program and factors affecting program implementation.

All data was collated and analyzed at an aggregate level. Quantitative data was analyzed to prepare descriptive statistics, and qualitative data was analyzed by question to identify common themes. All non-responses (e.g. not applicable, not reported) were removed from the analysis. Throughout this report, "n=" is used to represent the number of responses to a given question or data point.

Data Limitations

Outlined below is a description of the data limitations that occurred during the H.O.M.E Program evaluation. Data limitations occur with any evaluation and provide context for the results. They should not be considered to negate the findings of the evaluation.

- **Self-Reported Data** – Results from the client survey, collaborative partner survey, and collaborative partner focus group are based on self-reported information. Based on their level of comfort reporting their experiences, some participants may have responded in a way they believed to be "right" or socially acceptable. To address this limitation, survey respondents were not asked to share their name to maintain anonymity, and focus group participants were encouraged to be candid in their responses.
- **Overcounting of Unique Individuals** – To support client engagement and maintain anonymity, clients who engage with the H.O.M.E Program are asked to provide a unique identification code, which is given by the client at each encounter. While clients are encouraged to continue using the same identification code across each encounter, they may forget their code or provide a different identification code across encounters. Therefore, a unique individual may be counted more than once within the program database.

A SNAPSHOT OF THE RESULTS

Between January 11, 2021 and January 10, 2022, through the H.O.M.E Program...

1,059
unique clients accessed medical and wraparound care services

71% of clients accessed care **1 time**
29% of clients accessed care **2+ times**

1,175
non-essential emergency room visits were potentially **prevented**

780
chronic illness **care visits** were conducted

498
visits were focused on **mental health care**

182
visits were conducted to provide **infectious disease care**

84
individuals without a care provider were **rostered to primary care**

64
prenatal care visits were provided

18
emergency medical interventions were given

12
overdose responses were conducted

Client feedback survey respondents reported...

100%
find it **easier to access care** because of the H.O.M.E Program

92%
would recommend the H.O.M.E Program to others

100%
feel comfortable accessing the H.O.M.E Program

84%
were treated with respect by H.O.M.E Program staff

95%
are **using harm reduction strategies** more often because of the H.O.M.E Program

72%
have **experienced improved well-being** because of the H.O.M.E Program

When collaborative partners were asked how the H.O.M.E. program impacted them...

95%
reported the **coordination of services** for highly marginalized individuals in London **has improved**

94%
have a **deepened relationship with other service providers** implementing the program

88%
feel **better able to support highly marginalized individuals** in London

82%
said **communication between service providers** supporting highly marginalized individuals in London **has improved**

76%
reported **partners are working differently to support highly marginalized individuals** in London

RESULTS: PROGRAM CLIENTS

This section of the report provides results related to client engagement and their ongoing access of care services through the H.O.M.E Program, the range of services provided by the H.O.M.E Program, reaching clients where they are, ease of access to services for clients, client uptake of harm reduction strategies, and impacts of the program on client well-being. Client experiences accessing the H.O.M.E Program are also presented, including their comfort accessing the program, their satisfaction accessing services, feedback about what they have liked most, and suggestions for improvement.

CLIENT ENGAGEMENT

Finding: Over 1,000 clients accessed the H.O.M.E Program, demonstrating a high level of demand for the program in the community.

Number of Clients Served

1,059 clients

Between January 11, 2021 and January 10, 2022, 1,059 unique clients accessed the H.O.M.E Program.

Number of Days of Service

231 days of service

The H.O.M.E Program operated for a total of 231 days during the first year of program implementation.

Number of Client Visits

2,723 client visits

In total, clients made 2,723 visits to the H.O.M.E Program's mobile supports.

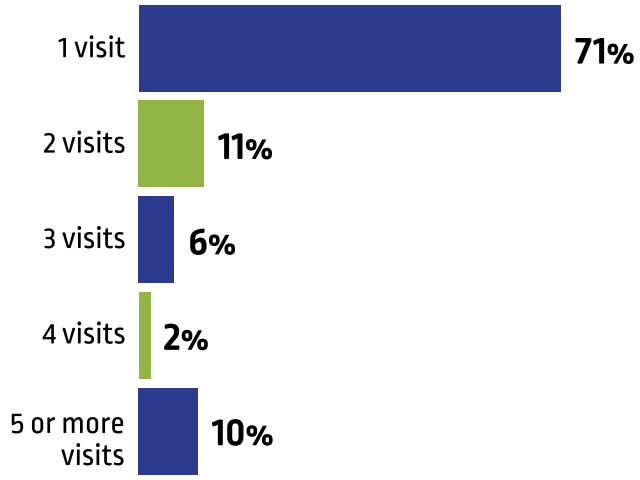
> *It's great you are out here, and it's helpful for people that can't get to the clinic."*
>
> *- H.O.M.E Program Client*

ONGOING ENGAGEMENT IN SERVICES

Finding: While many clients are engaging with the H.O.M.E Program one time, approximately 3 in 10 clients are returning to access services from the H.O.M.E Program on an ongoing basis.

Number of Return Clients (n=1,059)

Of the 1,059 unique clients who accessed the H.O.M.E Program, 71% (n=748) had one visit and 29% (n=311) were return clients with two or more visits.



Highest Number of Visits

77 visits by a single client

The most visits a single client made to the H.O.M.E Program between January 11, 2021 and January 10, 2022 was 77 visits.

Client Transitions to Site-Based Care

84 clients rostered to primary care

In total, 84 clients who accessed the H.O.M.E Program and did not have a primary care provider are now rostered to primary care at the London InterCommunity Health Centre.

> *"I'm afraid to go to the hospital or to the clinic. Too many people around I can't run into. I feel safe on the [mobile clinic]."*
>
> *- H.O.M.E Program Client*

SERVICES PROVIDED

Finding: Clients are accessing a wide range of primary care and wraparound services through the H.O.M.E Program.

Types of Services Provided

Type of Service	Number of Times Provided
Medical Care	2,194
Healthcare System Navigation	992
Harm Reduction Equipment	475
Social Service System Navigation	453
Harm Reduction Education	320
Basic Needs Food/Drink	265
Basic Needs Personal Needs Items	163
Harm Reduction Case Management	113
Addiction Services Education	97
ID Services	93
Infectious Disease Testing	91
LIHC Referral	79
Other Community Resource Referral	79
Basic Needs Clothing	69
Transportation Assistance	65
Other Type of Service	45
Housing Support	44
Addiction Services Screening/Assessment	32
RHAC Referral	20
CMHA TVAMHS Referral	18
London Cares Referral	14
Addiction Services Case Management	12

> *I can go to the [mobile clinic] for help."*
>
> *- H.O.M.E Program Client*

> *[I am getting] better health care."*
>
> *- H.O.M.E Program Client*

Medical Care Services

Between January 11, 2021 and January 10, 2022, the H.O.M.E Program mobile health clinic conducted...

- **780** chronic illness care visits for 480 unique clients
- **498** mental health care visits for 240 unique clients [1]
- **238** referrals to another social or medical service agency for 202 unique clients
- **182** infectious disease care visits for 70 unique clients
- **64** prenatal care visits for 18 unique clients

> *"I am able to get my medical needs met if I can't get to the clinic."*
>
> *- H.O.M.E Program Client*

A Snapshot of the Mobile Health Clinic

Here's an example of what happens in an 8-hour day of the H.O.M.E Program mobile health clinic...

- **65** people received care
- **8+** people were diverted from a non-essential hospital emergency room visit
- **4** women experiencing homelessness were provided with prenatal care, 3 of whom were more than 7 months pregnant and received care for the first time
- **3+** potentially fatal medical issues were identified and treated
- **3** calls to emergency services were prevented
- **2** mental health related calls to police were avoided

[1] In the context of this report, mental health care refers to the provision of care and support to individuals experiencing severe, persistent, and chronic mental illness.

DIVERSION AND EMERGENCY MEDICAL INTERVENTION

Finding: Individuals are being diverted from non-essential visits to the emergency room and are receiving life-saving emergency medical intervention through the H.O.M.E Program.

Emergency Room Diversions

1,175 emergency room diversions [2]

In total, 1,175 non-essential emergency room visits by 400 unique individuals were potentially avoided as a direct result of the care and support provided by the H.O.M.E Program.

> *I used to have to call the ambulance all of the time. I live on the street, and I didn't have any other access to health care. No way I could make it anywhere, but now [they] come to me."*
>
> *- H.O.M.E Program Client*

Emergency Medical Intervention

12 overdose responses

18 emergency medical interventions

Using a collaborative approach across service partners, the H.O.M.E Program medical team responded to and prevented 12 overdoses and delivered 18 life-saving emergency medical interventions in order to prevent imminent serious harm, disability, or death.[3]

[2] In this context, determination of an emergency room diversion is based on the assessment of the clinically certified providers part of the H.O.M.E Program team and refers to an occurrence where an individual who does not have access to primary care, walk-in clinic care, or any other source of health care in the community presents with an acute medical concern and, based on the providers' knowledge of disease processes and the healthcare system in London, would ultimately require an emergency room visit the same day or within one week from the date they are seen by the H.O.M.E Program providers.

[3] Types of emergency medical interventions provided may include CPR, artifical respiration/airway management, administration of life-saving medications, identification and pre-hospital treatment of critical medical conditions such as myocardial infarction (i.e. heart attack), and arrangement of transportation to the hospital.

How the H.O.M.E Program Is Unique...

The way the [mobile clinic] is set up, we can do anything in that [mobile clinic] that we do in the [health centre] clinic. *We've done everything we can to make the health centre accessible and barrier free, but at the end of the day, it's a brick-and-mortar structure that has a sign over the door, and that makes it inaccessible for some people, especially people with a history of mistreatment in the medical system, like judgement and unfair treatment. For people who are deeply marginalized and people who have a traumatic past, that kind of treatment cuts really deep. People say, 'Yes, I understand I'm going to die if I don't go to the hospital, but I'm not going,' and it's more common than you think.*

But with this [mobile clinic], we've engaged with those people and connected with those people, and it's actually worked. There are a very high number of folks who have never received care from the health centre or anywhere else in the city for that matter, who happily come onto the [mobile clinic]. There is something about it that effectively makes it barrier free, which is exactly what the goal was. ***We found a way to provide care to the most marginalized people in this community and do it effectively and efficiently, and to ensure it isn't just band-aids.***

We can provide full scope primary and acute care on this [mobile clinic] with follow-up. People are coming back, we're able to make referrals and see them in two days or the next week and follow up with what we did, and that's the goal. ***There is nothing else out there that is providing this level of care to this particular sub-section of our community, so that, I think, is a big thing on a long list of what makes H.O.M.E an essential service in the city of London."***

– H.O.M.E Program Collaborative Partner

REACHING CLIENTS WHERE THEY ARE

Finding: Clients have access to services where they are in the community as a result of the H.O.M.E Program, reducing barriers to care.

Service Locations

Service Location	Number of Visits
Home Visit (via the urgent or non-urgent support SUV) [4]	1,059
Downtown	504
WISH York/Colborne [5]	348
YMCA Centre Branch	174
Goodwill Industries	165
Men's Mission	138
Youth Opportunities Unlimited	91
Victoria Park	85
241 Simcoe St.	73
Dundas Corridor	59
WISH Elizabeth	18
580 Dundas St.	9

> *It's amazing that you come to us. I've never seen anything like this."*
>
> *- H.O.M.E Program Client*

> *I would not seek services elsewhere."*
>
> *- H.O.M.E Program Client*

[4] Through the development of community partnerships, home visits also included visits to individuals accessing shelter at a local hotel, individuals supported by WISH to Be Home, and individuals accessing SafeSpace London.

[5] Due to proximity, services may also have been provided to individuals at Men's Mission while the mobile clinic attended the WISH York/Colborne location.

Reaching Clients

In order to optimize reach, the H.O.M.E Program has:

- **Brought Services to People Where They Are (n=6)** – Using a mobile approach, the H.O.M.E Program has brought care to clients where they are in the community, including emergency shelters, social service agencies, the street, encampments, hotels, and clients' homes, which has helped clients feel more comfortable accessing care and has reduced barriers to services, particularly for those with limited mobility, more severe illness, and those who may be unable to attend a service location due to a restriction.
- **Built Rapport and Raised Awareness Through Word of Mouth (n=4)** – As a result of building strong rapport and trust with clients, the H.O.M.E Program has increased its reach in the community through word of mouth. Many referrals and connections have occurred through clients sharing their experience and encouraging their peers to access services from the H.O.M.E Program.

> *"I get to go do my medical stuff not at a hospital."*
>
> *- H.O.M.E Program Client*

Suggestions to further improve the reach of the H.O.M.E Program include:

- **Increasing Mobility and Locations (n=5)** – To further improve the reach of the program, collaborative partners suggested being "even more mobile" and expanding the number of locations the program visits each week.
- **Expanding the Hours of Service (n=3)** – It was also recommended that the number of hours of service be increased in order to reach more clients, including offering evening hours and having the mobile clinic out in the community more often.

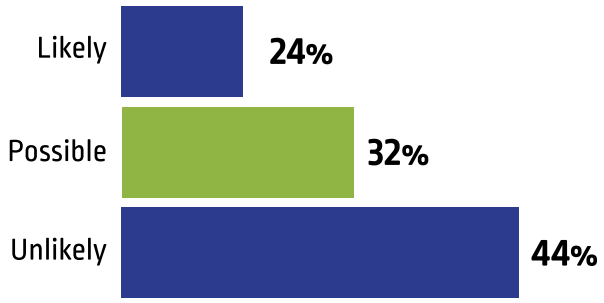
> *"[I like the] proximity to where I am. Getting care quickly."*
>
> *- H.O.M.E Program Client*

EASE OF ACCESS TO SERVICES

Finding: It is easier for clients to access the services they need because of the H.O.M.E Program.

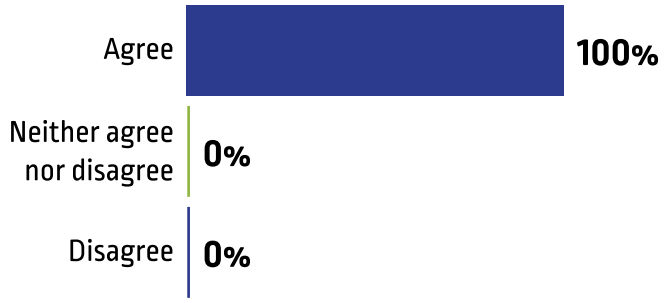
Likelihood of Clients Accessing Services Without the H.O.M.E Program (n=25)

In total, 44% (n=11) of clients reported they were unlikely to access services to address their health, mental health, addiction, and/or basic needs if the H.O.M.E Program did not exist. Further, approximately one-third (32%, n=8) of clients reported it was possible they would access services without the H.O.M.E Program, and one-quarter (24%, n=6) were likely to still access services if the H.O.M.E Program did not exist.



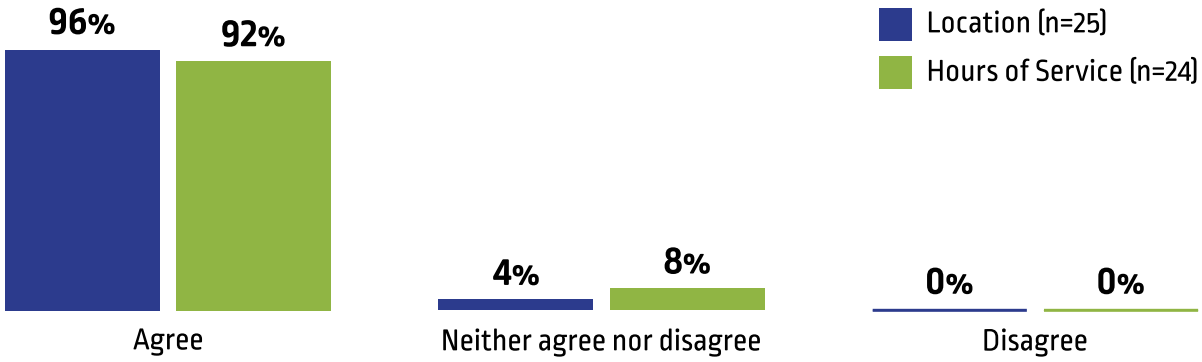
Because of the H.O.M.E Program, It Is Easier for Me to Get the Care or Services I Need (n=25)

In total, 100% (n=25) of clients said it was easier for them to get the care or services they need for their health, mental health, addiction, and/or basic needs because of the H.O.M.E Program.



> *I'm finally accessing health care."*
>
> *- H.O.M.E Program Client*

Factors That Made It Easier for Clients to Access Services



When asked what about the H.O.M.E Program made it easier to access needed care or services, 96% (n=24) of clients reported the location made it easier for them to get care, and 92% (n=22) said the hours of service made it easier to access services.

How the Program Model Is Impacting Access to Services

By using a collaborative, mobile, integrated service model, the H.O.M.E Program is:

- **Helping Marginalized Individuals Access Medical and Life-Saving Care (n=7)** – According to collaborative partners, the H.O.M.E Program approach and providing fully accessible, non-judgemental, barrier-free service has not only improved access to medical supports and follow-up care for highly marginalized individuals who may not seek medical care elsewhere, but has also directly saved lives by providing needed medical care in the moment.
- **Building Relationships, Trust, and Awareness (n=4)** – The H.O.M.E Program approach is helping to build trust with clients, increase client awareness of the partner agencies and available services, reduce stigma, and increase understanding amongst service providers about the reality and experiences of highly marginalized individuals in the community.
- **Improving Access to Wraparound Supports for Clients (n=3)** – Because of the collaborative, mobile, integrated service model, clients are being referred to a variety of services and have ready access to wraparound supports such as ID support, harm reduction services, and addiction counselling that can "fill in gaps in care pathways."

> *It's faster to get medication and convenient. Always have someone that will look out for me. People recognize me and say, 'Hello.'"*
>
> *- H.O.M.E Program Client*

How the H.O.M.E Program Is Making Care Accessible...

I think this is a revolutionary approach to care and is unlike anything I've ever seen. I've been working [in the field] for six years and every day, ***we are meeting people I've never seen and never engaged with who have no history with any of the folks on the program team.*** *These are the most isolated and marginalized people in this community who are not only freely coming on the [mobile clinic], but are also coming back for multiple follow-up appointments.*

Last winter, H.O.M.E saved the lives of at least 45 people. *It's a fully accessible, non-judgemental, barrier-free service. It's remarkable the effect it's having on folks who seek out services on the [mobile clinic]. I think that all medical services should be offered this way. It's genuinely incredible. Folks come in to see us for a variety of things, but right off the bat, you can see how it's different, they can see how it's different, and they respond to that."*

- H.O.M.E Program Collaborative Partner

Individuals who have chronic conditions or injuries living on the streets who normally say 'no' to going to the hospital are saying 'yes' to the [mobile clinic] because of how accessible it is."

- H.O.M.E Program Collaborative Partner

UPTAKE OF HARM REDUCTION STRATEGIES

Finding: Clients have access to harm reduction equipment and are increasing their use of harm reduction strategies.

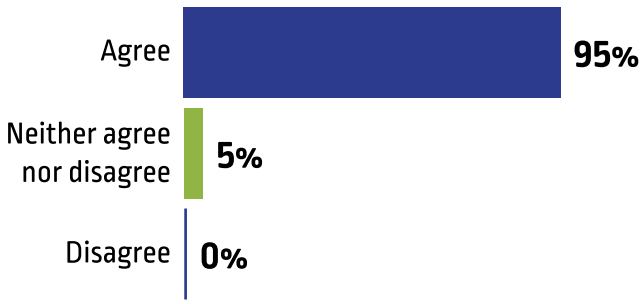
Distribution of Harm Reduction Equipment

475 engagements providing harm reduction equipment

Harm reduction equipment was distributed through the H.O.M.E Program during 475 client engagements.

Because of the H.O.M.E Program, I Use Harm Reduction Strategies More Often (n=22)

Because of the H.O.M.E Program, 95% (n=21) of clients use harm reduction strategies (e.g. new needles or gear, condoms, lube, etc.) more often. Five percent (n=1) of clients neither agreed nor disagreed that they use harm reduction strategies more often because of the program.



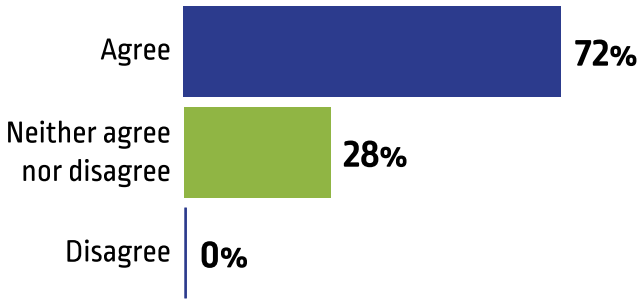
> *I am able to get clean gear and not use old stuff."*
>
> *- H.O.M.E Program Client*

CLIENT WELL-BEING

Finding: Clients are experiencing improved well-being as a result of accessing the H.O.M.E Program.

My Overall Well-Being Has Gotten Better Because of the Care or Service I've Received From the H.O.M.E Program (n=25)

When asked whether their overall well-being has gotten better because of the care or services provided by the H.O.M.E Program, 72% (n=18) of clients agreed and 28% (n=7) provided a neutral response.



Most Significant Change Experienced by Clients

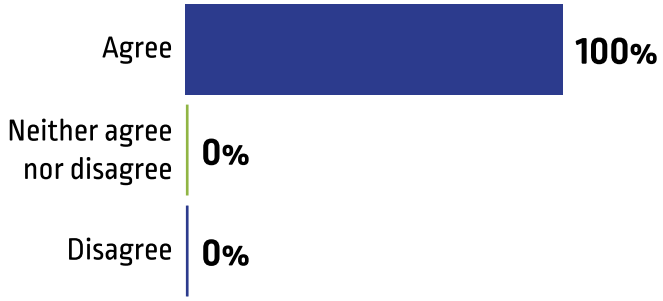
The **4** most common changes clients reported they experienced because of the H.O.M.E Program are:

1. **Better Access to Care and Positive Care Experiences (n=7)** – Clients are receiving better health care and feel cared for, are seeking services and care when they didn't before, are able to get their medical needs met, and have faster, more accessible, and more convenient access to medication and care.
2. **Receiving Wound Care (n=5)** – Because of the H.O.M.E Program, clients are getting the wound care they need, including cleaning bad abscesses.
3. **Improved Health and Well-Being (n=4)** – Clients are feeling healthier since accessing the H.O.M.E Program. Further, one client said they are alive because of the program, and another reported their mental health has improved.
4. **Increased Sense of Safety (n=3)** – According to clients, they feel safe knowing the H.O.M.E Program is available and that people are looking out for them.

COMFORT ACCESSING SERVICES

Finding: Clients feel comfortable accessing services from the H.O.M.E Program.

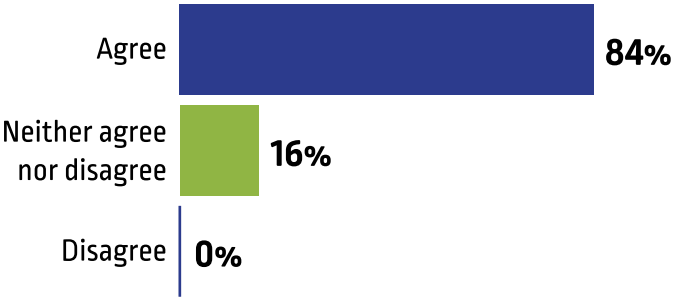
I Feel Comfortable Accessing the H.O.M.E Program (n=25)



Overall, 100% (n=25) of clients agreed they felt comfortable accessing the H.O.M.E Program.

> *I feel safe knowing you're out there."*
>
> *- H.O.M.E Program Client*

H.O.M.E Program Staff Treated Me With Respect (n=25)



When asked whether H.O.M.E Program staff treated them with respect, 84% (n=21) of clients agreed and 16% (n=4) provided a neutral response.

> *I like how friendly staff are."*
>
> *- H.O.M.E Program Client*

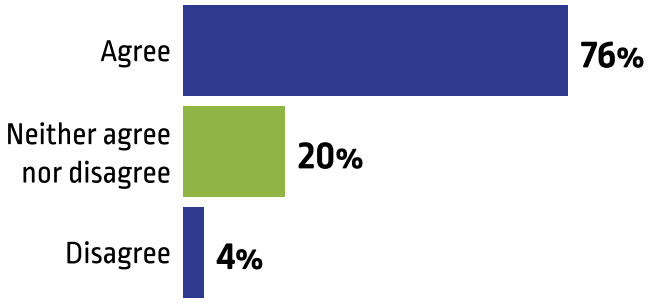
> *I feel cared for."*
>
> *- H.O.M.E Program Client*

CLIENT EXPERIENCE ACCESSING SERVICES

Finding: Clients have had a positive experience accessing services from the H.O.M.E Program.

Overall, I Am Satisfied With the Services I've Received From the H.O.M.E Program (n=25)

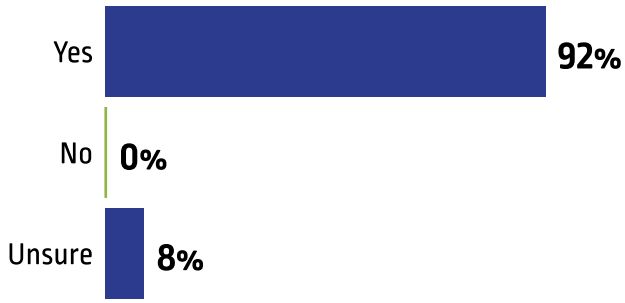
Approximately three-quarters (76%, n=19) of clients reported they were satisfied with the services they received from the H.O.M.E Program. Further, 20% (n=5) of clients neither agreed nor disagreed with this statement, and one client (4%) disagreed.



> *If I didn't happen to find out about [the H.O.M.E Program], I don't know what would have happened to me. After being treated like s*** and dehumanized by everyone I ever trusted, this saved my life."*
>
> *- H.O.M.E Program Client*

I Would Recommend the H.O.M.E Program to Others (n=25)

Clients were asked whether they would recommend the H.O.M.E Program to anyone else. In total, 92% (n=23) of clients reported they would recommend the program to others and 8% (n=2) were unsure.



What the Program Has Done Well

The **4** aspects of the H.O.M.E Program clients liked most are:

1. **Mobile Service That Is Accessible Where People Are (n=15)** – One aspect of the H.O.M.E Program clients liked most was its mobility. Clients liked being able to access medical care outside of the hospital and noted services are "out here where we are," accessible, convenient, and easy to get to.
2. **Access to Clean Gear (n=5)** – Clients appreciated being able to access clean gear (i.e. harm reduction equipment) through the H.O.M.E Program.
3. **Knowing You Can Get Help (n=2)** – Clients reported that they like being able to go to the mobile clinic for help and knowing they will be able to get support to address their needs.
4. **Access to Safe and Friendly Care (n=2)** – It was also noted by clients that they like how friendly staff are and that staff provide support in a way that makes them feel safe.

> *Having people who actually care and aren't there judging how I live, and instead supporting how I live. I've never been treated with respect in a hospital. I would die before I would ever go there."*
>
> *- H.O.M.E Program Client*

Suggestions for Improvement

The **5** most common client suggestions to improve the program include:

1. **Providing More Basic Needs Products (n=8)** – Clients noted they would like the H.O.M.E Program to have more basic needs items available, such as food and snacks, blankets, clothing, weather-specific items, and hygiene products.
2. **Expanding Service Hours, Locations, and Staffing (n=7)** – It was suggested the H.O.M.E Program attend more locations outside of the downtown area, places people are camping, special events, and more apartment buildings. Increasing hours of service was also noted, including having the mobile clinic out five days a week instead of two and offering evening hours, as well as increasing the number of staff and including a doctor on the outreach team.
3. **Sharing and Maintaining the Service Schedule (n=3)** – Clients reported it would be helpful if the H.O.M.E Program provided a calendar outlining the schedule and locations where the mobile clinic will be and to ensure the schedule is maintained (i.e. the mobile clinic is out when it is scheduled to be).
4. **Providing Pamphlets (n=2)** – A couple of clients also noted they would appreciate if a pamphlet with more information about the H.O.M.E Program was available.
5. **Providing Housing Services (n=2)** – Clients also recommended the program develop a stronger connection to or provide more housing related supports.

> *"[I like the] accessibility, location. It's easy to get to."*
>
> *- H.O.M.E Program Client*

RESULTS: SERVICE PROVIDERS

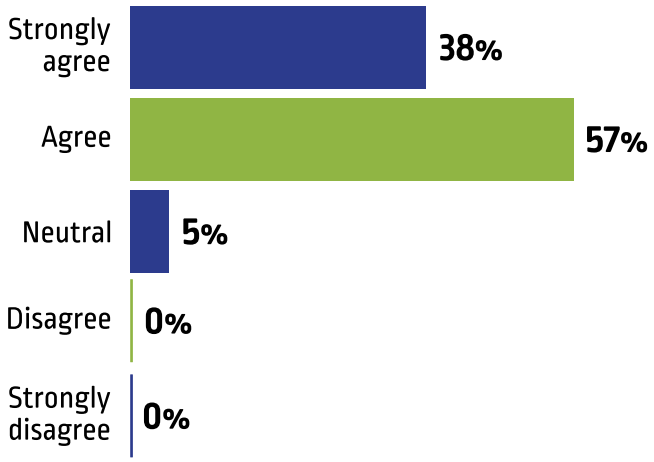
Presented in this section of the report are results from the surveys and focus group completed by collaborative partners regarding changes to service coordination, service provider communication, and service provider relationships, as well as collaborative partners' experiences implementing the H.O.M.E Program.

SERVICE COORDINATION

Finding: There is improved service coordination between collaborative partners, enabling partners to better support highly marginalized individuals in London.

As a Result of the H.O.M.E Program Approach, the Coordination of Services for Highly Marginalized Individuals in London Has Improved (n=21)

The majority of collaborative partners, 95% (n=20), strongly agreed or agreed that as a result of the H.O.M.E Program approach, the coordination of services for highly marginalized individuals in London has improved. One respondent (5%) provided a neutral response to this statement.



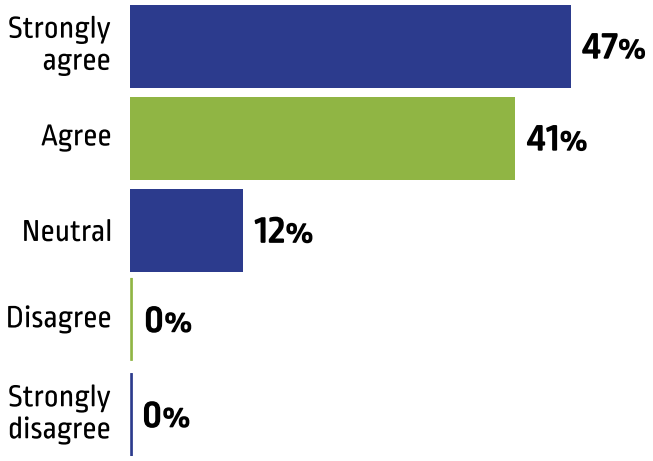
Factors that have influenced service coordination include:

- **Bringing Services Directly to Clients and Providing an Alternative Service Option (n=5)** – According to collaborative partners, being able to be on site where clients are and provide an alternative, accessible service option has supported greater coordination of services for clients and has allowed for a more proactive response to the needs in the community.
- **Having a Multi-Disciplinary Team Working Together to Provide a Range of Services (n=5)** – Creating a multi-disciplinary team that can offer a wide range of medical and wraparound care has also supported improved service coordination, as communication and referral between service providers and agencies can happen more quickly, follow-up can be facilitated more easily, and service providers are "on the same page" with respect to client care.

As a Result of Being Part of the H.O.M.E Program, I Feel Better Able to Support Highly Marginalized Individuals in London (n=17)

In total, 88% (n=15) of collaborative partners strongly agreed or agreed that as a result of being part of the H.O.M.E Program, they are better able to support highly marginalized individuals in London, and 12% (n=2) provided a neutral response.

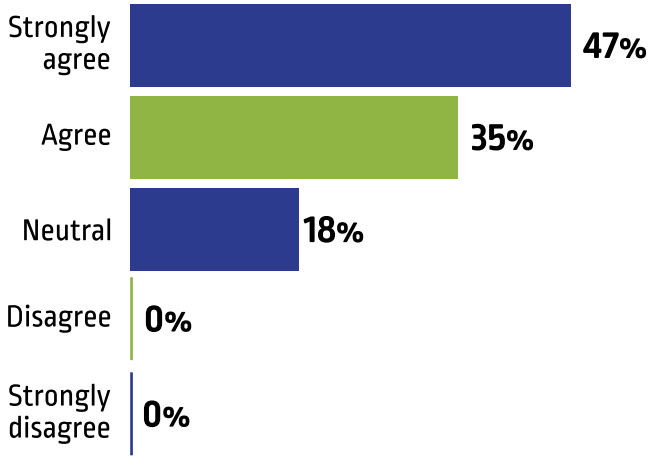
Collaborative partners commented they are able to support diversions from the hospital and emergency department, develop connections with other community partners, reach and provide care in a comfortable, safe space to individuals who would not access medical care elsewhere, and that "being on the street" has been important for supporting highly marginalized individuals in the community.



> *I think that some of our outcomes have brought realization that we can accomplish greater things if we all work together rather than as separate parts. Communication is benefitted when we are all working together and no one can slip through the cracks."*
>
> *- H.O.M.E Program Collaborative Partner*

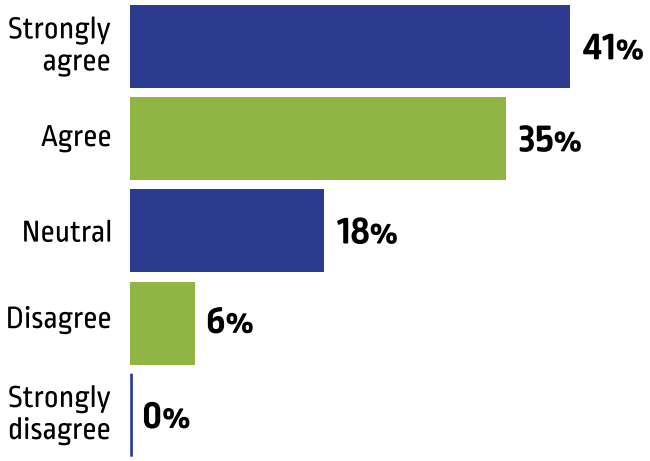
As a Result of Being Part of the H.O.M.E Program, My Organization Is Better Able to Support Highly Marginalized Individuals in London (n=17)

When asked whether their organizations are better able to support highly marginalized individuals in London as a result of being part of the H.O.M.E Program, 82% (n=14) of collaborative partners strongly agreed or agreed, and 18% (n=3) provided a neutral response. Collaborative partners noted that services are now more accessible and that clients experience decreased risk when they have somewhere they can go to address their needs.



As a Result of the H.O.M.E Program Approach, Collaborative Partners Are Working Differently to Support Highly Marginalized Individuals in London (n=17)

Approximately three-quarters (76%, n=13) of collaborative partners strongly agreed or agreed that as a result of the H.O.M.E Program approach, collaborative partners are working differently to support highly marginalized individuals in London. In total, 18% (n=3) of partners provided a neutral response and one partner (6%) disagreed with this statement.



How Collaborative Partners Are Working Differently

When asked how collaborative partners are working differently to support highly marginalized individuals, partners reported:

- There is a greater emphasis on client needs instead of system needs.
- Services are now flexible, proactive, and reaching people where they are instead of requiring individuals to seek help and overcome barriers to do so.
- Clients have more choice.
- Partners can help clients apply for ID.
- Service providers are now on the same page with respect to client care.
- Service providers have developed relationships that allow for direct referrals between agencies, which makes it quicker and easier for clients to access care.

> *"We now have faces to put to names, direct contacts, and are able to leverage our relationships to do direct referrals between agencies."*
>
> *- H.O.M.E Program Collaborative Partner*

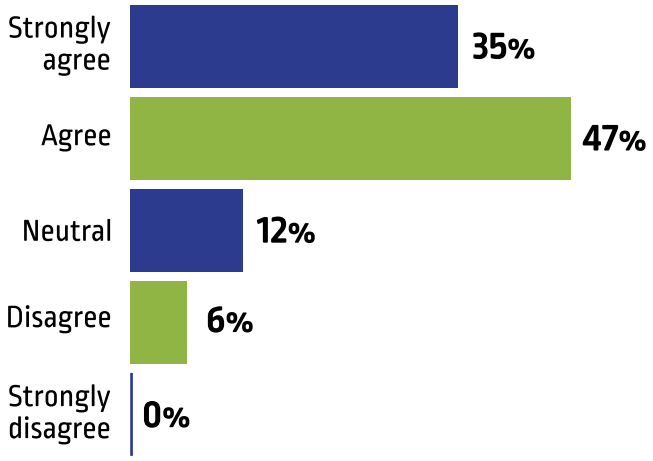
Collaborative partners also noted the COVID-19 pandemic has affected the program's ability to fully realize the ways service providers can work differently together (e.g. not being able to have wraparound services and outreach team members in the mobile clinic due to capacity limits), and that in order to be able to work differently to support highly marginalized individuals, strong communication between agencies and within the program team is critical.

SERVICE PROVIDER COMMUNICATION

Finding: There is improved communication between collaborative partners supporting highly marginalized individuals in London.

As a Result of the H.O.M.E Program Approach, the Level of Communication Between Service Providers Supporting Highly Marginalized Individuals in London Has Improved (n=17)

In total, 82% (n=14) of collaborative partners strongly agreed or agreed that the level of communication between service providers supporting highly marginalized individuals in London has improved as a result of the H.O.M.E Program approach. Twelve percent (n=2) of collaborative partners gave a neutral response and one partner (6%) disagreed with the statement.



Factors Impacting Service Provider Communication

Factors that have helped improve communication between service providers include:

- **Greater Familiarity With and Known Contacts at Other Agencies (n=4)** – Collaborative partners reported that having multiple agencies working together all in one place, having consistent members of the team, getting to know other service providers better, and having direct contacts at another agency have all made communication between service providers easier, which has resulted in improved referrals and follow-up between agencies.
- **Sharing Information and Talking Regularly (n=3)** – Collaborative partners are also sharing information about available resources and talking "person-to-person" more often, which has helped to improve communication and collaboration.

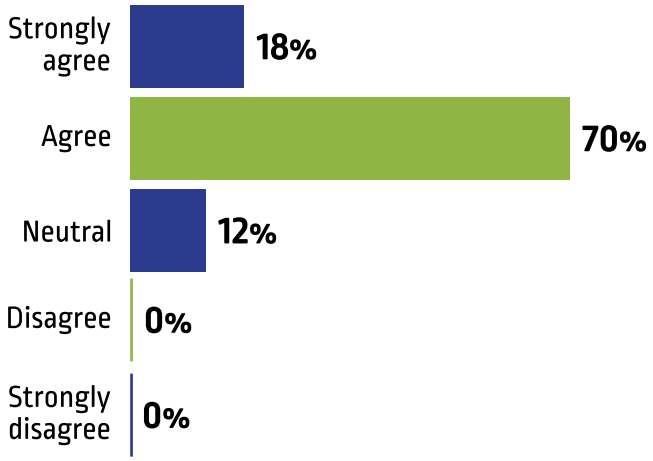
A few collaborative partners also noted communication between service providers and consistent use of program communication tools are areas that can continue to grow and improve, particularly to support communication between management and frontline teams, communication between the outreach and medical teams, and communication about any changes to the plan or staffing complement for the day.

RELATIONSHIPS BETWEEN SERVICE PROVIDERS

Finding: Collaborative partners have developed strong, trusting relationships with other service providers supporting highly marginalized individuals in London.

There Is a High Level of Trust Between Service Providers Involved in the H.O.M.E Program (n=17)

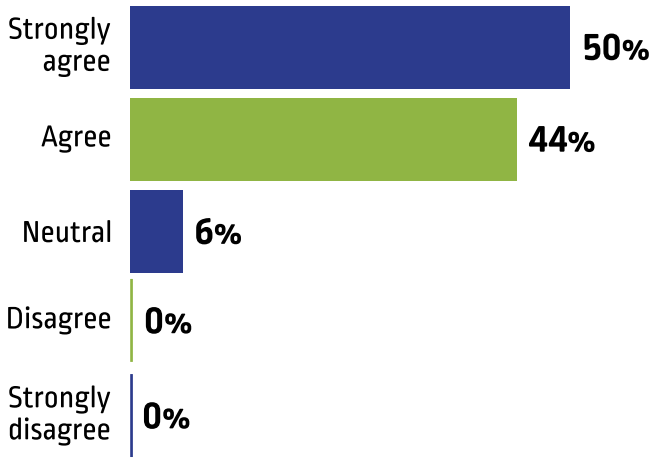
Overall, 88% (n=15) of collaborative partners strongly agreed or agreed there is a high level of trust between service providers involved in the H.O.M.E Program. Two partners (12%) provided a neutral response.



> *I like the knowledge exchange that happens between service providers and how that strengthens functional relationships and the system in general."*
>
> *- H.O.M.E Program Collaborative Partner*

My Relationships With Other Service Providers Have Deepened as a Result of Working Together Through the H.O.M.E Program (n=16)

Most collaborative partners, 94% (n=15) strongly agreed or agreed their relationships with other service providers have deepened as a result of working together through the H.O.M.E Program. One partner (6%) provided a neutral response to this statement, noting that based on their role, they have not had much engagement with other service providers.



SERVICE PROVIDER EXPERIENCE WITH PROGRAM IMPLEMENTATION

Finding: Collaborative partners are working and learning together to implement a multi-disciplinary, adaptive, mobile service model that is reducing barriers to services, meeting clients where they are, and providing essential and life-saving care.

What Has Gone Well With Program Implementation

The **5** most common successes collaborative partners reported experiencing with implementing the H.O.M.E Program are:

1. **Reducing Barriers and Improving Access to Services for Highly Marginalized Community Members (n=17)** – According to collaborative partners, the H.O.M.E Program has had great success bringing services to clients, reducing barriers to service, and reaching highly marginalized individuals who may be unable or are reluctant to access services elsewhere. As a result, clients have more immediate access to health care and wraparound services, have reduced risk of serious and life-threatening infections, and are building connections in the community that support follow-up and continued care.
2. **Developing Relationships With and Providing a Positive Experience for Clients (n=8)** – The H.O.M.E Program has also been successful in providing non-judgemental and empathetic care, helping clients feel more comfortable reaching out to and accessing services, reducing experiences of stigma for clients, helping clients feel valued and supported, and building trusting relationships with clients.
3. **Using a Multi-Disciplinary, Multi-Agency Approach (n=4)** – By applying a multi-disciplinary, multi-agency approach to service provision, clients can readily access a range of supports at one time in a single location.
4. **Partner Collaboration and Relationship Development (n=3)** – Collaborative partners noted there has been great collaboration between the partners involved in the program, which has supported the development of functional relationships between staff, across disciplines, and between agencies.
5. **Providing Life-Saving Intervention (n=2)** – The H.O.M.E Program has also provided life-saving care to individuals who would have died had they not received treatment from the program's medical team or a referral to another medical facility.

Factors that have supported program implementation and are critical to the success of the model include:

- **The Values Used to Provide Care (n=7)** – According to collaborative partners, working with organizations that share a similar value system and philosophy and are supportive of the approach being implemented has been important. Further, embodying the values of kindness and empathy, accessible, barrier-free, and non-judgemental care, and working to reduce stigma and experiences of trauma have been critical to the success of the H.O.M.E Program.
- **Providing a Mobile Service That Meets Clients Where They Are (n=5)** – Collaborative partners highlighted the H.O.M.E Program has been successful at operationalizing the approach of meeting clients where they're at by being mobile and "being out where the clients are" instead of requiring clients to come to service providers, which has been integral to the way the H.O.M.E Program operates and has created opportunities to build rapport with clients.
- **Collaboration Between Partner Agencies (n=5)** – Multi-agency collaboration has also been a key factor that has supported the implementation of the H.O.M.E Program. By coming together, it is easier for organizations to understand the work each community partner does and how their services can complement each other, create a cohesive team, refer clients to each other's services, and work together to support individuals who may not otherwise access care.
- **Rapport and Trust Building (n=4)** – Building trust and rapport not only with community members, but also between partners has been critical to the successful implementation of the H.O.M.E Program. Partners are able to build on the trust their colleagues have developed in the community to better connect with clients, and through developing rapport with each other, partners are better able to give and receive feedback, work through differences or challenges, and trust each other's knowledge and expertise.
- **The Ability to Adapt (n=3)** – Being adaptable to changing circumstances, "embracing outside-of-the-box thinking," and using the knowledge, insights, and lessons learned from both partners and clients to improve and grow have all been critical to the H.O.M.E Program's success.
- **A Passionate, Skilled, and Dedicated Team (n=2)** – It was also noted that the commitment of partners to supporting the community and developing a team that is passionate about this work and has the skills required to support individuals with complex needs are key factors that have supported the implementation of the program.

> *"The H.O.M.E Program has been a huge success. We have been able to engage with a population that wouldn't access health services any other way. We have built the trust of this population, and mainly through word of mouth, have treated and cared for hundreds of people."*
>
> *- H.O.M.E Program Collaborative Partner*

Challenges Experienced During Program Implementation

The **5** most common challenges collaborative partners reported experiencing with implementing the program include:

> *I think the secret sauce is being out where the clients are and not being stuck in a building. Being mobile and around where they gather the most. That's the biggest key."*
>
> *- H.O.M.E Program Collaborative Partner*

1. **Service Adjustments (n=13)** – There is only one Special Operations Bus available in the London community, and therefore, in alignment with the service agreement for the Special Operations Bus, the bus used by the H.O.M.E Program may be reassigned elsewehre in the community when required, such as in the event of an emergency situation. Collaborative partners noted that at times, reassignment of the bus and staffing challenges required the program to adjust its planned service operations, and that service consistency is critical when serving marginalized communities.
2. **Communication and Coordination (n=8)** – Communication and coordination within the program team was also noted as a challenge at times. For example, it was discussed that it can sometimes be challenging for the outreach and medical teams to stay connected. It was also noted that communicating service or schedule changes to clients can be a challenge when clients may not have access to a phone or the Internet, and that a communication strategy to provide clients and partner sites with timely updates would be valuable.
3. **The COVID-19 Pandemic (n=4)** – Collaborative partners reported the COVID-19 pandemic created some barriers in implementing the program, as it impacted staffing, the number of service providers that could be in the mobile clinic or at a partner site to conduct more in-depth client work, and the team's ability to access amenities while conducting outreach.
4. **Utilization of the Outreach Team (n=3)** – Collaborative partners identified there is potential for the outreach team to be utilized to a greater extent, and it was suggested that more members of the outreach team be trained in completing ID paperwork, opportunities for more in-depth provision of care by members of the outreach team be explored, and that outreach team members be equipped with more seasonal and basic needs items.
5. **Limited Time and Resources (n=3)** – A few collaborative partners also indicated there are limited resources and service hours to meet the high level of need in the community.

Opportunities for Improvement or Change

The **5** most common strategies collaborative partners reported could help improve the H.O.M.E Program include:

> *I feel this is a great initiative and would hope it could be expanded on."*
>
> *- H.O.M.E Program Collaborative Partner*

1. **Improved Communication and Coordination Amongst Partners (n=5)** – Strategies to further improve communication and coordination between partners included maintaining regular communication, having a consistent lead on the operations team to support allocation of tasks and responsibilities, creating more opportunities for team building and understanding of partners (e.g. their reporting requirements, roles, goals, etc.), and developing strategies to improve communication between the medical and outreach teams and between the leadership and operation-focused teams.
2. **Obtaining Dedicated Resources for the Program (n=4)** – Collaborative partners identified that having resources dedicated solely to the program (e.g. funding, a mobile clinic, etc.) would help to improve consistency of service delivery.
3. **Expanding Service Times and Locations (n=4)** – Collaborative partners recommended increasing the number of days mobile clinic services are available, re-assessing current service locations to ensure they are effective in meeting the need in the community, and identifying additional service locations to help further increase the program's reach in the community.
4. **Providing Additional Resources and Staff to Address the Community Need (n=3)** – In order to meet the demand for service and the need in the community, it was recommended by collaborative partners that additional resources such as snacks and basic needs items be provided to the outreach team, outreach team members be trained on how to complete ID paperwork, wraparound supports be incorporated in the mobile clinic, and additional healthcare staff be brought on to the program team.
5. **Communication to the Community About the Schedule (n=2)** – A couple of collaborative partners also suggested providing a schedule to clients online or in the form of a business card so they know when and where the mobile clinic will be in the community.

Advice for Others Looking to Implement a Similar Approach

The **4** most common pieces of advice collaborative partners would give to others are:

1. **Build Community Connections and Leverage Existing Relationships (n=7)** – Collaborative partners recommended developing strong connections in the community to create awareness about and support for the program (e.g. gathering basic needs items for clients from support networks), as well as leveraging existing relationships partners have with community members to facilitate warm transfers and connections to each other's agencies or services and help build trusting relationships with clients.
2. **A Multi-Agency Wraparound Approach Is Key (n=7)** – Working collaboratively across multiple agencies to create a shared vision and values and implement a multi-disciplinary, wraparound approach that leverages the skills and strengths of each partner has been identified by collaborative partners as a best practice model for reaching and providing critical services to marginalized individuals in the community.
3. **Ensure Adequate Resources and Guidelines Are in Place (n=4)** – Collaborative partners noted that securing adequate program funding for staffing and resources is critical to providing comprehensive, wraparound care that is "not just band-aids," that there is high demand for basic needs items such as food, drinks, and seasonal items, and that developing guidelines and protocols specific to the program help to empower staff in their work.
4. **This Work Requires a Passionate and Skilled Team (n=4)** – It was recommended that others looking to implement a similar program ensure they engage staff at both a leadership and frontline level that are passionate, skilled, and able to adapt quickly, and that peer workers or advisors be engaged as part of the team.

> *"Make sure you are prepared to provide primary care, follow-up, and wraparound supports, not just acute care/band-aids. Ensure you have a highly skilled, capable team that is capable of acting quickly and adapting to intense situations. Be prepared to continuously modify your approach and plan."*
>
> *- H.O.M.E Program Collaborative Partner*

Impact on Service Providers

The **3** most common types of impacts the H.O.M.E Program has had on collaborative partners include:

1. **Development of New Skills, Knowledge, and Experiences (n=7)** – Through participating in the H.O.M.E Program, collaborative partners have had the opportunity to gain new perspectives on their work, develop a better understanding of the clients they serve and the challenges they are experiencing, learn more about other agencies and the services they provide, and become more adaptable and empathetic in their work.
2. **An Improved Ability to Support Clients (n=5)** – By being able to provide an alternative approach to care, collaborative partners feel their work is more impactful, as they can connect with clients who may not typically access their services and are able to provide better support and facilitate connections to wraparound services for these clients.
3. **Development of Strong Working Relationships With Other Service Providers (n=3)** – Collaborative partners are also "working together more in building one another up to wrap support around clients," are sharing knowledge and expertise in order to meet the needs of the community, and feel more comfortable reaching out to one another.

> ***"Through outreach, it does give me the ability to connect with folks who don't typically access our services. I am able to provide further support and make connections to other departments as well."***
>
> *- H.O.M.E Program Collaborative Partner*

Impact on Partner Organizations

The **4** most common types of impacts the H.O.M.E Program has had on partner organizations are:

1. **An Improved Ability to Provide and Reduce Barriers to Care and Services (n=6)** – By being part of the H.O.M.E Program, partner organizations are finding new service solutions and ways to utilize the skills of their staff, are improving the way they provide care to marginalized individuals, are increasing client access to their services, and are developing trust in the community.
2. **Increased Staff Ability to Make Meaningful Connections With Clients (n=4)** – Through the H.O.M.E Program and "getting feet on the street," staff can more easily and meaningfully engage with the most marginalized members of the community and in ways they would not have been able to without the H.O.M.E Program, which has also helped clients get to know the partner organizations better.
3. **Information Sharing and Collaboration Between Colleagues and Agencies (n=4)** – Collaboration, networking with staff and agencies that work in other fields or have differing areas of expertise, and knowledge exchange have been key benefits of the H.O.M.E Program for partner organizations. Working more closely together has also improved the ability of partner organizations to offer clients connections to wraparound care.
4. **Greater Awareness of the Community Being Served (n=2)** – Being part of the H.O.M.E Program has also helped partner organizations increase their awareness and understanding of the community they serve, which can support greater empathy in the provision of services.

> *Improved access and gained trust in the community – this I feel has made clients feel they are worthy of care because we are willing to come to them. This shows them they too are important and worthy of high quality health care."*
>
> *- H.O.M.E Program Collaborative Partner*

STORIES OF IMPACT

This section of the report shares three stories highlighting the experiences of highly marginalized individuals in London, the services and supports offered by the program, and the impacts the H.O.M.E Program has had on clients.[6]

Anna Received Immediate Care to Address Life-Threatening Injuries

While accompanying two clients to the mobile clinic, members of H.O.M.E Program outreach team spotted Anna standing on a traffic island and stumbling into traffic. When the outreach workers approached Anna, she appeared groggy, had blood coming from her head, and kept telling them she just wanted to rest. The outreach workers spoke with Anna and told her about the services available from the H.O.M.E Program mobile clinic and encouraged Anna to get her head wound assessed. Anna agreed and was supported by the outreach workers to the mobile clinic. When Anna arrived on the mobile clinic, medical staff completed a full assessment. They found Anna had sustained life-threatening injuries and that there was spinal fluid leaking from her nose. EMS was called immediately to take Anna to the hospital. The medical team continued to support Anna until EMS arrived and explained the situation to them. Anna was taken to the hospital and members of the H.O.M.E Program team followed up to ensure she received the care she needed.

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

Gabe Was Supported to Return to the Hospital and Provided With Follow-Up Care

Gabe was in the hospital after being assaulted and receiving multiple stab wounds to his leg and lower back and fractures to his face. He was experiencing difficulty lifting his foot (foot drop) and had damage to his eye. Gabe needed multiple surgeries, but felt he was not receiving sufficient care for the opiate withdrawal he was experiencing, and he left the hospital against medical advice before all of his surgeries were finished. Gabe returned to the street where the H.O.M.E Program connected with him, and he was open to seeking medical support from the mobile clinic. After reviewing Gabe's charts and procedures from the hospital, the medical team determined he was at high risk if he remained on the street. The medical and outreach teams advocated for Gabe to stay at an emergency shelter in order to receive proper care. Further, they helped Gabe to return to the hospital for further care by creating an emergency safer supply plan to prevent Gabe from experiencing opiate withdrawal while in the hospital. With the support of the H.O.M.E Program, Gabe was able to access adequate shelter for the duration of his recovery, was provided with follow-up care three days a week, and was supported to attend follow-up medical appointments at the hospital. As a result, Gabe did not miss any of his appointments and healed in approximately six weeks.

Steph and Darien Received Support to Access Housing, Wound Care, and Wraparound Services

Steph and Darien were experiencing homelessness and were camping in a field with several other people. One day, an accident with a lighter led to a large tent fire, leaving Steph and Darien with burn wounds and no belongings. Steph and Darien attended the hospital to get their wounds checked. At the hospital, Steph's wounds were treated, but Darien was asked to remain overnight in the hospital for ongoing care. Due to COVID-19 policies, Steph was unable to stay with Darien and visiting was limited. Darien felt nervous leaving Steph alone on the street and in the elements, as they had lost their tent. As a result, Darien left the hospital against medical advice to make sure Steph was safe that night.

Members of the H.O.M.E Program outreach team encountered Steph and Darien the next day, learned what had happened, and encouraged them to attend the mobile clinic for medical care. After assessing Darien's wounds, the medical team discussed with Darien and the outreach team how serious his wounds were and that if he wasn't treated and able to access hygienic living conditions where he could receive aftercare, he could die. Together, the medical and outreach teams worked with Darien to determine what would help him feel most comfortable to stay in the hospital. Program staff secured a spot for Steph to stay in a shelter for women while Darien was in the hospital so that he didn't have to worry about her safety. The program team also provided support for Steph and Darien to remain in contact during Darien's hospital stay. Further, the outreach team worked with the City to secure a safe, clean space for Darien and Steph to stay once Darien was discharged from the hospital. Steph and Darien were very thankful for the care they received from the H.O.M.E Program team, are comfortable in their new unit, and have continued receiving wraparound supports from the H.O.M.E Program and partner agencies.

CONCLUSION

The data and findings presented in this report from the first year of the H.O.M.E Program demonstrate that the H.O.M.E Program and its application of a collaborative, multi-disciplinary, mobile service model is reducing barriers to primary care and wraparound supports for highly marginalized individuals in London, many of whom are not accessing care elsewhere.

Results indicate that by being mobile and bringing multiple service providers to where people are in the community, clients are better able to access and feel more comfortable engaging with the services they need. Further, service providers are able to make more meaningful connections with clients, provide them with follow-up care, and connect them to additional services and resources. Findings also show that by being where clients are, the H.O.M.E Program team is able to address life-threatening issues in the moment, and where appropriate, divert individuals from accessing emergency services.

By providing harm reduction equipment and education, H.O.M.E Program clients are also increasing their use of harm reduction strategies. Findings also indicate that because of the services and supports clients are accessing through the H.O.M.E Program, they are experiencing improved well-being.

The H.O.M.E Program has not only made a positive difference for highly marginalized individuals in the community, but it has also had positive impacts on collaborative partners and the provision of services. Specifically, the H.O.M.E Program has facilitated the development of strong, trusting relationships between service providers and has improved service coordination and communication between collaborative partners so they can better meet the needs of the community they serve.

The findings presented in this report will be used to guide the ongoing implementation of and improvements to the H.O.M.E Program. Further, lessons and insights from the evaluation of the H.O.M.E Program can be used to inform new and innovative approaches for providing primary care and wraparound services to highly marginalized individuals.

H.O.M.E

Health Outreach Mobile Engagement

H.O.M.E Program Year 1 Evaluation Report

January 11, 2021 – January 10, 2022

Canadian Mental Health Association
Thames Valley
Addiction and Mental Health Services

London InterCommunity Health Centre

Regional HIV/AIDS Connection

Middlesex-London Paramedic Service

London CARES
Homeless Response Services